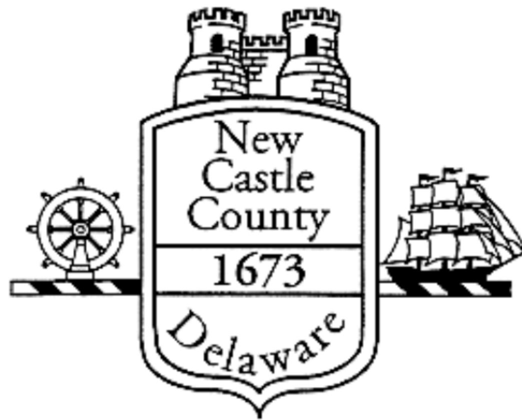
A GUIDE TO YOUR BENEFITS



NEW CASTLE COUNTY ACTIVE EMPLOYEES
BLUE CHOICE® PPO PLAN

Discrimination is Against the Law

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

The claims administrator:

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

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

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, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY： 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dę́ę́' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

WELCOME!

Thank you for choosing Blue Choice, Highmark Blue Cross Blue Shield Delaware's PPO plan. Our goal is to bring you the best in health care coverage.

This booklet explains your benefits. Please read this booklet carefully and keep it handy.

In this booklet, we sometimes abbreviate terms. For instance:

- **DME** means Durable Medical Equipment
- **Highmark Delaware** means Highmark Blue Cross Blue Shield Delaware
- **PPO** means Preferred Provider Organization

This plan pays "covered services" only. See the *Schedule of Benefits* for a list.

This booklet is not a contract. It explains your plan for easy reference. The benefits and terms and conditions of your plan are in a group contract with your employer. Your employer holds a copy of the contract.

This booklet explains the benefits in effect as of January 1, 2017. It replaces all previous booklets.

HINTS TO GET THE MOST FROM YOUR HEALTH CARE PLAN

- Always show your ID card when you need care.
- Always follow Highmark Delaware's Managed Care Requirements.
- Read this booklet.
- Call us if you have any questions!

Remember! If you go to a preferred provider, your benefits are higher.

WHEN YOU HAVE QUESTIONS OR COMMENTS

Highmark Delaware welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Member Service anytime you have a concern about Highmark Delaware's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

Here are reasons you may need to call us:

- asking about your plan
- obtaining information about providers
- reporting a lost or stolen ID card
- ordering a new ID card
- letting us know when you have a new address
- asking about a claim
- getting language assistance

So that we can learn about our network providers, you may also call or write us when you have a concern about

- access to providers
- the care you received

To Reach Us By Phone

All Calls: 800.633.2563

To talk to a Member Service Representative, call 8:00 AM to 8:00 PM Eastern Standard Time (EST), Monday through Friday.

You can also get the following information when you call outside the Member Service Representative hours. Our automated system (VRU) is available Monday through Friday, 24 hours a day, and Saturday until midnight EST for:

- Enrollment information
- Claims status
- Check on managed care approvals
- ID card requests

To Reach Us By Letter

Write to:

Member Services
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

To Reach Us In Person

You may also visit us at several places in New Castle, Kent and Sussex Counties. To find out the days, times and locations, call Highmark Delaware's Member Service Department.

To Reach Us On The Internet

Internet Address: **highmarkbcbsde.com**

To Reach the Medical Management Department (for Managed Care)

Medical Management Department
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.572.2872

Medical Management representatives are available by telephone from 8:00 a.m. to 4:45 p.m. EST, Monday through Friday.

To Reach the Behavioral Health Care Department (for Mental Health and Substance Abuse Managed Care)

Behavioral Health Care Department
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.421.4577

Drug Program Questions

Prescription drug benefits are administered by Express Scripts®, an independent prescription benefits administrator.

For mail order prescriptions:

Express Scripts
PO Box 747000
Cincinnati, OH 45274-7000

All Calls: 800.633.2563

Website: **express-scripts.com**

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SCHEDULE OF BENEFITS

This Schedule of Benefits outlines your covered services. More details can be found in later sections of this booklet. All payments are based on Highmark Delaware's allowable charge.

Benefits	In-Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	 $200 $400	
Plan Payment Level - Based on the plan allowance	100% after deductible until coinsurance expense limit is met; then 100%	80% after deductible until coinsurance expense limit is met; then 100%
Out-of-Pocket Maximum Individual Family	 $2,000 $4,000	
Total Maximum Out-of-Pocket (includes deductibles, coinsurance and copays (Network only)). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,150 $14,300	 Not Applicable
Office/Urgent Care Visits		
Physician Office/Home Visits[1]	100% after $15 copayment; deductible does not apply	80% after deductible
Specialist Office Visits[1]	100% after $25 copayment; deductible does not apply	80% after deductible
Specialist Virtual Visits[1]		
Specialist	100% after $25 copayment; deductible does not apply	80% after deductible
Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $25 copayment; deductible does not apply	80% after deductible
Preventive Care Services[2]		
Comprehensive routine eye exam	100%; deductible does not apply	Not Covered
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult immunizations	100%; deductible does not apply	80% after deductible
Hemoglobin test	100%; deductible does not apply	80% after deductible
Cholesterol test	100%; deductible does not apply	80% after deductible
Blood sugar test	100%; deductible does not apply	80% after deductible
Blood antigen test	100%; deductible does not apply	80% after deductible
Lab charges for Pap test	100%; deductible does not apply	80% after deductible
Routine gynecological exams	100%; deductible does not apply	Not Covered
Mammograms, annual routine	100%; deductible does not apply	Not Covered

Benefits	In-Network	Out-of-Network
Blood occult	100%; deductible does not apply	80% after deductible
Routine sigmoidoscopy	100%; deductible does not apply	80% after deductible
Colonoscopy	100%; deductible does not apply	80% after deductible
Barium enema	100%; deductible does not apply	80% after deductible
Hearing care services	100%; deductible does not apply	Not Covered
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Lead poison screening test	100%; deductible does not apply	80% after deductible
Pediatric immunizations	100%; deductible does not apply	Not Covered
Prescription Drugs - preventive covered medications (outpatient)	100%; deductible does not apply	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	100%; deductible does not apply	80% after deductible
Hospital Services - Outpatient[3]	100%; deductible does not apply	80% after deductible
Maternity (non-preventive facility and professional services)	100%; deductible does not apply	80% after deductible
Medical/Surgical Expenses (except office visits)	100%; deductible does not apply	80% after deductible
Second Surgical Opinion	100% after $25 copayment; deductible does not apply	80% after deductible
Emergency Services		
Emergency Room Services (facility)	100% after $50 copayment (waived if admitted as an inpatient); deductible does not apply	Same as in-network services
Emergency Room Services (professional)	100%; deductible does not apply	Same as in-network services
Ambulance	100%; deductible does not apply	Same as in-network services
Outpatient Therapy and Rehabilitation Services		
Chemotherapy, Radiation and Respiration Therapy, Dialysis	100%; deductible does not apply	80% after deductible
Occupational Therapy	100%; deductible does not apply	80% after deductible
Physical Therapy	100%; deductible does not apply	80% after deductible
Speech Therapy	100%; deductible does not apply	80% after deductible
Cognitive Therapy	100%; deductible does not apply	80% after deductible
Cardiac Therapy	100%; deductible does not apply	80% after deductible
Chiropractic Care	80%; deductible does not apply	80% after deductible
	Combined Limit: 30 visits per benefit period	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)[4]	100%; deductible does not apply	80% after deductible
Diagnostic Services		
Laboratory Services	100%; deductible does not apply	80% after deductible
Advanced Imaging Services	100% after $10 copayment; deductible does not apply	80% after deductible
Standard Imaging Services	100% after $10 copayment; deductible does not apply	80% after deductible
Machine Tests	100%; deductible does not apply	80% after deductible
Allergy Testing	100% after $25 copayment; deductible does not apply	80% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	100%; deductible does not apply	80% after deductible
Mental Health Care Services - Outpatient	100%; deductible does not apply	80% after deductible
Substance Abuse Services -	100%; deductible does not apply	80% after deductible

Benefits	In-Network	Out-of-Network
Inpatient Detoxification/ Rehabilitation		
Substance Abuse Services - Outpatient	100%; deductible does not apply	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after $15 copayment for primary physicians and $25 copayment for specialists; deductible does not apply	80% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	100%; deductible does not apply	80% after deductible
Assisted Fertilization Treatment	Not Covered	
Bariatric Surgery	100%; deductible does not apply	80% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible
Home Infusion Therapy Services	100%; deductible does not apply	80% after deductible
Home Health Care	100%; deductible does not apply	80% after deductible
	Combined Limit: 100 visits per benefit period	
Hospice	100%; deductible does not apply	100%; deductible does not apply
Private Duty Nursing	100%; deductible does not apply	80% after deductible
	Combined Limit: 240 hours per 12-month period	
Skilled Nursing Facility Care	100%; deductible does not apply	80% after deductible
	Combined Limit: 120 days per confinement. Benefits renew after 180 days without care.	
Transplant Services	See Benefit Description	
Precertification Requirements	Yes[5]	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

[1] You ***may*** be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

[2] Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.

[3] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., therapies, diagnostic services, mental health/substance abuse visits.

[4] Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

[5] Highmark Delaware must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission, or prior to skilled nursing services. Some facility providers will contact Highmark Delaware and obtain pre-certification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark Delaware for pre-certification. If not, you are responsible for contacting Highmark Delaware. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Prescription Drug Benefits Mandatory Generic[1]	Up to 34-day supply	Up to 90-day supply
Generic Prescription Drug	$5 copayment	$10 copayment
Preferred Brand Prescription Drug	$15 copayment	$30 copayment
Non-Preferred Brand Prescription Drug	$30 copayment	$60 copayment

[1] Unless the prescribing physician indicates Dispense as Written, if an individual chooses a Preferred or Non-Preferred Brand drug when a Generic drug is available, he or she will have to pay the difference between the charge for the Preferred or Non-Preferred Brand drug and the Generic drug, plus the copay for the Preferred or Non-Preferred Brand Drug.

COPAYMENTS, DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

In the *Schedule of Benefits*, we refer to copayments, deductibles and out-of-pocket maximums. These amounts are your share of payment. These terms are described below.

COPAYMENTS

A copayment is an amount you pay at the time you have care. Generally, after the copayment, care is paid at 100%, unless otherwise indicated on the *Schedule of Benefits*. Copayments apply only to certain services. See the *Schedule of Benefits* for a list of services with a copayment.

Here's how copayments work:

- You pay only one copayment to the same provider in the same day.
- If you see more than one provider the same day, you pay copayments to each provider.
- If you have more than one prescription filled the same day, you pay copayments for each prescription.

Copayments should be paid at the time you receive care.

IN-NETWORK DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

Your In-Network benefits have a $200 calendar year deductible per person. You pay the first $200 for In-Network services.

You also have a $400 calendar year family deductible. This applies when two members each meet their $200 deductible (totaling $400). Then, no more deductible is taken for all members for the rest of the year.

After the deductible is met, most In-Network benefits are paid at 100% of the allowable charge.

Most of your In-Network benefits have a $2,000 calendar year out-of-pocket maximum per person. The deductible and coinsurance you pay combine to meet the out-of-pocket maximum. Then, except for services with copayments, we pay 100% for the rest of the plan year. The 100% is based on the allowable charge.

You have a $4,000 calendar year family out-of-pocket maximum. This applies when two members each meet their $2,000 out-of-pocket maximum (totaling $4,000). Then, we pay 100% for all members for the rest of the year. The 100% is based on the allowable charge.

OUT-OF-NETWORK DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

Your Out-of-Network benefits have a $200 calendar year deductible per person. You pay the first $200 for Out-of-Network services.

You also have a $400 calendar year family deductible. This applies when two members each meet their $200 deductible (totaling $400). Then, no more deductible is taken for all members for the rest of the year.

After the deductible is met, most Out-of-Network benefits are paid at 80% of the allowable charge. This means the difference of 20% is your coinsurance.

You Out-of-Network benefits have a $2,000 calendar year out-of-pocket maximum per person. The deductible and coinsurance you pay combine to meet the out-of-pocket maximum. Then, except for services with copayments, we pay 100% for the rest of the plan year. The 100% is based on the allowable charge.

You have a $4,000 calendar year family out-of-pocket maximum. Deductible and coinsurance payments for all enrolled family members combine to meet the out-of-pocket maximum. Then, except for those services with copayments, we pay 100% for all enrolled family members for the rest of the plan year. The 100% is based on the allowable charge**.**

TOTAL MAXIMUM OUT-OF-POCKET

The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance and copayments incurred for network covered services in a benefit period.

When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, Highmark Delaware begins to pay 100% of all covered expenses and no additional deductible, coinsurance or copayment will be incurred for network covered services in that benefit period. See the Schedule of Benefits for the total maximum out-of-pocket. The total maximum out-of-pocket does not include out-of-network cost-sharing or amounts in excess of the plan allowance.

HOW THE DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM WORK

Example #1:

Suppose you have In-Network medical expenses of $50.00 in allowable charges. Here's how your In-Network deductible would be reduced:

Your In-Network deductible is $200

Less: Your medical expenses $50

Equals: The amount you still have to pay to meet your In-Network deductible: $150

Example #2:

When you meet your deductible, your Out-of-Network benefits are paid at 80%. This means your coinsurance is 20% (100% - 80% = 20%). Suppose you've met your deductible, and have Out-of-Network medical expenses of $500 in allowable charges. Here's how your Out-of-Network out-of-pocket maximum is reduced:

Your Out-of-Network out-of-pocket maximum is $2,000

Less: Your deductible $200

Less: Your coinsurance times the medical expenses (20% X $500) $100

Equals: The amount of cost sharing you still have to pay to meet
your out-of-pocket maximum: $1,900

When you meet your out-of-pocket maximum, benefits that are paid at 100% for the rest of the plan year. Copayments, if any, will still apply until you reach the total maximum out-of-pocket.

MEMBER SERVICES

As a Highmark Delaware member, you have access to a wide range of readily available health education tools and support services.

CUSTOMER SERVICE

Whether it's for help with a claim or a question about your benefits, you can call your Customer Service toll-free telephone number on the back of your ID card or log onto the Highmark Delaware website at **www.highmarkbcbsde.com**. A Highmark Delaware Customer Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

Highmark Delaware realizes the importance of a healthy lifestyle. Our goal is to help you reach your healthiest potential. That's why, in addition to your website wellness tools, we keep you informed via your quarterly member newsletter, *Looking Healthward*. This newsletter contains new product updates, as well as a wide variety of health and preventive care articles and "stay healthy" tips. Watch for your copy in the mail. Better yet, go paperless by logging onto our member website and signing up to receive the newsletter on-line.

HIGHMARK DELAWARE WEBSITE

As a Highmark Delaware member, you have a wealth of health information at your fingertips. It’s easy to access all your online offerings. Whether you are looking for a health care provider or managing your claims, want to make informed health care decisions on treatment options or lead a healthier lifestyle, Highmark Delaware can help with online tools and resources.

Go to **www.highmarkbcbsde.com**. Then click on the "Members" tab and log in to your homepage to take advantage of these resources.

CALL MYCARE NAVIGATOR FOR HELP

myCare Navigator is a health navigation and advocacy service. It connects you to a dedicated health advocate who addresses and resolves health care issues for you. This service is available to you and to your spouse, domestic partner, parents, parents-in-law and dependent children as part of your health care coverage. myCare Navigator can help you to:

- Find the right doctor
- Schedule an appointment
- Understand your care costs and options
- Locate helpful support services
- Get a second opinion
- Have you medical records transferred
- Make smart health care decisions

To contact a health advocate, any time of the day, any day of the week, call **1-888-BLUE-428 (1-888-258-3428).**

BLUES ON CALL℠ - 24/7 HEALTH DECISION SUPPORT

Just call **1-888-BLUE-428 (1-888-258-3428)** to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week. **Member Services – 1-800-633-2563**

Health Coaches are specially-trained registered nurses, therapists and other medical professionals who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you've received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a child or elder

You don't have to be ill to talk to a Health Coach. Call to learn about programs and other resources available to help-you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself. You can even establish a relationship with a specific Health Coach arid schedule time talk about your concerns and conditions.

BABY BLUEPRINTS®

If you are pregnant, now is the time to enroll in *Baby BluePrints*.

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your health and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark Delaware offers the *Baby BluePrints Maternity Education and Support Program.*

By enrolling in this free program you will have access to online information on all aspects of pregnancy and childbirth. *Baby BluePrints* will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy.

Enrollment is easy! Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy.

HOW TO USE YOUR BLUE CHOICE BENEFITS

In this section, we describe how the Blue Choice PPO plan works. Please read these rules carefully. Call us if you have any questions.

TWO LEVELS OF BENEFITS

With the Blue Choice plan, you can receive two levels of benefits:

- With In-Network benefits, your care is covered at the highest level.
- With Out-of-Network benefits, coverage is reduced. The amount you pay is greater.

HOW TO RECEIVE IN-NETWORK BENEFITS

To receive In-Network benefits, see a network provider when you need care. The network providers are listed in the Provider Network Directory or online at **highmarkbcbsde.com. If you receive care without using a network provider, your benefits are reduced. This means, your share of payment is greater!**

You must also follow Highmark Delaware's Managed Care Requirements to avoid penalties.

Some network providers are not approved by us to give all health services at the In-Network level. For example, a network hospital may not be approved as a network provider for outpatient lab tests. You should always check the Provider Network Directory before you have care.

HOW TO RECEIVE OUT-OF-NETWORK BENEFITS

With Out-of-Network benefits, you may see any provider you choose. There are higher deductibles and coinsurance. This means your share of payment is greater. **You must also follow Highmark Delaware's Managed Care Requirements to avoid penalties.**

With Out-of-Network benefits, you may choose any provider you wish.

When choosing a provider, there are ways to save money. Many doctors and other providers contract with Highmark Delaware. These providers agree to accept Highmark Delaware's allowable charge as full payment. They are called "participating providers." They cannot bill you more than our allowable charge, even if their normal charge is higher. And, these providers file claims with Highmark Delaware for you. So, you don't need to complete claim forms.

Non-participating providers don't have contracts with Highmark Delaware. They may bill for amounts over our allowable charge. **Be sure to ask if your provider participates with Highmark Delaware.**

EXCEPTIONS TO THE BLUE CHOICE RULES

Here are some instances when you don't have to use a network provider. You'll still get benefits at the In-Network level. Please be careful when you read the following. It's important that you understand the exceptions.

EMERGENCY CARE

If you need emergency care, go to the nearest emergency provider. Benefits will be paid at the same level for both In-Network and Out-of-Network. See the *Emergency and Urgent Care* section for more information.

OUTPATIENT LAB AND IMAGING TESTS

Usually you'll need to go to a network lab or imaging provider. However, sometimes a network provider will give you a lab or imaging test in the course of other treatment. For example:

- Lab and imaging tests done during outpatient surgery are paid In-Network if the surgical facility is a network provider.
- X-rays done for oral surgery are paid In-Network if the surgeon is a network provider. See Surgical Benefits to see when oral surgery is paid.
- Lab and imaging tests done as part of hospice or home health care are paid In-Network. These tests must be billed by the provider.
- Imaging done and billed by a network orthopedic doctor is paid In-Network.

OUT OF AREA SERVICES

You can use other Blue Cross Blue Shield provider networks when you have care outside Highmark Delaware's provider area. If you use an Out-of-Area network provider, your benefits will be paid In-Network. When you need out-of-area care, call 800.810.BLUE (800.810.2583) to find out which providers are in the network.

THE BLUECARD® PROGRAM

Follow these five easy steps for health coverage when you're away from home in the United States:

1) Always carry your current Highmark Delaware ID card.
2) Call Highmark Delaware for pre-certification or prior authorization, if necessary (refer to the phone number on your Blue Plan ID card).
3) To find names and addresses of nearby doctors and hospitals, visit the Blue National Doctor and Hospital Finder (accessed through **highmarkbcbsde.com** or **bcbs.com**) or call BlueCard *Access*® at 800.810.BLUE (800.810.2583).
4) When you arrive at the participating doctor's office or hospital, simply present your Highmark Delaware ID card.
5) In an emergency, go directly to the nearest hospital.

After you receive care:

- If you've used a participating provider, you should not have to complete any claim forms.
- You may have to pay up front for medical services, including the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance, if any)
- If your claim is subject to out-of-pockets expenses, Highmark Delaware will send you an explanation of benefits.

BLUE CROSS BLUE SHIELD GLOBAL CORE

When you are a Blue[SM] member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to medical assistance services, doctors and hospitals when traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands.

When You Need Healthcare Outside the U.S., Puerto Rico and U.S. Virgin Islands

1) Always carry your Blue Cross and Blue Shield ID card.
2) Contact your Blue Plan before leaving as your health care benefits may be different outside the U.S., Puerto Rico and U.S. Virgin Islands.
3) In an emergency, go directly to the nearest hospital or doctor. Call the Blue Cross Blue Shield Global Core Service Center if hospitalized.
4) If you need to locate a doctor or hospital, or need medical assistance services, call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
5) Call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.2583 or collect at 1.804.673.1177 when you need inpatient care. In most cases, you should not need to pay upfront for inpatient care at Blue Cross Blue Shield Global Core hospitals except for the out-of-pocket expenses (noncovered services, deductible, copayment and co-insurance) you normally pay. When cashless access is arranged, the hospital will submit your claim on your behalf.
6) Call your Blue Plan for precertification or prior authorization, if necessary. Refer to the phone number on the back of your ID card.

Claims Filing and Payment Information

- **For inpatient care at a Blue Cross Blue Shield Global Core hospital that was arranged through the Blue Cross Blue Shield Global Core Service Center**, you should only pay the provider the usual out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) when cashless access is arranged. The provider files the claim for you.
- **For all outpatient and professional medical care, you pay the provider and submit a claim.** You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-Blue Cross Blue Shield Global Core hospital or when inpatient care was not arranged through the Blue Cross Blue Shield Global Core Service Center.

The Medical Assistance vendor offers the following services:

- Responds to general call from members
- Provides referral for non-medical situation (for example, will provide a list of providers)
- Provides telephone translations
- Provides medical referrals
- Performs medical monitoring of inpatient care

MANAGED CARE REQUIREMENTS

The benefits provided under this plan are subject to Highmark Delaware's managed care requirements. These requirements are described below, and are administered by Highmark Delaware's Medical Management and Policy Department (MMP).

MEDICAL MANAGEMENT SERVICES

Determining Care Coverage

For benefits to be paid under your PPO plan, services and supplies must be considered "Medically Necessary and Appropriate."

MMP will review your care to assure it is "medically necessary and appropriate." Such care:

- is consistent with the symptom or treatment of the condition
- meets the standard of accepted professional practice
- is not primarily for anyone's convenience
- is the most appropriate supply or level of care safely provided
- is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

A Summary of Highmark Delaware's Care/Utilization Process

To help determine that care is provided in the appropriate setting, MMP administers a care utilization review process comprised of prospective, concurrent and retrospective reviews. In addition, MMP conducts discharge planning. These activities are conducted via telephone or on-site by an MMP nurse working with a physician advisor who is in direct contact with the member's physician.

Here is a brief description of these review procedures:

Prospective Review:

Prospective review, also known as precertification or pre-admission review, begins once a request for inpatient services is received. Requests can be for inpatient hospital care (for medical, mental health and substance abuse diagnoses) and for skilling nursing facility care. When you use a Highmark Delaware network provider for inpatient or skilled nursing care, the provider will contact Highmark Delaware for you to receive authorization for your care.

Out-of-Area Network Care

When you use an *out-of-area network facility provider*, **both the facility and you are responsible for notifying Highmark Delaware of your proposed admission**. Even if the facility provider contacts Highmark Delaware to obtain preauthorization of the inpatient admission on your behalf, you are also responsible for contacting Highmark Delaware prior to the proposed admission to confirm our determination of Medical Necessity and Appropriateness

Out-of-Network Care

When you use an *out-of-network facility provider*, **you are responsible for notifying Highmark Delaware prior to your proposed admission** to obtain pre-authorization of the inpatient admission and our determination of Medical Necessity and Appropriateness.

Remember:

Out-of-network providers are not obligated to contact Highmark Delaware or to abide by any determination of medical necessity and appropriateness we make. It is possible, therefore, for you to receive services which are not medically necessary and appropriate for which you will be solely responsible.

After receiving the request for inpatient hospital or skilling nursing services, the MMP nurse:

- Gathers information needed to make a decision, including patient demographics, diagnosis, and plan of treatment
- Confirms care is "Medically Necessary and Appropriate"
- Authorizes care or refers to a physician advisor for a determination
- When required, assigns an appropriate length of Hospital stay

Emergency and Maternity Admissions

For emergency admissions, you must call us within 48 hours of admission. If you can't call yourself, your provider, a family member or a friend may call us. Highmark Delaware will review the admission. If approved, we'll assign an initial length of stay.

Maternity admissions don't require Highmark Delaware's prior authorization. However, extended hospital stays must be authorized.

Your doctor should call us at least two weeks before the admission.

Concurrent Review

Concurrent review occurs during the course of inpatient hospitalization and considers appropriateness of admission, length of stay and level of care at an inpatient facility.

The MMP Nurse:

- Contacts the facility's utilization reviewer
- Checks the Member's progress and ongoing treatment plan
- Decides, when necessary, to either extend the Member's care, offer an alternative level of care, or refer to the physician advisor for further determination of care

Discharge Planning

Discharge planning is a review of the case to identify the Member's discharge needs. The process begins prior to admission and extends throughout the Member's stay in a facility. Discharge planning enhances continuous, quality care and is coordinated with input from the Member's physician.

To plan effectively, the MMP nurse assesses the Member's:

- Level of function pre- and post-admission
- Ability to perform self-care
- Primary caregiver and support system
- Living arrangements pre- and post-admission
- Special equipment, medication and dietary needs
- Obstacles to care
- Need for referral to case management or disease management
- Availability of benefits or need for benefit adjustment

Retrospective Review

Retrospective review occurs when a service or procedure has been rendered already.

Case Management Services

When a Member is injured, seriously ill or considering certain types of surgery, Case Management may begin a collaborative process that involves MMP and case managers, the member, their family or significant others, physicians and institutional providers. Using communication, education and available resources, Case Management assesses plans, implements, coordinates, monitors and evaluates all of the options and services required to meet the member's health needs…always with the goal of enabling the member to reach optimum recovery in a timely manner.

Preauthorization for Other Services

In addition to inpatient care, certain other services require preauthorization by Highmark Delaware. These include:

- advanced radiology (Some examples include: CAT and PET scans, MRIs, and MRAs)
- physical medicine. An example of a physical medicine service is physical therapy. (Care beyond the eighth physical medicine visit during a benefit period requires authorization by Highmark Delaware.)
- bariatric surgery
- certain home health services
- certain outpatient services and goods (a list of these is available at highmarkbcbsde.com)

Highmark Delaware network providers are responsible for obtaining preauthorization for any service that requires it.

AUTHORIZATION FOR URGENT CARE SERVICES

You do not need to obtain prior authorization (for those services that require it) from Highmark Delaware, for services that your physician considers to be urgent, if these services are obtained outside of Highmark Delaware's normal business hours (8:00 AM to 4:45 PM), over the weekend or during holidays. See the definition of Urgent Care in the *Emergency and Urgent Care* section, below. You must contact Highmark Delaware for post-service authorization for these services within two business days following your care.

Care in an urgent care center or medical aid unit does not require prior authorization.

CARE MANAGEMENT PROGRAMS

Individual Case Management

Highmark Delaware may provide a case manager to work with you and your doctor to coordinate your care and maximize your existing benefits. The case manager may assist you with:

- coordinating care when you leave the hospital
- providing care in your home
- providing educational materials
- locating network providers
- identifying community services

You may contact the Medical Management Department to request a case manager. Highmark Delaware will evaluate your needs and determine if you meet criteria for case management services. You may choose to decline case management services at any time.

Highmark Delaware may also choose to provide optional benefits not normally included under your plan. These benefits will replace or minimize the need for existing health care plan benefits, and may include modification to copayments, coinsurance, deductibles, limits or covered services. Optional benefits will only be provided as long as they are medically necessary, and the total benefits paid aren't more than the plan benefits. When we provide optional benefits for you, it doesn't mean we need to provide optional benefits for you or anyone else at any other time or in any other situation.

You may accept or reject the optional benefits. If you reject the optional benefits, you are still entitled to benefits under this plan.

Disease Management

Highmark Delaware provides disease management programs that help members with certain chronic conditions better manage those illnesses.

If you are identified as having one of the specific health conditions for which a program is offered by Highmark Delaware, you will automatically be enrolled in that program. You may choose to opt out of any disease management program at any time.

More information can be found at highmarkbcbsde.com. Highmark Delaware reserves the right to change or discontinue these programs at any time.

USE OF PARTICIPATING PROVIDERS

All providers who participate with Highmark Delaware have agreed to follow Highmark Delaware's managed care requirements. In circumstances where an authorization for a service is required, the participating provider cannot bill you unless:

- Highmark Delaware's authorization requirements were followed
- the service was not authorized
- having been informed of Highmark Delaware's decision, you chose to have the service anyway, and agreed in writing to be responsible for payment

Non-participating providers and providers outside the Delaware service area may not know about the requirements. It's up to you to call Highmark if you have care that requires authorization. If the requirements aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- Highmark Delaware does not pay for services that are not covered, even when Medical Management authorizes, for example, an inpatient admission, except for optional benefits authorized by Highmark Delaware through individual case management.
- If you do not comply with the managed care requirements, Highmark Delaware will reduce or deny payment. However, upon appeal Highmark Delaware reserves the right to approve payment for care that was not authorized in advance but is subsequently determined to have been medically necessary.
- Any payments you must make because you or your provider fail to follow the managed care requirements are not credited toward any deductible or coinsurance requirement.

- You don't need to follow Highmark Delaware's managed care requirements if this plan is secondary. See the section, *Coordination of Benefits*, for more information.

APPEALS

You may disagree with a decision either the Medical Management or Behavioral Health Department makes. If you disagree, you may file a written appeal with us. See the section, *A Guide To Filing Claims and Appeals*, for more information.

PREVENTIVE SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

PREVENTIVE SERVICES

Highmark Delaware promotes preventive care to help you stay well. We administer these benefits according to the Highmark Delaware Preventive Health Guidelines materials. These materials contain details of when we pay for Preventive Care. They are available from Highmark Delaware, or online at **highmarkbcbsde.com**. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

Please note: Highmark Delaware has the right to change these benefits at any time. Claims for care provided for preventive services submitted with a medical or family history diagnosis are paid at the diagnostic benefit level.

EXAMINATIONS

Benefits are provided for:

- well baby care
- routine physical exam
- routine GYN exam and Pap smear

TESTS AND SCREENINGS

Some examples of covered routine tests, screenings and counseling are:

- blood antigen test for prostate cancer
- blood occult
- blood sugar test
- cholesterol test
- colonoscopy
- flexible sigmoidoscopy
- hemoglobin test
- lead screening
- mammogram
- osteoporosis screening
- alcohol misuse, and tobacco use and tobacco-caused disease counseling
- depression screening for adolescents and adults
- tuberculin testing

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- DTaP and combinations (diphtheria, pertussis, tetanus)
- Hepatitis A
- Hepatitis B
- Hib (haemophilus influenza)
- Influenza
- IPV (polio)
- Meningitis

- MMR (measles, mumps, rubella)
- Pneumococcal
- Td (Tetanus)
- Varicella (chickenpox) vaccine

Immunizations considered by Highmark Delaware to be experimental are not covered.

ROUTINE VISION EXAMS

Visual acuity tests are covered for adults and children as part of their routine physical exams.

Visits to a specialist (optometrist or ophthalmologist) for routine vision exams are covered as follows:

For adults age 18 and older:

- Routine eye exams are covered every 24 months, and only when provided by a network optometrist or ophthalmologist.

For children:

- Routine eye exams are covered as part of routine physical exams.
- The eye exam may also be given by a network optometrist or ophthalmologist.

Vision exams are covered only by a network optometrist or ophthalmologist.

ROUTINE HEARING EXAMS

Hearing exams are covered as part of a routine physical exam Visits to a specialist or audiologist are covered under *Specialist Care*.

HOSPITAL AND OTHER FACILITY BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

INPATIENT HOSPITAL CARE

Your care is covered for the following services when you're in the hospital. Please check the *Schedule of Benefits* for any day limits.

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary. We also cover intensive care when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- use of operating room and recovery room
- drugs listed in the U.S. Pharmacopoeia or National Formulary
- therapy:
  - chemotherapy and infusion therapy by a doctor
  - occupational therapy as called for in your doctor's treatment plan when:
    - needed to help your condition improve in a reasonable and predictable time, or
    - needed to establish an effective home exercise program
  - physical therapy as called for in your doctor's treatment plan when:
    - done by a doctor or licensed physical therapist, and
    - needed to help your condition improve in a reasonable and predictable time, or
    - needed to establish an effective home exercise program
  - radiation therapy for cancer and neoplastic diseases
  - inhalation therapy by a doctor or registered inhalation therapist
  - speech therapy, when:
    - done by a licensed or state certified speech therapist; and
    - ordered by a doctor; and
    - done to improve speech impairment caused by:
      - disease
      - trauma
      - congenital defect, or
      - recent surgery
  - cognitive therapy done by an approved provider. The diagnoses eligible for coverage are:
    - stroke with cognitive impairment, or
    - head injury or trauma.
  - cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.
- surgical dressings
- administration of blood or blood plasma (but not blood itself)
- machine tests
- imaging exams (such as X-rays)

- durable medical equipment
- lab tests
- dialysis

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy
- childbirth
- miscarriage

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

This plan conforms with this federal law, which states that group health plans may not restrict mothers' and newborns' benefits for a hospital length of stay related to childbirth to less than:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean section.

Maternity lengths of stay may be less than the 48 or 96 hours *only* if both the patient and physician agree.

NEWBORN CARE

Hospital care for a newborn child is covered, provided the newborn is enrolled. See *Changes in Enrollment, Newborns* in the Guide to Enrollment section.

OUTPATIENT SURGICAL FACILITY

You're covered for minor surgeries done as an outpatient. Surgeries may be done at:

- hospitals
- approved ambulatory surgical centers

Dental surgery is normally only covered when done in a dentist's or an oral surgeon's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by Highmark Delaware.

EMERGENCY ROOM

You're covered for emergency care in emergency facilities. See the *Emergency and Urgent Care* section for more information.

SKILLED NURSING FACILITY

You're covered for confinement in a skilled nursing facility. Highmark Delaware must approve your stay. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient skilled nursing facility care.

The plan covers:

- skilled nursing and related care as an inpatient
- rehabilitation when needed due to illness, disability or injury

The plan doesn't cover intermediate, rest and homelike care.

SURGICAL AND MEDICAL BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

SURGICAL BENEFITS

Surgical services include:

- cutting and operative procedures
- treatment of fractures and dislocations
- delivery of newborns

These services can be done:

- in hospitals
- in approved ambulatory surgical centers
- at home
- in the doctor's office

The allowable charge includes pre- and post- operative care done by surgeons. We don't pay separate charges for such care.

Dental Surgery

Dental surgery is only covered for:

- extracting bony impacted teeth; or
- correcting accidental injuries (to the jaws, cheeks, lips, tongue, roof and floor of mouth)

Such surgery is covered when done in a dentist's or an oral surgeon's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by us.

Coverage is not provided for the extraction of normal, abscessed or diseased teeth or for the removal, repair or replacement of teeth damaged due to accidental injuries or disease even if such services are necessary to correct other injuries suffered as a result of accident or disease.

When it is medically necessary, due to a member's physical, intellectual or other medically compromised condition, for dental services to be performed under general anesthesia outside of a dentist's or oral surgeon's office, Highmark Delaware will cover the anesthesia and facility charges. Highmark Delaware must approve such care.

Multiple Surgical Procedures

When one doctor does more than one procedure on a patient in a single day:

- we provide full contract benefits for the procedure with the highest allowable charge
- we determine coverage for the other procedures using special rules on multiple surgical procedures

When a procedure normally done in one stage is done in two or more stages:

- we cover the entire procedure as one stage

Women's Health and Cancer Rights Act of 1998

This federal law requires coverage of mastectomy-related services, provided in a manner determined in consultation with the attending physician and patient. This coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas

ANESTHESIA

Anesthesiologist services are covered when medically necessary.

ORGAN TRANSPLANTS

This section describes the coverage for the following human organ transplants:

- heart
- lung/lobar lung
- combined heart and lung
- pancreas
- combined pancreas and kidney
- small bowel
- liver
- combined small bowel and liver
- multivisceral
- autologous bone marrow/stem cell
- allogenic bone marrow/stem cell
- kidney

The level of coverage for these transplants depends upon the facility where the transplant is performed:

- Transplants performed at a Blue Distinction Center for Transplant® (BDCT) are covered at the level of the member's inpatient facility benefit for network providers.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
  - The benefit includes all organ acquisition costs.
- Transplants performed at non-BDCT, but participating hospitals are covered at the out-of-network inpatient or outpatient facility and professional service benefit levels.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
- There are no BDCT facilities for kidney transplants. Kidney transplants are covered at the member's benefit plan's facility and professional benefit levels.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a $10,000 coinsurance expense limit would apply.
  - Allowable charges for harvesting/procurement for kidneys are determined by Highmark Delaware.
- Bone Marrow/Stem Cell Transplants are covered at the member's benefit plan's facility and professional benefit level.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a $10,000 coinsurance expense limit would apply.
  - Allowable charges for donor treatment and harvesting for bone marrow/stem cells are determined by Highmark Delaware.
- Transplants performed at non-participating hospitals are not covered.

- Travel Reimbursement. For transplants that occur at a facility that is located greater than 50 miles from the recipient's home, the following will be covered during the reimbursement period:
  - $150/day limit for reasonable lodging and meals.
  - Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant facility. Reimbursement is calculated using Highmark Delaware's current mileage reimbursement rate.
  - Air travel is reimbursed at the price of the airline ticket (coach class).
  - Tolls and parking incurred while traveling between recipient's home or temporary lodging and transplant facility.
  - There is a $10,000 aggregate limit for all travel costs.

  The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered.

You must have appropriate medical clearances to be eligible for the surgery.

If you have questions about Highmark Delaware's organ transplant policy, please contact the Medical Management Department at the number listed in the front of this booklet.

INPATIENT MEDICAL SERVICES

Medical visits by the attending doctor are covered when you're an inpatient. This does not include when you're having surgery. Surgeon pre- and post-operative care is covered under global surgery payment.

We normally cover one doctor visit per day. Usually this is your attending doctor. If another specialist visits you, we may cover the visit, under the following conditions:

- the doctor in charge certifies in writing it's medically necessary
- the specialist isn't the attending doctor or operating surgeon
- the specialist is a doctor

Only one consultation per specialty per admission is covered.

See the *Mental Health and Substance Abuse Care* section for a description of related doctor visits.

EMERGENCY CARE

You're covered for emergency care in emergency facilities. See the *Emergency and Urgent Care* section for more information.

OBSTETRIC CARE

Obstetric care by doctors and midwives is covered. Coverage is the same as for other surgical and medical care. This includes:

- prenatal care
- anesthesia
- delivery
- postnatal care

Midwives are licensed and certified nurses. They must be practicing within the scope of their license. When we cover midwife care, we do not cover a doctor's care for the same services.

NEWBORN CARE

Medical care of a newborn child by a physician is covered, provided the newborn is enrolled. See *Changes in Enrollment, Newborns* in the Guide to Enrollment section.

EMERGENCY AND URGENT CARE

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

EMERGENCY CARE

If you have a life-threatening emergency, go directly to the nearest emergency provider. We cover the emergency facility, ancillary services and physician care when:

- the condition is serious enough to cause a prudent person to seek emergency care
- a delay in care might cause permanent damage to your health

Some examples are:

- broken bones
- heavy bleeding
- sudden, severe chest pain
- poisoning
- choking
- convulsions
- loss of consciousness
- severe burns

Mental Heath and Substance Abuse Emergencies

An emergency mental health or substance abuse condition is one which requires voluntary or involuntary hospitalization because the individual patient is a danger to himself or herself, or to others.

COVERAGE FOR EMERGENCIES:

The facility must be a hospital, or a freestanding emergency facility operating with physicians and nursing personnel on a 24 hour, 7 days per week schedule. You may have a copayment for the emergency facility. The copayment is waived if you're admitted to the hospital directly from the emergency room.

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

- a sudden, serious condition requires travel right away
- you are taken to the nearest hospital that can treat you

When you can travel by private car, the ambulance isn't covered. Only one-way travel to the hospital is covered, except when being transported from hospital to hospital for specialized care. In such cases round trip transportation is covered.

Air ambulance is covered only when no other means of travel is appropriate.

When billed separately, these items are not paid:

- patient care equipment
- reusable devices
- first aid supplies

Benefits are not provided when paramedic services are given by state, county or local government.

URGENT CARE AND URGENT CARE FACILITIES/MEDICAL AID UNITS

WHEN YOU'RE HOME

Urgent care is for an injury or sudden illness that isn't life threatening, but you need care within a day or two to avoid:

- jeopardizing your life, health, or ability to regain maximum function
- in the opinion of your physician, would subject you to severe pain that cannot be adequately managed without the care

Some examples include ear infections, migraine headaches and significant gastro-intestinal pain.

For urgent care you can either:

- see your regular doctor
- seek care at an urgent care center

An urgent care facility (also known as a medical aid unit) is a medical facility staffed by physicians and other medical personnel equipped to provide treatment of minor illnesses and injuries of an urgent nature which require prompt, but not emergency treatment.

WHEN YOU'RE TRAVELING

If you're traveling out of state and need urgent care, follow these steps:

Step 1

Find a provider. You can call 800.810.BLUE (800.810.2583) to get connected to a 24-hour referral service. This service helps you find doctors who participate with the local Blue Cross Blue Shield plan where you're traveling. If a doctor is found, you're given the doctor's name, office address and phone number.

You can also use the **highmarkbcbsde.com** website to find a provider. The website can access the names, office addresses and phone numbers of network providers nationwide.

Step 2

Call the doctor's office for an appointment and tell them that you're a Highmark Delaware customer. **To get the highest benefit, be sure the provider participates with the local Blue Cross Blue Shield plan.** The doctor's office will check your enrollment. When you receive care, you will be charged the copayment listed on your I.D. card, if any. The doctor's office will then bill the local Blue Cross Blue Shield plan, and the claim will be forwarded to us.

DIAGNOSTIC AND THERAPEUTIC SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

INPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

When you're an inpatient, professional care for diagnostic and therapeutic care is covered. See the *Inpatient Hospital Care* section for more information.

OUTPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

DIAGNOSTIC SERVICES

The diagnostic benefits described below apply when you're an outpatient in:

- a provider's office
- an approved freestanding lab, imaging or machine testing provider
- a hospital's outpatient department

Covered care includes:

- imaging services
- lab tests, and
- machine tests

PREADMISSION TESTING

We cover tests done before a scheduled admission for surgery.

Tests must be done

- as an outpatient
- within 7 days before the admission

Tests are not covered if

- they are done for diagnosis
- they are repeated after you enter the hospital
- you, not the hospital or physician, cancel or postpone the admission

THERAPY SERVICES

The therapeutic benefits described below apply when you're an outpatient in:

- a provider's office
- a hospital's outpatient department

Covered care includes only:

- chemotherapy and infusion therapy by a doctor
- occupational therapy as called for in your doctor's treatment plan when:
  - needed to help your condition improve in a reasonable and predictable time, or
  - needed to establish an effective home exercise program
- physical therapy as called for in your doctor's treatment plan when:
  - done by a doctor or licensed physical therapist, and

  - needed to help your condition improve in a reasonable and predictable time, or
  - needed to establish an effective home exercise program

- radiation therapy for cancer and neoplastic diseases

- inhalation therapy by a doctor or registered inhalation therapist

- speech therapy. Therapy must be:
  - done by a licensed or state certified speech therapist
  - ordered by a doctor, and
  - needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery

- dialysis

- cognitive therapy done by a provider approved by Highmark Delaware. The diagnoses eligible for coverage are:
  - stroke with cognitive impairment, or
  - head injury or trauma

- cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.

- vision therapy as called for in your doctor's treatment plan, which must include the projected period of treatment

APPLIED BEHAVIOR ANALYSIS

Benefits are provided for applied behavior analysis for the treatment of autism spectrum disorders in persons under 21 years of age. We may ask for a review of the patient's treatment once every 12 months.

OTHER COVERED SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

HOSPICE

Hospice provides palliative and support care to terminally ill patients and their families.

You may have hospice care at home, in an inpatient hospice facility or a short or long term nursing facility. Highmark Delaware must authorize hospice provided as an inpatient or in a skilled nursing facility.

What Is Covered Under Hospice:

- care by a hospice doctor
- nursing care
- home health aide supervised by a registered nurse
- social service guidance
- nutritional counseling and meal planning
- physical therapy
- speech therapy
- occupational therapy
- spiritual counseling by the hospice
- medical supplies that are needed to manage the illness
- prescription drugs related to the palliative management of the patient's terminal illness
- bereavement counseling for the family for up to 13 months following the death of the patient

Some services you have during hospice care are not paid under this benefit. They are paid like other covered benefits, such as

- care by a non-hospice doctor
- prescription drugs other than those drugs used for palliative management
- durable medical equipment (DME) not related to palliative management
- palliative chemotherapy or radiation therapy when needed to manage the illness
- inhalation therapy
- imaging and lab tests

If your plan covers these benefits, they will be paid according to the coverage indicated for that specific benefit.

What's Not Covered Under Hospice:

- private duty nursing
- respite care
- care not prescribed in the approved treatment plan
- financial, legal or estate planning
- hospice care in an acute care facility, except when a patient in hospice care requires services in an inpatient setting for a limited time

HOME HEALTH CARE

Home health care is covered. The provider and treatment plan must be approved by Highmark Delaware. Medical records or a suitable summary of the progress of the treatment plan must be reviewed by the attending doctor at regular intervals, or at least every 30 days.

Guidelines:

- Care must be needed to treat or stabilize a condition. Care to maintain a chronic condition is not covered.
- There's a limit of one visit per day per specialty. (A nurse and home health aide count as one specialty for this benefit.)
- Care must be under the direction of a doctor.
- The patient must be home bound and medically unable to get care as an outpatient.
- Care must be in lieu of inpatient care.

What Is Covered Under Home Health:

- skilled nursing care by an RN or LPN
- therapy by licensed or state certified therapists for:
  - physical therapy
  - speech therapy
  - occupational therapy
- medical and surgical supplies
- social service guidance by a licensed or state certified social worker, and
- home health aide when supervised by an RN (limit of 3 visits per week)

What's Not Covered Under Home Health:

- drugs
- lab tests
- imaging services
- inhalation therapy
- chemotherapy and radiation therapy
- dietary care
- durable medical equipment
- disposable supplies
- care not prescribed in the approved treatment plan, and
- volunteer care

HOME INFUSION

Infusion services are covered in the home for receiving needed infusion medicine. It involves the use of an infusion pump with fluids, nutrients and drugs. Highmark Delaware must approve the treatment plan. The plan must be prescribed by a doctor in lieu of inpatient care.

What Is Covered Under the Infusion benefit:

- nursing care
- medications (includes drug preparation and monitoring)
- solutions, and
- needed infusion pumps, poles and supplies.

What's Not Covered Under Home Infusion:

- delivery costs
- record keeping costs
- doctor management
- other services which do not involve direct patient contact
- drugs normally covered under a drug program (whether or not Highmark Delaware provides your drug coverage)

INPATIENT PRIVATE DUTY NURSING

Private duty nursing care is covered when you are an inpatient in an acute hospital. We may review the case in advance. We may review the case again after 80 hours of care. Care must be:

- ordered by the attending doctor
- for the same condition you're hospitalized for
- approved by the hospital

This care isn't covered when done in special care units of the hospital, such as:

- self-care units
- selective care units
- intensive care units

This care isn't covered when done as a convenience even if authorized by your doctor.

DOCTOR'S VISITS

Visits with a doctor in the office or your home are covered. This includes visits for injury or illness.

Unless stated on the *Schedule of Benefits*, routine physical exams and tests are not covered.

SPECIALIST/REFERRAL CARE

Home and office visits with specialists are covered. Benefits are also provided for a specialist virtual visit, which is subsequent to the member's initial in-person visit with his or specialist for the same condition. The provider-based location from which the member communicates with the specialist is referred to as the "originating site".

ALLERGY TESTING AND TREATMENT

Allergy testing and treatment are covered.

CHIROPRACTIC CARE

The following care is covered when done by a licensed chiropractor for the treatment of spinal conditions:

- office visit for initial evaluation
- manual manipulation of the spine
- ultrasound, traction therapy and electrotherapy

The following limits apply:

- three modalities per visit
- one visit per day

Chiropractic services must either provide significant improvement in your condition in a reasonable and predictable period of time or be necessary to the establishment of an effective maintenance program. Chiropractic services that are part of a maintenance program are not covered.

Chiropractic X-rays are covered only for X-rays of the spine.

Durable medical equipment (DME) is covered. This includes cervical collars and lumbar sacral supports. These are covered under your DME benefit.

Machine tests are covered under your Therapeutic and Diagnostic Services benefit.

DURABLE MEDICAL EQUIPMENT & PROSTHETICS

Durable Medical Equipment

Covered durable medical equipment (DME) includes items that are:

- prescribed by a doctor
- useful to a person only during an illness or injury
- deemed by Highmark Delaware to be medically necessary and appropriate

Some examples of DME are:

- orthopedic braces
- wheel chairs
- orthotics
- hospital beds

We may pay for rent or purchase. If we rent the equipment, our total payment won't exceed the purchase price.

Prosthetics

Covered prosthetics includes items that are

- intended to replace all or part of an organ or body part lost to disease or injury, or absent from birth, or permanently inoperative or malfunctioning
- prescribed by a qualified provider
- removable and attached externally to the body
- deemed by Highmark Delaware to be medically necessary and appropriate

Some examples of prosthetics are:

- hair prostheses for hair loss caused by alopecia areata resulting from an autoimmune disease
- limb, ear, or eye prostheses
- electro-larynx devices

We also pay to replace or repair prosthetic devices.

We also pay for:

- medical foods and formula for the treatment of inherited metabolic disorders
- hearing aids. Benefits are limited to $1,000 per individual hearing aid, per ear, every three (3) years.

DME & Prosthetics Not Covered:

- items for comfort or convenience
- dental prosthetics
- foot orthotics

CARE FOR MORBID OBESITY

Patients who are overweight and have serious, weight-related diseases, such as hypertension, type II diabetes, and cardiac disease, are considered morbidly obese.

If you are morbidly obese, we cover the following:

- Office visits – payable on the same basis and at the same reimbursement level as other covered outpatient physician visits.
- Laboratory tests - payable on the same basis and at the same reimbursement level as other covered outpatient laboratory services.

Surgical treatment of morbid obesity is covered when certain conditions are met. All such care must be approved by Highmark Delaware.

SURGERY FOR MORBID OBESITY

If you are morbidly obese, we cover the following surgical procedures:

- gastric bypass
- gastric stapling
- biliopancreatic bypass with duodenal switch
- gastric banding
- sleeve gastrectomy

You must:

- have achieved full growth and be 18 years or older (members under age 18 may also qualify under certain circumstances), and
- have no specific, treatable, correctable cause for the morbid obesity (e.g., endocrine disorder), and
- complete a structured diet program in the 2-year period that immediately precedes the request for the surgery, and
- have received a psychological evaluation specifically for the diagnosis of obesity or morbid obesity,
- have received appropriate medical (including cardiac and pulmonary) clearances from your physician, and
- meet any of the following criteria:
  - you weigh at least 100 pounds above or are twice the ideal body weight; or
  - have a BMI of at least 40 (at least 50 for sleeve gastrectomy and biliopancratic bypass with duodenal switch); or
  - have a BMI equal or greater than 35, in conjunction with one or more of the following co-morbid conditions: degenerative joint disease, hypertension, coronary artery disease, diabetes, sleep apnea, lower extremity venous/lypmphatic obstruction, obesity related pulmonary hypertension.

Unless otherwise specified on the *Schedule of Benefits*, benefits for surgery for morbid obesity are paid like other surgical procedures.

PRESCRIPTION DRUG BENEFITS

Check the *Schedule of Benefits* pages for limits and payments. If required by law, copayments will not apply.

If you have questions about your drug benefits, call Highmark Delaware Member Services at 800.633.2563.

DEFINITIONS

Generic Drugs means those drugs that are copies of the Preferred or Non-Preferred Brand Drugs in dosage form, strength, route of administration, quality and performance characteristics, and intended use. They are not marketed under a specific trade name. These drugs

- contain the same active ingredients in the same strength as the Preferred or Non-Preferred Brand Drugs
- are equally effective as the Preferred or Non-Preferred Brand Drugs at treating the medical condition
- meet the same Federal requirements as the Preferred or Non-Preferred Brand Drugs

Preferred Drug List (PDL) means the list of preferred drugs for certain conditions. Several similar drugs may work equally well for a given medical condition. For various reasons, one drug may be given a preferred status over other similar drugs and placed on the PDL. We may make changes to the PDL periodically. You can check **highmarkbcbsde.com** or call Highmark Delaware Member Services at 800.633.2563 for the current list of drugs on the PDL.

Preferred Brand Drugs means those drugs on the PDL which are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection.

Non-Preferred Brand Drugs means those drugs not on the PDL which are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection.

BENEFITS

The following are covered when prescribed for use outside the hospital:

- those drugs which, under federal law, are required to bear the legend: "Caution: federal law prohibits dispensing without a prescription"
- legend drugs under applicable state law and dispensed by a licensed pharmacist
- certain over-the-counter (OTC) drugs when prescribed by your doctor and required by law to be covered. See highmarkbcbsde.com for a list of these drugs.
- preventive drugs that are offered in accordance with Highmark Delaware's Preventive Health Guidelines and are prescribed for preventive purposes
- injectible insulin prescribed by your doctor
- diabetic supplies prescribed by your doctor, including needles and syringes

DISPENSING LIMITS

Prescription drugs may also have dispensing limits. These include:

- 90-day supply at a retail pharmacy or through mail order
- limit of a 3-month supply for oral contraceptives at one time
- renewals past one year from the original prescription are not accepted

NOTE: Highmark Delaware may apply other dispensing limits.

PRESCRIPTION DRUG MANAGEMENT

Your prescription drug program provides the following provisions which will determine the medical necessity and appropriateness of covered medications and prescriptions. These include:

- Quantity Limits – these limits are based on the manufacturer's recommended daily dosage or are determined by Highmark Delaware. They apply each time a new prescription order or refill is dispensed. The list of drugs that are subject to Quantity Limits can be found at: highmarkbcbsde.com.
- Quantity Level Limits for Initial Prescription Orders – Additional quantity level limits may be imposed for your initial prescription order for certain covered medications, to reduce the quantity to the level necessary to establish that you can tolerate the medication. Any cost sharing will be adjusted accordingly.
- Managed Prescription Drug Coverage – A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by Highmark Delaware when presented to the pharmacy provider. We may contact the prescribing physician to determine if the prescription drug is medically necessary and appropriate. If is determined by us that it is, the drug will be dispensed.
- Prior Authorization – Some prescriptions require prior approval before dispensing to be eligible for coverage. Prior authorization is used to ensure that appropriate medical criteria are met for the use of a particular drug. When you receive a prescription for one of these drugs, please explain to the prescribing physician that prior authorization is needed before benefits will be available for you. A list of drugs that require prior authorization may be found at: highmarkbcbsde.com.

HOW THE RETAIL PROGRAM WORKS

PHARMACIES IN THE NETWORK

To fill or refill prescriptions, show your Highmark Delaware ID card at the pharmacy. You'll be asked to pay any copayment, deductible and/or coinsurance that apply. (See the *Schedule of Benefits*). There's a separate copayment and/or coinsurance for each prescription. The drug store handles all other billing for you.

PHARMACIES NOT IN THE NETWORK

You must pay the pharmacy the full charge. Prescription drugs are not covered out-of-network.

HOW THE MAIL SERVICE PROGRAM WORKS

Mail order services provided by Express Scripts.

Express Scripts
PO Box 747000
Cincinnati, OH 45274-7000

You can also register and activate a mail order account at highmarkbcbsde.com.

WHAT'S NOT COVERED UNDER THE DRUG PROGRAM

In addition to the exclusions listed in the section *What is Not Covered*, there is no coverage for:

- Drugs other than caution legend drugs and injectable insulin (except for aspirin and certain OTC drugs as required by law)
- Administration or injection of drugs
- Vitamins, except those that by law need a prescription
- Drugs you get while a patient in a health care facility
- Drugs provided under Workers Compensation laws
- Drugs covered through any government agency, unless required by law
- Drugs for weight loss
- Drugs that have either a generic or brand name equivalent available without a prescription
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances) other than those related to diabetic care
- Any charges by any pharmacy provider or pharmacist except as provided herein
- Food supplements
- Immunizations/biologicals
- Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care described herein
- Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider
- Services of your attending physician
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA)
- Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility
- Any prescription for more than the retail days' supply or mail-service days' supply as outlined in the *Schedule of Benefits* and *Dispensing Limits*, above
- Any prescription drug which has been disallowed under the Prescription Drug Management section of this booklet
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes
- Any drugs and supplies which can be purchased without a prescription order, including but not limited to blood glucose monitors and injection aids, unless specifically described as provided herein
- Compounded prescriptions
- Any selected diagnostic agents

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Check the *Schedule of Benefits* for benefit levels.
Follow managed care requirements to get the highest benefit!

This plan provides benefits for the treatment of behavioral health disorders, including mental illness and substance abuse. For inpatient, partial hospital and intensive outpatient care, managed care requirements must be followed.

INPATIENT HOSPITAL CARE

Inpatient hospital care is covered on an emergency or planned basis. The following services are covered when you're in the hospital:

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- Electroconvulsive therapy by a doctor
- Detoxification
- Drugs listed in the U.S. Pharmacopoeia or National Formulary
- Lab tests

PARTIAL HOSPITAL CARE

This plan also covers partial hospital programs. A partial hospital program provides an intermediate level of care as an alternative to inpatient hospitalization or as an option following inpatient hospitalization. Partial hospital programs generally are provided within a psychiatric hospital or behavioral health department of a hospital.

INTENSIVE OUTPATIENT CARE

Intensive outpatient care in a free-standing or hospital-based program is covered. Intensive outpatient programs provide a step down from acute inpatient or partial hospitalization, or a step up from outpatient care in office settings.

OUTPATIENT CARE – OFFICE VISITS

Outpatient care covers:

- brief crisis intervention psychotherapy
- psychiatric consultations
- supportive psychotherapeutic treatment
- psychological tests

Care must be by a network provider such as a:

- doctor
- licensed clinical psychologist
- licensed professional counselor of mental health (LPCMH)
- licensed clinical social worker
- nurse practitioner

Care must be done in the provider's office or as a hospital outpatient.

WHAT IS NOT COVERED

The following services and items are not covered.

- Acupuncture.
- Ancillary services (including but not limited to, office visits, physician care, lab and radiology procedures and prescription drugs) in conjunction with a non-covered service.
- Artificial insemination procedures.
- Artificial reproductive technologies (ART), including, but not limited to:
  - In vitro fertilization (IVF) procedures
  - Gamete intrafallopian transfer (GIFT) procedures
  - Zygote intrafallopian transfer (ZIFT) procedures.

  Any procedures, services, supplies, physician care or drugs related to ART are also not covered.
- Biofeedback
- Blood, blood components and donor service.
- Care as a result of any criminal act in which you conspired or took part. One example is Highmark Delaware does not pay for the court mandated instruction course or rehabilitation program resulting from driving under the influence of alcohol or drugs.
- Care, unless required by law, by:
  - a school infirmary
  - a student health center
  - staff working at the above
- Care for complications or consequences of services and items not covered.
- Care for cosmetic reasons.
- Care for weight loss, unless co-morbid conditions are present.
- Care given by a family member. "Family" means yourself, your spouse or domestic partner, your parents, step-parents, children or step-children, your parents, children or siblings-in-law, your grandparent or grandchild, and your siblings, stepbrother or stepsister.
- Care given by any person living with you.
- Care given by institutions or agencies owned or operated by the government, unless the law requires otherwise.
- Care given by your employer's health department.
- Care needed through an act of war if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care not directly related to or necessary for the diagnosis or treatment of illness or injury. Care must:
  - be consistent with the symptom or treatment of the condition
  - meet the standard of accepted professional practice

    - not be solely for anyone's convenience
    - be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient
    - is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

- Care we consider to be experimental or investigational. Some examples are:
    - care we consider not to be accepted medical practice, and
    - care that requires government agency approval, and the approval hasn't been granted.

  Routine care costs related to approved clinical trials, as determined by Highmark Delaware, are covered.

- Care you can have without charge in the absence of insurance.

- Certain mental health and substance abuse services, including:
    - aptitude tests
    - testing and treatment for learning disabilities
    - treatment for personality disorders
    - treatment factitious disorders
    - treatment of sleep disorders
    - treatment of sexual disorders
    - care beyond that needed to determine mental deficiency or retardation
    - marital/relationship counseling, and
    - care at behavioral health facilities

- Convenience items. Some examples are:
    - phones
    - TVs
    - radios
    - other personal items

- Custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care, whether or not prescribed by a physician.

- Dental care, except certain dental care noted in the *Surgical and Medical Benefits* section.

- Drugs or care received in violation of law.

- Exams or tests done as inpatient for convenience when such care could be done as outpatient.

- Eye or hearing exams, unless noted elsewhere in this booklet.

- Eyeglasses, contact lenses and all procedures for refractive correction.

- Immunization or inoculations, unless noted elsewhere in this booklet. Immunizations or inoculations for travel are not covered, except as required by law.

- Injury or illness on the job. One example is any care normally covered under Workers' Compensation or occupational disease laws.

- Items or services that can be purchased without a prescription, unless noted elsewhere in this booklet. Some examples are:

- Blood pressure cuffs
- Contraception, first aid and other medical supplies
- Exercise equipment
- Incontinence and personal hygiene supplies

- Methadone Maintenance (methadone hydrochloride treatment) for which no additional functional progress is expected to occur.

- Occupational or physical therapy for developmental delay.

- Orthotic equipment and devices for feet. Some examples are:
  - foot inserts
  - arch supports
  - lifts
  - corrective shoes

  Dental orthotics are also excluded.

- Physical exams, or any other services or treatments required by or intended for:
  - potential employers or licensing authorities (for example, marriage physicals)
  - insurers
  - schools or camps
  - courts or legal representatives
  - any other third party

- Routine foot care.

- Services in excess of your covered benefit limits.

- Speech therapy for:
  - attention disorders
  - behavior problems
  - conceptual handicaps
  - learning disabilities
  - developmental delays

- Surgery to reverse voluntary sterilization.

- Thermography.

- Transcutaneous electrical nerve stimulation (TENS) units, replacement lead wires, other related supplies or batteries.

- Treatment of developmental delay unless there is an identifiable underlying cause.

- Treatment of Temporomandibular Joint (TMJ) Dysfunction Syndrome, unless there is documented organic joint disease, or joint damage resulting from physical trauma. This includes exams for fittings, occlusal adjustment and TMJ devices.

- Unless otherwise noted in this booklet, we cover one service per day by a professional provider. If more than one service is done, we cover only the service with the greater allowable charge.

VALUE ADDED FEATURES

Highmark Delaware offers Value Added Features. They are described below.

Value Added Features are administered only as specified in the Highmark Delaware Value Added Features materials.

Please note: Highmark Delaware has the right to change or discontinue these programs at any time.

EYEWEAR DISCOUNTS

On behalf of Highmark Delaware, your eyewear discount program is administered by Davis Vision, an independent managed vision care company.

You can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 888.235.3119 (TTY: 800.523.2847) or visit **www.davisvision.com**.

DISCOUNT PROGRAMS

Savings on a variety of product and services are available to Highmark Delaware members, including:

- Fitness clubs
- Alternative health services (i.e., acupuncture, chiropractic care)
- Laser vision corrective surgery
- Fitness gear
- Weight loss programs and healthy eating options
- Hearing aids

For a full listing of our discounts go to **highmarkbcbsde.com** or call us at 800.633.2563.

WELLNESS PROGRAMS

A comprehensive wellness program is built into every Highmark Delaware member's plan at no extra charge. The program includes:

- Personalized Health Plan – tailored health program just for you based on your health status
- Online Health Risk Assessment – an online questionnaire that helps identify any health risks you may have
- Online Programs – self-directed courses for smoking cessation, weight management, walking, physical activity, alcohol and stress
- Telephone Health Coaching – One-on-One coaching to guide and support you with your Personalized Health Plan

YOUR RIGHTS AND RESPONSIBILITIES

As a Highmark Delaware member, you have certain rights and responsibilities. Please review them. Please call us if you have any questions.

You have the RIGHT to:

- Be treated with courtesy, consideration, respect and dignity.
- Have your protected health information (PHI) and health records kept confidential and secure, in accordance with applicable laws and regulations.
  - Receive communications about how Highmark Delaware uses and discloses your PHI.
  - Request restrictions on certain uses and disclosures of your PHI.
  - Receive confidential communications of PHI.
  - Inspect, amend and receive a copy of certain PHI.
  - Receive an accounting of disclosures of PHI.
  - File a complaint when you feel your privacy rights have been violated.
- Available and accessible services when medically necessary, including urgent and emergent care 24 hours a day, seven days a week.
- Receive privacy during office visits and treatment.
- Refuse care from specific practitioners.
- Know the professional background of anyone giving you treatment.
- Discuss your health concerns with your health care professional.
- Discuss the appropriateness or medical necessity of treatment options for your condition, regardless of cost or benefit coverage for those options.
- Receive information about your care and charges for your care.
- Receive from your provider, in easy to understand language, information about your diagnoses, treatment options including risks, expected results and reasonable medical alternatives.
- All rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medications and treatment after possible consequences of this decision have been explained to you in your primary language.
- Receive information about Highmark Delaware, its policies, procedures regarding its products, services, practitioners and providers, complaint procedures, and members'/enrollees' rights and responsibilities.
- Prompt notification of termination or changes in benefits, services or the provider network.
- Play an active part in decisions about your health care including formulating an advance directive.
- Receive benefits and care without regard to race, color, gender, country of origin, or disability.
- File a complaint with Highmark Delaware and receive a response to the complaint within a reasonable period of time.
  - This includes requesting an internal appeal or review by an Independent Utilization Review Organization. To register a complaint or request an appeal members are instructed to call the Customer Service number listed on their ID card.
- Submit a formal complaint about the quality of care given by your providers.

- Make recommendations regarding Highmark Delaware's members' rights and responsibilities policies.

You have the RESPONSIBILITY to:

- Double-check that any facilities from which you receive care are covered by Highmark Delaware. Visit highmarkbcbsde.com or call the Customer Service number listed on your ID card to ask about a facility.
- Show your ID card to all caregivers before having care.
- Keep your appointments. If you will be late or need to cancel, give timely notice (in accordance with your provider's office policy). You may be responsible for charges for missed appointments.
- Treat your providers with respect.
- Provide truthful information (to the extent possible) about your health to your providers. This includes notifying your providers about any medications you are currently taking.
- Understand your health and participate in developing mutually agreed upon treatment goals.
- Tell your health care providers if you don't understand the care he or she is providing.
- Follow the advice of your health care provider for medicine, diet, exercise and referrals.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Pay all fees in a timely manner.
- Maintain your Highmark Delaware eligibility. Notify us of any change in your family size, address or phone number.
- Tell Highmark Delaware about any other insurance you may have.

A GUIDE TO ENROLLMENT INFORMATION

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You
- Your spouse or domestic partner,
- Your children

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

- **Self** for you only
- **Self and Child(ren**) for you and your children
- **Self and Spouse** for you and your spouse (or domestic partner),
- **Family** for you, your spouse (or domestic partner), and your children

SPOUSE

You may enroll your spouse. The words "spouse", "spousal", "marry", "married", "marriage", and "marital" refer to the legal relationship between two persons united together in either:

- a marriage
- a civil union

that is recognized by and valid under Delaware law. Similarly, the word "divorce" refers to the legal dissolution of a marriage or civil union.

CHILDREN

To be covered, a child must be:

- age 26 or younger
- either:
  - born to the employee or his or her spouse (or domestic partner)
  - adopted by the employee or his or her spouse (or domestic partner)
  - placed in the home of the employee or his or her spouse
  - someone for whom health care coverage is your or your spouse's responsibility under the terms of a qualified medical child support order. A copy of the order must be provided to Highmark Delaware.

Highmark Delaware may require proof of dependency.

DISABLED CHILDREN

Disabled children can be covered after age 26. They may be covered if they:

- meet all of the criteria for a 'child', except age
- are not married
- were covered continuously as a child by a group plan through their parent before exceeding age 26

- are receiving 50% or more of their support from a parent because of a disability that:
  - occurred before exceeding age 26
  - is expected to last more than 12-months or is in terminal in nature
  - is so severe the child is incapable of self-support
- are not eligible for coverage under another health plan, Medicare or Medicaid, unless federal or state law requires otherwise

Other rules may apply in the case of divorced parents.

You must file a *Disabled Child Application* form with Highmark Delaware. You may get the form from us or your employer.

DOMESTIC PARTNER

You may enroll your domestic partner (and his or her dependents) in lieu of a spouse, provided your domestic partnership is recognized by Delaware law.

Domestic Partner means a person who meets all of the following criteria:

- Is considered by the subscriber as a life partner, and considers himself or herself a life partner of the subscriber
- Shares an intimate, committed relationship with the subscriber; intends to do so indefinitely; and has no such relationship with any other person
- Is, with the subscriber, jointly responsible for the welfare and financial obligations of each party
- Shares a primary residence with the subscriber and intends to do so indefinitely
- Is not related by blood to a degree of kinship that would prevent a marriage to the subscriber from being recognized under the law of the state of residence of both partners
- Is over age 18, of legal age, and mentally competent to enter a contract
- Is not married to, a partner in a civil union or a domestic partner with, a third party

To be covered, children of your domestic partner must meet the requirements for children described above.

Note: In this context, the use of the word 'spouse' in this booklet also connotes a domestic partner.

ENROLLMENT

HOW TO ENROLL

You may enroll yourself and your dependents by completing the enrollment materials and returning them to your employer (with any premium owed). You can get the enrollment materials from your employer.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You may need to complete a form and return it to your employer.

WHEN COVERAGE BEGINS

When your coverage begins is determined by:

- when you are eligible for coverage, and

- when you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee
- Special Enrollee
- Late Enrollee

TIMELY ENROLLEES

Who Can Be A Timely Enrollee

You are a Timely Enrollee if you enroll within 30 days of when you are first eligible to be covered.

When Coverage Begins

Coverage for new employees (and their dependents) begins on the first day of the month after you complete a 60-day eligibility waiting period.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

You are a Special Enrollee if you enroll within the 30-day enrollment period. The enrollment period is within 30 days of:

- losing other health coverage under certain conditions
- obtaining a new dependent because of marriage, domestic partnership, birth (enrollment period is 31 days, see section below entitled *Changes in Enrollment, Newborns*), adoption or placement in the home for adoption, or court ordered support

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- *Employees*: if you're not already enrolled in this plan, you must:
  - be eligible to enroll in this plan
  - enroll at the same time you enroll a dependent
- *Spouses* (or domestic partners), *and Children*: you're a dependent of an employee:
  - who is already enrolled or is eligible to enroll in this plan
  - who enrolls at the same time you enroll

If you don't enroll within the 30-day enrollment period, you are a Late Enrollee.

Loss Of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- you were covered under another group or individual health plan when coverage was previously offered under this plan (such as at the last reopening period)
- when this plan was previously offered, you declined coverage under this plan because you had other coverage
- the other coverage was either:
  - COBRA continuation coverage that is exhausted
  - other (non-COBRA) coverage that was lost because
    - you are no longer eligible

        - the lifetime limits under the other coverage were reached
        - the employer stopped contributing
- you enrolled within 30 days of the date the other coverage was lost
- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*

Special Enrollment Rights for Loss of Medicaid or Children's Health Insurance Program (CHIP) Enrollment

Effective April 1, 2009, you may enroll within 60 days of the date your Medicaid or CHIP coverage was terminated because you were no longer eligible.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of

- marriage
- domestic partnership
- birth
- adoption
- placement of a child in the home for adoption
- court ordered support

When Coverage Begins

Coverage for Special Enrollees begins as follows if we receive the enrollment materials and premium before the end of the 30-day enrollment period.

- *Employees*: the first day of the month after you enroll
- *Spouses*: the first day of the month after you enroll
- *Domestic Partners*: the first day of the month after you enroll
- *Children*: either
    - the date of birth (within 31 days), adoption or placement in the home for adoption
    - the first day of the month after you enroll if
        - you lost coverage under a prior plan
        - you, as a parent, got married or established a domestic partnership

Remember, if you enroll after the 30-day (31-day for newborns) enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be A Late Enrollee

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at a reopening period.

Children are Late Enrollees if they were not enrolled within 30 days of

- birth (31 days),
- adoption
- placement in the home for adoption

When Coverage Begins

Coverage for Late Enrollees begins the first day of the new plan year.

CHANGES IN ENROLLMENT

You can change your enrollment because of one of the reasons described below. *If added premium is due, you must pay when you enroll.*

You must enroll yourself (and any dependents) within a 30-day period from the dates of the events listed below to be Special Enrollees. You and/or your dependent(s) will be Late Enrollees if you are not enrolled within the 30-day period. Newborns must be enrolled within a 31-day period.

MARRIAGE

You may add your spouse when you get married or enter into a civil union. To ensure the earliest effective date of coverage for your spouse, you must postmark or send your enrollment materials to Highmark Delaware prior to the marriage, or no later than 10 days after the event (or requested effective date).

You may also add any eligible children or stepchildren when you marry.

NEWBORNS

You may add your newborn child. Care for newborns is covered from the child's date of birth if:

- You have coverage that already covers children. You must enroll the newborn within 31 days of the child's birth.
- You have coverage that doesn't cover children and you enroll for coverage that includes children. You must enroll within 31 days of the child's birth. If added premium is due, you must pay when you enroll.

ADOPTED CHILDREN

You may add a child because of adoption or placement in your home for adoption.

OTHER CHILDREN

If you add a newborn or an adopted child, you may also add other eligible stepchildren or siblings.

DOMESTIC PARTNERS

You may add your domestic partner (and his or her children) when your employer's requirements for a domestic partner are met.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may enroll in this plan.

MEDICARE ELIGIBILITY

Anyone covered by this plan who becomes eligible for Medicare must apply for and retain both Parts A and B of Medicare in order to remain eligible for this plan, unless:

- federal law requires the group health plan be primary, or
- through Medicare's ESRD program, he or she is not subject to a penalty for non-enrollment

This applies to you, your spouse (or domestic partner) and your children.

Highmark Delaware will not provide primary coverage to persons eligible for primary reimbursement under Medicare.

Discuss your options under federal law with your employer.

WHEN COVERAGE ENDS

Your employer must provide you and your dependents with a *Certificate of Coverage* when you lose coverage under this plan. You have up to 24 months following the loss of coverage to request a certificate. The *Certificate of Coverage* will show how long you were covered under this plan.

Please read the section, *Continuing your Coverage Under COBRA,* to see how you may extend your coverage.

Coverage ends the last day of the month in which you lose eligibility because of one of the events below:

DIVORCE

Former spouses aren't eligible to be covered. You must send an enrollment form when you become divorced.

LEAVE YOUR JOB

Coverage ends when you leave your job.

DEATH

Coverage ends for your dependents when you die.

CHANGE IN YOUR JOB STATUS

Coverage ends when you're no longer eligible through your job. This might happen if you begin to work fewer hours, etc.

CHANGE IN CHILD'S STATUS

Your child's coverage ends the earlier of:

- the end of the month in which the child reaches age 26
- if disabled, when the child no longer meets the criteria for coverage of disabled children; for example, when he or she marries, or no longer depends on you, your spouse or domestic partner for support

CHANGE IN DOMESTIC PARTNER STATUS

Coverage for your domestic partner (and his or her children) ends when you or your partner no longer meet your employer's domestic partner eligibility requirements.

MEDICARE ELIGIBILITY

Coverage ends when Highmark Delaware’s eligibility rules require you to have Medicare Parts A & B and you don’t.

THE PLAN IS CANCELED

Coverage ends the day your employer's contract with Highmark Delaware ends.

CONTINUING YOUR COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to continue your coverage after you lose coverage under this plan, provided you meet COBRA's definition of a *qualified beneficiary*.

Highmark Delaware will also extend COBRA-equalivalent continuation of coverage to domestic partners and their children. Use of the word 'spouse' in this section also connotes domestic partners.

If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the COBRA law:

EMPLOYEE

You (and your spouse and children) can continue coverage for up to 18 months if you lose group coverage because

- your hours at work are reduced
- your job ends (for reasons other than misconduct)

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage
- become disabled within the first 60 days of COBRA coverage
- are considered disabled by Social Security

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the plan cost for months 19 through 29.

SPOUSE OF EMPLOYEE

Your spouse can continue coverage for up to 36 months if coverage ends because

- you die
- you divorce or legally separate from your spouse
- you become eligible for Medicare

CHILD OF EMPLOYEE

A child can continue coverage for up to 36 months if coverage ends because

- you die
- you divorce or legally separate from your spouse
- you become eligible for Medicare
- the child is no longer considered a dependent under this plan

WHEN YOUR COVERAGE UNDER COBRA ENDS

You can lose the coverage you continued under COBRA if:

- your employer no longer has any group health coverage
- you don't pay the premium on time
- you become eligible for Medicare
- you get coverage under another group plan. An exception may apply if the other plan
  - has a preexisting condition waiting period
  - provides credit for prior creditable coverage to offset the preexisting condition waiting period

In such cases, you can be covered under both plans.

You are eligible to receive a standard *Certificate of Coverage* after you lose coverage under COBRA.

NOTIFYING YOUR EMPLOYER

You need to let your employer know within 60 days of

- your divorce or legal separation
- your child becoming ineligible under this plan
- your becoming disabled as determined by Social Security

You need to let your employer know within 30 days if Social Security determines you are no longer disabled.

Your employer will give you information about COBRA and how much it costs. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this plan ends.

DIRECT BILLED PLANS

If your coverage under a group plan with Highmark Delaware ends, you may apply to Highmark Delaware for a direct billed Conversion Plan. You may also apply for a Conversion Plan when COBRA continuation coverage is exhausted.

With a Conversion Plan, Highmark Delaware bills you directly for your coverage.

The Conversion plan may have different benefits from your group plan. It may cover fewer items and pay a lower amount. Conversion plans cover children through the end of the month in which they reach age 26. Children over age 26 can apply for a direct billed plan of their own.

The following information applies to conversion plans:

- You must apply within 30 days after the group plan ends.

- You cannot be eligible for any other group plan. This applies if you're eligible through your or your spouse's (or same-sex domestic partner's), employer or any organization. It applies even if:
  - the other plan has a preexisting condition limit
  - the other plan denied your application.
- You cannot be eligible for Medicare.
- There is no medical underwriting.

For more information about Conversion Plans or other direct billed plans, call Highmark Delaware's Member Services department at the number listed in the front of your booklet. If you do not reside in Delaware, you may contact your local Blue Cross Blue Shield plan for more information.

A GUIDE TO FILING CLAIMS AND APPEALS

Always be sure to show your Highmark Delaware ID card when you receive care!

HOW TO FILE CLAIMS

In most cases, claims are filed for you by your provider. This is usually true when you use a **participating provider.**

Always be sure to show your Highmark Delaware ID card when you receive care!

WHEN YOU USE A NETWORK PROVIDER

Highmark Delaware network providers file claims with Highmark Delaware for you. They also accept Highmark Delaware's allowable charge as full payment for covered services. You still pay your share (any copayment, deductible or coinsurance). Highmark Delaware pays network providers for your care.

WHEN YOU USE A NON-NETWORK PROVIDER

Non-Network providers fall into two categories: those who have contracts to participate with Highmark Delaware, and those who do not.

Many doctors and other providers contract with Highmark Delaware. They are called "participating providers". These providers agree to accept Highmark Delaware's allowable charge as full payment. They cannot bill you more than our allowable charge for covered services, even if their normal charge is higher. And, these providers file claims with Highmark Delaware for you. So you don't need to complete claim forms.

Some providers don't have contracts with Highmark Delaware. They may ask you to pay the full cost for your care, and they may bill you for amounts over Highmark Delaware's allowable charge.

If you receive care from a non-participating provider you may need to submit a claim for your care. If the services are covered by Highmark Delaware, we'll pay the allowable charge to you, less any copayment, deductible or coinsurance. This is the same payment we make to participating providers. You must pay any balance over our payment.

WHEN YOU'RE OUT OF AREA

When you receive care in another state, show your Highmark Delaware ID card. Providers participating with the local plan may file your claim with the local plan.

Under the BlueCard® Program:

- you pay any copayment or coinsurance
- the local plan accepts the provider's claim
- payment is made to the provider

IF YOU NEED TO FILE A CLAIM

To obtain a form, call Member Service. You may also get the form from the Highmark Delaware website, **highmarkbcbsde.com**.

Please follow the instructions on the form. Attach an itemized receipt from the provider. Send your claim to this address:

Claims
Highmark Blue Cross Blue Shield Delaware
P. O. Box 8831
Wilmington, DE 19899-8831

The section, *Prescription Drug Benefits*, explains how to file claims for drugs.

HOW TO APPEAL A CLAIM DECISION

You have the right to a full and fair review of all claim decisions. Here's how the appeal process works:

HIGHMARK DELAWARE'S APPEAL PROCESS

- To appeal a Highmark Delaware decision, you or your representative must contact Highmark Delaware Member Service ***within 180 days*** from receipt of a claim denial. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld. You may call us or you may use the Highmark Delaware *Appeal/External Review Form*, available at **highmarkbcbsde.com/downloads/AppealForm.pdf**. There is no cost to appeal. Please explain why you believe the decision was wrong and provide any additional relevant information.
- You should use the *Designation of Personal Representative for Appeal Purposes* form (available at **highmarkbcbsde.com/downloads/PersonalRepDesignationAppeal.pdf**) to designate a personal representative. If you consent to the filing of an appeal by your authorized representative, you cannot file a separate appeal.
- You may submit any comments, documents, records and other information relevant to your appeal. In addition, you have the right to request copies of any documents, records or other information relevant to the claim decision including but not limited to copies of any plan rule, guideline or protocol used in making the decision and diagnostic and treatment codes and explanations of these codes for the services referenced in the denial.
- Standard Appeals will be reviewed and you will be notified with 30 to 60 days of your appeal request.
- Expedited Appeals are available if waiting the 30 to 60 days for a standard appeal decision could seriously jeopardize your life, ability to regain maximum function or, in the opinion of your physician, would subject you to severe pain that cannot be managed without the care or treatment that is the subject of you appeal. If you receive an expedited appeal, we will notify you and your provider of our decision within 72 hours of your appeal request. To request an expedited appeal, call the Highmark Member Service Department.

EXTERNAL REVIEW OPTIONS

- If you have completed the Highmark Delaware appeal process and are not satisfied with the outcome, or if you have requested an expedited Highmark appeal, you may be eligible for an external review.
- For review of decisions involving medical judgment including experimental and investigational care, you or your authorized representative must contact Highmark Delaware

in writing within four months from that you received the Highmark Delaware appeal decision.

- For review of all other decisions, you must contact the Delaware Department of Insurance (DOI) directly within 60 days of the date you received the Highmark Delaware appeal decision.

OTHER IMPORTANT INFORMATION

- If your health plan is subject to the Employee Retirement Income Security Act (ERISA), and you have exhausted all appeal options, you have the right to file a civil action under Section 502 (a) of ERISA. To determine your ERISA status, please contact your employer or plan administrator.
- Mediation Services Available

  The Delaware Department of Insurance (DOI) may be available to provide mediation services or to assist you with filing your appeal. For information, please contact the DOI directly. Please note that appeal and external review deadlines will still apply if you choose mediation services.

Questions

If you whave any questions about your appeal rights, please contact the Highmark Delaware Member Service.

Contact Information

Delaware Department of Insurance Consumer Services Division
Phone: **302.674.7300** or **800.282.8611**
Mail/In-Person: 841 Silver Lake Boulevard, Dover, Delaware, 19904
Hours: Monday through Friday, 8:00 AM-4:30 PM
Email: consumer@state.de.us

Highmark Blue Cross Blue Shield Delaware Member Service
Phone: 800.633.2563
Mail/In-Person: 800 Delaware Avenue, P.O. Box 8832, Wilmington, DE 19899-8832
Online Member Self-Service: highmarkbcbsde.com

COORDINATION OF BENEFITS

Highmark Delaware coordinates payments with any other plan that covers you. We assure the combined payments don't exceed 100% of the Allowable Expense. This process is described below.

TERMS

These terms are used to explain the rules for Coordination of Benefits (COB):

- *Allowable Expense* is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- *COB Provision* sets the order in which plans pay when you're covered by two or more plans.
- *Other Plan* is any arrangement you have that covers your health care.
- *Primary Plan* is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- *Secondary Plan* is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan which covers you as an employee is primary over a plan which covers you as a dependent.
- A plan which covers you as an active employee is primary over a plan which covers you as a non-active employee. Non-active means a laid off or retired employee. This rule also applies if you're the employee's dependent.
- For a child covered by plans under both parents, these rules apply:
    - The plan of the parent whose birthday comes first in the year is primary.
    - If both parents have the same birthday, the plan that covered one parent longer is primary.
    - The other plan's COB rules may set the payment order by the parent's gender. In this case, the male parent's plan is primary.
- If the parents are divorced or separated, this order applies:
    - First, the plan of the parent with custody
    - Then, the plan of the spouse of the parent with custody
    - Last, the plan of the parent not having custody

  This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.
- If these rules don't decide the primary plan, then the plan covering you longest is primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

EFFECT ON BENEFITS

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- When this plan is secondary, you don't need authorization from us as long as you follow the primary carrier's managed care requirements. However, if you meet the maximum (either day or dollar) for a particular benefit covered by the primary carrier, you must follow Highmark Delaware's managed care requirements to get the highest coverage under this plan for that particular benefit.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed.

You must give us the information we need to apply COB rules. This includes information about you and your dependents. If you do not cooperate, we may deny payment.

FACILITY OF PAYMENT

If we're primary, but the other plan paid a claim, we have the right to pay the other plan. Our payment will be the amount we decide is our share under COB rules. Such a payment will meet our obligation under this plan.

RIGHT OF RECOVERY

If we paid more than our share under COB rules, we'll recover the excess from:

- you or any person to or for whom such payments were made
- any insurance plan
- other organizations

HOW WE DETERMINE IF A TECHNOLOGY OR DRUG IS EXPERIMENTAL

OUR EVALUATION PROCESS

Medical researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies. We believe that decisions for evaluating new technologies, as well as new applications of existing technologies for medical and behavioral health procedures, pharmaceuticals and devices, should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications of existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one network-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within our service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmaco-economic impact. After their review is complete, the P & T Committee makes a recommendation. We recognize that situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Customer Service to determine coverage.

GENERAL CONDITIONS

RELEASING NEEDED RECORDS

Your providers have information about you we need to apply benefits. When you applied for coverage, you agreed to let providers give us information we need. This includes the diagnosis and history of your care. This applies to any condition or symptom you had or for which you sought care. It may also include other information. We'll keep these records private as allowed by law.

When you applied for coverage, you authorized us to share records of your health when needed. We'll only share your records to apply your benefits. We may share your records with:

- a medical review board
- a utilization review board or company
- any other health benefit plan
- any other insurance company

If the records relate to fraud or other illegal act, we may disclose them to legal authorities. We may also use them in legal actions.

We may charge a fee for making copies of claim records.

DUAL ENROLLMENT

You may have two or more benefit plans with us. If so, we'll coordinate benefits.

TIME LIMITS

You must file a claim within 2 years after you receive care. We won't pay a claim filed past the 2 year limit.

DENIAL OF LIABILITY

We're not responsible for the quality of care you receive from a provider. Your coverage doesn't give you any claim, right or cause of action against us based on care by a provider.

NON-ASSIGNABILITY

Any right you have to care is personal and cannot be assigned. Any right you have to payments is personal. Your payment rights cannot be assigned without our written approval.

FINANCIAL RISK DISCLAIMER

Highmark Delaware provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

SUBROGATION, OR RIGHT OF REIMBURSEMENT

When we pay a claim, we are subrogated to all rights of reimbursement you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing you uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of Highmark Delaware's rights include:

- **Constructive trust.** Accepting benefits from Highmark Delaware makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until Highmark Delaware receives payment. Failure to pay funds to Highmark Delaware will be considered a breach of your duty to the health care plan. No settlement can be made without Highmark Delaware's written permission.
- **Subrogation lien.** Accepting benefits from Highmark Delaware will result in an automatic lien by Highmark Delaware against any recovery from any third party. This means Highmark Delaware has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that Highmark Delaware has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. Highmark Delaware is entitled to recovery from any party possessing the funds.
- **Recovery from a third party.** Highmark Delaware is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying Highmark Delaware.** If you are involved in an accident or incident that results in both Highmark Delaware paying a claim and you having a claim against any third party, you must notify Highmark Delaware in writing within 30 days.
- **Cooperating with Highmark Delaware.** You are required to cooperate with Highmark Delaware and assist in the recovery from the third party.

LEGAL ACTION

There's a 2 year time limit past which you cannot bring legal action against us for not paying a claim. The period begins on the date of service.

POLICIES AND PROCEDURES

To make sure this plan functions as it should, we may adopt any reasonable:

- policies
- procedures
- rules
- interpretations

You agree to abide by these rules. If you don't, we may cancel your coverage.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

- Statements you made when you applied or afterward were untrue or not complete.
- You received or tried to receive benefits under this plan through misrepresentation, fraud or other intentional misconduct.
- You helped someone else in either of the acts noted above.

Out-of-Area ServicesHighmark Delaware has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you

obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Highmark Delaware's payment practices in both instances are described below.

BLUECARD PROGRAM

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, Highmark Delaware will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services
- The negotiated price that the Host Blue makes available to us

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

NON-PARTICIPATING HEALTHCARE PROVIDERS OUTSIDE HIGHMARK DELAWARE'S SERVICE AREA

Your (Member) Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in the New Castle County Active Employees contract.

ERISA INFORMATION

ERISA stands for *Employee Retirement Income Security Act of 1974*. ERISA was enacted by the Federal Government. ERISA requires us to give you this description.

Type of Plan

The ERISA Plan is a self-insured welfare benefit plan. It provides the health care benefits described in this book.

Type of Administration

The Plan is administered through a group contract issued by Highmark Delaware.

Agent for Service of Legal Process

You may have a dispute under the ERISA Plan. Service of legal process is made upon the ERISA Plan Administrator. This is done through your employer.

Your ERISA Rights

You have rights and protections under ERISA. You are entitled to:

- **Examine, without charge, all Plan documents.** You may examine documents at the Plan Administrator's office. Such documents include:
  - insurance contracts
  - copies of documents filed by the Plan with the U.S. Department of Labor, including:
    - detailed annual reports
    - ERISA Plan descriptions
- **Obtain copies of all Plan documents.** Make your request in writing to the Plan Administrator. The Plan Administrator may charge you for copies.
- **Receive a summary of the Plan's annual financial report.** The Plan Administrator must give each member a copy of a Summary Annual Report.
- **Receive a written explanation of the reason for a claim denial.** This applies if your claim is denied in whole or in part. At your request, we must reconsider your claim.
- **File suit if your claim is denied or ignored.** This applies if your claim is denied in whole or in part. You may file suit in state or federal court.
- **File suit if you disagree with the plan's decision or lack thereof concerning a medical child support order.**
- **File suit if you do not receive materials you request within 30 days.** You may file suit in state or federal court. The court may fine the administrator. The fine may be up to $110 for each day's delay. This does not apply if the delay is beyond the administrator's control.

ERISA also imposes duties on the people who operate the Plan. These people are called **fiduciaries**. They have a duty to operate the Plan prudently and in the interest of all Plan members.

You may seek help from the U.S. Department of Labor, or file suit in federal court if:

- Plan fiduciaries misuse Plan money
- You are discriminated against for asserting your rights

If you file suit in federal court, the court decides who pays court costs and legal fees. If you win, the court may order the person you sued to pay costs and fees. If you lose, the court may order you to pay them.

No one may fire you or discriminate against you to prevent you from:

- obtaining a benefit under this Plan
- exercising your rights under ERISA

Questions

If you have any questions about the Plan:

- contact the ERISA Plan Administrator

If you have questions about this statement or your ERISA rights, you can either:

- contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor (the address and phone are listed in your phone book), or
- contact the following:

Division of Technical Assistance & Inquiries
Room N-5625
200 Constitution Ave., N.W.
Washington, DC 20210
Phone: 202.219.8776

DEFINITIONS

Admission: The time you're an inpatient in a

- hospital
- skilled nursing home
- other facility

The admission runs from the day you're admitted until discharge.

Allowable Charge: The price Highmark Delaware determines is reasonable for care or supplies. See "Allowable Charge Calculations Under the BlueCard Program" in *General Conditions* for more information.

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

Birthing Center: Maternity centers that monitor normal pregnancies and perform deliveries.

Blue Distinction Centers for Transplants (BDCT): BDCTs are facilities which participate in a Blue Cross Blue Shield Association transplant program and have demonstrated commitments to quality care, resulting in better overall outcomes for organ transplant patients. A list of these facilities and their transplant programs may be found at **bcbs.com**

Coinsurance: The percent of allowable charges you pay.

Consultation: An interview or exam by a doctor other than the doctor treating you. The doctor is usually a specialist.

Copayment: The amount you pay at the time of service.

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist or dentist. Such a provider must be acting within the scope of his or her license. (Coverage for dental care is limited. See *Surgical and Medical Benefits* and *What Is Not Covered* sections, above.)

Experimental/Investigative: the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Highmark Delaware to be medically effective for the condition being treated.

Highmark Delaware will consider an intervention to be Experimental/Investigative if:

a. the intervention does not have FDA approval to be marketed for the specific relevant indication(s)
b. available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes
c. the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies
d. the intervention does not improve health outcomes
e. the intervention is not proven to be applicable outside the research setting

If an intervention as defined above is determined to be Experimental/Investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date.

Facility: A hospital, skilled nursing home, outpatient care site or like institution.

Highmark Delaware: Highmark Blue Cross Blue Shield Delaware.

Hospital:

- *Acute Hospital:* An institution or division of an institution. On an inpatient basis, it primarily provides diagnostic and therapeutic facilities for:
  - surgical and medical diagnosis and treatment
  - care of obstetric cases

  Acute hospitals must be approved by:
  - the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
  - the American Osteopathic Association (AOA)

  Such hospitals charge for their care and receive payments from patients. Facilities and care are supervised or rendered by a staff of licensed doctors. Such hospitals provide 24 hour a day nursing care. The nursing care is under the supervision of registered graduate nurses.
- *Non-Acute Hospital:* An institution that provides care distinct from care usually received in an Acute Hospital. It may be a division, section or part of an Acute Hospital. Non-Acute Hospitals must be approved by:
  - Highmark Delaware
  - the appropriate state or local agency (if required by law)

  Such hospitals charge for their care and receive payments from patients.
- The term **Hospital** does not include the following:
  - nursing homes
  - rest homes
  - health resorts
  - homes for aged
  - infirmaries or places solely for domiciliary care, custodial care, care of drug addiction or alcoholism
  - similar facilities that provide mostly nonmedical services

Imaging: A diagnostic process that shows soft tissue and bones. This includes X-rays, mammograms and magnetic resonance imaging (MRI).

Inpatient: A person in a hospital, skilled nursing home or other facility for an overnight stay.

Machine Test: A test using a device to diagnose a condition. This includes EKGs and EEGs.

Medically Necessary: Care, required to identify or treat a condition, which:

- is consistent with the symptoms or treatment of the condition
- meets the standards of accepted practice
- is not solely for anyone's convenience
- is the most appropriate supply or level of care which can be safely provided. For inpatient care, it means the care cannot be safely provided as an outpatient.

Network Provider: A provider with a contract to be a member of Highmark Delaware's preferred network. Network Provider also means any provider available to the Insured through the National Blue Cross Blue Shield BlueCard network.

Outpatient: A person receiving care while not an inpatient.

Participating Provider: A provider with a Highmark Delaware participating contract. Participating providers will not bill you over the allowable charge for a covered service.

Prescription Drugs: Drugs which are:

- obtained only through a doctor's prescription
- listed in the U.S. Pharmacopoeia or National Formulary

- approved by the Food & Drug Administration

Provider: The organization or person giving care, supplies or drugs.

Reopening Period/Open Enrollment Period: The time when you may make changes to your coverage.

Semiprivate Room: A room with at least two beds.

Specialist: A doctor to whom you are referred for care. Sometimes called a *Referral Doctor.*

Specialized Care Facility: A facility for drug and alcohol treatment.

Spouse: A person to whom you are married or partnered in a civil union, pursuant to the laws of the State of Delaware.

Total Maximum Out-of-Pocket: The total amount of deductible and coinsurance you pay. When you reach the Maximum, our payments increase to 100% of allowable charges. The Maximum does not include:

- premiums
- amounts over the allowable charge
- charges for services which exceed the maximum benefit
- charges for non-covered care

We, Us or Our: Refers to Highmark Blue Cross Blue Shield Delaware.

You and Your: Refers to the employee or any of the employee's eligible dependents enrolled in this plan.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Member Service:
(For questions about benefits, claims and membership)

Member Service
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.633.2563

Medical Management Department:
(For Managed Care)

Medical Management Department
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.572.2872

Behavioral Health Care Department:
(For Mental Health and Substance Abuse Managed Care Program)

Behavioral Health Care Department
Highmark Blue Cross Blue Shield Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

All Calls: 800.421.4577

Claims:
(For sending in your health care claims)

Claims
Highmark Blue Cross Blue Shield Delaware
P.O. Box 8831
Wilmington, DE 19899-8831

Express Scripts:
(For information about your drug plan or to submit claims)

Highmark Blue Cross Blue Shield Delaware
P. O. Box 8799
Wilmington, DE 19899

All Calls: 800.633.2563

(For mail order prescriptions)

Express Scripts
PO Box 747000
Cincinnati, OH 45274-7000

Your Doctor(s):

(Write down your doctors' Names and Phone Numbers for all family members)

Member's Name	Doctor's Name	Phone Number

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark Delaware al número al réves de su tarjeta de identificación de Highmark Delaware. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00.

HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark Blue Cross Blue Shield Delaware ("Highmark Delaware"), we are committed to protecting the privacy of your "Protected Health Information" (PHI). PHI is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark Delaware customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

- For example:

  We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits/payments to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

- For example:

  We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information To Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering services to our members.

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support,

utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.

In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. **Inmates**

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. **Workers' Compensation**

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. **Others Involved in Your Health Care**

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

O. **Underwriting**

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. **Health Information Exchange**

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur. The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images.
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes/Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out." In order to opt-out, you must complete an opt-out Form, which is available at highmarkbcbsde.com or by calling the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. **Required Disclosures of Your Protected Health Information**

The following is a description of disclosures that we are required by law to make:

A. **Disclosures to the Secretary of the U.S. Department of Health and Human Services**

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. **Disclosures to You**

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. **Other Uses and Disclosures of Your Protected Health Information**

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

a. Used by the person who created the psychotherapy note for treatment purposes, or

b. Used or disclosed for the following purposes:

(i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;

(ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;

(iii) if required for enforcement purposes;

(iv) if mandated by law;

(v) if permitted for oversight of the provider that created the note,

(vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or

(vii) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure. You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Delaware Privacy Office, P. O. Box 8835, Wilmington, DE 19899-8835. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Delaware Privacy Office, P. O. Box 8835, Wilmington, DE 19899-8835. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits/payments to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/or policy information online.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark Delaware Privacy Office
Telephone: 1-866-568-3790 (toll free)
Fax: 1-877-750-2364
Address: P.O. Box 8835
Wilmington, DE 19899-8835

PART II ─ NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH-BLILEY)

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark Delaware member and will annually reaffirm our privacy policy for as long as the group remains a Highmark Delaware customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark Delaware health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with Highmark Delaware, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.
- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Delaware Privacy Office
Telephone: 1-866-568-3790 (toll free)
Fax: 1-877-750-2364
Address: P.O. Box 8835
Wilmington, DE 19899-8835

SG/G-U65-AHP(PPO/HSA PPO/HRA PPO)-11/1/15
SG-ON/OFFX-AHP(GMF)-11/1/15
SG/G-U65-AHP(RX)-11/1/15
x-10006182/10006173
Print Date: 03/31/17