



FROM



arizona
complete health.

A black and white photograph of a woman and a young girl blowing bubbles. The woman is on the left, smiling and holding a bubble wand. The girl is on the right, blowing into a bubble wand. The background is a bright, outdoor setting with trees and a fence.

Your 2019 Member Handbook

Everything you need to know about your plan

For more information, visit [Ambetter.AZcompletehealth.com](https://www.Ambetter.AZcompletehealth.com)

If this information is not in your primary language, please call 1-888-926-5057 (TTY/TDD 1-888-926-5180)



FROM



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.

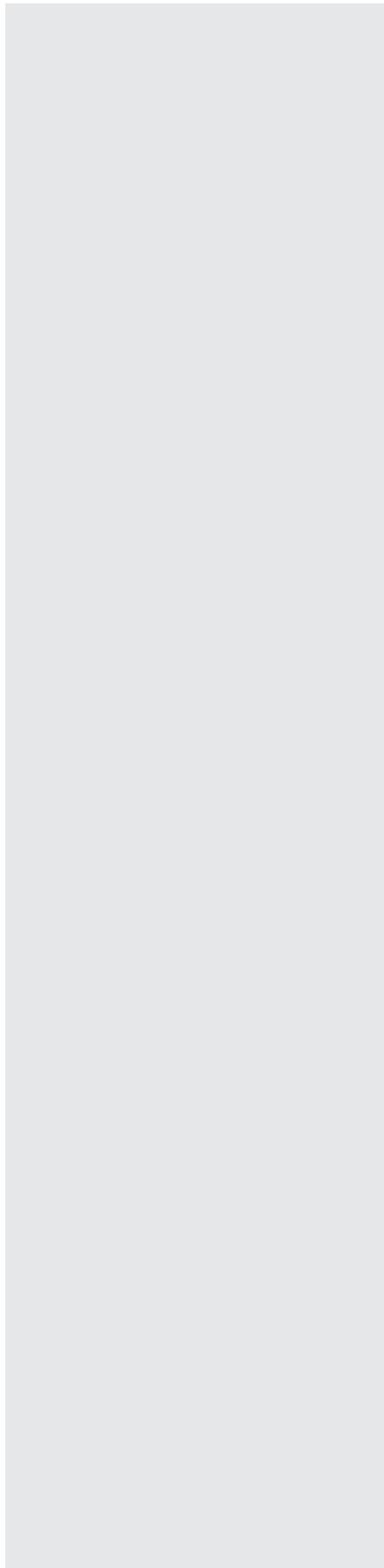
If you have questions, we're always ready to help. And don't forget to check out our online video library at Ambetter.AZcompletehealth.com. It's full of useful information.

Member Services:

1-888-926-5057 (TTY/TDD 1-888-926-5180)

Ambetter.AZcompletehealth.com

Table of Contents



Member Handbook Overview	2
How To Contact Us	3
How Your Plan Works	4
Membership & Coverage Information.....	8
Covered Services Medical Service Expense Benefits	12
Your Primary Care Provider	15
Where To Go For Care.....	19
Health & Wellness Programs.....	22
Behavioral Health Services	25
Pharmacy Benefits	26
Utilization Management	28
Quality Improvement Program.....	30
Member Complaints & Appeals Process.....	31
Member Rights & Responsibilities	35
Words To Know.....	37

Member Handbook Overview



To request print versions of all informational materials, you can contact Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180)

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 *Schedule 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 Member Secure Portal under “Reference Materials”.

Login to your Secure Member Portal at Member.AmbetterHealth.com

Once you’re logged in, go to:

“My Benefits”

Use the drop down arrow to select your current benefit year and click the “Select Year” button.

Here you will find your Member Contract information.

Your Summary of Benefits and Coverage is an overview of what your plan covers and what it costs.

If you want more details about your coverage and costs, you can get the complete terms in your *Schedule of Benefits* and *Evidence of Coverage*.

Schedule of Benefits

Your *Schedule 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 1-888-926-5057 (TTY/TDD 1-888-926-5180).

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 5 p.m. MST.

Member Services	1-888-926-5057
Fax	1-866-687-0518
TTY/TDD	1-888-926-5180
Make a Payment	1-888-926-5057
Behavioral Health Services	1-888-926-5057
24/7 Nurse Advice Line	1-888-926-5057
Complaints and Grievances	1-888-926-5057
Emergency	911
Website	Ambetter.AZcompletehealth.com

When you call, have these items ready:

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

Interpreter Services

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

Call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180). to learn more.

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 1-888-926-5057 (TTY/TDD 1-888-926-5180). We're available Monday through Friday, 8 a.m. to 5 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 *Schedule 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 us design your plan around your specific needs and it helps you earn \$50 in *myhealthpays*™ rewards! See [page 23](#) 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 \$50 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 1-888-926-5057 (TTY/TDD 1-888-926-5180).

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 1-888-926-5057 (TTY/TDD 1-888-926-5180) between 8 a.m. and 5 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

4. Pay with MoneyGram®

- a. MoneyGram® is fast and easy to use when you need to make same-day premium payments. MoneyGram offers convenient locations, so you can avoid the stress of making a late payment. Plus, Ambetter covers the MoneyGram fee — so you just pay your premium!



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



How Can I Pay My Monthly Bill? (Continued)

- b. To find a MoneyGram location near you, visit [MoneyGram.com/BillPayLocations](https://www.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](https://www.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. 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 card 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](https://www.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.



Have total or partial hearing loss? Call TTY/TDD 1-888-926-5180 or visit [Ambetter.AZcompletehealth.com](https://www.ambetter.com)



Deciding whether or not you need to visit the emergency room can be tricky. Call our 24/7 nurse advice line at 1-888-926-5057. They can help you decide where to go for care.

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 1-888-926-5057 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 and Arizona Resident within the Ambetter coverage area (lawfully present)
- Live within the Ambetter service area
- Not be incarcerated, institutionalized, or emancipated
- Not be covered by or eligible for: 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)

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 \$2,700 in 2019 under IRS rules. For an individual to qualify, the plan must have an annual deductible of \$1,350 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



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



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/pub/irs-drop/rp-18-30.pdf>.

Finding The Right Care

We're proud to offer you quality care. 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 he/she is 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 1-888-926-5057 (TTY/TDD 1-888-926-5180).

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 Card. 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 Card

Your member ID card 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 card(s) before your Ambetter health coverage begins. If you don’t get your member ID card before your coverage begins, call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180). We will send you another card.
- You will not receive your Welcome Packet and Member ID card(s) until your binder payment and first month’s premium are paid in full.

If you need a temporary ID card or if you would like to request a Replacement ID card, log in to your secure member account.

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

 FROM 		IN NETWORK COVERAGE ONLY	
Subscriber: [Jane Doe]	Effective Date of Coverage: [1/1/2020]	SAMPLE	
Member: [John Doe]	PLAN: [04326]		
Policy #: [XXXXXXXXXX]	RXPCN: [0000]		
Member ID #: [XXXX-XXXX]	RXGROUP: [RX5463]		
Plan: [Ambetter Plan Coverage]			
COPAYS		Deductible (Med/Rx): [\$250/\$500]	
PCP: [\$10 coin. after ded.]		Coinurance (Med/Rx): [50%/30%]	
Specialist: [\$25 coin. after ded.]			
Rx (Generic/Brand): [\$5/\$25 after Rx ded.]			
Urgent Care: [20% coin. after ded.]			
ER: [\$250 copay after ded.]			

Front

Ambetter.AZcompletehealth.com	
Member/Provider Services: 1-888-926-5057 TTY/TDD: 1-888-926-5180 24/7 Nurse Line: 1-888-926-5057	Medical Claims: Arizona Complete Health Attn: CLAIM Phoenix, AZ 85004 Franklin, NJ 08840 3640
Numbers below for provider:	
Pharmacy Help Desk: 1-844-333-3333	
EDI Payor: 6806	
EDI Help: Ambetter.AZcompletehealth.com	
<small>Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.AZcompletehealth.com.</small>	
<small>AMB18-AZ-C-00056</small>	<small>© 2018 Arizona Complete Health. All rights reserved.</small>

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 a secure portal 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 card 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*, *Schedule of Benefits*, this handbook)
- Complete your Wellbeing Survey
- Contact Nurse via web
- Review out-of-pocket costs, copays and progress toward deductible





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



To see all of your covered preventive care services, refer to your *Evidence of Coverage*. Refer to your *Evidence of Coverage* to get the details for each covered service. Some have certain exclusions and limitations.



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.

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 policy
- 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 1-888-926-5057 (TTY/TDD 1-888-926-5180). 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 *Schedule of Benefits*. For a list of exclusions, refer to your *Evidence of Coverage*. Your Schedule of Benefits 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.



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 1-888-926-5057 (TTY/TDD 1-888-926-5180) 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 and cost sharing percentage. If you receive a provider bill that doesn't reflect your cost share as listed in your *Schedule of Benefits*, contact us right away. This is very important.

"Out of Pocket Costs" and "Member Cost Share" are your deductible, copay and/or coinsurance, this is your payment responsibility. In cases where a claim line 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. You should not be balanced billed for covered services beyond your cost sharing responsibility. If you are billed by a provider and need assistance, contact our Member Services team at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

You can also refer to our [Transparency Notice](#) by visiting Ambetter.AZcompletehealth.com. It's located under "For Member", Member Materials and Forms", under Reference Materials.

If you have questions about a bill or statement that you received, please contact us. The fastest way to get a response is by sending us an email through your secure member portal, but you can also call Member Services, or mail or fax us the bill or statement.

Ambetter from Arizona Complete Health

1870 W Rio Salado
Suite 2A
Tempe, AZ 85281

Ambetter Member Services: 1-888-926-5057
TTY/TDD: 1-888-926-5180
Fax: 1-866-687-0518



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

Provider Billing: What To Expect (Continued)

Your secure member portal contains information that may help you answer questions about your bill. In your portal you can check your Explanation of Benefits (EOB) for the date of service to verify what you're being billed for — a copayment, coinsurance or non-covered services.

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 63640-3800

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

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.

Your PCP may require a referral 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 card 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 1-888-926-5057 (TTY/TDD 1-888-926-5180). You can also see our provider list on the **Find a Provider** page at Ambetter.AZcompletehealth.com

Your primary care provider (PCP), also known as your personal doctor, is the person you should see for all aspects of your healthcare — from your preventive care to your basic health needs and more. Choose your in-network PCP by using our online **Find a Provider** tool.

What's A Primary Care Provider?

Your primary care provider (PCP) is your main doctor. He/she is 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. 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 *Schedule 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 1-888-926-5057 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 card 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 1-888-926-5057 (TTY/TDD 1-888-926-5180). 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. The Ambetter plans include services to providers outside of the Ambetter network. If you have a problem finding an in-network provider, please call us at 1-888-926-5057 (TTY/TDD 1-888-926-5180).



Are you having trouble getting an appointment with your PCP? Do you need help with your follow-up care? Call Member Services: 1-888-926-5057 (TTY/TDD 1-888-926-5180). 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 1-888-926-5057 (TTY/TDD 1-888-926-5180). 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 Telehealth

Ambetter Telehealth 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 Telehealth, you will need to set up your account.

Contact Ambetter Telehealth 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 Telehealth for illnesses such as:

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

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 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.**

If you are currently receiving services from a specialist that terminates from our provider network, we will also notify 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.

To learn more about a specific PCP, call 1-888-926-5057 (TTY/TDD 1-888-926-5180). 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 co-payment amounts are the same as they would be for services from other participating providers. Review your *Schedule of Benefits* for more information.



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



What Happens If Your Provider Leaves Our Network?

Please contact Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180) 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 1-888-926-5057 (TTY/TDD 1-888-926-5180). We will work with you to help you.

If you are currently receiving services from a specialist that terminates from our provider network, we will also notify 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 Card. 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 card.

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 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



Call our 24/7 nurse advice line anytime: 1-888-926-5057 (TTY/TDD 1-888-926-5180).



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:

- Flu, 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. 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 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 health management programs, which are all included in your plan for free.

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 1-888-926-5057 (TTY/TDD 1-888-926-5180).

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.



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: 1-888-926-5057 (TTY/TDD 1-888-926-5180).



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 1-888-926-5057 (TTY/TDD 1-888-926-5180) 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 1-888-926-5057 (TTY/TDD 1-888-926-5180).

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 \$125 this year with myhealthpays™.

As an Ambetter member, you can earn reward dollars for taking charge of your health. Our myhealthpays™ program rewards you for completing healthy activities.

You will receive your myhealthpays™ Visa® Prepaid Card when you earn your first reward. If you already have your myhealthpays™ Visa Prepaid Card, your reward dollars will be added to your existing card.

We'll automatically add any new rewards you earn to your myhealthpays™



myhealthpays™ Rewards Program

(Continued)

Visa Prepaid Card. The more you do, the more reward dollars will be added to your card. It's that simple!

You can use your rewards to help pay for your

- Doctor copays
- Deductibles
- Coinsurance
- Everyday items at Walmart*
- Utilities (water, electric, gas)
- Telecommunications (cell phone bill)
- Transportation
- Education
- Rent
- Childcare



Sample Card

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..

Here is how you can earn myhealthpays™ rewards:

\$50	Complete your Ambetter Wellbeing Survey during the first 90 days of your membership. Start the survey now!
\$50	Get your annual wellness exam with your primary care provider (PCP). Find a PCP.
\$25	Receive your annual flu vaccine in the fall (9/1-12/31). Schedule it with your PCP.

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.

My Health Pays™ rewards cannot be used to pay premiums.

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.

Consult a tax professional to understand any possible tax implications for the My Health Pays™ program. Funds expire 90 days after termination of insurance coverage.

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 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.

Log in to your secure online member account at Member.AmbetterHealth.com to track your rewards and view your card balance. And complete healthy activities, such as your Wellbeing Survey.



Track your myhealthpays™ rewards on your online member account at Member.AmbetterHealth.com



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 abuse 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](https://providersearch.ambetterhealth.com/) tool at <https://providersearch.ambetterhealth.com/>. Or you can call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

In addition, Integrated Care Management is available for all of your healthcare needs, including behavioral health and substance use. Please call 1-888-926-5057 (TTY/TDD 1-888-926-5180) to be referred to a care manager for an assessment.

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



We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases.

Learn about coverage for your medications and our Ambetter Drug List, or Preferred Drug List (PDL). You can find it at [Ambetter.AZcompletehealth.com](https://www.ambetter.com/AZcompletehealth.com) under “For Members”, Pharmacy Resources”

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](https://www.ambetter.com/AZcompletehealth.com).

Ambetter Formulary or Prescription Drug List (PDL).

Our AmbetterFormulary, or Prescription Drug List is the list of prescription drugs we cover. You can find it on our website at [Ambetter.AZcompletehealth.com](https://www.ambetter.com/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.



For the most current Ambetter Formulary, or for more information about our pharmacy program, visit [Ambetter.AZcompletehealth.com](https://www.ambetter.com/AZcompletehealth.com) or call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).



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 card.

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.”



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 1-888-926-5057 (TTY/TDD 1-888-926-5180). We are always happy to share information about our progress and goals with you.

Member Complaints & 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 (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 Card?"
- "Can you help me find a Provider?"
- "Is this benefit covered?"
- "When will I get my MyHealth Pays card?"

If you have any questions about your plan, you can first call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

How To File A 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.

Examples of a Complaint could be:

- "I can't get an appointment with the doctor for 4 months"
- "I can't find a provider in my area, as the local doctors are all stating they are not participating with my plan and the ones participating with my plan are too far away"
- "I've called Member Services multiple times and my issue is still not resolved"
- "I can't get enrolled on your website"

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



How To File A Complaint (Continued)

- “I can’t find what I am needing on your website”
- “The doctor and/or the staff were rude to me”

To file a complaint, call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

How to File a Grievance

A Grievance is 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.

Examples of a Grievance would be:

- “My generic prescription didn’t have the generic co-pay applied”
- “I had a preventive procedure and they are making me pay out of pocket, when it should have been covered at 100%”
- “I’m in need of home healthcare and I haven’t gotten a call back from my Case Coordinator”
- “I did not consent to blood products during surgery but found out they gave me some anyway ”
- “My doctor prescribed a medication that I’m allergic to and I’ve had a terrible reaction”
- “I was told that I was active with the plan, and the plan kept taking premiums out automatically, but now they are going back and saying I had no coverage for 10 months, and now I have over \$100,000.00 in hospital bills”

You may file a grievance, verbally, or in writing, either by mail or by facsimile (fax). If you require assistance in filing a grievance or if you are unable to submit the grievance in writing, you can call Member Services at Ambetter.AZcompletehealth.com to ask for help through the process. We will send you a Grievance Acknowledgment letter after receipt of your written Grievance.

Send your written Grievance form to:

Ambetter from Arizona Complete Health
Attn: Complaints Department
PO Box 277610
Sacramento, CA 95827
Fax: 1-866-687-0518

Expedited Grievance: If your grievance concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, or if a standard resolution process will risk serious jeopardy to your life or health.

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

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

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



How To File An Appeal

An Appeal is a request to reconsider a decision about the member's benefits either where 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. 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.

Examples of an Appeal would be:

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;
6. other matters as specifically required by state law or regulation

To file a written appeal, you can mail or Fax your request to us at the contact information below:

Ambetter from Arizona Complete Health

Attn: Appeals & Grievances Department

PO Box 277610

Sacramento, CA 95827

Fax: 1-866-687-0518

To file a verbal appeal, you can call us at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

How quickly we answer your appeal depends on the type of appeal that you file:

Expedited Appeal: If your appeal concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, or if you believe a standard resolution process will risk serious jeopardy to your life or health. An expedited appeal requires your treating provider to certify in writing, and provide supporting documentation that the time needed to review your appeal under the standard process (60 days) is likely to cause a significant negative change in your medical condition.

Standard Appeal: An appeal that does not meet the Expedited definition

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



Continued Coverage During An Appeal

If you file an appeal, your coverage will continue until:

- The end of the approved treatment period

OR

- The determination of the appeal

You may be financially responsible for the continued services if your appeal is not approved.

You can request continued services by calling Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

NOTE: You can't request an extension of services after the original authorization has ended. For more details, call Member Services at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

External Review Process

If we don't approve a service, you have another option for a review. This is known as an independent review organization (IRO), or a third-party reviewer. Doctors who don't work for us make up the IRO.

If you want to ask for an IRO, we can help. Call us at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

View your Evidence of Coverage for full complaint and appeal procedures and processes, 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. That's why we have communication programs for people who only know a little English or may have sensory impairments. 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 1-888-926-5057 (TTY/TDD 1-888-926-5180)

Member Rights & Responsibilities



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 care 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 1-888-926-5057 (TTY/TDD 1-888-926-5180)

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>



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 1-888-926-5057 (TTY/TDD 1-888-926-5180).



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 card 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. 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 Card

At every appointment, always show your Ambetter member ID card 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 him/her. At any time, you can change your PCP by contacting our Member Services Department at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Treatment

You should treat all of our staff, providers and other members with respect and dignity. If you have concerns about your care, please let us know in a useful manner.

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 either where 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 and 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 something is in our network, it is covered on your health insurance plan. If something is out-of-network, you will probably have to pay extra 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 Card. 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 he/she is 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.

Schedule of Benefits

Your *Schedule of Benefits* is a document that lists covered benefits available to you and lets you know when you are eligible to receive them. Your *Schedule 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.

Statement of Non-Discrimination

Ambetter from 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. Ambetter from 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
 - Information written in other languages

If you need these services, contact Ambetter from Arizona Complete Health at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

If you believe that Ambetter from Arizona Complete Health has 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: Ambetter from Arizona Complete Health Appeals Unit, PO Box 277610, Sacramento, CA 95827, 1-888-926-5057 (TTY/TDD 1-888-926-5180), Fax 1-877-615-7734. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Arizona Complete Health is available to help you. 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 or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Health Net, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Navajo:	Ni da éi doodago háida bíká anilyeedígíí Ambetter from Health Net yína`iditkídgo t`áá ni nizaad k`ehjí níká a`doowl dóó hazhó`ó bee nił hodooniigo bee ná haz`á dóó báhá ilínígóó. Ata` halne`igíí la` bich`j` hadeesdzih nínízíngo kojí` hólne` 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Health Net 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-888-926-5057 (TTY/TDD 1-888-926-5180)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Health Net, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Health Net ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Health Net, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalín, tumawag sa 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Health Net 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-926-5057 (TTY/TDD 1-888-926-5180) 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Health Net, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-888-926-5057 (TTY/TDD 1-888-926-5180).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Health Net hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-926-5057 (TTY/TDD 1-888-926-5180) an.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Health Net вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Japanese:	Ambetter from Health Net について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-888-926-5057 (TTY/TDD 1-888-926-5180) までお電話ください。
Persian:	اگر شما، یا کسی که به او کمک می کنید مؤالی در مورد Ambetter from Health Net دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-888-926-5057 (TTY/TDD 1-888-926-5180) تماس بگیرید.
Syriac:	ان اتلوخن خورنه مبفورى المساعدة بمصيون متلفلنن النوا مشى Ambetter from Health Net بمصيون مبقرىوتن المساعدة.. وخنى لا شفلخ زوزة منوخن . ان اتلوخن بارا الانى مندى .وان مترجم رقم تلفون 1-888-926-5057 (TTY/TDD 1-888-926-5180)
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Health Net, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-888-926-5057 (TTY/TDD 1-888-926-5180).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีความเกี่ยวข้องกับ Ambetter from Health Net ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-888-926-5057 (TTY/TDD 1-888-926-5180).