



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/de/2026-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 <a href="#">deductible</a> ?                                | \$6,000 individual / \$12,000 family.                                                                                                                                                                                                                                            | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services, primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> visits, and certain <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> (see additional information below). | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$8,900 individual / \$17,800 family. Not applicable for <a href="#">out-of-network providers</a> .                                                                                                                                      | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.                                                                      | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://ambetterhealth.com/en/de/fi/ndadoc">https://ambetterhealth.com/en/de/fi/ndadoc</a> or call 1-833-919-3214 (TTY 711) for a list of <a href="#">network providers</a> .                                                                                  | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |

 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<br>(You will pay the least)                                                                                                                                                                                                                                 | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's</a> office or clinic                                           | Primary care visit to treat an injury or illness       | \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                | Not covered                                        | Covered No Limit.                                                                                                                                                                                                                                                          |
|                                                                                                                  | <a href="#">Specialist</a> visit                       | \$80 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                | Not covered                                        | None                                                                                                                                                                                                                                                                       |
|                                                                                                                  | <a href="#">Preventive care/screening/immunization</a> | No charge; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                         | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                  |
| If you have a test                                                                                               | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 40% <a href="#">Coinsurance</a> for laboratory & professional services<br>40% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging<br>40% <a href="#">Coinsurance</a> 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)                           | 40% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                              | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                     |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug</a> | Generic drugs                                          | Tier 1a - Preferred Generic Retail: \$20 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply                                                                                                                                                     | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.                                                |

| Common Medical Event                                                                                                                                                                              | Services You May Need                                      | What You Will Pay                                                                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                   |                                                            | Network Provider<br>(You will pay the least)                                                                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                |
| <a href="https://ambetterhealth.com/en/de/2026formulary">coverage</a> is available at <a href="https://ambetterhealth.com/en/de/2026formulary">https://ambetterhealth.com/en/de/2026formulary</a> |                                                            | Tier 1b - Generic Retail: \$20 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply |                                                    |                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                   | Preferred brand drugs                                      | Tier 2 - Retail: \$40 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply          | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.                                                                                                    |
|                                                                                                                                                                                                   | Non-preferred brand drugs and Non-preferred generic drugs. | Tier 3 - Retail: \$80 <a href="#">Copay</a> / prescription                                                     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                   | <a href="#">Specialty drugs</a>                            | Tier 4 - Retail: \$125 <a href="#">Copay</a> / prescription                                                    | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 30 days through mail order.                                                                                                                                                                                |
| If you have outpatient surgery                                                                                                                                                                    | Facility fee (e.g., ambulatory surgery center)             | 40% <a href="#">Coinsurance</a>                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                   | Physician/surgeon fees                                     | 40% <a href="#">Coinsurance</a>                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                                                                                                                                           | <a href="#">Emergency room care</a>                        | 40% <a href="#">Coinsurance</a>                                                                                | 40% <a href="#">Coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                   | <a href="#">Emergency medical transportation</a>           | 40% <a href="#">Coinsurance</a>                                                                                | 40% <a href="#">Coinsurance</a>                    | 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 <a href="#">network</a> ground/water ambulance <a href="#">provider</a> , you may be subject to <a href="#">balance billing</a> . |
|                                                                                                                                                                                                   | <a href="#">Urgent care</a>                                | \$60 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                                                                                                                                                       | Facility fee (e.g., hospital room)                         | 40% <a href="#">Coinsurance</a>                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                   | Physician/surgeon fees                                     | 40% <a href="#">Coinsurance</a>                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                          |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least)                                                                                                               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office Visit: \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply;<br>Other Outpatient Services: 40% <a href="#">Coinsurance</a> | Not covered                                        | Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.)                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                        | 40% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                             | \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> 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. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services | 40% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                        | Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                                                                                                |
|                                                                           | Childbirth/delivery facility services     | 40% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                        | Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                                                                                                |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 40% <a href="#">Coinsurance</a>                                                                                                                            | Not covered                                        | Prior authorization may be required. Limited to 100 visits per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Rehabilitation services</a>   | Outpatient: \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply<br>Inpatient: 40% <a href="#">Coinsurance</a>                    | 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.                                                                                                                                                                                                                                                  |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                             |
|----------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Network Provider<br>(You will pay the least)                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                                           |                                                                                                                                         |                                                    | Inpatient: Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                  |
|                                        | <a href="#">Habilitation services</a>     | Outpatient: \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply<br>Inpatient: 40% <a href="#">Coinsurance</a> | 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.<br>Inpatient: Prior authorization may be required. Covered No Limit. |
|                                        | <a href="#">Skilled nursing care</a>      | 40% <a href="#">Coinsurance</a>                                                                                                         | Not covered                                        | Prior authorization may be required. Limited to 120 days per admission in a facility. Benefits renew after 180 days without care.                                                                                                                                                                                                                                  |
|                                        | <a href="#">Durable medical equipment</a> | 40% <a href="#">Coinsurance</a>                                                                                                         | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                             |
|                                        | <a href="#">Hospice services</a>          | 40% <a href="#">Coinsurance</a>                                                                                                         | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                             |
| If your child needs dental or eye care | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply                                                                                    | Not covered                                        | Limited to 1 visit per year.                                                                                                                                                                                                                                                                                                                                       |
|                                        | Children's glasses                        | No charge; <a href="#">deductible</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                              |                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>                                                                              | <ul style="list-style-type: none"> <li>Dental care (Children)</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)     |                                                                                                                                              |                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion</li> <li>Bariatric surgery</li> <li>Chiropractic care (Limited to 30 visits per year)</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids (Limited to 1 hearing aid per ear per 3 years)</li> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul> |

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

**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, Phone: 1-800-282-8611; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Delaware Consumer Assistance Program at 1-800-282-8611; 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](http://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, Phone: 1-800-282-8611. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Delaware Consumer Assistance Program at 1-800-282-8611.

**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 1-833-919-3214 (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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$6,000        |
| <a href="#">Copayments</a>        | \$50           |
| <a href="#">Coinsurance</a>       | \$1,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,710</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

|                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>English:</b>               | 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).                                                          |
| <b>Spanish:</b>               | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter Health of 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).                                      |
| <b>Chinese (Traditional):</b> | 如果您或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得幫助和資訊。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 1-833-919-3214 (TTY 711)。                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Haitian Creole:</b>        | Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter Health of Delaware, 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 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 1-833-919-3214 (TTY 711).                                                                       |
| <b>French:</b>                | 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). |
| <b>Hindi:</b>                 | 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 अंग्रेजी 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.                                 |
| <b>Arabic:</b>                | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter Health of Delaware، ولم تكن تجيد التحدث باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت تعاني، أنت أو أي شخص تساعد، 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 بخدمات الأعضاء على 1-833-919-3214 (TTY 711).                                                                                                                                              |
| <b>Gujarati:</b>              | જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો 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 હો 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.                                   |



|                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tagalog:</b> | 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 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 1-833-919-3214 (TTY 711). |
| <b>German:</b>  | 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).                                                                             |
| <b>Telugu:</b>  | మీకు లేదా మీరు సహాయం చేస్తున్న వ్యక్తికి Ambetter Health of Delaware గురించి ప్రశ్నలు ఉంటే మరియు మీరు ఇంగ్లీష్ లో నిపుణులు కాకపోతే, మీకు మీ భాషలో సహాయం మరియు సమాచారం సమయానుకూలంగా మరియు ఉచితంగా పొందే హక్కు ఉంది. మీకు లేదా మీరు సహాయం చేస్తున్న వ్యక్తికి వినికిడి మరియు/లేదా దృశ్య సంబంధిత శారీరక పరిస్థితి వల్ల కమ్యూనికేషన్ లో ఆటంకం కలిగితే, మీరు సహాయక పరికరాలు మరియు సేవలను సమయానుకూలంగా మరియు ఉచితంగా పొందే హక్కు కలిగి ఉన్నారు. అనువాదం లేదా సహాయక సేవలను పొందడానికి, దయచేసి మెంబర్ సర్వీస్ ను 1-833-919-3214 (TTY 711) ద్వారా సంప్రదించండి.                                                                                                |
| <b>Korean:</b>  | 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. 통역 또는 보조 서비스를 받으시려면 1-833-919-3214 (TTY 711)번으로 가입자 서비스부에 연락해 주십시오.                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Urdu:</b>    | 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 ہے جس سے مواصلت میں رکاوٹ پیدا ہوتی ہے، تو آپ کو مفت اور بروقت 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۔                                                                                                                             |
| <b>Yoruba:</b>  | Bí iwọ, tàbí ẹnikan tí iwọ ń ràn lówọ, bá ní ibéèrè nípa Ambetter Health of Delaware, tí o kò sì mọ èdè Gẹ̀ẹ̀sì sọ dádádára, o ní ẹ̀tọ́ láti rí irànlówọ́ àti àlàyé gbà ní èdè rẹ lófẹ́ẹ́ àti ní àkókò tó yẹ. Bí iwọ, tàbí ẹnikan tí iwọ ń ràn lówọ, bá ní ìsòrò ìgbọ̀rọ́ àti/tàbí ìrírán tó ń dí ìbáraenisòrọ́ lówọ, o ní ẹ̀tọ́ láti gba àwọn ohun irànlówọ́ ìgbọ̀rọ́ àti àwọn isẹ́ irànlówọ́ láisanwó àti ní àkókò tó yẹ. Láti gba àwọn isẹ́ itumọ́ èdè tàbí àwọn isẹ́ irànlówọ́, jọwọ kàn sí Àwọn isẹ́ Ọmọ ẹgbẹ ní 1-833-919-3214 (TTY 711).                                                                                                       |
| <b>Dutch:</b>   | 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).                                                                                                                                  |
| <b>Swahili:</b> | Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu Ambetter Health of Delaware, na huelewi Kiingereza vizuri, una haki ya kupata usaidizi na maelezo kwa lugha yako bila kulipa ada yoyote na kwa wakati ufaao. Ikiwa wewe, au mtu unayemsaidia, ana tatizo la kusikia na/au la kuona ambalo linazuia mawasiliano, una haki ya kupata usaidizi na huduma za ziada bila kulipa ada yoyote na kwa wakati unaofaa. Ili kupata huduma za tafsiri au za ziada, tafadhali wasiliana na Huduma kwa Wanachama 1-833-919-3214 (TTY 711).                                                                                                                      |