HIGHMARK® Delaware
HEALTH OPTIONS

Highmark Health Options 2018 Member Handbook

Diamond State Health Plan Plus LTSS

For inquiries, please call
Member Services at
1-855-401-8251

Please visit our website at
www.highmarkhealthoptions.com

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Welcome to
Highmark Health Options

Highmark Health Options is a managed health care plan. This means that we work with you and your doctor, or primary care physician (PCP), to service your total health care needs. Your PCP's name and phone number are on your Highmark Health Options ID card. Carry this card with you and show it whenever you seek medical attention. You must also show your Delaware Medicaid Card. Please call us right away if there are any mistakes on your ID card.

This Member Handbook explains the benefits and services available to you. It also explains what to do if you have an emergency or urgent medical situation. Please read this handbook carefully. It will help you learn more about the health care services paid for by Highmark Health Options. Keep this handbook in a safe place so you can look up information later on.

We urge you to use your Highmark Health Options benefits to help get the care that you need to stay healthy. Please call the Member Services Department for help and questions about what is covered. Member Services Representatives are available from 8 a.m.-8 p.m. (Monday-Friday) at 1-855-401-8251.

Your Member Services Representative can answer questions about your health care, ID card, benefits and doctors. Also visit our website, www.highmarkhealthoptions.com, to find other useful information, such as doctors, guidelines and health & wellness programs.

If you speak other languages than English, language assistance services are available to you free of charge. Call Member Services at 1-855-401-8251 (TTY 711 or 1-800-232-5460).

You can ask for this Member Handbook and other materials and brochures in other formats such as other languages, large print, audio CD or Braille at no charge to you.

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：711）。

For additional languages see pages 46-47.

HIGHMARK. Delaware HEALTH OPTIONS

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Important Words You Should Know

Below are some terms that you should know that we use to describe how your medical care is arranged.

Assisted Living Facility (ALF): A licensed entity that provides assisted living services, defined in State law as a special combination of housing, supportive services, supervision, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).

Attendant Care Employee: An individual who has been hired by a member participating in Self-Directed Attendant Care Services or his/her Employer Representative to provide Self-Directed Attendant Care Services to the member. Attendant Care Employee does not include an employee of a provider that is being paid by the Contractor to provide attendant care services to a member.

Benefits: The health care services covered under this plan.

Case Manager: An individual who coordinates, monitors and ensures that appropriate and timely care is provided to the member.

Co-pays or Cost Sharing: Money that you need to pay at the time of service.

DHSS: Department of Health and Social Services

Dis-enroll: To stop using the health plan because you are no longer eligible or you change your health plan.

DMMA: Delaware Division of Medicaid and Medical Assistance

Emergency medical condition: A sudden start of a medical illness or serious pain that a normal person with no medical training feels:

- Places your health (or the health of your unborn child) at serious risk.
- Harms the function of your body.
- Harms the function of a body part or organ.

Employer Representative: For Self-Directed Attendant Care Services, the representative designated by a member to assume the employer responsibilities on the member's behalf.

Health care provider: Any doctor, hospital, agency, or other person who has a license or is approved to give health care services.

Home and Community Based Services (HCBS): Services that are provided to DSHP Plus LTSS members as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility.

Hospital: A place for inpatient and outpatient care from doctors and nurses.

Immunization: A shot that protects you from disease. Children and adults get different shots at different ages during regular doctor visits.

Inpatient care: When you have to stay the night in the hospital or other facility for the medical care you need.

Medically Necessary: Items or services that have been given or will be given to a patient that are needed to treat or prevent a medical condition and are not mainly for the ease of the patient, doctor or other health care provider.

Examples are to:

- find the cause of an illness or treatment of illness or injury;
- help a body part that is not normal work better;
- avoid illness; or
- help a patient meet the right growth and development levels.

Member: A person approved by the state of Delaware to join a Highmark Health Options health plan.

Member Advocate: Someone from the Plan that can help assist you, your provider and your Case Manager with obtaining care, scheduling appointments, and the grievance and appeal processes.

Member Handbook: The Member Handbook tells you how Highmark Health Options works. If you do not understand some parts of this handbook, you can call Member Services at 1-855-401-8251. We will mail this handbook to you upon enrollment and upon request.

Mental (behavioral) health: A term used to describe nervous/psychiatric, mental, relationship, emotional, or behavioral problems.

MFP: Money Follows the Person. A program to assist eligible individuals who choose to move from an eligible long term care facility, including a nursing facility, to an eligible residence in the community with available community services and supports.

Outpatient care: Care you get when you do not have to stay overnight in a hospital or other place of treatment.

Primary Care Physician (PCP): The doctor you choose for most of your health care. This person helps you get the care you need.

Prior authorization: The approval you get from us before you get a service.

PROMISE: Promoting Optimal Mental Health for Individuals through Supports and Empowerment program for members with behavioral health needs overseen by the Delaware State Division of Substance Abuse and Mental Health (DSAMH).

Respite: Care that includes services provided to members unable to care for themselves furnished on a short-term basis because of the absence or need for relief for the member's caregiver.

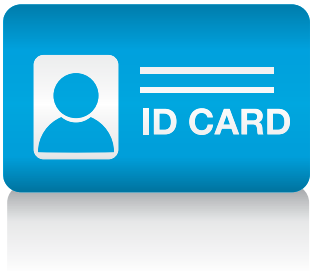
Self-Directed Attendant Care Services (SDAC): Attendant care services that are provided by attendant care workers to members who have opted to self-direct their attendant care services.

Specialist: Any doctor who has special training for a specific condition or illness.

Urgent medical condition: Not an emergency, but is a condition that should have medical care within 48 hours.

Utilization review: A process that allows Highmark Health Options and your health care providers to work together to decide if a service you ask for is medically necessary.

Your ID Card



Your Highmark Health Options member identification (ID) card was sent to you separately from this handbook. If you did not get it, call our Member Services Department at 1-855-401-8251. If you have trouble hearing or speaking, please call our Member Services TTY line at 711 or 1-800-232-5460. If you need assistance in languages other than English, call Member Services at 1-855-401-8251.

Your ID card lists your main doctor or PCP. Check that the PCP listed is the one you want. If the PCP on your ID card is not the PCP you want, call us right away so we can fix it. Every member of your family enrolled with Highmark Health Options will have his or her own ID card. Check the information on the ID card to make sure it is right.

Keep your Highmark Health Options ID card and Delaware Medicaid card with you at all times. Show them every time you need health care services. Do not let anyone else use your Highmark Health Options ID card. Your Highmark Health Options ID card does not replace your Delaware Medicaid card. Keep both cards!

Your Primary Care Physician (PCP)

When you sign up, **you must select a Primary Care Physician (PCP).** Your ID card shows the name of the doctor (PCP) you picked when you signed up. If you didn't select a PCP, one may have been given to you. Your PCP helps arrange your health care needs and works with Highmark Health Options to make sure you get the care you need. You can have the same PCP for the whole family, or another doctor for each person in your family.

Some PCP offices use medical residents, nurse practitioners and physician assistants to help the doctor (PCP). Your PCP is there to help you 24 hours a day, 7 days a week and should be called if you need help even after normal business hours.

How Can I Change My Doctor?

If you want to change your PCP for any reason, call Member Services at 1-855-401-8251. A Member Services Representative will help you make the change and will tell you when you can start seeing the new doctor. Based on when you call, you may not be able to see your new doctor until the 1st day of the next month. You will get a new ID card, which will have your new doctor's name and phone number.

You can find a complete listing of our doctors by visiting our website at www.highmarkhealthoptions.com. The list will include name, address, phone numbers, specialty and board certification status. If you wish to learn more about a doctor's education, residency, and qualifications please contact member services. You can receive a mailed provider directory by calling the Member Services Department at 1-855-401-8251 or TTY 711 or 1-800-232-5460, Monday through Friday between the hours of 8 a.m. and 8 p.m.

PCP Appointments

If you need an appointment, call your doctor. The doctor's phone number is on your ID card, and there is no charge for visits to your PCP. It is key that you keep your appointments with your doctor. If you cannot make it for any reason, call the doctor's office right away to let them know.

Highmark Health Options has appointment rules that Primary Care Physicians (PCP) and specialists are asked to follow. These appointment rules are different based on why you need to be seen:

NEW MEMBERS	
First visit	**For your first visit, you must be seen by:**
Members with HIV/AIDS	PCP or specialist no later than seven calendar days after you have become a member unless you are being treated by a PCP or specialist.
Members who get Supplemental Security Income (SSI)	PCP or specialist no later than 45 calendar days after you have become a member, unless you are being treated by a PCP or specialist.
Members under the age of 21	PCP for an EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) screen no later than 45 calendar days after you have become a member, unless you are being treated by a PCP or specialist and are up-to-date with screens and immunizations.
All other members	PCP visit no later than three weeks after you have become a member.

PCPS AND OB-GYNS	
Emergency	PCP appointments that meet the definition of an "emergency condition" are available the same day. Examples of emergency conditions are: high temperature, persistent vomiting or diarrhea or symptoms which are of sudden or severe onset but do not require emergency room services.
Urgent medical concern	PCP appointments for Urgent Care are available within two calendar days. Examples of Urgent Care include: persistent rash, recurring high grade temperature, non-specific pain or fever.
Routine care	Routine Care appointments (e.g., well-child exams, routine physical exams) are available within three weeks of member request.
Wellness (whole body, wellness exam, well-child exam)	Must be scheduled within 3 weeks of asking
Well-woman exams	Must be scheduled within 3 weeks of asking
Maternity care	First prenatal care appointments **must** be scheduled: First three months— within 21 calendar days of asking. Second three months—within 7 calendar days of asking. Third three months—within 3 calendar days of asking High-risk pregnancies —within 3 calendar days of a contractor or the provider identifying a high risk member or immediately if an emergency exists.
SPECIALISTS	
Emergency cases	Emergency Services are available 24 hours a day, seven days a week.
Urgent medical concern	Urgent Care appointments within 48 hours of asking.
Routine care	Must be scheduled within three weeks of asking for any specialty doctor listed below:
All other Specialty	Must be scheduled within 10 working days of asking for all other specialty Otolaryngology Orthopedic Surgery Dermatology Pediatric Allergy & Immunology Pediatric Endocrinology Pediatric Gastroenterology Pediatric Common Surgery Pediatric Hematology Pediatric Infectious Disease Pediatric Nephrology Pediatric Neurology Pediatric Oncology Pediatric Pulmonology Pediatric Rehab Medicine Pediatric Rheumatology Pediatric Urology Dentist

Covered Benefits and Limits

Covered Benefits

Some services may require prior authorization. Please call Member Services at 1-855-401-8251 if you have any questions.

Bed Liners	Covered for members age 4 and up
Behavioral Health— Outpatient Mental Health and Substance Abuse Services	Under age 18: Covered for 30 visits per year. After 30 visits per year, services are covered by the Department of Services for Children, Youth and Families (DSCYF) Age 18 and older: Covered
Blood and Plasma Products	Covered
Bone Mass Measurement (bone density)	Covered
Case Management	Covered
Chemotherapy	Covered
Colorectal and Prostate Screening Exams	Covered
Contact Lenses	Covered if prior authorized as medically necessary for covered conditions
CT Scans	Covered
Diabetic Education	Covered
Diabetic Equipment	Covered, your doctor has to get prior authorization if over $500
Diabetic Supplies	Covered
Glucose monitors/Strips	Covered
Drugs Prescribed by a Doctor	Covered
Durable Medical Equipment	Covered, your doctor has to get prior authorization if over $500
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services (for under age 21)	Covered
Emergency Room Care	Covered
"Sick" Eye Office Visits (For conditions such as eye infections, glaucoma, diabetic retinopathy. Sick eye office visits do not include routine exams.)	Covered for all members
Eye Exam, Routine	Covered if under 21
Eye Glasses	Covered if medically necessary and limited to one (1) standard pair of eye glasses every twelve (12) months for members under 21
Family Planning Services	Covered
Genetic Testing	Covered
Glaucoma Screening	Covered
Gynecology Visits	Covered
Hearing Aids and Batteries	Covered for members under 21 if prior authorized as medically necessary

Hearing Exams	Covered
HIV/AIDS Testing	Covered
Home Health Care and Infusion Therapy	Covered
Hospice Care	Covered
Hospitalization	Covered
Immunizations	Covered
Lab Tests and X-rays	Covered
Mammograms	Covered
Medical Supplies	Covered, your doctor has to get prior authorization if over $500
MRI, MRA, PET Scan	Covered
Nursing Home	Covered up to 30 calendar days per year, more days are considered long term care; an application must be given to and approved by the Delaware Medical Assistance Program for long term care.
Obstetrical/Maternity Care	Covered
Outpatient Surgery, Same Day Surgery, Ambulatory Surgery	Covered
Pain Management Services	Covered
Parenting/Child Birth Education	Covered
Personal Care/Aide Services (in home)	Covered with a prior authorization
Podiatry Care (routine diabetic care or peripheral vascular disease)	Covered
Primary Care Provider Visits	Covered
Private Duty Nursing	Covered
Prosthetics and Orthotics	Covered
Radiation	Covered
Rehabilitation (inpatient hospital)	Covered
Skilled Nursing Facility Care	Covered up to 30 calendar days per year
Sleep Apnea Studies	Covered
Smoking Cessation Counseling — Quit Line	Covered
Specialty Physician Services	Covered
Surgical Center	Covered
Therapy—Outpatient Occupational, Physical, Speech	Covered

Non-Covered Services

Non-Covered Services include but are not limited to:

- Infertility treatments
- Sterilization, ages 0-20
- NOT medically necessary abortion
- Single antigen vaccines
- Cosmetic services
- Christian science nurses and sanitariums
- DESI drugs

If you are not sure if something is covered please contact our Member Services Department at 1-855-401-8251/TTY 711 or 1-800-232-5460. If you need assistance in languages other than English, call Member Services at 1-855-401-8251.

Different Types of Care

There are different types of care that you may get. These include:

Routine Care

Routine care is the normal care you get from your PCP, such as checkups to help keep you healthy and office visits when you are sick. You can call your PCP's office to make an appointment for routine care. Your PCP should plan your appointment within three weeks from when you call the office for an appointment.

Urgent Care

Sometimes you will need to get care for things that may not be thought of as a medical emergency, such as a cold or flu. Urgent care is there for when you need to see a doctor and it is not a life threatening condition or you are not able to reach your PCP or if it is after hours. Some examples of urgent care are:

- Sore throat
- Fever
- Sprain
- Flu
- Ear infection
- Minor cut or burn

Emergency Services

Your PCP or an on-call doctor, is offered 24 hours a day, 7 days a week, for when you need medical care. If you are having an emergency and must get urgent medical care, go to the nearest emergency room. If you do not need urgent emergency care, call your PCP first.

Your doctor will tell you what to do. If your doctor is not in, an answering service will give your doctor a message to call you back.

You should only go to the hospital emergency room for emergency care. An emergency is a sudden start of a medical illness or serious pain that a normal person with no medical training feels:

1. Places the person's health (or if it is a pregnant woman, the health of the woman or her unborn child) in danger.
2. Would result in serious harm to bodily functions.
3. Would result in serious harm to an organ or body part.

Every situation is not the same. If you or your family has an emergency, go to the nearest emergency room or 24-hour care center. Dial 911 or the phone number for your local ambulance service.

The hospital should give the right medical tests to find out if there is an emergency medical illness no matter if you can pay for treatment or not, your citizenship, or the legality of your being in the United States.

There are times when it is hard to know what a real emergency is. If you call your PCP before going to the emergency room, the doctor can tell you what to do.

Here are some examples of when you probably do **not** need to go to the emergency room. At these times, if you call your PCP, the doctor can tell you what you should do.

- Bruises or swelling
- Cold or cough
- Cramps
- Small cuts or burns
- Earache
- Rash
- Sore throat
- Vomiting (throwing up)

Your PCP should arrange all follow-up care after an emergency room visit. Do not go back to the emergency room for bandage changes, taking out of stitches, cast checks, or more testing. Do not return to the emergency room unless you have a new emergency.

After-Hours Care

You can reach your PCP 24 hours a day at the phone number on your Highmark Health Options ID card. After normal business hours, leave your name and phone number with the PCP's answering service. Either your PCP or an on-call doctor will call you back.

You also can call the 24-hour Nurse Help line. It is best to work with your PCP for your health care needs. But if you have a medical question and don't know what to do, call our 24-hour Nurse Help line. They can help you figure out what to do when you need health care. They can tell you if you should call your PCP, make an appointment or go right to the emergency room. The toll-free number for the Nurse Help line is 1-844-325-6251 (TTY 711 or 1-800-232-5460). This number is on the back of your Highmark Health Options ID card. If you need assistance in languages other than English, call Member Services at 1-855-401-8251.

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：711）。

Specialist Care

Doctors that work with a certain area of medical care are called specialists. Some types of these specialists are heart doctors, skin doctors, or someone who does surgery. If you need special care that your PCP cannot give you, your doctor may send you to a specialist.

Your PCP and the specialist will work together for your total health care needs. If you have been seeing a specialist for an ongoing problem, you can ask your PCP to allow a standing referral to the specialist or the specialist can choose to be your PCP. Please call Member Services at 1-855-401-8251 for help in getting your specialist to be your PCP or talk to your PCP about ordering a standing referral.

Telemedicine

Telemedicine is an option to help diagnose and treat patients by video conferencing. This is to improve access to medical specialty care, treatment plans, and improve overall health outcomes.

Getting Different Care through Highmark Health Options

There are some services that Highmark Health Options must approve before you can get them. This is called prior authorization. **You may have to pay when a service is given without prior authorization.** There are doctors and nurses who work for Highmark Health Options to help your doctor choose the best way to take care of you. They make choices about the care that is most likely to help you by using special rules for medical choices.

The rules are based on whether the service is medically necessary. Medically necessary means the service is reasonably needed to stop the beginning of an injury, or an illness or disability; is reasonably needed to shrink the physical, or mental effects of an illness, condition, injury or disability; or will help you gain or continue to do daily chores.

If you need a service that must be approved by Highmark Health Options before it is done, your doctor will call to get an approval. The doctors and nurses who work for Highmark Health Options will look at all the medical facts given by your doctor within certain time limits to decide if this service is the best way to take care of you. Highmark Health Options doctors and nurses make a choice based on your plan and whether the care is medically necessary and needed for you. There is no extra money given to these doctors and nurses no matter what they decide about your care. Doctors and nurses are not paid for changing the amount of care approved.

Please contact Member Services at 1-855-401-8251 if you are unsure if something may need to be approved. The TTY line is 711 or 1-800-232-5460.

Second Opinions

You may want to be seen by another doctor, other than the one you have been seeing, for a second opinion. Your PCP can refer you to another doctor in our network for a second opinion or you can call Member Services at 1-855-401-8251 to find another in network doctor. If a network doctor is not available, we will arrange for you to get a second opinion at no cost to you from an out-of-network doctor. The doctor giving the second opinion must not be in the same office as the first doctor. If you have any questions, please call Member Services at 1-855-401-8251 (TTY 711 or 1-800-232-5460).

Hospital Services

Your Primary Care Physician (PCP) or specialist will arrange all of your stays in the hospital. You should not be admitted to a hospital without your doctor's orders unless it is an emergency as described on page 8. If a doctor other than your Highmark Health Options doctor admits you to the hospital, you or your authorized representative should call your Primary Care Physician (PCP) within 24 hours of being admitted. If you have any questions on hospital services, call Member Services at 1-855-401-8251 (TTY 711 or 1-800-232-5460).

Post-Stabilization Services

Post-stabilization services are covered and provided without prior authorization. These are services that are medically necessary after an emergency medical condition has been stabilized.

No Medical Coverage Outside of U.S.

If you are outside of the United States and need medical care, any health care services you receive will not be covered by Highmark Health Options. Medicaid cannot pay for any medical services you get outside of the United States.

Out of Network Care

Many doctors and hospitals work with us. They are called the "network." There may be a time when you need to use a doctor or hospital that is not a part of our network. If this happens, your PCP can call us to make this request. We will check to see if there is a doctor or hospital within our network that can give you the same care. If there is a doctor or hospital within the network, we will let your doctor know. If they cannot offer in network care, Highmark Health Options will cover the care with a doctor out of network for as long as Highmark Health Options can't give the needed services within network. The cost to you would be no greater than if the care was given by a network doctor.

New members have the right to keep seeing an out-of-network doctor to finish a series of treatment. The doctor must agree to our rules. If you have been getting ongoing care from a doctor that is not a network doctor, and you need to stay with this same doctor to finish a series of treatment, please call Member Services at 1-855-401-8251 for help. Please keep in mind that any services you get from doctors not in our network must be approved by us.

If you ask to use a doctor or hospital outside of our network and are denied, you can file an appeal by calling Member Services at 1-855-401-8251 (TTY 711 or 1-800-232-5460). **If you get services from a doctor that is not in our network without approval, that doctor may be allowed to bill you for the costs of the services.**

If You Need Care Out of Area

If you or your family members are out of the service area and have a medical emergency, such as a heart attack or a car accident, go to the nearest emergency room. Make sure that you or your authorized representative calls your PCP as soon as possible.

Family Planning

Family planning can help teach you how to:

- Be as healthy as you can before you become pregnant.
- Keep you or your partner from getting pregnant.
- Keep you from getting diseases.

Any member (including minors) may see a licensed family planning provider without getting an OK from us first. This includes providers who are not part of our network, such as:

- Clinics
- OB/GYNs
- PCPs
- Certified nurse-midwives

You do not need to get an OK from your PCP for family planning care. Members may use any licensed family planning clinic or provider in Delaware. The provider does not have to be part of our network. If you choose to see a family planning provider, let your PCP know so you can get the best health care. Your family planning provider and your PCP will work together to make sure you get the right care.

Family planning records are kept private. Doctors should keep all family planning records private, unless the law says it is OK. Your doctor is allowed to share your medical information with other doctors who take care of you, public health officials, or government agencies.

Pregnant Women and Newborns

Call us right away if you are pregnant. If you are in the last three months of your pregnancy and you just joined our health plan, you may be allowed to stay with your current doctor even if that doctor is not in our network.

Enrolling Your Newborn

As soon as you can after your baby is born, within 30 calendar days, call the DSS Change Report Center at 1-302-571-4900 to make sure your baby is added for health benefits.

Call Member Services at 1-855-401-8251 to tell us what PCP you want for your baby. If you do not choose a PCP for your baby, we will choose one for you.

You will get an ID card for your baby with the PCP's name and phone number on it.

Changes in Benefits or Services

Highmark Health Options will let you know if there are changes in your benefits or the way you get your services. An example of a change would be if your

PCP or specialist were no longer part of the Highmark Health Options list of participating doctors, called the "network". Highmark Health Options will send a letter to see if you would like to pick a new doctor, so there will not be a delay in the care you need. If you do not pick a new PCP, Highmark Health Options would pick one for you.

Medicines/ Drug Formulary

Highmark Health Options uses an approved medication list, called a Preferred Drug List (PDL), to decide if your drug is covered. The PDL is published by DHSS for Delaware Medicaid members and lists the drugs that are covered. There are also some supplemental drugs that are not on the PDL that Highmark Health Options will cover. These drugs are covered under the Supplemental Formulary.

Highmark Health Options charges copays for your drugs filled at the pharmacy. Your copay is the money that you need to pay at the time of service.

Your copay is based on the cost of each prescription.

COST OF YOUR PRESCRIPTION	YOUR COPAY
$10.00 or less	$0.50
$10.01-$25.00	$1.00
$25.01-$50.00	$2.00
$50.01 and above	$3.00

The most that you will pay for your prescription copays each month is $15.00 total. Once you meet the $15.00 copay maximum for the month, you will pay zero copays for drugs filled for the rest of the month. Each month this copay maximum will start over.

Copays will be $0 for the following:

- Prescriptions for members that are under the age of 21
- Prescriptions filled for medications to stop smoking
- Prescriptions filled for birth control
- Prescriptions for members in a long term care facility
- Prescriptions for pregnant women, including up to 90 calendar days after the end of the pregnancy

Can the Drug Formulary Change?

Highmark Health Options may make changes to the PDL or Supplemental Formulary during the year. These changes must first be approved by the Delaware Division of Medicaid & Medical Assistance. Changes in the PDL or Supplemental Formulary may affect which drugs are covered.

If you are taking a drug that is being removed from the drug formulary, we will notify you 30 calendar days prior to the change.

You can view the drugs covered by the PDL and Supplemental Formulary by visiting our website www.highmarkhealthoptions.com, then click on the "Drug Formulary" link.

Safe and Effective Drug Management

Highmark Health Options has rules for coverage or limits on drugs. Our online Formulary will tell you which drugs may have any added rules or limits on them. The online Formulary can be found at www.highmarkhealthoptions.com These rules and limits help us be sure that our members use these drugs in a safe and useful way while helping to control drug plan costs. A team of doctors and/or pharmacists work to make these rules and limits for Highmark Health Options to help give quality coverage to our members. The rules for coverage or limits on certain drugs are listed as follows:

- **Prior Authorization:** Highmark Health Options needs prior authorization (prior approval) for certain drugs. Some drugs on the Formulary need added information from your doctor to make sure the drug is being used safely and will work well in treating your condition. This means that your doctor will need to get approval from Highmark Health Options before you fill your prescription. If they don't get prior approval, Highmark Health Options will not cover the drug.
- **Quantity Limits:** For certain drugs, Highmark Health Options has limits that the FDA has approved to be safe and useful. A quantity limit

is the most amount of the drug Highmark Health Options will cover per prescription over a certain period of time.

- **Step Therapy:** Some medications on Highmark Health Options Formulary need specific drugs to be tried first before you can get a step therapy medication that treats your medical condition. For example, if Drug A and Drug B both treat your medical condition, we may need your doctor to order Drug A first. If Drug A does not work for you, then we will cover Drug B.
- **Generic Substitution:** Most of the time when there is a generic version of a brand-name drug offered, Highmark Health Options requires the generic drug be given to you. If your doctor orders a brand-name drug, our network pharmacies will always give you the generic version. If your doctor feels you must take the brand-name drug, he or she must contact Highmark Health Options pharmacy services to have that request reviewed.

If you would like a copy of the approved drug Formulary, or have any questions on drug coverage, please call Member Services at 1-855-401-8251. You can also let Highmark Health Options know if you feel a new drug should be placed on the Formulary.

A drug that is **not** included on the Highmark Health Options PDL or Supplemental Formulary is called a non-formulary drug. If you are on a non-formulary drug, talk to your doctor to see if your drug can be switched to a drug from the PDL or Supplemental Formulary that has the same or similar effect. If your doctor feels that the drug you take now is medically necessary and cannot be switched, you or your doctor can call Highmark Health Options to request an exception. You can also request an exception on the Member Portal. If the exception request is approved, Highmark Health Options will cover your current drug.

We will notify you and your doctor in writing if your request for a formulary exception is approved or denied. If the request is denied, the written notice will have information on how to file an appeal with Highmark Health Options. It will also have information on how to ask for a State Fair Hearing with the Delaware Division of Medicaid & Medical Assistance.

Where to Get Your Prescriptions Filled

Highmark Health Options has contracts with a number of pharmacies in your area. These are called in-network pharmacies. In-network pharmacies include specialty, compounding and 24/7 pharmacies for your convenience. You should always use an in-network pharmacy to get your prescriptions.

You can find a list of these network pharmacies in our Provider Directory by going to the website www.highmarkhealthoptions.com, and clicking on "FIND A PROVIDER" and then clicking "Pharmacies." Or we can help you find a pharmacy in the network near you. Call Member Services at 1-855-401-8251 for help. The TTY line is 711 or 1-800-232-5460. If you need assistance in languages other than English, call Member Services at 1-855-401-8251.

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：711）。

You may only use an out-of-network pharmacy if you have an emergency. If you have to go to an out-of-network pharmacy in an emergency, ask them to call Highmark Health Options at 1-855-401-8251. If you are out of state and have an emergency and need prescriptions, the pharmacy can call the pharmacy provider number on the back of your member ID card to make sure your drugs are covered. Most drugs that are covered by Highmark Health Options can be filled for a maximum of a 34-day supply at a time.

Refilling Your Prescription

Your prescription may be refilled if:

- Your doctor ordered a refill
- The refill is permitted by law
- You have used 83 percent of your last fill

You do not need to wait until you are out of your drug to get a refill. It is best to get the drug refilled when you have three days left. If you have a problem with your prescription, call Member Services to report it at 1-855-401-8251 (TTY 711 or 1-800-232-5460).

Emergency Supply of Medication

If a drug needs an OK from us and not getting the drug will cause loss of life, limb, or organ function, you can ask your pharmacist to give you a 3-day emergency supply of the drug. The 3-day emergency supply benefit will be given to you once per 60 calendar day period for each medication. For additional doses beyond the 3-day supply, your doctor should fax in an exception request. We will let your doctor know if we say OK to your request. If we do not OK your request, we will send you a letter that tells you why and how to appeal the denial.

Pharmacy Lock-In

Some members may have a medical problem that requires your providers and pharmacy to carefully coordinate your care. If you need this coordinated care, you will be assigned to one pharmacy to fill your prescriptions. This is called the lock-in program. If a member is locked into a specific pharmacy, they must use only that pharmacy to get covered medications. Highmark Health Options will not cover medications for locked-in members if they use a different pharmacy. If the lock-in pharmacy does not have your medicine, contact Member Services at 1-855-401-8251 to be advised how to get that medicine from a different pharmacy. Highmark Health Options must verify that your lock-in pharmacy does not have enough of the medication before you can get your medication from a different pharmacy.

We will send you a letter if we believe you will benefit from the lock-in program. Highmark Health Options will choose your lock-in pharmacy based on the pharmacy where you visit the most often or nearest to your home. If you disagree with our decision to include you in the lock-in program, you have the right to file an appeal.

The Kinds of Drugs Highmark Health Options Covers

We cover:

- Drugs included on Delaware's Preferred Drug List
- Prenatal vitamins for women
- Multivitamins
- Prescriptions for mental (behavioral) health conditions
- Drugs to help you stop smoking. These include:
  - Nicotine patches, gum, lozenges, and nasal spray
  - Bupropion
- Diabetic supplies including:
  - Blood glucose monitors (continuous blood glucose monitors are covered under your medical benefit)
  - Tests strips
  - Lancets
  - Lancing devices
  - Urine glucose testing strips
- Aerochambers
- Shots that you give yourself, such as insulin, are covered by your pharmacy benefit. Shots that must be given by your doctor in his or her office are covered under your medical benefit, not your pharmacy benefit.
- Prescriptions to replace lost or stolen drugs are allowed one time per year for each drug and you must make a police report for all stolen medications. If you lose your drugs, call us toll-free at 1-855-401-8251 for help. Members with trouble hearing or speaking can call the TTY line at 711 or 1-800-232-5460. We will help you

replace the lost drugs. If you need assistance in languages other than English, call Member Services at 1-855-401-8251.

- Vaccines administered at pharmacies for treatment of Flu, Pneumonia, Shingles, and Chicken Pox

Limits on Your Prescription Drug Benefit

Highmark Health Options does not cover all drugs. The items we **do not cover:**

- Drugs used for weight loss or gain are not routinely covered
- Drugs used for cosmetic purposes like wrinkles or hair growth
- Over-the-counter (OTC) drugs, except those listed on the supplemental formulary
- Over-the-counter (OTC) drugs and supplies when you live in a Long Term Care facility
- Drugs used in fertility treatments or drugs used for erectile dysfunction
- Herbal or homeopathic drugs
- Nutritional supplements
- Direct Member Reimbursement (DMR) - repayment for a prescription drug you paid for out-of-pocket
- Prescriptions for any drugs that are not medically necessary
- Experimental or investigational drugs
- DESI drugs
- Drugs ordered by a physician who has been barred or suspended from participating in the Delaware Medicaid Program
- Drugs that duplicate a therapy that you are already taking
- Drugs marketed by a drug company that does not participate in the Federal Medicaid Drug Rebate Program

Durable medical equipment (DME) and supplies will still be covered by your medical benefit.

Eye Exams

Regular eye exams are very important. That is why we give this benefit to children under 21. There is no waiting period to get your vision benefit. You must go to an eye care doctor in our network. Be sure to show your Highmark Health Options ID card and say that you are a Highmark Health Options member.

Highmark Health Options covers one routine eye exam every twelve months for children under 21.

For adults 21 and over, the vision benefit is limited to contact lenses to treat ocular conditions such as keratoconus, corneal dystrophy and aphakia if medically necessary and prior authorized for coverage.

Dental Care

Dental services for children up to age 21 are covered by the Delaware Medicaid fee-for-service program. Dental services are not covered for adults 21 and over, except the extraction of bony-impacted wisdom teeth.

Mental Health, Drug & Alcohol Services

Services for mental health care such as depression, or drug and alcohol abuse are offered to you. Please see pages 40-42 of this handbook for the phone numbers in your area.

As aligns with government regulations, you have unlimited medically necessary treatment for drug and alcohol dependencies with the following services:

- Treatment provided in a residential setting
- Intensive outpatient programs
- Inpatient withdrawal management

If you have questions on coverage, medical necessity, or need help finding these services, you can call Member Services at 1-855-401-8251.

Chiropractic Benefits

- One manipulation per day with a maximum of 20 manipulations per calendar year. Additional manipulations per calendar year may be allowed if deemed medically necessary.
- One X-ray or PART (diagnostic) exam each year to detect spinal subluxation.
- One PART exam each calendar year to determine progress. More than one per calendar year may be allowed if deemed medically necessary.
- X-rays to determine progress only if medically necessary.
- Manipulation and Adjunctive therapy for neck, back, pelvis or sacrum pain, or dysfunction, and chiropractic supportive care.
- Treatment is not included for conditions not related to a diagnosis of subluxation or pain of the neck, back, pelvis, and sacrum.

Case Management

If you have complex or special health care needs, your Case Manager can help. Nurses, social workers, and other health care staff are on hand to talk with you to make sure you get the medical care that you need. They can help you with any problems you have in getting your care.

Case Managers can also help you with:

- Information about programs in your community such as food banks, utility assistance, HIV, or nutrition and weight loss programs.
- Case Management for members with specific, specialized needs.
- Moving from hospital to home. If you were just in the hospital, the Case Manager may:

1. **Call you while you are in the hospital**
    - Answer any questions you may have about going home
    - Remind you to ask about medicines
    - Remind you to make a doctor's appointment
2. **Call you after you get home**
    - Remind you to make a doctor's appointment
    - Ask you to review your discharge orders
    - Talk about your medicines
    - Help you make a list of questions for your doctor
    - Help you arrange a ride to the doctors if needed
3. **Call you after you see your doctor**
    - Talk about the doctor's orders
    - Talk about your medications

It can be hard to remember all of the things you need to do when you get home. To help make this easier for you and your family or caregiver, here are things you should do and the Case Manager can help you in doing:

- Keep your discharge orders
- Make sure you understand your medicines
- Always keep a list of your medicines
- See your doctor
- Make sure you have a ride to the doctors
- Ask for help
- Call your PCP if you have questions

For further information, please call: 1-855-401-8251. You have the option to receive services from a Case Manager and can stop services at any time.

Transportation

If you need assistance scheduling transportation for a non-emergency medical service, contact LogistiCare at 1-866-412-3778 or schedule online through https://member.logisticare.com

DSHP Plus LTSS

This section is for members who qualify for Highmark Health Options Diamond State Health Plan-Plus Long-Term Services and Supports (DSHP Plus LTSS). DSHP Plus LTSS covers nursing home care and home and community-based services (HCBS). HCBS services help you with everyday activities such as bathing, dressing, meal preparation and household chores so you can stay at home.

DSHP Plus LTSS services do not replace services that are paid for by Medicare or other insurance. DSHP Plus LTSS home and community-based services are over and above the help you get from others so you can stay in the comfort of your home and community.

Case Management and Role of the Case Manager

Highmark Health Options is in charge of taking care of all of your physical, mental and LTSS needs. We do this through Case Management. You will be assigned to a Case Manager. Your Case Manager is your main contact and the first person you should go to if you have questions about your services.

We will send you a letter with the name and phone number of your Case Manager. Write down your Case Manager's name and phone number in this handbook when you get the letter with your Case Manager's name and phone number.

Your Case Manager's name:
Your Case Manager's phone number to call during regular business hours Monday – Friday from 8:30 a.m. to 5:00 p.m. EST:
The Nurse Line phone number to call evenings, weekends and holidays: **1-844-325-6251**

Please contact your Case Manager anytime you have a question or concern about your health care – you do not need to wait until your Case Manager comes to your home or calls you.

Your Case Manager will…

- Give information about DSHP Plus LTSS and answer your questions.
- Work with you to make sure you have all the information you need to make good choices about your health care.
- Help you get the right kind of long-term services and support in the right setting.
- Coordinate all of your physical, mental and long-term care service and support needs.
- Help solve issues that you have about your care.
- Make sure that your plan of care is carried out and is working for you.
- Be aware of your needs as they change and will update your plan of care to make sure that the services you get are appropriate for your changing needs.
- Talk with your doctors to make sure they know about your health care and to arrange your services.

If you get nursing home care, your Case Manager will…

- Be part of the care planning with the nursing home where you live.
- Perform any other needs assessment that may be helpful in managing your health.
- Add to the nursing home's plan of care if there are things Highmark Health Options can do to help manage health problems or plan other kinds of physical and mental health care you need.
- Work with the nursing home when you need services the nursing home isn't responsible for providing.
- Have face-to-face visits at least every 180 calendar days.
- Check at least once a year to make sure that you still need the level of care provided in a nursing home.

- Determine if you want to and are able to move from the nursing home to the community and if so, help make sure this happens safely.

If you receive home care, your Case Manager will…

- Work with you to do a complete, individual assessment of your health and long- term service and support needs and figure out the services best for you.
- Work with you to create your own plan of care.
- Consult with the right health care professionals when we make your plan of care.
- Give you information to help you choose doctors in our network.
- Meet with you face-to-face at least every 90 calendar days. (DSHP Plus LTSS members with AIDS waiver will get a face-to-face visit at least once a year.)
- Make sure your plan of care is carried out and working for you.
- Check to make sure you are getting what you need and that gaps in care are addressed right away.
- Give you information about community resources that might be helpful to you.

Member Advocates

The Highmark Health Options DSHP Plus LTSS and Non-LTSS Member Advocates are people that can help you. The Highmark Health Options Member Advocate is available to …

- Provide information about the DSHP Plus LTSS program.
- Help you file a grievance, change your Case Manager or find the care you need.
- Make referrals to the right Highmark Health Options staff.
- Help solve problems with your care.

Contact Member Advocates at: **1-855-430-9853**

LONG-TERM CARE BENEFITS COVERED BY DSHP-PLUS LTSS	
LTSS Covered Benefit	**What it Means**
Adult Day Services	A community-based setting that gives supervised care and personal services during the day. Meals and therapies may also be included. Not offered to persons living in assisted living or nursing facilities.
Attendant Care	Help with activities of daily living (ADLs) such as bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility. Not offered to persons living in assisted living or nursing facilities.
Cognitive Services	Counseling and therapy for members and their families. Limited to 20 visits per year plus a valuation. Provided to members who have cognitive deficits or social conflict, such as those shown as a result of a brain injury. Not offered to persons living in assisted living or nursing facilities.

Long-Term Care Benefits Covered by DSHP-PLUS LTSS
Continued on next page

DSHP Plus LTSS Benefits—Continued

LONG-TERM CARE BENEFITS COVERED BY DSHP-PLUS LTSS	
LTSS Covered Benefit	**What it Means**
Community-based Residential Alternatives	Homelike residential settings, including assisted living facilities, which offer support services as well as social and recreational programs.
Day Habilitation	Help with skill development and self-help to keep your independence at home. The Day Habilitation takes place in a non-residential setting, separate from your home. Meals and therapies may also be included. Provided to members who have cognitive deficits or social conflict, such as those shown as a result of a brain injury. Not offered to persons living in assisted living or nursing facilities.
Home-delivered Meals	Up to one (1) nutritionally well-balanced meal per day brought to your home. Not offered to persons living in assisted living or nursing facilities.
Independent Activities of Daily Living (IADL) or Chore Service	Help with chores such as shopping, meal preparation, light housekeeping and laundry. Not offered to persons living in assisted living or nursing facilities.
Minor Home Modifications	Changes to your home to aid your independence (e.g., grab bar, wheelchair ramp, etc.). Benefit covers up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime. Not offered to persons living in assisted living or nursing facilities.
Nursing Facility	Services for residents of a nursing facility, including skilled nursing, rehabilitation and healthcare.
Nutritional Supplements for Individuals Diagnosed With HIV/AIDS	Oral supplements for those experiencing weight loss and malnutrition as result of HIV/AIDS. Not offered to persons living in assisted living or nursing facilities.
Personal Emergency Response System	A personal, electronic device that you keep nearby. The device provides 24-hour access in an emergency. The device is connected to your phone and sends a signal to someone who can help you when you push the button of your personal device. Not offered to persons living in assisted living or nursing facilities.
Respite Care	Personal care at home, at an assisted living facility or a nursing home when your everyday caregiver needs a rest. Limited to no more than 14 calendar days per year.
Specialized Medical Equipment not covered under the State Plan	Items or devices that help you do things easier or safer in your home. For example, grabbers to reach things. Not covered under the Medicaid State Plan.
Support for Self-directed Attendant Care Service	Financial management and general support for members who choose to self-direct their attendant care services. This means the member, or an Employer Representative selected by the member, serves as the legal employer of the paid caregiver. This benefit gives the member or member's Employer Representative with support from a Fiscal Employer Agent that takes care of the taxes, payroll withholding and paychecks for the caregiver. The Fiscal Employer Agent also helps the member find and train an Attendant Care Employee.
MONEY FOLLOWS THE PERSON (MFP)	
MFP Transition Services	Help with costs related to your change from a nursing facility to your home or community under the MFP Program. Examples may include, security deposit, telephone connection fee, groceries, furniture, linens, etc. Benefit covers up to $2,500 per transition.
MFP Workshops	Workshops to help you and your family prepare for community living under the MFP Program.

Freedom of Choice

In DSHP Plus LTSS, if you qualify for nursing home care, you have the right to select care: In your home,

- OR in another place in the community (such as an assisted living),
- OR in a nursing home.

You have a right to choose between a nursing facility and home/community-based services if:

- You qualify for nursing facility care, and
- Your needs can be safely and effectively met at home or in the community.

Talk with your Case Manager to discuss your choices to move between nursing and home/community care. You may change your choice at any time as long as you qualify and we can arrange to get care in the setting you want.

In DSHP Plus LTSS, you may choose providers from our network. Services may include assisted living, care at home or nursing care. You also may be in charge and hire/train your own caregiver (called Self-Directed Attendant Care). See the next section for more detail.

The provider you choose must be contracted with Health Options to be in our provider network and must be willing and able to provide the care you need. Your Case Manager will be help you find the right providers.

Self-Directed Attendant Care

Self-direction gives you more choice and control over who provides your Attendant Care Services and how your care is given.

If you choose to self-direct your Attendant Care Services, you employ the Attendant Care Employee who will give your Attendant Care Services – You are the employer of the caregivers who work for you. You must be able to do the things that an employer would do such as:

Hiring and training your Attendant Care Employee:

- Develop a job description for your Attendant Care Employee.
- Find, interview and hire an Attendant Care Employee to deliver care for you.
- Define your Attendant Care Employee's job duties.
- Train your Attendant Care Employee to deliver your care based on your needs and likes.
- Setting and managing your Attendant Care

Employee's schedule:

- Set a work schedule in advance of when your Attendant Care Employee should start and end the work day.
- Make sure your Attendant Care Employee documents each time they start and end the work day.
- Make sure your Attendant Care Employee does not work beyond approved work hours.

Supervising your Attendant Care Employee:

- Watch your Attendant Care Employee.
- Evaluate how your Attendant Care Employee does job duties.
- Address problems or concerns with how your Attendant Care Employee does job duties.
- Fire an Attendant Care Employee when needed.

Managing your Attendant Care Employee's pay and service notes:

- Make sure your Attendant Care Employee starts and ends the day based on the work schedule.
- Keep good notes in your home about how well your Attendant Care Employee gives care.

Having and using a back-up plan when needed:

- Make a back-up plan to address times that a scheduled Attendant Care Employee is not available or doesn't show up. You must plan ahead since you cannot be without services. Start your back-up plan when needed.

If you can't do some or all of these duties:

Choose a family member, friend, or someone close to you to act as an employer. It's called an "Employer Representative." Select someone who knows you very well and is dependable. **Your Employer Representative cannot get paid for doing these duties and must:**

- Be at least 18 years of age.
- Know you very well.
- Know the kinds of care you need and how you want care to be given.
- Know your schedule and routine.
- Know your health care needs and the medicine you take.
- Be willing and able to do all of the things that are required to be in Self-Direction.

JEVS or Easter Seals will help you or your Employer Representative for Self-Direction to perform employer duties. There are 2 kinds of help you will get:

1. JEVS or Easter Seals will help you and your Attendant Care worker complete and file the payroll tax forms that you must fill out as an employer. They will pay your Attendant care worker for the care they give.
2. JEVS or Easter Seals will also serve as a Support Broker. A Support Broker is a person who will help you with other employer duties such as:
    - Finding and interviewing Attendant Care Employees.
    - Writing job descriptions.
    - Training your Attendant Care Employee.
    - Scheduling your Attendant Care Employee.
    - Make a back-up plan to address times when a scheduled Attendant Care Employee is not available or doesn't show up.

Your Support Broker cannot help you supervise your Attendant Care Employee. You or your Employer Representative must be able to do that alone.

You can pay a family member or friend to give self-directed care but you **cannot** pay your Employer Representative to give your care.

Enrolling in self-directed care:

Services and the care you need are listed in your plan of care. You get the same services whether you choose self-directed care or not. You get only the services you need that are listed in your plan of care. You may choose to split care between a self-directed Attendant Care Employee or home care from providers in our network that you do not employ.

Talk with your Case Manager about self-directed Attendant Care if you are interested. Your Case Manager will work with you to enroll you in self-directed care only if you want. You will continue with your current plan of care until self-directed care is set up. You must have support in place to give you the care you need until self-directed care is set up.

You may start or stop self-directed care at any time. You will still get Attendant Care Services if you stop self-directed care. The only change is you will get the Attendant Care Services you need from a Home Health Agency in the Highmark Health Options network.

Paying for DSHP Plus Long-Term Services and Support

You may have to pay part of the cost of your care in DSHP Plus LTSS. It's called "patient liability." The amount of patient liability depends on your income. If you do have patient liability and live in a nursing facility or assisted living facility, you must pay the patient liability amount to the nursing facility or assisted living facility.

If you refuse to pay your patient liability, the facility may not let you live there. Highmark Health Options will try to help you find another facility.

Abuse, Neglect and Exploitation

DSHP Plus LTSS members have the right to be free from abuse, neglect and exploitation. It is important that you understand how to identify these situations and how to report it.

Abuse can be…

- Physical abuse;
- Emotional abuse; or
- Sexual abuse.

It includes pain, injury, mental suffering, being locked up or held in a place against your will or other cruel treatment.

Neglect can be…

- When you can't take care of yourself or get the care your need, placing your life at risk. This is "self-neglect".
- When your caregiver is not taking care of your basic needs putting you at risk for harm to your health or safety. The neglect may be unintended due to the caregiver's failure to give or arrange for your care. Neglect also may be due to the carelessness of the caregiver to meet your needs.

Exploitation (made to do something you don't want to do or were asked to do without knowing the real reason for doing so) can include…

- Fraud or bullying;
- Forgery; or
- Unauthorized use of banking accounts or credit cards.

Financial exploitation occurs when a caregiver improperly uses funds planned for your care. These are funds paid to you or the caregiver by a governmental agency.

If you think you or another DSHP Plus LTSS member is a victim of these situations, please tell your Case Manager or call one of the numbers below.

IF YOU OR SOMEONE YOU KNOW IS A VICTIM CALL:

Adult Protective Services (APS) at 1-800-223-9074

Child Protective Services (CPS) at 1-800-292-9582

http://iseethesigns.org/

Critical Incidents

Critical Incidents shall include but not be limited to the following incidents:

a. Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician;

b. Suspected physical, mental or sexual mistreatment, abuse and/or neglect of a member;

c. Suspected theft or financial exploitation of a member;

d. Severe injury sustained by a member;

e. Medication error involving a member; or

f. Inappropriate/unprofessional conduct by a provider involving a member.

Wellness & Lifestyle Management Programs

We want you to have a happy, healthy life. Below are programs that are offered to help you stay well and manage any conditions you may have. These are all voluntary and you can opt out of them at any time.

Asthma Program

Do asthma symptoms interfere with your life? If so, you may want to join our Asthma Program. This program is offered to Highmark Health Options members 2 years of age and older. A Case Manager can help you deal with your asthma. This can help you to have less trouble in your life so that you can do the things that you want to do.

Here are a few tips to help you stay on track:

- Take your maintenance medicine every day. This helps to control swelling and shrink mucus in your airways so you can feel better and have less trouble breathing.
- Tell your doctor if you need to use your rescue inhaler more than 2 days a week. This is a sign that your asthma is not controlled.
- Uncontrolled asthma may cause scarring and lasting narrowing of the airways. It's key to tell your doctor, because you may need a change in your medicine.
- Ask your doctor about an asthma action plan. This will help you know what to do when you are sick.
- Visit your doctor at least 2 times a year. If you need to go to the hospital, make an appointment to see your doctor within 2 weeks of leaving the hospital.
- Stop smoking and avoid second-hand smoke. Get help to quit smoking by calling 1-866-409-1858.

Chronic Obstructive Pulmonary Disease (COPD) Program

Living with chronic obstructive pulmonary disease (COPD) can be hard. Highmark Health Options wants to help! If you are at least 21 years of age and are living with COPD, you may benefit from our COPD program. A Case Manager can help you to learn how to deal with your symptoms so that you can be more active and enjoy life.

Here are a few tips for dealing with your COPD:

- Take your breathing medicines as your doctor ordered. Tell your doctor if you have side effects or if you have trouble using your inhaler. Do not stop taking your medicines on your own. This may cause your COPD to flare up.
- Quit smoking. This is the most important change you can make. You can get help by calling 1-866-409-1858.
- Get a yearly flu shot. Ask your doctor about a pneumonia shot if you have not had one.
- Talk to your doctor about an exercise program. Daily exercise can help you to breathe better.
- Make sure you use your oxygen if it was ordered for you. It can help you to be more active.
- Don't go outside when air quality levels are bad. Air pollution can make your breathing worse. Pay attention to alerts on the radio and television.
- If you need to go to the hospital, get all of your medicines filled when you come home. This can help stop your symptoms from flaring up again. Make an appointment to see your doctor within 2 weeks of leaving the hospital.

Cardiac Program

Highmark Health Options members age 21 or older with heart disease or heart failure may benefit from the Cardiac Program. A specially trained Case Manager is available and can help you and your doctor better manage your heart disease. You will get the help you need to take an active role in staying healthy.

Understanding a heart healthy life cuts the chances of flare ups and hospital stays. Case Managers are available by phone and look forward to hearing from you.

Here are a few key tips for dealing with your heart problems:

- Take your medicine the way your doctor ordered. If you can't, let your doctor know. Wait to hear from your doctor's office before you stop taking your pills.
- Some pills have to be slowly stopped over many days so don't just stop taking a pill. You can have bad side effects if you do.
- Visit your doctor at least twice a year. If you are admitted to the hospital make an appointment to see your doctor within 2 weeks of leaving the hospital.
- If you are admitted to the hospital, be sure to ask which medicines you should take. Medicines may have different names for the same pill. Don't assume that you are to take the medicines that you have at home and make sure you know what each of your pills is for.
- Know the signs and symptoms for when to tell your doctor when you don't feel well.
- Ask your doctor which blood tests you need to control your heart disease.
- Stop smoking and stay away from second-hand smoke. Get help to quit smoking by calling 1-866-409-1858.

Diabetes Program

Highmark Health Options members of any age who are living with diabetes may benefit from the Diabetes Program. A specially trained Case Manager is here to help you learn about:

- Keeping blood sugars under control to help stop diabetic problems like heart disease, blindness, amputations and kidney problems.
- Taking your medications, testing your blood sugar and having labs done as ordered by your doctor can help you stay on top of your diabetes.

Here are a few tips about managing your diabetes:

- Take your blood sugar readings the way your doctor ordered them and know your goals.
- Make sure you get these tests at least once a year or more often if your doctor tells you to:
  - A1c: a blood test that measures your normal blood sugar for the past 2-3 months. It doesn't replace checking your own blood sugar, which tells you what your blood sugar is only at the time you are checking.
  - Urine test **(microalbumin)** - a simple urine test that checks for small amounts of protein in the urine. Protein in the urine can be an early sign of kidney problems.
  - Blood pressure: diabetes and high blood pressure raises your risk of heart attack, stroke, and eye and kidney disease. Knowing your goal and having it checked often can stop or delay problems.
  - Dilated Retinal Eye Exam - this exam checks for eye disease, which is more common in people with diabetes. Tell your eye doctor you have diabetes. This exam isn't the same as a vision exam for glasses or contacts. It can help find eye problems early and even stop problems from forming.

- Stop smoking and stay away from second-hand smoke. Get help to quit smoking by calling 1-866-409-1858.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

EPSDT means Early and Periodic Screening, Diagnostic and Treatment. EPSDT is a program that is mandated by the Federal government for people under the age of 21 who get medical assistance. Highmark Health Options provides this program free of charge.

The purpose of the EPSDT program is to catch children's health problems early and to keep checking on them so they can stay healthy.

This program includes all of the services recommended by the state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Any Highmark Health Options member from birth up to the age of 21 is eligible for EPSDT services. The doctor that you choose as your child's primary care physician (PCP) will provide the EPSDT screens and immunizations.

The doctor will complete the EPSDT screenings and immunizations during a well visit that you can schedule for your child. Your PCP will check your child's hearing, vision, dental (teeth), nutritional evaluation (diet), do a lead screen and a mental (behavioral) health evaluation.

For the EPSDT visit, the doctor could:

- Give your child shots
- Ask about your child's nutrition or diet
- Test your child's urine or blood for medical conditions such as lead screening which can impact their development
- Ask questions about your child's mental health and speech, social interactions and behavior- how they relate to kids their own age, and the way they relate to others.
- Ask about social actions and behavior – the way your child relates to other kids their age
- Ask family and relatives to put together a family medical history

During your child's EPSDT exam, the PCP will decide if your child is due for a dental appointment based on his or her age. This benefit is offered through your Medicaid ID card. Please know dental health is very important even with very young children. Talk to your PCP about your child's dental health at each EPSDT visit.

It is very important that you keep your EPSDT appointments with the doctor. These physical exams can sometimes be used as the exam your child needs to get into Head Start, or for school, or for a driver's license physical.

The doctor may find that your child needs a medically necessary service or a piece of equipment to treat a problem found during a screening visit. If so, the doctor can call Highmark Health Options to ask for the service or equipment, and it will be reviewed for approval.

If you need more information please call Member Services at 1-855-401-8251. Member Services can help you find the providers/specialist that are closest to you. They can also refer you to a Resource Coordinator or Case Manager who can also help you make appointments, setting up transportation to the appointments and ensuring your child has all the services recommended by your child's PCP.

Pregnancy Care

Care when you are pregnant is called Maternity care. Maternity care includes:

- Office visits and tests before your baby is born called prenatal care.
- The hospital stay when you have your baby.
- Office visits and tests after your baby is born called postpartum care.

Take good care of yourself and your baby. See your doctor as soon as you know you are pregnant. We have a special program for pregnant women. This program gives education and support to help you have a healthy pregnancy. You should try to stay with us throughout your pregnancy to get the most of this program. Case Managers can answer your questions or fears about your pregnancy. The Case Managers can also help with community service referrals. You will also get information on pregnancy and baby care in the mail. Your first visit with your doctor should be within 14 calendar days of finding out you are pregnant. If you would like more information about the Maternity Program, call our Case Management department at 1-844-325-6251.

Your doctor will tell Highmark Health Options about your pregnancy and we will send you information about our *MOM Options* program and how you can join.

Here are some helpful tips for your pregnancy:

- Keep all of your prenatal appointments. If you miss an appointment, call your doctor to reschedule. Do not wait until your next visit.
- Take the prenatal vitamins prescribed by your doctor. Prenatal vitamins are an important part of your prenatal care for both the health of you and your baby. There are many prenatal vitamins available that we pay for.
- Avoid alcohol, illegal drugs, and smoking. Second-hand smoke can also harm you and your unborn child. Get help to quit smoking by calling the Delaware Quit line at 1-866-409-1858.
- Never take any medicines without checking with your doctor first. This includes prescription medications and over the counter medications like aspirin, Tylenol and cough syrup.
- Eat at least 3 meals a day and choose healthy foods like fruit, meat, milk, vegetables, breads, and cereals.
- Stop foods like coffee, soda pop, fast foods, candy, and doughnuts.
- Drink at least 6 to 8 glasses of water every day. Juice and milk are also healthy choices.
- Keep your teeth and gums healthy by brushing and flossing daily. Gum infections can increase the risk your baby being born too soon.
- Wear your seat belt when you are in a car. Make sure the bottom part of the belt goes low under your belly and touching your legs, not across your belly.

Women, Infants, and Children Program (WIC)

WIC is a program that gives food coupons, nutrition teaching and counseling, and referrals to health and other social services to pregnant women, post-partum mothers, breastfeeding mothers and children under age five who are at nutritional risk, at no charge.

As well as the foods normally offered such as milk, eggs, cheese, cereal and juices, WIC may give families coupons that are redeemable for many other nutritious foods, plus whole wheat breads/rolls, brown rice, oats, whole wheat/corn soft tortillas, soymilk, tofu, fresh fruits/vegetables, jarred baby foods, canned beans, pink salmon or sardines.

Many grocery stores take WIC food coupons.

You can apply for WIC by calling 1-800-222-2189.

If you would like more information about WIC, call our Case Management Department at (1-844-325-6251) (TTY/TDD users 711 or 1-800-232-5460). The Case Managers are available Monday through Friday between 8 a.m. and 5 p.m. by phone. If you need assistance in languages other than English, call Member Services at 1-855-401-8251.

Adding New Members or Removing

When you have a new baby or add a new member to your family, you must call the DSS Change Report Center: at 1-302-571-4900.

After you call the DSS Change Report Center, call Member Services at 1-855-401-8251. If you don't tell us and the DSS Change Report Center, your new family member's insurance may be delayed.

If someone in your family with Highmark Health Options dies, or moves out of your home, please contact Member Services. They can help you. You also need to let the DSS Change Report Center know about your family member's death or that they moved out of your home.

What to do if You Move

If you move or change your phone number, you must call the DSS Change Report Center: at 1-302-571-4900.

After you call the DSS Change Report Center, call Member Services at 1-855-401-8251. Member Services will help you pick a new PCP near your new home.

If you move outside of Delaware or the United States, please contact the DSS Change Report Center for information you will need.

If Your Membership Stops

Medicaid may stop your membership with Highmark Health Options. This is called disenrollment. Your membership may end because you:

- Gave your Medicaid ID card to someone else to use.
- Go to prison.
- Lose eligibility for Medicaid.
- Have a change in your Medicaid benefits that keeps you from being covered by Highmark Health Options.
- Fail to re-enroll.

Changing Your Health Plan

You can change your health plan during the first 90 calendar days after you are first enrolled in Medicaid. You can also change your health plan during the Annual Open Enrollment period once a year from October 1 to October 31. To change your health plan, please call the Health Benefits Manager at 1-800-996-9969.

Claims – What Do I Do with a Bill?

Delaware Medicaid providers cannot charge you for services that are covered by us. If you get a bill from your doctor or the hospital by mistake, do **not** pay the bill. Please call Member Services at 1-855-401-8251 with the billing information and someone will help you. You are not responsible for sending in claims to us; your doctor or the hospital will do that.

You Have Other Insurance or a Third Party Liability (TPL)

You or one of your family members might have other types of insurance. Call Member Services at 1-855-401-8251 if you or any member of your family is covered by us and another insurance plan. Your caseworker at your local DHSS office also needs to know this information. If you have health, dental or vision insurance through another insurance company, you must use that insurance coverage first as a primary insurance. The other insurance carrier must pay first and we are always the last payer to other insurance coverage you may have. It is important to show your health care doctors all of your insurance cards.

You also need to call us if:

- You have a workers' compensation claim.
- You are waiting for a decision on a personal injury or medical malpractice lawsuit.
- You have an auto accident.

If you have received care due to an accident or work related injury, Highmark Health Options will work with the other insurance companies or associates to make sure your claims are paid correctly. Call Member Services and tell us about any time where you have received medical care following an accident, work related injury, or any other situation where a different insurance, company, or lawyer is involved.

We can, and should, know about everyone giving you care. We need to know this to pay for your health care. We will not share this information with anyone except your health care provider and others as the law allows.

New Technology

Highmark Health Options evaluates new technology to decide if it should be included as a covered benefit. New Technology means any new skills, new equipment, or improved way of giving medical care. Highmark Health Options looks at new technologies to make sure it is safe and is as good as or better than current medical products or procedures.

Highmark Health Options has pharmacists and physicians who look at new drugs and new uses for drugs throughout the year. New drugs may be added or removed to the PDL and/or supplemental Formulary list on an on-going basis.

Doctors at Highmark Health Options will review research, like medical articles and scientific studies, to see if the new technology has been shown to be safe and helpful to people. If the research shows that the new technology is safe and has been shown to help people, then the doctors will submit the new technology to a committee of health care professionals at Highmark Health Options for approval to be a covered benefit for Health Options' members.

Confidentiality

Highmark Health Options stays vigilant in protecting patient and provider information. Our expectation is that our employees protect all information, in all formats, all the time, this includes protecting information in verbal, paper or electronic format. Also, private information must be protected to the same level as Protected Health Information (PHI).

Highmark Health Options employees are trained on all applicable Federal and state laws protecting privacy, including HIPAA (Health Insurance Portability and Accountability Act). Additionally, we have policies and procedures to promote strong privacy and security practices and to support compliance with HIPAA requirements. Our Notice of Privacy Practices, a document explaining how we protect our members' privacy, can be found on pages 43-45 of this handbook. The Notice can also be requested any time through Member Services.

If you have any questions or concerns about how your information is handled, please contact our Privacy Officer at:

Corporate Compliance & Privacy
Highmark Health Options
PO Box 22188
Pittsburgh, PA 15222

Phone: 1-855-401-8251
TTY/TDD Line: 711 or 1-800-232-5460

Americans with Disabilities Act

We meet the terms of the Americans with Disabilities Act (ADA) of 1990. This act protects you from discrimination because of a disability. If you feel you have not been treated the same as others because of a disability, call our Member Services number. If you have trouble hearing or speaking, you may call our Member Services TTY line at 711 or 1-800-232-5460.

What is a Member Advocate?

A Member Advocate is someone from the Plan that can help assist you, your provider and your Case Manager with obtaining care, scheduling appointments, and the grievance and appeal processes.

How can I request a Member Advocate?

You can talk to a Member Advocate by calling 1-855-430-9853.

Case Management

You may ask for a new Case Manager if you are unhappy with the current person you are given. Highmark Health Options will assign a new Case Manager who best fits your needs.

Call the Member Advocate at 1-855-430-9853 if you want to change your Case Manager and tell us why you want to change your Case Manager.

If we cannot give you a new Case Manager, we will tell you why, AND we will address any problems or concerns you have with your Case Manager.

There may be times when Highmark Health Options has to change your Case Manager. This may happen if your Case Manager is no longer with Highmark Health Options, is currently not working or has a workload that is too large to manage. If this happens, Highmark Health Options will send you a letter with the name and telephone number of your new Case Manager.

Requesting Medical Records

- You have the right to ask for your medical information.
- You have the right to ask to change your medical information if you can show that it is wrong or that information is missing. If Highmark Health Options disagrees, we may not be able to honor the request to change your records.
- You have the right to get a list of who received your medical information within a six-year period. You must tell us the dates for which you are requesting the list. The list will not cover information that was given to you or your personal representative, or information given for health care payments, for Highmark Health Options operations or for law enforcement needs.

Other Information

If you would like any information about Highmark Health Options including who sits on the Board of Directors, what the education of your doctor is or the way we plan to improve the care and services to our members through the Highmark Health Options' Quality Improvement Program, call Member Services at 1-855-401-8251.

Member Portal

Self Service through the Member Portal

The member portal is customized to meet your needs, keep you healthy and help you take control of your own health care. When you play an active role in your health care, you can improve the quality of your health. It's your personal way to understand your health, improve it and partner with your doctors.

Login is Simple

Registration is free, quick and simple. Members have the convenience of secure, 24/7 access to the tools and information available on www.highmarkhealthoptions.com

The online service will be secure and have measures in place to protect your privacy by having you or your caregiver submit both a user name and password when you log on.

Advantages to using the member portal:

- Find a doctor, hospitals or specialists within your network
- Pharmacy tools:
  - Find a pharmacy
  - Start the exception process
  - Look up potential drug-drug interactions, side effects and risks, and availability of generic substitutes
  - Look up drug copays and pricing
- Email Member Services
- Access your wellness
- Request a new member ID card
- Complete a Health Risk Assessment

Your Rights and Responsibilities

Your Rights

- Learn about your rights and responsibilities.
- Get the help you need to understand this Member Handbook.
- Learn about us, our services, doctors, and other health care providers.
- See your medical records as allowed by law.
- Have your medical records kept private unless you tell us in writing that it is OK for us to share them or it is allowed by law.
- All facts from your doctor of any information about your medical condition, treatment plan or ability to look at and offer corrections to your own medical records.
- Be part of honest talks about your health care needs and treatment options no matter the cost and whether your benefits cover them. Be part of choices that are made by your doctors and other providers about your health care needs.
- Be told about other treatment choices or plans for care in a way that fits your condition.
- Get news about how doctors are paid.
- Find out how we decide if new technology or treatment should be part of a benefit.
- Be treated with respect, dignity and the right to privacy all the time.
- Know that we, your doctors, and your other health care providers cannot treat you in a different way because of your age, sex, race, national origin, language needs, or degree of illness or health condition.
- Talk to your doctor about private things.
- Have problems taken care of fast, including things you think are wrong, as well as issues about your coverage, getting an approval from us, or payment of service.
- Be treated the same as others.
- Get care that should be done for medical reasons.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Choose your PCP from the PCPs in our Provider Directory that are taking new patients.
- Use doctors who are in our network.
- Get medical care in a timely manner.
- Get services from doctors outside our network in an emergency.
- Refuse care from your PCP or other caregivers.
- Be able to make choices about your health care.
- Make an Advance Directive (also called a living will).
- Tell us your worries about Highmark Health Options and the health care services you get.
- Question a choice we make about coverage for care you got from your doctor.
- File a complaint or an appeal about Highmark Health Options, any care you get or if your language needs are not met.
- Ask how many grievances and appeals have been filed and why.
- Tell us what you think about your rights and responsibilities and suggest changes.
- Ask us about our Quality Improvement Program and tell us how you would like to see changes made.

- Ask us about our utilization review process and give us ideas on how to change it.
- Know that we only cover health care services that are part of your plan.
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing.
- Ask for this Member Handbook and other member books and brochures in other formats such as other languages, large print, audio CD or Braille at no charge to you.
- Ask for an oral interpreter and translation services at no cost to you.
- Use interpreters who are not your family members or friends.
- Know you are not responsible if your health plan becomes bankrupt (broke).
- Know your provider can object to the denial of service if you agree.
- Know that you can request a copy of the Member Handbook at any time. You will be told every year of your right to request a Member Handbook.
- You can get a list of network providers that includes the following details about the doctors: name, specialty, hospitals the doctor can visit, education, language spoken, gender, and office location.

Your Responsibilities

- Tell us, your doctors, and other health care providers what they need to know to treat you.
- You can ask us to correct your health and claims records if you feel they are incorrect or incomplete. We may say "no" to your request but we'll tell you why in writing within 60 calendar days. If we cannot change your records, you may have a statement of your disagreement added to your personal medical information. If you would like to make a request, please contact Member Services at 1-855-401-8251.
- Learn as much as you can about your health issue and work with your doctor to set up treatment goals you agree on with your doctor.
- Ask questions about any medical issue and make sure you know what your doctor tells you.
- Follow the care plan and orders that you have agreed on with your doctors or other health care professionals.
- Do the things that keep you from getting sick.
- Make and keep medical appointments and tell your doctor at least 24 hours in advance when you cannot make it.
- Always show your member Highmark Health Options ID card and Delaware Medicaid card when you get health care services.
- Use the emergency room only in cases of an emergency or as your doctor tells you.
- If you owe a co pay to your pharmacies, pay at the time the services are received.
- Tell us right away if you get a bill that you should not have gotten or if you have a complaint.
- Treat all Highmark Health Options staff and doctors with respect and courtesy.
- Know and follow the rules of your health plan.
- Know that laws guide your health plan and the services you get.
- Know that we do not take the place of workers' compensation insurance.
- Tell the DSS Change Report Center and us when you change your address, family status or other health care coverage.

If a minor becomes emancipated, or legally freed from control by his or her parents (over the age of sixteen), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

Advance Directives

If you are admitted as a patient to a hospital, you will be asked if you have any Advance Directives. An Advance Directive is any order you give about your medical care before medical services are done. Advance Directives are only followed in the future when you are not able to say what medical care you want.

There are two kinds of Advance Directives. One is called a "living will" and the other is called a "durable power of attorney."

A "living will" spells out what kind of life-sustaining care you want to get in a terminal condition or permanent state of coma.

A "power of attorney for health care" allows you to appoint someone to make health care choices for you when you are unable to make your own health care choices. This would be if you could not make and tell people your choices.

It is your legal right to make Advance Directives about your medical care. It is also something you may want to talk to your doctor about.

Delaware Health and Social Services (DHSS) has an advance directive form you can fill out.

The form can be downloaded at:
www.dhss.delaware.gov/dhss/dsaapd/advance1.html

You can also request the form through Member Services at 1-855-401-8251.

To make this form legal, you must have two people witness you signing the Advance Directive form. It is suggested but not required that you have a notary public witness you signing the Advance Directive form.

How to File a Grievance or Appeal

We want you to be happy with the health care and service you get. Please let us know if a doctor, hospital, or we do something that you are unhappy about. We will try to fix any problems over the phone. If you don't like something or we can't fix your problem, you can file a grievance or an appeal.

This section tells about the process. You may call Member Services at 1-855-401-8251 if you need help or have questions about how to file a grievance or appeal. You cannot be punished for filing a grievance or appeal. You can have someone file an appeal for you or speak for you.

If you want to have someone file an appeal or speak for you, we will need to have your OK in writing.

You or your representative may contact an appeal coordinator at any time for help or any questions about the grievance or appeal process. You may also ask for help with a grievance or appeal by asking for a Member Advocate. You can ask for a Member Advocate by calling Member Services at 1-855-401-8251 (TTY at 711 or 1-800-232-5460). A Member Advocate can help you:

- File your grievance or appeal
- Help you through the grievance or appeal process
- Answer your questions about the grievance or appeal process
- Help you get additional information from your doctor to help with your grievance or appeal

See page 30 for more information about Member Advocates.

Grievances

A grievance is a statement of unhappiness, like a complaint, and can either be filed in writing or verbally over the phone. A grievance can be about any service that you received from a doctor or by us. A grievance does not include a denial of benefits for health care service. Those matters are handled as appeals (see "Appeals" below).

Some examples of a grievance are:

- If a provider or our employee was rude to you
- If you feel a provider or we did not respect your rights as a member of our plan
- If you have a problem with the quality of care or services, you have received
- If you have trouble finding or getting services from a provider

You can send or attach any papers to the Member Grievance Form that will help us look into the problem. You can contact us at:

Highmark Health Options
Appeals and Grievances
PO Box 22278
Pittsburgh, PA 15222-0188

Phone: 1-855-401-8251

How do I file a grievance? A grievance may be filed at any time orally or in writing.

What happens after I file a grievance? After you file a grievance, you will get a letter from us within five (5) business days. This letter will tell you that we have received your grievance. It will include information about the grievance process and your rights including:

- Your right to appoint a representative to act on your behalf.
- Your right to submit additional information.
- Your right to review or request a copy of all documentation regarding the grievance upon request free of charge.

Your grievance will be reviewed by one of our staff members who has not been involved with your grievance but knows the most about your issue. A decision will be made within thirty (30) calendar days after we receive your grievance.

After a decision is made, a decision letter will be mailed to you. This letter will tell you the reason(s) for the decision.

What if I need help during my grievance? If you need help filing a grievance, understanding the grievance process, or need help getting information for us to review, please contact a Member Advocate at 1-855-430-9853.

Appeals

An appeal is a request for a review of our action. An action is a decision to deny or limit a requested service, including the type or level of service, the reduction, suspension or termination of a service, the denial, in whole or in part or payment for a service; or the failure to provide a service in a timely manner.

What should I do if I have an appeal? To file an appeal, you can call Member Services at 1-855-401-8251 and they will help you file your appeal. You may also have a representative or doctor file an appeal for you if you give your OK in writing to do so. Please note that if your representative or doctor files an appeal for you, you cannot file a separate appeal on your own. If you file your appeal by phone, you must also put your appeal request in writing within thirty (30) calendar days of calling Member Services. An appeal review will not take place without your written signature.

You, your representative, or doctor can also file an appeal by mail. You can also fill out a *Member Appeal Form*. You can find this form on our website **www.highmarkhealthoptions.com**

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

- Your name and member I.D. name (found on your Highmark Health Options I.D. card)
- Your phone number
- Your address
- What are you appealing?
- Why are you appealing?
- What do you want as a result of your appeal?

You may send or attach any papers that will help us with the review of your appeal. You can contact us at:

Highmark Health Options
Appeals and Grievances
PO Box 22278
Pittsburgh, PA 15222-0188

Phone: 1-855-401-8251

When should I file an appeal? You or your representative must file your appeal within sixty (60) calendar days from the date of the "Notice of Adverse Benefit Determination" letter.

What can I do to continue getting services during the appeal process?

- You may ask to continue to receive services during the appeal process if:
  - You file the request for the appeal timely
  - If we are terminating, suspending, or reducing previously approved services
  - The services were ordered by a doctor
  - The original time period covered by the original authorization has not run out
  - You ask to continue receiving services within ten (10) calendar days of us sending the Notice of Adverse Benefit Determination (Notice of Action)
- If we continue your services during the appeal process, we will cover these services until:
  - You or your representative withdraw the appeal
  - You or your representative fail to request a State Fair Hearing and to continue getting services with ten (10) calendar days of us sending the Notice of Adverse Benefit Determination (Notice of Action)
  - You receive a decision from the State Fair Hearing officer that was not in your favor

It is important to know that you may have to pay for the services you received while your appeal was pending if the final decision is not in your favor.

What happens after I file an appeal? You will get a letter from us within five (5) business days after your appeal. This letter will tell you that we have received your appeal. It will also include information about the appeal review process. You may choose to have someone to act on your behalf. You or your representative may submit additional information and may ask to look over all documents for the appeal. You may also request a copy of the information used to review your appeal free of charge. In addition, you or your representative have the right to give additional information in person at the time of the appeal hearing, telephonically or in writing by sending it to the address or faxed to 1-844-325-3435.

An Appeal Committee will review your appeal and make a decision. The Appeal Committee members include a representative of the State, a Physician and our Director of Quality or his/her designee. The committee members have not been involved with the issue of your appeal.

You or your representative may extend the timeframe for making the appeal decision for up to fourteen (14) calendar days. We may also extend the timeframe for decision up to fourteen (14) calendar days if additional information is necessary and the delay is in your best interest. If we extend the timeframe, we will call you and send you a written notice with the reason for the delay.

A decision letter will be mailed to you within thirty (30) calendar days from the date you filed your appeal or within two (2) business days of the decision, whichever is sooner. This letter will tell you the reason for our decision and further appeal rights including your right to ask for a State Fair Hearing (see "What should I do to get a State Fair Hearing" below).

What if I need help during my appeal? If you need help filing an appeal, figuring out the appeal process, or help getting information for us to review, please contact Member Services at 1-855-401-8251 and ask for a Member Advocate. If you need a translator, we will arrange one for you at no cost. Call Member Services for a translator.

What if I don't like Highmark Health Options decision about my appeal? If you do not agree with our decision, you or your representative, may ask for a State Fair Hearing (see "What should I do to get a State Fair Hearing" below).

Expedited ("Fast") Appeals

What should I do if I need a decision faster than 30 calendar days? If you think the normal timeframe to review your appeal could cause you serious health concerns, you or your representative may ask for an expedited ("fast") appeal.

You, your representative, or doctor can ask for a fast appeal orally or in writing. If we agree that you should get an appeal decision faster, you will receive a decision within 72 hours. If we do not agree, we will tell you by phone within two (2) calendar days of getting your request that your appeal will follow the standard appeal process.

What happens after I file a fast appeal? You may choose someone to act on your behalf. You, your representative, or doctor may submit additional information. Also, you or your representative may look over all papers regarding the appeal upon request free of charge. An Appeal Committee will review your appeal and make a decision. The Appeal Committee members include a representative of the State, a Physician and our Director of Quality or his/her designee. The committee members have not been involved with the issue of your appeal.

Your fast appeal will be resolved and you will be notified of a decision within 72 hours from the date you filed your fast appeal. Your letter will tell you the reason for the decision and further appeal rights, including your right to ask for a State Fair Hearing (see "What should I do to get a State Fair Hearing" section on this page).

State Fair Hearing

A State Fair Hearing is an appeal process given by the State of Delaware. You may ask for a State Fair Hearing instead of or in addition to filing an appeal with us.

What should I do to get a State Fair Hearing? You, or your representative, may ask for a State Fair Hearing if:

- We have denied, suspended, terminated, or reduced a service
- We have delayed service
- We have failed to give you timely service

You can ask for a State Fair Hearing by calling or writing to the State's Division of Medicaid and Medical Assistance (DMMA) office at:

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

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

When should I file a State Fair Hearing? If you or your representative are not happy with the denial in the "Notice of Adverse Benefit Determination" or an appeal decision, you may ask for a State Fair Hearing within one hundred twenty (120) calendar days of the date on the "Notice of Adverse Benefit Determination".

What happens after I file a State Fair Hearing? You or your representative will get a letter from the State Fair Hearing officer that will tell you the date, time, and place of the hearing. The hearing can be held

in-person or by telephone. The letter will also tell you what you need to know to get ready for the hearing. You or your representative may review all papers regarding the State Fair Hearing. Highmark Health Options will also have a representative at a State Fair Hearing.

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

How do I continue getting services during the State Fair Hearing process? If you were previously authorized and getting services that we are now terminating, suspending, or reducing, you may ask to continue getting services if:

- You ask to continue receiving services
- You file a State Fair Hearing within ten (10) calendar days of the date on the "Notice of Adverse Benefit Determination"
- You file for a State Fair Hearing on or before the effective date of the proposed action
- The services were ordered by a doctor
- The original time period covered by the original authorization has not run out

If we continue your services during the State Fair Hearing process, we will continue to cover these services until:

- You get the State Fair Hearing decision
- You or your representative withdraw the State Fair Hearing
- The time period or service limits you were previously authorized for has been met

It is important to know that you may have to pay for the services you received while your State Fair Hearing was being decided if the final decision is not in your favor. If the decision was in your favor, Highmark Health Options will arrange for these services right away.

What if I do not like the State Fair Hearing decision? If you, or someone you choose, are unhappy with the State Fair Hearing decision, you or your representative can ask for a judicial review in Superior Court. To do this, you must file with the clerk (Prothonotary) of the Superior Court within thirty (30) calendar days of the date of the State Fair Hearing decision.

Fraud and Abuse

Fraud, Waste, and Abuse of medical or pharmacy benefits is taken seriously at Highmark Health Options.

If you think that someone is using your Highmark Health Options' identification card or another member's identification card to get medical or prescription drug benefits, please call Highmark Health Options' Fraud and Abuse Hotline at 1-844-325-6256 (TTY users: 711 or 1-800-232-5460). You can also report any provider (for example a doctor, dentist, therapist or hospital) you suspect for providing services that are fraudulent, wasteful or abusive.

Your name will be kept private. You do not even have to give your name but if you do give your name, the provider will not be told you called. You can use this hotline to report any activity you think is fraudulent, wasteful or abusive. Each call that we receive will be reviewed and investigated.

You may also report this information to the Division of Medicaid & Medical Assistance Fraud Reporting phone number at 1-800-372-2022 or by sending an email to SURreferrals@state.de.us.

Some common examples of fraud and abuse are:

- A doctor that bills you or makes you pay cash for services that your health plan covers
- A person who is not a Highmark Health Options' member using a member's identification card
- A doctor who is billing for services that you did not get

- A person who moves to another state but keeps using a Highmark Health Options' member Identification card.
- A doctor who gives you medicines that you do not need or gives you too much
- A doctor or staff person who offers you gifts or money to get services if you give them your Medicaid number
- A doctor who gives you services that you do not need
- Physical, mental or sexual abuse by medical staff

The Highmark HealthOptions' Fraud Hotline is available 7 days a week, 24 hours a day. If you do not speak English, an interpreter will be made available. If you are hearing impaired, you can call the hotline using your TTY device.

Important Phone Numbers

IMPORTANT PHONE NUMBERS	
Member Services (Monday-Friday, 8 a.m.-8 p.m.)	**1-855-401-8251**
Pharmacy	
24-Hour Nurse Help Line	**1-844-325-6251**
Case Management (Monday-Friday, 8 a.m.-5 p.m.)	
Mental (Behavioral) Health (Monday-Friday, 8 a.m.-5 p.m.)	
Fraud and Abuse Hotline	1-844-325-6256
TTY/TDD Line	711 or 1-800-232-5460
MENTAL (BEHAVIORAL) HEALTH CRISIS SERVICES	
Northern Delaware (serving New Castle County and greater Smyrna in Northern Kent County)	1-800-652-2929
Southern Delaware (serving Sussex County and Kent County south of greater Smyrna)	1-800-345-6785
OTHER IMPORTANT PHONE NUMBERS	
Health Benefit Manager – Enrollment Call this number to join in a new health plan or disenroll from your current plan.	1-800-996-9969
LogistiCare Transportation Services Non-Emergency Transportation	1-866-412-3778
LogistiCare Transportation Services Where's My Ride? Hotline	1-866-896-7211
State of Delaware Division of Social Services – Customer Relations	1-800-372-2022 or 1-302-571-4900
4900 Delaware Relay Service This number lets people who have a hearing or speech loss to communicate with a trained person who can help them speak with someone who uses a regular telephone.	711 or 1-800-232-5460
Delaware Tobacco Quit Line to help stop smoking	1-866-409-1858

Urgent Care Locations in Delaware

Please check **www.highmarkhealthoptions.com** for the most recent list of Urgent Care providers.

BEAR

Eden Hill Express Care LLC
1011 East Songsmith Drive
Bear, DE 19701-1194
1-302-674-1999

CAMDEN

Got a Doc
379 Walmart Drive Suite 100
Camden, DE 19934-1365
1-302-698-4441

CLAYMONT

Got a Doc
3001 Philadelphia Pike Suite 100
Claymont, DE 19703-2580
1-302-793-7506

DOVER

Eden Hill Express Care LLC
200 Banning Street Suite 170
Dover, DE 19904-3491
1-302-674-1999

MedExpress Inc Delaware
15 South Dupont Highway
Dover, DE 19901-7430
1-302-674-1514

GEORGETOWN

BeeBe Physician Network Inc
21635 Biden Avenue
Georgetown, DE 19947-4574
1-302-856-9729

LEWES

Got a Doc
1309 Savannah Road
Lewes, DE 19958-1514
1-302-644-1441

MILFORD

Medical Alternative Care
301 Jefferson Ave
Milford, DE 19963-1800
1-302-430-5705

MILLSBORO

BeeBe Physician Network Inc
28538 Dupont Boulevard
Millsboro, DE 19966-4791
1-302-934-5052

Got a Doc
25935 Plaza Drive
Millsboro, DE 19966-6289
1-302-947-4111

MILLVILLE

BeeBe Physician Network Inc
32550 Docs Place
Millville, DE 19967-6975
1-302-539-4302

NEW CASTLE

MedExpress Inc Delaware
129 N Dupont Highway
New Castle, DE 19720-3135
1-302-328-5150

NEWARK

Newark Emergency Center
324 East Main Street
Newark , DE 19711-7150
1-302-738-4300

Go Care at Abby
1 Centurian Drive Suite 106
Newark, DE 19713-2154
1-302-999-0003

MedExpress Inc Delaware
1 C Chestnut Hill Plaza
Newark, DE 19713-2701
1-302-266-0930

Omega Urgent Care LLC
15 Omega Drive Building K
Newark, DE 19713-2057
1-302-368-5100

SUSSEX

Got a Doc
1309 Savannah Road
Sussex, DE 19958-5927
1-302-644-1441

WILMINGTON
Delaware Medical Care Inc Medical Aid Unit 2700 Silverside Rd Wilmington, DE 19810-3719 1-302-225-6868
MedExpress Inc Delaware 2722 Concord Pike Wilmington, DE 19803-5007 1-302-477-1406
MedExpress Inc Delaware 3926 Kirkwood Highway Wilmington, DE 19808-5110 1-302-998-2417

Mental Health, Drug & Alcohol Crisis Services

If you are having a mental health or drug or alcohol crisis, please call Crisis Intervention Services for help:

- In Northern Delaware, call: 1-800-652-2929
- In Southern Delaware, call: 1-800-345-6785

You can also go to:

- Crisis Intervention Service
- Community Mental Health
- Recovery Response Centers
- Hospital Emergency Rooms

Crisis Intervention Service staff are available 24 hours a day to help people with severe personal, family or marital problems. These problems may include depression, major life changes such as unemployment or loss of an important relationship, anxiety, feelings of hopelessness, thoughts of suicide, delusions, paranoia and abuse of drugs or alcohol.

Members can call or drop-in to the crisis intervention location closest to them. Crisis Intervention Services are listed:

ELLENDALE
Recovery Innovations 700 Main Street Ellendale, DE 19941-2066 1-302-424-5660
WILMINGTON/NEWARK
CAPES Unit Wilmington Hospital Emergency Department 1-302-428-2118
Recovery Innovations Crisis/Restart Program 659 East Chestnut Hill Newark DE 19711 Restart Program: 1-302-300-3100 Crisis Center: 1-302-318-6070

HIGHMARK. Delaware HEALTH OPTIONS

Highmark Health Options
Notice of Privacy Practices

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

Highmark Health Options℠ ("Highmark Health Options") is required by law to protect the privacy of your health information and non-public personal (financial) information. This protection extends to all forms of communication (oral, written, and electronic) of this information. Also, Health Options is required to give you this notice about how it uses or shares ("discloses") your health and personal ("non-public") information. We are required to notify you if you are affected by a breach of unsecured health information.

In order to provide services to you, Highmark Health Options will share your health information with:

- You or someone who acts for you
- Doctors and health care providers who care for you
- Our contracted vendors who help us provide services to you (such as member services support and pharmacy benefit management)
- Other government programs such as Medicare and Medicaid to manage your benefits and payments
- State and federal agencies that have the legal right to receive such data
- The Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected

Highmark Health Options will use your health information to:

- Coordinate and manage your care
- Determine your eligibility for your plan benefits
- Pay for your health care
- Contact you about new or changed benefits
- Contact you for appointment reminders, medication management, or disease management programs and alternative treatments that may interest you
- Check the quality of our services and make improvements where required
- Complete medical reviews
- Arrange legal services, audit services, and fraud and abuse detection programs
- Plan and carry out our business activities, management and general administration
- Give you information about health-related benefits and services that may be of interest to you

Highmark Health Options may also use or share your health information:

- For public health activities (such as reporting disease outbreaks; child abuse and neglect; reporting domestic violence; preventing or controlling disease, injury or disability)
- For government health care oversight activities (such as fraud investigations, audits, and activities related to oversight of the health care system)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes or when required by law, for example, locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.
- For purposes of national security
- To comply with worker's compensation or similar laws
- For research studies that meet all privacy law requirements such as research related to the prevention of disease or disability
- To avoid a serious and likely threat to health or safety
- To create a collection of information that can no longer be traced back to you
- To group health plans, to coordinate plans and to permit the plan to administer benefits
- To coroners, medical examiners, funeral directors and organ donations

- To your school when proof of immunization is required by law
- To others involved in your health care (if you are not present or able to agree to these disclosures of your health information, we may use our professional judgment to determine whether the disclosure is in your best interest)
- For underwriting purposes if needed, however, we are not allowed to use or share your genetic information to decide whether coverage can be given or at what price.

Marketing
If we receive compensation from another company for providing you with information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this other company.

Sharing information for other purposes
Highmark Health Options must have your written permission (an "authorization") to use or give out your health and claims information for any purpose that is not listed in this notice. Giving us permission to use or give out your health and claims information will not be a condition for getting health care and will not be used to determine your eligibility for enrollment or benefits, or for paying claims. You may take back ("revoke") your written permission at any time, except if Highmark Health Options already took action based on your permission.

Some examples of when we need your permission to use or give out your information are:
- For fundraising
- For selling your protected health information (PHI)

You have the right to:

Get a copy of your health and claims information. You can ask to see or get a copy of your health or claims records and other health information we have about you. We will provide a copy or a summary of your health or claims records within 30 days of your request.

Ask us to correct health and claims records. You can ask us to change your health and claims records if you feel they are incorrect or incomplete. We may say "no" to your request but we'll tell you why in writing within 60 days. If Highmark Health Options cannot change your records, you may have a statement of your disagreement added to your personal medical information.

Get a list of those with whom we've shared information. You can ask for a list (called "an accounting") of the times we've shared your health information within the last six years. You must tell Highmark Health Options the dates for which you are requesting the list. The list will not cover information that was given to you or your personal representative, or information given for health care payments, for Highmark Health Options business operations, or for law enforcement needs.

Request Confidential Communications. You can ask us to contact you in a specific way, for example, on a home or office phone or to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share. You can ask us not to share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Choose someone to act for you. If you have given someone medical power of attorney, or if someone is your legal guardian, that person can act for you and make choices about your health information. We will make sure the person has this authority before we take any action.

Get a copy of this privacy notice. Contact us for a separate paper copy or e-mail copy of this Notice.

What is the *non-public information* that Highmark Health Options collects and shares about you?

- It is personal information but is non-medical, for example, the information you completed on your enrollment application that identifies who you are and how you can be contacted
- Also, it is information collected for a request for services by you or your doctor.
- Also, it is information collected to answer a question or concern from you.

With whom does Highmark Health Options share your *non-public information*?

- With health care providers, for example, physicians, hospitals, long term care agencies, durable medical equipment providers, and pharmacies.
- With those who plan your benefits and your care, for example, for utilization reviews; external reviews; and case management.

How does Highmark Health Options protect your *non-public information*?

- Highmark Health Options does not make your non-public information available to anyone other than those necessary to provide medical or health plan services to you.
- Highmark Health Options does not give out your non-public information, except if required or permitted by law.
- Highmark Health Options does not give out your non-public information to anyone unrelated to providing your care under the health plan unless you or your representative gives permission.
- You have the right to give or withhold permission for other uses or disclosures of this information, except as required by law.

Questions and Complaints

If you have a question about this notice or believe Highmark Health Options has violated your privacy rights as stated in this notice, you can file a complaint by contacting:

Privacy Officer
Highmark Health Options
PO Box 22188
Pittsburgh, PA 15222
Phone: 1-855-401-8251

For more information on filing a complaint or your rights stated in this notice, you may call our Member Services at 1-855-401-8251 (TTY/TDD users: 711 or 1-800-232-5460). Filing a complaint will not affect your benefits. Translations services are available at no cost to you.

You may also file a complaint with the Secretary of the Department of Health and Human Services:

U.S. Department of Health and Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201

Customer Response Center: 1-800-368-1019
Fax: (202) 619-3818
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

Or, for more information see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Change to the terms of this notice

Highmark Health Options is required to follow the terms in this privacy notice. Highmark Health Options has the right to change the way your medical information is used and given out and to apply those changes to all the information we maintain about you. If Highmark Health Options makes any material changes they will be posted on our website, and you will be notified within sixty (60) days of the change.

The initial privacy practices were effective April 14, 2003.

These privacy practices have been revised as of February 6, 2017.

HIGHMARK. Delaware HEALTH OPTIONS

For Help in Your Language - Discrimination is Against the Law

Highmark Health Options complies with applicable Federal civil rights laws and regulations and does not discriminate on the basis of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options does not exclude people or treat them differently because of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options offers:

- 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 the Civil Rights Coordinator.

If you believe that Highmark Health Options has failed to provide these services or discriminated in another way you can file a grievance with: Civil Rights Coordinator, P.O. Box 22278, Pittsburgh, PA 15222, Phone: 1-844-207-0336, TTY: 711, Fax: 412-255-4503. You can file a grievance in person, by mail, or fax. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：711）。

Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do kat idantifikasyon w lan (TTY: 711).

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ તો, તમારા માટે ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર પર ફોન કરો (TTY: 711).

ATTENTION : Si vous parlez français, des services d'assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 카드 뒷면의 번호로 전화하십시오(TTY: 711).

ATTENZIONE: Se parla italiano, per Lei sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero presente sul retro della Sua carta di identificazione (TTY: 711).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tawagan ang numero sa likod ng iyong card (TTY: 711).

कृपया ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निशुल्क उपलब्ध हैं। अपने पहचान काड के पीछे दिए गए नंबर पर कॉल करें (TTY: 711)।

توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ کے پیچھے درج نمبروں پر ہمیں کال کریں (ٹی ٹی وائی: 711)۔

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجّان. اتصل على الرقم المدوّن على ظهر بطاقة هُويتك (الهاتف النصي: 711).

గమనిక: మీరు తెలుగు మాట్లాడే వారైతే, భాషా సహాయక సేవలు, ఖర్చు లేకుండా, మీరు లభిస్తున్నాయి. మీ ఐడి కార్డుకు (TTY: 711) వెనుక వైపు ఉన్న నెంబర్ కి ఫోన్ చేయండి.

WICHDIG: Wann du Pennsylvania Deitsch schwetzscht, kenne mer dich ebber griege as dich helfe kann mit die Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer uff as uff die hinnerscht Seit vun dei Card is (TTY: 711).

Highmark Health Options is an independent licensee of the Blue Cross and Blue Shield Association.

Notes

HIGHMARK® Delaware
HEALTH OPTIONS

Member Services
1-855-401-8251

Please visit our website at
www.highmarkhealthoptions.com