ambetter. FROM arizona complete health

Your 2020 Member Handbook

Everything you need to know about your plan

For more information, visit Ambetter.AZcompletehealth.com

If this information is not in your primary language, please call 1-866-918-4450 (TTY: 711)

ambetter. FROM | arizona complete health

Welcome to Ambetter from Arizona Complete Health!

Thank you for choosing us as your health insurance plan. We're excited to help you take charge of your health and to help you lead a healthier, more fulfilling life.

As our member, you have access to lots of helpful services and resources. This member handbook will help you understand all of them. Inside, you'll find important information about:

- How your plan works
- Payment information
- My Health Pays®
- Where to go for care
- Pharmacy benefits
- TeleHealth
- And much more!

YOUR HEALTH IS OUR PRIORITY.

If you have questions, we're always ready to help. And don't forget to check out our online video library at Ambetter.AZcompletehealth.com. It's full of useful information.

Member Services:
1-866-918-4450 (TTY: 711)

Ambetter.AZcompletehealth.com

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Member Handbook Overview

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To request print versions of all informational materials, you can contact Member Services at 1-866-918-4450 (TTY: 711)

The Resources You Need. Right Here.

Understanding your health insurance coverage is important. This member handbook explains everything you need to know — so take a look! For information about your specific plan's covered benefits and cost sharing, check out your *Summary of Benefits* and *Evidence of Coverage*. You can find both in your online member account.

This is your Member Handbook.
Your Member Handbook provides you with a high-level overview on how to get the most out of your plan. And it helps you better understand your health insurance coverage and services available to you.

Find your Member Handbook at Ambetter.AZcompletehealth.com under "For Members", "Member Materials and Forms". Or it is also available to you when you login to your online member account under "Reference Materials".

Login to your online member account at Member.AmbetterHealth.com

Summary of Benefits
Your *Summary of Benefits* is a high-level summary of the benefits your plan covers and how much you will have to pay for them.

Evidence of Coverage
Your *Evidence of Coverage* is a detailed listing of the benefits your plan covers, as well as any exclusions the plan has.

Explanation of Benefits (EOB):
An *Explanation of Benefits* (EOB) is a statement that we send to members to explain what medical treatments and/or services we paid for on behalf of a member. This shows the amount billed by the provider, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy. We will send an EOB to a member after we receive and adjudicate a claim on your behalf from a provider. If you need assistance interpreting your *Explanation of Benefits*, please contact Member Services at 1-866-918-4450 (TTY: 711).

How To Contact Us

How To Contact Us

Ambetter from Arizona Complete Health
1870 W Rio Salado
Suite 2A
Tempe, AZ 85281

If you want to talk, we're available
Monday through Friday, 8 a.m. to 8 p.m. MST.

Member Services	1-866-918-4450
Fax	1-866-687-0518
TTY:	711
Make a Payment	1-866-918-4450
Behavioral Health Services	1-866-918-4450
24/7 Nurse Advice Line	1-866-918-4450
Complaints and Grievances	1-866-918-4450
Emergency	911
Website	Ambetter.AZcompletehealth.com

When you call, have these items ready:

- Your ID
- Your claim number or invoice for billing questions

Interpreter Services

If you don't feel comfortable speaking English, we provide free interpreter services.

Please call Member Services at 1-866-918-4450 (TTY: 711) for free interpreter services as needed.

How Your Plan Works

Learn about how to get the most out of your plan. Set up your online member account to get started.

Want more information about our service area and in-network providers? Visit Ambetter.AZcompletehealth.com

So You Have Health Insurance — Now What?

Having health insurance is exciting. To get the most out of your plan, complete this simple checklist. If you need assistance, call Member Services at 1-866-918-4450 (TTY: 711). We're available Monday through Friday, 8 a.m. to 8 p.m. MST.

1. Set up your secure online member account. Do this by visiting the "For Members" page on Ambetter.AZcompletehealth.com. Your member account stores all of your plan's benefits and coverage information in one place It gives you access to your *Summary of Benefits* and *Evidence of Coverage*, claims information, this member handbook and more.

2. Complete your online Ambetter Wellbeing Survey within the first 90 days of your membership. All you have to do is log in to your online member account. Completing this survey helps you earn 500 points in myhealthpays® rewards! See page 22 to learn more about the myhealthpays® program.

3. Enroll in automatic bill pay. Call us or log in to your online member account to sign up. Automatic bill pay automatically withdraws your monthly premium payment from your bank account. It's simple, helpful, convenient and secure.

4. Pick your primary care provider (PCP). Just log in to your member account and view a list of Ambetter providers in your area by using the *Provider Directory* available on our website. Remember, your PCP, also known as a personal doctor, is the main doctor you will see for most of your medical care. This includes your checkups, sick visits and other basic health needs.

5. Schedule your annual wellness exam with your PCP. After your first checkup, you'll earn 500 points in myhealthpays® rewards! And anytime you need care, call your PCP and make an appointment!

If you have questions about paying your bill, give billing services a call at 1-866-918-4450 (TTY: 711) .

How Can I Pay My Monthly Bill?

1. **Pay online (Our recommendation!)**
   a. Quick Payment: https://centene.softheon.com/Equity/#/search. Create your online member account on Ambetter.AZcompletehealth.com and enroll in automatic bill payment. You can set up automatic bill pay using your credit card, prepaid debit card, bank debit card or bank account.
   b. You can also pay by credit card, prepaid debit card or bank debit card. Just follow the "pay online" instructions at Ambetter.AZcompletehealth.com.
2. **Pay by phone**
   a. Pay by Automated Phone. Call us at 1-844-PAY-BETTER (729-2388) and use our Interactive Voice Response (IVR) system. It's quick and available 24/7!

Or

   b. Call billing services at 1-866-918-4450 (TTY: 711) between 8 a.m. and 8 p.m. MST. You can pay using our Interactive Voice Response (IVR) system or by speaking to one of our billing service representatives.

3. **Pay by mail**
   a. Send a check or money order to the address listed on your billing invoice payment coupon. **Be sure to mail your payment at least seven to 10 days prior to your premium payment due date. Remember to write your member ID number on the check or money order and detach the payment coupon from the billing invoice and mail with your payment.**
   b. Mailing to the correct address will ensure your payments are processed in a timely manner.

Ambetter from Arizona Complete Health
Attn: Billing Services
PO Box 748701
Los Angeles, CA 90074-8701

Sign up for Paperless Billing to receive your monthly invoices online.

What Happens If I Pay Late?

Your bill is due before the first day of every month. For example, if you are paying your premium for June, it will be due May 31.

If you don't pay your premium before its due date, you may enter a grace period. This is the extra time we give you to pay. During a grace period, we may hold — or pend — payment of your claims. During your grace period, you will still have coverage. However, if you don't pay before a grace period ends, you run the risk of losing your coverage. Refer to your *Evidence of Coverage* for grace period details.

Have total or partial hearing loss? Call TTY: 711 or visit Ambetter.AZcompletehealth.com

If you need help deciding where to go for care, call our 24/7 nurse advice line at 1-888-926-5057 (TTY:711). In an emergency, call 911 or head straight to the nearest emergency room. Seek ER services only if your life is at risk and you need immediate, emergency medical attention.

Member Services

We want you to have a great experience with Ambetter. Our Member Services Department is always here for you. They can help you:

- Understand how your plan works
- Learn how to get the care you need
- Find answers to any questions you have about health insurance
- See what your plan does and does not cover
- Pick a PCP that meets your needs
- Get more information about helpful programs, like Care Management
- Find other healthcare providers (like in-network pharmacies and labs)
- Request your member ID or other member materials

You must contact the Health Insurance Marketplace to:

- Update your enrollment information such as your date of birth, address, or when reporting an income or life change.
- End your coverage with Ambetter.

Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325). When you're connected, be ready to provide your state and then ask for a representative to help you.

24/7 Nurse Advice Line

Our free 24/7 nurse advice line makes it easy to get answers to your health questions. You don't even have to leave home! Staffed by registered nurses, our 24/7 nurse advice line runs all day, every day. Call 1-866-918-4450 if you have questions about:

- Your health, medications or a chronic condition
- Whether you should go to the emergency room (ER) or see your PCP
- What to do for a sick child
- How to handle a condition in the middle of the night
- Accessing our online health information library

Membership & Coverage Information

Be aware of important information on keeping your coverage. You can always access helpful resources and information about your plan. Visit Ambetter.AZcompletehealth.com and take charge of your health.

Important Coverage Details

Your Ambetter coverage is good for as long as you continue to pay your premium and meet the eligibility requirements* of the Health Insurance Marketplace.

*In order to maintain Eligibility with a marketplace plan you must:

- Live in the United States
- Be a legal, U.S. Citizen or lawfully present immigrant in the U.S., and Arizona Resident within the Ambetter coverage area (lawfully present)
- Not be incarcerated, institutionalized, or emancipated
- Not be covered by Medicaid, Medicare, Medicare-Medicaid Plan or similar State or Federal Programs

We do not discriminate against your income, health history, physical or mental condition, previous status as a member, pre-existing conditions and/or expected health or genetic status or on the basis of race, color, national origin, sex, religion, sexual orientation, gender identity, age, disability, or housing status.

If you need information on Dependent Member Coverage, refer to your *Evidence of Coverage*.

Health Savings Plan (HSA)

For information about HSA contribution Limits, check out https://www.irs.gov/pub/irs-drop/rp-17-37.pdf

If you are enrolled in an HSA compatible -qualified high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum will work differently. In HDHPs linked to HSAs, an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met.

The Individual Deductible in an HSA family plan must be at least $2,800 in 2020 under IRS rules. For an individual to qualify, the plan must have an annual deductible of $1,400 for self-only coverage. The Out-of-Pocket Maximum includes the Deductible, Copayments and Coinsurance. In a self-only plan, the Member is responsible for all applicable Deductibles, Copayments and Coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all Deductibles, Copayments and Coinsurance up to the Individual Out-of-Pocket Maximum, until the combined Deductibles, Copayments and Coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined Deductibles, Copayments and

Health Savings Plan (HSA) (Continued)

Coinsurance equal the family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.

If you are unsure whether you are enrolled in an Ambetter HSA - HDHP plan type of HDHP, please call Member Services.

For information about HSA contribution Limits, check out https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25.

Finding The Right Care

We're proud to offer you quality service. Our local provider network is the group of doctors, hospitals and other healthcare providers who have agreed to provide you with your healthcare services.

To search our *Provider Directory*, visit Ambetter.AZcompletehealth.com/findadoc and use our ***Find a Provider*** tool. This tool will have the most up-to-date information about our provider network, including information such as name, address, telephone numbers, hours of operation, professional qualifications, specialty, and board certification. It can help you find a primary care provider (PCP), pharmacy, lab, hospital or specialist. You can narrow your search by:

- Provider specialty
- ZIP code
- Gender
- Languages spoken
- Whether or not they are currently accepting new patients

For more information about a provider's medical school and residency, call Member Services.

A Provider Directory is a listing of providers near you. If you would like a printed copy of this listing, please call Member Services at 1-866-918-4450 (TTY: 711).

In-Network or Network Provider means a physician or provider who is identified in the most current list for the network shown on your identification card.

Out-of-Network or Non-Network Provider means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage (EOC)*.

Remember to select an in-network PCP! Check out our *Provider Directory* for a full list of your options and their contact information. It's on the ***Find a Provider*** page of Ambetter.AZcompletehealth.com/findadoc.

Refer to your *Evidence of Coverage* for more information on your Provider Directory.

Every time you receive care, make sure to stay within the Ambetter network.

Refer to the "Words to Know" section to learn more about Copays, Coinsurance and Deductibles.

Your Ambetter Member Welcome Packet

When you enroll with Ambetter, you will receive a Member Welcome Packet. Your Welcome Packet includes basic information about the health plan you selected. You will receive your Welcome Packet before your Ambetter health coverage begins.

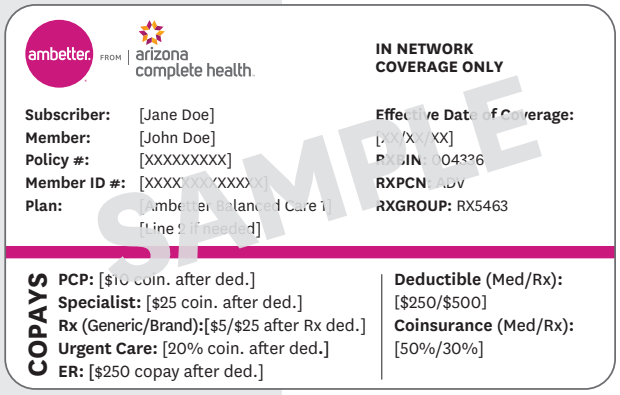
Your Ambetter Member ID

Your member ID is proof that you have health insurance with us. It may seem small, but it's very important. Here are some things to keep in mind:

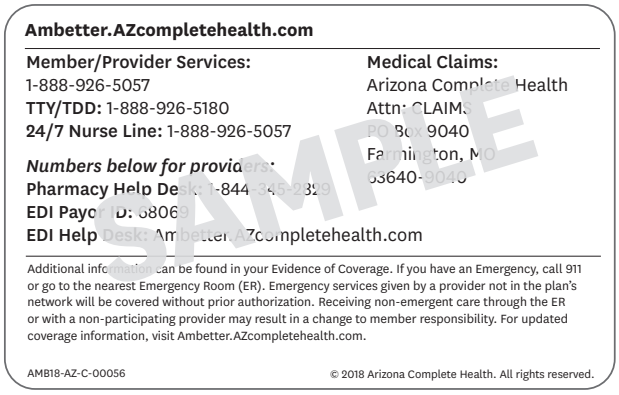
- Keep this card with you at all times
- You will need to present this card anytime you receive healthcare services
- You will receive your Member ID(s) before your Ambetter health coverage begins. If you don't get your member ID before your coverage begins, call Member Services at 1-866-918-4450 (TTY: 711). We will send you another card.
- You will not receive your Welcome Packet and Member ID(s) until your binder payment and first month's premium are paid in full.

To download your Digital ID, request a Replacement ID, or need a temporary ID, please log in to your secure member account.

Here is an example of what a member ID typically looks like.



Front



Back

Refer to your *Evidence of Coverage* for information on Dependent Member Coverage.

Visit us online at Ambetter.AZcompletehealth.com

Our website helps you get the answers you need to get the right care, the right way, including an online member account for you to check the status of your claim, view your *Evidence of Coverage (EOC)* or understand your out-of-pocket costs, copays and progress towards meeting your annual deductible.

Get Online And Get In Control

Did you know you can always access helpful resources and information about your plan? It's all on our website! Visit Ambetter.AZcompletehealth.com and take charge of your health.

On our website, you can:

- Find a PCP
- Locate other providers, like a pharmacy
- Find health information
- Learn about programs and services that can help you get and stay healthy.

Use your online member account to:

- Pay your monthly bill
- Print a temporary ID or request a new one
- View your claims status and payment information
- Change your PCP
- Find pharmacy benefit information
- Send us a secure email
- Read your member materials (your *Evidence of Coverage*, *Summary of Benefits*, this handbook)
- Complete your Wellbeing Survey
- Contact Nurse via web
- Review out-of-pocket costs, copays and progress toward deductible

Covered Services | Medical Service Expense Benefits

Our plans provide coverage for a wide range of healthcare services. Understand your benefits and coverage included in your Ambetter health plan.

What Does Your Plan Cover?

We want to meet your healthcare needs. So our plans provide coverage for a wide range of medical and behavioral health services.

For a service to be covered and eligible for reimbursement, it must be:

- Described in your *Evidence of Coverage*
- Medically necessary
- Prescribed by your treating provider or primary care provider (PCP)
- Authorized by us (when required)
  - For example:
    - » Services from or visits to an out-of-network provider
    - » Certain surgical procedures
    - » Inpatient admissions

A complete listing of preventive care services, recommendations and guidelines can be found at www.Healthcare.gov/center/regulations/prevention.html.

The Ambetter Drug List has a complete list of all covered medications. Read your copy at Ambetter.AZcompletehealth.com/resources/pharmacy-resources.html.

Prior Authorization

Prior authorization means a service needs to be approved by Ambetter before you go to the provider.

Want to see if a service needs authorizing or check on the status of a service that was submitted for authorization? Call Member Services at 1-866-918-4450 (TTY: 711). If you do not obtain prior authorization before you receive the services, you may be held responsible for total payment.

You can find information about your specific copayments, cost sharing and deductible in your *Summary of Benefits*. For a list of exclusions, refer to your *Evidence of Coverage*. Your *Summary of Benefits* and *Evidence of Coverage* can be found online. Just log in to your online member account.

What's Not Covered?

We offer many important wellness benefits and health screenings. However, there are still some things that your coverage doesn't include.

Refer to your *Evidence of Coverage* to get the details for each covered service. Your *Evidence of Coverage* has a full list of coverage limitations and exclusions, plus a list of which healthcare and preventive services are covered on your particular plan.

Note: If a service is not specifically listed as covered, then it is not covered under the Ambetter Health Plan.

To see details of all your preventive care services and other covered services refer to your *Evidence of Coverage*.

Every time you receive care, make sure to stay within the Ambetter network. Remember to use an in-network provider when you get your preventive care services. Use our ***Find a Provider*** tool on Ambetter.AZcompletehealth.com to see if a provider is in-network.

How To Get Medical Care When You're Out Of Town

When you're outside of the service area, we do not cover your routine or maintenance care. However, we do cover emergency care outside of your service area.

If you are temporarily out of the area and have a medical or behavioral health emergency, call 911 or go to the nearest emergency room. Be sure to call us and report your emergency within one business day. You don't need prior approval for emergency care.

You may have additional financial responsibility for non-emergent services if you are out of network. Refer to your *Evidence of Coverage* or call Member Services at 1-866-918-4450 (TTY: 711) for more information.

Use our Find a Provider tool at Ambetter.AZcompletehealth.com to search for in-network providers in other areas.

Provider Billing: What To Expect

After receiving medical care, you may get a bill from your provider. Providers can only bill you for your share of the cost of covered services. This includes your deductible, copayment, cost sharing percentage, and any unauthorized or non-covered services. If you receive a bill from a provider that does not reflect your cost share as listed in your *Summary of Benefits* or your *Explanation of Benefits*, please contact us right away. You should not be balanced billed by In-Network Providers for **Covered Services** beyond your responsibility.

In cases where a service is denied for reasons that are your responsibility, such as not being eligible on the date of service, or obtaining non-emergent services at a non-network provider without proper authorization, you may be billed for such denials. In addition, these expenses will not be credited to your deductible or maximum out of pocket cost share.

It is a good idea to keep track of your expenses. For your convenience, you may log in to our member secure website at Ambetterhealth.com and then select the Benefits tab where your year to date cost share is displayed. This information is current within 48 hours of claim payment and is the same information available to our member and provider service agents. The cost share is credited as claims are paid, not by date of service.

You can also refer to our Transparency Notice by visiting Ambetterhealth.com and selecting Member Materials and Forms. If you have questions about a bill or statement that you received, please contact us.

How To Submit A Claim For Covered Services

Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for covered services. This usually happens if:

- Your provider is not contracted with us
- You have an out-of-area emergency

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your deductible, copayment or cost sharing to reimburse you.

To request reimbursement for a covered service, you need a copy of the detailed claim from the provider. You also need to submit an explanation of why you paid for the covered services along with the member reimbursement claim form posted on the health plan website under "Member Resources". Send this to us at the following address:

Ambetter from Arizona Complete Health
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Our Transparency Notice provides additional information on the claims submission process. It's located at Ambetter.AZcompletehealth.com under "Member Materials and Forms"

Refer to your *Evidence of Coverage* to get the details for each covered service. Some have certain exclusions and limitations.

We only cover in-network services (unless it's an emergency service). If you go to an out-of-network provider without prior approval, you will be responsible for all costs associated with those services. Make sure your providers are in-network by using our ***Find a Provider*** tool on Ambetter.AZcompletehealth.com

When Do You Need A Referral?

If you have a specific medical problem, condition, injury or disease, you will probably need to see a specialist. A specialist is a provider who is trained in a specific area of healthcare. To see a specialist, you may need get a referral from your PCP.

Your benefits may be reduced or not covered if referral requirements are not met.

A prior authorization may be required for certain services. Refer to your *Evidence of Coverage* for more information.

Your Primary Care Provider

When you see your PCP, always remember to bring your member ID and a photo ID!

Seeing your PCP for regular checkups helps you find problems early and qualifies you for a reward on your myhealthpays® account.

When you became a member, you may have selected your PCP. If you didn't, we may assign you to a PCP. You can change your PCP at any time. To learn more, visit Ambetter.AZcompletehealth.com

To learn more about a specific PCP, call 1-866-918-4450 (TTY: 711). You can also see our provider list on the ***Find a Provider*** page at Ambetter.AZcompletehealth.com

What's A Primary Care Provider?

Your primary care provider (PCP) is your main doctor. They are also known as your personal doctor. Your PCP is the person you should see for all aspects of your healthcare — from your preventive care to your basic health needs and more. When you're sick and don't know what to do, you should contact your PCP.

Having a PCP is important. We encourage you to choose a PCP for your primary and preventive care needs. You can choose your in-network PCP by using our online **Find a Provider** tool. After you pick a PCP, schedule a preventive care visit. Remember, you should get to know your PCP and establish a healthy relationship — get started today!

Your PCP will:

- Provide preventive care and screenings
- Give you regular physical exams as needed
- Conduct regular immunizations as needed
- Deliver timely service
- Work with other doctors when you receive care somewhere else
- Coordinate specialty care with Ambetter in-network specialists
- Provide any ongoing care you need
- Update your medical record, which includes keeping track of all the care that you get from all of your providers
- Treat all patients the same way with dignity and respect
- Make sure you can contact him/her or another provider at all times
- Discuss what advance directives are and file directives appropriately in your medical record

Picking The Right PCP

You can select any available PCP in our network. The choice is up to you! You will be able to choose from:

- Family practitioners
- General practitioners
- Internal medicine
- Nurse practitioners*
- Physician assistants
- Obstetricians/gynecologists
- Pediatricians (for children)

*If you choose a nurse practitioner as your PCP, your benefit coverage and copayment amounts are the same as they would be for services from other in-network providers. See your *Summary of Benefits* for more information.

Choosing An Adult PCP

As a young adult, having your own healthcare plan means you'll want to make healthy choices. Start by choosing an adult primary care provider (PCP) or other healthcare provider. Your adult PCP will replace your pediatrician. So you can take charge of your health with a yearly wellness exam, an annual flu vaccination and other important healthy habits. Call Member Services at 1-866-918-4450 and let us help you find your adult PCP today!

Making An Appointment With Your PCP

To make an appointment with your PCP, call his/her office during business hours and set up a time and date. If you need to cancel or change your appointment, call 24 hours ahead of time. At every appointment, make sure you bring your member ID and a photo ID.

How long should it take to get an appointment?

It's important for you to be able to schedule appointments when you need medical care. That's why Ambetter has developed a guide to help you understand what to expect when you need an appointment.

- Routine PCP Visits – within 15 calendar days
- Urgent PCP Visits – within 48 hours of request
- Adult Sick Visits – within 48 hours of request

You should not have to wait more than 30 minutes for a scheduled appointment. If the waiting time is expected to exceed 30 minutes, the office should offer you the choice of waiting or rescheduling the appointment.

Care Around The Clock

Sometimes, you need medical help when your PCP's office is closed. If this happens, don't worry. Just call our 24/7 nurse advice line at 1-866-918-4450 (TTY: 711). A registered nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

We encourage you to always see a provider who is in network with Ambetter. If you have a problem finding an in-network provider, please call us at 1-866-918-4450 (TTY: 711). Please refer to your *Summary of Benefits* to make sure that you understand you may be responsible for all costs associated with care if you choose to see providers outside of our network.

Are you having trouble getting an appointment with your PCP? Do you need help with your follow-up care? Call Member Services: 1-866-918-4450 (TTY: 711). We're here to help.

You can call your PCP's office for information on receiving after-hours care in your area. If you have an urgent medical problem or question and cannot reach your PCP during normal office hours, you can call the 24/7 Nurse Advice Line at 1-866-918-4450 (TTY: 711). If you have an emergency, call 911 or go to the nearest emergency room.

If you are not sure where to go for care, call your PCP. If your PCP is not available, call the Nurse Advice Line or check Ambetter.AZcompletehealth.com for where to go for care.

Ambetter Telemedicine

Ambetter Telemedicine is our 24-hour access to in-network Ambetter healthcare providers when you have a non-emergency health issue. It's available to use when you're at home, in the office or even on vacation.

Before you start using Ambetter Telemedicine, you will need to set up your account at AmbetterTelehealthAZ.com.

Contact Ambetter Telemedicine phone or video when you need medical care, a diagnosis or a prescription. You can choose to receive immediate care or schedule an appointment for a time that fits in your schedule.

Contact Ambetter Telemedicine for illnesses such as:

- Colds, flu and fevers
- Rash, skin conditions
- Sinus problems, allergies
- Ear Infections
- Upper respiratory infections, bronchitis
- Pink Eye

Ambetter does not provide medical care. Medical care is provided by individual providers through Teladoc Health.

To find another provider or specialist in our network, check out our provider list on the ***Find a Provider*** page at Ambetter.AZcompletehealth.com/findadoc

Selecting A Different PCP

We want you to be happy with the care you receive from our providers. So if you would like to change your PCP for any reason, visit Ambetter.AZcompletehealth.com. Please remember, you can switch your PCP only one time per month. Log in to your online member account and follow these steps:

1. **Click on the "My Health" heart icon on your account home page.**
2. **On your current health overview page, click "Choose Provider."**
3. **Pick a PCP from the list. Make sure you select a PCP who is currently accepting new patients.**

To learn more about a specific PCP, call 1-866-918-4450 (TTY: 711). You can also visit Ambetter.AZcompletehealth.com to see our provider list on our **Find a Provider** web page.

*If you choose a nurse practitioner or physician assistant as your PCP, your benefit coverage and copayment amounts are the same as they would be for services from other participating providers. Review your *Summary of Benefits* for more information.

What Happens If Your Provider Leaves Our Network?

Please contact Member Services at 1-866-918-4450 (TTY: 711) as soon as you know that your PCP is leaving. We can help you.

If you have a specialist that disenrolls from our provider network, please call Member Services at 1-866-918-4450 (TTY: 711). We will work with you to help you.

There are special circumstances which will allow you to continue treatment for a limited time, with a provider who has left the network. You will be able to do this as long as your provider's termination isn't for quality-related reasons. Please refer to your *Evidence of Coverage* for details on special circumstances.

What About Providers That Aren't In-Network?

You should always try to see providers that are in our network.

In-Network or Network Provider means a physician or provider who is identified in the most current list for the network shown on your identification card.

Out-of-Network or Non-Network Provider means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage (EOC)*.

Refer to your *Evidence of Coverage* for details regarding out-of-network providers, care, services and expenses.

Where To Go For Care

Get The Right Care At The Right Place

When you need medical care, you need to be able to quickly decide where to go or what to do. Get to know your options! They include:

1. **Calling our 24/7 nurse advice line**
2. **Making an appointment with your primary care provider (PCP)**
3. **Visiting an urgent care center**
4. **Going to the emergency room (ER)**

Your decision will depend on your specific situation. The next section describes each of your options in more detail, so keep reading.

And remember — always make sure your providers are in-network. Using in-network providers can save you money on your healthcare costs. Every time you receive medical care, you will need your member ID.

What To Do If Your Condition Isn't Life Threatening

Call our 24/7 nurse advice line or visit your PCP.

Call our 24/7 nurse advice line anytime: 1-866-918-4450 (TTY: 711).

Call our 24/7 nurse advice line if you need:

- To know whether you should seek medical treatment immediately
- Help caring for a sick child
- Answers to questions about your health

Visit your PCP if you need:

- Help with medical problems such as colds, flus and fevers
- Treatment for an ongoing health issue like asthma or diabetes
- A general checkup
- Vaccinations
- Advice about your overall health
- Preventive Care or Screenings

Have your member ID and photo ID ready. You will need them whenever you receive any type of care.

Urgent care is not emergency care. Only go to the ER if your doctor tells you to or if you have a life-threatening emergency.

Always make sure your providers are in-network. Using in-network providers can save you money on your healthcare costs.

If you need help deciding where to go for care, call our 24/7 nurse advice line at 1-866-918-4450 (TTY: 711). In an emergency, call 911 or head straight to the nearest emergency room. Seek ER services only if your life is at risk and you need immediate, emergency medical attention.

When To Go To An Urgent Care Center

An urgent care center provides fast, hands-on care for illnesses or injuries that aren't life threatening but still need to be treated within 24 hours. Typically, you will go to an urgent care if your PCP cannot get you in for a visit right away.

Common urgent care issues include:

- Sprains
- Ear infections
- High fevers
- Flu symptoms with vomiting

If you think you need to go to an urgent care center, follow these steps:

- Call your PCP. Your PCP may give you care and directions over the phone or direct you to the right place for care.
- If your PCP's office is closed, you can do one of two options:
  1. Visit our website, Ambetter.AZcompletehealth.com/findadoc, type in your ZIP code and click "Detailed Search". In the "Type of Provider" dropdown, select, "Urgent Care AND Walk-in-Clinics" and then click the green "Search" bar.
  2. Call our 24/7 nurse advice line at 1-866-918-4450 (TTY: 711). A nurse will help you over the phone or direct you to other care. You may have to give the nurse your phone number.

Check your *Summary of Benefits* to see how much you must pay for urgent care services.

After your visit, let your PCP know you were seen at an urgent care and why.

When To Go To The ER

Anything that could endanger your life (or your unborn child's life, if you're pregnant) without immediate medical attention is considered an emergency situation. Emergency services treat accidental injuries or the onset of what appears to be a medical condition. We cover emergency medical and behavioral health services both in and out of our service area. We cover these services 24/7.

Please note some providers that treat you within the ER may not be contracted with Ambetter. If you go to an in-network facility as a result of an emergency and the provider that treats you is not an in-network provider, it is not your fault. You cannot be balance billed because you did not choose the providers. If you are balance billed for the covered services, please contact Member Services.

It is a good idea to ask your providers if they are in-network with Ambetter so you don't receive unexpected charges.

Refer to your *Evidence of Coverage* for more information on provider billing and balance billing.

When To Go To The ER (Continued)

Go to the ER if you have:

- Broken bones
- Bleeding that won't stop
- Labor pains or other bleeding (if you're pregnant)
- Severe chest pains or heart attack symptoms
- Overdosed on drugs
- Ingested poison
- Bad burns
- Shock symptoms (sweat, thirst, dizziness, pale skin)
- Convulsions or seizures
- Trouble breathing
- The sudden inability to see, move or speak
- Gun or knife wounds

Don't go to the ER for:

- Flus, colds, sore throats or earaches
- Sprains or strains
- Cuts or scrapes that don't require stitches
- More medicine or prescription refills
- Diaper rash

What if you need Emergency Care out of our service area?

Our plan will pay for emergency care while you are out of the county or state. If you go to an out-of-network ER and you aren't experiencing a true emergency you may be responsible for any amounts above what your plan covers. If you go to an in-network facility as a result of an emergency and the provider that treats you is not an in-network provider, it is not your fault. You cannot be balance billed because you did not choose the providers. If you are balance billed for the covered services, please contact Member Services. Those additional amounts could be very large and would be in addition to your plan's cost sharing and deductibles.

When a covered service is received from a non-network provider and a network exception (as defined below) exists or the non-network provider is approved or authorized by us, the eligible service expense is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge), or (2) the amount accepted by non-network provider (not to exceed the provider's charge). In either circumstance, you will not be billed for the difference between the negotiated or accepted fee, as applicable, and the provider's charge. A "network exception" occurs when you receive covered service from a non-network provider either because there is no network provider accessible or available that can provide such services to you timely, or we determine it is in your best interest to receive care from a non-network provider.

For further details, please refer to the Eligible Service Expense or Allowable Expense definition located in the *Evidence of Coverage* under the Definition Section.

Learn more about your options https://Ambetter.AZcompletehealth.com/resources/handbooks-forms/where-to-go-for-care.html

Health & Wellness Programs

We Make It Easier To Manage Your Health

We are committed to providing quality healthcare for you and your family. We want to get you healthy, keep you healthy and help you with any illness or disability.

To help you manage your health, we provide several programs: Care Management, Health Management and Start Smart for Your Baby®, our healthy pregnancy and family planning program. These helpful programs are all included in your plan.

Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. Our Care Management services can help with complex medical or behavioral health needs. If you qualify for Care Management, we will partner you with a care manager. Care managers are registered nurses or social workers that are specially trained to help you:

- Better understand and manage your health conditions
- Coordinate services
- Locate community resources

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your primary care provider (PCP) and managing providers to develop a care plan that meets your needs and your caregiver's needs.

If you think you could benefit from our Care Management program, please call Member Services at 1-866-918-4450 (TTY: 711).

Care Management programs help you manage complex health conditions. Disease Management programs help you manage a specific health condition. Have more questions? Call Member Services: 1-866-918-4450 (TTY: 711).

Health Management Programs

Healthy Solutions for Life

If you have a chronic condition or specific health problem, our Health Management program, *Healthy Solutions for Life* can help. We partner with a nationally recognized Health Management program to provide Health Management services. These services include telephonic outreach, education and support. We want you to be able to feel confident, understand and manage your condition, and have fewer complications. Refer to your *Evidence of Coverage* for a full list of conditions covered by our Health Management programs and services.

Are you ready to quit smoking? It's the most important thing you can do for your health. We know how hard it can be to quit, so we are here to help. Our Tobacco Cessation program provides you with the support and information you need to quit once and for all.

If you're pregnant, let us know as soon as possible! Please call us at 1-866-918-4450 (TTY: 711) or log in to your secure member account and complete a Notification of Pregnancy form.

Health Management Programs (Continued)

Ambetter offers a Health Management Program for these conditions:

- Asthma (Children and Adult)
- Coronary Artery Disease (Adult Only)
- Depression
- Diabetes (Children and Adult)
- Hypertension (high blood pressure) & High Cholesterol
- Low Back Pain
- Tobacco Cessation

If you think you could benefit from our Health Management programs, please call Member Services at 1-866-918-4450 (TTY: 711).

Family Planning Services

Family planning services provide you with the tools and resources needed to anticipate and achieve your desired outcome.

Refer your *Evidence of Coverage* to review the list of services covered by Family Planning.

Pre-Pregnancy And Pregnancy Services

- See your doctor before you get pregnant to get your body ready for pregnancy.
- Go to the doctor as soon as you think you are pregnant. To stay healthy and get off to a good start, you and your baby need to see a doctor as early as possible.
- Take care of yourself! Maintain healthy lifestyle habits like exercising, eating balanced healthy meals and resting for 8-10 hours at night.
- Do not use tobacco, alcohol or drugs now or while you're pregnant.

myhealthpays® Rewards Program

Earn up to $500 this year with myhealthpays®.

With the new My Health Pays®* program, you'll earn points for completing healthy activities, such as eating right, moving more, saving smart and living well. You can also earn rewards for completing your Wellbeing Survey, visiting your PCP for a wellness exam or receiving your flu vaccine. The more activities you complete, the more points you'll earn! Use your points to shop at the My Health Pays® Rewards Store or convert them to dollars on your My Health Pays® Visa® Prepaid Card to help pay for your your healthcare-related costs and other healthcare related items.

myhealthpays® Rewards Program (Continued)

Here is how you can earn myhealthpays® rewards:

500 Points	Complete your Ambetter Wellbeing Survey during the first 90 days of your 2020 membership. Start the survey now!
500 Points	Get your annual wellness exam with your primary care provider (PCP). Find a PCP.
250 Points	Receive your annual flu vaccine in the fall (9/1-12/31). Schedule it with your PCP.

And NOW there are new ways to earn rewards! Set and reach goals at your own pace or complete quick activities to earn rewards. The more activities you complete, the more you earn.

Eat Right | Move More | Be Well | Save Smart

You can use your rewards+ to help pay for:

Your healthcare related costs±, such as:

- Doctor copays
- Deductibles
- Coinsurance
- Utilities (water, electric, gas)

Your monthly bills, such as:

- Telecommunications (cell phone bill)
- Transportation
- Education
- Rent
- Childcare

Sample Card

Participate in the My Health Pays® program by logging on to your online member account at Member.AmbetterHealth.com

Beginning on January 1, 2020, My Health Pays® rewards are not redeemable at Walmart and Sam's Club.

*Consult a tax professional to understand any possible tax implications for the My Health Pays® program.

This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

±My Health Pays® rewards cannot be used to pay premiums.

+**IMPORTANT INFORMATION:** My Health Pays® rewards cannot be used for pharmacy copays. This card is limited to qualifying products and services as listed above. Eligible items up to the amount of your balance will be covered. Any remaining balance will remain on your card. You can use it for future purchases. The card may not be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions. This card cannot be used at ATMs, and you cannot get cash back. This card may not be used to buy alcohol, tobacco, or firearms products. If you select DEBIT at the point of sale, you will need to provide your PIN. You will select a PIN at the time of card activation. If you select CREDIT, you will not need to provide your PIN; however, you may need to provide your signature. You will only be able to purchase public transportation directly from the agency either in-person or online. Passes can not be purchased through retail locations such as grocery or convenience stores. This card is not a gift card or a gift certificate. You have received this card as a gratuity without the payment of any monetary value or consideration. Funds expire 90 days after termination of insurance coverage. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all members. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-866-918-4450 (TTY: 711) and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

myhealthpays® Rewards Program (Continued)

Don't miss out on the exciting NEW myhealthpays® program and start earning points today!

Log in now and activate your account to start earning more rewards.

1. Log into your online Ambetter member account or create your account now.
2. Click the My Health Pays® Rewards banner on the home page.
3. Confirm your mailing address. Then, start earning points!

If you already activated your account, log back in to complete healthy activities and keep earning!

Mental Health And Substance Use Disorder Services

We're here to help with treatment services for mental health or substance use disorders. If you need mental health or substance use disorder treatment, you may choose any of our participating providers and do not need a referral from your PCP in order to initiate treatment. You can search for in-network Behavioral Health providers by using our Find a Provider tool at https://providersearch.ambetterhealth.com/. Or you can call Member Services at 1-866-918-4450 (TTY: 711).

In addition, Integrated Care Management is available for all of your healthcare needs, including behavioral health and substance use. Please call 1-866-918-4450 (TTY: 711) to be referred to a care manager for an assessment.

Ambetter has a policy to address any network exception needs. Qualified instances in which Ambetter will make a network exception include:

- There is no provider in our network that is accessible or available that can provide you covered services in a timely manner; or
- We review your case and determine that it is the best interest of your care for you to see a provider outside of our network.

Ambetter follows the Mental Health Parity and Addiction Equity Act (MHPAEA). We make sure that requirements for behavioral health are the same and not more restrictive than your medical benefits. Some behavioral health services may require authorization. Please refer to your *Evidence of Coverage* or contact Member Services for more details.

To find out more, please refer to your *Evidence of Coverage*.

Pharmacy Benefits

Coverage For Your Medications

Our pharmacy program provides high-quality, cost-effective medication therapy. We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases. When ordered by a provider, we cover prescription medications and certain over-the-counter medications.

Our pharmacy program does not cover all medications. Some medications require prior authorization or have limitations on age, dosage and maximum quantities. Please refer to the Ambetter Drug List, or formulary, for a complete list of all covered medications.

For more details on your outpatient prescription drug coverage, read your *Evidence of Coverage* — you can find it on your online member account at Ambetter.AZcompletehealth.com.

For the most current Ambetter Formulary, or for more information about our pharmacy program, visit Ambetter.AZcompletehealth.com or call Member Services at 1-866-918-4450 (TTY: 711) .

Ambetter Formulary or Prescription Drug List (PDL).

Our Ambetter Formulary, or Prescription Drug List is the list of prescription drugs we cover. You can find it on our website at Ambetter.AZcompletehealth.com under "For Members", "Pharmacy Resources".

Definition of formulary – The formulary is a guide to available brand and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 to help identify brand drugs that are clinically appropriate, safe and cost-effective treatment options, if a generic medication on the formulary is not suitable for your condition.

Please note, the formulary is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated and may be subject to change. Drugs may be added or removed, or additional requirements may be added in order to approve continued usage of a specific drug.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. Please check your benefits for coverage limitations and your share of cost for your drugs.

Over-The-Counter (OTC) Prescriptions

We cover a variety of over-the-counter (OTC) medications. You can find a list of covered over-the-counter medications in our formulary — they will be marked as "OTC." Our formulary covers your prescriptions when they're from a licensed provider. Your prescription must meet all legal requirements.

How To Fill A Prescription

Filling a prescription is simple. You can have your prescriptions filled at an in-network retail pharmacy or through our mail-order pharmacy.

If you decide to have your prescription filled at an in-network pharmacy, you can use our *Provider Directory* to find a pharmacy near you. You can access the *Provider Directory* at Ambetter.AZcompletehealth.com on the ***Find a Provider*** page. This tool will not only let you search for doctors, but also for hospitals, clinics and pharmacies. You can also call a Member Services representative to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your member ID.

We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on Ambetter.AZcompletehealth.com. We can also mail you the list directly.

Mail Order Pharmacy

If you have more than one prescription you take regularly, our home delivery program might be right for you. If you select to enroll, you can get your prescriptions safely delivered right to your door. This service is fast, convenient and is offered at no extra charge to you. You will still be responsible for your regular copays/co-insurance. To enroll for home delivery or for any additional questions, call our mail-order pharmacy at 1-888-239-7690. Alternatively, you can fill out the enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on our Ambetter website. Once on our website, click on the section "For Members," "Pharmacy Resources." The enrollment form will be located under "Forms."

Utilization Management

What Is Utilization Management?

We want to make sure you get the right care and services. Our utilization management process is designed to make sure you get the treatment you need.

We will approve all covered benefits that are medically necessary. Our Utilization Management (UM) Department checks to see if the service needed is a covered benefit. If it is a covered benefit, the UM nurses will review it to see if the service requested meets medical necessity criteria. They do this by reviewing the medical notes and talking with your doctor. Ambetter does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities. Utilization Management's (UM) decision making is based only on appropriateness of care, services and existence of coverage. Ambetter from Arizona Complete Health does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

What Is Utilization Review?

Ambetter reviews services to ensure the care you receive is the best way to help improve your health condition. Utilization review includes:

Preservice or prior authorization review

Ambetter may need to approve medical services before you receive them. This process is known as prior authorization. Prior authorization means that we have pre-approved a medical service.

To see if a service requires prior authorization, check with your PCP, the ordering provider, or Ambetter Member Services. When we receive your prior authorization request, our nurses and doctors will review it. If prior authorization is not received on a medical service when required, you may be responsible for all charges.

Concurrent review

Concurrent utilization review evaluates your services or treatment plans (like an inpatient stay or hospital admission) as they happen. This process determines when treatment may no longer be medically necessary. It includes discharge planning to ensure you receive services you need after your discharge from the hospital.

Retrospective review

Retrospective review takes place after a service has already been provided. Ambetter may perform a retrospective review to make sure the information provided at the time of authorization was correct and complete. We may also evaluate services you received due to special circumstances (for example, if we didn't receive an authorization request or notification because of an emergency).

What Is Utilization Review? (Continued)

Adverse determinations and appeals

An adverse determination occurs when a service is not considered medically necessary, appropriate, or because it is experimental or investigational. You will receive written notification to let you know if we have made an adverse determination. In the notice, you will receive detailed information about why the decision was made, as well as the process and time frame you should follow for submitting appeals.

New Technology

Health technology is always changing and we want to grow with it. If we think a new medical advancement can benefit our members, we evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our members. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we should change any of our benefits to include the new technology.

If the CPC doesn't review a request for coverage of new technology, our Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request at a future meeting.

Quality Improvement Program

Quality Improvement (QI) Program

Ambetter has a comprehensive Quality Improvement (QI) Program to make sure you get quality care and services. The QI Program is an important part of your health plan. The QI Program monitors the quality of care and services provided in the areas below:

- Making sure members get the care they need, when and where they need it
- Making sure members are receiving quality care
- Cultural needs of our members
- Member satisfaction
- Member safety and privacy
- Offering a wide variety of provider specialties
- Health plan services members are using

The goal of the QI Program is to improve member health. This is achieved through many different activities. Some of our goals include the following:

- Good health and quality of life for all members
- Care provided by Ambetter healthcare providers meet industry-accepted standards of care
- Ambetter customer service meets industry-accepted standards of performance
- Provide members with preventive care reminders annually
- Incomplete or duplicate services will be kept to a minimum through QI activities across health plan departments
- The member experience will meet the health plan's expectations
- Compliance with all State and Federal laws and regulations
- Evaluate the quality of health care through HEDIS® (Healthcare Effectiveness Data and Information Set); these scores tell us you have received the type of care you need

If you would like more information about our QI Program, visit our website at https://Ambetter.AZcompletehealth.com/privacy-practices.html or give us a call at 1-866-918-4450 (TTY: 711). We are always happy to share information about our progress and goals with you.

Member Complaints & Appeals Process

For a full list of complete definitions, please refer to your *Evidence of Coverage*.

We have steps for handling any problems you may have. To keep you satisfied, we provide processes for filing appeals or complaints. You have the right to file a complaint, file an appeal, and right to an external review.

If You're Not Happy With Your Care

We hope you will always be happy with our providers and us. But if you aren't, or you aren't able to find answers to your questions, we have steps for you to follow:

- Inquiry Process
- Complaint Process
- Grievance Process
- Complaint to the state Department of Insurance (DOI)
- Appeal Process
- External review by an independent review organization (IRO)

How to Make an Inquiry

An Inquiry is a request for clarification of a benefit, product, or eligibility where no expression of dissatisfaction was made.

Examples of an Inquiry could be:

- "Can I make a payment?"
- "Can you help me change my Primary Care Provider?"
- "Why did I receive this bill?"
- "Why did my premium change?"
- "Can I get a copy of my ID?"
- "Can you help me find a Provider?"
- "Is this benefit covered?"
- "When will I get my My Health Pays® card?"

If you have any questions about your plan, you can first call Member Services at 1-866-918-4450 (TTY: 711).

Have A Complaint?

Please call Member Services and we will review your concern. Certain complaints can be addressed and resolved with one phone call. Examples of Complaints include (but are not limited to):

- Trouble finding a provider in the area
- Difficulty enrolling into the My Health Pays Program
- Trouble finding information on the Ambetter website
- Member materials not received upon request

Call Member Services at 1-888-926-5057 (Relay 711) to have your concern reviewed.

For a full list of complete definitions, please refer to your *Evidence of Coverage*.

Have A Complaint? (Continued)

If we have not satisfactorily resolved your concern or we have denied a covered service you have a right to file a grievance or appeal.

Notification of Denial

AzCH issues the following written notices of denial when applicable:

1. A "Notice of Action" for pre service request denials;
2. An "Explanation of Benefits" (EOB) document for post service denials.

Both documents have information about your right to appeal or grieve the AzCH decision.

Dispute Options and Timeframes

- If we denied a claim or a pre-certification for a service, you and your treating provider have 2 years from the date of denial to request an appeal.
- You have 1 year from the date of the AzCH decision or action to file a grievance. AzCH reviews requests to file grievance beyond the 1-year timeframe on a case-by-case bases and allows in limited circumstances for good cause as determined by AzCH.

How to File a Grievance

A grievance includes complaints about quality of service or medical care, including dissatisfaction with medical care received, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. Examples of grievance reasons include (but are not limited to):

- Ability to understand member materials
- Difficulty accessing the plan's find-a-provider online network search tool
- A provider's lack of accessibility for individuals with disabilities
- Hold time for AzCH Member Services
- Being balanced billed for covered services
- Dispute with accumulator information (accumulation of out of pocket cost sharing)
- Network inadequacy
- Lack of network providers that speak languages other than English
- Primary Care Provider (PCP) refusal to refer to a specialist

Standard Grievance: A grievance that does not meet the Expedited Grievance definition.

Expedited Grievance: If your grievance concerns a clinically urgent situation, such as forced to leave the hospital prematurely or if the standard resolution process presents a serious health risk to you, an Expedited Grievance is available. AzCH responds to expedited grievances verbally or in writing no later than 3 days from the receipt date.

For a full list of complete definitions, please refer to your *Evidence of Coverage*.

How to File a Grievance (Continued)

The AzCH Quality Improvement (QI) Department is responsible for investigating and responding to all Quality of Care (QOC) complaints (grievances). QOC cases are subject to specific confidentiality requirements. If AzCH is unable to notify you of the details of a final decision for legal or regulatory reasons, you receive written or verbal confirmation of the grievance receipt and completed investigation.

You can file a grievance verbally or in writing to:

Ambetter from Arizona Complete Health
Attention: Member Grievances
P.O. Box 277610
Sacramento, CA 95827

Email: AzCHMarketplace2@azcompletehealth.com
Fax: (877) 615-7734 Toll Free Call: Customer Contact Center
1-888-926-5057 (Relay 711)

If you are not satisfied with the first review resolution, you have a right to have second review. AzCH will issue a written or verbal notifications of resolution to the second review of the grievance.

How To File An Appeal

When Ambetter from Arizona Complete Health does not authorize or approve a service or pay for a claim, we notify you of your right to appeal that decision. Examples of appealable decisions include (but are not limited to):

- We do not approve a service that you or your treating provider has requested.
- We do not pay for a service that you have already received.
- We deny authorization or payment for a service as not "medically necessary."
- We do not authorize a service or pay for a claim as not covered under your policy, and you believe it is covered.
- We fail to notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
- We do not authorize a referral to a specialist.

Either you or your treating provider can file an appeal on your behalf. In the member information packet, is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has three levels available. The appeals operate in a similar fashion, except that expedited appeals process much faster because of your condition.

How To File An Appeal (Continued)

Expedited Appeals (Urgently Needed Services - Not Yet Received)

- Level 1: Expedited Medical Review
- Level 2: Expedited Appeal (Optional for pre service)
- Level 3: Expedited External Independent Medical Review

Standard Appeals (Non-Urgent Services or Denied Claims)

- Level 1: Informal Reconsideration*
- Level 2: Formal Appeal (Optional for pre service)
- Level 3: External Independent Medical Review
- Level 4: Informal Reconsideration is mandatory for pre-service appeals. Post service claims payment appeals start at Level 2.

We send an information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request.

Standard appeals are required to be filed in writing. Expedited appeals can be filed verbally or in writing and require an written provider certification.

Ambetter from Arizona Complete Health
Attention: Member Grievances
P.O. Box 277610
Sacramento, CA 95827

Email: AzCHMarketplace2@azcompletehealth.com
Fax: (877) 615-7734 Toll Free Call: Customer Contact Center
1-888-926-5057 (Relay 711)

For a full list of complete definitions, please refer to your *Evidence of Coverage*.

Independent Review Organization (IRO) Process

You may request a Level 3 review only after you have appealed through Levels 1 or 2. For Level 3 Expedited Medical Necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

If the IRO decides that we should provide the service, Ambetter from Arizona Complete Health authorizes the service. If the IRO agrees with our decision to deny the service, the appeal is over. Neither you nor your treating provider is responsible for the cost of any external independent review.

Send your request and any more supporting information to:

Ambetter from Arizona Complete Health
Attention: Member Grievances
P.O. Box 277610
Sacramento, CA 95827

Independent Review Organization (IRO) Process (Continued)

Email: AzCHMarketplace2@azcompletehealth.com
Fax: (877) 615-7734 Toll Free Call: Customer Contact Center
1-888-926-5057 (Relay 711)

Decisions You Cannot Appeal

You cannot appeal the following decisions:

- You disagree with our decision as to the amount of "usual and customary charges."
- You disagree with how we are coordinating benefits when you have other health insurance.
- You disagree with how we have applied your claims or services to your plan deductible.
- You disagree with the amount of coinsurance or copayments that you paid.
- You disagree with our decision to issue or not issue a policy to you.
- You are dissatisfied with any rate increases you may receive under your insurance policy.
- You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Department of Insurance and Financial Institutions (DIFI) 100 N. 15th Avenue Suite 261 Phoenix, AZ 85007-2630.

View your Evidence of Coverage for full complaint, grievance and appeal processes and procedures, including specific filing details and timeframes. You can access your Evidence of Coverage in your online member account.

Communication Matters

All of our members are important to us. No matter who you are, we want to make sure we communicate with you the best way that we can. Our members, prospective members, patients, clients and family of members can all use these services.

If you need communication aids or materials related to complaints and appeals, you can get them at no cost. We keep records of each complaint and appeal for 10 years.

To request language assistance or to request a material in another language or format, call Member Services at 1-866-918-4450 (TTY: 711)

Member Rights & Responsibilities

View a full list of your rights in your *Evidence of Coverage*.

If you would like to exercise any of your rights, please contact Member Services at 1-866-918-4450 (TTY: 711).

We want to make sure you understand the rights and responsibilities you have as an Ambetter member. For a full list of your specific rights and responsibilities, please see your *Evidence of Coverage*.

As an Ambetter member, you have the right to:

- Be treated with dignity, respect, and privacy. And you deserve the same from doctors in our network and their office staff.
- Receive information about our organization, our services and providers, and your member rights and responsibilities.
- Change your doctor without reason, to know about other doctors who can treat you, and to be told if your doctor is no longer available.
- To voice a complaint or file an appeal about Ambetter or the service we provide.
- Care from qualified health professionals and the right to participate with providers in making decisions about your health care.
- An honest discussion or appropriate treatment options for your condition, regardless of cost or coverage.
- Make recommendations about our member rights and responsibilities policies.

You have the responsibility to:

- Always provide accurate and complete information about your health to Ambetter and your providers so you receive the best care possible.
- Follow instructions and treatments plans you have agreed to with your providers.
- Understand your health problems and work with your providers to develop treatment goals.
- Ask your doctor or Ambetter if you have questions about your care or don't understand your benefits.

For a full list of your rights and responsibilities, please review your *Evidence of Coverage*.

Your Information Is Safe With Us

Your health information is personal. So we do everything we can to protect it. Your privacy is also important to us. We have policies in place to protect your health records.

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://Ambetter.AZcompletehealth.com/privacy-practices.html or call Member Services at 1-866-918-4450 (TTY: 711)

We protect all of your PHI. We follow HIPAA to keep your healthcare information private.

Language
If you don't speak or understand the language in your area, you have the right to an interpreter.

Language Assistance: https://Ambetter.AZcompletehealth.com/language-assistance.html

Member Responsibilities

Understand how your Ambetter health plan works. And know what you should do as an Ambetter health plan member.

You are responsible for telling us if your member ID gets lost or stolen, for supplying information that we need in order to provide care and for informing your provider if you cannot follow the prescribed treatment of care recommended to you.

Here's What You Should Do

Your *Evidence of Coverage* can help you understand how your plan works. Make sure you read it. Here are a couple of key points:

Giving Information
Always provide accurate and complete information about your health. This includes your present conditions, past illnesses, hospitalizations, medications and any other matters. Let us know that you clearly understand your care and what you need to do. Ask your doctor questions until you understand the care you are receiving. You need to review and understand the information you receive about us. Make sure you know how to use the services we cover.

Your Doctor's Advice and Your Treatment Plan
You should follow the treatment plan your medical providers suggest. If you do not agree with the suggested treatment plan, you have the right to obtain a second opinion from another In-Network provider. Ask questions to make sure that you fully understand your health problems and treatment plan. Work with your primary care provider (PCP) to develop treatment goals. If you don't follow your treatment plan, your doctors may tell you the likely results of your decision.

Member ID
At every appointment, always show your Ambetter member ID before you receive care.

Emergency Room Use
Only use an emergency room (ER) when you think you have a medical emergency. For all other care, you should call your PCP.

Appointments
Make sure you keep your appointments. If you cannot keep an appointment, you should call to cancel or reschedule. Whenever possible, schedule your appointments during office hours.

Your PCP
You should know the name of your PCP and establish a relationship with them. At any time, you can change your PCP by contacting our Member Services Department at 1-866-918-4450 (TTY: 711).

Treatment
You should treat all of our staff, providers and other members with respect and dignity. Please let us know if you have concerns about your care.

Words To Know

Your Healthcare Glossary

We know that health insurance can feel confusing sometimes. To help you out, we put together a list of words you may need to know as you read through this member handbook. Check it out!

Adverse Determination Notice
This is the notice you receive if we deny coverage for a service you have requested.

Appeal
An Appeal is a request to reconsider a decision about the member's benefits where either a service or claim have been denied. A denial includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. Failure to approve or deny a prior authorization request timely may be considered as a denial and also subject to the appeal process.

1. access to healthcare benefits, including an Adverse Determination made pursuant to utilization management;
2. admission to or continued stay in a healthcare Facility;
3. claims payment, handling or reimbursement for healthcare services;
4. matters pertaining to the contractual relationship between a Member and us;
5. cancellation of your benefit coverage by us; and
6. other matters as specifically required by state law or regulation.

Complaint
A complaint can be an appeal or a grievance. Some complaints can be resolved through first call resolution if they can be fully addressed and closed.

Copay or Copayment
The set amount of money you pay every time you receive a medical service or pick up a prescription.

Emergency Care/Emergencies
Emergency care is care that you receive in an emergency room (ER). Only go to the ER if your life is at risk or you need immediate, emergency medical attention.

Evidence of Coverage
The document that lists all of the services and benefits that your particular plan covers. Your *Evidence of Coverage* has information about the specific benefits covered and excluded under your health plan. Read through your *Evidence of Coverage* — it can help you understand exactly what your plan does and doesn't cover.

Grievance
Any complaint about quality of service or medical care is a grievance, including dissatisfaction with the quality of medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Your Healthcare Glossary (Continued)

In-Network (Providers and/or Services)
The Ambetter network is the group of providers and hospitals we partner with to provide care for you. If your provider or service is within our network, it is covered on your health plan. If a provider or service is out of network, you will be responsible for services you receive. When possible, always stay in-network!

Inquiry
A request for clarification of a benefit, product, or eligibility where no expression of dissatisfaction was made.

Out-of-Network Provider
Means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage (EOC)*. Refer to your *Evidence of Coverage* for details regarding out-of-network providers, care, services and expenses.

Premium Payment
Your premium is the amount of money you'll pay every month for health insurance coverage. Your monthly bill shows your premium payment.

Preventive Care Services
Preventive care services are regular healthcare services designed to keep you healthy and catch problems before they start. For example: your checkups, blood pressure tests, certain cancer screenings and more. A list of Preventive Care services can be found within your *Evidence of Coverage*, as well as on our website at Ambetter.AZcompletehealth.com.

Primary Care Provider (PCP)
Your PCP is the main doctor you will see for your healthcare needs. Get to know your PCP well and always stay up-to-date with your well-visits. The better your PCP knows your health, the better they are able to serve you.

Prior Authorization
Prior authorization may be required for covered services. When a service requires prior authorization, then the covered service needs to be approved before you visit your provider. Your provider will need to submit a prior authorization request.

Summary of Benefits
Your *Summary of Benefits* is a document that lists covered benefits available to you and lets you know when you are eligible to receive them. Your *Summary of Benefits* has information about your specific copayment, cost sharing and deductible amounts.

Subsidy
A subsidy is a tax credit that lowers your monthly premium. Subsidies come from the government. Whether or not you qualify for one depends on your family size, your income and where you live.

Your Healthcare Glossary (Continued)

Urgent Care
Urgent care is medical care that you need quickly. You can get urgent care at an urgent care center.

Utilization Management
This is the process we go through to make sure you get the right treatment. We review your medical and health circumstances and then decide the best course of action.

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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 Ambetter from Arizona Complete Health at: 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.

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).

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'ashchį́įgo nich'į' ádoolníiłgo bee haz'ą́ ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'į' ąą'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 1-866-918- 4450 (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 برىا شما قابل دسترسی میباشد با شمار1-866-918-4450 (TTY:TDD 711)T ه تماس بگـیرید.
Syriac	[illegible] 1-866-918-4450 (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)