2021

Member Handbook

The Resources You Need. Right Here.

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
- Where to go for care
- Information on your Member ID
- Optional adult dental and vision 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

How To Contact Us

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. MT.

1. Set up your secure online member account. Do this by visiting the "Member Login" 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 *Schedule of Benefits*, claims information, this member handbook and more.

2. Our *my*healthpays® program helps you focus on your total health. When you complete healthy activities, such as eating right, moving more, saving smart and living well, you can earn reward points! All you have to do is log in to your online member account to get started. Please note: My Health Pays cannot be used or applied to premiums.

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 *my*healthpays® rewards! And anytime you need care, call your PCP and make an appointment!

Answers To Your Payment Questions

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

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

How Can I Pay My Monthly Premium?

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. EST. You will have the option to pay using the Interactive Voice Response (IVR) system or by speaking to a billing services representative.

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
PO Box 748701
Los Angeles, CA 90074-8701

How Can I Pay My Monthly Premium?

(Continued)

c. To find a MoneyGram location near you, visit MoneyGram.com/BillPayLocations or call 1-800-926-9400. Learn more about using MoneyGram to make your Ambetter premium payment by visiting MoneyGram.com/BillPayment.

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.

Member Services

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

If you enrolled through the Health Insurance Marketplace you must contact them to: update your enrollment information, such as your date of birth, address or income or life changes; or to end your coverage with Ambetter. You can do this by visiting Healthcare.gov or calling 1-800-318-2596 (TTY: 1-855-889-4325). When you are connected, be ready to provide your state and then ask for a representative to help you.

If you are enrolled in an off-exchange plan, please contact Member Services to update your enrollment information, such as your date of birth, address or income or life changes; or to end your coverage with Ambetter.

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Have total or partial hearing loss? Call 1-866-918-4450 (TTY:711) or visit Ambetter.AZcompletehealth.com

Membership & Coverage Information

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.

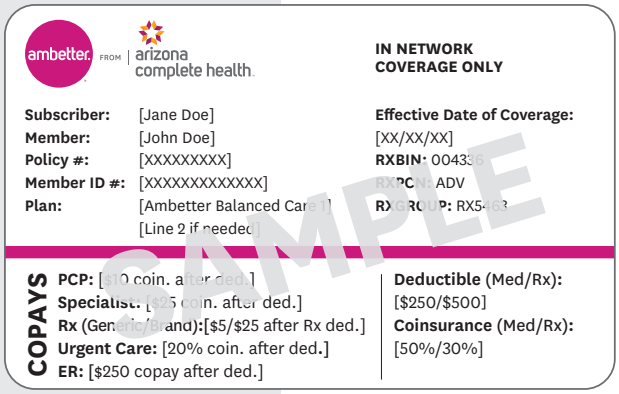
Your Ambetter Member ID

Your member ID is proof that you have health insurance with us. And it's very important. Here are some things to keep in mind:

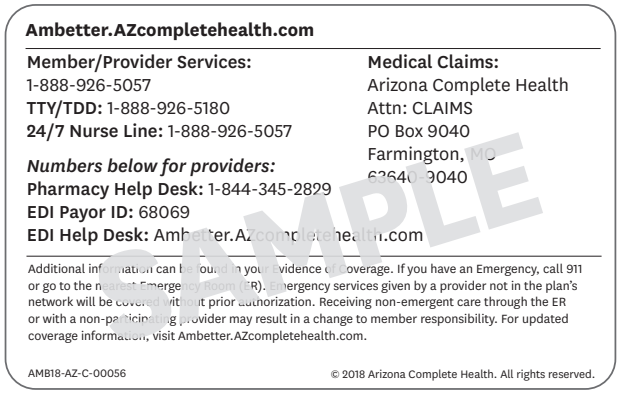
- Keep this card with you at all times
- You will need to present this card anytime you receive healthcare services
- You will receive your Member ID(s) before your Ambetter health coverage begins. If you don't get your member ID before your coverage begins, call Member Services at 1-866-918-4450 (TTY: 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 request a temporary ID, please log into 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.

Finding the Right Care

We're proud to offer our 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 online Provider Directory, visit guide.ambetterhealth.com and use our **Ambetter Guide- the new Ambetter provider search tool**. This guide 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

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 Member ID.

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).

Throughout the year, the providers available in-network may change. It is important that you review the provider directory for the latest information on whether or not the provider you are planning to see is in-network. We encourage you to ask providers if they participate with Ambetter before they treat you, so you know whether or not you may receive an additional bill for their services. For more information, contact Member Services.

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 Doctor*** page of guide.ambetterhealth.com.

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

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. **Ambetter Telehealth**
3. **Making an appointment with your primary care provider (PCP)**
4. **Visiting an urgent care center**
5. **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.

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

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

Your Primary Provider (PCP)

Your primary care provider is your main doctor — the one you see for regular checkups. If your condition isn't life-threatening, calling your PCP should be your first choice. Use our online Ambetter Guide to find an in-network provider in your area.

Visit or call your PCP if you need:

- Your annual wellness checkup & vaccinations
- Advice about your overall health
- Help with medical problems such as cold, the flu and fevers
- Treatments for an ongoing health issue like asthma or diabetes

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. Log in to your online member account and follow these steps

1. **Click on Coverage Overview or Edit Account**
2. **Select the Change icon located in the My Primary Provider section on the page.**
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 Doctor** web page.

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

Ambetter from Arizona Complete Health is here to help you find the healthcare professionals you need. You can find more info on our website at https://ambetter.azcompletehealth.com/find-a-provider.html. If you don't find your preferred doctor in the network, please give us a call. We are always working to contract with the highest quality doctors in the area so your doctor could have been added recently.

Access to Care

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

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.

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 center 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 our 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 *Schedule 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. Note that you should only receive a bill from these out-of-network providers for your cost share which includes deductible, copayments or coinsurance. If you do receive a bill in excess of those amounts, you should contact Member Services. You should make sure that any post stabilization care and all follow-up care is provided by an in-network provider to avoid unexpected charges.

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

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 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. Those additional amounts could be very large and would be in addition to your plan's cost sharing and deductibles.

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

Ambetter Telehealth

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

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

Ambetter Telehealth providers are available by phone or video when you need medical care, a diagnosis or a prescription. As part of our Health Management Program, Ambetter offers $0 copay for in-network Telehealth providers. You can choose to receive immediate care or schedule an appointment for a time that fits in your schedule.

Contact Ambetter Telehealth for illnesses such as:

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

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

$0 Telehealth copay does not apply to plans with HSA until the deductible is met. $0 copays are for in-network medical care. Ambetter does not provide medical care.

To find another provider or specialist in our network, check out our provider list on the ***Find a Doctor*** page at guide.ambetterhealth.com

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 licensed 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
- Urgent care

Member Complaints, Grievances, & Appeals Process

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 and Financial Institutions (DIFI)
- 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). **Your satisfaction is very important to us. We want to know your issues and concerns so we can improve our services. Please contact our Member Services team at 1-866-918-4450 (TTY: 711) if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.**

How To File A Complaint

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:

- A "Notice of Action" for pre service request denials;
- 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.

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

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, being billed beyond cost sharing for covered services, 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 cost sharing 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 calendar days from the receipt date.

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.

View your *Evidence of Coverage* for full complaint and appeal procedures and processes. You can access your *Evidence of Coverage* in your online member account.

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

How to File a Grievance (Continued)

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
1-866-918-4450 (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. Refer to your *Evidence of Coverage* for more information.

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.

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

How To File An Appeal (Continued)

Standard Appeals (Non-Urgent Services or Denied Claims)

Level 1: Informal Reconsideration (Pre Service ONLY)*

Level 2: Formal Appeal (optional for pre service)

Level 3: External Independent Medical Review

**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: AzCH Appeals & Grievances
P.O. Box 277610
Sacramento, CA 95827
Email: AzCHMarketplace@azcompletehealth.com
Fax: (877) 615-7734 Toll Free Call: Customer Contact Center
1-866-918-4450 (Relay 711)

Independent Review Organization (IRO) Process

You may request a Level 3 review only after you have appealed through Level 1 for pre service and Level 2 for post service claims payment issues. . 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: AzCH Appeals & Grievances
P.O. Box 277610
Sacramento, CA 95827

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).

Notification of Approved Services

All claims info (including prior authorizations) can be found by logging into the member secure portal and selecting the activity and usage link.

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.

Member Resources & Rewards

Visit us online at Ambetter.AZcomplete health.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.

Member Experience Matters! Ambetter from Arizona Complete Health is committed to providing the best possible care we can and would greatly appreciate your feedback. If you are selected for an annual member satisfaction survey known as the QHP Enrollee Survey, please share your thoughts with us by completed the survey administered by SPH Analytics.

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.

Log into your online member account to:

- Pay your monthly bill
- Print a temporary ID or request a replacement ID
- 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*, *Schedule of Benefits*, this handbook)
- Participate in the myhealthpays® rewards program
- Complete your Wellbeing Survey
- Contact a nurse online
- Review out-of-pocket costs, copays and progress towards deductibles.

myhealthpays® Rewards Program

Don't miss out on the exciting 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 Rewards on the home page.
3. Accept Terms & Conditions. Then, start earning points!

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

Funds expire immediately upon termination of insurance coverage.

Words To Know

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

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.

Your Healthcare Glossary (Continued)

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.

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 https://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.

Your Healthcare Glossary (Continued)

Schedule of Benefits
Your *Schedule of Benefits* is a document that lists covered benefits available to you. Your *Schedule of Benefits* has information about your specific copayment, cost sharing and deductible amounts for covered benefits.

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.

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.

AMB20-AZ-C-00466

Statement of Non-Discrimination

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.

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 hólǫ́ dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchį́igo 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 بری‌ا شما قابل دسترسی میباشد با شمار 1-866-918-4450 (TTY:TDD 711)T ه تماس بگیرید.
Syriac	،ܐܢ ܟܡܡܠܠܝܬܘܢ ܣܘܪܝܬ، ܡܨܝܬܘܢ ܠܐܘܪܚܐ ܕܡܠܦܢܐ ܟܝܠ ܬܪܓܡܐ ܡܠܠܝܐ ܘܟܬܝܒܬܐ ܡܓܢܝܬܐ 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)