



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://ambetterhealthofdelaware.com/2024-brochures.html>, or call 1-833-919-3214 (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 1-833-919-3214 (TTY 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$1,500 individual / \$3,000 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, generic, preferred brand drugs and Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4) are covered before you meet your deductible . | 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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | For network providers : \$8,700 individual / \$17,400 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, 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 network provider ? | Yes. See https://ambetterhealthofdelaware.com/findadoc or call 1-833-919-3214 (TTY 711) for a list of network providers . | 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 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 |
|--|--|--|--|---|
| | | Network Provider (You will pay the least) | 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 | \$30 Copay / visit; deductible does not apply | Not covered | Covered No Limit. |
| | Specialist visit | \$60 Copay / visit; deductible does not apply | Not covered | Covered No Limit. |
| | 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 provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 25% Coinsurance for laboratory & professional services 25% Coinsurance for x-ray & diagnostic imaging 25% 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) | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need drugs to treat your illness or condition | Generic drugs (Tier 1) | Preferred Generic Retail: \$15 Copay / prescription; deductible does not apply Generic Retail: \$15 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| More information about prescription drug coverage is available at https://ambetterhealthofdelaware.com/2024formulary . | Preferred brand drugs (Tier 2) | Retail: \$30 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. |
| | Non-preferred brand and non-preferred generic drugs (Tier 3) | Retail: \$60 Copay / prescription; deductible does not apply | Not covered | |
| | Specialty drugs (Tier 4) | Retail: \$100 Copay / prescription; deductible does not apply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need immediate medical attention | Emergency room care | 25% Coinsurance | 25% Coinsurance | Covered No Limit. |
| | Emergency medical transportation | 25% Coinsurance | 25% 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 . |
| | Urgent care | \$45 Copay / visit; deductible does not apply | Not covered | Covered No Limit. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$30 Copay / visit; deductible does not apply; Other Outpatient Services: 25% 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.) |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Inpatient services | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you are pregnant | Office visits | \$30 Copay / visit; 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). |
| | Childbirth/delivery professional services | 25% 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). |
| | Childbirth/delivery facility services | 25% Coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 25% Coinsurance | Not covered | Prior authorization may be required. Limited to 100 visits per year. |
| | Rehabilitation services | Outpatient: \$30 Copay / visit; deductible does not apply Inpatient: 25% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Limited to 30 visits per year (combined for occupational and physical therapy), limited to 30 visits per year for speech therapy. Note: Limits do not apply when treatment is provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Habilitation services | Outpatient: \$30 Copay / visit; deductible does not apply Inpatient: 25% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Limited to 30 visits per year (combined for occupational and physical therapy), limited to 30 visits per year for speech therapy. Note: Limits do not apply |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | when treatment is provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Skilled nursing care | 25% Coinsurance | Not covered | Prior authorization may be required. Limited to 120 days per admission in a facility. Benefits renew after 180 days without care. |
| | Durable medical equipment | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 25% 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 .) | | |
|---|--|--|
| <ul style="list-style-type: none"> Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) Acupuncture Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult) Dental care (Children) Long-term care | <ul style="list-style-type: none"> 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.) | | |
| <ul style="list-style-type: none"> Bariatric surgery Chiropractic care (Limited to 30 visits per year.) | <ul style="list-style-type: none"> Hearing aids (Limited to 1 hearing aid per ear per 3 years) Infertility treatment | <ul style="list-style-type: none"> Private-duty nursing 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 Health of Delaware at 1-833-919-3214 (TTY 711); Delaware Department of Insurance, Insurance Commissioner, 1351 West North Street, Suite 101 Dover, DE 19904, (302) 674-7300; 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 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: Delaware Department of Insurance, Insurance Commissioner, 1351 West North Street, Suite 101 Dover, DE 19904, (302) 674-7300

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 1-833-919-3214 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-919-3214 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-919-3214 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-919-3214 (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 | \$1,500 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 25% |
| ■ Other coinsurance | 25% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$40 |
| Coinsurance | \$2,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,700 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,500 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 25% |
| ■ Other coinsurance | 25% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$900 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,820 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,500 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 25% |
| ■ Other coinsurance | 25% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$300 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

| | |
|-----------------------|--|
| English: | If you, or someone you are helping, have questions about Ambetter Health of Delaware, 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 1-833-919-3214 (TTY 711). |
| Spanish: | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter Health de Delaware 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 1-833-919-3214 (TTY 711). |
| Chinese: | 如果您，或是您正在協助的對象，有關於 Ambetter Health of Delaware 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。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 1-833-919-3214 (TTY 711)。 |
| French Creole: | Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter Health of Delaware, epi nou pa mètize 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 yon pwoblèm pou wè ki pètibè 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 1-833-919-3214 (TTY 711). |
| Gujarati: | જો તમને અથવા તમે જેમની મદદ કરી રહ્યા છો એવી કોઈ વ્યક્તિને Ambetter Health of Delaware વિશે પ્રશ્નો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા છો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-833-919-3214 (TTY 711) પર સભ્યની સેવાઓનો સંપર્ક કરો. |
| French: | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711). |
| Korean: | 귀하 또는 귀하의 도움을 받는 분이 Ambetter Health of Delaware에 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 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-833-919-3214 (TTY 711)번으로 가입자 서비스부에 연락해주시십시오. |
| Italian: | Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter Health of Delaware e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-833-919-3214 (TTY 711). |
| Vietnamese: | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711). |
| German: | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter Health of Delaware 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 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 1-833-919-3214 (TTY 711).

Tagalog:

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter Health of Delaware, 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 paningin 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 1-833-919-3214 (TTY 711).

Hindi:

अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter Health of Delaware से जुड़े प्रश्न हैं और आप दोनों अंग्रेज़ी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ्त और समय पर सहायता और जानकारी प्राप्त करने का अधिकार है. अगर आपको या किसी ऐसे व्यक्ति को जिसकी आप मदद कर रहे हैं, सुनने 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. अनुवाद या सहायक सेवाएं प्राप्त करने के लिए कृपया 1-833-919-3214 (TTY 711) पर सदस्य सेवाएं से संपर्क करें.

Urdu:

اگر آپ، یا جس کی آپ مدد کر رہے ہیں وہ Ambetter Health of Delaware کے بارے میں سوالات کرنا چاہتے ہیں، اور وہ انگریزی میں ماہر نہیں ہیں، تو آپ کو اپنی زبان میں بلا معاوضہ اور بروقت مدد اور معلومات حاصل کرنے کا حق ہے۔ اگر آپ، یا جس کی آپ مدد کر رہے ہیں، انہیں سماعت اور/یا بصارت میں کوئی پریشانی درپیش ہو جس سے مواصلت میں رکاوٹ پیدا ہوتی ہے، تو آپ کو مفت اور بر وقت معاون امداد اور خدمات حاصل کرنے کا حق ہے۔ ترجمہ یا معاون خدمات حاصل کرنے کے لیے، براہ کرم 1-833-919-3214 (TTY 711) پر ممبر سروسز سے رابطہ کریں۔

Arabic:

إذا كان لديك أو لدى شخص تساعدك حول Ambetter Health of Delaware ، ولم تكن بارعًا باللغة الإنكليزية، فلدنياك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعدك تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلدنياك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بخدمات الأعضاء على 1-833-919-3214 (TTY 711).

Telugu:

మీకు లేదా మీకు సహాయం చేస్తున్న ఎవరికైనా Ambetter Health of Delaware గురించి ప్రశ్నలు ఉంటే మరియు ఇంగ్లీష్ లో ప్రావిణ్యం లేకుంటే, ఎటువంటి ఖర్చు లేకుండా మరియు సకాలంలో మీ భాషలో సహాయం మరియు సమాచారాన్ని పొందే హక్కు మీకు ఉంది. మీకు లేదా మీకు సహాయం చేస్తున్న ఎవరికైనా కమ్యూనికేషన్ కు అటంకం కలిగించే వినికిడి మరియు/లేదా కంటిచూపుకి సంబంధించిన సమస్య ఉంటే, ఎటువంటి ఖర్చు లేకుండా మరియు సకాలంలో అనుబంధ సహాయాలు మరియు సేవలను పొందే హక్కు మీకు ఉంది. అనువాదం లేదా అనుబంధ సేవలను పొందడానికి, దయచేసి సభ్యుడి సేవలను 1-833-919-3214 (TTY 711)లో సంప్రదించండి.

Dutch:

Als u, of iemand die u helpt, vragen heeft over Ambetter Health of Delaware en de Engelse taal niet machtig is, hebt u het recht om kosteloos en tijdig hulp en informatie in uw taal te krijgen. Als u, of iemand die u helpt, een auditieve en/of visuele beperking heeft die de communicatie belemmert, hebt u recht om kosteloos en tijdig hulpmiddelen en ondersteuning te ontvangen. Om vertaal- of ondersteuningsdiensten te ontvangen, kunt u contact opnemen met Ledenservice via 1-833-919-3214 (TTY 711).

Statement of Non-Discrimination

Ambetter Health of Delaware is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Delaware Health Insurance Marketplace. Celtic Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. © 2023 Celtic Insurance Company. All rights reserved.

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If you, or someone you are helping, have questions about Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711). If you believe that Celtic Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-919-3214 (TTY 711). You may also submit a grievance by phone to 1-833-919-3214 (TTY 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>.

AMB23-DE-C-00056

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