delaware first health

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

2026 Member Handbook

Diamond State Health Plan Plus Long-Term Services and Support (LTSS)

DelawareFirstHealth.com
1-877-236-1341 (TTY: 711)

750 Prides Crossing
Suite 200
Newark, DE 19713

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Caid-MHB-LTSS-DE-Eng-01012026

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WELCOME TO DELAWARE FIRST HEALTH

Delaware First Health is a managed care organization (MCO) offering healthcare for people in Delaware enrolled in Medicaid. We work with providers, clinics, and hospitals to give you and your family the care you need. Our staff will be managing your long-term services and supports (LTSS), and our mission is to ensure you get the personalized care you need to live your life to the fullest. Whether you need help with daily activities, long-term planning, or simply to stay connected, we're committed to providing the highest quality of service.

As a valued member of Delaware First Health, you have access to a wide range of resources designed to help you maintain your independence, well-being, and dignity. Our dedicated team is here to listen, support, and work with you every step of the way along your care journey.

This handbook will be your guide to the full range of Medicaid healthcare services available to you. If you have any questions about the information in this handbook, or any questions about your Medicaid benefits, please call Member Services at **1-877-236-1341** (TTY: **711**) or visit our website at **DelawareFirstHealth.com**.

English: If you need this in another language, oral interpretation, auxiliary aids and services, or an alternative format call us. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
Español (Spanish): Si necesita esto en otro idioma o en un formato alternativo, o si necesita interpretación oral o servicios y dispositivos auxiliares, llámenos. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
中文 **(Chinese):** 如您需要以其他語言、口譯、輔助工具和服務或其他文件格式檢閱此資訊，請致電我們。 **Delaware First Health** : **1-877-236-1341 (TTY: 711)**。
Kreyòl Ayisyen (Haitian Creole): Si w bezwen sa a nan yon lòt lang, entèpretasyon oral, èd ak sèvis oksilyè, oswa nan yon lòt fòma, rele nou. **Delaware First Health: 1-877-236-1341 (TTY: 711).**

IMPORTANT PHONE NUMBERS

If you are in danger or need immediate medical attention, call **911**.

For a behavioral or mental health emergency, call or text **988**, the National Suicide Prevention Lifeline.

Delaware First Health Assistance Line	
Service:	**Contact Information:**
Member Services: **Monday-Friday, 8 a.m. to 7 p.m. Call this number for all Member Service needs, such as:** • Benefits questions. • Help changing or picking a primary care provider (PCP). • Vision and dental services. • Pharmacy services. • Member advocates.	**1-877-236-1341** (TTY: **711**)
24-Hour Nurse Advice Line: Our Nurse Advice Line is ready to answer your health questions 24 hours a day, seven days a week — every day of the year.	**1-877-236-1341** (TTY: **711**)
Care Coordination / Case Management: Monday through Friday, 8 a.m. to 5 p.m. Care coordination and case management are part of your benefits and are provided to you at no cost.	**1-877-236-1341** (TTY: **711**)
Delaware Behavioral and Mental Health toll-free Hotline(s)	
Service:	**Contact Information:**
Northern Delaware Hotline.	**1-800-652-2929**
Southern Delaware Hotline.	**1-800-345-6785**
Delaware Department of Services for Children, Youth and Their Families (DSCYF) 24/7 Youth Crisis Support.	**1-800-969-4357**

Delaware Medicaid and Medical Assistance Services	
Service:	**Contact Information:**
Non-emergency medical transportation services: • Please contact ModivCare for help scheduling non-emergency medical transportation (NEMT). You must call 72 hours in advance to schedule transportation. • For more information, visit **dhss.delaware.gov/dmma/medical.html**.	**1-866-412-3778**
Division of Social Services (DSS) and Division of Medicaid and Medical Assistance (DMMA) Customer Relations Unit: • The Customer Relations Unit provides general information, referrals, and assistance to DMMA and Division of Social Services applicants, clients, staff, and others inquiring about Medicaid benefits and services.	**1-866-843-7212**
Medicaid Health Benefits Manager: Helps you enroll in a managed care organization (MCO) and understand your benefits.	**1-800-996-9969**

ALTERNATIVE FORMATS

Interpretation and Translation Services

We provide oral interpretation services in ALL languages, free of charge. We also provide translated printed materials in the following languages, free of charge, when requested:

- Spanish
- Chinese
- Haitian Creole
- Gujarati
- French
- Korean
- Italian
- Vietnamese
- German
- Tagalog
- Hindi
- Urdu
- Arabic
- Telugu
- Dutch

Call Member Services at 1-877-236-1341 (TTY: 711) to get any of these services at no cost to you:

- Immediate over-the-phone interpreter services.
- Interpretation at your doctor visits, with at least five business days' notice.
- This member handbook or any other written materials in your preferred language.

Auxiliary Aids and Services

We will provide written materials in alternative formats and/or through the provision of auxiliary aids, free of charge, when requested.

Please call Member Services at **1-877-236-1341** (TTY: **711**). We are here for you Monday through Friday, from 8 a.m. to 7 p.m., Eastern time, if you need interpretation or translation services or auxiliary aids and services.

GLOSSARY OF TERMS

If you need help understanding any of the words used in this handbook, you can find the glossary of terms in the back of this handbook. You can also call Member Services at **1-877-236-1341** (TTY: **711**) for help.

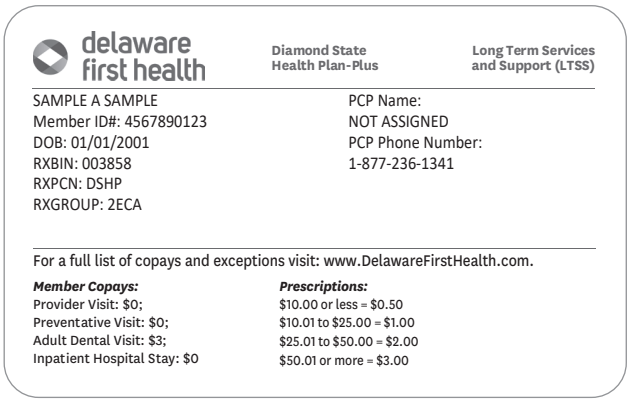
GETTING STARTED

Your Member ID Card

When you enroll, Delaware First Health will mail you a member identification (ID) card. Bring your ID card with you to all your medical appointments. Show your card to the office staff when you check in for your appointment.

Your Delaware First Health ID card for DSHP Plus LTSS will have the information below. Your actual card may look different from this example.

Front:


delaware first health

Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

SAMPLE A SAMPLE
Member ID#: 4567890123
DOB: 01/01/2001
RXBIN: 003858
RXPCN: DSHP
RXGROUP: 2ECA

PCP Name:
NOT ASSIGNED
PCP Phone Number:
1-877-236-1341

For a full list of copays and exceptions visit: www.DelawareFirstHealth.com.

Member Copays:
Provider Visit: $0;
Preventative Visit: $0;
Adult Dental Visit: $3;
Inpatient Hospital Stay: $0

Prescriptions:
$10.00 or less = $0.50
$10.01 to $25.00 = $1.00
$25.01 to $50.00 = $2.00
$50.01 or more = $3.00

Back:


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

Diamond State Health Plan-Plus

Long Term Services and Support (LTSS)

- **Member Services, 24/7 Nurse Line, Behavioral Health Line:** 1-877-236-1341 (TTY: 711)
- **Providers:** 1-877-236-1341
- **Pharmacy Services:** 1-833-236-1887 (TTY: 711)
- **Dental:** 1-877-236-1341 (TTY: 711)

Medical Claims:
Delaware First Health
P.O. Box 8001
Farmington, MO 63640

Pharmacy Paper Claims:
Pharmacy Services
Member Reimbursements
P.O. Box 989000
West Sacramento, CA 95798

In case of an emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

When you get your card, please confirm that your name and date of birth are correct.

Please check that the PCP listed is the one that you chose. Your PCP is a doctor, nurse, or physician assistant (PA) who provides, plans, and/or helps you get healthcare services.

If you chose a PCP during your Medicaid enrollment, your PCP's information will be on your ID card. If you did not choose a PCP, you will have 30 calendar days from your Effective Date of Enrollment to pick a PCP. If you need help choosing a PCP, call Member Services at **1-877-236-1341** (TTY: **711**). You can also visit our secure member portal at **Member.DelawareFirstHealth.com** to pick or change your PCP. If you do not choose a PCP within 30 calendar days, we will choose one for you and mail you a new ID card.

Your member ID card is proof that you are a Delaware First Health member. Show this ID card every time you need care. This includes:

- Medical appointments.
- Urgent care.
- Vision appointments.
- Behavioral health appointments.
- Emergency visits.
- Picking up prescriptions from the pharmacy.

Anytime you get a new member ID card from us, please destroy your old one. If you lose your Delaware First Health member ID card or did not get one, we can replace it for you. To replace your card, please visit the secure member portal on our website **Member.DelawareFirstHealth.com** or call Member Services at **1-877-236-1341** (TTY: **711**).

Keep your ID card with you and safe at all times. Make sure your card is not stolen or used by someone else. Delaware First Health coverage is for you only. It is up to you to protect your member ID card. It is against the law to give or sell your member ID card to anyone.

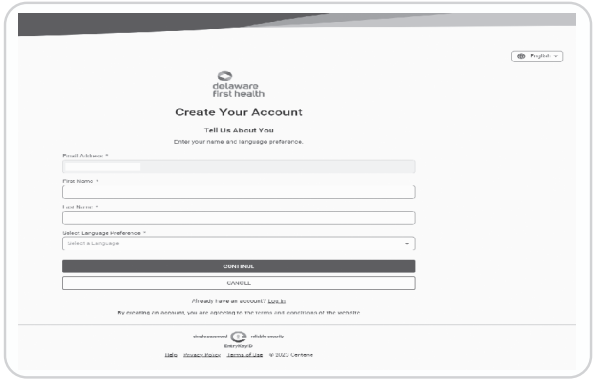
Set Up Your Online Member Account

FOLLOW THESE STEPS BELOW TO CREATE YOUR MEMBER PORTAL ACCOUNT:

Getting your healthcare information online is easy. You can also earn a **$10 reward on your My Health Pays® rewards card.** To get started, go to **Member.DelawareFirstHealth.com** and click "Create New Account" to make an account with EntryKeyID. If you already have an EntryKeyID login, you can use the same email and password for the Delaware First Health member portal.

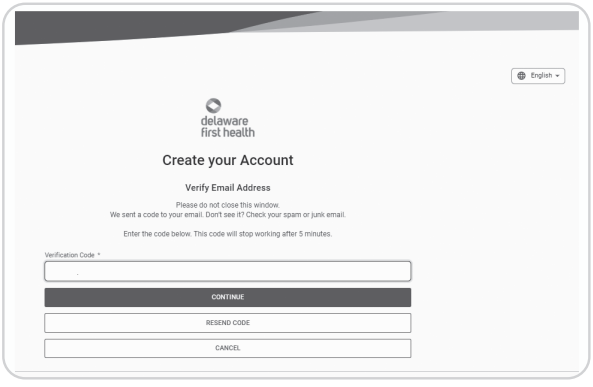
To make an account, you will need:

- An email address.
- Your member ID, found on your membership card.
- Your first name, last name, and date of birth.



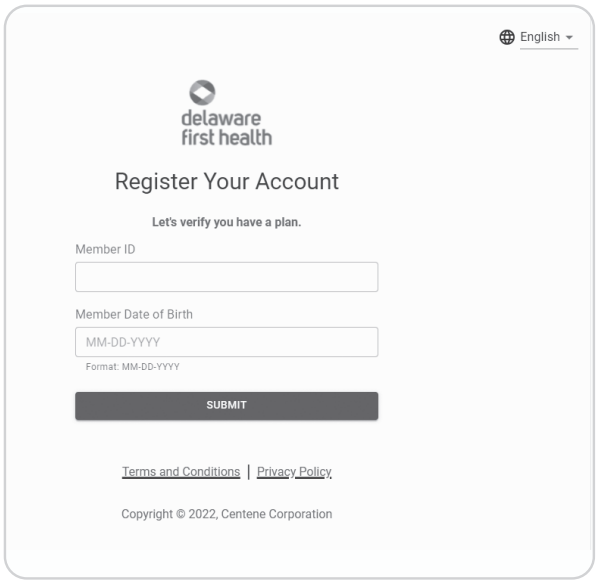
STEP 1:

Follow the steps on screen to create your account and password. You will need to verify your email address with a Verification Code to continue.



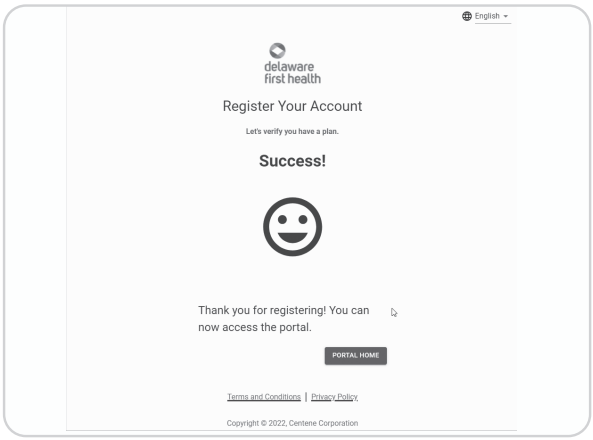
STEP 2:

After you log in, you will have to enter your member ID and date of birth to link your new EntryKeyID.



STEP 3:

Once your account is set up on the Delaware First Health member portal, you will be able to see your ID card, eligibility status, health data, claims, risk assessments, and more. Your EntryKeyID can also be used to access your health data from third-party applications that support patient access.



You can now access your account on the member portal by going to **Member.DelawareFirstHealth.com** and logging in.

How to Get Help

You can find the following on our website at DelawareFirstHealth.com:

- Updated Member Handbook.
- Provider Directory.
- Preferred Drug List (PDL) and formulary information.
- Whole You member newsletters.
- Up-to-date benefits and coverage information.
- Upcoming Delaware First Health events.

Member Advocates

Delaware First Health has member advocates who can help you with a variety of services. The main role of a member advocate is to be a go-between for you, the health plan, providers, and community resources. Our member advocates can:

- Help you with scheduling medical appointments and transportation (ride) services.
- Educate you on plan benefits and community resources.

- Help you connect with resources on Findhelp.
- Educate and assist you through the appeals and grievance process.

To reach a member advocate, please call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Member Advisory Council

Delaware First Health's Member Advisory Council (MAC) is diverse and inclusive. It is our main space for member input, and that includes participation from LTSS members and stakeholders. Our MAC represents a broad cross-section of Delaware First Health membership with respect to race, ethnicity, gender, sexual orientation, gender identity, primary language, geographic location, age, disability, and health status. The MAC meets quarterly and rotates the location of its meetings among Delaware's three counties, with the option to attend in person, by phone, or via webinar. The MAC will ask for direct feedback from members to shape Delaware First Health's programs, materials, and communications.

To learn more about the MAC, talk with your case manager or call Delaware First Health at **1-877-236-1341** (TTY: **711**).

RIGHTS & RESPONSIBILITIES

Member Rights & Responsibilities

As a member, you have certain rights and responsibilities. Delaware First Health respects your rights. We will not discriminate against you for using your rights. We expect our providers to also respect your rights.

You have the right to:

- Dignity, respect, and privacy from the health plan and our providers.
- Have access to creating and using an advance directive.
- Get information about the organization, its services, its practitioners and providers, and your member rights and responsibilities.
- Be given information about treatment options and care alternatives related to your health condition in a way you will understand.
- Partner with practitioners to make decisions about your care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion by means of coercion, discipline, convenience, or retaliation.
- Request and get one free copy of your medical records and be able to request amendments or corrections. Once requested, the medical records will be provided within 10 calendar days of the request.
- Request and get a copy of our practice guidelines, which are followed by Delaware First Health and your providers, and is based on your health needs.
- Amend your data in accordance with HIPAA (Health Insurance Portability and Accountability Act) and state law.
- Exercise your rights without impacting the way Delaware First Health, your providers, or the State of Delaware treats you.

- Get culturally and linguistically appropriate services free of charge.
- Have your personal and medical information kept private.
- File complaints (grievances) or appeals about us or the care we provide.
- Choose a representative to help with making care decisions.
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Get a copy of member rights and responsibilities and the right to make recommendations regarding this policy.
- Ask for the Member Handbook and other member information and brochures in other formats such as other languages, large print, audio CD, or Braille, free of charge.

Member Responsibilities:

- Tell Delaware Health and Social Services (DHSS) if:
  - You move out of the State of Delaware or have other address changes.
  - You get or have health coverage under another policy, other third party, or if there are changes to the coverage you have on file.
- Tell Delaware First Health when you go to the emergency room (ER) or have been in an auto accident.
- Tell Delaware First Health if your member ID card is lost or stolen.
- Learn about your health status, understand your health, and take part in your treatment goals.
- Talk to your providers about prior authorization of services they recommend.
- Provide Delaware First Health and participating providers with accurate and complete medical information they need to provide care.
- Follow the care plans and instructions that you have agreed to with your provider.
- Be aware of cost-sharing responsibilities and make payments that you are responsible for.
- Know Delaware First Health's procedures, coverage rules, and restrictions the best you can.
- Contact Delaware First Health if you need information or have a question.
- Ask your provider questions to help you understand your treatment. Be actively involved in your treatment. Learn about possible risks, benefits, and costs of treatment alternatives. Make care decisions after you have considered these things.
- Follow the grievance or appeal process if you have concerns about your care.

As noted above, our member advocates can help. To reach a member advocate, please call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Reporting Changes

Major life changes can affect your eligibility with Delaware Medicaid. Be sure to let both Delaware First Health and DHSS know when you have a major life change. Some examples of major life changes are:

- A change to your name.
- A change to your address
- If you add or lose other insurance coverage.
- If you are added to or removed from someone else's insurance.
- A new job.
- Your ability or disability changes.
- Your family size changes.
- Changes in your income or assets.
- You become pregnant.

If you have one or more of these major life changes, please call the DHSS Change Report Center at **1-866-843-7212** and Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

Fraud, Waste, and Abuse

Delaware First Health is required to report when Medicaid funds are used in the wrong way. This is called fraud, waste, and abuse.

Fraud means a member, provider, or other person is misusing Medicaid program resources. This could include things like:

- Giving someone your member ID card so they can get services under your name.
- Using another person's member ID card to get services under their name.
- A provider billing for the same service twice.
- A provider billing for a service that never happened.

Your healthcare benefits are given to you because you met the rules of the program. They are not for anyone else. You must not share your benefits with anyone. If you misuse your benefits, you could lose them. The Delaware Division of Medicaid and Medical Assistance could also take legal action against you if you misuse your benefits.

If you think a provider, member, or other person is misusing Delaware Medicaid benefits, please tell us right away. Delaware First Health will take your call seriously. You do not need to give your name.

- Call the Delaware First Health Fraud, Waste, and Abuse Hotline at **1-866-685-8664**. All calls are private.
- If a TTY line is needed, call Member Services at **1-877-236-1341** (TTY: **711**).

You can also report suspected Medicaid fraud directly to the Delaware Division of Medicaid and Medical Assistance. Call the Diamond State Health Plan Helpline at **1-800-372-2022**. Press "1" for English or "2" for Spanish. Then press "7" for fraud, waste, or abuse.

HOW TO USE YOUR BENEFITS

It's time to take control of your health — and this is the place to start. Your new health insurance plan with Delaware First Health offers comprehensive medical care and benefits. It also includes valuable programs, educational tools, and support.

Delaware First Health is committed to providing our members with the resources they need to ensure the best possible care. Don't forget, you also have access to helpful tools through your Delaware First Health online account at **DelawareFirstHealth.com**.

Delaware First Health Benefits

Benefits and Services

In this section, you can learn about the health benefits, pharmacy services, and the value-added benefits Delaware First Health offers.

Do you need help understanding these benefits and services? Call us at **1-877-236-1341** (TTY: **711**).

All services must be medically necessary. Your PCP will work with you to make sure you get the services you need. These services must be given by your PCP or by another provider.

Some services may:

- Have copays.
- Have coverage limits.
- Need a doctor's order.
- Need prior approval.

Some Medicaid members may not be eligible for all the benefits listed. Call Member Services to learn more about your eligibility.

The Delaware Division of Social Services (DSS) determines the covered benefits and services you get. You must use a Delaware First Health network provider to get these benefits and services, unless:

- The services are emergency services.
- The services are family planning services. You have the freedom to choose any family planning provider, including those not in the Delaware First Health network (except for Delaware Healthy Children Program members).
  - Delaware Healthy Children Program members must use a participating provider for family planning services.
- You get prior authorization (prior approval) to use a provider who is not in Delaware First Health network.
- You are covered by a primary insurance company.

Choice of Provider

As a Delaware First Health member, you can choose who you see for your healthcare needs from our network of providers. If you need help choosing a healthcare provider, call Member Services at **1-877-236-1341** (TTY: **711**).

Delaware First Health provides healthcare services and benefits covered by your plan. However, the Delaware Medicaid state plan covers some services directly. Please see the *State Benefits* section for more

details. If you need more information on how to get these services from the state, please call Member Services at **1-877-236-1341** (TTY: **711**).

Some services are not covered by the Delaware Medicaid state plan or Delaware First Health. Please see the ***Non-Covered Services*** section for more details. For a full list of non-covered services or for questions, please call Member Services at **1-877-236-1341** (TTY: **711**).

Copays

In some situations, members must share the cost of the service provided. This is called a **copayment** (or copay). It is a set amount members pay when they get a service. **You can find your copays on your member ID card.**

Paying Copays and Other Payments

- You must make copays directly to providers at the time of service.
- If you do not pay your copay, the provider and/or Delaware Medicaid may use legal action to collect payment from you.
- You may be responsible for paying for non-covered services if you sign a release agreeing to pay for these services before you get them. Note that the cost of non-covered services is likely to be more than a copay for a covered service.

Exemptions

These types of members are always exempt from copays:

- Pregnant individuals.
- Individuals who recently gave birth and are getting pregnancy-related services for up to 90 days after delivery.
- Members getting hospice care.
- Children (under the age of 21).
- AI/AN (American Indian/Alaskan Native).
- Chronic Renal Disease Program (CRDP) members.
- Family planning services and supplies.
- Long Term care nursing facility group or the acute care hospital group.

"In Lieu of" Services

What are In Lieu of Services (ILOS)

In Lieu of Services (ILOS) are cost-effective, medically appropriate alternatives to physical and behavioral health services you can get from Delaware First Health. This helps us give you more options for your care. An example of this may be that in lieu of inpatient mental health services in a general hospital or a general hospital psychiatric unit, Delaware First Health provides mental health services in an IMD (Institution of

Mental Disease).

What you should know about ILOS:

- ILOS is voluntary.
- There can be many different types of services offered as ILOS.

You have the right to:

Keep all your guarantees and protections as a Delaware First Health member and choose to get or decline any ILOS offered by Delaware First Health. Use of an ILOS in the past or present does not prohibit you from getting any state plan-covered services or settings. You have the right to file an appeal and/or grievance in connection with receipt or denial of an ILOS, same as any other covered service.

Coordination of Benefits

If you have other medical insurance, including Medicare:

- Make sure you show all your medical ID cards to your healthcare providers and pharmacies.
- Remember that other medical insurance must be billed before Delaware First health.

Be sure to let Delaware Health and Social Services (DHSS) know if you have other medical insurance coverage by calling **1-800-372-2022**.

DSHP Plus LTSS Benefit Package

The following is a list of covered benefits, services, and limitations for Diamond State Health Plan Plus LTSS members. Some services may require prior authorization. This is not a complete list of services. Please call Member Services at **1-877-236-1341** (TTY: **711**) for full details.

Diamond State Health Plan Plus LTSS

LTSS Benefits	Details
Adult day services.	Offers supervised care and personal services during the day, overseen in a community-based setting. Therapies and meals may also be available*.
Attendant care.	Helps members with daily tasks, like bathing, getting dressed, other personal hygiene (cleanliness), moving from one place to another, going to the bathroom, and eating*.
Cognitive services.	Offered to members and their families who have problems with those close to them or cognitive deficits, such as those that may occur after a brain injury. These services include therapy or counseling, limited to 20 visits per year and an assessment*.
Community-based residential alternatives.	Home-like settings, such as assisted living, that have services to support your needs and offers programs for socializing and recreation.

LTSS Benefits	Details
Day habilitation.	Services to help members learn and develop skills to live on their own in and out of their home. These services take place in a nonresidential setting, away from the member's home. Day habilitation is for members who have problems with those close to them (also known as interpersonal conflict) or cognitive deficits, such as those that may occur after a brain injury. In some cases, meals and therapies may be included**.
Home-delivered meals.	Offers up to two meals per day, fit for a well-balanced diet and delivered to the member's home*.
Independent activities of daily living.	Offers help with daily tasks, like light cleaning, meal preparation (cooking), shopping, and more*.
Minor home modification.	Based on medical necessity, changes can be made to the member's home to help them be able to live on their own. Changes include modifications such as widening doors for a wheelchair, tub cut outs, or putting in a wheelchair ramp or a grab bar. This benefit covers up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. Service providers must be approved by Delaware First Health*.
Nursing facility.	A setting where members get skilled nursing care and other services, such as rehabilitation services and health-related services.
Nutritional supplements for HIV / AIDS.	Help with HIV / AIDS-associated weight loss and malnutrition through oral supplements*.
Personal emergency response system (PERS).	An electronic device that is connected to the member's phone that gives the member access to a 24-hour emergency response service. When the button on the device is pushed, it sends a signal to someone who is available to help the member*.
Respite care.	Personal care given to members in their home or at a nursing or assisted living facility to give unpaid caregivers time to rest*. This service is limited to 14 days per year. **Please note:** Assisted living facilities do not provide respite services.

LTSS Benefits	Details
Self-directed attendant care (SDAC) service.	Offers members financial management and general support if they choose SDAC in the form of a Fiscal Employer Agent. SDAC is when the member serves as the legal employer of a paid caregiver; the member can also choose someone to fill this role for them, known as the member's Employer Representative. The member's Fiscal Employer Agent takes care of taxes, payroll withholding, and paychecks for the employee. They also help find and train an Attendant Care Employee, a worker to help the member with daily tasks*.
Specialized medical equipment.	Help items are available to members, such as grabbers. This benefit covers only items that are not covered by the state.
Nursing facility transition (NFT) services.	Offers help with the costs of moving from a nursing or assisted living facility to a community or home. These costs can include groceries, furniture, security deposit, telephone / internet connection fees, etc. Additional benefits may be available under Delaware First Health's value-added benefits (see below).

These services are not available for members in assisted living or nursing facilities.

****Not offered to members living in non-acquired brain injury (ABI) assisted living or nursing facilities.***

Standard DSHP Benefits Package

Standard Medicaid Benefits	Coverage and Limitations
Behavioral Health Services.	
Inpatient behavioral health services.	Covered for members ages 18 and older. Inpatient behavioral health services for members under age 18 are provided by the Delaware Department of Services for Children, Youth, and Families (DSCYF).

Standard Medicaid Benefits	Coverage and Limitations
Medications for addiction treatment (MAT) and medications for opioid use disorder (MOUD), including outpatient addiction services and residential addiction services.	Covered for members ages 18 and older. Residential addiction services for members under the age of 18 are provided by DSCYF. For members participating in the PROMISE program (Promoting Optimal Mental Health for Individuals through Supports and Empowerment), these services are covered by the state.
Substance use disorder (SUD) treatment services.	Covered for members ages 18 and older. Covers 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services, except for medically managed intensive inpatient detoxification, are covered through the state.
Licensed behavioral health practitioner services, including licensed psychologists, clinical social workers, professional counselors, and marriage and family therapists.	Covers 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services are covered by the state.
Behavioral services to treat autism spectrum disorder (ASD) pursuant to EPSDT.	Covered for members under age 21.
Crisis response and subacute mental health services.	Covered.
Physicians' services.	**Physician oversight and direct therapy are part of the following state-covered PROMISE services for participating members:** · Assertive community treatment services. · Intensive case management services. · Supervision of group home services.

Standard Medicaid Benefits	Coverage and Limitations
Dental Services	
Dental benefits.	Covered with limits. See more details in the *Dental Benefits* section.
Durable Medical Equipment	
Medical equipment and supplies.	Covered.
Diabetes equipment and supplies.	Covered.
Hearing aids.	Covered for members ages 0 to 20.
Orthotics and prosthetics.	Covered.
Emergency Care	
Ambulance.	Covered for emergency services only.
Freestanding emergency room.	Covered.
Hospital emergency room.	Covered.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	
EPSDT services, including periodic preventive health screens and necessary diagnostic and treatment services.	Covered for members under age 21.
EPSDT rehabilitative services, including community psychiatric support and treatment (CPST), psychosocial rehabilitation (PSR), crisis intervention, and family peer support services.	Covered for members under 21. Covers 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF).

Standard Medicaid Benefits	Coverage and Limitations
Home Health, Home Visiting, and Nursing Facility Services	
Home health services, including: • Intermittent or part-time nursing. • Home health aid services. • Medical supplies, equipment, and appliances suitable for use in the home. • Physical therapy, occupational therapy, and speech pathology and audiology services.	Covered.
Nursing facility services.	Covered for up to 30 calendar days, then services are covered as part of the DSHP Plus LTSS benefit package.
Pediatric respite (rest) services.	Covered for members under age 21 with a physical health or behavioral health condition. Pediatric respite services are provided on a short-term basis to allow temporary relief from caretaking duties for a child's primary unpaid caregiver, parent, court-appointed guardian, or foster parent. The covered benefit is for a total of 285 hours or 15 days per year. Respite care can either be skilled or unskilled and at home or outside the home (for example, at a center). Emergency respite is limited to a maximum of six 72-hour episodes per year.
Private duty nursing.	Covered.
Home visiting services.	Covered.
Self-directed attendant care for children.	Covered for members under age 21 who have a chronic medical condition, intellectual / developmental disability, or behavioral health condition that results in the need for assistance with age-appropriate activities of daily living.
Support for self-directed attendant care for children.	Covered for members approved to get self-directed attendant care for children services.

Standard Medicaid Benefits	Coverage and Limitations
Hospice	
Hospice services.	Covered.
Inpatient Hospital Services	
Room and board.	Covered.
Inpatient physician services.	Covered.
Inpatient supplies.	Covered.
Organ and tissue transplants.	Covered.
Laboratory and Radiology Services	
Mammography.	Covered.
Routine radiology screening and diagnostic services.	Covered.
Sleep study testing.	Covered.
Maternity Services	
Doula services.	Covered for eligible members.
Free standing birthing center services.	Covered.
Licensed midwife services.	Covered.
Postpartum nutrition supports.	Covered for eligible members.
Medicare Coinsurance	
Medicare deductible/co-insurance and remainder up to Medicaid allowed amount.	Covered.

Standard Medicaid Benefits	Coverage and Limitations
Outpatient Hospital Services	
Abortions.	Federal regulations allow coverage so long as the pregnancy is the result of rape or incest, or if the individual suffers a life-endangering physical condition caused by or arising from the pregnancy itself.
Ambulatory surgical center.	Covered.
Clinic services.	Covered.
Dialysis.	Covered.
Outpatient diagnostic lab and radiology.	Covered.
Outpatient Therapy Services	
Occupational therapy.	Covered.
Physical therapy.	Covered.
Speech / language pathology.	Covered.
Prescriptions	
Prescribed drugs, including physician-administered drugs.	Covered.
Preventative Services	
Preventive services.	Covered.
Routine check-ups.	Covered.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT).	Covered for children under age 21.
Immunizations.	Covered.

Standard Medicaid Benefits	Coverage and Limitations
Primary care provider.	Covered.
Routine hearing exam.	Covered under EPSDT for children under age 21.
Office visit.	Covered.
Professional Office Services	
Allergy testing.	Covered.
Birthing center (freestanding) services.	Covered.
Certified nurse midwife services.	Covered.
Chiropractor.	Covered.
Contraceptive devices.	Covered.
Face-to-face tobacco cessation counseling services.	Covered.
Family planning and family planning-related services.	Covered.
Federally qualified health centers (FQHC).	Covered.
Laboratory tests.	Covered.
Lactation counseling services.	Covered.
Licensed midwife.	Covered.
Office visit.	Covered.
Optometrist.	Covered.
Pediatric or family nurse practitioner's services.	Covered.

Standard Medicaid Benefits	Coverage and Limitations
Podiatry.	Covered.
Routine patient cost in qualifying clinical trials.	Covered.
Specialist office visit.	Covered.
Tobacco cessation counseling services.	Covered.
Vision Services	
Routine eye exam.	Once every 12 months for members under 21 years of age.
Eyeglasses or contact lenses.	Once every 12 months for members under 21 years of age.
Repairs.	Covered for members under age 21.

Vision and Dental Benefits

Vision Benefits

Members ages 20 and younger: Eyecare benefits are available to Delaware Medicaid members under the age of 21 as a standard benefit. This benefit includes a routine eye exam every 12 months and coverage for eyeglasses or contacts every 12 months. Call your child's eye doctor to schedule a routine eye exam.

Members ages 21 and older: Delaware First Health provides additional eyecare benefits, beyond the state standard benefit for members ages 21 and older **as a value-added benefit**. This includes one routine eye exam every 12 months and coverage for frames, lenses, lens upgrades, or contact lenses (includes fitting) up to $160 per year. Call Member Services at **1-877-236-1341** (TTY: **711**) for more information.

Dental Benefits

Standard dental benefit for members, ages 20 and younger:

Delaware First Health covers dental services for members ages 20 and younger. Members can use their Delaware First Health ID card to get dental services through providers in the Delaware First Health dental network.

Members can get services such as:

- Preventative care: Two dental exams per year, including cleanings, fluoride treatments, and sealants.
- Restorative care: Care for cavities, fillings, crowns, and root canals.
- Orthodontic screening: Exams by an orthodontist.

- Orthodontic work (such as braces): Covered when medically necessary.

For a list of participating providers, visit **DelawareFirstHealth.com** and use the "Find a Provider" tool. For questions about your dental benefits or for help finding a provider, please call Member Services at **1-877-236-1341** (TTY: **711**).

Standard dental benefit for members, ages 21 and older:

Dental services are available to Delaware Medicaid members ages 21 and older. This includes $1,000 of coverage per year for dental services, such as cleanings, X-rays, cavity fillings, and more. Each visit has a $3 copay. For details, visit **DelawareFirstHealth.com**.

Emergency dental benefit:

Medicaid members ages 21 and older also have an emergency dental benefit. Once members have used their $1,000 standard benefit, they can get up to $1,500 of coverage per year for dental work that meets the extended benefit criteria. Call Member Services at **1-877-236-1341** (TTY: **711**) for more information.

Note: Delaware First Health will cover the removal of bony-impacted wisdom teeth for adult members under the medical benefit.

Behavioral Health Services

Delaware First Health covers the following behavioral health services for our members. Please call Member Services at **1-877-236-1341** (TTY: **711**) if you have questions.

Service	Coverage Limitations
Inpatient behavioral health services in a general hospital, in a general hospital psychiatric unit, or in a psychiatric hospital. This includes institutions for mental disease for members over age 65 and under age 21 that are: • In a private residential treatment facility (PRTF) for under age 21; or • In SUD treatment for those who are short-term residents in an institution for mental disease (IMD).	Covered for members ages 18 and older. For members under age 18, inpatient behavioral health services are provided by the Delaware Department of Services for Children, Youth and Families (DSCYF).
Medications for addiction treatment (MAT) and medications for opioid use disorder (MOUD), including outpatient addiction services and residential addiction services.	Covered. For members participating in PROMISE, these services are the responsibility of the state and paid FFS through the state's DMES. However, the contractor is responsible for payment of covered outpatient drugs.

Service	Coverage Limitations
Substance use disorder (SUD) treatment services, including outpatient and residential addiction services which include all levels of the American Society of Addiction Medicine (ASAM), including residential services to members who are primarily receiving treatment for SUD who are short-term residents in an IMD.	Covered. Included in the 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services are the responsibility of the state and paid FFS through the state's DMES, except for medically managed intensive inpatient detoxification.
Office visits.	Covered as part of the 30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services are the responsibility of the state and paid FFS through the state's DMES.
Outpatient mental health and substance abuse.	Covered as part of the 30-unit outpatient behavioral health benefit for members under the age of 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services are the responsibility of the state and paid FFS through the state's DMES.
Behavioral services to treat autism spectrum disorder (ASD) pursuant to EPSDT.	Covered for members under age 21.
Crisis response and subacute mental health services.	Covered.

If you are experiencing emotional or mental distress, call or text the appropriate crisis line below at any time to speak with someone who will listen and help. **If you are in danger or need immediate medical attention, call 911.**

National Suicide Prevention Lifeline: **988**

Crisis Text Line: Text "DE" to the number **741741**

Northern Delaware Hotline: **1-800-652-2929**

Southern Delaware Hotline: **1-800-345-6785**

DSCYF 24/7 Youth Crisis Support: **1-800-969-4357**

Delaware First Health BH Crisis Line: **1-877-236-1341**

Value-Added Benefits

As a Delaware First Health member, you can get extra services that go beyond Delaware's standard Medicaid benefits. These are called value-added benefits.

Service	Description
Over-the-counter (OTC) program	$120 per household per year ($30 per quarter) to spend on select OTC items including diapers, period products (such as pads and tampons), and lots more. No prescription needed.
Tutoring services.	Up to $200 per year in tutoring for members in grades K-12 who are at risk of falling behind on one or more core subject areas.
GED services.	Members ages 16 and older not currently enrolled in school can get up to $200 in select GED testing and tutoring services.
Cell phone.	Free cell phone for high-needs members in Care Coordination or Case Management with qualifying needs.
Extra prenatal doula visits.	Two extra prenatal doula visits for members who have had three covered prenatal doula visits and want extra support during pregnancy.
Behavioral health support app.	Access to a mobile app to help manage stress, anxiety, chronic pain, and more. The mobile app provides personalized online learning to address common behavioral health conditions. For members ages 13 and older.
Vision services for adults.	Members ages 21 and older are eligible for a routine comprehensive eye exam with refraction every 12 months and an eyewear allowance of up to $160 every year.

Service	Description
Whole health transportation.	Transportation to Delaware First Health events and value-added benefits (GED testing, etc.), as well as transportation to additional health-related services such as SUD recovery support meetings, food pantries, and job interviews.
Community-based wellness programs.	Up to $250/year for programs to support population-specific wellness goals. Members can choose one organization per year: **All members ages 5 and older:** · YMCA memberships. (Requires completion of annual well visit.) **Children (ages 5-18):** · Boys & Girls Clubs memberships and programs. **Adults (18 and older) with BMI 25+:** · LEAN (Lifelong Essentials of Activity and Nutrition) 12-week in-person program at the YMCA. (Requires primary care provider form.) **Seniors (age 60+):** · Senior center membership and additional programs.
Diabetes prevention program.	Lifestyle change program focused on healthy eating and physical activity for qualifying members ages 18 and older with pre-diabetes.
Home-based interventions for asthma.	Up to $250 per year for non-clinical, home-based asthma support, such as hypoallergenic bedding, air purifiers, and pest control for qualifying members with an asthma diagnosis. PCP or specialist form required.

Service	Description
Housing transition allowance.	Up to $2,500 per member per lifetime in housing resources to help establish stable housing. For members in Case Management experiencing homelessness, transitioning from foster care to independent living (ages 18-26), or transitioning from a facility to community or independent living. This service is in addition to the standard $2,500 per transition benefit offered to LTSS members.
Practice dental visit.	Practice dental visits give members time to meet the dental team and ask questions before a dental appointment. For all members under age 21 and for adults with intellectual and developmental disabilities. Up to four visits per lifetime. Cannot be used on the same day as a dental appointment.
Blood pressure self-monitoring program.	Sixteen-week program to help lower and manage high blood pressure. For members ages 18 and older with high blood pressure (hypertension).
Senior healthy food benefit.	For members ages 65 and older, up to $150 per year to buy select healthy foods.

My Health Pays® Rewards Program

With the My Health Pays® rewards program, you can earn rewards when you do healthy activities, like going for your annual wellness visit, getting a flu shot, seeing your dentist, and more. Once you complete your first qualifying healthy activity, you will get your My Health Pays Visa® prepaid card* from Delaware First Health. Rewards will be added to your card each time you complete a qualifying activity.

**This card is issued by The Bancorp Bank, Member FDIC, pursuant to a license from Visa U.S.A. Inc. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage instructions.*

2026 My Health Pays® Rewards:

Activity	Reward	Reward Frequency
Register through the member portal.	**$10**	One time reward.
PCP confirmation within 30 days of enrollment.	**$15**	One time reward.
Complete health risk assessment (HRA).	**$20**	One time reward.
Complete notification of pregnancy (NOP).	**$20**	One per pregnancy.
Go to a prenatal visit in your first trimester or within 42 days of joining Delaware First Health.	**$50**	One per pregnancy.
Complete your third prenatal visit.	**$20**	One per pregnancy.
Complete your sixth prenatal visit.	**$20**	One per pregnancy.
Prenatal Tdap vaccine.	**$15**	One per pregnancy.
Prenatal RSV vaccine.	**$15**	One per pregnancy.
Go to your postpartum visit.	**$40**	One per pregnancy.
Attend three infant well visits for children 0 to 15 months old.	**$50**	**This reward can be earned twice!** Requires three visits or claims to get $50 reward. $100 for both rewards.
Get a lead screening at 12 months.	**$25**	One time reward.
Get a lead screening at 24 months.	**$25**	One time reward.
Attend infant well visit for children ages 15-30 months.	**$25**	**This reward can be earned twice!** $25 per visit.
Attend child well visit, for children ages 3 to 18.	**$25**	Once per year.
Get your asthma controller medication filled.	**$25 per prescription fill**	Earn this reward up to six times per year. If you fill your asthma controller medication six times in a year, you will earn $150.

Activity	Reward	Reward Frequency
Attend adult well visit, for those ages 18 and older.	**$25**	Once per year.
Get your flu vaccination, for those ages 6 months and up.	**$20**	Once per year.
Go to annual adult dental visit.	**$20**	Once per year.
Complete diabetes HbA1c test, for members with diabetes ages 18 and older.	**$20**	Once per year.
Complete a retina exam, for members with diabetes age 18-75.	**$25**	Once per year.
Complete breast cancer screening, for those ages 40 and older.	**$25**	Every two years.
Complete cervical cancer screening, for those ages 21 and older.	**$30**	Every three years.
Complete colorectal cancer screening, for those ages 50 and older.	**$20**	One time reward.
Get your first tobacco cessation medication fill.	**$20**	Once per year.
Adolescent HPV vaccine (ages 9-13).	**$15**	One-time reward.
Childhood rotavirus vaccine (by 2nd birthday).	**$15**	One-time reward.
Follow-up visit after hospitalization.	**$20**	Once per year.
HbA1c test for people with schizophrenia or bipolar disorder on antipsychotic medications.	**$20**	Once per year.
Opioid treatment.	**$50**	Twice per year.
Low-dose aspirin fills for pregnant members.	**$10**	Up to four times per year.

Activity	Reward	Reward Frequency
Go to behavioral health hospitalization follow-up visit.	**$20**	Once per year.
Go to substance use disorder residential stay follow-up visit.	**$20**	Once per year.

State-Covered Benefits

The Delaware Medicaid State Plan provides healthcare services and benefits that are not covered under the standard DSHP or DSHP Plus LTSS benefits. To get these benefits, call the Care Management Department at **1-877-236-1341** (TTY: **711**). The Care Management team will work with providers to help you get connected with these benefits.

These services include:

- Prescribed pediatric extended care (PPEC).
- Early introduction of peanut and egg allergens.
- Non-emergency medical transportation (NEMT).
- Specialized services for nursing facility residents.
- Additional behavioral health services for children under the age of 18.

Service	Definition / Limitation
Prescribed pediatric extended care (PPEC).	**PPEC is a package that includes:** • Nursing. • Nutritional assessment. • Development assessment. • Speech. • Physical. • Occupational therapy services. These services are provided in an outpatient setting, as ordered by an attending physician. This is covered by the state.

Service	Definition / Limitation
Early introduction of peanut and egg allergens.	Introducing peanut and egg proteins into an infant's diet by 6 months of age — and continuing regularly through the first year — can significantly reduce the risk of developing allergies to these foods, unless a medical reason prevents it. When prescribed, infants can get one peanut and one egg allergen supplement at no cost to support early introduction.
Non-emergency medical transportation (NEMT).	Non-emergency medical transportation is available to all DSHP, DSHP Plus and DHCP members. This is covered by the state. Transportation arrangements should be made at least 72 hours in advance of a scheduled appointment. Modivcare will verify that the recipient is Delaware Medicaid eligible, and that transportation is required to a covered service. Once both criteria are confirmed, Modivcare will arrange for a ride to the covered medical service by one of their contracted transportation providers. Eligible Delaware Medicaid clients in need of non-emergency transportation should call Modivcare at **1-866-412-3778**.
Specialized services for nursing facility residents not included in covered services.	The state will provide specialized services as determined necessary by the state as part of the PASRR Level II process that are not included in the DSHP Plus LTSS benefit package.
Employment services and supports provided through Pathways.	**Services are available to members participating in Pathways to supplement covered services provided by Delaware First Health. The following services are covered by the state:** • Career exploration and assessment. • Job placement supports. • Supported employment for individuals. • Supported employment for small groups. • Benefits counseling. • Financial coaching. • Non-medical transportation. • Personal care. • Orientation, mobility, and assistive technology.

Service	Definition / Limitation
Additional behavioral health services.	**Behavioral health services for children under the age of 18:** • Behavioral health services provided to members under the age of 18 beyond those included in the standard DSHP benefit package are covered by the state. This includes outpatient services beyond what is included in the standard DSHP benefit package, as well as residential and inpatient behavioral health services. **Behavioral health services for members ages 18 and older who participate in PROMISE:** • As provided in the standard DSHP benefit package above, Delaware First Health will no longer cover the following services when a member is participating in PROMISE. For members participating in PROMISE, these services are covered by the state: – Substance use disorder (SUD) services other than medically managed intensive inpatient detoxification. – Licensed behavioral health practitioner services. • The following services are covered by the state and available to members participating in PROMISE to supplement covered services provided by Delaware First Health: – Care management. – Benefits counseling. – Community psychiatric support and treatment. – Community-based residential supports, excluding assisted living. – Community transition services. – Financial coaching. – IADL / chore. – Individual employment support services. – Non-medical transportation. – Additional nursing services. – Peer supports. – Personal care. – Psychosocial rehabilitation (PSR). – Respite. – Short-term small group supported employment.

Service	Definition / Limitation
Delaware Division of Developmental Disabilities (DDDS) lifespan waiver services.	**The following services are covered by the state and available to members participating in the DDDS lifespan waiver as a supplement to covered services provided by Delaware First Health:** • Assistive technology. • Behavioral consultation. • Community participation. • Community transition. • Day habilitation. • Home or vehicle accessibility adaptations. • Nurse consultation. • Personal care. • Prevocational services. • Residential habilitation. • Respite. • Additional specialized medical equipment and supplies. • Supported employment. • Supported living.
DMMA pharmacy carve-out list.	Certain medications are not covered by Delaware First Health and are instead covered by the state. A list of these medications can be found on the Pharmacy Corner of the state's Delaware Medical Assistance Portal website at **medicaid.dhss.delaware.gov**.

Non-Emergency Medical Transportation

Delaware Medicaid members can get non-emergency medical transportation (NEMT) services. Your NEMT services are provided by the State of Delaware through ModivCare. Please call ModivCare at **1-866-412-3778** for help with NEMT. Members must call at least 72 hours in advance to schedule a ride. For more information, visit **dhss.delaware.gov/dmma/medical.html**.

Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman Program is provided by the Delaware Department of Health and Social Services (DHSS).

The Ombudsman advocates for residents who live in long-term care facilities, as well as those who live in other settings (such as their own homes) and get home- and community-based services. The Ombudsman program investigates and resolves complaints on behalf of these individuals. Complaints can be made by residents, family members, or other concerned parties.

The Long-Term Care Ombudsman Program may be reached by calling **1-855-773-1002** (TTY: **1-302-391-3505**) or by emailing **DHSS_OSEC_Ombudsman@delaware.gov**.

Prior Authorization

Some services must be approved by Delaware First Health before they can be provided. This is called prior authorization. Failure to get authorization may result in administrative claim denials. Delaware First Health providers cannot bill a member for any service that was administratively denied by Delaware First Health because the provider did not get authorization in time. Your provider can request an authorization by fax, phone, or secure web portal with all necessary clinical information.

Check to see if prior authorization is necessary by using our online tool at **DelawareFirstHealth.com**. If you have any questions, call Member Services at **1-877-236-1341** (TTY: **711**).

Services Needing Prior Authorization

Some of the services that need prior authorization are:

- Inpatient hospital care.
- Dental services.
- Care at a skilled nursing facility.
- Home healthcare.
- Habilitation services.
- DME, orthotics, and prosthetics.
- CT scans, MRIs, MRAs, nuclear cardiology, nuclear radiology, and PET scans.
- Genetic and molecular diagnostic testing.
- Quantitative drug testing.
- Implantable hearing devices.
- Physical therapy, occupational therapy, or speech therapy.
- Transplants.
- Bariatric surgery.
- Certain orthopedic surgeries, such as joint replacement and spinal surgery.
- Pain management procedures.
- Facility-based sleep studies.
- Inpatient psychiatric admissions.
- Chemical and substance use admissions.

- Behavioral health partial hospitalization.
- Behavioral health intensive outpatient program.
- Behavioral health residential treatment facilities.
- Electroconvulsive therapy (ECT).
- Transcranial magnetic stimulations (TMS).
- Psychological and neuropsychological testing.
- Services received through an out-of-network provider (except for emergency care, post-stabilization, and some family planning services).

This is not a complete list. Please use our online tool at **DelawareFirstHealth.com** to see if prior authorization is needed for a specific procedure. If you have any questions, call Member Services at **1-877-236-1341** (TTY: **711**).

Non-Covered Services

Some services are not covered by Delaware Medicaid state plan or by Delaware First Health. These include:

- Services that are not medically necessary.
- Infertility treatments.
- Cosmetic services (unless the service is medically necessary).
- Services provided outside of the continental United States.
- Sterilization of a mentally incompetent or institutionalized individual.
- Christian science nurses and sanitariums.
- Inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner (except in an emergency).
- Some pharmacy-related services, such as:
  - Any drug or device marketed by a manufacturer who does not participate in the Medicaid Drug Rebate Program.
  - Drugs that are lifestyle drugs or are not medically necessary.
  - All "Drug Efficiency Study Implementation" (DESI) drugs, as defined by the FDA.
  - Any drug, device, or class of drugs listed in Section 1927(d)(2)(B), (C), (H), or (K) of the Social Security Act.

If You Get a Bill

If you get a bill that you think you do not owe, **do not ignore it**. Call Member Services at **1-877-236-1341** (TTY: **711**) right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Delaware First Health will contact the provider and help fix the problem for you.

Delaware First Health wants to make sure you can get the most up-to-date medical care. We have a team that watches for advances in medicine. This may include new medicines, tests, surgeries, or other treatment options. The team checks to make sure the new treatments are safe. We will tell you and your PCP about new services covered under your benefits.

LTSS MEMBER SUPPORT SYSTEM

Case Management

Case managers are healthcare professionals who serve as advocates to support, guide, and coordinate care for you, your family, and your caregivers. Case managers coordinate your physical and behavioral health with long-term services and supports.

Case Management Services

If you are living in a community setting, your case manager will contact you by phone and meet with you in person. The purpose of the visit is to complete a comprehensive assessment to help understand your needs and develop a care plan, called an integrated member plan (IMP), that meets your goals. Your IMP will include all services that you need, including help addressing health-related social needs, such as food, transportation (rides), and housing.

If you are living in a nursing facility setting, your case manager will meet with you in person to complete a comprehensive assessment and to discuss your goals. Your case manager will work with you and the nursing home to ensure all your needs are met. Your case manager will also ask about your interest and ability to move to the community and talk with you about the services available to support your move.

Your case manager can help you:

- Understand your benefits and answer questions.
- Get medical care and services that you need.
- Meet goals that are important to you.
- Learn about your condition and medicines.
- Coordinate your physical health, behavioral health, and LTSS needs.
- Arrange and coordinate services.
- Resolve barriers to access needed services.
- Update your care plan when your needs change.

Service Gaps

A service gap is when you do not receive a service that you are approved to have. Please contact your case manager if there is a gap in your approved services. This can include when a provider does not show up to work. It is important to work with your case manager to have a good emergency and back-up plan in case of service gaps.

Home- and Community-Based Services (HCBS)

Home- and community-based services can help you live at home or in another community setting such as an assisted living facility. Home- and community-based services include attendant care, chore services, respite care, and other services to give you support for your everyday needs and keep you safe. Your case manager will help you get the services you need.

Self-Directed Home- and Community-Based Services

As a DSHP Plus LTSS member, you may opt to self-direct your attendant care, chore, or respite services.

Self-directed attendant care (SDAC) gives you the ability to choose your personal caregiver(s) and develop a personalized care plan to meet your needs. You can choose to select and hire people that meet your needs and control the quality of your services.

After a self-assessment, your case manager may determine that you need help directing your services. In this case, you will need to name a representative to perform the employer responsibilities on your behalf. An Employer Representative Agreement will be signed by your selected individual and yourself.

Self-directed home- and community-based services (HCBS) is optional, and you can choose to participate or withdraw from self-directed HCBS at any time.

If you choose self-directed care, you will have decision-making authority over self-directed employees.

This includes, but is not limited to:

- Recruiting SDAC employees.
- Selecting SDAC employees.
- Hiring SDAC employees.
- Verifying SDAC employee qualifications.
- Obtaining a criminal background check of SDAC employees.
- Including any special qualifications based on your needs and preferences.
- Evaluating SDAC employee performance.
- Electronic Verification Visit (EVV) requirements, including verifying time worked and approving time sheets.
- Discharging, or ending the employment, SDAC employees.

The minimum qualifications required for the intended employee include:

- Must be at least 18 years of age.
- Must have the skills necessary to perform the required services.
- Must have a valid Social Security number (SSN).
- Must be willing to submit to a criminal background check.

To help you with choosing SDAC, you will have the choice of a Financial Management Service (FMS) provider, the role and responsibilities of the FMS provider are:

- Complete the initial and ongoing training of SDAC employees.
- Maintain a roster (list) of SDAC employees.
- Assist with completing forms related to employers.

- Conduct and pay for the criminal background check.
  - FMS will provide a copy to you when requested. In the event the person does not pass the background check, you will be alerted about the risk of employing the individual and sign a risk agreement.
- Provide information on employer/employee relations.
- Assist with problem resolution.
- Assist with executing the member's back-up plan.

We will work together to ensure you are getting the services as needed, this will include:

- Quality of service delivered and the health, safety, and welfare of members electing SDAC.
- Care is provided according to the member's plan of care, in all specifications.
- The implementation of the back-up plan by the member or vendor.
- Member participation in the program.
- The success of the member within the program.
- Patterns within the program that require intervention by the case manager.

We will support your choice of self-directed HCBS by helping you select an entity to help you with this process. There is a choice of agencies available to help with the onboarding process of your employees. If you would like help managing your employees, you can choose a representative you trust to manage the tasks for you. Please speak to your case manager to learn more about self-directed HCBS.

Delaware First Health reserves the right to disenroll members from self-directed HCBS if member's health, safety, or welfare needs are not met through the program. If members are unable to carry out tasks needed to self-direct services or if there is fraudulent use of Medicaid funds through this program.

Electronic Visit Verification

Some services (such as attendant care provided through agencies or through the self-directed option, in-home respite services, and chore services) are subject to electronic visit verification (EVV). EVV is a web-based system that verifies when provider visits occur and documents the precise time services begin and end. It ensures that you get approved services. EVV does not impact the amount, scope, and duration of services, or your choice of provider.

EVV captures details of home visits and services provided by caregivers through the self-directed HCBS option. It is your role to make sure the employee(s) are present during the times they are clocking in and out of the EVV system and that you are getting the services approved. Contact your case manager with any questions or concerns.

Nursing Facility Services

Nursing facility services include skilled nursing care and related services, rehabilitation, and health-related long-term care. Short-term skilled care and / or rehabilitation is when the plan is for you to return home. A

prior authorization request would be submitted by your PCP, specialist, or the hospital. Prior authorization must be given prior to admission.

Long-term custodial care in a nursing facility is a covered benefit when you do not have skilled nursing needs, but you need help with activities of daily living.

Nursing Facility Transition (NFT)

We want you to have the right care, at the right time, and in the setting of your choice. If you are able and want to move from a facility to a community setting, your case manager will tell you about the NFT program. The NFT program is here to help you move from an eligible long-term care facility (nursing home, intermediate care facility for developmental disabilities, or state hospital) to an eligible residence in the community. You can get home- and community-based services to support you. Your choice is important to make sure your move is a success.

Your case manager will work with you to fill out assessments to make sure that where you choose to live meets your needs and provides you with access to your community. You may be able to get help with transition costs, up to $2,500. This money is provided by the State of Delaware and may be used for housing applications fees, security deposits, and / or making sure your home is equipped with daily living needs. These items include furniture, kitchen items, personal items, and other needed items to keep you supported and safe. Your case manager will work with you and those that support you to get everything ready for you before you move. That may include minor home modifications, services, providers, medicines, and more.

To learn more about nursing facility transition services, talk to your case manager or call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Patient Liability

You may be required to pay for part of the cost of your care in a nursing home or assisted living facility. This is called patient liability. The facility may not let you live there if you refuse to pay. The amount you pay depends on your income. Talk to your case manager if you have questions or concerns.

Informed Consent

It is important for seniors and individuals with disabilities who use LTSS services to know what's going on with their healthcare to help in decision making. *Informed consent* means you have the right to know and understand all the important details about any medical treatment, procedure, or service before you agree to it. This includes knowing what the treatment or service is for, how it may help you, any potential risks or side effects, and any other options you might have. You can ask questions to make sure you understand everything before you decide whether or not to go ahead with a certain treatment or service. Your consent shows that you agree to the treatment or service after having all this information. Here's a breakdown of what it involves: Here's a breakdown of what it involves:

Understanding of Information

- You must be given clear, comprehensive, and accessible details about the nature, benefits, risks, and alternatives of the proposed treatment, procedure, or action.
- Information should be presented in a way that is understandable, considering any cognitive or sensory impairments that may affect comprehension.

Capacity to Decide

- The person must have the mental capacity to understand the information provided and to fully grasp the consequences of their decisions.
- Assessing capacity is particularly important for seniors and individuals with disabilities, as conditions like dementia, cognitive impairments, or mental health issues may impact their ability to give informed consent.

Voluntariness

- Consent must be given voluntarily, without any form of coercion, undue influence, or pressure. You should feel free to ask questions and take time to consider the options.
- This is crucial for seniors and individuals with disabilities, who may be more vulnerable to influence from caregivers, family members, or healthcare providers.

Communication and Support

- Adequate support will be provided to ensure that you can communicate your decision. This may include the use of assistive devices, interpreters, or simplified explanations.
- Family members, legal guardians, or advocates may be involved, but the focus should remain on the individual's preferences and autonomy.

Ongoing Process

- Informed consent is not a one-time event; it should be an ongoing conversation, especially if the individual's condition changes over time. Regular reassessment of the person's understanding and willingness is needed.

Legal and Ethical Considerations

- For those who are not capable of giving informed consent, a legal guardian or power of attorney may be needed to make decisions on their behalf, always prioritizing the individual's best interests.
- Healthcare providers must adhere to legal standards and ethical guidelines to ensure that consent is valid and respects the rights and dignity of seniors and individuals with disabilities.

This process is to protect the autonomy (self-rule) and rights of seniors and disabled individuals, ensuring that they are fully informed and actively participating in decisions that affect their lives.

Advance Directive (Living Will)

Planning Your Living Will

You are the most important person who will ever be involved in your care. You have the right to make decisions about your care, including the right to accept or refuse medical or surgical treatment. We want you to be active in all your healthcare choices.

It is an unpleasant thought, but what if you became too sick to tell your provider what you want your care to be? An advance directive (also known as a living will) is a way to make sure that your wishes are known. You can make decisions about your care in advance or name someone, known as a *medical power of attorney*, to make those choices if you cannot.

Making Your Living Will

Delaware First Health recommends that all members make a living will, designate a power of attorney, and provide their advance directive to their PCP.

Once you have completed your advance directive, ask your doctor to put the form in your file. You can also talk to your doctor about the decision-making process of creating your living will or advance directive. Together, you can make decisions that will set your mind at ease.

You can change your advance directive at any time. You should make sure others know that you have an advance directive. You may also choose to designate a medical power of attorney. That person should be made aware of your advance directive or living will as well.

With an advance directive, you can be sure that you are cared for as you wish, at a time when you cannot give the information.

You can access this form online through a link at **DelawareFirstHealth.com**. On our website click "Member Resources", then scroll down to "Member Rights and Responsibilities", there you will find the "Advance Directive" section which will take you the forms you need. For more information, you can also call the Delaware Aging and Disability Resource Center at **1-800-223-9074**.

For more information about advance directives or to file a complaint if your wishes have not been followed, you can call the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) at **1-800-223-9074**.

YOUR PROVIDERS

Managed care organizations like Delaware First Health work to coordinate your healthcare needs.

- Delaware First Health has a contract with the State of Delaware to meet the healthcare needs of people with Medicaid. We partner with a group of healthcare providers (doctors, dentists, therapists, specialists, hospitals, home care providers, and other healthcare facilities) who make up our provider network.
- When you join Delaware First Health, our provider network is here to support you. Most of the time, your main contact will be your PCP. If you need to have a test, see a specialist, or go into the hospital, your PCP can help arrange it. Your PCP is available to you day and night. If you need to speak to your PCP after hours or on weekends, leave a message. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for healthcare, in some cases you can go to certain providers for some services without checking with your PCP first.
- You can visit **DelawareFirstHealth.com** to find the provider directory online or call Member Services at **1-877-236-1341** (TTY: **711**) to get a copy of the provider directory mailed to you.

Finding a Provider

Choosing Your PCP

When you become a Delaware First Health member, you must choose a PCP within 30 calendar days. If you do not choose a PCP, we will pick one for you.

DSHP Plus LTSS members: If you did not choose a PCP, Delaware First Health will assign one to you. You can pick a different PCP if you do not like the one, we chose for you.

If you would like to know more about a PCP, call Member Services at **1-877-236-1341** (TTY: **711**). We can tell you what language the provider speaks, if they are in the network, where they are located, and their location accessibility accommodations.

How to Change Your PCP

There are two ways to change your PCP:

1. Use the secure member portal on our website at **Member.DelawareFirstHealth.com**.
2. Call Member Services at **1-877-236-1341** (TTY: **711**) to help you. We will send you a new Delaware First Health member ID card after you choose a new PCP.

You can view our provider directory at **DelawareFirstHealth.com** or call Member Services at **1-877-236-1341** (TTY: **711**) to have a copy mailed to you.

Right to Choose a Provider

Your PCP will be your main doctor. They can help coordinate your health needs. You can choose any PCP in our network and can change your PCP any time. You can choose the same PCP for your whole family or have a different PCP for each family member.

Your PCP can be a:

- Family or general practitioner.
- Internal medicine provider.
- Advanced nurse practitioner.
- Obstetrician or gynecologist (OB/GYN).
- Pediatrician.
- Physician assistant (under the supervision of a physician).
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- Attending specialist (for members requiring specialty care for their acute or chronic conditions, or for a condition related to a disability).

Your Primary Care Provider (PCP)

A primary care provider (PCP) is either a licensed physician or advanced nurse practitioner. They directly provide or coordinate your healthcare services. A PCP is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals. Your PCP will also coordinate care with your other health providers.

When choosing a PCP, you may want to find someone who:

- You have seen before.
- Understands your health history.

- Is taking new patients.
- Can serve you in your language.
- Is easy to get to.

You can find all the doctors, clinics, hospitals, labs, and others who partner with Delaware First Health in our provider directory. View our provider directory at **DelawareFirstHealth.com** or call Member Services at **1-877-236-1341** (TTY: **711**) to have a copy mailed to you.

To search the Provider Directory, visit DelawareFirstHealth.com and use the "Find a Provider" tool. This tool will have the most up to date information about the provider network, including information such as:

- Name.
- Address.
- Telephone numbers.
- Whether they are accepting new patients.
- Professional qualifications.
- Languages spoken.
- Gender.
- Specialty and board certification status.

For more information about a provider's medical school and residency, call Member Services at **1-877-236-1341** (TTY: **711**).

If you choose a new provider as your PCP, call to make a first appointment with them. This will give you both a chance to get to know each other. Your PCP can give you medical care, advice, and information about your health. Plan to see your PCP within three months of joining our plan.

Remember to bring your Delaware First Health member ID card and Delaware Medicaid ID card with you to your appointment. If you need help getting an appointment with your PCP, call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

How to prepare for your first visit with a new provider:

- Request a transfer of medical records from your current provider to your new PCP.
- Be prepared to talk about your general health, past major illnesses, surgeries, etc.
- Make a list of problems you have now.
- Make a list of questions you want to ask your PCP.
- Bring a list of medications and supplements you are taking. Don't forget to include any vitamins and OTC medications.

If you need care before your first appointment, call your PCP's office to explain your concern. Your PCP will give you an earlier appointment to address that particular health concern. You should still keep the first appointment to talk about your medical history and ask questions.

Appointment Standards

Type Of Appointment	Scheduling Requirement
Primary Care and OB/GYN Providers	**Timeframe**
Emergency medical condition.	Same day.
Urgent medical condition.	Within two calendar days.
Routine care appointments.	Not to exceed three weeks.
Specialists	**Timeframe**
Specialty providers — urgent.	Within 48 hours.
Specialty providers — routine.	Within three weeks.
Maternity Care	**Timeframe**
First trimester care.	Within three weeks of member request.
Second trimester care.	Within seven calendar days of member request.
Third trimester care.	Within three calendar days of member request.
High-risk pregnancies.	Within three calendar days of identification of high risk by Delaware First Health or maternity care provider, or immediately if an emergency exists.
Behavioral Health	**Timeframe**
Behavioral health — routine.	Routine outpatient services within seven calendar days of request with a non-prescribing clinician for an initial assessment. Non-emergency outpatient services within three weeks of request for prescribing clinician services.
Behavioral health — non-life-threatening emergency.	Within one hour of request, or direct member to crisis center or ER.

Type Of Appointment	Scheduling Requirement
Behavioral Health	**Timeframe**
Behavioral health — mobile crisis.	Immediate treatment for members experiencing a behavioral health crisis, including a mobile team. Response based on the acuity of the member and not to exceed one hour from the request.
Outpatient Services	**Timeframe**
Follow-up outpatient services.	Within two business days for members being discharged from an inpatient or residential setting to a community placement or members seen in an emergency room, or by a behavioral health crisis provider for a behavioral health condition.
Routine outpatient services.	Within seven calendar days of request with a non-prescribing clinician for an initial assessment.
Non-emergency outpatient services.	Within three weeks of request of prescribing clinician services.

Office Wait Times

If you have an appointment, you should not have to wait longer than an hour. If the doctor or another provider is running late, you should be told right away so you know what's happening. If you have to wait more than 90 minutes, you should be offered a new appointment.

Appointment Assistance

If you need help getting an appointment with your PCP or Specialist, call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

Getting a Second Opinion

Members have the right to ask for a second opinion about a diagnosis, procedure, or treatment at no cost to the member. You can get a second opinion from a network provider or a non-network provider if a network provider is not available. Please call Member Services at **1-877-236-1341** (TTY: **711**) if you need help finding a provider for a second opinion.

Specialist Care

If you need care that your PCP cannot give, your PCP will refer you to a specialist. A specialist is a provider who has special training for a specific condition or illness (like a cardiologist or oral surgeon). No referral is needed for you to see an in-network specialist. If you need help checking if a specialist is in-network please call Member Services at **1-877-236-1341** (TTY: **711**).

Hospital Services

Delaware First Health covers inpatient hospital services. If you need to be admitted to a hospital and it is not an emergency, your PCP or specialist will arrange for you to go to a hospital in the Delaware First Health network and will follow your care even if you need to see other providers during your hospital stay. No prior authorization is needed for emergency services. Delaware First Health must approve all other services.

To find out if a hospital is in the Delaware First Health network or if you have any other questions about hospital services, please call Member Services at **1-877-236-1341** (TTY: **711**). You can also go to the provider directory on **DelawareFirstHealth.com**. If you have an emergency and are admitted to the hospital, you, a family member, or a friend should let your PCP know as soon as possible, but no later than 24 hours after you were admitted to the hospital.

Important: You have unlimited visits to your PCP. There is no cost to you. Make appointments with them when you feel sick. You should also have a wellness check-up every year.

You can request to change your PCP at any time and for any reason. If you want to change your PCP, we can help you find or choose another PCP in your area. Call Member Services at **1-877-236-1341** (TTY: **711**). You can also change your PCP on our secure member portal at **DelawareFirstHealth.com**.

If you are not getting the care you need, within the time limits described in this handbook, call Member Services at **1-877-236-1341** (TTY: **711**).

Getting Care Outside of Your Network

There may be times when you need to get services outside of our network.

If you are new to Delaware First Health and you are already getting treatment from an out-of-network provider, we will work with this provider to make sure you can finish your treatment.

Out-of-Network Emergency Care

If you are out of the area when you have an emergency, go to the nearest emergency room. Emergency care means any hospital service that is necessary to prevent death or serious harm to your health. As a Medicaid member you can get emergency care from any healthcare provider in the United States. Make sure you call your PCP as soon as possible after your emergency visit.

Out-of-Network Non-Emergency Care

If Delaware First Health does not have a provider who can treat your covered condition or give you a covered service, you may ask to see a provider who is not in the Delaware First Health network. Before you see an out-of-network provider, check with your PCP to get a referral. The out-of-network provider will need to get approval from Delaware First Health. This approval is known as a prior authorization, and it is required for out-of-network providers.

Getting Care Outside of the United States

Medicaid health insurance does not cover medical costs outside of the United States. Therefore, Delaware First Health cannot cover any medical care you get outside of the country.

If you have questions about out-of-network care coverage, call Member Services at **1-877-236-1341** (TTY: **711**).

EMERGENCY AND URGENT CARE

Emergency care means inpatient and outpatient hospital services necessary to prevent death or serious harm to one's health.

Urgent care is when you have an injury or illness that is not an emergency but still needs care within a day or two.

What is An Emergency?

Emergency Medical Condition

An emergency medical condition is when you could die or be hurt permanently if you don't get care right away. Some examples of an emergency are:

- A heart attack or severe chest pain.
- Bleeding that won't stop or a bad burn.
- Broken bones.
- Trouble breathing, convulsions, or passing out.
- When you feel you might hurt yourself or others.
- If you are pregnant and have pain, bleeding, fever, or vomiting.
- A possible drug overdose.

Emergency Services

Emergency Services are services you get to evaluate, treat, or stabilize your emergency medical condition. You are always covered for emergencies.

Receiving Emergency Services

If you think you have an emergency, call 911 or go to the nearest emergency room (ER). You do not need approval from your plan or PCP before getting emergency care. You also do not have to use our hospitals or doctors. If you're not sure what to do, call your PCP. If it is after hours, you can leave a message for someone to call you back. You can also call the Delaware First Health 24-Hour Nurse Advice Line at 1-877-236-1341 (TTY: 711). The Nurse Advice Line is available 24 hours a day, seven days a week. Our nurses can:

- Give you things to try at home.
- Tell you to go to your PCP the next day.
- Tell you to go to the nearest urgent care clinic or ER.

If you are out of the area when you have an emergency, go to the nearest emergency room.

Remember: Use the emergency room only if you have an emergency. Some examples of non-emergencies include:

- Colds.
- An upset stomach.
- Minor cuts and bruises.

Non-emergencies may also be family issues or a break-up. These may feel like an emergency, but they are not a reason to go to the emergency room. Unless you are in immediate danger of harm, you should not go to the ER. If you aren't sure, call your PCP or Delaware First Health's 24-Hour Nurse Advice Line at **1-877-236-1341** (TTY: **711**).

Post-Stabilization Services

After an ER visit, you may need to go to your PCP or behavioral health specialist for follow-up care. Medically necessary services are called post-stabilization services. They are covered and provided without prior authorization. Your PCP can arrange this kind of follow-up care or additional testing.

What Is Urgent Care?

Urgent care is when you have an injury or illness that is not an emergency but still needs care within a day or two. This could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying.
- Flu symptoms.
- A wound that needs stitches.
- A sprained ankle.
- A bad splinter you cannot remove.

Receiving Urgent Care

You can go to an urgent care clinic to get care the same day or make an appointment for the next day.

If you're not sure what to do, call your PCP. If it is after hours, you can leave a message for someone to call you back. Or you can call the Delaware First Health 24-Hour Nurse Advice Line at 1-877-236-1341 (TTY: 711). The Nurse Advice Line is available 24 hours a day, seven days a week. Our nurses can:

- Give you things to try at home.
- Tell you to go to your PCP the next day.
- Tell you to go to the nearest urgent care clinic or ER.

If you go to an urgent care clinic or the ER, be sure to call your PCP the next day to set up a visit. Your PCP must schedule an appointment for you within two calendar days of your visit to an urgent care clinic.

Urgent Care Providers

To find the most up to date information on urgent care providers near you, use the "Find a Provider" tool on **DelawareFirstHealth.com** or call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**). You can find a list with some of our in-network *Urgent Care Locations* at the end of this handbook.

TELEHEALTH

What is Telehealth?

Telehealth, also known as *telemedicine*, lets your provider care for you without an in-person office visit. Telehealth can be done over the phone or online through your computer, tablet, or smartphone.

Telehealth gives you 24-hour access to in-network Delaware First Health providers for non-emergency health issues. It's available for you to use when you're at home, in the office, or even on vacation.

Get medical advice, a diagnosis, or even a prescription during your virtual visit. If you need medication, your prescription can be sent electronically to an in-network pharmacy near you. Use telehealth when you need it or set up a visit for a time that works with your schedule.

Use telehealth for things like:

- Colds, coughs, and fevers.
- Flu or COVID-19 symptoms.
- Sinuses or allergies.
- Respiratory infections, asthma, or bronchitis.
- Rashes, skin conditions, poison ivy, poison oak, mild insect, or animal bites.
- Ear infections.
- Pink eye or styes.
- Behavioral health counseling and treatment.

Telehealth should not be used during an emergency. If you are in a life-threatening situation, please call 911.

How is telehealth better than urgent care?

If you or a loved one is really feeling under the weather, consider using telehealth. That way you can save yourself the extra stress of getting to an urgent care clinic. Plus, you'll keep others from getting sick if your condition is contagious.

What is needed for a telehealth visit?

For best results, members can access a Delaware First Health telehealth virtual provider on a smartphone, a tablet, or a computer with a camera and microphone. Visit **DelawareFirstHealth.com/telehealth** for more details.

How much does a telehealth visit cost?

Telehealth visits for covered services are available for Delaware First Health members at no cost.

Can anyone access telehealth providers?

Any Delaware First Health member qualifies for telehealth visits if they need access to a provider for urgent care.

Behavioral Health visits are limited to members 18 years of age and older.

How do prescriptions work with telehealth?

When medication is prescribed during your telehealth visit, the prescription will be sent electronically to your in-network pharmacy. You'll be able to pick it up there when it is ready. Due to state and federal laws, certain prescriptions and narcotics cannot be prescribed during telehealth visits.

MATERNITY CARE

Congratulations on your pregnancy! As soon as you find out you are pregnant be sure to:

- Make an appointment with your OB/GYN.
- Let us know you are pregnant by filling out a notification of pregnancy (NOP), available online or over the phone. You could get a reward for letting us know.
- Call Member Services at **1-877-236-1341** (TTY: **711**) to talk to our maternal care coordination team if you have questions about your pregnancy or your coverage.
- If you are using substances like opioids (heroin, oxycodone), marijuana, alcohol, or tobacco, talk with your provider or call Member Services for help with treatment and resources while you're pregnant and after delivery.

Maternity care is covered under your Medicaid benefits, this includes:

- **Prenatal care:** Care during your pregnancy including visits, ultrasounds, and screenings.
- **Labor and delivery:** Care at the hospital or birth center when you have your baby.
- **Postpartum care:** Care after you deliver your baby, including visits.

Doula Care

A doula is a trained professional who can support you before, during, and after childbirth. They can help answer questions about pregnancy, labor, and after birth; help with birth planning and pain management during labor; and support you after you have your baby.

As part of your benefits, you can get:

- Five total prenatal visits:
  - Three doula visits while pregnant (prenatal).
  - Two additional prenatal visits are available to you as a Delaware First Health value-added benefit.
- Support during your labor and delivery.
- Eight total postpartum visits:
  - Three doula visits after pregnancy (postpartum).
  - Up to five additional postpartum visits are available if recommended by your provider.

Postpartum Nutrition Benefit

You may be able to get meals, diapers, and wipes delivered to your home after you have your baby. Contact our maternal care coordination team to learn more about this benefit and see if you qualify.

Breastfeeding Resources and Support

Breastfeeding has many great benefits for both you and your baby. Breast milk is the best source of nutrition for most babies and can protect against short and long-term illnesses and disease for both you and your baby. If you choose to breastfeed your baby, you can get an electric breast pump*, as well as lactation education and support as part of your benefits.

**Benefit limited to one breast pump every three years.*

Home Visiting Program

If you are pregnant, you may be eligible for the Home Visiting Program. This free program teaches you how to help your child grow, learn, and thrive. A nurse or parent support specialist will visit your home (or any place else that is good for you) during your pregnancy and after your child is born. They will come at a time that works for you to give you tips and connect you with services. They can keep visiting as your child grows up.

To learn more about the Home Visiting Program, go to **dethrives.com/programs/home-visiting** or call **211** for more details. You can also contact our maternal care coordination team for this information. They can help you connect with a home visiting program.

Delaware First Health Start Smart for Your Baby® — A Maternity Care Management Program

Start Smart for Your Baby® is a maternity care management program from Delaware First Health. It helps our pregnant members stay healthy before and after the birth of their child.

Our Start Smart staff is a dedicated team of registered nurses, social workers, community health workers, and professional staff who can help support you through your pregnancy and postpartum. They provide information about your pregnancy and health, can connect you to various resources, answer questions about your coverage, and can help coordinate your care before and after your pregnancy.

To learn more about our Start Smart program and to sign up, call our Member Services number at **1-877-236-1341** (TTY: **711**).

As a DFH member, you can earn rewards for doing various activities. You can earn up to $180 in rewards for yourself and up to $215 in rewards by the time your baby is 30 months old. This includes completing a notification of pregnancy (NOP) and attending your prenatal and postpartum visits. Ask your Start Smart care coordinator about these rewards or call Member Services to learn more.

FAMILY PLANNING

Family planning is a covered benefit for all members. Members under age 20 who are covered by Delaware Health Children Program (DHCP) must use a network provider. Members ages 21 and older can see any licensed family planning provider, including non-participating providers.

Family planning helps individuals and families plan the number of children they want, as well as the spacing and timing of births. It includes a broad range of services including basic infertility services, contraceptive services, and sexually transmitted infection (STI) prevention, testing, and treatment. These services are available at no cost to you.

Your healthcare provider can review various options with you about how to prevent you or your partner from getting pregnant. If you recently had a baby, it is recommended to wait 18 months or longer after giving birth to get pregnant again. Discuss with your healthcare provider when you would like to get pregnant and how you can prepare your body for a baby.

Licensed family planning providers can be:

- OB/GYNs (obstetrics and gynecology specialists).
- Certified nurse-midwives.
- PCPs.
- Clinics.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a benefit for children and young adults under the age of 21. Through the EPSDT program, children and adolescents can get medical, dental, vision, and hearing screenings to find any health problems early. Problems that are found early can be treated as soon as possible.

To identify health problems, it is important for all children and adolescents to go to all their recommended visits, also known as well-child visits. These visits usually start a few days after children are born and provide important and necessary screenings and immunizations. These appointments can also help your child's healthcare provider know if your child or adolescent needs additional services or support.

Young children grow quickly so they need to visit their healthcare provider more frequently in the first couple of years of life.

When to schedule well-child visits:	
The first week visit (3-5 days old).	**12 months old.**
1 month old.	**15 months old.**
2 months old.	**18 months old.**
4 months old.	**2 years old (24 months).**
6 months old.	**2.5 years old (30 months).**
9 months old.	**Yearly for those ages 3 years and up.**

Well-child visits are a good time to ask your child's PCP questions about their development, behavior, and any other concerns you may have.

If you have questions about EPSDT, talk to your child's PCP or call Member Services at

1-877-236-1341 (TTY: **711**).

To learn more about the dental coverage for children, see the *Vision and Dental* Benefits section.

YOUR PRESCRIPTION DRUG BENEFITS

Delaware First Health covers prescription drugs for Diamond State Health Plan and Diamond State Health Plan Plus members. The Delaware First Health list of covered drugs is called a preferred drug list (PDL) and follows the State of Delaware's formulary and prior authorization guidelines. The drugs on this list include both generic and brand-name drugs that have been carefully selected with help of doctors and pharmacists.

The PDL includes some OTC drugs that require a prescription. See the *Enhanced OTC Items* section for additional OTC items not on the PDL that do not require a prescription. Drug coverage rules and restrictions may apply.

Delaware First Health providers know about our PDL. They know how to request prior authorization and the special procedures for urgent requests. The Delaware First Health network of pharmacies also knows how to submit pharmacy claims to Delaware First Health.

You can call Delaware First Health's Pharmacy Services department for help finding out what drugs are covered, how to find a network pharmacy, or how to fill your prescription. Pharmacy Services can be reached at **1-833-236-1887** (TTY: **711**). You can also use the "Drug Lookup" and "Find a Provider" tools at **DelawareFirstHealth.com**.

About Prescription Drugs

When your Delaware First Health provider gives you a prescription, here are some questions you should ask about your prescription:

- What is the name of the medicine?
- Why do I take it?
- How much do I take?
- How often should I take it?
- How long do I keep taking it?
- Are there any side effects? For example, will I feel sleepy or have an upset stomach?
- Can I take this prescription with my other medications and supplements?
- Are there foods or drinks I should avoid?
- Should I stop taking it when I feel better?
- What should I do if I forget to take it?
- What should I do if I take too much?
- Can I crush, chew, or break the pill?

Generic Drugs

Generally, a "generic" drug works the same as a brand-name drug but costs less. When a generic version of a brand-name drug is available and has been proven effective for most people with your condition, network pharmacies will provide the generic version.

However, your provider can ask for the brand-name drug if your provider:

- Has told Delaware First Health the medical reason that the generic drug will not work for you.
- Has written "Brand Medically Necessary" on your prescription for a brand-name drug.
- Has told Delaware First Health the medical reason that neither the generic drug nor another covered drug that treats the same condition will work for you.

How to Get a Prescription Drug

You can have your prescription filled at any pharmacy in the Delaware First Health network. To get your prescription:

- Go to a Delaware First Health network pharmacy.
- Show the pharmacy your Delaware First Health ID card.
- Give the pharmacy the prescription order.

Call Delaware First Health Pharmacy Services at **1-833-236-1887** (TTY: **711**) if you need help finding a network pharmacy. You can also find a pharmacy by using the "Find A Provider" tool at **DelawareFirstHealth.com**. It can be found in the *Pharmacy* section of the site.

The network pharmacy will automatically bill Delaware First Health for the covered prescription drug cost. You may need to pay the pharmacy a copay when you pick up your prescription.

Refilling Your Prescription

When your prescription has refills available, and you are almost out of your current medication, call or go to your pharmacy and request a refill. Delaware First Health suggests you get a refill at least a few days before you run out of your medication. This prevents you from running out of the medication you need.

90-Day Supply

You can get a 90-day supply of certain medications that you take regularly and oral contraceptives.

With a three-month, six-month, or 12-month prescription from your doctor, you can get a 90-day supply of maintenance medications at:

- In-network retail pharmacies:
  - Going to a network pharmacy that participates in the Delaware First Health 90-day supply program. You can find participating pharmacies by using the "Find a Provider" tool at **DelawareFirstHealth.com**.
  - You can also call Delaware First Health Pharmacy Services for help finding a participating 90-day supply pharmacy. Call **1-833-236-1887** (TTY: **711**).
- Mail-order pharmacy:

  You can enroll in the 90-day supply mail-order program through Express Scripts® Pharmacy. There are four ways to get started in the Express Scripts® Pharmacy mail-order program:

  1. Ask your doctor to electronically send or fax a new prescription to Express Scripts® Pharmacy. Your doctor can fax Express Scripts® Pharmacy at **1-800-837-0959**. This number is for provider fax use only.
  2. Visit **express-scripts.com/rx** to register or sign in and have your member ID number ready. Follow the guided steps to request a prescription. Once Express Scripts has your information, they will contact your doctor for approval of your prescription.
  3. Call Express Scripts® Pharmacy at **1-833-750-4300** (TTY: **711**). Express Scripts® Pharmacy can contact your doctor for a new prescription to be filled as mail order.
  4. Mail a home delivery order form. To get a copy of the form, register or log in at **express-scripts.com/rx**. Go to "Benefit Menu," click "Forms," and download the Home Delivery Order Form. Complete the form and mail it with your paper prescription to Express Scripts® Pharmacy. Make sure your doctor writes your mail service prescription(s) for a three-month supply.

To check if your prescription is available for a 90-day supply, see the PDL. If the drug has "MP" after the name, it is available for a 90-day supply. See next section.

Covered Prescription Drugs

The Delaware First Health Preferred Drug List (PDL) is a guide to available brand-name and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. It is continually reviewed and updated. The PDL includes all drugs available without prior

authorization, those that require prior authorization, and those that have step therapy restrictions. The PDL applies to drugs you get at both in-person retail and mail-order pharmacies.

The PDL is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. Sometimes a drug may appear more than once on the PDL. This is because of different ways the drug may be used by your doctor (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

How to find out if a specific drug is on the PDL

You can find out if a particular drug is on the preferred drug list by:

- Viewing the PDL online at **DelawareFirstHealth.com**. The PDL on the website is always the most current.
- Calling Pharmacy Services at **1-833-236-1887** (TTY: **711**) to ask about a specific drug or to have a paper copy of the PDL mailed to you.

Prior-Authorization of Some Prescription Drugs

Delaware First Health must approve some drugs before you can get them. You should ask your provider if the prescription needs approval. If it does, you should ask if there is another medicine that can be used that does not require prior authorization.

Your provider can decide if it is necessary to have a non-preferred drug. If so, your provider must give Delaware First Health a request for prior authorization. If Delaware First Health does not approve the request, we will notify your provider and mail you a letter explaining the reason for not approving the prior authorization request. Delaware First Health will include information on how to appeal the decision and the State Fair Hearing processes.

Delaware First Health may require you to try at least two different preferred drugs before you can get a non-preferred drug. You need to ask your provider to write a prescription for a preferred drug first.

You may find information about prior authorization and step therapy by:

- Viewing the PDL online at **DelawareFirstHealth.com**. The PDL on the website is always the most current.
- Calling Pharmacy Services at **1-833-236-1887** (TTY: **711**) to ask about a specific drug's prior authorization or step therapy, or to have a paper copy of the PDL mailed to you.

Prescription Drug Copays

Some Delaware First Health members will have a copay for prescription medications, based on the cost of the medication:

$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The most you will pay for prescription copays, in a calendar month, is $15. Once you reach this limit, you do not have to pay copays for the rest of the calendar month. The copays and the $15 copay maximum will start over on the next calendar month.

If you have questions about prescription copays, call Pharmacy Services at **1-833-236-1887** (TTY: **711**).

Members and services exempt for copays:

- Children under the age of 21.
- Pregnant individuals and those who have given birth within the past 12 months.
- Members in the chronic renal disease program (CRDP).
- Long-term care nursing facility group or the acute care hospital group.
- Family planning services and supplies.
- Hospice services.
- Naloxone opioid overdose rescue medications.
- Medications for addiction treatment (MAT) and medications for opioid use disorder (MOUD).
- Smoking cessation products.

Member Lock-In Program

Delaware First Health reviews member prescription claims data and works with providers, pharmacies, and the State of Delaware to find opportunities to support members with complicated drug regimens. Members that may benefit from lock-in support will be entered into the Delaware First Health lock-in program. Through this state-approved program, Delaware First Health may designate a single participating pharmacy and/or a single provider to write and fill prescriptions for a member.

Delaware First Health will let members know if they qualify for the lock-in program. This means members can only get their medication from a single "locked-in" provider and pharmacy.

When a member is "locked in" to a doctor and/or pharmacy, the member will get information on how to submit a grievance for the lock-in each year.

Should the member not be able to fill their prescription, the member should call Delaware First Health's Pharmacy Services. The Pharmacy Services team helps members find another network pharmacy. Call Delaware First Health for any lock-in issues at **1-833-236-1887** (TTY: **711**).

Enhanced Over-the-Counter (OTC) Items

Members can get up to $120 per household per year ($30 per quarter) to spend on OTC items as part of our Value-Added Benefits. These items do not require a prescription.

To view a full list of OTC items, visit DelawareFirstHealth.com/VAB. Orders can be placed:

- Online at **DelawareFirstHealth.com/VAB**.
- On the OTC Health Solutions app, available in the iOS App Store or Google Play.
- By phone by calling **1-888-628-2770** (TTY: **711**).

GRIEVANCES AND APPEALS

Grievances

This section gives the rules for making a grievance (complaint). State law says you can make a grievance about any part of your medical care as a Delaware First Health member. The state has helped set the rules about what you need to do to make a complaint. The state also has rules about what we must do when we get a grievance. We must be fair in handling your grievance. You cannot be dropped from the plan for filing a grievance. We will not penalize you for making a grievance or complaint.

Let us know right away about any problems you have with your healthcare services. Call Member Services at **1-877-236-1341** (TTY: **711**). Let us know if you need an interpreter.

What is a Grievance?

A "grievance" is a complaint that you make to your plan about your healthcare. A grievance can cover anything you are unhappy about, except for an adverse benefit determination made to Delaware First Health by a member or their authorized representative. Members may file grievances regarding the quality of care or service received. You, or someone you choose to help you, may file a grievance by phone or in writing. Delaware First Health can help you fill out forms to file a grievance or an appeal.

A grievance may be about anything you are unhappy with while getting services as a member of Delaware First Health. Some examples are:

- Unclear or wrong information from staff.
- Poor quality of care or access to care.
- Rudeness from a provider or employee.
- Failing to respect your member rights.
- Unpaid medical bills.
- Wait time to see your PCP/specialist.
- Eligibility issues.
- Pharmacy issues.

How to File a Grievance

You can file a grievance at any time by:

- Calling Member Services at **1-877-236-1341** (TTY: **711**). We are here for you Monday through Friday, from 8 a.m. to 7 pm., Eastern time. Translation services are also available if needed.
- Sending a fax to **1-833-525-0054**.
- Writing to:
  Delaware First Health
  ATTN: Appeals and Grievances
  P.O. Box 10353
  Van Nuys, CA 91410-0353

Be sure to include:

- Your first and last name.
- Your Medicaid or Delaware First Health ID number.
- Your address and telephone number.
- What made you unhappy.
- Where did the incident take place.
- The provider's information (name, address, and telephone number).
- What you would like to have happen.

There is also a grievance form that you can use on our website at **DelawareFirstHealth.com/Grievance**.

If you want someone to file a grievance for you, we need your written or verbal permission. This will make them an authorized representative. If you want to give verbal permission for someone else to file a grievance for you, call Member Services and give your verbal consent. If you want to give written permission, you can call Member Services or visit **DelawareFirstHealth.com** to get a form. The form is titled "Release of Information (ROI)." Parents or guardians of minors do not need to fill out this form.

Delaware First Health will not treat you differently for filing an appeal or grievance.

What to Expect After You File a Grievance

We will send you a letter within five business days after you file a grievance to let you know we got it. If you have information to help us with your grievance, please send it to us by calling, faxing, or mailing it in. You can request copies of the documents we used to resolve your grievance free of charge.

We will send a resolution letter to you within 30 calendar days, which will inform you of our decision.

If more information is needed to resolve your grievance, a 14-calendar day extension may be requested by Delaware First Health. We will only ask for an extension if it is in your best interest. If more time is needed, we will let you know by phone and in writing at least two calendar days before the 30 calendar days are up. You may file a grievance if you disagree with the extension. You can also request an extension if you need more time to support your grievance. If you want an extension, please call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

Timeframe for Filing a Grievance

You, your authorized representative, or your provider (with your written consent) may file a grievance at any time. Delaware First Health must resolve your grievance within 30 calendar days of receipt.

Within five business days of getting your grievance, we will mail you a letter acknowledging your grievance. We will send you a resolution letter within 30 calendar days of receipt of your grievance.

Appeals

What Is an Appeal?

An appeal is a request for your health plan to review a decision made to deny, terminate, or reduce a benefit. You, your authorized representative, or your provider (with your written consent) may request an appeal by:

- Calling Member Services at **1-877-236-1341** (TTY: **711**).
- Sending a fax to **1-833-525-0054**.
- Writing to:

  Delaware First Health
  ATTN: Appeal Coordinator
  P.O. Box 10353
  Van Nuys, CA 91410-0353

If you are appealing behavioral health services, send your request:

- In writing to:

  Delaware First Health
  ATTN: Appeal Coordinator
  P.O. Box 10378
  Van Nuys, CA 91410-0378

- By fax: **1-866-714-7991**

If you are appealing a pharmacy service, send your request:

- In writing to:

  Delaware First Health
  ATTN: Pharmacy Appeals
  P.O. Box 31398
  Tampa, FL 33631-3398

- By fax: **1-888-865-6531**

You can also submit an appeal request on our secure member portal at **DelawareFirstHealth.com**. If you are unable to appeal for yourself, you have the option to designate someone else as an authorized representative to do it on your behalf. This person can be your provider, family member, or friend. You must have a written request authorizing them to appeal on your behalf.

When you file your appeal, you should include:

- Your name and member ID number.
- Your phone number.
- Your address.
- What you are appealing.
- Why you are appealing.

If you need help asking for an appeal or understanding the process, call Member Services at **1-877-236-1341** (TTY: **711**). We can help you file your appeal. If you need a translator, we can find one for you free of charge.

There is only one level of appeal with the plan. We will send you a letter within five business days to confirm that we have received your appeal. The letter will provide additional details about the appeal process.

You have the right to submit comments, documents, or other information relevant to your request with your appeal request. You, or your authorized representative, have the right to speak or present information to the person or people reviewing your appeal. This can be done in person or over the phone. You have the right to take part in the appeal committee when you ask for an appeal. You have the right to request a copy of your appeal file free of charge.

An appeal committee will review your appeal and make a decision. The appeal committee consists of a staff member from the State of Delaware, a plan medical director, and a plan nurse. The committee members will not have been involved in the previous decision.

We will send you a letter letting you know our decision within 30 calendar days of getting your request for an appeal. If your appeal request is not approved, the decision letter will also explain your rights to request a State Fair Hearing.

If the plan does not make an appeal decision within the 30-calendar day timeframe, you can request a State Fair Hearing.

Timeframe for Filing an Appeal

You, your authorized representative, or your provider (with your written consent) may request a fast (expedited) or standard appeal within 60 calendar days of when Delaware First Health notifies you about a decision to deny, terminate, or reduce a service.

Expedited Appeals

A fast (expedited) appeal may be requested if the normal timeframe to review your appeal could cause you serious health concerns. You, your authorized representative, or your provider (with your written consent) may request a fast appeal by:

- Calling **1-877-236-1341** (TTY: **711**).
- Faxing **1-833-525-0054**.
- Writing to:
  Delaware First Health
  ATTN: Appeal Coordinator
  P.O. Box 10353
  Van Nuys, CA 91410-0353

You can also submit an appeal request on our secure member portal at **DelawareFirstHealth.com**.

If you are appealing behavioral health services, send your appeal:

- In writing to:
  Delaware First Health
  P.O. Box 10378
  Van Nuys, CA 91410-0378
- By fax: **1-866-714-7991**

If you are appealing a pharmacy service, send your appeal:

- In writing to:

  Delaware First Health
  ATTN: Pharmacy Appeals
  P.O. Box 31398
  Tampa, FL 33631-3398

- By fax: **1-888-865-6531**

If we agree that you should get a fast appeal decision, you will get a decision within 72 hours after Delaware First Health receives your request. If we do not agree, we will notify you by phone that your appeal will follow the standard appeal process. We will send you a written notice within two calendar days. Your doctor may send supporting notes requesting a fast appeal for Delaware First Health to reconsider giving you a fast decision on your appeal.

If you need help asking for an appeal or understanding the process, call Member Services at **1-877-236-1341** (TTY: **711**). We can help you file your appeal. If you need a translator, we can arrange one for you free of charge.

Expedited Appeal Process

You have the right to submit comments, documents, or other information relevant to your request with your appeal request. The timeframe to submit additional information is limited due to the quick timeframe to resolve an expedited appeal. You or your authorized representative has the right to speak or present information to the person or people reviewing your appeal. This can be done in person or over the phone. You must request to take part in the appeal meeting when you ask for an appeal.

An appeal committee will review your appeal and decide. The appeal committee consists of a staff member from the State of Delaware, a plan medical director, and a plan nurse. The committee members will not have been involved in the previous decision.

We will notify you of a decision via phone and written letter within 72 hours of when we receive your appeal request. If we do not approve your request during the appeal review, the appeal decision letter will explain your rights for a State Fair Hearing.

14-Day Extension Process

You may ask for an extension, or Delaware First Health may ask for an extension if there is a need for additional details.

When Delaware First Health asks for an extension, the plan will do the following:

1. Notify you by phone that an extension is needed.
2. Send you a written notice within two calendar days of the decision to extend the timeframe.
3. Inform you of your right to file a grievance if you disagree with the decision to extend the timeframe.
4. Resolve the appeal as quickly as possible but no longer than the date the extension expires.

Continued Benefits

If we are going to reduce or stop a service that we already approved, you can keep getting benefits during the appeals and State Fair Hearing process. To have your benefits continue you must:

- File an appeal within 10 calendar days of the date your denial letter was mailed.
- OR file an appeal on or before the date your services are set to be discontinued.

The service will stop if:

- You withdraw your appeal or State Fair Hearing request.
- You did not ask for a State Fair Hearing for continued benefits within 10 calendar days of when your appeal decision letter was mailed.
- A State Fair Hearing decision was made against you.

In accordance with federal policy, if the decision of the State Fair Hearing is made against you, Delaware First Health may recover the cost of the services provided to you while your appeal or State Fair Hearing were pending.

State Fair Hearings

You or your authorized representative have the right to request a State Fair Hearing with the State of Delaware. A State Fair Hearing is a meeting between you, your authorized representative, a hearing officer, and a representative from Delaware First Health.

You can submit evidence, present your case, examine records, and ask questions about your request during the hearing process. You must ask for a State Fair Hearing within 120 calendar days of the appeal decision letter you get from us. You must go through Delaware First Health's appeal process before asking for a State Fair Hearing. You may request a hearing by calling, emailing or writing to the state's division of Medicaid and Medical Assistance (DMMA) office:

- In writing to:
  Division of Medicaid and Medical Assistance
  DMMA State Fair Hearing Officer
  1901 North DuPont Highway
  PO Box 906, Lewis Building
  New Castle, DE 19720
- By Phone: **1-302-255-9500** or toll-free at **1-800-372-2022**.
- By fax: **1-302-255-9614**.

Para español u otros idiomas, llame al **1-866-843-7212**.

若需中文或其他語言，請致電 **1-866-843-7212**。

Pou Kreyòl Ayisyen, oswa lòt lang, rele **1-866-843-7212**.

للغة العربية أو للغات الأخرى، اتصل على الرقم **1-866-843-7212**.

For other languages, call **1-866-843-7212**.

To ask for a fair hearing by email, please send your request to **DHSS_DSS_FHRequest@delaware.gov**.

State Fair Hearing Process

You or your representative will get a letter from the State Fair Hearing office that will tell you the date, time, and place of the hearing. The hearing can be held in person or by phone. The letter will tell you more information about the hearing process.

You or your representative may review all information regarding the State Fair Hearing. Delaware First Health will also have a representative at the hearing.

In accordance with Federal policy, if the decision of the State Fair Hearing is made against you, Delaware First Health may recover the cost of the services provided to you while your appeal or State Fair Hearing were pending.

CHANGING YOUR PLAN

You can ask to change your MCO for any reason during the 90 calendar days following your initial enrollment. After that, you can choose a new MCO during open enrollment or if you have a reason to request a good cause transfer.

Good Cause Transfer

Members may ask to transfer between MCOs at any time for good cause, as determined by the state. There is no limit on the number of transfer requests that you can initiate for good cause. Examples of good cause reasons include:

- Your provider is not in the MCO's network.
- You need related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within your MCO's provider network. Or your PCP or another provider determined that getting the services separately would subject you to unnecessary risk.
- Lack of access to providers experienced in dealing with your healthcare needs.
- Your provider has been terminated or no longer participates with your MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by your MCO.
- The MCO plan does not cover the services you need due to moral or religious objections.

If you want to change your MCO, and you are within 90 days of your initial enrollment or you have reason to request a good cause transfer, you can call the Health Benefits Manager at **1-800-996-9969**.

Annual Open Enrollment

Each year, the state provides an opportunity for members to change their health plan. This period is known as open enrollment and it happens during the month of October for coverage beginning January 1. During open enrollment, members can change their plan for any reason, without good cause.

If you decide to change your health plan during open enrollment, call the Health Benefits Manager at **1-800-996-9969**. Your Health Benefits Manager will help you transfer to a new plan. If you decide not to switch health plans, you will automatically stay in your current plan.

Your Enrollment

Depending on eligibility, Delaware Medicaid programs may offer coverage for children, pregnant individuals, families with children, senior citizens, and adults or children with disabilities. If you think you might be eligible for Medicaid coverage, you can apply with the Delaware Department of Health and Social Services. There are several ways to apply and enroll:

- **Online:** Apply online at the Delaware Department of Health and Social Services website at **assist.dhss.delaware.gov**.

- **By Mail:** You may download the form and instructions:
  - English application at **assist.dhss.delaware.gov**
  - Spanish application at **assist.dhss.delaware.gov/?Language=es-US**.

Need Help?

For help with your Medicaid application, call the Delaware Health and Social Services Customer Relations Unit at **1-866-843-7212** (TTY: **1-855-889-4325**).

Delaware First Health offers medical assistance to eligible low-income families, older adults, blind, and/or disabled people whose income is not enough to meet the cost of necessary medical services. Medicaid pays for doctor visits, hospital care, labs, prescription drugs, non-emergency medical transportation, routine shots for children, mental health services, and substance abuse. To enroll, eligible recipients must fill out an application through the Delaware Health and Social Services ASSIST portal.

Your Effective Date of Enrollment

Once you enroll or are enrolled with Delaware First Health, you will receive a letter with your ID card. You can find more information about your effective date on our member portal at **DelawareFirstHealth.com**.

Continuity of Care

If you join Delaware First Health from another health plan, we will work with your old health plan to get your health details, like your service history, service authorizations, and other information about your current care.

You can keep seeing your provider if:

- At the time you join Delaware First Health, you are getting an ongoing course of treatment or have an ongoing special condition. In that case, you can ask to keep your provider for up to 120 days.
- You are more than three months pregnant when you join Delaware First Health and are getting prenatal care. In that case, you can keep your provider until after your delivery and for up to 60 days of postpartum care.
- You are getting DSHP Plus LTSS benefit package services. In that case, you can continue the services authorized at the same level and with the same provider for a minimum of 30 calendar days.

If you want to keep getting care from a provider who is not in our network, you or your provider need to contact us by:

- Calling Member Services at **1-877-236-1341** (TTY: **711**).
- Submitting a request through the Provider Portal.
- Faxing an authorization request form to Delaware First Health at **1-833-967-0502**.

Delaware First Health doctors and nurses will review the authorization request. Call Member Services at **1-877-236-1341** (TTY: **711**) if you have questions about services that require prior authorization.

OTHER PLAN INFORMATION

Confidentiality

Know that your medical records and discussions with your providers will be private and confidential.

We are committed to keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We use some of the following methods to protect your information:

- Maintaining paper documents in locked file cabinets.
- Requiring that all electronic information remain on physically secure media.
- Maintaining your electronic information in password-protected files.

We may use or disclose your REL and SOGI information to perform our operations. These activities may include:

- Designing intervention programs.
- Designing and directing outreach materials.
- Informing healthcare practitioners and providers about your language needs.
- Assessing healthcare disparities.

We will never use your REL and SOGI information for underwriting, rate setting, or benefit determinations or disclose your REL or SOGI information to unauthorized individuals.

New Technology

Health technology is always changing, and we want to grow with it. If we think a new medical advancement can benefit our members, we evaluate it for coverage. These advancements include:

- New tests.
- New medical procedures.
- New surgeries.
- New drugs.
- New devices.
- New application of existing technology.

Delaware First Health wants to make sure you have access to the most up-to-date medical care. We have a team that watches for advances in medicine. The team checks to make sure the new treatments are safe. We will tell you and your doctor about new services covered under your benefits.

Third Party Liability (TPL) Reporting

Notify Member Services at 1-877-236-1341 (TTY: 711) and DSS and DMMA Customer Relations at 1-866-843-7212 if you:

- Get or have health coverage under another policy or other third party, or if there are changes to that coverage.
- Have a workers' compensation claim.

- Have a pending personal injury or medical malpractice lawsuit.
- Have been involved in an auto accident.

Reporting of Suspected Child and Dependent Adult Abuse, Neglect, or Exploitation

Abuse can be physical, emotional, or sexual. It is the mistreatment of an adult or child.

If you suspect a child under the age of 18 is abused or neglected, call the Child Abuse Hotline at **1-800-292-9582**. More information is available online at **dhss.delaware.gov/dhss/dmma/medicaid.html**.

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call **1-800-223-9074**. More information is available online at **https://dhss.delaware.gov/dhss/dsaapd/index.html**.

Critical Incidents

Delaware First Health Members can report critical incidents to Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

Critical incidents include but are not limited to the following incidents:

- Unexpected death of a member.
- Suspected physical, mental, or sexual mistreatment, abuse and/or neglect of a member.
- Suspected theft or financial exploitation of a member.
- Severe injury sustained by a member when source of injury is unknown, and injury is suspicious, or injury requires transfer to acute care.
- Medication or treatment error or omission that jeopardizes a member's health or safety.
- Inappropriate/unprofessional conduct by a provider involving a member.

URGENT CARE LOCATIONS

New Castle County			
Bear	**ChristianaCare GoHealth Urgent Care** 1011 E Songsmith Dr. Bear, DE 19701 **1-302-546-5538**		
Greenville	**ChristianaCare GoHealth Urgent Care** 360 Buckley Mill Rd. Ste. B Greenville, DE 19807 **1-302-504-0253**		
Middletown	**ChristianaCare GoHealth Urgent Care** 749 Middletown Warwick Rd. Middletown, DE 19709 **1-302-273-1614**		
Newark	**Go-Care Urgent Care at Abby Medical** 1 Centurian Dr. Ste. 106 Newark, DE 19713 **1-302-999-0003**	**Newark 24/7 Emergency** 324 East Main St. Newark, DE 19711 **1-302-738-4300**	**ChristianaCare GoHealth Urgent Care** 200 Hygeia Dr. Newark, DE 19713 **1-302-273-1701**
	ChristianaCare GoHealth Urgent Care 1 Chestnut Hill Plaza Ste. C Newark, DE 19713 **1-302-267-7534**	**ChristianaCare GoHealth Urgent Care** 550 S College Ave. Ste 115 Newark, DE 19713 **1-302-273-0727**	**PM Pediatric Urgent Care** 3180 Fashion Center Blvd. Newark, DE 19702 **1-302-500-5437**

New Castle County (Continued)		
Wilmington	**Go-Care Urgent Care at Silverside Medical** 2700 Silverside Rd. Wilmington, DE 19810 **1-302-225-6868**	**ChristianaCare GoHealth Urgent Care** 2305 Concord Pike Wilmington, DE 19803 **1-302-467-3588**
	ChristianaCare GoHealth Urgent Care 4724 Limestone Rd. Wilmington, DE 19808 **1-302-467-3595**	**ChristianaCare GoHealth Urgent Care** 3926 Kirkwood Hwy. Wilmington, DE 19808 **1-302-455-2730**

Kent County		
Dover	**Coastal Medical Center Walk-In & Primary Care** 4601 S DuPont Hwy. Ste. 2 Dover, DE 19901 **1-302-698-1100**	**ChristianaCare GoHealth Urgent Care** 200 Banning St. Ste. 170 Dover, DE 19904 **1-302-546-5533**
Milford	**Bayhealth Walk-in Medical Care** 800 N. DuPont Blvd. Milford, DE 19963 **1-302-430-5705**	
Milton	**Bayhealth Emergency and Urgent Care Center, Total Care - Milton** 18383 Hudson Rd. Milton, DE 19968 **1-302-725-3500**	
Smyrna	**ChristianaCare GoHealth Urgent Care** 300 Jimmy Dr. Smyrna, DE 19977 **1-302-273-1163**	

Sussex County	
Georgetown	**Beebe Medical Group Walk-In Georgetown** 21635 Biden Ave. Unit 101 Georgetown, DE 19947 **1-302-856-9729**
Laurel	**TidalHealth Immediate Care** 30549 Sussex Hwy. Laurel, DE 19956 **1-302-297-2585**
Lewes	**AtraCare Walk-In** 18068 Coastal Hwy. Lewes, DE 19958 **1-302-567-1500**
Millsboro	**Beebe Medical Group Walk-In Millsboro** 28538 Dupont Blvd. #1 Millsboro, DE 19966 **1-302-934-5052**
Millville	**Beebe Medical Group Walk-In Millville** 32550 Docs Place Extension Unit 1 Millville, DE 19967 **1-302-541-4175**
Milton	**Beebe Medical Group Walk-In Milton** 23900 Milton Ellendale Hwy. Milton, DE 19968 **1-302-684-5635**
Rehoboth Beach	**Beebe Medical Group Walk-In Rehoboth Beach** 19161 Healthy Way Unit 100 Rehoboth Beach, DE 19971 **1-302-645-3010**

Sussex County (Continued)		
Seaford	**Ambient Medical Care** 24459 Sussex Hwy. Unit 2 Seaford, DE 19973 **1-877-629-2621**	**TidalHealth Immediate Care** 8472 Herring Run Rd. Seaford, DE 19973 **1-302-297-2510**
Selbyville	**Lower Shore Immediate Care of Selbyville** 38229 DuPont Blvd. Selbyville, DE 19975 **1-302-433-6440**	

Maryland	
Delmar	**Best Remedy Urgent Care LLC** 9315 Ocean Hwy. Ste. B Delmar, MD 21875 **1-410-896-5550**
Elkton	**ChristianaCare GoHealth Urgent Care** 310 E Pulaski Hwy. Elkton, MD 21921 **1-443-485-6213**
North East	**ChristianaCare GoHealth Urgent Care** 101 North East Plaza North East, MD 21901 **1-410-656-7867**

GLOSSARY OF TERMS

Words/Phrases
appeal: When you ask your plan to review a decision to deny or reduce a benefit.
benefits: The healthcare items or services covered under your plan.
copayment / copay: A set cost you must pay to get a covered benefit at the time of service.
durable medical equipment (DME): Equipment and supplies that your doctor orders as part of your healthcare.
emergency medical condition: A medical problem so serious that you must seek care right away to avoid severe harm or death.
emergency medical transportation: The ambulance that takes you to the hospital in an emergency.
emergency room care: The services you get in an emergency room, or ER, to treat an emergency medical condition.
emergency services: Treatment of an emergency medical condition to keep it from getting worse.
excluded services: Healthcare services that your plan does not pay for or cover.
grievance: A complaint that you make to your plan about your healthcare.
habilitation devices: Healthcare devices that help you keep, learn, or improve skills and functioning for daily living.
habilitation services: Healthcare services that help you keep, learn, or improve skills and functioning for daily living.

Words/Phrases

health insurance: A contract that requires your plan to pay some or all of your healthcare costs.

home healthcare: Healthcare services a person gets at home.

hospice services: Services to provide comfort and support for people who are terminally ill and their families.

hospitalization: Care in a hospital where you are admitted and usually stay overnight. An overnight stay for observation could be outpatient care.

hospital outpatient care: Care in a hospital that usually does not require an overnight stay.

immunization: A shot that protects you from disease. Also known as a *vaccination* or *vaccine*.

Long Term Services and Supports (LTSS): Medical and non-medical care for people who are unable to perform basic Activities of Daily Living (ADLs), such as dressing or bathing. LTSS can happen at home, in the community, in assisted living, or in nursing homes.

medically necessary: Healthcare services or supplies that help to identify or treat an illness, injury, condition, disease, or its symptoms and that meet medical standards.

network: The providers that your plan has contracted with to provide healthcare services.

non-participating provider: A provider who does not have a contract with your plan to provide services to you.

physician services: Healthcare services a licensed medical doctor provides or plans for you.

plan: A benefit the State of Delaware provides to you to pay for your healthcare services. Also called a Managed Care Organization (MCO).

Words/Phrases

prior authorization: An approval from your plan in advance for a healthcare service that hasn't happened yet. Also called *preapproval* or *pre- authorization*.

participating provider: A provider who has a contract with your plan to provide healthcare services to you.

Preferred Drug List (PDL): A list of prescription drugs that your plan will cover. Also called a *formulary*.

premium: The amount you pay for your health insurance every month.

prescription drug coverage: The part of your plan that helps pay for prescription drugs and medications.

prescription drugs: Drugs and medications that, by law, require a prescription.

primary care provider (PCP): A doctor, nurse, or physician assistant who provides, plans, and/or helps you access healthcare services.

provider: A healthcare professional, facility, or medical business that offers healthcare services to you.

rehabilitation devices: Healthcare devices that help you keep, get back, or improve skills and functioning you need for daily living that have been lost or impaired because you were sick, hurt, or disabled.

rehabilitation services: Healthcare services that help you keep, get back, or improve skills and functioning you need for daily living that have been lost or impaired because you were sick, hurt, or disabled.

skilled nursing care: Healthcare services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

specialist care: Healthcare from a provider who has special training for a specific condition or illness.

urgent care: When you need care or medical treatment within 48 hours.

Statement of Non-Discrimination

Delaware First Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Delaware First Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Delaware First Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at **1-877-236-1341** (TTY:**711**).

If you believe that Delaware First Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity) you can file a grievance with:

1557 Coordinator
P.O. Box 31384
Tampa, FL 33631
Phone: **1-855-577-8234** (TTY: **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html.**

This notice is available at Delaware First Health website:
https://www.delawarefirsthealth.com/non-discrimination.html.

Delaware First Health: **1-877-236-1341** (TTY: **711**)

English: If you need this in another language, or need auxiliary aids and services, large font, oral translation, or other alternative formats, we can provide them to you free of charge. Call **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
Español (Spanish): Si necesita esta información en otro idioma o necesita ayudas y servicios auxiliares, letra grande, interpretación oral u otros formatos alternativos, podemos proporcionarlos para usted de manera gratuita. Llame a **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
中文 (Chinese): 如您需要以其他語言，或需要輔助工具和服務、較大的字型、口譯服務或其他替代格式檢閱此資訊，我們可以免費提供給您。請致電 **Delaware First Health**：**1-877-236-1341** (TTY：**711**)。
Kreyòl Ayisyen (Haitian Creole): Si ou bezwen sa nan yon lòt lang, oswa si ou bezwen aparèy ki bay asistans ak sèvis oksilyè, dokiman ki ekri ak gwo lèt, tradiksyon nan bouch, oswa lòt fòma altènatif, nou kapab ba ou yo gratis. Rele **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
ગુજરાતી (Gujarati): જો તમને બીજી ભાષામાં આની જરૂર હોય અથવા સહાયક સહાય અને સેવાઓ, મોટા ફૉન્ટ, મૌખિક અનુવાદ અથવા અન્ય વૈકલ્પિક ફોર્મેટની જરૂર હોય, તો અમે તમને તે મફતમાં પ્રદાન કરી શકીએ છીએ. **Delaware First Health**ને આના પર કૉલ કરો: **1-877-236-1341** (TTY: **711**).
Français (French): Si vous avez besoin de ce document dans une autre langue, d'aides et de services auxiliaires, de polices de caractères plus grandes, d'une traduction orale ou d'autres formats, nous pouvons vous les fournir gratuitement. Contactez **Delaware First Health** : **1-877-236-1341** (TTY : **711**).
한국어 (Korean): 다른 언어, 보조 도구 및 서비스, 큰 글씨, 구두 번역 또는 기타 대체 형식으로 필요한 경우 무료로 제공해 드릴 수 있습니다. **Delaware First Health**: **1-877-236-1341**(TTY: **711**)로 전화해 주십시오.

Kiswahili (Swahili): Ikiwa unahitaji hii katika lugha nyingine, au unahitaji usaidizi na huduma za usaidizi, fonti kubwa, ukalimani, au maumbizo mengine mbadala, tunaweza kuzitoa bila malipo. Pigia **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Yorùbá (Yoruba): Bí o bá nílò èyí ní èdè mìíràn, tàbí o nílò àwọn ìrànwọ́ arannilọ́wọ́ àti àwọn iṣẹ́, lẹ́tà kíkọsílẹ̀ títóbi, ìtumọ̀-èdè aláfẹnusọ, tàbí àwọn ọ̀nà ìkọsílẹ̀ àfirọ́pò mìíràn, a leè pèsè wọn fún ọ lọ́fẹ̀ẹ́ láàìsan owó rárá. Pe **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Deutsch (German): Wenn Sie diese Informationen in einer anderen Sprache oder zusätzliche Unterstützung und Dienstleistungen wie Großdruck, Verdolmetschung oder alternative Formate benötigen, stellen wir Ihnen dies kostenfrei zur Verfügung. Wenden Sie sich dazu an **Delaware First Health** unter: **1-877-236-1341** (TTY: **711**).

Tagalog (Tagalog): Kung kailangan ninyo ito sa ibang wika, o kung kailangan ninyo ng mga karagdagang tulong at serbisyo, malalaking font, o iba pang alternatibong format, maibibigay namin sa inyo ang mga ito nang libre. Tawagan ang **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

हिंदी (Hindi): अगर आपको यह किसी अन्य भाषा में चाहिए या सहायक साधन और सेवाओं, बड़े फ़ॉन्ट, मौखिक अनुवाद, या अन्य वैकल्पिक फ़ॉर्मेट की आवश्यकता है, तो हम उन्हें आपको निःशुल्क प्रदान कर सकते हैं। **Delaware First Health** को इस पर कॉल करें: **1-877-236-1341** (TTY: **711**)।

اردو (Urdu): اگر آپ کو یہ کسی دوسری زبان میں چاہیے، یا معاون امداد اور خدمات، بڑے فونٹ، زبانی ترجمہ، یا دیگر متبادل فارمیٹس کی ضرورت ہے، تو ہم انہیں آپ کو مفت فراہم کر سکتے ہیں۔ **Delaware First Health** کو اس پر کال کریں: **1-877-236-1341** (TTY: **711**)۔

العربية (Arabic): إذا كنت بحاجة إلى ذلك بلغة أخرى، أو إذا كنت بحاجة إلى مساعِدات وخدمات إضافية أو ملف بخط كبير أو ترجمة شفهية أو تنسيقات بديلة أخرى، فيمكننا تزويدك بذلك مجانًا. اتصل بـ **Delaware First Health** على الرقم: **1-877-236-1341** (TTY: **711**).

తెలుగు (Telugu): మీకు ఇది మరొక భాషలో కావాలంటే లేదా సహాయక టూల్‌లు మరియు సేవలు, పెద్ద ఫాంట్, మౌఖిక అనువాదం లేదా ఇతర ప్రత్యామ్నాయ ఫార్మాట్‌లు అవసరమైతే, మీకు ఎలాంటి ఛార్జీలు లేకుండా ఉచితంగా మేము వాటిని అందించగలము. ఈ నంబర్‌లో **Delaware First Health** కి కాల్ చేయండి: **1-877-236-1341** (TTY: **711**).
Nederlands (Dutch): Als u dit in een andere taal nodig hebt, of aanvullende hulpmiddelen en diensten, een groot lettertype, gesproken vertaling of een ander formaat nodig hebt, kunnen wij deze gratis leveren. Bel **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Delaware First Health
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY*.

Effective 1/1/2026

For help to translate or understand this, please call **1-877-236-1341** (TTY: **711**).

Si necesita ayuda para traducir o comprender esta información, llame al **1-877-236-1341** (TTY: **711**).

Covered Entity's Duties:

Delaware First Health is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Delaware First Health is required by law to maintain the privacy of your Protected Health Information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect, and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Delaware First Health reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Delaware First Health will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Our legal duties
- Your rights
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written and Electronic PHI:

Delaware First Health protects your PHI. We are also committed to keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment —*** We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment —*** We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.
- ***Healthcare Operations —*** We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

  In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

  - Quality assessment and improvement activities
  - Reviewing the competence or qualifications of healthcare professionals
  - Case management and care coordination
  - Detecting or preventing healthcare fraud and abuse

  Your race, ethnicity, language, sexual orientation, and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with health care providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

  This information helps us to:

  - Better understand your healthcare needs.
  - Know your language preference when seeing healthcare providers.
  - Providing healthcare information to meet your care needs.
  - Offer programs to help you be your healthiest.

  This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

- ***Group Health Plan/Plan Sponsor Disclosures —*** We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities —*** We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes —*** We may use or disclose your PHI for underwriting purposes, such as to decide about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives —*** We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law —*** If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities —*** We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA. This includes Substance Use Disorder (SUD) records.
- ***Victims of Abuse and Neglect —*** We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings —*** We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- ***Law Enforcement —*** We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.
- ***Substance Use Disorder (SUD) Records —*** We will not use or disclose your SUD records in legal proceedings against you unless:
  - We receive your written consent, or
  - We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.
- ***Coroners, Medical Examiners and Funeral Directors —*** We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation —*** We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.
- ***Threats to Health and Safety —*** We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions —*** If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.
- ***Workers' Compensation —*** We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work–related injuries or illness without regard to fault.
- ***Emergency Situations —*** We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates —*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research —*** Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization:

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- ***Sale of PHI —*** We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- ***Marketing —*** We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- ***Psychotherapy Notes —*** We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

You have the right to revoke your authorization in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Request Restrictions —*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to people involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications —*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the mean of communication or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.
- ***Right to Access and Receive a Copy of your PHI —*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you with a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI —*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures —*** You have the right to receive a list of instances within the last 6-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint —*** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling **1-800-368-1019**, (TTY: **1-800-537-7697**) or **hhs.gov/hipaa/filing-a-complaint/index.html.**

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- ***Right to Receive a Copy of this Notice —*** You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our web site or by electronic mail (email), you are also entitled to request a paper copy of the Notice.

Contact Information

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights, you can contact us in writing or by phone by using the contact information listed below.

Delaware First Health
Attn: Privacy Official
750 Prides Crossing, Suite 200
Newark, DE 19713
Toll-free phone number: 1-877-236-1341 (TTY: **711**)

delaware first health

DelawareFirstHealth.com
1-877-236-1341 (TTY: 711)

750 Prides Crossing
Suite 200
Newark, DE 19713