Ambetter from Louisiana Healthcare Connections
Enhanced Silver: Limited Cost Sharing Plan Variation

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://ambetter.louisianahealthconnect.com/2023-brochures.html, or call 1-833-635-0450 (TTY 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-833-635-0450 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or $3,850 individual / $7,700 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive care services, primary care, specialist, urgent care office visits and generic and preferred brand drugs are covered before you meet your deductible except for Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	$0 at IHCP or with IHCP referral at non-IHCP; or Yes, $3,850 individual / $7,700 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $8,600 individual / $17,200 family. Not applicable for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://ambetter.louisianahealthco	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a

	nnect.com/findadoc or call 1-833-635-0450 (TTY 711) for a list of network providers.	provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$35 Copay / ; deductible does not apply	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply. Cost sharing waived at non-IHCP with IHCP referral.
	Specialist visit	No charge	$65 Copay / ; deductible does not apply	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Preventive care/screening/ immunization	No charge	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Cost sharing waived at non-IHCP with IHCP referral.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	$40 Copay / ; deductible does not apply for laboratory & professional services $75 Copay / ; deductible does not apply for x-ray & diagnostic imaging 40% Coinsurance for laboratory &	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. Cost sharing waived at non-IHCP with IHCP referral.

			professional services and x-ray & diagnostic imaging at other places of service		
	Imaging (CT/PET scans, MRIs)	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://ambetter.louisianahealthconnect.com/2023formulary**.	Generic drugs (Tier 1)	No charge	Preferred Generic Retail: $5 Copay / ; deductible does not apply Generic Retail: $20 Copay / ; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral.
	Preferred brand drugs (Tier 2)	No charge	Retail: $65 Copay / ; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral.
	Non-preferred brand drugs (Tier 3)	No charge	Retail: 50% Coinsurance; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. $3,850 individual / $7,700 family Rx drug deductible for non-preferred brand and specialty drugs. Cost sharing waived at non-IHCP with IHCP referral.
	Specialty drugs (Tier 4)	No charge	Retail: 50% Coinsurance. $150 max applies is met.	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. (Note: Limited to copayment or coinsurance applicable to specialty tiered drug amount not to exceed $150 dollars per month for each drug up to a thirty-day supply, is met). $3,850 individual / $7,700 family Rx drug deductible for non-preferred brand and specialty drugs. Cost sharing waived at non-IHCP with IHCP referral.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you need immediate medical attention	Emergency room care	No charge	50% Coinsurance for facility; 50% Coinsurance for physician fee	50% Coinsurance for facility; 50% Coinsurance for physician fee	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Emergency medical transportation	No charge	40% Coinsurance	40% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider, you may be subject to balance billing. Cost sharing waived at non-IHCP with IHCP referral.
	Urgent care	No charge	$60 Copay / ; deductible does not apply	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$35 Copay / office visit; deductible does not apply; 40% Coinsurance for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (Primary care provider (PCP) and other practitioner visits do not require prior authorization).Cost sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No charge	$35 Copay / ; deductible does not apply	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing

					does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery professional services	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery facility services	No charge	40% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No charge	Outpatient: $45 Copay / ; deductible does not apply Inpatient: 40% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral
	Habilitation services	No charge	Outpatient: $45 Copay / ; deductible does not apply Inpatient: 40% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Skilled nursing care	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Durable medical equipment	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Note: Medical foods/low protein food

					products for the treatment of inherited metabolic diseases are subject to applicable deductible, coinsurance & copayment amounts; member's cost share shall not exceed more than $200 dollars per month. Cost sharing waived at non-IHCP with IHCP referral.
	Hospice services	No charge	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's eye exam	No charge	No charge; deductible does not apply	Not covered	Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's glasses	No charge	No charge; deductible does not apply	Not covered	Limited to 1 item per year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental (Adult)
- Infertility treatment (Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.)
- Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids (Limited to 1 per ear every 3 years.)
- Private-duty nursing (Inpatient private duty nursing services are not covered, only outpatient.)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Louisiana Healthcare Connections at 1-833-635-0450 (TTY 711); 1702 N. Third Street; P.O. Box 94214; Baton Rouge, LA 70802; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Office of Personnel Management Multi State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1702 N. Third Street; P.O. Box 94214; Baton Rouge, LA 70802 Additionally, a consumer assistance program can help you file your appeal. Contact 800-259-5300

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Not Applicable**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-833-635-0450 (TTY 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-635-0450 (TTY 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-635-0450 (TTY 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-635-0450 (TTY 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,850
Specialist copayment	$65
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,850
Specialist copayment	$65
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

The plan's overall deductible	$3,850
Specialist copayment	$65
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Louisiana Healthcare Connections, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-635-0450 (TTY 711).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Louisiana Healthcare Connections, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le 1-833-635-0450 (TTY 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Louisiana Healthcare Connections, 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 1-833-635-0450 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Louisiana Healthcare Connections 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 1-833-635-0450 (TTY 711)。
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter from Louisiana Healthcare Connections، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-635-0450 (TTY 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Louisiana Healthcare Connections, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-635-0450 (TTY 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Louisiana Healthcare Connections 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-635-0450 (TTY 711) 번으로 전화하십시오.
Portuguese:	Se você ou alguém que estiver a ajudar tiver dúvidas sobre a Ambetter from Louisiana Healthcare Connections, tem o direito de obter ajuda e informações no seu idioma gratuitamente. Para falar com um intérprete, ligue para 1-833-635-0450 (TTY 711).
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Louisiana Healthcare Connections, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-635-0450 (TTY 711).
Japanese:	Ambetter from Louisiana Healthcare Connections 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、1-833-635-0450 (TTY 711) までお電話ください。
Urdu:	اگر Ambetter from Louisiana Healthcare Connections کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے 1-833-635-0450 (TTY 711) پر کال کریں۔
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Louisiana Healthcare Connections 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 1-833-635-0450 (TTY 711) an.
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Louisiana Healthcare Connections داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-833-635-0450 (TTY 711) تماس بگيريد.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Louisiana Healthcare Connections вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-635-0450 (TTY 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Louisiana Healthcare Connections ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-635-0450 (TTY 711).

Statement of Non-Discrimination

Ambetter from Louisiana Healthcare Connections Inc. 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 Louisiana Healthcare Connections Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Louisiana Healthcare Connections Inc.:

- 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 Louisiana Healthcare Connections Inc. at 1-833-635- 0450 (TTY 711).

If you believe that Ambetter from Louisiana Healthcare Connections Inc. 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 Louisiana Healthcare Connections Inc., Attn: Appeals and Grievances PO Box 10341 Van Nuys CA, 91410, 1-833-635-0450 (TTY 711), Fax 1-833-886-7956. You
can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Louisiana Healthcare Connections Inc. 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*.