Coverage Period: 01/01/2026 – 12/31/2026 Coverage for: Individual/Family | Plan Type: EPO

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://ambetterhealth.com/en/la/2026-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?	\$7,500 individual / \$15,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .	
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services, primary care, <u>specialist</u> , and <u>urgent care</u> visits, and certain <u>prescription drugs</u> are covered before you meet your <u>deductible</u> (see additional information below).	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .	
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.	
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$10,000 individual / \$20,000 family. Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.	
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.	
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://ambetterhealth.com/en/la/findadoc dadoc or call 1-833-635-0450 (TTY 711) for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.	

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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

	Services You May Need	What You Will Pay		Limitations Everytions 9 Other
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not covered	Covered No Limit.
	Specialist visit	\$100 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not covered	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	50% Coinsurance for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition More information about prescription drug	Generic drugs	Tier 1a - Preferred Generic Retail: \$25 Copay / prescription; 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.

	Services You May Need	What You Will Pay		Limitationa Evacationa & Other
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
coverage is available at https://ambetterhealth.com/en/la/2026formulary		Tier 1b - Generic Retail: \$25 <u>Copay</u> / prescription; <u>deductible</u> does not apply		
	Preferred brand drugs	Tier 2 - Retail: \$50 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30
	Non-preferred brand drugs and Non-preferred generic drugs.	Tier 3 - Retail: \$100 Copay / prescription	Not covered	days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Specialty drugs	Tier 4 - Retail: \$150 Copay / prescription	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).
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
surgery	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Emergency room care	50% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency medical transportation	50% Coinsurance	50% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	\$75 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not covered	None
If you have a hospital	Facility fee (e.g., hospital room)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
stay	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

		What You Will Pay		Limitations Exceptions & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$50 Copay / visit; deductible does not apply; Other Outpatient Services: 50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$50 <u>Copay</u> / visit; <u>deductible</u> 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 prenatal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% Coinsurance	Not covered	Prior authorization may be required. Cost- sharing does not apply for preventive
	Childbirth/delivery facility services	50% Coinsurance	Not covered	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).
	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: \$50 Copay / visit; deductible does not apply Inpatient: 50% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: \$50 Copay / visit; deductible does	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
		not apply Inpatient: 50% Coinsurance		authorization may be required. Covered No Limit.
	Skilled nursing care	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Durable medical equipment	50% 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.
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to 1 item per year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

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

- Dental care (Adult)
- Dental care (Children)
- Infertility treatment
- Long-term care

- 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 (On home and outpatient basis only (inpatient excluded))
- 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); Louisiana Department of Insurance, P.O. Box 94214, Baton Rouge, LA, 70804, Phone: 1-800-259-5300; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or 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 /multi-state-plan-program/external-review/. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Louisiana Department of Insurance, P.O. Box 94214, Baton Rouge, LA, 70804, Phone: 1-800-259-5300.

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 the 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 <u>plan</u> 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 <u>plan's</u> overall <u>deductible</u>	\$7,500
■ Specialist copayment	\$100

This EXAMPLE event includes services like:

Diagnostic tests (ultrasounds and blood work)

■ Hospital (facility) coinsurance

Specialist office visits (prenatal care)

Childbirth/Delivery Facility Services

Specialist visit (anesthesia)

Childbirth/Delivery Professional Services

■ Other coinsurance

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a wellcontrolled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%

■ Other coinsurance

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Total Example Cost

50%

Durable medical equipment (glucose meter)

This EXAMPLE event includes services like:

\$5,600

Emergency room care (including medical supplies)

Mia's Simple Fracture

(in-network emergency room visit and

follow up care)

Diagnostic tests (x-ray)

■ Other coinsurance

Durable medical equipment (crutches)

■ The plan's overall deductible

■ Hospital (facility) coinsurance

■ Specialist copayment

Rehabilitation services (physical therapy)

Total Example Cost \$12,700 In this example, Peg would pay: Cost Sharing **Deductibles** \$7,500 Copayments \$60 \$1.200 Coinsurance What isn't covered Limits or exclusions \$60 The total Peg would pay is \$8,820

\$4,000
\$700
\$0
\$20
\$4,720

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$2,100
Copayments	\$500
Coinsurance	\$0
What isn't covered	'
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

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

\$7,500

\$100

50%

50%





English:	If you, or someone you are helping, have questions about Ambetter from Louisiana Healthcare Connections, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-635-0450 (TTY 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Louisiana Healthcare Connections y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros 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 et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-833-635-0450 (TTY 711).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Louisiana Healthcare Connections và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-833-635-0450 (TTY 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Louisiana Healthcare Connections، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على (TTY 711) 635-633-1.
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Louisiana Healthcare Connections, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o pannikin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-635-0450 (TTY 711).
Chinese:	如果您或您正在協助的對象對 Ambetter from Louisiana Healthcare Connections 所提供的任何服務有問題,且不精通英語,您有權利免費並及時以您的母語獲得幫助和訊資訊。如果您或您正在協助的對象有聽力和/或視力上的問題,阻礙了溝通,您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務,請聯絡會員服務部,電話是 1-833-635-0450 (TTY 711)。
Portuguese:	Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca do Ambetter from Louisiana Healthcare Connections e não falar inglês, tem direito a obter ajuda e informações no seu idioma, sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem direito a receber equipamentos ou serviços de assistência, sem qualquer custo e de forma atempada. Para ter acesso a traduções ou a serviços de assistência, contacte os Serviços de Membros através do número 1-833-635-0450 (TTY 711).

Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter from Louisiana Healthcare Connections, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa **Haitian Creole:** yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-833-635-0450 (TTY 711). Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Louisiana Healthcare Connections hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör und/oder Sehbeeinträchtigung German: hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-833-635-0450 (TTY 711). หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from Louisiana Healthcare Connections และไม่ชำนาญในการใช้ภาษาอังกฤษ คณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมลในภาษาของคณโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที Thai: หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการ สื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-635-0450 (TTY 711) अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter from Louisiana Healthcare Connections से जुड़े प्रश्न हैं और आप दोनों अंग्रेज़ी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ़्त और समय पर सहायता और जानकारी प्राप्त करने का अधिकार है. अगर आपको या किसी ऐसे Hindi: व्यक्ति को जिसकी आप मदद कर रहे हैं, सूनने और/या देखने में समस्या होती है और इससे बातचीत बाधित होती है, तो आपको बिना किसी लागत के और समय पर सहायक सहायता और सेवाएं प्राप्त करने का अधिकार है. अन्वाद या सहायक सेवाएं प्राप्त करने के लिए कृपया 1-833-635-0450 (TTY 711) पर सदस्य सेवाएं से संपर्क करें. اگر شما یا فردی که دارید به او کمک می کنید، سؤالی دریاره Ambetter from Louisiana Healthcare Connections دارید، و انگلیسی نمیدانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک میکنید مشکلات شنّوایی یا بینایی دارد که برقراری ارتباط را سخت میکند، حقّ دارید کمکها و خدمات امدادی را به زیان Farsi: خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمکها و خدمات امدادی لطفاً با خدمات اعضا به شماره (TTY 711) 1-833-635-0450 تماس بگیرید. 귀하 또는 귀하의 도움을 받는 분이Ambetter from Louisiana Healthcare Connections에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 Korean: 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 통역 또는 보조 서비스를 받으시려면1-833-635-0450 (TTY 711)번으로 가입자 서비스부에 연락해주십시오. Haddii adiga, ama qof aad caawinaysaa, uu qabo su'aalo ku saabsan Ambetter from Louisiana Healthcare Connections, oo aanu si wanaagsan ugu hadal Ingiriisiga, waxaad xaq u leedahay inaad hesho caawimo iyo macluumaad ah luqaddaada oo aan kharash ahayn iyo wakhti habboon. Somali: Haddii adiga, ama qof aad caawinayso, aad qabtaan xaalado maqalka ah iyo/ama araga ah oo xanibta wada xidhiidhka, waxaad xaq u leedahay inaad hesho kaalmada wada xidhiidhka iyo adeegyada oo aan kharash kugu joogin qaab wakhti habboon ah. Si aad u hesho turjumaad iyo adeegyada kaalmada wada xidhiidhka, fadlan la xidhiidh Adeegyada Xubinta lambarka 1-833-635-0450 (TTY 711). আপনি অথবা অন্য কেউ যাকে আপনি সাহায্য করছেন তার Ambetter from Louisiana Healthcare Connections নিয়ে প্রশ্ন থেকে থাকলে ও ইংরাজিতে সড়গড় না হলে নিখরচায় ও সময় মতো আপনার নিজের ভাষাতে সাহায্য ও তথ্য পাওয়ার অধিকার রয়েছে। আপনি বা অন্য কেউ যাকে আপনি সাহায্য করছেন তার শ্রবণ এবং/অথবা দৃশ্যগত রোগাবস্থা থেকে থাকে Bengali: যা কমিউনিকেশনকে বিলম্বিত করে সে ক্ষেত্রে আপনার নিখরচায় ও সময় মতো সহায়ক ও পরিষেবা পাওয়ার অধিকার রয়েছে। অনুবাদ ও সহায়ক পরিষেবা পেতে অনুগ্রহ করে 1-833-635-0450 (TTY 711)-এ সদস্য পরিষেবাসমূহ-এর সাথে যোগাযোগ করুন।