Member Handbook 2025

Learn All About Your Highmark Health Options Coverage

Medical | Prescription Drug | Dental | Hearing | Vision | Behavioral Health | And More

Diamond State Health Plan & Delaware Healthy Children Program

HIGHMARK HEALTH OPTIONS

Because Life.™

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

HighmarkHealthOptions.com

Highmark Health Options is a managed care organization serving people who qualify for Medicaid. We help each of our more than 125,000 members get the care and services they need to live healthier and more independent lives, and we collaborate with providers and regulators to improve health outcomes, simplify the health care experience, and ensure affordability. Medicaid covers 1 in 5 Americans as a state-run health insurance program. Highmark Health Options members include individuals and families with low income or complex needs, expecting mothers, children, and people with disabilities.

For Help in Your Language

Highmark Health Options 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, Braille, audio, accessible electronic formats, other formats).

Free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

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).

ATANSYON: 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).

Find more information at the end of this guide.

If you cannot see or read information that Highmark Health Options sends you, call Member Services.

Si usted no puede ver o leer las cartas que le envía Highmark Health Options, llámenos servicios a los miembros.

Table of Contents

When you see this icon, click it to return to the table of contents.

Hi. We're glad you're here.

Thank you for choosing Highmark Health Options. Look to us for Medicaid coverage and managed care—plus so much more, even when you're not sick. Our coverage goes beyond the basics so you can live your best life.

The basics include care for your physical and mental well-being, including prescription drug coverage—all from the doctors, hospitals, and pharmacies you need.

Some of the benefits that Highmark Health Options covers are "extra" benefits. This means they are not the standard benefits that all Medicaid plans cover.

With extra benefits from Highmark Health Options, you can:

- **Have adult coverage for vision and hearing:** Adults have coverage for glasses or contact lenses and hearing aids. (These benefits for children are standard Medicaid benefits.)
- **Earn healthy rewards:** Watch your rewards add up when you have certain exams and screenings and complete wellness classes and healthy activities. See how much you can earn by signing up for the Healthy Rewards program.
- **Focus on wellness:** Join the free Diabetes Prevention Program or LEAN Program, offered by Highmark Health Options and the YMCA of Delaware.
- **Connect with us:** Get a free smartphone (one per household). Your calls and texts to us are always free and won't affect your plan balance.
- **Get where you need to go:** Use free transportation to your health care visits or to the pharmacy, grocery store, community events, health and wellness activities, and more.
- **Take care when you're pregnant:** Extra benefits include the MOM Options program, free use of the Pacify app, and a free diaper bag that contains all the essentials and converts to a changing pad.

Find more details about all your benefits inside. The full list starts on page 28.

Read Me! Read this handbook to learn about all your benefits. There may be changes to your coverage and this handbook. The most current benefits information is on our website under Medicaid.

Here for You

Call Us

- If you're not sure where to go for health care or have questions about a health concern, call the 24-Hour Nurse Line at **1-844-325-6251**.
- If you have questions about your benefits, call Member Services at **1-844-325-6251**, Monday–Friday, 8 a.m.–8 p.m.
- TTY callers should dial **711** or **1-800-232-5460**.
- Para asistencia en español llame al **1-844-325-6251**.
- For free language translation services, call **1-844-325-6251**.

Visit Us Online

Here are some of the things you can do at HighmarkHealthOptions.com:

- Find a new doctor or pharmacy. Click Find Care in You Area to reach the Provider Directory.
- Sign into myHHO, which is all about you. You can use myHHO to schedule an online visit with a care provider, look up your claims information, fill out forms, update your contact information, and much more. Use the login button on the homepage to enter myHHO.
- See the Here for You newsletters.
- Search the Health Library to learn more about your health conditions.
- File an appeal or grievance.
- Plus much more.

Look for Us

With the Food Bank of Delaware, we organize food distribution events in your county. With the YMCA, we provide wellness classes for diabetes prevention and healthy weight. We plan and attend community events.

And we do so much more to provide what you need, right where you live. Watch this short video to find out about Highmark Health Options in Delaware. Follow us on Facebook to learn what we'll be doing in your neighborhood.

About Highmark Health Options

Highmark Health Options is a Medicaid managed care plan offered through the Delaware Diamond State Health Plan (DSHP) and Delaware Healthy Children Program (DHCP).

Managed care means:

- We work with your primary care provider (PCP) to manage all your health care needs.
- You go to health care providers in our network.

Your PCP is very important in managing your care. At times, your PCP or another provider may need to ask us for approval before you can get a service.

Some Services Must Be Approved

Highmark Health Options must approve some services before they can be provided. This requirement is called prior authorization. Note: You may have to pay when a service is given without prior authorization.

Your PCP or another doctor can request prior authorization for services. Highmark Health Options approves services that are medically necessary.

A medically necessary service:

- Is reasonably needed to stop the beginning of an injury, an illness, or a disability.
- Is reasonably needed to shrink the physical or mental effects of an illness, condition, injury, or disability.
- Will help you become able to or continue to do daily chores.

Highmark Health Options doctors and nurses review the authorization request. Call Member Services if you have questions about services that require prior authorization.

Changes in Benefits or Services

Highmark Health Options will let you know if there are changes to your benefits or the way you get services. For example, if your PCP is no longer in our network, we will send you a letter. We will ask you to pick a new doctor so there is no delay in your care.

New Ways to Help You

Highmark Health Options looks at new ways of giving care before adding new benefits to your coverage.

We use medical technologies (products, services, and solutions) that:

- Are safe.
- Help people.
- Are as good as or better than what is already used.

Americans with Disabilities Act

Highmark Health Options complies with the Americans with Disabilities Act (ADA) of 1990. This act prohibits discrimination because of a disability. Call Member Services if you feel you have not been treated the same as others because of a disability.

Your Privacy

Highmark Health Options carefully protects your personal information and personal health information (PHI). We expect our employees to protect all information, in all formats, all the time. This includes spoken, written, and electronic information. Our employees are taught federal and state laws protecting privacy, including HIPAA. We have policies and procedures to promote strong privacy and security practices, and to support compliance with HIPAA requirements. Refer to the Notice of Privacy Practices on the Highmark Health Options website. The notice explains how we protect your privacy. Call Member Services to ask for a printed copy of this notice.

If you have questions or concerns about how your information is handled, call Member Services or write to:

Privacy Office
Highmark Health Options
P.O. Box 1991
Wilmington, DE 19889-8835

Important Phone Numbers

Highmark Health Options	
24-Hour Nurse Line	**1-844-325-6251**
Member Services Monday–Friday, 8 a.m.–8 p.m.	**1-844-325-6251**
Care Coordination Monday–Friday, 8 a.m.–5 p.m.	**1-844-325-6251**
Behavioral Health (mental health and substance use disorder) Monday–Friday, 8 a.m.–5 p.m.	**1-844-325-6251**
Member Advocate	**1-855-430-9852**
Fraud, Waste, and Abuse Hotline	**1-844-325-6256**
TTY Line People with hearing or speech loss can communicate with a trained person who will help them speak with someone who uses a regular telephone.	**711** or **1-800-232-5460**

Emergencies

In a medical emergency, call **911**.

In a mental health emergency, call **988**, the national Suicide and Crisis Lifeline.

Behavioral Health Crisis Services For mental health and substance use disorder.	
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**

Delaware Phone Numbers	
Delaware Quitline Stop smoking and using tobacco or vaping.	**1-866-409-1858**
Medicaid Health Benefits Manager	**1-800-996-9969**
ModivCare Transportation Services For travel to a health care visit. Not to be used for an emergency.	**1-866-412-3778**
State of Delaware Division of Social Services Customer Relations	**1-800-372-2025**
State of Delaware Division of Social Services Change Report Center	**302-571-4900**

Find more contact information in the back of this handbook, like:

- Crisis services for mental health and drug and alcohol.
- Detoxification services for mental health and drug and alcohol.
- Helplines: Local and national.

Frequently Asked Questions

We are often asked these questions, so we're putting answers right up front. Call Member Services if you have more questions. Or find answers on our website.

How do I update my information?

To provide other new information about you and your family, call the Delaware Division of Social Services Change Report Center at **302-571-4900**, Monday–Friday, 8 a.m.–4:30 p.m. Or send a fax to **302-571-4901**. Remember to include your case number on all of your documents.

Tell us about changes in:

- Name
- Phone number
- Address
- Employment
- Household size and expenses, including birth of a baby
- Income
- Insurance coverage

What is my dental coverage?

- Age 21 and older: Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care. $3 copay.
- Age 20 and younger: Covers preventive and corrective dental care with no yearly limit, excluding removal of bony impacted wisdom teeth. Includes braces and retainers. $0 copay.

Note: Removal of bony impacted wisdom teeth is covered under the Highmark Health Options medical benefit.

How do I get prior authorization for a service?

Ask your doctor. Your primary care provider (PCP) or other health care provider must ask us for approval before a service is provided.

What should I do if I get a bill?

Call Member Services with the billing information. Delaware Medicaid providers cannot charge you for services that Highmark Health Options covers.

Am I covered if I see out-of-state providers?

Yes. You're covered for emergency services in the U.S. and its territories. Routine care from out-of-state providers may require prior authorization.

Am I covered outside the U.S.?

No. Your benefits do not cover you for any services provided outside the U.S. Medicaid cannot pay for any health care services you get outside the U.S.

Answers to More Questions

What do you need to do? Find out how to:

- Change your PCP.
- Add or remove members.
- Report a problem with a caregiver.
- Report a concern about your care.
- Request your medical records for a new PCP. Or for you.
- And more.

Get Started

Your Highmark Health Options ID card and primary care provider (PCP) are very important. Read about them here, along with tips on how to get the most from your benefits.

Pick a Primary Care Provider (PCP)

Your PCP is your family doctor. You must choose a PCP when you sign up. If you do not, we will choose one for you. You can have the same PCP for your entire family. Or you can have a different PCP for each person in your family. The choice is yours.

Find a complete list of network PCPs on our website in the Provider Directory. Go to the Find Care in Your Area link to find the Provider Directory. Each listing includes the PCP's name, address, phone numbers, and board certification status. You can also call Member Services for help finding a PCP. Ask Member Services if you want to know about a PCP's race, ethnicity, education, language, residency, and qualifications.

Check Your ID Card

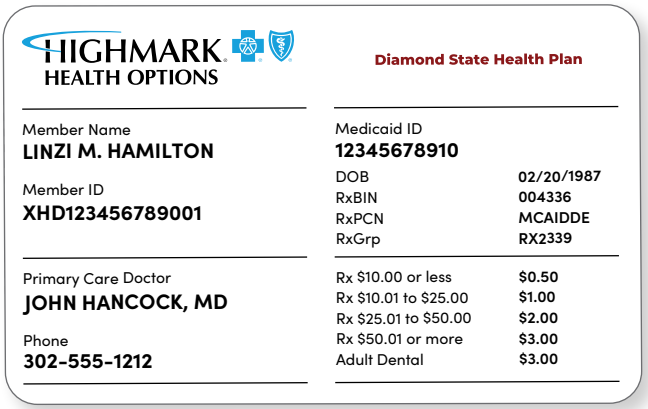
Your Highmark Health Options ID card was mailed to you. Call Member Services if you did not get it. Every member of your family enrolled with Highmark Health Options will have an ID card.

Make sure the PCP listed on your ID card is the one you want. Call Member Services right away if the PCP on your ID card is not the PCP you want. Check other information on the ID card to make sure it is right, too.

Call the phone number on the back of your ID card when you need help or information. The number is **1-844-325-6251 (TTY: 711)** and connects you with Member Services, the 24-Hour Nurse Line, and Behavioral Health.

Important:

- Always keep your Highmark Health Options ID card and Delaware Medicaid card with you.
- Show both cards every time you need health care services.
- Do not let anyone else use your Highmark Health Options ID card.


HIGHMARK HEALTH OPTIONS

Diamond State Health Plan

Member Name
LINZI M. HAMILTON

Member ID
XHD123456789001

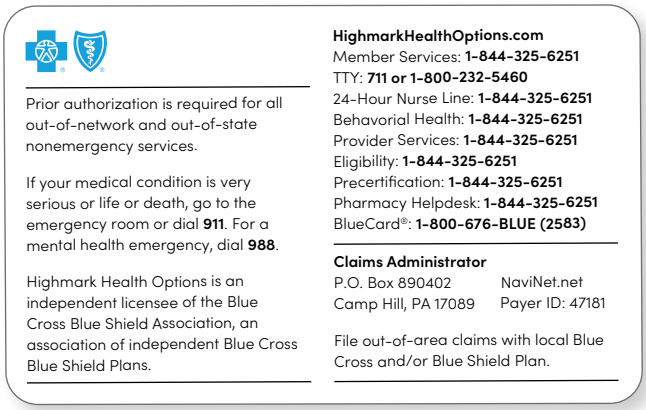
Primary Care Doctor
JOHN HANCOCK, MD

Phone
302-555-1212

Medicaid ID
12345678910

DOB	02/20/1987
RxBIN	004336
RxPCN	MCAIDDE
RxGrp	RX2339

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


Prior authorization is required for all out-of-network and out-of-state nonemergency services.

If your medical condition is very serious or life or death, go to the emergency room or dial **911**. For a mental health emergency, dial **988**.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

HighmarkHealthOptions.com
Member Services: **1-844-325-6251**
TTY: **711 or 1-800-232-5460**
24-Hour Nurse Line: **1-844-325-6251**
Behavorial Health: **1-844-325-6251**
Provider Services: **1-844-325-6251**
Eligibility: **1-844-325-6251**
Precertification: **1-844-325-6251**
Pharmacy Helpdesk: **1-844-325-6251**
BlueCard®: **1-800-676-BLUE (2583)**

Claims Administrator
P.O. Box 890402
Camp Hill, PA 17089
NaviNet.net
Payer ID: 47181

File out-of-area claims with local Blue Cross and/or Blue Shield Plan.

Get the Most from Your Benefits

It's important to know what your benefits are. It's also important to know how to get the most from the benefits you have.

Discover Your Health Needs

One of the most important things you can do is complete your health needs survey, sometimes called the HRA, when asked. This survey gives you and us a complete picture of your health care needs and other needs.

For example, do you need any of these:

- Health screening tests
- A doctor with a specialty, like a heart doctor
- Financial assistance
- Housing, food, or transportation

Find Help Where You Live

Call Member Services or go to the Community Support website to find free or reduced-cost services in your community. Get food, housing, legal aid, transportation, and more. Even get help with utility bills.

Need a Ride? Use Your Transportation Benefits.

Rides for Medical Care

Free rides for medical care are a benefit provided by the State. The service provider is ModivCare. Call ModivCare at **1-866-412-3778 (TTY: 1-866-288-3133)** to schedule your ride three days in advance or schedule online. This benefit is new for Delaware Healthy Children Program members as of July 1, 2025. This benefit cannot be used in an emergency. In an emergency, call **911**.

Rides for Nonmedical Reasons

Free rides for some nonmedical reasons are a benefit provided by Highmark Health Options. Call Member Services to talk about your transportation need and schedule a ride.

Schedule three days in advance for a ride to places that qualify, such as:

- Community events
- Food bank
- Grocery store
- Highmark Health Options event
- Local organization (e.g., library, Weight Watchers, YMCA)
- Pharmacy
- Social Security office
- State Service Center

Rides are also available if you are returning home after an inpatient stay. The service provider is American Logistics. Service is limited to Delaware within 50 miles of your home. Cars and wheelchair vans are available.

Take the GED Test for Free

Highmark Health Options covers the cost if you want to take the GED test. Passing the GED test is like having a high school diploma. Earning your GED can lead to more job choices and a chance to enter college.

You qualify for this benefit if you:

- Are age 18 or older.
- Are not enrolled in high school or a college program.
- Do not have a high school diploma.

Call a Member Advocate at **1-855-430-9852 (TTY: 711)** for more information about the voucher program that covers test costs.

Earn Healthy Rewards

Healthy Rewards is one of your Highmark Health Options benefits. You can earn rewards when you complete certain healthy activities.

After you've signed up, you'll get a Healthy Rewards card in the mail. You can use your card like a credit card at most retail stores.

Reward activities can include:

Reward Activity	Amount
Lead screening (up to age 24 months)	**$5**
Flu shot for babies (ages 6 months to 24 months)	**$5 per shot/2 shots total**
Annual well-child visit (ages 3–20)	**$10**
Annual wellness visit (age 21 and older)	**$10**
Doctor visit after giving birth (up to 84 days after delivery)	**$10**
Well-baby visits (through age 15 months)	**$10 per visit/up to 6 visits**
Well-baby visits (age 15 months to 30 months)	**$10 per visit/up to 2 visits**
Asthma controller medicine (age 18 and younger)	**$15 per fill/up to 6 fills**
A1c test for people with diabetes	**$15**
Retina exam for people with diabetes	**$15**
Doctor visit after leaving the hospital (within 7 days)	**$20**
Breast cancer screening	**$25**
Cervical cancer screening	**$25**
Colorectal cancer screening	**$25**

To sign up and see the rewards you can earn, visit **My.TheraPayRewards.com/HHO**, call **1-866-469-7973 (TTY: 711)**, Monday–Friday, 8 a.m.–8 p.m., or scan the QR code.

Tell Us If You Have Other Insurance

Call Member Services if you or any member of your family is covered by Highmark Health Options and another insurance plan. Your Delaware Health and Social Services caseworker 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. This means that insurance company must pay first. Highmark Health Options is always the last payer if you have other insurance coverage.

Note: It is important to show your health care providers all your insurance cards.

You also need to call us if:

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

Call Member Services and tell us if you have received medical care after an accident, work-related injury, or any other situation when a different insurer or lawyer is involved. If you have received care due to an accident or work-related injury, we will work with the other insurer to make sure your claims are paid correctly.

We will not share this information with anyone except your health care provider and others as the law allows.

Have an Advance Health Care Directive

It is your legal right to make an advance directive about your medical care. Make sure your wishes will be honored if you cannot speak for yourself.

When you're admitted to the hospital, you will be asked if you have an advance directive. An advance directive gives you the chance to state what kind of medical care you want before medical care is needed. An advance directive is followed only when you're not able to say what medical care you want.

There are two kinds of advance directives:

- A living will is a statement about the kind of care you want to help you stay alive if you are 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're unable to make your own.

Call Member Services for a form or use the online form. Talk to your doctor about your advance directive. Ask to have yours filed in your medical record. If your wishes have not been followed and you wish to file a complaint, contact the Division of Services for Aging and Adults with Physical Disabilities at **1-800-223-9074**.

Note: You must have two people witness you signing the form. It is suggested but not required that you have a notary public witness you sign the form.

Your PCP and Other Professionals

Your PCP Manages Your Care

Your primary care provider (PCP) provides routine care and manages other kinds of care and hospital stays. Your PCP is your family doctor. There is no charge for PCP visits. Your PCP is usually the first person you call when you need health care. Your PCP may ask you to come to the office for some emergency conditions, such as high fever or vomiting that does not stop.

Routine Care

Your PCP provides routine care, or primary care. This includes checkups to help you stay healthy and office visits when you're sick. It can also include prescription drug refills or changes.

After-Hours Care

You can call your PCP 24 hours a day, 7 days a week. Use the PCP phone number on the front of your ID card. After office hours, your call will go to an answering service. You can leave your name and phone number. Your PCP or an on-call doctor will call you back.

Call the 24-Hour Nurse Line at **1-844-325-6251 (TTY: 711)** if you have a medical concern and do not know what to do. The nurse can help you decide if you should schedule a visit with your PCP, seek urgent care, or go directly to the emergency department. (See more about routine care, urgent care, and emergency care.)

Specialist Care and Referrals

If you need care that your PCP does not provide, your PCP may schedule a visit with a specialist. This is called a referral. A specialist focuses on a specific health issue. For example, a heart doctor, skin doctor, or someone who does surgery.

Your PCP and the specialist will work together to care for you. If you have been seeing a specialist for an ongoing problem, you can ask your PCP to allow a standing referral to the specialist. A standing referral means you can schedule a visit with the specialist yourself, without help from your PCP. Another option is for your specialist to be your PCP.

Hospital Stays

Your PCP or specialist will arrange all your hospital stays. You will not be admitted to a hospital without your PCP's orders, except in an emergency. If a doctor other than your PCP admits you to a hospital, you or your authorized representative should call your PCP within 24 hours.

Second Opinions

When you're getting care for a medical condition, it can be a good idea to get a second opinion. This means an opinion from another doctor. Your PCP can refer you to another network doctor for a second opinion. Or call Member Services to find a doctor who can provide a second opinion. If a network doctor is not available, we will arrange for you to get a second opinion from an out-of-network doctor at no cost. The doctor giving the second opinion must not be in the same office or group as the doctor who provided the first opinion.

Prior Authorization

Your PCP or another doctor must call us to request services that require prior authorization. We will look at all the medical facts that your doctor gives us to decide if a requested service is the best way to take care of you.

Schedule a PCP Visit

Use the PCP phone number on the front of your ID card. Your PCP should schedule the visit within three weeks of your request. Call the PCP's office to let them know if you cannot keep your appointment.

Change Your PCP

Call Member Services if you want to change your PCP at anytime for any reason. A representative will make the change for you. At the beginning of the next month, you will get an updated ID card in the mail. It will include your new PCP's name and phone number.

Care Coordination

If you have complex health care needs, have a difficult time navigating the health care system, or have trouble finding community resources, the Care Coordination Department can help.

Care Coordination nurses, social workers, and service coordinators can talk to you over the phone or in person to help you get the medical, behavioral health, and substance use care you need. They will develop a care plan with you and work with your care team to help you achieve your care plan goals.

The Care Coordination team is always available to address any issues you may have. Call **1-844-325-6251 (TTY: 711)** toll-free and ask for the Care Coordination Department. Staff are available Monday–Friday, 8 a.m.–5 p.m., and after hours. You have the option to receive services from a Care Coordinator and can stop services at any time.

Your Care Coordinator can help you:

- Learn about your condition and medicines.
- Obtain medicines.
- Obtain durable medical equipment.
- Find programs in your community, such as food banks, utility assistance, or nutrition and weight loss programs.
- Understand your discharge plan when you move from the hospital to home.

When you leave the hospital and go home, it can be hard to remember all the things you need to do. Your Care Coordinator can help.

Your Care Coordinator will call you before you leave the hospital to:

- Answer any questions you may have about going home.
- Remind you to ask about your medicines.
- Remind you to make a doctor appointment.

Your Care Coordinator will call you when you are at home to:

- Review your discharge orders.
- Talk about your medicines.
- Remind you to make a doctor appointment.
- Help you make a list of questions for your doctor.
- Help you arrange a ride to the doctor if needed.

Your Care Coordinator will call you after you see your doctor to:

- Talk about the doctor's orders.
- Talk about your medicines.

In addition, you can always call your doctor if you have questions.

A Member Services Representative is the first person you talk to when you call Highmark Health Options. Representatives are there to answer your questions and listen to your concerns. If they cannot provide the help you need, they will connect you to someone who can.

A Member Advocate can help you, your provider, and your Care Coordinator obtain care, schedule appointments, and file a grievance or an appeal. Call **1-855-430-9852 (TTY: 711)** to talk to a Member Advocate.

Where to Get Care

Your benefits cover in-person and online care, and routine, urgent, and emergency care. Here are descriptions of the different types of care. It's important to go to network providers and know the best place to get care when you need it.

Choose In-Person or Online Care

To see a doctor in person, find a provider near you in the Provider Directory. You can also choose virtual visits (online care) for urgent and behavioral health care. Register on the HHO on the Go app or online at **HHOontheGo.com**. You can use HHO on the Go wherever you are, around-the-clock.

Get the HHO on the Go app on the Apple App Store or Google Play.

Note: The HHO on the Go doctor is not the same as your PCP. Some PCPs also offer online care. Call your PCP to ask.

Different Kinds of Care

If you have a medical problem but are not sure if it is an emergency, call your PCP or behavioral health specialist first. (A behavioral health specialist is someone who focuses on mental health and help for substance use.) Your PCP or on-call doctor is available 24 hours a day, 7 days a week. Use the PCP phone number on the front of your ID card.

Routine care is provided at your PCP's office. When you call, your PCP may ask you to come into the office. Or your PCP may say you need urgent care or emergency care. Go to the emergency department only in case of an emergency or if your doctor tells you to. See examples of routine care.

Urgent care facilities are for conditions that are not life threatening but need attention within 48 hours. If you cannot reach your PCP and need help after hours, you may want to go to an urgent care provider. Do not go to the emergency department for urgent care. See examples of conditions that require urgent care.

Emergency care is needed when you must be treated right away for a serious medical or behavioral health problem. This is so your condition does not get worse or cause you severe harm. If you have an emergency, call **911** for an ambulance or get to your closest hospital emergency department as soon as possible. See examples of conditions that require emergency care.

It's important to know that at the emergency department:

- You have the right to get the medical or behavioral health care you need. The hospital should give the right medical tests to find out if you have an emergency medical illness.
- You can ask to go to a different hospital if you want.
- You can say no to care.

Know Where to Get Care

This care chart will walk you through your options. Here's where to go based on symptoms, location, and hours of operation.

Online Doctor Visits

Get care online for at-home treatment of common symptoms:

- **Cold and flu**
- **Earaches**
- **Sinus infections**
- **Mental health:** Talk therapy and psychiatry

Access 24/7 with **HHOontheGo.com**

Doctor's Office

Get in-person care for routine checkups and chronic conditions:

- **Ear, throat, and urinary tract infections**
- **Stomach issues**
- **Diabetes**
- **Mental health:** Talk therapy and psychiatry

Monday–Friday, 9 a.m.–5 p.m.

Urgent Care

Get in-person care for urgent conditions that are **not** life-threatening:

- **Sprains and strains**
- **Asthma/breathing conditions**
- **Flu or cold with fever**
- **Moderate allergic reactions and rashes**

Mornings, evenings, and weekends

Emergency Room (ER)

Get in-person care for serious or life-threatening problems:

- **Difficulty breathing**
- **Uncontrolled bleeding**
- **Severe injury**
- **Mental health:** Severe depression and suicidal thoughts

Open 24/7

Ask a nurse about the kind of care you need. Call the 24-Hour Nurse Line at **1-844-325-6251 (TTY: 711** or **1-800-232-5460)**.

If you're having a medical emergency, call **911**.

If you're having a mental health emergency, call **988**.

After an Emergency

After an emergency department visit, you may need to go to your PCP or behavioral health specialist for follow-up care. Any medically necessary services are called post-stabilization services. They are covered and provided without prior authorization.

Do not go back to the emergency department to have a bandage changed, stitches removed, or a cast checked. Your PCP can arrange this kind of follow-up care or additional testing. If you have a new emergency, go to the emergency department.

Out-of-Network Care

There may be a time when you need to use a provider or hospital that is not part of the Highmark Health Options network. Here's what you need to know.

If you need care from an out-of-network provider, your PCP can call us to request out-of-network coverage. If we find a provider or hospital in the network, we will let your PCP know.

If network care is not available, Highmark Health Options will cover out-of-network care for as long as you cannot get network services.

If you're new to Highmark Health Options, you have the right to keep seeing an out-of-network provider to finish a series of treatment. The provider must agree to our rules.

Keep in mind that Highmark Health Options must approve any services you get from providers who are not in our network. If you do not get approval, the provider may be allowed to bill you for the costs of the services. If you ask to use a provider or hospital outside of our network and your request is denied, you can file an appeal. (Learn more about appeals.)

Care Outside Your Area

If you're out of the service area and have a medical emergency, such as a heart attack or car accident, go to the nearest emergency department. All health care providers in the U.S. are required to provide services to Medicaid members. You or your authorized representative must call your PCP as soon as possible.

No Coverage Outside the U.S.

If you're outside the U.S. and need medical care, Highmark Health Options will not cover any services you receive. Medicaid cannot pay for any health care services you get outside the U.S.

Medical and Behavioral Health Benefits

Here's the full list of covered medical and behavioral health services for adults and children. Age limits for services are noted. Some services may require prior authorization. Call Member Services if you're not sure if a service is covered.

Extra Benefits from Highmark Health Options	Details
Benefits for expecting and new moms	• MOM Options program for expecting moms who have regular exams before baby's birth. Rewards include choice of infant car seat, stroller, Pack 'n Play, or Baby Shower in a Box. • Essentials diaper bag packed with diapers and more for the new baby. The bag is also a changing pad. Provided by Care Coordination. • Free use of the Pacify app for video visits and calls, 24/7. No appointment needed. Experts answer in 5 minutes or less. Users can ask about breastfeeding, formula feeding, pumping, weaning, adding solid foods, crying and colic, and teething. Plus look up these topics on the app.
Diabetes Prevention Program	Age 18 and older: A one-year program from Highmark Health Options and the YMCA of Delaware for members who qualify. Can be done in person or online.
Digital bathroom scale	Age 20 and older: Covered for adults with specific heart conditions enrolled in the Disease Management program for chronic conditions.
Eyeglasses and contact lenses	Age 21 and older: Covers choice of select eyeglass frames or contact lenses. (See Standard Benefits for age 20 and younger.)
GED voucher program	Age 18 and older: Covers the cost of GED testing through a voucher program.
Healthy Rewards program	Provides the chance to earn rewards of $10–$25 for activities like wellness visits and screenings. Rewards are put on a Healthy Rewards card that can be used like a credit card. And rewards add up. Sign up online.

Healthy Transitions food delivery	Provides free meal delivery to the home for qualified members who have had a recent hospital stay.
Hearing aids	Age 21 and older: Covers one hearing aid per ear every two years, and batteries for one year. (See Standard Benefits, below, for age 20 and younger.)
LEAN Program	Age 18 and older: A 12-week program from Highmark Health Options and the YMCA of Delaware to help members eat healthier, move more, and lose weight.
SafeLink Smartphone Program	Provides a free smartphone to members who qualify. Includes free minutes to call Highmark Health Options.
Transportation services (provided by American Logistics)	Free rides are available for some nonmedical reasons. Call Member Services to schedule three days in advance for a ride to a place that qualifies. (Free rides to health care visits are provided by Modivcare. See Standard Benefits, nonemergency transportation.)

Standard Medicaid Benefits	Details
Allergy testing	Covered
Ambulance services	Covered
Ambulatory surgical centers	Covered
Behavioral health (mental health) and substance use treatment, outpatient care	• Age 18 and older: Covered • Age 17 and younger: Covered for 30 outpatient hours per year. Additional outpatient hours are covered through the Department of Services for Children, Youth, & Their Families (DSCYF). Note: For those participating in PROMISE, services are covered through the State.
Behavioral health (mental health) and substance use treatment, inpatient care	• Age 18 and older: Covered • Age 17 and younger: Covered through the Department of Services for Children, Youth, & Their Families (DSCYF).
Blood and plasma products	Covered
Bone density screening	Covered

Cancer screening	Covers screenings for: • Breast cancer (mammogram) • Cervical cancer (Pap test) • Colorectal cancer (colonoscopy) • Prostate cancer
Care coordination services and care management	Covered
Chemotherapy and radiation	Covered
Chiropractic care	Covers diagnostic imaging and manipulation of the spine to reduce neck, back, pelvis, and sacrum pain. Also covers services to reduce pain and help healing, such as acupuncture and massage.
Dental care	• Age 21 and older: Covers preventive and corrective dental care with $1,000 limit, excluding removal of bony impacted wisdom teeth. Additional $1,500 may be approved for emergency care. $3 copay. • Age 20 and younger: Covers preventive and corrective dental care with no yearly limit, excluding removal of bony impacted wisdom teeth. Includes braces and retainers. $0 copay. Note: Removal of bony impacted wisdom teeth is covered under the Highmark Health Options medical benefit.
Diabetes care	Covers education, equipment, and supplies, including blood glucose monitors and strips.
Dialysis	Covered
Doula care	Covers all aspects of pregnancy, including prenatal care, childbirth, postpartum care, and pregnancy losses like miscarriage and stillbirth.
Durable medical equipment and supplies	Covers equipment and supplies ordered by a doctor, including bed liners and diapers for those age 4 and older.
Emergency department care	Covered
Eye exam, routine visit	Covers one routine exam each year.
Eye exam, sick visit	Covers sick visits for conditions such as diabetic retinopathy, glaucoma, and infections.
Eyeglasses and contact lenses	Age 20 and younger: One pair of eyeglasses or contact lenses per year, limitations apply. (See Extra Benefits for age 21 and older.)

Family planning services	• Covers network or out-of-network services for DSHP members. • Covers services from network providers for DHCP members. Does not cover services from out-of-network providers for DHCP members.
Federally qualified health centers	Covered
Genetic testing	Covered
Glaucoma screening	Covered
Gynecology visit	Covers pelvic exam and Pap test.
Hearing aids and batteries	Age 20 and younger: Covered (See Extra Benefits, above, for age 21 and older.)
Hearing exams	Covered
HIV/AIDS testing	Covered
Home health care	Covered
Hospice care	Covers hospice care in a facility or at home.
Hospital care	Covers inpatient care, including inpatient rehabilitation, and outpatient care. Note: As described in the behavioral health inpatient entry above, services for those age 17 and younger are covered through the Department of Services for Children, Youth, & Their Families (DSCYF).
Imaging services	Covers diagnostic imaging services: X-rays; CT, PET, MRI, and SPECT scans; and nuclear studies.
Infusion therapy	Covers inpatient and outpatient services.
Long-term services and supports	Covered only for DSHP Plus LTSS members.
Maternity care	Covers care before, during, and following birth. Also covers childbirth and parenting education.
Nonemergency transportation	Covered by the State for transportation to health care visits via ModivCare.
Nursing home care	Covered up to 30 days per year; additional days are considered long-term care. Apply to the Delaware Medical Assistance Program for long-term care.
Observation	Covered

Online doctor visits	Covers online doctor visits at HHO on the Go website or app. Available 24/7. • All ages: Urgent care. • Age 18 and older: Therapy and psychiatry.
Opioid addiction treatment	Covers medication-assisted therapy.
Organ transplant	Covers transplant and evaluation before transplant.
Orthopedic shoes	Covered*
Outpatient surgery	Covers same-day and ambulatory surgery.
Pain management	Covered
Personal care	Covers services provided by aides in the home.
Physical, speech, and occupational therapy	Covers outpatient services.
Podiatry care	Covers routine podiatry care for people with diabetes or blood flow problems in the legs.
Prescription drugs	Covers medicine prescribed by a doctor. New: A 90-day supply is available for some medicines for chronic conditions.
Primary care physician visits	Covers doctor office visits, checkups, and sick visits.
Private-duty nursing	Covered with prior authorization.
Prosthetics and orthotics	Covered*
Respite care (pediatric)	Age 20 and younger: Covers short-term services so a child's regular unpaid caregiver can take time away. The covered benefit is for a total of 285 hours or 15 days per year. Respite care can either be at home or outside the home (for example, at a center). Emergency respite is a maximum of six 72-hour episodes per year. Note: This benefit is no longer provided by the Department of Education.
School-based wellness centers	Covered
Second opinion	Covers advice from a second doctor to compare with the advice of another doctor.
Self-directed attendant care (S-DAC)	Age 20 and younger: Covered for children who receive personal care services. Includes help with activities of daily living, as directed by a parent or other caregiver.

Skilled nursing facility	Covers nursing home care up to 30 days per year.
Sleep apnea study	Covered
Specialist visits	Covers care from a doctor who has special training for a specific condition or illness.
Stop smoking or vaping help	Covered by Quitline. Available in person and online.
Surgery	Covers inpatient and outpatient surgery.
Urgent care/Walk-in care	Covers care or medical treatment needed within 48 hours. Not an emergency.
Well-baby and well-child visits, vaccinations	Covers care for children with Medicaid coverage through the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT).
Wheelchair rental	Requires prior authorization.

*Requires prior authorization if cost is more than $500.

Benefits That Are Not Covered	
Abortion	Covered only in cases of incest, rape, or threat to the mother's life.
Acupuncture	Unless provided by a chiropractor.
Care from Christian Science providers and sanitariums	
Cosmetic services	
DESI drugs*	
Infertility treatments	
Sterilization for those age 20 and younger	

*Drug Efficacy Study Implementation (DESI): A Food and Drug Administration (FDA) program that requires that all drugs be effective as well as safe. Drugs coded as DESI are not covered by the Medicaid program.

Mental Health and Drug and Alcohol Services

Behavioral health means your mental and emotional well-being as well as any problems with substance use. Per government rules, you have unlimited treatment when it is medically necessary for drug and alcohol dependencies.

This includes:

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

Call Member Services if you have questions about this coverage.

EPSDT Benefits for Children (age 20 and younger)

The federal government requires Highmark Health Options to offer a preventive health program to people age 20 and younger who get Medicaid. It's called the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT). Its purpose is to catch health problems early so children can stay healthy. Highmark Health Options provides the EPSDT program free of charge.

EPSDT wellness visits are also called well-baby and well-child visits. It is important to go to all visits. They provide a range of wellness care. They also give parents or guardians the chance to learn more about diet, safety, ways to meet the child's needs, and the child's mental well-being. And the visits can sometimes be used as the exam a child needs to get into Head Start or school, or to get a driver's license.

At wellness visits, the child's PCP provides screenings and immunizations. The Centers for Disease Control recommends this child and adolescent immunization schedule. The PCP also asks questions, perform tests, and checks how much the child has grown.

Depending on the child's age and needs, the PCP may provide these services:

- Complete physical exam
- Immunizations (vaccinations)
- Autism screening
- Blood lead level screening test
- Developmental screening
- Depression screening (starting at age 12)
- Hearing test
- Vision test
- Nutrition evaluation
- Oral health exam (mouth)

During the oral health exam, the PCP will decide if the child is due for a dental appointment. The PCP will refer the child for a dental screening when the first tooth shows, or no later than 12 months of age.

If the PCP finds the child has a medical condition that requires treatment or equipment, the PCP will call Highmark Health Options to ask for the service or equipment.

Maternity and Newborn Benefits

Maternity care is covered under your medical benefits. We're here for you before and after your baby is born.

Maternity Care

It's very important to see your doctor regularly before and after your baby is born.

Maternity care includes:

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

As soon as you find out you're pregnant:

- See your PCP within 14 days.
- Call Highmark Health Options. We will send you information about the MOM Options program (see below).
- Talk to a Care Coordinator if you have questions about your benefits and pregnancy. Also ask about ways to get help in your community.

Note: If you joined Highmark Health Options during the last three months of your pregnancy, you may be allowed to stay with your current doctor, even if that doctor is not in our network.

MOM Options

To be eligible for this program, visit your doctor by week 14 of your pregnancy and go to a series of visits before the baby is born. These are called prenatal visits. Visits happen every month and then more often closer to your due date.

When we learn you're pregnant, we will send you a MOM Options brochure. Take the brochure to every prenatal visit to get your doctor's signature. When you have your doctor's signature for all your visits, return the brochure to us.

We will send you the item you choose:

- Infant/toddler car seat
- Baby stroller
- Pack 'n Play (playpen)
- Baby Shower in a Box

We also will ask if you want a Care Coordinator. This is a nurse or social worker to talk to when you have questions and help you arrange prenatal visits. Call Member Services for more information.

Delaware WIC

The Special Supplemental Nutrition program for Women, Infants, and Children, known as WIC, is a free program for:

- Pregnant women
- New mothers
- Breast-feeding mothers
- Children age 5 and younger who are not getting the nutrition they need

The program provides:

- Food coupons
- Information and counseling about nutrition
- Referrals to health and social services

Food coupons can be used to buy nutritious foods, such as fresh fruits and vegetables, whole wheat bread or rolls, brown rice, oats, whole wheat or soft corn tortillas, soymilk, tofu, jarred baby foods, canned beans, pink salmon, and sardines. Many grocery stores take food coupons. Sign up online or call **1-800-222-2189**.

Benefits for Newborns

Make sure your baby has health care coverage and the PCP you want.

As soon as you can after your baby is born (and within 30 calendar days):

- Call the Delaware Division of Social Services Change Report Center at **302-571-4900** to make sure your baby is added for health benefits.
- Call Member Services to tell us which 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.

Help for Opioid Use When You're Pregnant or Breastfeeding

You could harm yourself and your baby by using opioids during and after pregnancy. Opioids can be prescription medicine for pain, such as codeine or oxycodone, and street drugs, such as heroin. Drugs you use during pregnancy will be passed along to your baby. There is a chance this will cause health problems. You may lose the baby or have the baby too early. The baby may be born with serious side effects from the drug. These include painful opioid withdrawal and birth defects.

If you use drugs when you are breastfeeding, the drug will be passed along to your baby. Your baby may have side effects that can be serious, like trouble breathing or stopping breathing.

It can be dangerous to suddenly stop using opioids. Talk to your doctor about treatment options. A combination of therapy and medicines can help you quit using opioids. This is called medication-assisted treatment.

To learn about safe treatment when you're trying to quit opioids:

- Call **1-800-652-2929** in New Castle County.
- Call **1-800-345-6785** in Kent and Sussex Counties.

Family Planning Benefits

Family planning is a covered benefit. People age 21 and older who are covered by DSHP can see any licensed family planning provider. People age 20 and younger who are covered by DHCP must use a network provider.

Family planning can help you learn 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.

Licensed family planning providers can be:

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

If you see a family planning provider who is not your PCP, let your PCP know so the providers can work together. You do not need to get prior authorization from Highmark Health Options or a referral from your PCP to get family planning care.

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

Dental, Hearing, and Vision Benefits

In addition to medical benefits, adults and children have dental, hearing, and vision benefits covered by Delaware Medicaid and Highmark Health Options.

Dental Benefits for Adults (age 21 and older)

Smile! Dental care can make your mouth happy. Take advantage of dental benefits to help you fix dental problems now and prevent new ones in the future.

You have $1,000 coverage each year for dental care. Additional coverage may be available if urgent dental care is requested by your dentist and approved by Highmark Health Options. Your copay is $3, and you don't need a referral to see a dentist.

Dental benefits for adults include:

- Dental exam
- X-rays
- Routine cleaning
- Fluoride treatment
- Fillings
- Extractions
- Denture repairs and relines
- Periodontics (may require prior approval)

Dental benefits for adults do not include:

- Dentures
- Removal of bony and impacted wisdom teeth covered by your medical benefit

Dental Benefits for Children

Coverage for children does not have yearly limits for dental care. Your copay is $0, and you don't need a referral to see a dentist.

Dental benefits for children include:

- Dental exam
- X-rays
- Routine cleaning
- Fluoride treatment
- Braces and retainers (orthodontics)
- Fillings
- Extractions
- Root canals
- Periodontics (may require prior approval)
- Sedation and anesthesia (may require prior approval)

For children ages 14–20 with a prior approval:

- Crowns
- Dentures, including repairs and relines

Dental benefits for children do not include:

- Removal of bony and impacted wisdom teeth covered by your medical benefit

Call Member Services or search the Provider Directory to find a dentist.

Hearing Benefits for Adults (age 21 and older)

Highmark Health Options now offers this extra benefit, which is not a standard Medicaid benefit:

- Routine annual hearing exam with no copay.
- Selection from six brands of hearing aids.
- One hearing aid for each ear every 2 calendar years.
- Ear molds and fitting.
- 60-day trial period.
- One-year supply of batteries.
- Three-year manufacturer's warranty for repairs and maintenance.

Call **1-877-759-3272 (TTY: 711)** to talk with a hearing consultant and schedule a visit.

Hearing Benefits for Children

Hearing aids are a standard covered benefit for children age 20 and younger.

Vision Benefits for Adults (age 21 and older)

Adults are covered for one routine eye exam per year with no copay. Coverage also includes sick visits for conditions like diabetic retinopathy, glaucoma, and infections.

Highmark Health Options now offers adults these extra benefits, which are not standard Medicaid benefits:

- Contact lenses or clear plastic prescription lenses and frames.
- Contact lenses include disposable and extended wear.
- Limited selection of stylish frames to choose from.

Call Member Services or search the Provider Directory to find an eye doctor.

Note: Be sure to show your ID card to your eye care provider.

Vision Benefits for Children

Children are covered for one routine eye exam per year with no copay. Coverage also includes sick visits for conditions such as diabetic retinopathy, glaucoma, and infections. Glasses or contact lenses are a standard benefit, covered up to a $120 limit.

If your child's glasses are broken and need repair or replacement, take the glasses to the store where you bought them. The store will repair or replace your child's glasses.

Note: Be sure to show your child's ID card to the eye care provider.

Chiropractic Benefits

Chiropractic benefits cover diagnostic imaging and manipulation of the spine to reduce some kinds of pain. This includes neck, back, pelvis, and sacrum pain. Coverage includes services to reduce pain and help healing, such as acupuncture and massage.

Covered Services

Services are provided to members who have a significant nerve or muscle condition that requires treatment. Services are covered only when provided by a chiropractor licensed by the State and legally authorized by the State to perform manual manipulation of the spine. Chiropractic care may require prior authorization and medical review.

Coverage includes:

- Manipulation for neck, back, pelvis, or sacrum pain or dysfunction.
- One manipulation per day. Maximum is 20 manipulations per calendar year. Additional manipulations may be allowed if medically necessary.
- One diagnostic exam each year to determine progress. More than one may be allowed if medically necessary.
- X-rays may be used to diagnose spinal subluxation, or partial dislocation. Coverage of spinal X-rays is limited to one set per member in a rolling 12-month period.
- Additional X-rays may be taken within the same calendar year to document a new condition or a problem with an existing condition.
- X-rays used to determine progress are limited to one study per calendar year.
- Progress X-rays, beyond the first in a calendar year, may be preauthorized.

Timing of Your Health Care Visit

Schedule a Health Care Visit

Highmark Health Options asks PCPs and specialists to follow rules about scheduling visits. The rules say how much time should pass between the date of your visit request and the date of the scheduled visit. The rules differ based on the reason for your visit and the health care provider you need to see.

First Health Care Visit for Children	
Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) for members age 20 and younger: Regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.	New members must be seen by a PCP no more than 45 calendar days after becoming a member, unless being treated by a PCP or specialist and up-to-date with screenings and immunizations. If treated by a PCP or specialist: • Must be seen within 2 weeks of asking. • Exams that are not periodic must be promptly provided when needed. Treatment for a condition found as a result of an EPSDT screening must be provided within 90 day of the screening.

Health Care Visits with PCPs and OB/GYNs (obstetrics and gynecology)	
Emergency care	Appointments for conditions that meet the definition of an "emergency condition" are available the same day. See examples of conditions requiring emergency care.
Urgent care	Appointments for urgent care are available within 2 calendar days. See examples of conditions requiring urgent care.
Routine care (physical exams)	Must be scheduled within 3 weeks of asking. See examples of routine care.
Wellness care (whole-body, wellness exam, well-child exam, well-woman exam)	Must be scheduled within 3 weeks of asking.
Maternity care	Prenatal care appointments must be scheduled for each trimester (three-month period): • First trimester, within 21 days of asking. • Second trimester, within 7 calendar days of asking. • Third trimester, within 3 calendar days of asking. For women with high-risk pregnancies, appointments must be scheduled: • Immediately if an emergency exists. • Within 3 calendar days after high risk is determined.

Health Care Visits with Specialists	
Emergency care	Emergency care is available 24 hours a day, 7 days a week.
Urgent care	Urgent care appointments must be scheduled within 48 hours of asking.
Routine care (physical exams)	Routine care appointments must be scheduled within 3 weeks of asking for any specialist.

Health Care Visits for Behavioral Health (Mental Health and Substance Use Disorder)	
Care for an emergency that is not life-threatening	Must be scheduled within 6 hours of asking. Examples may include: • Involuntary muscle spasms caused by drug • Manic mood caused by drug, without functional impairment • Significant, severe, distressing thoughts
Care for an immediate life-threatening emergency	Must be scheduled within 1 hour. Examples may include: • Potential suicide • Emergency requiring mobile response team
Urgent care	Must be scheduled within 24 hours. Examples include: • Acute major depression • Acute panic disorder
Routine care for an initial visit	Must be scheduled within 7 days of asking. Examples include: • Initial assessments • Discharge from an inpatient setting into community placement • Care after a visit to the emergency department or a behavioral health crisis provider for a behavioral health condition
Routine care that is a follow-up or not an emergency	Must be scheduled within 3 weeks of asking. Examples include: • General anxiety disorder • Marital problems • Tension at work

Prescription Drug Benefits

Your benefits cover many prescription drugs. Here's what you need to know about your prescription drug benefit. Use a network pharmacy to get your prescription drugs. Find pharmacies in the Provider Directory on our website.

Covered Prescription Drugs

Highmark Health Options uses a list of prescription drugs approved by Delaware Health and Social Services for people with Medicaid. This is called the preferred drug list. Highmark Health Options covers additional medicines on the supplemental drug list. The drugs on these two lists make up the drug formulary. Find the generic and brand names of all covered prescription drugs on our website at **HighmarkHealthOptions.com**.

Types of Drugs That Are Covered

Your prescription drug benefit covers these types of items:

- Aero chambers for inhalers
- Multivitamins and prenatal vitamins
- Prescriptions for behavioral health conditions
- Stop-smoking medicines, including the nicotine patch, gum, lozenges, nasal spray, and bupropion (Zyban®)
- Vaccinations given at pharmacies for flu, pneumonia, shingles, and chicken pox
- Shots that you give yourself, such as insulin (Shots that must be given by your doctor are covered under your medical benefit.)
- Diabetes supplies, including:
    - Blood glucose (sugar) monitors
    - Blood glucose (sugar) test strips
    - Lancets and lancing devices
    - Urine glucose (sugar) testing strips
    - Continuous blood glucose monitors (covered with prior authorization)

Types of Drugs That Are Not Covered

Your Highmark Health Options prescription drug benefit does not cover all types of drugs, including prescription drugs for certain uses and over-the-counter drugs.

Your prescription drug benefit does not cover drugs that:

- Are not medically necessary.
- Duplicate a therapy that you're already taking.
- Are ordered by a physician who has been barred or suspended from participating in the Delaware Medicaid program.
- Are marketed by a drug company that does not participate in the Federal Medicaid Drug Rebate program.
- Are experimental or investigational.
- Are DESI drugs (Drug Efficacy Study Implementation is a Food and Drug Administration program that requires that all drugs be effective as well as safe. DESI drugs are not covered by the Medicaid program.)

Your prescription benefit does not cover drugs used for:

- Cosmetic purposes (for example, for wrinkles or hair growth)
- Erectile dysfunction
- Fertility treatments
- Weight loss or gain

Your prescription drug benefit does not cover over-the-counter (OTC) drugs, except those listed on the supplemental drug list:

- Herbal or homeopathic drugs
- Nutritional supplements
- OTC drugs and supplies when you live in a long-term care facility

Prescription Drug Benefits Can Change

Highmark Health Options may make changes to the drug formulary. These changes must be approved by the Delaware Division of Medicaid & Medical Assistance and may affect which drugs are covered.

If you're taking a drug that will no longer be covered, Highmark Health Options will notify you 30 calendar days prior to the change.

Questions or Requests? Call Us. Call Member Services if you would like a list of covered prescription drugs or have questions about drug coverage. You can also let us know if you feel a new drug should be covered.

Prescription Drug Copays

Highmark Health Options charges copays for prescription drugs you fill at the pharmacy. Your copay is the money you need to pay at the time of service. Your copay is based on the cost of each prescription.

Prescription Cost	Your Copay
$10 or less	50 cents
$10.01–$25	$1
$25.01–$50	$2
$50.01 and above	$3

The most you will pay for prescription copays every 30 days is $15. Once you meet the $15 copay maximum for the 30 days, you will pay zero copays for drugs filled for the rest of the month. This copay maximum will start over every 30 days.

There are no copays for prescriptions for:

- Birth control
- Buprenorphine, buprenorphine/naloxone, and vivitrol for opioid use disorder
- Naloxone (Narcan®) for opioid overdose
- Stop-smoking medicines

There are no copays for:

- Children age 20 and younger
- People in the Chronic Renal Disease program
- People in hospice care
- Some people in a long-term care facility
- Pregnant women (including up to 90 calendar days after the end of the pregnancy)

Safe and Effective Prescription Drug Use

Highmark Health Options has rules about some prescription drugs. The rules include coverage limits. These rules and limits ensure you use prescription drugs in a safe and effective way. And they help promote quality care and control drug costs.

These rules apply to some prescription drugs:

- Generic prescription drugs are often available instead of brand-name drugs. If your PCP orders a brand-name drug, our network pharmacies will always give you the generic version. If your PCP wants you to have the brand-name drug, your PCP must request coverage through Pharmacy Services. If the request is approved, Highmark Health Options will cover the drug.

- Prior authorization (prior approval) is needed for some drugs. Your PCP must supply information to show the drug will work well for your medical condition and will be safe. If prior authorization is not given, Highmark Health Options will not cover the drug.
- A quantity limit is the largest amount of a prescription drug Highmark Health Options will cover during a certain period. The Food and Drug Administration has approved these amounts to be safe and useful.
- Step therapy means you must try one drug before you can use a step therapy drug. For example, if Drug A and Drug B both treat your medical condition, your doctor may be required to order Drug A first. If Drug A does not work for you, your doctor can order Drug B, the step therapy drug. Then Highmark Health Options will cover Drug B, the step therapy drug.

See the drug formulary on our website to see if any rules or limits apply to your prescription drugs. Or call Member Services.

Guide to Getting Prescription Drugs

Fill Your Prescription

Highmark Health Options has many network pharmacies. Always use a network pharmacy to get your prescription drugs.

You can find a list of network pharmacies online:

1. Go to **HighmarkHealthOptions.com**.
2. Click on Find Care in Your Area.
3. You have reached the Provider Directory.
4. Choose Places by type.

Or call Member Services to help you find a network pharmacy near you.

Refill Your Prescription

You can call or visit any network pharmacy to request a refill. Your prescription can be refilled if:

- Your PCP ordered a refill.
- The refill is permitted by law.
- You have used 83% of your last fill.

Do not wait until you're out of your drug to get a refill. Order a refill when you have about 20% of your medicine left.

Request a 90-Day Supply

Do you take a prescription drug for a long-term condition?

You may be able to get a 90-day supply instead of a 30-day supply. This means you only need to refill your prescription four times a year. See the following page for a list of some drugs that are covered for a 90-day supply. For the most current list of drugs covered for a 90-day supply, visit our website.

The medicines covered by this benefit treat ongoing conditions like asthma, depression, high cholesterol, high blood pressure, and more. Covered medicines are listed below. The list includes brand and generic names. Look on your prescription bottle for either the generic or brand name.

See below for a list of some drugs that are covered for a 90-day supply. For the most current list of drugs covered for a 90-day supply, visit our website.

If you take one of these medicines, ask your doctor if a 90-day prescription is right for you. If so, your doctor can write the prescription for 90 days. And you can pick up your medicine at your local pharmacy.

Drugs Covered for a 90-Day Supply
Advair Diskus
Advair HFA Inhaler
Alendronate Sodium Tablet
Amlodipine Besylate Tablet
Asmanex Twisthaler
Atenolol Tablet
Atoravastatin Tablet
Benazepril Tablet
Bisoprolol Hydrochlorothiazide Tablet
Budesonide Inhalation Solution
Carvedilol Tablet
Citalopram Hydrobromide Tablet
Clonidine Hydrochloride Tablet
Dulera Inhaler
Enalapril Tablet
Escitalopram Tablet
Flovent Inhaler
Fluoxetine Capsules
Furosemide Tablet
Glimepiride Tablet
Glipizide ER Tablet
Glipizide Tablet
Hydralazine Tablet
Hydrochlorothiazide Tablet
Lisinopril Tablet
Lisinopril Hydrochlorothiazide Tablet
Losartan Potassium Tablet
Losartan Hydrochlorthiazide Tablet
Metformin Hydrochloride ER Tablet
Metformin Hydrochloride Tablet
Metoprolol Succinate Tablet
Metoprolol Tartrate Tablet
Montelukast Sodium Tablet
Paroxetine Hydrochloride Tablet
Pravastatin Sodium Tablet
Prazosin Capsule
Propranolol IR Tablet
Pulmicort Flexhaler
Quinapril Hydrochloride Tablet
Ramipril Tablet
Rosuvastatin Tablet
Sertraline Hydrochloride Tablet
Simvastatin Tablet
Symbicort Inhaler
Trazodone Tablet

Replace Stolen, Lost, or Damaged Drugs

When prescription drugs are stolen, lost, or damaged, replacement is allowed once per year.

Here's what to do:

- When prescription drugs are stolen, you must make a police report for all stolen drugs. Then call Member Services.
- When prescription drugs are lost or damaged, call Member Services.

In Case of Emergency

Here's what to do in emergency situations, such as using an out-of-network or out-of-state pharmacy.

Or getting an emergency supply of a drug when you need it.

- You may use a pharmacy that is not in our network only if you have an emergency. If this happens, ask the pharmacist to call Highmark Health Options at **1-844-325-6251 (TTY: 711)** so your drug will be covered.
- If you're out of state and have an emergency and need a prescription, call Member Services to make sure your drug is covered.
- You can ask for an emergency three-day supply of a drug if not getting the drug will cause loss of life, limb, or organ function. Highmark Health Options must approve this request. To request additional doses beyond the three-day emergency supply, your doctor should fax an exception request to Highmark Health Options. We will let your doctor know if we approve the request. If we do not approve the request, we will send you a letter that tells you why and how to appeal. (Learn more about appeals.)

Note: You can ask for a three-day emergency supply once every 60 days for a specific drug.

Exception Requests

To use a prescription drug that is not on the drug formulary, you or your doctor can request an exception. This means asking Highmark Health Options to cover the drug that is not on the formulary. If your request is approved, your drug will be covered. We will notify you and your PCP in writing if your exception request is approved or denied. If the request is denied, the written notice will tell you how to file an appeal. (Learn more about appeals.)

Pharmacy and PCP Lock-In Program

You may have a medical problem that requires your PCP and pharmacy to work together. If you need this coordinated care, you will be assigned to one PCP or one pharmacy to fill your prescriptions. This is called the lock-in program.

If you're locked into using a specific PCP or pharmacy, you must use only that PCP or pharmacy. Highmark Health Options will not cover the costs of your prescription drug if you use a different PCP or pharmacy. If the lock-in pharmacy does not have your drug, call Member Services to find out how to get the drug from a different pharmacy. Highmark Health Options must verify that your lock-in pharmacy does not have enough of the drug before you can get it from a different pharmacy.

Highmark Health Options will send you a letter if we believe you will benefit from the lock-in program. We will choose the PCP or pharmacy you visit the most or is 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. (Learn more about appeals.)

Wellness Programs

Highmark Health Options provides these programs in addition to your standard Medicaid benefits.

If you enroll in a wellness program, you can stop anytime. To learn if you are eligible and how to enroll, call Care Management at **1-844-325-6251 (TTY: 711)**. Or call the YMCA of Delaware Healthy Living Department at **302-572-9622**.

Diabetes Prevention Program

If you do not have Type 2 diabetes and want to prevent it, this program may be right for you. From Highmark Health Options and the YMCA of Delaware, this free program is open to members age 18 and older who qualify. The program lasts for one year and can be done in person or online.

A trained Lifestyle Coach will lead small group sessions to help you:

- Learn how to eat healthier.
- Increase physical activity.
- Lose weight.
- Overcome stress.
- Stay motivated.

LEAN Program

This 12-week program from Highmark Health Options and the YMCA of Delaware can help you eat healthier, move more, and lose weight. This free program is open to members age 18 and older.

The program will help you understand and manage your weight:

- Learn simple ways to take care of your health that will help you live longer.
- Make better choices about diet and activity.
- Identify the tools you need to give you the best health and nutrition options.
- Learn how making smart choices may prevent you from having other health problems, like high blood pressure or diabetes.

Programs for Long-Term Conditions

If you're managing a long-term condition, one of these programs may help.

These programs are voluntary, and you always have the option to stop at any time. Call Care Management at **1-844-325-6251 (TTY: 711)** to learn more.

Asthma (age 2 and older)

If asthma symptoms interfere with your life, a Care Coordinator can help you manage your asthma. This can help make it possible for you to do the things you want to do.

Chronic Obstructive Pulmonary Disease (COPD) (age 21 and older)

Living with COPD can be hard. A Care Coordinator can teach you how to handle your symptoms so you can be more active and enjoy life.

Diabetes (any age)

A Care Coordinator can help you learn how to manage your diabetes. The focus is on managing blood sugar levels and stopping problems linked to diabetes, like heart disease, blindness, amputations, and kidney problems.

Heart Disease or Heart Failure (age 21 and older)

A Care Coordinator is available to help you and your PCP manage your condition. Living a heart-healthy life can cut your chances of flare-ups and hospital stays.

Stop Smoking or Vaping. Smoking and vaping can make chronic conditions worse. Stop smoking or vaping and stay away from second-hand smoke. Call the Delaware Quitline at **1-866-409-1858**.

What Do You Need to Do? Here's How.

Here's a summary of who to call when you have specific questions. If you don't find the answer you need here, call Member Services.

Add or Stop Coverage for a Member

If you have a new baby or need to add a new member to your family, call both Member Services and the Delaware Division of Social Services (DSS) Change Report Center. Contact DSS at **302-571-4900**, Monday–Friday, 8 a.m.–4:30 p.m. Or send a fax to **302-571-4901**. Remember to include your case number on all of your documents. (If you do not call both, your new family member's insurance may be delayed.) Call both if you need to stop coverage for a Highmark Health Options member who has moved out of your home.

Report the Death of a Member

Call both Member Services and the DSS Change Report Center (**302-571-4900**).

Move Outside Delaware or the U.S.

Call the DSS Change Report Center at **302-571-4900**.

Change Your Address

Call the DSS Change Report Center at **302-571-4900**.

Change Your PCP for Any Reason

Call Member Services if you want to change your PCP for any reason. A representative will make the change for you. At the beginning of the next month, you will get an updated ID card in the mail. It will include your new PCP's name and phone number.

Find a complete listing of network PCPs in the Provider Directory on our website. Or ask Member Services to mail a directory to you. Each listing includes the physician's name, address, phone numbers, specialty, and board certification status. A PCP's education, residency, and qualifications can be provided upon request when you call Member Services.

Change Your Health Plan

Call the Health Benefits Manager at 1-800-996-9969. You can change your health plan during:

- The 90 calendar days after you're first enrolled in Medicaid.
- The Annual Open Enrollment period, from Oct. 1 to Oct. 31.

Change Your Care Coordinator

Call a Member Advocate at **1-855-430-9852 (TTY: 711)**. You can ask for a new Care Coordinator if you're unhappy with the person working with you. We will assign a new Care Coordinator who fits your needs the best. If we cannot give you a new Care Coordinator, we will tell you why, and we will address any problems or concerns you have. We may need to change your Care Coordinator if your Care Coordinator no longer works with us. If this happens, your new Care Coordinator will contact you.

Get a Ride

To get a ride to a health care visit, call ModivCare at **1-866-412-3778 (TTY: 1-866-288-3133)**. Book three days in advance. Give your Highmark Health Options ID number and say where you're going when you call. Because you must plan your ride in advance, you cannot use ModivCare during an emergency. Call **911** during an emergency.

You can also use our new free transportation service for rides to places other than a health care visit. This can include the pharmacy, grocery store, community events, health and wellness activities, and more. To schedule a ride, call Member Services.

Report a Problem with a Caregiver

When you're in the care of a caregiver, let us know if something is wrong. You have the right to report certain actions. The actions listed below are called critical incidents.

Call Member Services to report a caregiver who has:

- Not met basic needs, like food, medicine, and supervision.
- Injured you or caused emotional distress.
- Forced or tricked you into sexual activity.
- Taken money or medicine.
- Used a credit card without permission.
- Caused a severe injury, like a broken bone, deep cut, or serious burn.
- Been unprofessional. This includes yelling or refusing to do their job.

Transfer Your Medical Records to Your New PCP

When you switch to a new PCP, it's very important that you call Member Services to ask for your medical records to be sent to your new PCP. Records are transferred within 10 calendar days of your request. You can also request a copy of your medical records for your own use.

Request Medical Records for Your Own Use

Call Member Services to request a copy of your medical record free of charge.

You have a right to:

- Ask for your medical information.
- Change your medical information if you can show that it is wrong or that information is missing. If we disagree, we may not be able to honor the request to change your records, but we will 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.
- Get a list of who received your medical information within a six-year period. You must tell us the dates for the records you're requesting.

Records may not include information that was given to you or your personal representative, or information given for health care payments for our operations or for law enforcement needs.

Report a Concern About Your Care

Call a Member Advocate at **1-855-430-9852 (TTY: 711)** or Member Services if you have a concern about your care. It may be a Quality of Care concern. Examples include concerns about your safety or access to services.

Request Other Information

Call Member Services if you would like any information about Highmark Health Options or your provider, such as:

- The education your doctor has completed.
- Who sits on the Board of Directors.
- Plans to improve care and services through our Quality Improvement program.

Tell Us If You Get a Bill

Call Member Services with the billing information. Delaware Medicaid providers cannot charge you for services that Highmark Health Options covers. If you get a bill from your PCP or the hospital by mistake, do not pay the bill. You're not responsible for sending in claims to us. Your PCP or the hospital will do that.

Ask Why Your Membership Stopped

Call DHSS Customer Relations at **1-800-372-2025**. Medicaid may stop your membership with Highmark Health Options. This is called disenrollment.

Your membership may end because you:

- Did not re-enroll.
- Gave your Medicaid ID card to someone else to use.
- Lost eligibility for Medicaid.
- Had a change in your Medicaid benefits that keeps you from being covered by Highmark Health Options.

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 will 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, call Member Services at **1-844-325-6251 (TTY: 711)**.
- 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 copay 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 DHSS 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 (age 16 and older), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

Grievances and Appeals

We want you to be happy with the health care and service you get.

Let us know if a doctor, hospital, or we do something that you're unhappy about. We will try to fix any problems over the phone. If you do not like something or we cannot fix your problem, you can file a grievance or an appeal.

How to File a Grievance or Appeal

Call Member Services 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 approval in writing.

You or your representative can get help with a grievance or appeal by asking for a Member Advocate.

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.

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 you received from a doctor or us.

Note: Do not file a grievance if you have received a denial of benefits for health care service. Those matters are handled as appeals. Find information about how to file an appeal 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 service you have received.
- If you have trouble finding or getting services from a provider.

You can send or attach any papers to the grievance form that will help us look into the problem. You can find the grievance form on our website.

You can contact us at:

Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230
Phone: **1-844-325-6251 (TTY: 711)** / Fax: **1-833-841-8074**

How do you file a grievance?

A grievance may be filed at any time. You can call us, write to us, or send us a fax.

What happens after you file a grievance?

After you file a grievance, we will send you a letter within 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.
- Submit additional information.
- 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 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 you need help during the grievance process?

If you need help filing a grievance, understanding the grievance process, or getting information for us to review, call a Member Advocate at **1-855-430-9852 (TTY: 711)** or Member Services.

Appeals

If you are informed of a denial of benefits, you can file an appeal. An appeal gives you a chance to say why you disagree with a denial of benefits.

A denial of benefits means:

- You have been denied a service you asked for.
- The service you asked for has been limited.

When you receive a letter telling you that your request for services is denied, you have the right to ask for an appeal. The appeal process is a review of the decision to deny or limit the service you asked for.

This includes:

- Type or level of service.
- Reduction, suspension, or termination of a service.

- Denial in whole or in part of payment for a service.
- Failure to provide a service in a timely manner.

You can win or lose the appeal. If you lose the appeal, you can appeal a second time by asking for a State Fair Hearing.

If you are denied benefits, you or your representative may ask for a copy of the rules used to make the decision by calling **1-844-325-6251 (TTY: 711** or **1-800-232-5460)** or by writing to:

Highmark Health Options
Attn: Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230

Note: Highmark Health Options does not reward health care providers for delaying, limiting, or denying health care services or benefits. Our staff does not get paid from Highmark Health Options or any other provider for making decisions about benefits or medically necessary services that result in less or more health care coverage and services.

Read This If You Want to File an Appeal

You or your representative, including an attorney, can ask for an appeal from Highmark Health Options if you disagree with a denial. If a representative or doctor files an appeal for you, you must give them your approval in writing. If a representative or doctor files an appeal for you, you cannot file a separate appeal on your own. You have the right to submit written comments, documents, or other information about to the appeal.

How can you file an appeal?

- By filling out the appeal form that came with your letter and mailing it back.
- By filling out the appeal form online.
- By calling Member Services.
- By faxing us at **1-833-841-8074.**

When you file your appeal, include:

- Your name and member ID number (found on your ID card).
- Your phone number and address.
- What you are appealing.
- Why you are appealing.
- What you want as a result of your appeal.

Use this address. Include any information that will help us review your appeal:

Highmark Health Options
Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230
Phone: **1-844-325-6251 (TTY: 711)** / Fax: **1-833-841-8074**

When should you file an appeal?

You or your representative must file your appeal within 60 calendar days of the date of the Notice of Adverse Benefit Determination letter. This is the letter that tells you a service was denied or limited.

What can you 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 on time.
- We are ending, suspending, or reducing services that were approved before.
- 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 10 calendar days of us sending the Notice of Adverse Benefit Determination.

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 continue getting services within 10 calendar days of us sending the Notice of Adverse Benefit Determination.
- You receive a decision from the State Fair Hearing officer that was not in your favor.

What happens after you file an appeal?

You will get a letter from us within 5 business days. This letter will tell you that we have received your appeal. It will also include information about the appeal review process. You may have someone represent you. You or your representative may submit additional information and 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, in writing, by phone, or by fax to **1-833-841-8074**.

An Appeals Committee will review your appeal and make a decision. The committee members include a representative of the State, a physician, and a representative from our Quality Department or their designee. The committee members have not been previously involved with the issue of your appeal.

You or your representative may extend the time frame for making the appeal decision for up to 14 calendar days. We may also extend the time frame for decision up to 14 calendar days if additional information is necessary and the delay is in your best interest. If we extend the time frame, we will call you and send you a written notice within two calendar days. The notice will include the reason for the decision to extend the timeframe and tell you of your right to file a grievance if you disagree with our decision.

A decision letter will be mailed to you within 30 calendar days of the date you filed your appeal or within 2 business days of the decision, whichever is sooner. This letter will tell you the reason for our decision and your further appeal rights. This includes your right to ask for a State Fair Hearing.

What if you need help during your appeal?

If you need help filing an appeal, figuring out the appeal process, or getting information for us to review, call a Member Advocate or Member Services. If you need a translator, we will arrange one for you at no cost.

What if you do not agree with our appeal decision?

If you do not agree with our decision, you or your representative may ask for a State Fair Hearing.

How can you get help to understand our appeal decision?

You have the right to receive help with understanding this decision. You can:

- Speak with a Highmark Health Options Member Advocate or Member Services Representative by calling **1-844-325-6251 (TTY: 711** or **1-800-232-5460)**.
- Call one of the following community organizations for free legal assistance:

  Community Legal Aid Society Inc.
  New Castle County: **302-575-0660**
  Kent County: **302-674-8500**
  Sussex County: **302-856-0038**

  Delaware Volunteer Legal Services
  New Castle County: **302-478-8850** (toll-free)
  Kent and Sussex County: **1-888-225-0582**

Expedited (Fast) Appeals

What should you do if you need a decision in less than 30 days?

If you think that waiting up to 30 calendar days for an appeal decision 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 by talking or writing to us. 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 2 calendar days of getting your request that your appeal will follow the standard appeal process. You will also receive a letter stating your appeal will be processed as a standard appeal. It will also include information about the appeal review process.

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. You or your representative have the right to give additional information in person at the time of the appeal hearing, in writing, by phone, or by fax:

Highmark Health Options
Appeals and Grievances
PO. Box 106004
Pittsburgh, PA 15230
Phone: **1-844-325-6251 (TTY: 711)** / Fax: **1-833-841-8074**

What happens after you file a fast appeal?

You, your representative, or doctor may:

- Submit additional information.
- 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 a representative from our Quality Department or their designee. The committee members have not been involved with the issue of your appeal.

You will be verbally notified of a decision within 72 hours of the date you filed your fast appeal. The letter will tell you the reason for the decision and your further appeal rights. This includes the right to ask for a State Fair Hearing.

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 after receiving notice of the appeal decision.

Why do you 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 contacting:

DMMA Fair Hearing Officer
1901 North DuPont Highway
P.O. Box 906
New Castle, DE 19720
Phone: **302-255-9500** or toll-free at **1-800-372-2025**

When should you file a State Fair Hearing?

If you or your representative are not happy with an appeal decision, you may ask for a State Fair Hearing within 90 calendar days of the date on the Appeal Notice of Resolution.

What happens after you 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 phone. 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. We 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 90 calendar days of the date of your request. If you request a fast State Fair Hearing, they will send you a letter within 3 business days of the date of the hearing.

How do you 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 file a State Fair Hearing within 10 calendar days of the date on the Appeal Notice of Resolution.
- 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 you do not like the State Fair Hearing decision?

If you or your representative are unhappy with the State Fair Hearing decision, you can ask for a judicial review in Superior Court. To do this, you must file with the clerk (prothonotary) of the Superior Court within 30 calendar days of the date of the State Fair Hearing decision.

Fraud, Waste, and Abuse

Highmark Health Options takes fraud, waste, and abuse involving medical or pharmacy benefits seriously.

Call the Highmark Fraud and Abuse Hotline at 1-844-325-6256 (TTY: 711) if you think that someone is using your or another member's Highmark Health Options ID card to:

- Get services, equipment, or medicine.
- Forge or change their prescriptions.
- Get services they do not need.

You can report any provider (for example a doctor, dentist, therapist, or hospital) you suspect of providing services that are fraudulent, wasteful, or abusive. Your name will be kept private. You do not have to give your name. If you do, 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 we receive will be reviewed and investigated.

You may also report this information to DMMA Fraud Reporting at **1-800-372-2025** or **SURreferrals@delaware.gov**.

Some common examples of fraud, waste, and abuse are:

- A doctor who 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 ID 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 ID 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.

Our Fraud Hotline is available 24/7. If you do not speak English, an interpreter will be made available. Call the hotline using your TTY device if you're hearing impaired.

Mental Health, Drug, and Alcohol Crisis Services

Call Mobile Crisis Intervention Services for help if you are having a mental health or drug or alcohol crisis:

- Northern Delaware (New Castle County and greater Smyrna), **1-800-652-2929** or **302-577-2484**
- Southern Delaware (Sussex County and Kent County south of Smyrna), **1-800-345-6785** or **302-424-5550**
- For children and teens age 17 and younger, call the Division of Prevention and Behavioral Health Services 24-Hour Mobile Response and Stabilization Services, **1-800-969-4357** or **1-800-969-HELP**.

Crisis Intervention Services are located throughout the state. You can call or go to:

- Crisis Intervention Service Centers
- Recovery Response Centers
- Hospital Emergency Departments

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 substance use disorder.

Call or go to the crisis intervention location closest to you.

Crisis Intervention Services

Ellendale

Mobile Crisis Intervention Services
700 Main St. (rear entrance)
Ellendale, DE 19941
302-424-5550

Recovery Innovations Recovery Response Center
700 Main St.
Ellendale, DE 19941
302-424-5660

New Castle

Mobile Crisis Intervention Services
Fernhook Building
14 Central Ave.
New Castle, DE 19720
302-577-2484

Newark

Psychiatric Emergency Services:
Christiana Hospital
4755 Ogletown-Stanton Road
Newark, DE 19718
302-320-2118

Recovery Innovations Recovery
Response Center
659 East Chestnut Hill Rd.
Newark, DE 19711
302-318-6070

Wilmington

Psychiatric Crisis Team,
Wilmington Hospital
501 W. 14th St.
Wilmington, DE 19801
302-320-2118

Helplines: Local and National

Delaware Coalition Against
Domestic Violence
100 W. 10th St., Suite 903
Wilmington, DE 19801
302-658-2958
Hotline: **1-800-701-0456**

ContactLifeline
1-800-262-9800
(Crisis helpline, 24/7.)

Disaster Distress Helpline
1-800-985-5990
(Immediate crisis counseling related to disasters, 24/7.)

National Domestic Violence Hotline
1-800-799-SAFE (7233)
TTY: 1-800-787-3224
Text: **SAFE to 88788**

National Suicide Prevention Lifeline
1-800-SUICIDE (1-800-784-2433)
1-800-273-TALK (1-800-273-8255)
(Free and confidential support for people in distress, 24/7.)

National Helpline
1-800-662-4357
(Treatment referral and information, 24/7.)

Veterans Crisis Line
1-800-273-8255, Press 1
(Free and confidential support for any service member or veteran or someone concerned about one, 24/7.)

Drug and Alcohol Detox Services

NorthEast Treatment Centers
Kirkwood Recovery Center
3315 Kirkwood Highway
Wilmington, DE 19804
302-691-0140

Important Words to Know

Below are terms to know. You may hear these terms when you call Member Services. Or you may see these terms in letters that you get from Highmark Health Options.

In these entries, the term "the plan" refers to Highmark Health Options and the term "member" refers to the people covered by the plan.

Term	Meaning
Abortion	A procedure to end a pregnancy.
Advance directive (living will)	A choice you make ahead of time about the medical care you want or do not want if you're unable to decide at the time you need it. In Delaware, two documents can be used as an advance directive: • Durable power of attorney for health care: A legal document that lists the person you've chosen to make decisions about your health care in case you can't make your own decisions. • Living will: If you're no longer able to decide or speak for yourself, this written document records the type of medical care or treatments you want or do not want.
Adverse benefit determination	A denial, reduction of, or failure to provide a requested service or make payment, in whole or in part, for a benefit. This can be based on a determination of eligibility, application of utilization review, or medical necessity.
Ambulatory service center	A facility where outpatient or same-day surgery is done.
Antibody	Any substance that causes the immune system to produce antibodies against it. This means the immune system does not recognize the substance and is trying to fight it off.
Antigen	A protein produced by the body's immune system when it detects harmful substances called antigens.
Appeal	A request for the plan to review a decision to deny or reduce a benefit.
Authorization	Approval for a service.
Authorized representative	Someone you choose to act on your behalf, like a family member or other trusted person. An authorized representative may have the lawful right to act on your behalf.

Behavioral health	A term for mental health conditions and substance use disorders (involving addiction to a mood- or mind-altering drug). Also refers to preventing and treating substance use disorders (illness that disrupts normal physical or mental function) as well as mental health disorders.
Benefits	The health care services or items covered under the plan.
Brand-name drugs	If a drug completes development and is approved by the Food and Drug Administration (FDA), it is approved with both a brand and generic name. The brand name is the name given by the company that makes the drug.
Care Coordinator	A health care professional who is specifically assigned and trained to intervene on behalf of members experiencing serious and complex medical and psychosocial issues.
Caregiver	A person who is a family member or is unrelated to the member and is routinely involved in providing unpaid support and assistance to the member.
Certified nurse midwife	A registered nurse with additional training as a midwife who delivers babies, cares for the mother before and after the baby is born, cares for the baby, and provides routine care (such as gynecological exams).
Community Support	The Highmark Health Options online web-based search site that helps you get the support you need. Link to local resources that provide goods and services, such as food banks, shelter and housing, childcare, clothing and furniture, legal assistance, transportation assistance, pastoral care, and financial assistance with utilities.
Contractor	Highmark Health Options is the managed care organization that contracts with the State of Delaware to provide services to members as specified by the contract in accordance with contract requirements.
Copays or cost sharing	A set cost you need to pay to receive a covered benefit at the time of service.
Covered services	The physical and behavioral health services included in the benefit package of the managed care contract between the Department of Health and Social Services (DHSS) and Highmark Health Options.
Department of Social Services (DSS) Change Report Center	The Change Report Center makes it easy for you to ask questions, resolve issues, and report changes, such as address changes, income changes, changes in household expenses, and the addition of newborns. The phone number is **302-571-4900**.
Disenroll/ Disenrollment	When you change health plans or no longer meet eligibility requirements.

Division of Health and Social Services (DHSS)	The State of Delaware government department with divisions that provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, state service centers, management services, financial coaching, and Medicaid and medical assistance.
Division of Medicaid and Medical Assistance (DMMA)	The Delaware agency that manages Medicaid.
Division of Social Services (DSS)	The agency directly responsible for determining Medicaid eligibility and administering these programs: Delaware's temporary assistance for needy families (TANF), food benefits, subsidized childcare, general assistance, and refugee cash assistance.
Division of Substance Abuse and Mental Health (DSAMH)	Part of the Department of Health and Social Services (DHSS) that serves adults (age 18 and older) in need of behavioral health services. DSAMH includes the Delaware Psychiatric Center (DPC), a variety of community-based mental health programs, and substance abuse treatment programs.
Drug Efficacy Study Implementation (DESI)	A Food and Drug Administration (FDA) program that requires that all drugs be effective (efficacious) as well as safe. Drugs coded as DESI are not covered by the Medicaid program.
Drug formulary	A preferred drug list of medicines that are approved to be prescribed at a particular hospital, in a specific health system, or under a particular health insurance policy. Drugs are chosen based on success, safety, and cost-effectiveness.
Durable medical equipment (DME)	Equipment and supplies your doctor orders as part of your health care.
Emergency medical condition	A medical problem so serious you must seek care right away to avoid severe harm: • 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.
Emergency medical transportation	The ambulance that takes you to the hospital in an emergency.
Emergency department care	The services you get in an emergency department to treat an emergency medical condition.
Emergency services	Treatment of an emergency medical condition to keep it from getting worse.

Enrollment	The process by which you become a member of a managed care organization (MCO).
Excluded services	Health care services that your plan may not pay for or cover.
Family member	Includes your spouse, domestic partner, parents (including stepparents), children (natural or adopted), stepchildren, grandchildren, great-grandchildren, brothers and sisters (whole or half), grandparents and in-laws, or anyone living in the same residence as you. Also includes anyone who is financially dependent on you or anyone whose investments are controlled by you.
Food and Drug Administration (FDA)	The federal agency responsible for protecting and promoting public health through the control and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices, cosmetics, animal foods and feed, and veterinary products.
Fraud, waste, and abuse	Includes when providers purposely bill for a service that was never given or for a service that has a higher reimbursement than the service provided. Also includes payment for items or services the provider bills by mistake.
General Educational Development (GED)	GED tests are four subject tests that, when passed, provide certification that the test taker has high school-level academic skills. It is an alternative to the U.S. high school diploma.
Generic drug	A prescription drug that has the same substance as an already sold brand-name drug. It has the same intended use and quality. It is as safe and given in the same amount, strength, and manner (for example, by mouth).
Grievance	A complaint that you make to your plan about how you feel about your health care.
Habilitation devices and services	Health care devices and services that help you keep, learn, or improve skills and functioning for daily living.
Health care provider	Any doctor, hospital, agency, or other person who has a license or is approved to give health care services.
Health care services	All Medicaid services, including medical and behavioral health, provided by Highmark Health Options.
Health insurance	A contract that requires your plan to pay some or all of your health care costs.

Health Insurance Portability and Accountability Act (HIPAA)	Privacy rules that require health care providers and organizations, as well as their business associates, to have and follow procedures that safeguard the privacy and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, oral, and electronic, etc. The rule also requires that the least amount of necessary health information be used or shared to conduct business.
Home health care	Health care services you receive at home.
Homeopathic	An alternative approach to medicine based on the belief that natural substances, prepared in a special way and used in very small amounts, can restore health.
Hospice services	Services to provide comfort and support for people who are terminally ill and their families.
Hospital	A place for inpatient and outpatient care from doctors and nurses.
Hospital outpatient care	Hospital care that usually doesn't require an overnight stay.
Hospitalization	Hospital care for which you're admitted and usually stay overnight. An overnight stay for observation could be outpatient care.
Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS)	HIV is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases. AIDS is a disease of the immune system due to infection with HIV.
Immune system	The body's defense against infections that attacks germs and helps you stay healthy.
Immunization	A shot that protects you from disease. Also called a vaccination.
In-network	Providers or health care facilities that are part of Highmark Health Options' network of providers. Also known as in-network providers or participating providers.
Inpatient care	Staying overnight in the hospital or other facility for medical care.
Level of care (LOC)	The type of services and supports required by a member based on the member's medical and functional needs. This includes these levels of care: acute hospital, rehabilitation, and skilled nursing facility.

Long-term services and supports (LTSS)	Medical and nonmedical care provided to people who are unable to perform basic activities of daily living (ADLs), such as dressing or bathing. LTSS can be provided at home or in the community, assisted living facilities, or nursing homes.
Malpractice	Medical malpractice occurs when a hospital, doctor, or other health care professional, through a negligent act or omission, causes an injury to a patient.
Managed care organization (MCO)	An organization, such as Highmark Health Options, that meets requirements and is under contract with the State of Delaware to provide services to members enrolled in Medicaid.
Medicaid	Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources.
Medicaid long-term care	Offers benefits not usually covered by Medicare, like nursing home care and personal care services.
Medically necessary	Health care services or supplies that meet medical standards and help to identify or treat an illness, injury, condition, and disease or its symptoms.
Medicare	A federal health insurance program that covers almost all Americans age 65 and older, and certain individuals under 65 years of age who are disabled or have chronic kidney disease.
Member	A Medicaid client who enrolls in the managed care organization (MCO) under the provisions of the managed care contract between the Department of Health and Social Services and Highmark Health Options.
Member Advocate	A professional who can help you, your provider, and your care coordinator obtain care, schedule appointments, and file grievances and appeals.
Member Handbook	This handbook, which tells you how Highmark Health Options works. If you do not understand some parts of this handbook, call Member Services at **1-844-325-6251 (TTY: 711)**. You can access the Member Handbook online or request a printed copy.
Mental (behavioral) health	A term used to describe nervous or psychiatric problems, including mental, relationship, emotional, and behavioral problems.
ModivCare	Provides transportation for eligible members for medical services when it's not an emergency.
Network	The providers that your plan has contracted with to provide health care services.

Nonparticipating provider	A provider who does not have a contract with your plan to provide services to you.
Notary public	A person legally empowered to witness and authenticate documents, administer oaths, take affidavits and depositions, and engage in other activities established by local law.
Obstetrician-gynecologist (OB/GYN)	A doctor who specializes in women's reproductive health
Out-of-network provider	A provider who does not have a contract with your plan to provide services to you. Also known as a nonparticipating provider.
Outpatient care	Care you get when you do not have to stay overnight in a hospital or other place of treatment.
Out-of-state coverage	Your plan covers you anywhere in the U.S. Your plan does not cover you for any services provided outside the U.S.
Participating provider	A provider who has a contract with your plan to provide health care services to you.
Physician services	Health care services that a licensed medical doctor provides or plans for you.
Plan	A benefit the State of Delaware provides to you to pay for your health care services. A plan can also be called a managed care organization (MCO) or accountable care organization (ACO).
Preauthorization	An approval from your plan for a health care service.
Preferred drug list (PDL)	A list of drugs selected by a pharmacy committee and deemed to be safe and effective, and to have a good value when prescribed.
Prescription	A doctor's order for a drug or device for the doctor's patient.
Prescription drugs	Drugs and medications that, by law, require a prescription.
Prescription drug coverage	The part of your plan that helps pay for prescription drugs.
Primary care physician (PCP)	A doctor who directly provides or plans your health care services.
Primary care provider	A doctor, nurse, or physician assistant who provides, plans, or helps you access health care services.
Prior authorization	The approval you get from us before you get a medication or service.

Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE)	Program for members with behavioral health needs that is overseen by the Division of Substance Abuse and Mental Health (DSAMH).
Protected health information (PHI)	Personal health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
Provider	A health care professional, facility, or medical business that offers health care services.
Quantity	An amount or number.
Quantity limit	Limiting the coverage of a drug to a certain amount (for example, 30 pills a month) so medications are prescribed safely and correctly.
Rehabilitation devices	Health care devices that help you keep, get back, or improve daily living skills and functioning that have been lost or impaired because you were sick, hurt, or disabled.
Rehabilitation services	Health care services that help you keep, get back, or improve daily living skills and functioning that have been lost or impaired because you were sick, hurt, or disabled.
Resource Coordinator	A nonclinical staff member who assists you with discharge planning following an acute inpatient stay, appointment setting, referrals, links to services, coordination of care, and access to wellness programs.
Skilled nursing care	Health care services from licensed nurses in your home or a nursing home.
Specialist	A doctor who has special training for a specific condition or illness.
Specialist care	Health care provided by a doctor who has special training for a specific condition or illness.
Sterilization	A medical method of birth control that permanently prevents pregnancy and leaves a person unable to reproduce. Methods can be surgical or nonsurgical and exist for both males and females.
Supplemental formulary list	A list of drugs that are not on the drug formulary but may be covered by the plan.
Technology	The use of scientific knowledge for practical purposes or applications. Medical technologies are products, services, or solutions used to save and improve people's lives.

Technology dependent	An individual who has a chronic disability that requires the routine use of specific medical equipment to compensate for the loss of a life-sustaining body function and requires daily, ongoing care or monitoring by trained personnel.
Telecommunication relay service (TTY)	A special device that lets people who are deaf, hard of hearing, or speech-impaired use the phone and communicate by typing messages back and forth to one another instead of talking and listening.
Third-party liability	In general, any type of insurance that is responsible for paying all or part of the costs for health care services.
Transfer	A member's change from enrollment in one managed care organization to another.
Urgent care	When you need care or medical treatment within 48 hours.
Urgent care center	A walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in a walk-in medical facility outside of a traditional hospital-based or freestanding emergency department. Urgent care centers offer a wide range of care.
Urgent medical condition	Not an emergency, but a condition that should have medical care within 48 hours.
Utilization management (UM)	A system for reviewing the proper and effective health care services that are provided, or proposed to be provided, to a member.
Women, Infant, and Children (WIC)	The Special Supplemental Nutrition Program for Women, Infant, and Children is a federal nutrition program that helps pregnant women, new mothers, and young children eat well, learn about nutrition, and stay healthy.
Workers' compensation	A type of business insurance that provides benefits to employees who suffer work-related injuries or illnesses.

HIGHMARK HEALTH OPTIONS

Highmark Health Options complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation. Highmark Health Options does not exclude people or treat them differently because of their race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Health Options provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in a different way, including large print, audio, and Braille.

Highmark Health Options 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 Highmark Health Options Member Services at 1-844-325-6251 (TTY: 711), Monday – Friday, 8 a.m. – 8 p.m.

If you believe that Highmark Health Options has failed to provide these services or discriminated against you in another way because of your race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation, you can file a complaint with Highmark Health Options or the Delaware Division of Human and Civil Rights by mail, phone, or web form.

Highmark Health Options
Attn: Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230
1-844-325-6251

Division of Human and Civil Rights
861 Silver Lake Blvd., Suite 145
Dover, DE 19904
302-739-4567
hho.fyi/ea-intake

If you need help filing a complaint, Highmark Health Options and the Division of Human and Civil Rights are 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 online at OCRPortal.hhs.gov, and by mail, phone, or email:

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

A printable version of the complaint form is available at hho.fyi/complaint-form.

HIGHMARK. HEALTH OPTIONS

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：如果您会说英语，则可以免费获得语言协助服务。 请拨打您身份证背面的号码（TTY：711）。

Atansyon: Si w pale anglè, sèvis asistans nan lang, gratis, disponib pou ou. Rele nimewo ki sou do kat idantite w la (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).

ध्यान दें: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएँ आपके लिए निःशुल्क उपलब्ध हैं। अपने आईडी कार्ड के पीछे दिए गए नंबर (TTY: 711) पर कॉल करें।

Pansin: Kung nagsasalita ka ng Ingles, ang mga serbisyo ng tulong sa wika, na walang bayad, ay magagamit mo. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ופמערקזאַמקייט :אויב איר רעדן ענגליש, שפּראַך הילף באַדינונגס זענען בארעכטיגט פֿאַר איר .רופן דעם נומער אויף די צוריק פון דיין שיין קאָרט (TTY: 711).

Akiyesi: Ti o ba sọ Gẹẹsi, awọn iṣẹ iranlọwọ ede, laisi idiyele, wa fun ọ. Pe nọmba ti o wa ni ẹhin kaadi ID rẹ (TTY: 711).

ધ્યાન આપો: જો તમે અંગ્રેજી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. તમારા ID કાર્ડની પાછળના નંબર પર કૉલ કરો (TTY: 711).

تنبيه :إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا .اتصل بالرقم الموجود على ظهر بطاقة الهوية الخاصة بك (TTY: 711).

கவனம்: நீங்கள் ஆங்கிலம் பேசினால், மொழி உதவி சேவைகள், உங்களுக்கு இலவசமாக கிடைக்கும். உங்கள் அடையாள அட்டையின் பின்புறத்தில் உள்ள எண்ணை அழைக்கவும் (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).

Makini: Ikiwa unazungumza Kiingereza, huduma za usaidizi wa lugha, bila malipo, zinapatikana kwako. Piga nambari iliyo nyuma ya kitambulisho chako (TTY: 711).

శ్రద్ధ: మీరు ఇంగ్లీష్ మాట్లాడితే, భాషా సహాయ సేవలు, ఉచితంగా, మీకు అందుబాటులో ఉంటాయి. మీ ID కార్డ్ వెనుక ఉన్న నంబర్‌కు కాల్ చేయండి (TTY: 711).

Chú ý: Nếu bạn nói tiếng Anh, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn có dành cho bạn. Gọi đến số ở mặt sau thẻ ID của bạn (TTY: 711).

HIGHMARK HEALTH OPTIONS

Because Life.™

LAST UPDATED Jan. 2025