delaware first health

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

2023 Member Handbook

Diamond State Health Plan

Diamond State Health Plan-Plus

Long Term Services and Supports

DelawareFirstHealth.com

1-877-236-1341

TTY: 711 (Hearing Impaired)

750 Prides Crossing
Suite 200
Newark, DE 19713

CAD_112019E State Approved 11142022

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Table of Contents

Welcome

Welcome to Delaware First Health! Delaware First Health is a Managed Care Organization (MCO) that offers health care for people in Delaware enrolled in the Medicaid program. We work with many doctors, clinics and hospitals to give you and your family the care you need. 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 your quick guide, this handbook, or your new health plan, please reach out to 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 nan yon lòt lang, entèpretasyon oral, èd ak sèvis oksilyè, oswa yon lòt fòma rele nou. **Delaware First Health: 1-877-236-1341 (TTY: 711).**

Important Phone Numbers

Member Services **1-877-236-1341** (TTY: **711**)

Call this number for all Member Services needs, such as:

- Benefit Questions
- Assistance changing or selecting a PCP
- Vision
- Dental
- Pharmacy Services
- Nurse Advice Line (24/7): Our Nurse Advice Line is ready to answer your health questions 24 hours a day – every day of the year.
- Care Management: Care management and disease coaching are part of your health benefits and are provided to you at no cost.

Toll-free Member Services number for TTY Access: **1-877-236-1341** (TTY: **711**)

DSAMH behavioral health crisis toll-free hotline(s):

- Northern Delaware Crisis line: **1-800-652-2929**
- Southern Delaware Crisis line: **1-800-345-6785**
- DSCYF Crisis Hotline for Youth: **1-800-969-4357**
- National Suicide Prevention Lifeline: **988**

Modivcare transportation services: Non-emergency transportation services are provided by Delaware Medicaid. This service is not available to Delaware Healthy Children Program (DHCP) members.

Members identified with transportation needs will be offered transportation services through Modivcare. Members need to work with Member Services to receive these services and review the number of covered trips. No prior authorization or copays will be required, if you qualify.

- Please contact Modivcare at **1-877-659-8416** for assistance with Non-emergency transportation scheduling.
- Where's My Ride? Hotline **1-877-659-8416**

DSS and DMMA Customer Relations: 1-866-843-7212

- Customer Relations provides general information, referrals and assistance to DMMA and Division of Social Services applicants, clients, staff and others inquiring about Medicaid benefits and services.

Toll-free contact number for the Medicaid Enrollment Broker or Health Benefit Manager: 1-800-996-9969

- The Medicaid Health Benefits Manager helps you enroll in a Managed Care Organization (MCO) and understand your benefits and prescriptions.

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:

- Over-the-phone interpreter services.
- Interpretation at your doctor visits, within 24 hours' 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 Delaware First Health at our toll-free number **1-877-236-1341** (TTY: **711**) Monday - Friday 8 AM - 7 PM ET if you are in need of interpretation or translation services or auxiliary aids and services.

Glossary of Terms

Words/Phrases
Appeal-A request for your plan to review a decision to deny or reduce a benefit.
Benefits-The health care items or services covered under your plan.
Co-payment-A set cost you must pay to receive a covered benefit at the time of service.
Durable Medical Equipment (DME)-Equipment and supplies that your doctor orders as part of your health care.
Emergency Medical Condition-A medical problem so serious that you must seek care right away to avoid severe harm.

Words/Phrases

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 to treat an emergency medical condition.

Emergency Services-Treatment of an emergency medical condition to keep it from getting worse.

Excluded Services-Health care services that your plan does not pay for or cover.

Grievance-A complaint that you make to your plan about your health care.

Habilitation Devices-Health care devices that help you keep, learn, or improve skills and functioning for daily living.

Habitation Services-Health care services that help you keep, learn, or improve skills and functioning for daily living.

Health Insurance-A contract that requires your plan to pay some or all of your health care costs.

Home Health Care-Health care services a person receives 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.

Words/Phrases

Long Term Services and Supports (LTSS)-Medical and non-medical care provided to people who are unable to perform basic activities of daily living (ADLs). ADLs include activities such as dressing or bathing. LTSS can be provided at home, in the community, in assisted living or in nursing homes.

Medically Necessary-Health care 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 health care services.

Non-Participating Provider-A provider who does not have a contract with your plan to provide services to you.

Physician Services-Health care services a licensed medical doctor provides or plans for you.

Plan-A benefit the State of Delaware provides to you to pay for your health care services. Also called a Managed Care Organization (MCO).

Preauthorization-An approval from your plan for a health care service.

Participating Provider-A provider who has a contract with your plan to provide health care services to you.

Premium-The amount you pay for your health insurance very 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 Physician-A doctor who directly provides or plans your health care services.

Primary Care Provider-A doctor, nurse, or physician assistant who provides, plans and/or helps you access health care services.

Words/Phrases

Provider-A health care professional, facility, or medical business that offers health care services to you.

Rehabilitation Devices-Health care 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-Health care 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-Health care 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-Health care provided by a doctor who has special training for a specific condition or illness.

Urgent Care-When you need care or medical treatment within 48 hours.

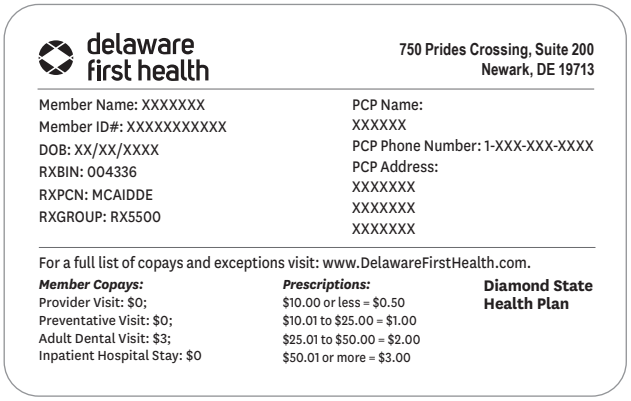
Getting Started

Your Member ID Card

When you enroll, Delaware First Health will mail you a member ID card. Bring your ID card to all appointments.

Your Delaware First Health ID card for DSHP will look like this:

Front:


delaware first health

750 Prides Crossing, Suite 200
Newark, DE 19713

Member Name: XXXXXXX
Member ID#: XXXXXXXXXXX
DOB: XX/XX/XXXX
RXBIN: 004336
RXPCN: MCAIDDE
RXGROUP: RX5500

PCP Name:
XXXXXX
PCP Phone Number: 1-XXX-XXX-XXXX
PCP Address:
XXXXXXX
XXXXXXX
XXXXXXX

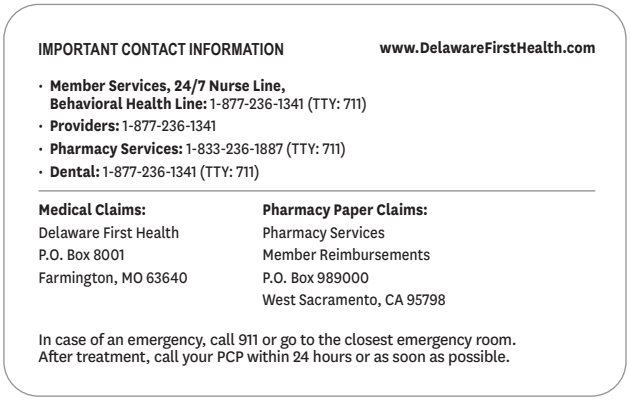
For a full list of copays and exceptions visit: www.DelawareFirstHealth.com.

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

Diamond State Health Plan

Back:


IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

- **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)

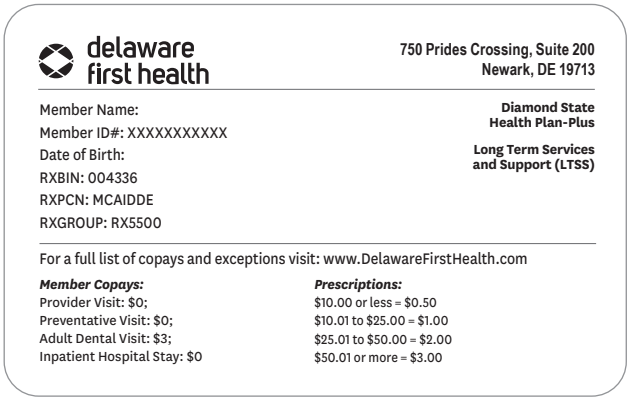
Medical Claims:
Delaware First Health
P.O. Box 8001
Farmington, MO 63640

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.

Your Delaware First Health ID card for DSHP Plus LTSS will look like this:

Front:


delaware first health

750 Prides Crossing, Suite 200
Newark, DE 19713

Member Name:
Member ID#: XXXXXXXXXXX
Date of Birth:
RXBIN: 004336
RXPCN: MCAIDDE
RXGROUP: RX5500

Diamond State Health Plan-Plus

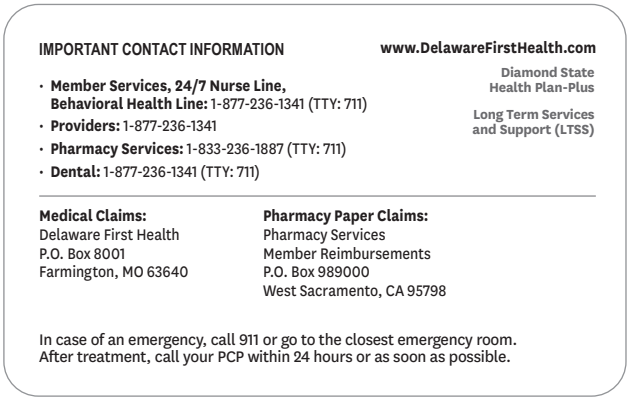
Long Term Services and Support (LTSS)

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.

Your member ID card is proof 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 receive 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 receive one, we can replace the card. To replace the card please visit the Secure Member Portal on our website to ask for a new one or call Member Services. The toll-free phone number is **1-877-236-1341** (TTY: **711**).

Keep your ID card with you and safe at all times. Make sure it 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. No one else can use your member ID card. It is against the law to give or sell your member ID card to anyone. If another person uses your card, you may be disenrolled from Delaware First Health and the state could charge you with a crime.

Your Enrollment

Delaware First Health furnishes medical assistance to eligible low-income families and to eligible aged, blind and/or disabled people whose income is insufficient to meet cost of necessary medical services. Medicaid pays for doctor visits, hospital care, labs, prescription drugs, transportation, routine shots for children, mental health, and substance abuse. To be enrolled in this program, eligible recipients must complete an application through the Delaware Health and Social Services ASSIST portal.

Your effective date of enrollment:

A new member letter will be included with your ID Card. You can find your effective date of enrollment with Delaware First Health by using our Member Portal on our website at **DelawareFirstHealth.com**.

DSHP Members: Your Primary Care Physician (PCP) assignment

If you selected a PCP during your enrollment, your PCP information will be on your ID Card. If you did not select a PCP, you will have 30 calendar days from your Effective Day of Enrollment to choose a PCP. You can call Member Services at **1-877-236-1341** (TTY: **711**) and a representative will assist you in selecting a PCP or you can also visit our website at **DelawareFirstHealth.com** to change your PCP or to select one. If you do not select a PCP within 30 calendar days, a PCP will be auto assigned to you and a new ID Card will be mailed to you.

DSHP Plus Members: Your Primary Care Physician (PCP) assignment

You can select a PCP during your enrollment with the Health Benefits Manager. You can also select or change your PCP by calling Member Services at **1-877-236-1341** (TTY: **711**) and a customer service representative will assist you in selecting a PCP or you can visit our website at **DelawareFirstHealth.com** to make a PCP change or to select one.

How to Get Help

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

- Updated Member Handbook
- Provider Directory
- Formulary information

Member Advocates

Member Advocates help members access care and navigate resources, engage difficult-to-reach members, work with community organizations, and staff healthy events. Case Management, and/or Member Advocate staff (Care Team staff) will support members who need appointment coordination and customized information. They will help address identified barriers like language and transportation by arranging for interpreters or coordinating transportation services. We have a "no wrong door" approach for assistance.

To contact a Member Advocate, please call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Case Management

The Case Managers (CM) main role is to support members and help them access Long Term Services and Supports (LTSS) and other services. The CM is responsible to lead the Person-Centered Service Plan (PCSP) process. The CM will identify, coordinate, and assist the member in accessing all needed services including covered and non-covered services, medical, social, housing, educational, and other necessary services and supports. The CM is responsible for locating and coordinating providers, specialists, or other services needed for service delivery. This includes coordination between physical, behavioral, and support services. The CM will work with the member to complete activities necessary to maintain LTSS eligibility. The CM will keep the member informed during the process of facilitating, locating, and monitoring services and support. Service alternatives and other options will be taken into consideration, such as Self-Directed HCBS for DSHP Plus LTSS Members and Self-Directed Attendant Care for Children and other LTSS services.

To contact a Case Manager, please call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Reporting Changes

Major life changes can affect your eligibility with Delaware First Health. It is important to let DHSS and Delaware First Health know when you have these life changes. If you have a major life change, please call DHSS Customer Relations at **1-866-843-7212** and Delaware First Health at our toll-free number **1-877-236-1341** (TTY: **711**).

Some examples of major life changes are:

- Changing your name.
- A change in your health insurance.
- If you add or lose other insurance coverage.
- If you are added to or removed from someone else's insurance.
- Changing jobs.
- Your ability or disability changes.
- Your family changes. This might mean your family got bigger because of a birth or a marriage. Or your family got smaller. This may be because a family member passed or moved away.
- Changes in your income or assets.

- You become pregnant. Call Delaware First Health if you are pregnant. We have special help for you and your baby. Contact Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

How to Enroll in Medicaid

Delaware Medicaid programs may offer coverage for children, pregnant women, families with children, elderly, adults with disabilities and children with disabilities.

If you think you might be eligible for services, you can apply for Medicaid services with the Delaware Department of Health and Social Services.

You can apply for Medicaid services and enroll in a health plan several ways.

Phone: To apply for Medicaid services and enroll in a health plan, call: Delaware Customer Relations Unit at **1-800-996-9969**

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

Download a Form:

You can use a form found on the Delaware Health and Social Services website at **https://assist.dhss.delaware.gov/** to apply for Diamond State Health Plan or Diamond State Health Plan Plus health insurance for yourself and everyone in your immediate family who lives with you. You may download the Diamond State Health Plan English application at **https://assist.dhss.delaware.gov/** or the Diamond State Health Plan Spanish application at **https://assist.dhss.delaware.gov/?Language=es-US**. Fill it out and mail it in.

If you need help filling out the form, call the Delaware Customer Relations Unit at **1-800-996-9969**.

- **1-800-372-2022** or **(302) 255-9500** to be directed to the Division of Social Services (DSS) office closest to where you live.

Changing Your Plan

Members may request to change their MCO for any reason during the 90 calendar days following initial enrollment. After that, you may select a new MCO once a year during open enrollment without good cause. If you want to change your plan, please call the Health Benefits Manager at **1-800-996-9969**.

Members may request 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 a member can initiate for good cause. Examples of good cause reasons include:

- You move out of the service area.
- Your provider is not in the MCO's network.
- You need related services to be performed at the same time. Not all related services are available within your MCO's provider network. Your primary care provider or another provider determined that receiving 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.

Transition Of Care

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

- You can finish receiving any services that have already been authorized by your previous health plan. After that, if necessary, we will help you find a provider in our network to get any additional services if you need them.
- In almost all cases, your providers under your former plan will also be Delaware First Health providers. If your provider is not part of our network, there are some instances when you can still see the provider that you had before you joined Delaware First Health. You can continue to see your provider if:
  - At the time you join Delaware First Health, you are receiving 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 3 months pregnant when you join Delaware First Health and you 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.
  - If your provider leaves Delaware First Health, we will tell you how you can choose a new PCP or how we will choose one for you if you do not make a choice within 30 days.
  - If you want to continue receiving care from a provider who is not in our network, you or your provider need to:
    - Contact Member Services at **1-877-236-1341** (TTY: **711**), or
    - Submit a request through the Provider Portal, or
    - Fax an authorization request form to Delaware First Health at **1-833-967-0502**

We will need the following information to review your request for service:

- Provider ordering services with contact information
- Provider to provide services with contact information
- Services requested
- Place where services will be performed (example: home, provider office, etc.)
- Dates the services will be provided
- Appropriate clinical information to support the preauthorization request (example: clinical notes, laboratory results, X-ray results, etc.)

We will make a decision on your request in the following timeframes:

- Standard review: A decision will be made within fourteen (14) days after we receive your request.
- Expedited (fast track) review: A decision will be made and you will hear from us within three (3) days of your request. If the request is approved, we will let you and your health care provider know. If the request is not approved, a letter will be sent to you and your health care provider giving the reason for the decision.

If you have any questions, call Member Services at **1-877-236-1341** (TTY: **711**).

LTSS Beneficiary Support System

General Information

Choice Counseling

Choice Counseling provides information and services designed to assist beneficiaries in making decisions; it includes answering questions and identifying factors to consider when choosing to enroll or disenroll from a plan or if they are thinking about transitioning from one setting to another, such as from a nursing facility back into the community.

Delaware First Health is a Managed Care Organization (MCO). A member is anyone who gets services from the MCO. The purpose of an MCO is to give members access to all of the health services they need through one company.

As an MCO, Delaware First Health will help coordinate your individual healthcare needs. By doing this, our goal is to improve health outcomes for every Delaware resident we have the privilege to serve.

Contact a Health Benefit Manager for support at

1-800-996-9969

Contact us to request information such as:

- Benefits, eligibility, claims or participating providers.
- How we work with your other health plans (if you have one).
- How we pay our providers.
- Results of member surveys.

If you want to tell us ways to improve or recommend changes in our policies, procedures or services, please contact your Delaware First Health Care Manager at **1-877-236-1341** (TTY: **711**).

Delaware First Health complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delaware First Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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 Delaware First Health 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, you can file a grievance with:

Delaware First Health
ATTN: Appeals & Grievances
PO Box 10353
Van Nuys, CA 90410-0353
Phone: 1-877-236-1341 (TTY: 711)
Fax: 1-844-273-2671

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, Delaware First Health 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 online at **https://www.hhs.gov/ocr/index.html**

LTSS Concerns and Questions

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 receive 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 **1-800-223-9074** (TDD **1-302-391-3505**) or by emailing **delawareadrc@state.de.us**.

You, or someone you choose to help you may file an appeal or grievance by phone or in writing. Delaware First Health can help you complete forms to file a grievance or an appeal. If you need help, please call Member Services at our toll-free number **1-877-236-1341** (TTY: **711**).

We have people to help you Monday - Friday, 8:00 AM - 7:00 PM ET. Translation services are also available if needed. Delaware First Health will not treat you differently for filing an appeal or grievance.

Grievance and Appeal Assistance

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.
- Rudeness from a provider or employee.
- Failing to respect your member rights.
- You disagree with the decision to extend an appeal timeframe.
- Unpaid medical bills.
- Any other access to care issues.

How to File a Grievance

You can file a grievance at any time by:

- Calling Member Services at our toll-free number **1-877-236-1341** (TTY: **711**).
- Sending a fax to **1-844-273-2671**.
- Give it to us by mail at:

  Delaware First Health
  ATTN: Appeals and Grievances
  PO Box 10353
  Van Nuys, CA 90410-0353

Be sure to include:

- Your first and last name.
- Your Medicaid ID number.
- Your address and telephone number.
- What made you unhappy.
- What you would like to have happen.

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

If you want someone to file the grievance for you, we need your written permission. We have a form you can use to give someone else this permission. You can find this on our website at **DelawareFirstHealth.com**. You can also call Member Services and ask for the form. The form is titled “Release of Information (ROI)”. Parents or guardians of members that are minors do not need to fill out this form.

What to Expect After You File a Grievance

We will send you a letter within three business days after you file a grievance to let you know we received it. If you have information to help us with your grievance, please send it to us by fax or mail. 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. If additional information is needed to resolve your grievance, a 14 calendar day extension may be requested by Delaware First Health. We will only request an extension if it is in your best interest. If additional time is needed, we will let you know by phone and in writing at least 2 days before the 30 calendar days are up. You may file a grievance if you disagree with the extension. Members can also request an extension if you need additional time to support your grievance. If you want an extension, please contact Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

Appeals

An appeal is a request for Delaware First Health to review a decision we made about a service that was denied, reduced, or limited. The Plan only offers one (1) level of appeal.

Examples of an appeal are:

- Denied requested care or services.
- Approved a smaller amount of a service than you asked for.
- Ends a service or care that was approved before.

These decisions are called "Adverse Benefit Determinations". You will get a letter in the mail that will tell you why that decision was made. If you do not agree with a decision, you have 60 calendar days from the date on the letter you received to ask for an appeal. You can ask to file the appeal by phone or in writing.

How to File an Appeal

You can file an appeal up to 60 calendar days from the date on the letter that states what decision was made. If you need help filing an appeal, please call Delaware First Health Member Services. Delaware First Health will help you complete the steps for filing an appeal.

Appeals may be filed by:

- Calling Member Services. The toll-free phone number is **1-877-236-1341** (TTY: **711**).
- Sending a fax to **1-833-938-0831**.
- Give it to us by mail:

  Delaware First Health
  ATTN: Appeal Coordinator
  PO Box 10353
  Van Nuys, CA 90410-0353

Be sure to include:

- Your first and last name.
- Your Medicaid ID number.
- Your address and telephone number.
- The reason for the appeal.

There is an appeal form that you can use located on our website at **DelawareFirstHealth.com**.

This form will also be included with the letter you received. You or someone you choose can help you file an appeal. If you want someone else to file the appeal, we need your permission in writing. We have a form you can use to give someone else permission to file the appeal. You can get this form from Delaware First Health Member Services or on our website at **DelawareFirstHealth.com**. The form is titled "Authorized Representative Designation". This form will also be included with the letter you received. Parents or guardians of members that are minors do not need to fill out this form.

What to Expect After You Request an Appeal

We will send you a letter within 5 business days to let you know we received your appeal. If you have information to help us resolve your appeal, please send it to us. You can send that information in by fax, email or mail. You can request copies of the documents used to resolve the appeal free of charge.

Appeals Processing Timeframe

We will send a resolution letter within 30 calendar days of receiving your appeal. If additional information is needed to resolve your appeal, a 14 calendar day extension may be requested by Delaware First Health. We will only request an extension if it is in your best interest. If we need more time, we will let you know by phone and in writing at least 2 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 additional time to prepare your appeal. If you want an extension, please contact Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

You may request an expedited appeal to be completed in 72 hours if it is a situation that may cause you physical or mental harm. If we agree that you should get a fast appeal decision, you will receive a decision within 72 hours after Delaware First Health receives your request. If we do not agree, we will notify you promptly by phone that your appeal will follow the standard appeal process. We will send you a written notice within two (2) 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.

We will not treat you differently for filing an appeal.

State Fair Hearings

If you are not happy with the outcome of your appeal, you can request a State Fair Hearing. Members must complete an appeal with Delaware First Health before they can ask for a State Fair Hearing. You will get a letter with the appeal decision on it. From the date on the letter, you have 90 calendar days to request a State Fair Hearing. You can request that services be continued during a State Fair Hearing. Requests can be made to the Department of Human Services for a State Fair Hearing.

Requests can be filed in person, by telephone or in writing to:

Division of Medicaid & Medical Assistance (DMMA)
Fair Hearing Officer
1901 North DuPont Highway
P.O. Box 906, Lewis Building
New Castle, DE 19720

If you need assistance or want to file by phone, call the DMMA at **1-302-255-9500** or **1-800-372-2022**.

Continuing to Receive Services

You can ask for services to continue while we review the appeal and during the State Fair Hearing process. You need to request that services be continued within 10 calendar days of the date on the letter you received about your service denial, reduction, or limitation.

IMPORTANT: If the appeal or State Fair Hearing finds our decision was right, you may have to pay for the service that was continued during the appeal and State Fair Hearing.

An adverse determination occurs when a service is not considered medically necessary, appropriate, or because it is experimental or investigational. You will receive written notification to let you know if we have made an adverse determination. In the notice, you will receive detailed information about why the decision was made, as well as the process and time frame you should follow for submitting appeals.

A Member Advocate is someone from the plan who can assist members, health care providers, and case managers in obtaining care, scheduling appointments, and with grievances and appeals.

Call this number to speak to a Member Advocate: **1-877-236-1341** (TTY: **711**).

Your 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:

- Be treated with dignity, respect, and privacy
- Have access to creating and using an Advance Directive
- Be given information about treatment options and care alternatives related to your health condition in a way you will understand
- Be able to make decisions about your care, including the right to refuse treatment
- Be free from any form of restraint of seclusion by means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records and be able to request amendments or corrections
- Exercise your rights without impacting the way Delaware First Health, your providers, or the State of Delaware treats you
- Receive culturally and linguistically appropriate services free of charge
- Have your personal and medical information be kept private
- File complaints (grievances) or appeals about us or the care we provide
- Be able to choose a representative to help with making care decisions

Member Responsibilities:

- Tell Delaware Human Services 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 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 participate in your treatment goals
- Talk to your providers about pre-authorization of services they recommend
- 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 when you need information or have 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 thought about all of these things.
- Follow the grievance or appeal process if you have concerns about your care.

Member Advocates help members access care and navigate resources, engage difficult-to-reach members, work with community organizations, and staff healthy events. To contact a Member Advocate, please call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Each year, the State will provide an opportunity for members to change their Health Plan during an Annual Open Enrollment Period which, shall be the month of October for Enrollment during the calendar year that begins the following January 1. During this Annual Enrollment period, you have an option to choose a new health plan. If you decide to change your health plan, you must inform your Health Benefits Manager (who will assist you in getting transferred to a new plan). If you decide not to select a new health plan, you will remain enrolled in your current plan.

Fraud & Abuse

Reporting Fraud, Waste, and Abuse

Delaware First Health is serious about finding and reporting times that Delaware Medicaid funds are used in the wrong way. This is called fraud, waste, or abuse.

Fraud means a member, provider or other person is misusing Delaware 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 health care 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. 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 Delaware First Health anonymous and confidential hotline at **1-866-685-8664**
- If TTY line 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, please contact the Diamond State Health Plan Helpline at **1-800-372-2022**.

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 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.

Delaware First Health offers health insurance plans with comprehensive health care benefits and services that suit the needs of families and individuals in our service areas in Delaware. View some of Delaware First Health's benefits and service below.

If you need help understanding any of the information, please call us at **1-877-236-1341** (TTY: **711**).

Don't forget, you also have access to helpful tools through your Delaware First Health online account at **DelawareFirstHealth.com**.

MCO Benefits

Benefits and Services

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

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

All services must be medically necessary. Your Primary Care Provider (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 that your PCP refers you to.

Some services may:

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

**Some Medicaid members may not have all the benefits listed.*

The Delaware Department of Health and Social Services (DSS) determines the covered benefits and services you receive. 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 (with the exception of Delaware Healthy Children Program members).
  - Delaware Healthy Children Program members are required to 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.

Choice of Doctor

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

Delaware First Health provides health care services and benefits covered by your plan. Some services are covered by the Delaware Medicaid state plan. Please see the State Benefits section for more details.

Please call Member Services at **1-877-236-1341** (TTY: **711**) for more information on how to get access to these services from the state.

Some services are not covered by the Delaware Medicaid state plan or Delaware First Health. Please see the Non-Covered Benefits section for more details.

Please call Member Services at **1-877-236-1341** (TTY: **711**) for a full list of non-covered services or questions.

The following is a list of covered benefits, services, and limitations for DSHP members. Please call Member Services at **1-877-236-1341** (TTY: **711**) for complete information.

Table of Coverages

Delaware First Health DSHP Benefit Package	
Preventative Services	
Preventive Services	Covered
Routine Check-Ups	Covered
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered for children under age 21
Immunizations	Covered
Primary Care Provider	Covered
Routine Hearing Exam	Covered under EPSDT for children 21 years of age and under
Office Visit	Covered
Professional Office Services	
Allergy Testing	Covered
Certified Nurse Midwife Services	Covered
Chiropractor	Covered
Contraceptive Devices	Covered
Family Planning & Family Planning Related Services	Covered
Gynecological Exam	Covered
Laboratory Tests	Covered
Podiatry	Covered

Delaware First Health DSHP Benefit Package	
Professional Office Services (continued)	
Federally Qualified Health Centers (FQHC)	Covered
Rural Health Clinic (RHC)	Covered
Office Visit	Covered
Specialist Office Visit	Covered
Inpatient Hospital Services	
Room and Board	Covered
Inpatient Physician Services	Covered
Inpatient Supplies	Covered
Bariatric Surgery for Morbid Obesity	Covered
Organ Transplants	Covered Medically Necessity Required
Outpatient Hospital Services	
Abortions	Covered Medically Necessity Required
Ambulatory Surgical Center	Covered
Dialysis	Covered
Outpatient Diagnostic Lab and Radiology	Covered
Emergency Care	
Ambulance	Covered Emergency Services Only
Free Standing Emergency Room	Covered
Hospital Emergency Room	Covered

Delaware First Health DSHP Benefit Package	
Behavioral Health Services	
Inpatient Behavioral Health Services	Covered for members ages 18 and older Inpatient BHs members under age 18 are provided by the DSCYF
Medication-Assisted Treatment (including outpatient addiction services and residential addiction services)	Covered
Substance Use Disorder Treatment Services	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Office Visit	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Outpatient Mental Health and Substance Abuse	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Behavioral Services to treat Autism Spectrum Disorder (ASD) pursuant to EPSDT	For members under age 21
Crisis Response and Subacute Mental Health Services	Covered
Outpatient Therapy Services	
Cardiac Rehabilitation	Covered
Occupational Therapy	Covered
Oxygen Therapy	Covered
Physical Therapy	Covered
Pulmonary Therapy	Covered
Speech Therapy	Covered

Delaware First Health DSHP Benefit Package	
Radiology Services	
Mammography	Covered
Routine Radiology Screening and Diagnostic Services	Covered
Sleep Study Testing	Covered
Laboratory Services	
Colorectal Cancer Screening	Covered
Pap Smears	Covered
Pathology Tests	Covered
Routine Laboratory Screening and Diagnostic Services	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) Testing	Covered
Durable Medical Equipment	
Medical Equipment and Supplies	Covered
Diabetes Equipment and Supplies	Covered
Hearing Aids	Covered for Ages 0-20 years old
Orthotics and Prosthetics	Covered
Long Term Services Support (LTSS) - Community Based	
Care Management HCBS Waiver and HCBS Habitation populations only	Not Covered
Section 1915(C) Home and Community-Based Services (HCBS)	Not Covered
Section 1915(I) Habilitation Services	Not Covered

Delaware First Health DSHP Benefit Package	
Long Term Services Support (LTSS) - Institutional	
Nursing Facility	Covered up to 30 days
Nursing Facility for the Mentally Ill (NF/MI)	Covered up to 30 days
Skilled Nursing Facility (SNF)	Not Covered
Community-based Neurobehavioral Rehabilitation Services	Not Covered
Hospice	
Hospice	Covered
Home Health	
Private duty nursing/personal care services per EPSDT authority	Covered
Vision Services	
Routine Eye Exam	Once per every 12 months ages 0-20 years old
Eyeglasses or contact lenses	Once per every 12 months ages 0-20 years old
Repairs	Covered for ages under 21 years old
Dental Services	
Adult Dental Ages 21 & Older	Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care.

The following is a list of covered benefits, services, and limitations for DSHP Plus members. Please call Member Services at **1-877-236-1341** (TTY: **711**) for complete information.

Table of Coverages

DSHP Plus LTSS Benefit Package	
Preventative Services	
Preventive Services	Covered
Routine Check-Ups	Covered
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered for children under age 21
Immunizations	Covered
Primary Care Provider	Covered
Routine Hearing Exam	Covered under EPSDT for children 21 years of age and under
Office Visit	Covered
Professional Office Services	
Allergy Testing	Covered
Certified Nurse Midwife Services	Covered
Chiropractor	Covered
Contraceptive Devices	Covered
Family Planning & Family Planning Related Services	Covered
Gynecological Exam	Covered
Laboratory Tests	Covered
Podiatry	Covered

DSHP Plus LTSS Benefit Package	
Professional Office Services (continued)	
Federally Qualified Health Centers (FQHC)	Covered
Rural Health Clinic (RHC)	Covered
Office Visit	Covered
Specialist Office Visit	Covered
Inpatient Hospital Services	
Room and Board	Covered
Inpatient Physician Services	Covered
Inpatient Supplies	Covered
Bariatric Surgery for Morbid Obesity	Covered
Organ Transplants	Covered Medically Necessity Required
Outpatient Hospital Services	
Abortions	Covered Medically Necessity Required
Ambulatory Surgical Center	Covered
Dialysis	Covered
Outpatient Diagnostic Lab and Radiology	Covered
Emergency Care	
Ambulance	Covered Emergency Services Only
Free Standing Emergency Room	Covered
Hospital Emergency Room	Covered

DSHP Plus LTSS Benefit Package	
Behavioral Health Services	
Inpatient Behavioral Health Services	Covered for members ages 18 and older. Inpatient BHs members under age 18 are provided by the DSCYF
Medication-Assisted Treatment (including outpatient addiction services and residential addiction services)	Covered
Substance Use Disorder Treatment Services	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Office Visit	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Outpatient Mental Health and Substance Abuse	30-unit outpatient behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Behavioral Services to treat Autism Spectrum Disorder (ASD) pursuant to EPSDT	For members under age 21
Crisis Response and Subacute Mental Health Services	Covered
Outpatient Therapy Services	
Cardiac Rehabilitation	Covered
Occupational Therapy	Covered
Oxygen Therapy	Covered
Physical Therapy	Covered
Pulmonary Therapy	Covered
Speech Therapy	Covered

DSHP Plus LTSS Benefit Package	
Radiology Services	
Mammography	Covered
Routine Radiology Screening and Diagnostic Services	Covered
Sleep Study Testing	Covered
Laboratory Services	
Colorectal Cancer Screening	Covered
Pap Smears	Covered
Pathology Tests	Covered
Routine Laboratory Screening and Diagnostic Services	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) Testing	Covered
Durable Medical Equipment	
Medical Equipment and Supplies	Covered
Diabetes Equipment and Supplies	Covered
Hearing Aids	Covered for Ages 0-20 years old
Orthotics and Prosthetics	Covered
Long Term Services Support (LTSS) - Community Based	
Care Management HCBS Waiver and HCBS Habitation populations only	Covered
Section 1915(C) Home- and Community-Based Services (HCBS)	Covered
Section 1915(I) Habilitation Services	Covered

DSHP Plus LTSS Benefit Package	
Long Term Services Support (LTSS) - Institutional	
Nursing Facility	Covered
Nursing Facility for the Mentally Ill (NF/MI)	Covered
Skilled Nursing Facility (SNF)	Covered
Community-based Neurobehavioral Rehabilitation Services	Covered
Hospice	
Hospice	Covered
Home Health	
Private duty nursing/personal care services per EPSDT authority	Covered
Vision Services	
Routine Eye Exam	Once per every 12 months ages 0-20 years old
Eyeglasses or contact lenses	Once per every 12 months ages 0-20 years old
Repairs	Covered for ages under 21 years old
Dental Services	
Adult Dental Ages 21 & Older	Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care.

Following are additional benefits members receive:

Durable medical equipment (DME) and medical supplies

Members living in or getting services from a licensed health care facility may choose to get certain durable medical equipment (DME) from the provider. In some cases, the equipment may be provided by the provider to the member during the inpatient stay. In other cases, it may be provided permanently. The provided equipment must be medically necessary and may need prior authorization. Your provider will help you get any needed DME. For more information, members may contact Member Services at **1-877-236-1341** (TTY: **711**).

Medical supplies are generally:

- Disposable.
- Required for the care of a medical condition.
- Used at home.

They do not include:

- Personal care items (such as deodorant, talcum powder, bath powder, soap, toothpaste, eye wash, or contact solution).
- Oral or injectable over-the-counter drugs and medicines.

DME is generally a device or other item that:

- Can be used again and again.
- Is primarily used for a medical purpose.
- Is used in the home.

Some examples of DME are oxygen tanks, special medical beds, walkers, and wheelchairs. Examples of supplies are diapers, catheters, and diabetes testing supplies. Some DME will need prior authorization. Your PCP or specialist will ask Delaware First Health for prior authorization before you get the DME.

Nursing facility services

Delaware First Health covers short-term skilled care in a nursing facility when the plan is for the member to return home. This type of care needs prior authorization by Delaware First Health. Your PCP or specialist will ask for prior authorization for you before you go to the nursing facility. Delaware First Health covers long-term care in a nursing facility when Delaware Health and Social Services (DHSS) confirms that a member qualifies for that level of care.

Home Visiting

If you are pregnant, you may be eligible for Home Visiting. Home Visiting is a free program that teaches you how to help your child grow, learn and thrive. A nurse or parent support specialist will visit your home, or anyplace else that is good for you. They will give you tips and connect you with services. Home visitors help when you are pregnant. Home visitors keep helping after your baby is born. Your home visitor will visit when it is good for you. And they can keep visiting as your child grows. To learn more about Home Visiting go online to **https://dethrives.com/home-visiting/help-at-home** or call **1-877-236-1341** (TTY: **711**) to speak with a Maternity Care Coordinator.

Vision benefits

Eye care benefits are available for members of all ages. This includes one routine eye exam every 12 months. These members are also eligible for eye glasses or contacts every 12 months. Call your or your child's eye doctor to schedule a routine eye exam. Call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**) for more information.

Dental benefits

Members Ages 20 and Younger

Dental services are available to Delaware Medicaid members ages 20 years and younger through the Delaware Medicaid fee-for-service (FFS) program. These services are not part of those provided by Delaware First Health. For questions about your dental benefits, call Delaware Medicaid Customer Relations at **1-866-843-7212** or **1-302-571-4900**.

Members Ages 21 and Older

Standard Benefit: Dental services are available to Delaware Medicaid members ages 21 years and older, effective October 1, 2020. This includes $1,000 of coverage per year for dental services, such as cleanings, X-rays, cavity fillings, and more. Each visit requires a $3 copay.

For details regarding covered services, visit envolvedental.com.

Emergency Benefit: Delaware Medicaid members ages 21 years and older are also enrolled in an emergency dental benefit. Once you've exhausted your $1,000 standard benefit, you may have access to up to $1,500 of coverage per year for dental work that meets the extended benefit criteria.

Call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**) for more information.

My Health Pays® Rewards Program

With the Delaware First Health My Health Pays Rewards program, you can earn rewards when you complete healthy activities like a yearly wellness exam, annual screenings, tests, and other ways to protect your health. Once you complete your first qualifying healthy activity, you will receive your My Health Pays® Visa® Prepaid Card* from Delaware First Health. Each time you complete a qualifying activity, we are notified, and your reward dollars will be added to your existing card.

*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.

GED Testing

Are you looking to further your education? By furthering your education, it can help you find a better job, earn more money, and improve your health. If you didn't get your high school diploma, we can help. For members age 16 and above, you can take the pre-GED and GED tests at no cost.

Delaware First Health provides vouchers to eligible members ages 16+ to be used toward the cost of GED testing.

* Delaware First Health will only cover costs for your pre-GED and GED test. All other costs, such as GED program fees, are the member's responsibility.

Delaware First Health members **Value-Added Services** include:

Benefit	Description
Home-based Interventions for Asthma	At home Asthma Support including $250 per year for non-clinical, home-based needs such as mold removal, carpet cleaning, hypoallergenic bedding, low VOC cleaning products, air purifiers, and pest control.
Post-discharge Home Meal Delivery	Post Discharge meal delivery benefits to members at high risk for readmissions. Eligible members can receive 3 meals a day for 7 days after being discharged from the hospital or other inpatient facility.
SafeLink and ConnectionsPlus®	Assistance with obtaining a free cell phone through SafeLink or through our ConnectionsPlus® program.
Social Isolation Support	Membership to local senior centers and classes for social, recreational, and education activities for members 60 and older. Virtual social isolation support. Members also receive a social isolation toolkit with education materials.
Virtual Behavioral Health Support	As a Delaware First Health member, you have access to a mobile app to help you manage stress, anxiety, chronic pain and more. The mobile app provides personalized online learning for online cognitive-based therapy programs to address common behavioral health conditions. They can be accessed on smartphones or other Internet platforms.
Vision Services for Adults	Every two years adults (21 and older) are eligible for a comprehensive eye exam with refraction and an eyewear allowance of up to $160.
Vision for youth in Foster Care	Children in foster care are eligible for replacement eyewear as often as needed.
Whole Health Transportation	Transportation to Value Added Services (YMCA, Weight Watchers, GED Testing, Etc.), to the hospital, as well as home delivery of prescriptions for members that do not live near a pharmacy, as applicable.
YMCA	Annual membership for members.

Benefit	Description
Community Wellness Center Membership	Delaware First Health offers eligible members (ages 5-18) up to $250 for 1 of the following services: annual membership for YMCA per calendar year, summer camps and/or sports teams offered through YMCA and Boys & Girls Club.
Weight Watchers	A 6 month membership to support healthy lifestyles and improve health outcomes.
Diabetes Prevention Program	Members with a pre-diabetes diagnosis can be enrolled in the YMCA's Diabetes Prevention Program. We also provide remote diabetes monitoring and information sharing with your provider.
Additional Pediatric Respite Care Hours	Additional pediatric respite services for those who meet medical necessity, we will provide 48 hours of additional respite care hours to families and caregivers.
Over the Counter (OTC) Program	Provides OTC (over-the-counter) items quarterly with an allowance of $30. No prescription required.
Tutoring Services	Delaware First Health offers up to $200 per year in tutoring vouchers for members k-12 grade who are at risk of falling behind on one or more core subject area.

Delaware First Health Plus LTSS members additional Value-Added Services include:

Benefit	Description
Practice Dental Visit for Adult Members with I/DD	Adult (21+) practice dental visits when they establish with a new dentist to meet with the dental team, voice preferences and concerns, and understand what happens in a dental appointment in advance of any exams or treatments.

For services not covered by the MCO because of moral or religious objections please contact Delaware Medicaid Customer Relations Department at **1-866-843-7212** or **1-302-571-4900**.

Copays

In most situations, members must share in the cost of the service provided.

This is a **Copayment** (or copay), or a set amount members pay when they receive 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 before services are received. Note, 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:

- AI/AN (American Indian/Alaskan Native)
- Pregnant Women for Pregnancy-Related Services
- Members receiving hospice care

State Benefits

Delaware Medicaid State Plan provides health care services and benefits. These services include:

- Dental services for children under age 21
- Prescribed pediatric extended care (PPEC)
- Non-emergency medical transportation
- Specialized services for nursing facility residents
- Behavioral Health Services

Service	Definition/Limitation
Dental Services for Children	Delaware First Health is not responsible for dental services for members under age of 21.

Service	Definition/Limitation
Prescribed Pediatric Extended Care (PPEC)	Prescribed Pediatric Extended Care (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.
Day Habilitation for Persons with Developmental Disabilities	Day habilitation services are provided to persons with developmental disabilities under the Rehab Option of the Delaware.
Non-emergency medical transportation	Non-emergency medical transportation is available to all DSHP and DSHP Plus members, except DHCP members. (Please see value added benefits for more information, as some restrictions apply).
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 or DSHP Plus LTSS benefit package.
Employment services and supports provided through Pathways	The following services are available to members participating in Pathways to supplement covered services provided by Delaware First Health. The following services are paid through the state's DMES and are the state's responsibility: · Career exploration and assessment · Job placement supports · Supported employment – individual; · Supported employment – small group; · 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 age 18 • Behavioral health services provided to members under age 18 beyond those included in the DSHP benefit package are the responsibility of the State. This includes outpatient services beyond what is included in the DSHP benefit package as well as residential and inpatient behavioral health services. Behavioral Health Services for Members age 18 and older who participate in PROMISE • As provided in the DSHP benefit package above, Delaware First Health will no longer be responsible for the following services when a member is participating in PROMISE. For members participating in PROMISE, these services become the responsibility of the State and are paid FFS through the State's DMES. – Substance disorder (SUD) services other than medically managed intensive inpatient detoxification; and – Licensed behavioral health practitioner services. • The following services are 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
DDDS Lifespan Waiver Services	The following services are available to members participating in the DDDS Lifespan Waiver as a supplement 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

Enhanced LTSS Benefits

In addition to the benefits listed above, DSHP Plus and DSHP Plus LTSS members are eligible for the following service:

- Housing: One-time housing transition grant of up to $2,500 for members who are experiencing homelessness to supportive or independent housing, or foster care to independent living.

For more information, call **1-800-996-9969** or visit: **https://dhss.delaware.gov/dhss/dmma/medicaid.html**

To apply for Delaware Medicaid ASSIST program, visit: **https://assist.dhss.delaware.gov/**

Self-Directed HCBS and Self-Directed Attendant Care for Children

DSHP Plus LTSS members may opt to self-direct their attendant care, chore, or respite services, and certain members under the age of 21 may be eligible for Self-Directed Attendant Care for Children. Self-Directed HCBS or Self-Directed Attendant Care for Children services means that you choose your personal caregiver(s). Self-Directed HCBS or Self-Directed Attendant Care for Children gives you control over a targeted amount of Medicaid dollars so that you can develop a plan to meet your needs by directly hiring employees and/or purchasing other goods and services. Self-Directed HCBS or Self-Directed Attendant Care for Children offers more choice, control and flexibility over your services and also includes more responsibility. This will allow more direction and flexibility with your Home and Community Based Services to enable you to stay in your

home and community. The Self-Directed HCBS or Self-Directed Attendant Care for Children program allows you to have control over when your services are provided, how they are provided and who will be hired to provide your services to you. This gives you the ability to make choices, select and employ staff, and control the quality of your services. If you would like assistance to help manage your employees and/or budget, you can choose to delegate the tasks to someone else you trust to manage this for you. Your Case Manager can work with you to delegate your budget authority. Self-Directed HCBS or Self-Directed Attendant Care for Children may be right for you if you answer yes to these questions:

- Do you want more control over how waiver Medicaid dollars are spent on your needs?
- Do you want to be the employer of the people that provide support to you?
- Do you want to be responsible for recruiting, hiring and firing your workers and service providers?
- Do you want to be responsible for training, managing and supervising your workers and service providers?
- Do you want the flexibility to be able to purchase goods or services in order to meet your needs?

Roles and Responsibilities

If you would like to choose this option, you simply let your Case Manager (CM) know you are interested. You will work with your CM to determine the services available for self-direction and develop a Person-Centered Service Plan (PCSP). You will choose a Supports Broker who will help you develop your individual budget, organize your services, and help you recruit employees. You will also work with a Financial Management Service (FMS) that will help manage your tasks as an employer. They will complete background checks on your employees and will use your budget to pay your workers on your behalf. You will be responsible for hiring and training your employees. Your caregivers must be able to pass a background check and be 18 years or older. You say how your care is given. Your caregiver works for you. You will sign the timesheets and monitor how the services are provided. The caregiver may do things like help you with dressing, cleaning, fixing meals or other care needs identified in your assessment. Your CM will complete a self-assessment tool with you to determine if you are eligible to self-direct your services. Please ask your CM for more details.

In order to be eligible to receive Self-Directed Attendant Care for Children, a member must be under age 21 and have a chronic medical condition, intellectual/developmental disability, or behavioral health condition that results in the need for assistance with age appropriate ADLs/IADLs.

Assistance with IADLs must be essential to the health and welfare of the member and provided to only the member and not for general utility within the household. The member's Employer Representative shall direct this service on behalf of the member. Members can hire a neighbor, friend, or family member, including a legally responsible family member, who meets all employee qualifications as verified by the Contractor. Legally responsible family members who provide Self-Directed Attendant Care for Children must designate another person to serve as the Employer Representative. Legally responsible family members are limited to providing 40 hours of service a week.

Please note that some services may be subject to Electronic Visit Verification (EVV), a tracking system that verifies when a person receives a Medicaid-funded personal care service. Currently, this applies to Self-Directed HCBS or Self-Directed Attendant Care for Children and Homemaker services. For questions regarding EVV services or your role as a member in them, please contact your assigned CM. If you feel the Self-Directed HCBS or Self-Directed Attendant Care for Children is right for you, talk with your CM to learn more.

You may choose to stop directing your own care at any time. Your CM can help you with the process to stop self-directing your services. Just talk with your CM.

To learn more about self-directed attendant care services ask your CM or call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Nursing Home Transition

The following transition services coverage may be available for DSHP Plus LTSS members:

Coverage of up to $2,500 in short-term nursing facility transition services to support a DSHP Plus member's transition from a nursing facility to an HCBS setting include:

- Payment for securing a community-based home:
  - DSHP Plus members may receive services for costs associated with securing a community-based home that are not coverable under Medicaid. These costs may include apartment application and administrative fees as well as HCBS goods and services essential for the transition.
- Payment for activities prior to transitioning from a nursing facility:
  - DSHP Plus members may receive services and activities such as home accessibility modifications, vehicle adaptations, pre-tenancy supports, community transition services, and case management prior to an individual transitioning from a nursing facility setting. Your CM may authorize service request exceptions above the $2,500 limit.
- Housing Transition Supplement:
  - Delaware First Health will provide a one-time housing transition funding of up to $2,500 in addition to the DSHP Plus LTSS Benefit Package $2,500 transition benefit for members who are transitioning from nursing facilities to community living.

Delaware First Health will ensure all members receive the right care, at the right time, and in the most integrated setting of their choice. Member choice and what is important to them are always key factors in ensuring a successful transition. During initial and subsequent assessments, the Case Manager (CM) will assess if the member's residence is chosen by the individual and is integrated in and supports full access to the greater community. If it is determined that an alternate HCBS or institutional setting is needed and/or desired by the member, the CM will record the alternative HCBS settings that were considered by the individual in the Person Centered Plan, and include a written justification of the specific and individualized assessed need for alternate HCBS or institutional-based care as well as the steps that will be taken to transition the member to the least restrictive setting, appropriate and safe setting of the members choice.

CMs will educate members and their caregivers about the member's right to receive care in the most integrated setting. CMs will assess member's transition interest during the comprehensive face-to-face assessments and if it is determined that the member would like to transition to a new residence setting, the CM will ensure that the member meets the standards for institutional transitions to HCBS and then engage the members providers to request appropriate referrals for services as needed.

To learn more about nursing home transition services ask your CM or please call Delaware First Health at **1-877-236-1341** (TTY: **711**).

Preauthorization

Please note, failure to obtain authorization may result in administrative claim denials. Delaware First Health providers are contractually prohibited from holding any participant financially liable for any service administratively denied by Delaware First Health for the failure of the provider to obtain timely authorization.

Check to see if a pre-authorization is necessary by using our online tool at **DelawareFirstHealth.com**. Contact Member Services with any questions at **1-877-236-1341** (TTY: **711**).

Services Needing Prior Authorization

Some of the services that need prior authorization are:

- Inpatient hospital care
- Skilled nursing facility
- Home health care
- Habilitation services
- Durable medical equipment (DME) and orthotics and prosthetics
- Computerized tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), nuclear cardiology, nuclear radiology, positron emission tomography (PET) scans
- Genetic and molecular diagnostic testing
- Quantitative drug testing
- Implantable hearing devices
- Therapy: physical therapy, occupational therapy, speech therapy
- Transplants
- Bariatric surgery
- Certain orthopedic surgeries such as joint replacement and spinal surgery
- Pain management procedures
- Facility based sleep studies
- Potentially cosmetic or plastic surgeries
- 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 refer to our online tool at **DelawareFirstHealth.com** to review requirements for a specific procedure and to check to see if a pre-authorization is necessary. Contact Member Services with any questions at **1-877-236-1341** (TTY: **711**).

Non-Covered Services

Some services that are not covered by the Delaware Medicaid state plan or Diamond State Health Plan. Some of those services include:

- Services that are not medically necessary
- Abortion, except for certain circumstances
- Infertility treatments
- Cosmetic Services
- Services outside of the continental United States. (Direct or indirect payments to out-of-country individuals and/or entities are prohibited.)

If You Get a Bill

If you get a bill for a treatment or service you do not think you owe, do not ignore it. Call Delaware First Health 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.

Wellness Programs

Delaware First Health is committed to helping members meet their health and wellness needs and offers the following expanded services and value-added benefits to our members. Please see descriptions in the Value Added Services section of the handbook.

- At home Diabetes Monitoring
- Diabetes Prevention Program
- Pregnancy Program
- Healthy Weight Program
- My Health Pays Rewards Program
- Practice Dental Visit
- Respite Care Hours for Medically Complex Children
- Vision Services

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. This may include new medicine, tests, surgeries or other treatment options. 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.

Behavioral Health Services

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

Service	Coverage Limitations
Inpatient behavioral health services in a general hospital, in a general hospital psychiatric unit, in a psychiatric hospital (including an institution for mental disease) for members over age 65 and under age 21 **A) and in a private residential treatment facility (PRTF) for under age 21** **B) and substance use disorder (SUD) treatment to members who are primarily receiving treatment for SUD who are short-term residents in an institution for mental disease (IMD)**	Covered for members aged 18 and older. For members under 18, inpatient behavioral health services are provided by the Delaware Department of Services for Children, Youth and Families (DSCYF).
Medication-assisted treatment (MAT), 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.
Substance use disorder 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 age 18 (thereafter provided by DSCYF). For members participating in PROMISE, these services, except for medically managed intensive inpatient detoxification, are the responsibility of the State and paid through the State's DMES.

Service	Coverage Limitations
Office Visit.	Covered. Included in 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. Included in 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.
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, 24 hours a day, 7 days a week, 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 Crisis line: **1-800-652-2929**
- Southern Delaware Crisis line: **1-800-345-6785**
- DSCYF Crisis Hotline for Youth: **1-800-969-4357**
- Delaware First Health BH Crisis Line: **1-877-236-1341**

Patient Liability

Patient liability is when you may have to pay a part of the cost of your care for LTSS. The amount of patient liability depends on your income and is calculated by DHSS. You are required to pay the patient liability amount to your facility service provider if you live in a nursing or assisted living facility. If you have patient liability and receive services, your Case Manager will determine who you pay the patient liability amount to.

If you have patient liability and do not pay, there may be consequences. This can include losing your nursing facility or assisted living facility provider.

If you have questions about patient liability, speak with your Case Manager or call Member Services at **1-877-236-1341** (TTY: **711**).

Your Providers

Managed Care works like a central home to coordinate your health care needs.

- Delaware First Health has a contract to meet the health care needs of people with Delaware Medicaid. We partner with a group of health care providers (doctors, therapists, specialists, hospitals, home care providers and other health care 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 Primary Care Provider (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 weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can go to certain doctors for some services without checking with your PCP.
- You can visit our website at **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.

Finding a Provider

Choosing Your Primary Care Provider (PCP)

When you become a Delaware First Health member, you must choose a family doctor. This doctor is called a Primary Care Provider (PCP). You must choose a PCP within 30 calendar days from your initial enrollment. If you do not choose one, we will assign you one.

DSHP members: If you did not choose a PCP, we will notify you of your assigned PCP when you receive your Delaware First Health member ID card. This mailing will include your assigned PCP's name, location, and office telephone number, as well as offering you an opportunity to select a different PCP, if you are not satisfied with the Plan-assigned PCP.

DSHP Plus members: If you did not choose a PCP, Delaware First Health will assign one to you. You have the opportunity to select a different PCP if you are not satisfied with the Plan assigned PCP.

If you would like to know more about a PCP, you can call Member Services at **1-877-236-1341** (TTY: **711**). They 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 A PCP

There are two ways to change your PCP:

1. Use the Secure Member Portal on our website at **DelawareFirstHealth.com**
2. Call Member Services at **1-877-236-1341** (TTY: **711**) to help you. After you tell us who your new PCP is, we will send you a new Delaware First Health member ID card.

You can view our provider directory on Delaware First Health website at **DelawareFirstHealth.com** or call Member Services at **1-877-236-1341** (TTY: **711**) if you require help in finding a provider or to request a copy of the provider directory.

Right to Choose a Provider

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

Your PCP can be a:

- Family or General Practitioner.
- Internal Medicine.
- 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 condition related to a disability).

Your Primary Care Provider (PCP)

A Primary Care Provider (PCP) is either a physician, a physician assistant or nurse practitioner, who directly provides or coordinates 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 deciding on a PCP, you may want to find a PCP 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 the list of all the doctors, clinics, hospitals, labs and others who partner with Delaware First Health in our provider directory. You can visit our website at **DelawareFirstHealth.com** to look at the provider directory online. You can also call Member Services at **1-877-236-1341** (TTY: **711**) to get a copy of the provider directory.

After you choose your PCP, if it is a new provider, 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. Remember to bring your Delaware First Health member ID card and Delaware Medicaid ID card. If you need help getting an appointment with your PCP, call Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**) and we will assist.

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.
- Make a list of problems you have now, as well as being prepared to discuss your general health, past major illnesses, surgeries, etc.
- Make a list of questions you want to ask your PCP.
- Bring medications and supplements you are taking to your first appointment.
- It's best to visit your PCP within three months of joining the plan.

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.

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**) and a representative will assist you. You may also make a PCP change on the secure Member Portal at **DelawareFirstHealth.com**.

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

Getting a Second Opinion

Members have the right to ask for a second opinion at no cost to the member about the diagnosis or the options for surgery or other treatment of a health condition. 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**).

Specialist Care

If you need specialized care that your Primary Care Provider (PCP) cannot give, your PCP will refer you to a specialist who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon).

To make a referral, your PCP can:

- Call **1-877-236-1341** (TTY: **711**).
- Fill out a form on our website at **DelawareFirstHealth.com**.

If your PCP refers you to a specialist, we will pay for your care. Most specialists are Delaware First Health providers. Talk with your PCP to be sure you know how referrals work.

Receiving Care Outside of Your Network

There may be times when you need to get services outside of our network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to you than if provided in-network.

If Delaware First Health does not have a provider who can treat your condition, you may ask to see a provider who is not in the Delaware First Health network. You should talk to your PCP about this. Prior authorization is required for out of network providers.

Appointment Standards

Appointment Guide	
If You Call For This Type of Service	**Your Appointment Should Take Place**
Adult preventive care (services like routine health check-ups or immunizations)	within 30 days
Pediatric preventive care (services like well-child check-ups)	within 14 days for members younger than 6 months; within 30 days for members 6 months or older
Urgent care services (care for problems like sprains, flu symptoms or minor cuts and wounds)	within 24 hours
Emergency or urgent care requested after normal business office hours	Go to hospital emergency room immediately (available 24 hours a day, 365 days a year) or go to urgent care clinic

Appointment Guide	
If You Call For This Type of Service	**Your Appointment Should Take Place**
First prenatal visit (1st or 2nd trimester)	within 14 days
First prenatal visit (3rd trimester or high-risk pregnancy)	within 5 days
Behavioral Health	
Routine Services	within 14 days
Urgent care services	within 24 hours
Emergency services (services to treat a life-threatening condition)	Go to hospital emergency room immediately (available 24 hours a day, 365 days a year) or go to urgent care clinic
Mobile crisis management services	within 30 minutes
Substance Use Disorders	
Routine services	within 14 days
Urgent care service	within 24 hours
Emergency services (services to treat a life-threatening condition)	Go to hospital emergency room immediately (available 24 hours a day, 365 days a year) or go to urgent care clinic

Emergency and Urgent Care

Emergency Care means inpatient and outpatient hospital services necessary to prevent the death or serious impairment of the health of the recipient.

Urgent Care is when you have an injury or illness that is not an emergency but still needs prompt care and attention.

What Is an Emergency?

Emergency Medical Condition

An emergency medical condition is a situation in which your life could be threatened, or you could be hurt permanently, if you don't get care right away.

Emergency Services

Emergency Services are services you receive to evaluate, treat or stabilize your emergency medical condition.

Receiving Emergency Services

If you believe you have an emergency, call **911** or go to the nearest emergency room.

You do not need approval from your plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.

If you're not sure, call your PCP at any time, day or night. Tell the person you speak with what is happening. Your PCP will:

- Tell you what to do at home;
- Tell you to come to the PCP's office; or
- Tell you to go to the nearest urgent care clinic or emergency room.

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. If you have questions, call your PCP or Delaware First Health Member Services at **1-877-236-1341** (TTY: **711**).

You are always covered for emergencies. An emergency medical condition is a situation in which your life could be threatened, or you could 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 loss of consciousness

- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever or vomiting
- Drug overdose

Some examples of non-emergencies are colds, upset stomach or 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.

What Is Urgent Care?

You may have an injury or an illness that is not an emergency but still needs prompt care and attention. This could be:

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

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your PCP any time, day or night.

If you cannot reach your PCP, call Member Services at **1-877-236-1341** (TTY: **711**). Tell the person who answers what is happening. They will tell you what to do.

Receiving Urgent Care

Urgent care is when you need care or medical treatment within 48 hours. This is when you need attention from a provider, but not in the Emergency Room. If you need urgent care but are not sure if it is an emergency, call your PCP or behavioral health specialist first. If you are unable to reach your PCP, call Delaware First Health 24/7 Nurse line at **1-877-236-1341** (TTY: **711**).

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

Urgent Care Providers

You can visit an Urgent Care clinic to get care the same day or make an appointment for the next day. To find an urgent care provider near you, visit our website at **DelawareFirstHealth.com** and use our Find a Provider tool.

Medical Coverage Outside of the U.S.

Services outside of the continental United States are not covered by Delaware Medicaid state plan or Delaware First Health. This includes direct or indirect payments to out-of-country individuals and/or entities are prohibited.

Telemedicine

Telemedicine Virtual Services are Available to Access 24/7

What is Telemedicine?

Telemedicine Virtual Visits are a form of Telehealth which is the delivery of clinical health care services by means of real time secured video conferencing to allow and support provider services to individuals remotely and to monitor and address health conditions.

Telehealth Virtual Visits are a convenient, 24-hour access to in-network Delaware First Health healthcare providers for non-emergency health issues through secure video transmission from member location and the provider's location. It's available for you to use when you're at home, in the office or even on vacation.

- Telehealth services are provided through a virtual visit with an in-network doctor via video conferencing using an online application or link provided by Telehealth Virtual Visit provider.
- After you register, you can schedule your visit within the online application or email link where you will provide your member information and electronically sign a consent form.
- Then, you and a doctor can meet to discuss your health issue, concern, or questions.

Get medical advice, or a diagnosis during your virtual visit or a prescription, if indicated, which can be sent electronically to an in-network pharmacy near you. Use Telehealth Virtual Visits when you need it. Or make an appointment for a time that works with your schedule.

Contact Telehealth for illnesses such as:

- Colds, flu and fevers,
- Coughs and COVID 19 or like symptoms,
- Sinuses, allergies,
- Respiratory infections, asthma, bronchitis,
- Rash, skin conditions, poison ivy, poison oak, mild insect or animal bites,
- Ear infections,
- Pink Eye, Stye,
- Behavioral Health Counseling and treatment

Telehealth Virtual Visits are not to be used when it's an emergency life threatening situation, please contact 911 directly in those situations.

How are Telehealth Virtual Visits better than urgent care?

If you or a loved one is really feeling under the weather, we recommend using Telehealth over Urgent Care.

That way you can save yourself the extra stress of getting to the clinic. Plus, if your condition is contagious, you'll keep others from getting sick

What is required for a Telehealth Virtual Visit?

For best results members can access a Delaware First Health Telehealth Virtual provider utilizing a smartphone, tablet, laptop with camera and microphone or desktop computer with camera and microphone connected to Wi-Fi. If possible, close any other applications you may have running or open in the background.

For best results connect to an email link or application utilizing google chrome if possible. If not available, access can also be gained using Explorer or FireFox as well.

After you register, you can schedule your visit within the online application or email link where you will provide your member information and electronically sign a consent form.

Then, you and a doctor can meet to discuss your health issue, concern, or questions.

How much does a Telehealth Virtual Visit cost?

Where applicable, Telehealth Virtual Visits for Delaware First Health members are at no cost.

Can anyone access Telehealth Virtual providers?

Any Delaware First Health member qualifies for Telehealth Virtual visits in the event they need access to a provider for urgent care.

Behavioral Health visits are limited to members ages 13 and above. Parental or Guardian consent will be required for those that are not of legal age of 18 or older or emancipated by court of law.

How are prescriptions received if ordered during Telehealth Virtual Visit?

When a prescription is prescribed during your visit with a Telehealth Virtual provider, the prescription will be sent electronically to your in-network pharmacy, where you may pick it up when ready. Certain prescriptions and narcotics cannot be prescribed by state and federal law when utilizing Telehealth Virtual Visits.

Maternity Care

Maternity Care includes:

- Pregnancy care
- Childbirth education classes
- Discuss birth control / contraception options
- OB/GYN and hospital services
- One medically necessary postpartum home visit for newborn care and assessment following discharge, but no later than 60 days after delivery
- Care management services for high-risk and low-risk pregnancies during pregnancy and for two months after delivery

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

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

Start Smart is available to high risk and low risk members up to and after childbirth. Members can enter the program in a few different ways. A member can sign themselves up, have their doctor refer them or agree to join when the Start Smart coordinator calls.

The Start Smart care team includes Registered Nurses, Care Coordinators, Community Health Workers and Doulas. Each member is assigned a primary care manager who will be with them throughout their pregnancy.

The program also connects members to community services. Finally, there are rewards available when members see their doctor before and after the birth of their child. Ask your Start Smart Care Coordinator or Care Manager about these rewards.

Family Planning

All members, except Delaware Healthy Children Program (DCHP), shall be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including non-participating providers are DMAP-enrolled providers.

Delaware Healthy Children Program members are required to use a participating provider for family planning services.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Delaware Healthy Children Program is a low cost health insurance program for Delaware's uninsured children. The Delaware Healthy Children Program features the same high-quality coverage you'd get with some of the best private insurance plans including a special set of benefits called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Members who need EPSDT benefits:

Can get EPSDT services through their health plan;

Do not have to pay any copays for EPSDT services; and

Can get help with scheduling appointments and arranging for free transportation to and from the appointments.

The Delaware Healthy Children Program covers everything from routine checkups to eye exams to doctor and hospital services. Families covered by the Delaware Healthy Children Program enjoy an extensive list of services for a single low monthly rate and no co-payments. Services covered include:

- Well-baby and well-child checkups
- Drug/alcohol abuse treatment

- Speech/hearing therapy
- Immunizations
- Physical therapy
- Eye exams
- Ambulance services
- Prescription drugs
- Hospital Care
- Physician services
- X-rays
- Lab work
- Assistive technology
- Mental health counseling
- Limited home health and nursing care
- Case management and coordination
- Hospice care
- Comprehensive Dental services - including oral exams, x-rays, cleanings, fluoride applications, fillings, and other restorative and specialty services. Orthodontic care is also available for children who meet specific program guidelines.

Some EPSDT services may require a prior authorization. EPSDT includes services that can help treat, prevent, or improve a member's health issue, including, but not limited to:

- Health and immunization history
- Physical exams
- Various health assessments and counseling
- Lab and screening tests
- Necessary follow-up care
- Applied behavioral analysis (ABA) services

Who qualifies?

- Do not have comprehensive health insurance,
- Are under the age of 19 and reside in the State of Delaware,
- Are U.S. citizens or legally-residing noncitizens,
- Are not dependents of a permanent State of Delaware employee, and
- Meet income eligibility requirements; the number of people in your family (children and adults combined) and your total family income determine the eligibility and premium cost for your family.

How to apply?

- It's easy and convenient. Parents or caregivers can fill out and mail an application form on paper, or complete and submit an application on the internet. A paper application form may be obtained either by calling the Delaware Healthy Children Program (DHCP) at **1-800-996-9969** or by printing a copy of the DHCP application form. The application form is also available in Spanish.
- On the internet, you can find out if your child may be eligible for DHCP medical coverage and complete an online application using ASSIST- the State of Delaware's Application for Social Service Programs.
- Proof of family income (full month's pay stubs, award letters, or latest tax-return if self-employed), proof of identity and citizenship or lawful alien status (copy of front & back of alien card or INS paperwork), and proof of pregnancy (if someone in the household is pregnant) also needs to be mailed in with your application.
- Find out more about the Delaware Healthy Children Program on our Frequently Asked Questions page. You may also print the DHCP flyer or view the flyer contents as a web page. For any other questions or for help filling out an application, you can call DHCP at **1-800-996-9969**.
- Mail the completed application and supporting documents to:

  Delaware Healthy Children Program
  PO Box 950
  New Castle, DE 19720

If you have questions about EPSDT services, talk with your child's Primary Care Provider (PCP). You can also find more information on EPSDT services online by visiting our website at **DelawareFirstHealth.com** by visiting the DE Medicaid EPSDT web page at **https://dhss.delaware.gov/dhss/dmma/dhcp.html**.

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 PDL list includes some Over-The-Counter (OTC) drugs that require a prescription. See the Enhanced OTC Items section for additional OTC items not on the preferred drug list and do not require a prescription.

Drug coverage rules and restrictions may apply.

Delaware First Health participating doctors are aware of the covered drugs, know how to request a prior authorization, and special procedures for urgent requests. Delaware First Health network of pharmacies know how to submit pharmacy claims to Delaware First Health.

You can call Delaware First Health's Pharmacy Services department for assistance in determining 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**. You can also use the "drug lookup" and "Find a Pharmacy" tools at **DelawareFirstHealth.com**.

How to Get a Prescription Drug

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

- What is the name of the medicine?
- Why do I need to take it?
- How much do I take?
- How often should I take it?
- How long do I keep taking it?
- Will it make me sleepy or feel bad?
- Can I take it with my other medicine?
- 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?

You can have your prescription filled at a pharmacy in the Delaware First Health network.

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

Delaware First Health Pharmacy Services (**1-833-236-1887**) can help you find a network pharmacy. You can also find a network pharmacy by using the "Find A Pharmacy" feature in the Delaware First Health website at **DelawareFirstHealth.com**, in the Pharmacy section.

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, if required.

Generic Drugs

Generally, a "generic" drug works the same as a brand name drug and usually 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, if your doctor has told Delaware First Health the medical reason that the generic drug will not work for you AND has written "Brand Medically Necessary" on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then Delaware First Health will allow an approved brand name drug.

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 your refill a few days prior to you running out of your medication.

Once you have used 83% of your prescription (based on day supply), your prescription can be filled early, if:

- The same prescription,
- For the same medication, and
- Prescription allows a refill.

This prevents you from having to go without a needed medication.

Covered Prescription Drugs

You can call Delaware First Health's Pharmacy Services for assistance in determining what drugs are covered. Pharmacy Services can be reached at **1-833-236-1887**. You can also use the "drug lookup" tool on our website at **DelawareFirstHealth.com**.

Delaware First Health has a Preferred Drug List (PDL) which is approved by the State of Delaware. The drugs on this list include both generic and brand name drugs carefully selected with help from a team of doctors and pharmacists.

The PDL is a guide to available brand and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. The PDL includes all drugs available without Prior Authorization (PA), those that require a Prior Authorization (PA), and those drugs that have the restrictions of Step Therapy (ST). The PDL applies to drugs you receive at Retail and Mail Order pharmacies. The PDL is continually evaluated by the Delaware First Health's Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications.

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. This list is periodically reviewed and updated.

Sometimes a drug may appear more than once in Delaware First Health's PDL. This is because different restrictions or factors such as the strength, amount, or form of the drug prescribed 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 Preferred Drug List (PDL)

You can find out if a particular drug is on the Preferred Drug List by:

- Visiting Delaware First Health's website at **DelawareFirstHealth.com**. The Preferred Drug List on the website is always the most current.
- Calling and asking Pharmacy Services to find out if the drug is on Delaware First Health's Preferred Drug List at **1-833-236-1887**.
- Calling and asking Pharmacy Services for a copy of the Preferred Drug List at **1-833-236-1887**.

Preauthorization of Some Prescription Drugs

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

Your doctor can decide if it is necessary to have a non-preferred drug. If so, they must give Delaware First Health a request for a prior authorization. If Delaware First Health does not approve the request, we will notify your doctor asking for the prior authorization 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 and State Fair Hearing processes.

Delaware First Health may require you to try at least 2 preferred drugs before you can get a non-preferred drug. You need to ask your doctor to write a prescription for a preferred drug first.

You may find the Preferred Drug List and indicators for Prior Authorizations required and Step Therapy by:

- Visiting Delaware First Health's website at **DelawareFirstHealth.com**. The Preferred Drug List is on the website.
- Calling and asking Pharmacy Services to find out if the drug requires a Prior Authorization or Step Therapy. Call **1-833-236-1887**.
- Calling and asking Pharmacy Services for a copy of the Preferred Drug List. Call **1-833-236-1887**.

Prescription Drug Co-Payments

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 the $15 of accumulated prescription copays in a calendar month, copays are waived for the remainder of the calendar month when you reach the $15 maximum. The copays and the $15 copay maximum will start over on the next calendar month.

If you have questions regarding prescription copays, call Pharmacy Services at **1-833-236-1887**.

Members and services exempt for copays:

- Children under the age of 21
- Pregnant women, including the post-partum period (90 days)
- Chronic Renal Disease Program (CRDP) members
- Long-term care nursing facility group or the acute care hospital group
- Family planning services and supplies
- Hospice services
- Naloxone opioid overdose rescue medications
- Medication-Assisted Treatment (MAT) used for Opioid Use Disorder

90-Day Supply

You have an option to fill certain medications you take regularly and oral contraceptives up to a 90-day supply.

With a 3-month, 6-month, or 12-month prescription from you doctor, you can receive a 90-day supply of maintenance medications by:

Retail Pharmacies

- Going to a network pharmacy that participates in the Delaware First Health 90-Day Supply Program. You can find these participating pharmacies on the pharmacy look up tool on the Delaware First Health website at **DelawareFirstHealth.com**
- Calling Delaware First Health Pharmacy Services and they will assist you in finding a participating 90-Day Supply pharmacy. Call **1-833-236-1887**.

Mail Order Pharmacy

- Enrolling in the 90-Day Supply Mail Order program through CVS Caremark.

There are four ways to get started in the CVS Caremark Mail Order program:

1. Ask your doctor to send an electronic prescription to CVS Caremark Mail Service Pharmacy. This is the easiest way to start. Your prescription will be processed and shipped in 7 to 10 business days.
2. Sign in to Caremark.com and select Start Rx Delivery by Mail. CVS Caremark will contact your doctor and get the process started for you. Once your doctor has been contacted and approval is received, it will take 7 to 10 business to process and ship your order.
3. Fill out a mail service request form and mail it with your 90-day prescription. Download the form in the pharmacy section at **DelawareFirstHealth.com**.
4. Call **1-888-624-1139** for live help from a Customer Care representative (TTY: **711**).

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

Member Lock-In Program

Delaware First Health reviews member prescription claim data, works with doctors, pharmacies, and the State of Delaware finding opportunities to support members with complicated drug regimens. Members that may benefit from Lock-in support from doctors and pharmacies 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 doctor to write and fill scripts for a member.

Delaware First Health will inform the member of the intent to lock-in to a pharmacy and/or a doctor. The member will be notified of the intent to lock a member. This means the member can only get a medication from the doctor lock-in and/or receive a medication from a network pharmacy lock-in.

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

Should the member not be able to fill the prescription at the pharmacy the member is lock-in to, the member should call Delaware First Health's Pharmacy Services. The Pharmacy Services team will assist the member by identifying another network pharmacy. The member may call Delaware First Health for any lock-in issues at **1-833-236-1887**.

Enhanced Over-The-Counter Items (OTC)

Members are eligible for additional Over The Counter (OTC) items up to a calendar quarterly maximum benefit of $30 per Household. A list of available OTC items can be found on the Delaware First Health website at **DelawareFirstHealth.com**. These items do not require a prescription.

To order Enhanced Benefit OTC product(s):

a. Call **1-888-628-2770**

- i Order from a customer service representative, or
- ii Use the automated phone option

b. Online: **https://www.cvs.com/otchs/DelawareFirstHealth**

Non-Emergency Medical Transportation

Non-emergency transportation services are provided by Delaware Medicaid. This service is not available to Delaware Healthy Children Program (DHCP) members.

Members identified with transportation needs will be offered transportation services through Modivcare. Members need to work with Member Services to receive these services and review the number of covered trips. No prior authorization or copays will be required, if you qualify. Please contact Member Services at **1-877-236-1341** (TTY: **711**) for assistance with transportation scheduling.

Members using Transportation Services must comply with the conduct policies of the transportation providers. Any conduct that jeopardizes the safety of other passengers or the driver may result in suspension of transportation services. Depending on the circumstances, not canceling a trip or canceling less than 24 hours in advance may result in a no-show. Repeated no-shows may result in a suspension from transportation services.

Grievances and Appeals

This section gives the rules for making a grievance/complaint. State law says you can make a grievance/complaint 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 grievance/complaint. The state also has rules about what we must do when we get a grievance/complaint. We must be fair in handling your grievance/complaint. You cannot be dropped from the plan for making a grievance/complaint. We will not penalize you for making a complaint.

Let us know right away about problems with your health care services. Call us with any questions you may have. 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 health care. A grievance might include a complaint about the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect your rights. You may file a grievance, or your authorized representative or your provider may file a grievance on your behalf so long as you give them written consent. You, or your authorized representative or provider with your written consent, may file a grievance by calling **1-877-236-1341** (TTY: **711**) or by mail at:

Delaware First Health
ATTN: Appeals and Grievances
PO Box 10353
Van Nuys, CA 90410-0353

If at any time you need help filing one, call us.

You may file a grievance by calling Member Services. If you need help filing your grievance Member Services can help. We will try to fix the issue over the phone. You may also write to us.

Timeframe for Filing a Grievance

You, or your authorized representative or provider with your written consent, may file a grievance at any time. Delaware First Health is required to resolve your grievance within 30 days from receipt of the grievance.

Within five (5) days of getting your grievance, we will mail you a letter. It will tell you we received your grievance.

We will send you another letter within 30 days from receipt of the grievance with our resolution to your grievance.

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, or your authorized representative or provider with your written consent, may request an appeal by:

- Calling Member Services at **1-877-236-1341** (TTY: **711**)
- By mail at:

  Delaware First Health
  ATTN: Appeal Coordinator
  PO Box 10353
  Van Nuys, CA 90410-0353

- By fax: **1-833-938-0831**

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

Delaware First Health
ATTN: Appeal Coordinator
PO Box 10353
Van Nuys, CA 90410-0353
Or Fax: **1-866-714-7991**

You can also submit an appeal request on your Member Portal by visiting our website at **DelawareFirstHealth.com** and logging into your member account.

You can ask another person to appeal for you (authorized representative). This person can be a provider, family member, or a friend. You must put it in writing that you want the person to appeal for you.

When you file your appeal, here are things you should include:

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

If you need help asking for an appeal or understanding the process, contact 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.

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
- You must ask to have the service continue

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 denial letter was mailed
- A State Fair Hearing decision is made against you

In accordance with state 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 was pending.

Appeal Process

There is only one (1) level of appeal with the Plan.

We will send you a letter within 5 working days that tells you that we have received your appeal. The letter will tell you more 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 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. 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 have not been involved in the previous decision.

We will send you a letter with our decision within 30 calendar days of when we received 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.

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

14-Day Extension Process:

A member may ask for an extension or Delaware First Health may ask for an extension if there is a need for additional information.

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. Within 2 calendar days send written notice of the reason for 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.

Timeframe for Filing an Appeal?

You, or your authorized representative or provider with your written consent, may request an 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 with written consent, or provider may request a fast appeal by:

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

Mail: **Delaware First Health**
ATTN: Appeal Coordinator
PO Box 10353
Van Nuys, CA 90410-0353

Fax: **1-833-938-0831**

You can also submit an appeal request on your member portal by visiting our website at **DelawareFirstHealth.com** and logging into your member account.

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

Delaware First Health
ATTN: Appeal Coordinator
PO Box 10353
Van Nuys, CA 90410-0353
Or Fax: **1-866-714-7991**

If we agree that you should get a fast appeal decision, you will receive a decision within 72 hours after Delaware First Health receives your request. If we do not agree, we will notify you promptly by phone that your appeal will follow the standard appeal process. We will send you a written notice within two (2) 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, contact 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.

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
- You must ask to have the service continue

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 denial letter was mailed
- A State Fair Hearing decision is made against you

In accordance with state 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.

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 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 have not been involved in the previous decision.

We will notify you of a decision via phone and written letter within 72 hours of when we received 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:

A member may ask for an extension or Delaware First Health may ask for an extension if there is a need for additional information.

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. Within 2 calendar days send written notice of the reason for 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.

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 have the opportunity to submit evidence, present your case, examine records, and ask questions regarding your request during the hearing process. You must ask for a State Fair Hearing within 90 calendar days of the appeal decision letter you receive from us. You must go through Delaware First Health's appeal process before requesting a State Fair Hearing. You may request a hearing by calling or writing to the State's division of Medicaid and Medical Assistance (DMMA) office at:

Division of Medicaid and Medical Assistance
DMMA Fair Hearing Officer
1901 North DuPont Highway
PO Box 906, Lewis Building
New Castle, DE 19720

Phone: **1-302-255-9500** or toll-free at **1-800-372-2022**

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. You may receive information or evidence from the Delaware First Health that will be discussed during the hearing. Delaware First Health will also have a representative at the hearing.

The DMMA State Fair Hearing officer will send you a letter with their decision within 90 calendar days from the date of your request. If you requested a fast State Fair Hearing, they will send you a letter within 3 working (business) days from the date of the hearing.

Other Plan Information

Confidentiality

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

LTSS Member Advisory Committee

Delaware First Health's LTSS Member Advisory Council (MAC) is diverse and inclusive, representing a broad cross section of Delaware First Health's membership with respect to race, ethnicity, gender, sexual orientation, gender identity, primary language, geographic location, age, disability, and health status. The LTSS MAC meets quarterly and rotates the location of the meeting among Delaware's three counties with the option for attendees to participate in person, by phone, or via webinar. The LTSS MAC will solicit direct feedback from members to shape Delaware First Health's programs, materials, and communications. Additionally, LTSS MAC meetings will serve as bi-directional education points for participating members and advocates to ensure they are aware of resources available and to identify ways for us to improve access, quality of care, services, HRSN, health equity, health literacy, member engagement, and member outcomes.

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

Advance Directives (Living Wills)

Planning Your Living Will

We think you are the most important person who will ever be involved in your care. You have the right to make decisions about your care. 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 the doctor 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 in advance of care or name someone, known as a Medical Power of Attorney, to make those choices if you cannot.

Creating Your Living Will

Delaware First Health recommends all of our plan members take the time to create a living will, designate a power of attorney and provide their advance directive to their primary care physician.

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.

If you should ever need or want to, you can change your Advance Directive at any time. You should make sure others know 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.

Third Party Liability (TPL) Reporting

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

- Your family size changes;
- You move out of the state or have other address changes;
- You get or have health coverage under another policy, other third party, or there are changes to that coverage, or if you have a workers' compensation claim, or pending personal injury or medical malpractice lawsuit, or have been involved in an auto accident

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. Delaware First Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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:

- Delaware First Health: **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, you can file a grievance with:

Delaware First Health
Appeals & Grievances
PO Box 10353
Van Nuys, CA 90410-0353
Toll Free Number: 1-877-236-1341
Fax: 1-833-938-0831

You can file a grievance in person or by mail or fax. If you need help filing a grievance, Delaware First Health 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: **http://www.hhs.gov/ocr/office/file/index.html**

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; or
- Inappropriate/unprofessional conduct by a provider involving a member.

Notice of Privacy Practice

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 07.01.2017

For help to translate or understand this, please call **1-877-236-1341**.

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

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

Interpreter services are provided free of charge to you.

Covered Entities 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
- Your rights
- Our legal duties
- other privacy practices stated in the notice.

We will make any revised Notices available upon member request, via Member Handbook and the Delaware First Health website.

Delaware First Health can be fined for failing to comply with federal and state requirements regarding protecting your privacy and keeping your information secure, and also failing to report violations in a timely manner. Delaware First Health can also be held financially responsible for all costs associated with failing to keep your information private and secure.

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
  - issuing premium billings
  - reviewing services for medical necessity
  - performing utilization review of claims
- ***HealthCare Operations*** - We may use and disclose your PHI to perform our healthcare operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment
  - improvement activities

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.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information 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:

- ***Underwriting Purposes*** – We may use or disclose your PHI for underwriting purposes, such as to make a determination 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.

- ***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.
- ***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 judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court
  - administrative tribunal
  - subpoena
  - summons
  - warrant
  - discovery request
  - similar legal request.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - court order
  - court-ordered warrant
  - subpoena
  - summons issued by a judicial officer
  - grand jury subpoena

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- ***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
  - 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
  - to intelligence activities
  - the Department of State for medical suitability determinations
  - for protective services of the President or other authorized persons
- ***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 interests. 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 purposed 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.

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 Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***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 persons 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 communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you 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 a written explanation and will tell you if the reasons for the denial can be reviewed and 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: 1-866-788-4989)**
or Visiting online: www.hhs.gov/ocr/privacy/hipaa/complaints/

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 list at the end of the Notice. If you receive this Notice on our website or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

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 using the contact information listed below.

Delaware First Health
Attn: Privacy/Compliance Official
750 Prides Crossing
Suite 200
Newark, DE 19713
Toll Free Phone Number: 1-877-236-1341 (TTY: 711)

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 nan yon lòt lang, entèpretasyon oral, èd ak sèvis oksilyè, oswa yon lòt fòma rele nou. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
ગુજરાતી (Gujarati): જો તમને આની બીજી ભાષા, મૌખિક ઇન્ટરપ્રિટેશન, સહાયક સહાયતા અને સેવાઓમાં અથવા વૈકલ્પિક ફોર્મેટમાં જરૂર હોય, તો અમને કૉલ કરો. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
Français (French): Veuillez nous contacter si vous avez besoin de ces informations dans une autre langue ou un autre format, d'une interprétation orale ou d'aide ou de services auxiliaires. **Delaware First Health : 1-877-236-1341 (TTY : 711).**
한국어 (Korean): 다른 언어, 구두 해석, 보조 도구 및 서비스 또는 대체 형식으로 된 본 자료가 필요하신 경우 당사로 연락하십시오. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
Italiano (Italian): Se ha bisogno del presente in un'altra lingua, di un'interpretazione orale, di servizi ausiliari o altri, oppure di un formato alternativo, ci chiami. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
Tiếng Việt (Vietnamese): Nếu quý vị cần tài liệu này bằng một ngôn ngữ khác, phiên dịch lời nói, hỗ trợ và dịch vụ phụ trợ, hoặc một định dạng thay thế, hãy gọi cho chúng tôi. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
Deutsch (German): Wenn Sie diese Informationen in einer anderen Sprache, eine mündliche Verdolmetschung, Hilfsmittel und zusätzliche Unterstützung oder ein alternatives Format benötigen, rufen Sie uns an. **Delaware First Health: 1-877-236-1341 (TTY: 711).**

Tagalog (Tagalog): Kung kailangan ninyo ito sa ibang wika, sa pasalitang interpretasyon, sa mga pansuportang tulong at serbisyo, o sa isang alternatibong format, tawagan kami. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
हिन्दी (Hindi): यदि आपको यह किसी अन्य भाषा, मौखिक व्याख्या, सहायक उपकरण और सेवाओं के साथ चाहिए या आपको किसी अन्य फ़ॉर्मैट में चाहिए, तो हमें कॉल करें. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
اردو (Urdu): اگر آپ کو یہ کسی دوسری زبان میں، زبانی تشریح، معاون امداد و خدمات، یا کوئی متبادل صورت میں چاہیے تو ہم سے رابطہ کریں۔ **Delaware First Health: 1-877-236-1341 (TTY: 711).**
العربية (Arabic): إذا كنت تريد هذا المستند بلغة أخرى أو إذا كنت تريد ترجمة شفهية أو أدوات مساعدة وخدمات إضافية أو تنسيقًا بديلاً، فيرجى الاتصال بنا. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
తెలుగు (Telugu): మీకు ఇది ఇంకొక భాషలో, మౌఖిక వివరణగా, సహాయక సహాయాలు మరియు సేవలుగా లేదా ఇది ఏ ఇతర రకంగానైనా కావాల్సివస్తే మాకు కాల్ చెయ్యండి. **Delaware First Health: 1-877-236-1341 (TTY: 711).**
Nederlands (Dutch): Als u dit in een andere taal nodig hebt, of behoefte heeft aan mondelinge vertolking, ondersteunende hulpmiddelen of diensten, of een ander formaat wenst, bel ons dan. **Delaware First Health: 1-877-236-1341 (TTY: 711).**

delaware
first health

DelawareFirstHealth.com

1-877-236-1341

TTY: 711 (Hearing Impaired)

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750 Prides Crossing
Suite 200
Newark, DE 19713