

A GUIDE TO YOUR BENEFITS



SMALL GROUP HEALTH PLAN SHARED COST EPO \$2,000-100 PLAN

WELCOME!

Thank you for choosing Shared Cost, Highmark Blue Cross Blue Shield Delaware's EPO 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
- **EPO** means Exclusive 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/the Diamond State Group Insurance Trust. Your employer holds a copy of the contract.

This booklet explains the benefits in effect as of January 1, 2014. 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 services are covered. If not, with a few exceptions, services are not covered.

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 Customer 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

You may call, write, email or visit with your questions.

To Reach Us By Phone

All Calls: 800.633.2563

To talk to a Customer 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 Customer 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:

Customer Service
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 Customer Service Department.

To Reach Us On The Internet

Internet Address: **highmarkbcbsde.com**

To Reach the Medical Management & Policy 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.

Drug Program Questions

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

Mail-order prescription drug benefits are administered by Medco[®] Health Solutions of Fort Worth, an independent pharmacy services administrator and one of the Express Scripts family of companies.

For mail order prescriptions:

Medco Health Solutions of Fort Worth
P.O. Box 650022
Dallas, TX 75265-9867

All Calls: 800.633.2563

Website: **highmarkbcbsde.com**

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SHARED COST EPO 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
General Provisions	
Benefit Period¹	Plan Year
Deductible (per benefit period)	
Individual	\$2,000
Family	\$4,000
Out-of-Pocket Maximums (Includes deductible, any coinsurance and copayments. Once met, plan pays 100% for rest of the benefit period.)	
Individual	\$6,250
Family	\$12,500
Office/Urgent Care Visits	
Physician Home/Office Visits^{2,3}	100% after \$40 copayment; deductible does not apply
Specialist Office Visits²	100% after \$60 copayment; deductible does not apply
Urgent Care Center Visits	100% after \$60 copayment; deductible does not apply
Telemedicine Services	100% after \$25 copayment; deductible does not apply
Preventive Care Services⁴	
<i>Adult</i>	
Routine physical exams	100%; deductible does not apply
Adult Immunizations	100%; deductible does not apply
Routine screening services and procedures	100%; deductible does not apply
Routine gynecological exams	100%; deductible does not apply
Lab charges for Pap Test	100%; deductible does not apply
Mammograms, annual routine	100%; deductible does not apply
Colorectal Cancer Screening	100%; deductible does not apply
Vision exams ⁵	100%; deductible does not apply
Hearing exams	100%; deductible does not apply
<i>Pediatric</i>	
Routine physical exams	100%; deductible does not apply
Pediatric immunizations	100%; deductible does not apply
Routine screening services and procedures	100%; deductible does not apply
Vision exams ⁵	100%; deductible does not apply
Hearing exams	100%; deductible does not apply
Hospital and Medical/Surgical Expenses (including maternity)	
Hospital Services - Inpatient	100% after deductible
Hospital Services – Outpatient⁶	100% after deductible
Maternity (non-preventive facility and professional services)	100% after deductible
Medical/Surgical Expenses	100% after deductible

Benefits	In-Network
(except office visits)	(Anesthesia is also covered out-of-network)
Emergency Services (Emergency services are also covered out-of-network)	
Emergency Room Services (facility)	100% after \$250 copayment (waived if admitted as an inpatient); deductible does not apply
Emergency Room Services (professional)	100%; deductible does not apply
Ambulance	100% after deductible
Therapy, Rehabilitative and Habilitative Services	
Chemotherapy, Radiation, Respiration and Infusion Therapy, Dialysis	100% after deductible
Physical Medicine and Occupational Therapy⁷ (Rehabilitative and Habilitative)	100% after \$60 copayment; deductible does not apply Limit: 30 visits each for rehabilitative and habilitative therapy per benefit period
Speech Therapy (Rehabilitative and Habilitative)	100% after \$60 copayment; deductible does not apply Limit: 30 visits each for rehabilitative and habilitative therapy per benefit period
Cardiac Therapy	100% after \$60 copayment; deductible does not apply Limited to 3 sessions per week and 12 weeks of treatment. Care beyond this limit requires medical review and approval.
Chiropractic Care	100% after deductible Limit: 30 visits per benefit period
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)⁸	100% after deductible Combined Limit: \$36,000 per benefit period for members under age 21
Diagnostic Services	
Laboratory Services	100% after \$25 copayment deductible does not apply
Advanced Imaging Services⁹	100% after \$250 copayment; deductible does not apply
Standard Imaging Services	100% after \$35 copayment; deductible does not apply
Machine Tests	100% after \$35 copayment after deductible
Allergy Testing	100% after \$40 copayment for primary physicians and \$60 copayment for specialists; deductible does not apply
Mental Health/Substance Abuse Services	
Mental Health Care Services - Inpatient	100% after deductible
Mental Health Care Services - Outpatient	100% after \$60 copayment; deductible does not apply
Substance Abuse Services - Inpatient Detoxification	100% after deductible

Benefits	In-Network
Substance Abuse Services - Partial Hospitalization/ Intensive Outpatient Services	100% after deductible
Substance Abuse Services - Outpatient	100% after \$60 copayment; deductible does not apply
Other Services	
Allergy Extracts and Injections	100% after \$40 copayment for primary physicians and \$60 copayment for specialists; deductible does not apply
Bariatric Surgery	50% after deductible
Durable Medical Equipment	100% after deductible
Home Infusion Therapy Services	100% after deductible
Home Health Care	100% after deductible Limit: 100 visits per benefit period
Hospice	100% after deductible
Inpatient Private Duty Nursing	100% after deductible Limit: 240 hours per 12-month period
Skilled Nursing Facility Care	100% after deductible Limit: 120 days per confinement. Benefits renew after 180 days without care.
Transplant Services	See Benefit Description
Precertification Requirements	Yes ¹⁰

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 Your group's benefit period is based on a plan year. The plan year is a consecutive 12-month period (for example, January 1st through December 31st or May 1st through April 30th) beginning on an effective date of coverage chosen by your employer. If you are unsure which plan year applies to your benefits, contact your employer or Highmark Delaware.
- 2 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.
- 3 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.
- 4 Services are limited to those on Highmark Delaware's Preventive Schedule. Gender, age and frequency limits may apply.
- 5 Eye exam must be performed by a provider in the Davis Vision provider network.
- 6 Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies and diagnostic services.
- 7 Effective March 1, 2014, physical medicine services will require authorization for continued services beyond the eighth visit during a benefit period.
- 8 Coverage for eligible members to age 21 Treatment for autism spectrum disorders does not reduce visit/day limits.
- 9 Authorization is required for non-emergency advanced radiology services performed by providers who participate with Highmark Delaware. If the required authorization is not received, Highmark Delaware will deny payment for all services.
- 10 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, home health, and certain outpatient services and goods. Some facility providers will contact Highmark Delaware and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark Delaware for precertification. 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 or outpatient care 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	\$15 copayment	\$15 copayment
Preferred Brand Prescription Drug²	50% covered after deductible	50% covered after deductible
Non-Preferred Brand Prescription Drug²	50% covered after deductible	50% covered after deductible
Preventive Medications³		
Prescriptive Covered Drugs – outpatient preventive medications only	100%; deductibles, coinsurance and copayments do not apply	

¹ You are responsible for the payment differential when a generic drug is authorized by the physician and the patient purchases a brand name drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.

² At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark Delaware has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member coinsurance or copayment required based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

³ This includes prescriptions and over-the-counter drugs that are set forth within the predefined preventive schedule and that are prescribed for preventive purposes

PEDIATRIC DENTAL SCHEDULE OF BENEFITS

The dental benefits provided under this plan are administered by United Concordia Companies, Inc., an independent dental benefits provider.

This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the federal Affordable Care Act. **These benefits are only available for children through the end of the plan year that they turn age 19.**

This plan will pay benefits for the services shown below subject to the Schedule of Exclusions and Limitations and other Policy terms. Payment is based on the Maximum Allowable Charge (MAC) for the specific Covered Service. Participating dentists accept contracted MACs as payment in full for services.

Services from non-participating dentists are not covered.

Plan Year Deductible per Member:	None
Plan Year Out-of-Pocket (OOP) Maximum per Member:	Combines with Medical Plan OOP Maximum
Annual Maximum per Member:	Unlimited

Service Category	Plan Pays:
Oral Evaluations (Exams)	100%
Radiographs (All X-Rays)	50%
Prophylaxis (Cleanings)	100%
Fluoride Treatments	50%
Palliative Treatment (Emergency)	50%
Sealants	50%
Other Diagnostic & Preventive Services	Not Covered
Space Maintainers	50%
Amalgam Restorations (Metal fillings)	50%
Resin-based Composite Restorations (White fillings)	50%
Crowns, Inlays, Onlays	50%
Crown Repair	50%
Endodontic Therapy (Root canals, etc.)	50%
Other Endodontic Services	50%
Surgical Periodontics	50%
Non-Surgical Periodontics	50%
Periodontal Maintenance	50%
Prosthetics (Complete or Fixed Partial Dentures)	50%
Adjustments and Repairs of Prosthetics	50%
Other Prosthetic Services	50%
Maxillofacial Prosthetics	Not Covered
Implant Services	Not Covered
Simple Extractions	50%

Surgical Extractions	50%
Oral Surgery	50%
General Anesthesia, Nitrous Oxide and/or IV Sedation	50%
Consultations	50%
Adjunctive General Services	Not Covered
Orthodontics (up to age 19) – medically necessary with prior approval; 12 month waiting period applies	50%

Coverage of Orthodontics:

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
 - Preventing irreversible damage to the Insured Person's teeth or their supporting structures, and
 - Restoring the Insured Person's oral structure to health and function.
2. Insured Persons must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services.
3. A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.
4. All Medically Necessary orthodontic services require prior approval and a written plan of care.

Medically Necessary Orthodontics Coverage:

"Medically Necessary" or "Medical Necessity" shall mean health care services that a physician or Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
2. in accordance with the generally accepted standards of medical/dental practice. "Generally accepted standards of medical/dental practice" means:
 - standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
 - recognized Medical/Dental and Specialty Society recommendations;
 - the views of physicians/Dentists practicing in the relevant clinical area; and
 - any other relevant factors.
3. not primarily for the convenience of the patient or physician/Dentist, and 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.

COPAYMENTS, DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

In the *Schedule of Benefits*, we refer to copayments, deductibles and out-of-pocket maximum. 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. After the copayment, care is paid at 100%. 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.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

In addition to copayments that apply to many services, your benefits have a 2,000 plan year deductible per person. You pay the first 2,000 for services.

You also have a 4,000 plan year family deductible. Deductible payments for all enrolled family members combine to meet the family deductible. Then, no more deductible is taken for any enrolled member for the rest of the plan year.

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

Your benefits have a 6,250 plan year out-of-pocket maximum per person. The deductible, coinsurance and any copayments you pay combine to meet the out-of-pocket maximum. Then, we pay 100% for the rest of the plan year. The 100% is based on the allowable charge.

You have a 12,500 plan year family out-of-pocket maximum. Deductible, coinsurance and any copayments for all enrolled family members combine to meet the out-of-pocket maximum. Then, we pay 100% for all enrolled family members for the rest of the plan year. The 100% is based on the allowable charge.

HOW THE DEDUCTIBLE WORKS

Example #1:

Suppose you have medical expenses of \$100 in allowable charges. Here's how your deductible would be reduced:

Your deductible is	\$2,000
Less: Your medical expenses	\$100
Equals: The amount you still have to pay to meet your deductible:	\$1,900

Example #2:

When you meet your deductible, most your benefits are paid at 100%, but some, for example, bariatric surgery, are paid at a lower percentage. Suppose you've met your deductible, and have medical expenses of \$500 in allowable charges for bariatric surgery, and have paid an addition \$250 in copayments during the plan year. Here's how your cost-sharing is reduced:

Your out-of-pocket maximum is.....	\$6,250
Less: Your deductible	\$2,000
Less: Your coinsurance times the medical expenses (50% X \$500)	\$250
Less: Your copayments.....	\$250
Equals: The amount of cost sharing you still have to pay to meet	
your out-of-pocket maximum:	\$3,750

When you meet your out-of-pocket maximum, benefits are paid at 100% for the rest of the plan year.

HOW TO USE YOUR SHARED COST EPO BENEFITS

In this section, we describe how the Shared Cost EPO plan works. Please read these rules carefully. Call us if you have any questions.

HOW TO RECEIVE IN-NETWORK BENEFITS

To receive benefits, see a network provider when you need care. The network providers are listed in the Provider Network Directory available online at highmarkbcbsde.com. **If you receive care without using a network provider, generally your services will not be covered. This means you will be responsible for all charges!**

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. 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.

EXCEPTIONS TO THE EPO RULES

Generally if you receive care from a provider that is not part of the EPO network, services will not be covered.

Here are some instances when you don't have to use a network provider, but will still get benefits. 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 Room* section for more information. If your treatment results in an admission, you will need Highmark Delaware's authorization. See the *Managed Care Requirements* 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 given by network providers 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.

IN-HOSPITAL ANESTHESIA

Inpatient services by non-network anesthesiologists are covered when the surgical procedure is performed in a network hospital.

APPROVED REFERRALS TO NON-NETWORK PROVIDERS

In very limited situations, services may not be available through a network provider within a reasonable period of time. In those instances, your network provider may refer you to a non-network provider. Highmark Delaware will approve and pay for those services at the in-network level based upon Highmark Delaware's allowable charge. Please contact Highmark Delaware Member Service if you have received a referral and your claim was denied.

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. When you need out-of-area care, call 1-800-810-BLUE (1-800-810-2583) 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 your claim is subject to out-of-pocket expenses, Highmark Delaware will send you a complete explanation of benefits.

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 Shared Cost plan, services and supplies must be considered "Medically Necessary and Appropriate."

Highmark Delaware's MMP, or its designated agent, is responsible for ensuring that quality care is delivered to members within the proper setting, at the appropriate cost and with the right outcome.

MMP or its designated agent 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, and
- 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 ensure 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 skilled 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-Network Care or Out-of-Area Care

When you are admitted to an *out-of-network or out-of-area facility provider*, **you are responsible for notifying Highmark Delaware of your admission.** However, some facility providers will contact Highmark Delaware and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark Delaware for preauthorization. If not, you are responsible for contacting Highmark Delaware.

After receiving the request for inpatient hospital or skilled 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 is used to ensure 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 ensures 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 prior to MMP notification.

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:

- Certain outpatient services and goods (a list of these is available at highmarkbcbsde.com)
- bariatric surgery
- advanced radiology (Some examples include: CAT and PET scans, MRIs, and MRAs)
- certain home health services.

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

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, and
- 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 the Medical Management or Behavioral Health Department 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 Schedule. The schedule contains details of when we pay for preventive care. The schedule is available from Highmark Delaware, or online at highmarkbcbsde.com. All the terms and conditions of your benefit plan apply to the Highmark Delaware Preventive Schedule.

Please note: Highmark Delaware has the right to change the benefits on the Preventive Schedule at any time.

Claims for care provided for preventive services submitted with a medical or family history diagnosis, or at a greater frequency than is indicated on the preventive schedule for routine care 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

For children:

- Routine eye exams are covered annually. See pediatric vision benefit.

Vision exams are covered only when obtained from providers in the Davis Vision network.

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
 - 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. Cardiac therapy or rehabilitation is the physiological rehabilitation of patients with cardiac conditions through regulated exercise programs
- surgical dressings
- blood, blood plasma and their administration
- 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, and
- 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.

Drugs administered in the outpatient department of a hospital are paid like other services for that facility.

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 concurrently. 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

(Note: see the Section, Dental Benefits for pediatric dental services available to members age to age 18.)

Dental surgery is only covered for:

- extracting bony impacted teeth; or
- correcting injury, due to accident or disease, to the jaws, cheeks, lips, tongue, roof and floor of mouth, or
- the correction of certain congenital defects, for example, cleft lip and palate.

Such surgery is covered when done in a dentist's or in 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, and
- 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 and;
- 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 out-of-pocket maximums apply.
 - The benefit includes all organ acquisition costs.
- Transplants performed at non-BDCT, but participating hospitals are covered at a level that is 20 percentage points lower than the member's inpatient or outpatient facility and professional benefit level for network providers.
 - Any copayments, deductibles, coinsurance and out-of-pocket maximums apply.
 - Except for kidney and bone marrow/stem cell transplants, the maximum benefit for organ harvesting and procurement is \$10,000 for each cadaveric organ and up to \$45,000 for each organ procured from a living donor (including harvesting). Maximums are subject to copayments, deductibles and coinsurance, if any.

- 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 out-of-pocket maximums apply.
 - Allowable charges for harvesting/procurement for kidneys are determined by Highmark Delaware.
 - Living donor costs are limited to \$50,000 (not including harvesting).
- Bone Marrow/Stem Cell Transplants are covered at the member's benefit plan's facility and professional benefit level.
 - Any copayments, deductibles, coinsurance and out-of-pocket maximums 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 & CONSULTATION 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, and
- 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, and
- 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, and
- you have care within 48 hours from the onset of the condition.

Some examples are:

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

Mental Health 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.

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

- a sudden, serious condition requires travel right away, and
- 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, or
- 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, or
- 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.

TELEMEDICINE SERVICES PROGRAM (TELEDOC)

Via the Telemedicine Service benefit, Teladoc is an affordable alternative to urgent care centers and emergency rooms. The Teladoc platform enables members to resolve many of their minor illness issues through the convenience of phone or online video consultations.

Teladoc provides a national network of physicians who can diagnose, treat and prescribe medication, when appropriate, for many medical issues. The medical consultation is performed over the web (video) or by telephone. Teladoc physicians are Board Certified and licensed to practice medicine in the state in which the member is located.

Telemedicine services are only available from an approved telemedicine provider.

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 **highmarkbcbssde.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. 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 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 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, or
- a hospital's outpatient department

Covered care includes:

- imaging services
- lab tests, and
- machine tests

Advanced radiology services, such as CAT and PET scans, MRIs, and MRAs are among the imaging services covered. See the *Schedule of Benefits* for more information about the benefit levels for these services. See *Managed Care Requirements* for information about authorizations for these services.

Lab tests include:

- an annual Pap smear
- an annual blood antigen test for men age 50 and over for prostate cancer screening
- lead poison screening test for children ages 9 to 12 months (children at high risk are covered through age 5), and
- allergy testing

PREADMISSION TESTING

We cover tests done before a scheduled admission for surgery.

Tests must be done:

- as an outpatient, and
- within 7 days before the admission

Tests are not covered if:

- they are done for diagnosis
- they are repeated after you enter the hospital, or
- 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, or
- 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 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 BEHAVIORAL ANALYSIS

Benefits are provided for Applied Behavioral Analysis for the treatment of autism spectrum disorders in persons less than 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 care 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, and
- 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 AND SUITE 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.

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 the Infusion benefit:

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

Suite infusion means infusions services provided in an outpatient setting, such as the outpatient department of a hospital or other facility. The benefit provided may vary depending on the setting. See the Therapeutic and Diagnostic section of the *Schedule of Benefits* for more information.

INPATIENT PRIVATE DUTY NURSING

Private duty nursing care is covered when you are an inpatient in an acute hospital. We may review the inpatient 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, and
- 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

Inpatient private duty nursing 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.

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 and other articulations of the body

- 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.

SECOND SURGICAL OPINION

You have coverage for a second surgical opinion (SSO). The second surgical opinion confirms that you need elective surgery. Coverage for an SSO includes:

- office visits to a doctor who didn't recommend the surgery in the first place
- tests related to your condition

Elective surgery is surgery that is:

- covered under this plan, and
- not an emergency

You decide whether or not you want a second surgical opinion. You don't have to follow the SSO doctor's suggestions in order to have coverage. If the first opinion and the second opinion don't agree, then we cover a third opinion and related tests.

DURABLE MEDICAL EQUIPMENT & PROSTHETICS

Durable Medical Equipment

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

- prescribed by a doctor, and
- useful to a person only during an illness or injury, and
- 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 chemotherapy or 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 one wearable hearing aid per ear every three (3) years for children less than 24 years of age.

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.

All care must be approved by Highmark Delaware and under the care of a doctor.

Surgical treatment of morbid obesity is covered when certain conditions are met.

SURGERY FOR MORBID OBESITY

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

- gastric bypass,
- gastric stapling,

- biliopancreatic bypass with duodenal switch and
- 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, and
- 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 biliopancreatic 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/lymphatic 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.

PEDIATRIC VISION BENEFITS

On behalf of Highmark Delaware, your pediatric vision program is administered by Davis Vision, a managed vision care company. All benefits must be obtained from a Davis Vision (Alliance Network) provider. For a list of network vision providers, please refer to: www.davisvision.com.

Vision benefits are provided to members under age 19.

Frequency – Once Every:

Pediatric Benefit Plan

Eye Examination inclusive of Dilation (when professionally indicated).....	12 Months
Spectacle Lenses	12 Months
Frame	12 Months
Contact Lens Evaluation, Fitting & Follow-Up Care	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months

Benefit/Copayments

Eye Examination	100% covered; medical plan deductible does not apply
Frames & Spectacle Lenses	100% covered; medical plan deductible does not apply
Contact Lenses	100% covered; medical plan deductible does not apply

Eyeglass Benefit – Frame

Pediatric Frame Selection	Included
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Eyeglass Benefit - Spectacle Lenses

Member Charges

Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	Included
Oversize Lenses	Included
Tinting of Plastic Lenses.....	Included
Scratch-Resistant Coating	Included
Polycarbonate Lenses/3	Included
Ultraviolet Coating	Included
Standard Anti-Reflective (AR) Coating.....	\$35
Premium AR Coating.....	\$48
Ultra AR Coating	\$60
Standard Progressive Lenses	Included
Select Progressives	\$70
Premium Progressives (Varilux®, etc.)	\$90
Ultra Progressives/3	\$195
Intermediate-Vision Lenses	\$30
Blended-Segment Lenses.....	\$20
High-Index Lenses	\$55
Polarized Lenses	\$75
Photochromic Glass Lenses	\$20
Plastic Photosensitive Lenses.....	Included

Scratch Protection Plan: Single Vision | Multifocal Lenses \$20|\$40

Contact Lens Benefit (in lieu of eyeglasses)

Pediatric Contact Lens Selection	Included
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Medically Necessary Contact Lenses (with prior approval)

- Materials, Evaluation, Fitting & Follow-Up Care	Included
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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 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 Brand Drugs,
- are equally effective as the Brand Drugs at treating the medical condition, and
- meet the same Federal requirements as the 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.

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.
- compounded prescriptions with at least two ingredients other than water, and at least one a legend drug
- 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 it 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. You may then complete the *Express Scripts Claim Reimbursement Form* and send it to Highmark Blue Cross Blue Shield Delaware. To obtain a form call Highmark Blue Cross Blue Shield Delaware Member Services. Express Scripts pays you the allowable charge less any copayment, deductible and/or coinsurance that applies. Because the allowable charge may be less than the actual charge for a prescription, you may pay more when you use a pharmacy that is not in the network.

Mail the completed form to:

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

To learn about pharmacies in the network, call Highmark Delaware Member Services.

HOW THE MAIL SERVICE PROGRAM WORKS

Mail order services provided by Medco Pharmacy Mail Order (part of the Express Scripts family of pharmacies).

To use the mail order program, follow the steps outlined in the Medco PharmaExcy Mail Order Form or call Medco at 800.473.3455 for information. Prescriptions may be mailed to:

Medco Health Solutions Of Fort Worth
PO Box 650022
Dallas, Tx 75265-9867

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.
- 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, and
- psychological tests (limit of 8 hours of tests per year)

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, or
- nurse practitioner.

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

PEDIATRIC DENTAL SERVICES

Check the *Schedule of Benefits* for benefit levels and coverage limitations.

Some services require prior approval!

Benefits are provided for the following when rendered by a Participating Dentist:

ORAL EVALUATIONS

- Comprehensive, periodic and limited problem focused - one (1) of these services per six (6) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
- Consultations - one (1) of these services per Dentist per patient per twelve (12) months for a consultant other than a Pedodontist or Orthodontist.
- Detailed problem focused - one (1) per Dentist per patient per twelve (12) months per eligible diagnosis.

RADIOGRAPHS

- Full mouth x-rays - one (1) every five (5) year(s). Bitewing x-rays - one(1) set(s) per twelve (12) months.

PROPHYLAXIS

- One (1) per six (6) months. One (1) additional for Members under the care of a medical professional during pregnancy.

FLUORIDE TREATMENTS

- Topical fluoride treatment - one (1) per twelve (12) months under age fourteen (14).
- Fluoride varnish - one per twelve (12) months under age fourteen (14).

PALLIATIVE TREATMENT (EMERGENCY)

SEALANTS

- One (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.

SPACE MAINTAINERS

- One (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

PREVENTIVE RESIN RESTORATIONS

- One (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.

PREFABRICATED STAINLESS STEEL CROWNS

- One (1) per tooth per lifetime for Members under age fifteen (15).

PERIODONTAL SERVICES:

- Full mouth debridement - one (1) per lifetime.
- Periodontal maintenance following active periodontal therapy - two (2) per twelve (12) months in addition to routine prophylaxis.
- Periodontal scaling and root planing - one (1) per thirty-six (36) months per area of the mouth.
- Surgical periodontal procedures - one (1) per thirty-six (36) months per area of the mouth.
- Guided tissue regeneration - one (1) per tooth per lifetime.

REPLACEMENT OF RESTORATIVE SERVICES

When they are not, and cannot be made, serviceable, include:

- Basic restorations - not within twenty-four (24) months of previous placement.
- Single crowns, inlays, onlays - not within five (5) years of previous placement.
- Buildups and post and cores - not within five (5) years of previous placement.
- Replacement of natural tooth/teeth in an arch - not within five (5) years of a fixed partial denture, full denture or partial removable denture.

DENTURE RELINING, REBASING OR ADJUSTMENTS

These are considered part of the denture charges if provided within six (6) months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

PULPAL THERAPY

- One (1) per eligible tooth per lifetime. Eligible teeth limited to those with no secondary permanent tooth to replace the primary tooth.

ROOT CANAL RETREATMENT

- One (1) per tooth per lifetime.

RECEMENTATION

- One (1) per five (5) years. Recementation during the first twelve (12) months following insertion by the same Dentist is included in the prosthetic service benefit.

GENERAL ANESTHESIA AND IV SEDATION

- Limited to thirty (30) minutes per session when Dentally Necessary and Appropriate and related to a Covered Service.

THERAPEUTIC DRUG INJECTION

- Covered in unusual circumstances, by report.

ORTHODONTICS

Covered Services which are intended to treat a severe dentofacial abnormality and are the only method capable of preventing irreversible damage to the Member's teeth or their supporting structures, and restoring the Member's oral structure to health and function.

Orthodontic Treatment Limitations

- All pediatric orthodontic treatment is subject to Precertification by the Plan, and must be part of an approved written plan of care.
- To be eligible for pediatric orthodontic treatment, a Member must:
 - have been enrolled under this Agreement for twelve (12) consecutive months (“waiting period”), and must continue to be enrolled during the duration of treatment; and
 - have a fully erupted set of permanent teeth.

Alternate Benefit Provision (ABP)

An alternative benefit provision will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Provider choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

Note: Coverage terminates for Pediatric Dental Services at the end of the plan year in which the Member reaches age nineteen (19).

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.
- Care as a result of any felony 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 cosmetic reasons.
- Care for complications or consequences of services and items not covered.
- Care for weight loss, unless co-morbid conditions are present.
- Care given by a family member. "Family" means yourself, your spouse, 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.
- 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 and gender identity disorders
 - care beyond that needed to determine mental deficiency or retardation
 - marital/relationship counseling, and
 - care at behavioral health facilities
- Change of sex surgery, except to correct congenital defect, or any medical services or pharmaceutical products related to gender identity disorder.
- Convenience items. Some examples are:
 - phones
 - TVs
 - radios
 - other personal items
- Custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care, whether or not prescribed by a physician.
- Dental care, except for pediatric dental care and certain other 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.
- Eyeglasses, contact lenses and all procedures for refractive correction, except as noted elsewhere in this booklet.
- Hearing aids for members age 24 and over.
- 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.
- 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
- Residential care or programs.
- Routine foot care.
- Services in excess of your covered benefit limits.
- Services, supplies or drugs for elective abortions. Exceptions are limited to non-elective abortions necessary to avert the death of the member or to terminate pregnancies caused by rape or incest.
- Speech therapy for:
 - attention disorders
 - behavior problems
 - conceptual handicaps
 - learning disabilities
 - developmental delays
- Surgery to reverse voluntary sterilization.
- Thermography.
- 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.

DENTAL EXCLUSIONS

- Care to increase vertical dimension. This includes:
 - periodontal splinting
 - restoration of tooth structure due to attrition
 - restoration for teeth that are not aligned correctly.
- Care to replace a lost, missing or stolen prosthetic device.
- Care to replace or repair orthodontic appliances.
- Care which is experimental, temporary or cosmetic in nature. This includes:
 - personalized dentures
 - precision attachments

- gold
- unusual procedures or techniques
- veneers of crown restorations or bridges (other than the 10 upper and 10 lower anterior teeth).
- Care not dentally necessary, or in the case of orthodontia, medically necessary.
- Care which is not consistent with dental professional standards.
- Charges for failing to keep a scheduled appointment.
- Charges for the completion of any form.
- Care which is available to you under any health contract with us.
- Care received before the effective date of your coverage.
- Care received after your coverage ends.
- Instructions in dental hygiene, plaque control or prescription drugs
- Care for temporomandibular joint (TMJ) conditions.
- Care for temporary fixed and/or removable crowns, bridges, dentures, or partial dentures
- Local anesthesia (when billed as a separate service).
- General anesthesia.
- Dental Implants.
- Charges for infection control (when billed separately).
- Care in excess of your covered benefits, and charges in excess of the maximum 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 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, grievance 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, or file a petition for arbitration for decisions made about your coverage. 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

You, the employee, can be covered if you

- work full-time, and
- work at least 30 hours per week.

Your plan may cover:

- Your spouse
- 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
- **Family** for you, your spouse and your children

The above types are standard. Your employer may have other options.

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; or
- 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

- under age 26, and
- 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 (or domestic partner) for adoption, or
 - someone for whom health care coverage is the employee's or his or her 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 relationship.

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.

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, or
- 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) may begin on

- the employee's hire date
- the day the employee completes an eligibility waiting period
- the first day of the month after the employee completes an eligibility waiting period.

Ask your employer which option applies.

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, or
- obtaining a new dependent because of marriage or civil union, 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, and
 - enroll at the same time you enroll a dependent.
- *Spouses and Children:* you're a dependent of an employee:
 - who is already enrolled or is eligible to enroll in this plan, and
 - 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), and
- when this plan was previously offered, you declined coverage under this plan because you had other coverage, and

- the other coverage was either:
 - COBRA continuation coverage that is exhausted, or
 - other (non-COBRA) coverage that was lost because
 - you are no longer eligible, or
 - the lifetime limits under the other coverage were reached, or
 - the employer stopped contributing, and
- you enrolled within 30 days of the date the other coverage was lost, and
- 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 or civil union,
- domestic partnership,
- birth,
- adoption,
- placement of a child in the home for adoption, or
- 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:* either
 - the **first day of the month** after you enroll, or
 - the **date** you enroll.
- *Spouses:* either
 - the **first day of the month** after you enroll, or
 - the **date** you enroll.
- *Children:* either
 - the date of birth, adoption or placement in the home for adoption, the effective date of court ordered support; or
 - if you lost coverage under a prior plan or your parent got married,
 - the **first day of the month** after you enroll, or
 - the **date** you enroll.

Remember, if you enroll after the 30-day enrollment period, you (and your dependents) will be late enrollees.

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 AND CIVIL UNION

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 civil union, 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 or enter into a civil union.

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) provided the domestic partnership meets the criteria for recognition under Delaware law.

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 standard *Certificate of Coverage* will show how long you were covered under this plan.

Your employer can advise you where to get a certificate. Some employers have asked Highmark Delaware to provide the *Certificate of Coverage* for them. If Highmark Delaware does provide the certificate, call Customer Service at the number listed in the front of this booklet to request one.

Your employer may be subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, you may extend coverage after one of the events noted below. You are eligible to receive a *Certificate of Coverage* after you lose coverage under COBRA. Check with your employer for more information.

There are two options for determining the date when coverage ends. Your employer chooses the option. Ask your employer which option applies.

- **Option One:** Coverage ends the **last day of the month** in which you lose eligibility because of one of the events below.
- **Option Two:** Coverage ends on the **date** you lose eligibility because of one of the events below.

Events that cause you to lose coverage are:

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 end of the month in which he or she reaches age 26.

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.

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when your coverage ends, except:

- if your employer cancels its contract with Highmark Delaware, and
- if you are an inpatient on the date the contract ends.

Then you're covered for the care you receive as an inpatient. The plan covers you through the earlier of:

- 10 days after the contract ends
- until you are discharged

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, or
 - 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 Customer 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.

CONTINUING YOUR COVERAGE UNDER COBRA

Your employer may be subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA), which 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*.

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, or
- 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, or
- become disabled within the first 60 days of COBRA coverage, and
- 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, or
- 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, or

- you become eligible for Medicare, or
- the child is no longer eligible 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, or
- you get coverage under another group plan. 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, or
- 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.

CONTINUING YOUR COVERAGE UNDER DELAWARE'S MINI-COBRA

Even if you are not eligible for COBRA, you may have the right to continue your coverage after you lose coverage under this plan, provided you meet the definition of a *qualified beneficiary and have lost coverage due to a qualifying event*. Qualifying events include, but are not limited to: termination of employment; divorce; or a dependent's status change due to age.

If you are eligible, your employer has 30 days to notify you when a qualifying event has occurred. You and/or eligible dependents will have 30 days from the notification date to enroll in Mini-COBRA. Your coverage under Mini-COBRA may be continued for a maximum of nine (9) months, and is contingent upon the payment of premiums and your maintenance of your employer's group health insurance policy. Additional requirements may apply in certain situations.

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, or
- 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 Mini-COBRA and how much it costs. You can choose to continue coverage under Mini-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.

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's 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

Services provided by non-network providers are not covered, except in the rare situations described in the section *Exceptions to the Simply Blue/Blue Advantage Rules*. 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 contract 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 deductible, copayment or coinsurance,
- the local plan accepts the provider's claim, and
- payment is made to the provider

IF YOU NEED TO FILE A CLAIM

To obtain a claim form, call Customer 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 your 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.
- Please note that you are not eligible for external review if you are covered under an Administrative Services Only (ASO) group health plan and your plan is considered a 'grandfathered' plan under the Patient Protection and Affordable Care Act of 2010. Please contact your employer or plan administrator regarding ASO and grandfathered status.

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 have 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; and
 - 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

BCBSD QUALITY INITIATIVES

Highmark Delaware is committed to offer you quality benefits and services. We have established a clearly defined process to evaluate whether new health care technology and treatments are medically appropriate and supported by sound research.

OUR EVALUATION PROCESS

Our Medical Technology Assessment Committee meets quarterly to evaluate newly proposed technology and treatment benefits. The Committee is made up of

- physicians
- nurses
- health care specialty providers
- senior-level quality administrators

The Committee consults comprehensive, nationally recognized research sources. These sources may include reports from the National Institute of Health, the Journal of the American Medical Association, the New England Journal of Medicine and others as needed.

The Committee uses the following evaluation criteria:

- The technology or treatment must have final approval from the appropriate regulatory body (such as the U.S. Food and Drug Administration).
- The scientific evidence must be conclusive.
- The technology or treatment must improve overall health outcomes. The health improvement must be available outside the investigational setting.
- The technology or treatment must be as good as other established treatment alternatives.
- The technology or treatment must be within the scope of local clinical practice and standards.

Through this process we help make sure that you receive quality health care benefits and services.

CURIOUS ABOUT QUALITY?

Highmark Delaware is proud to share with our members how we work to continuously improve upon the services we offer. We invite you to request copies of Highmark Delaware's quality improvement standards and initiatives by sending a written request to:

Highmark Blue Cross Blue Shield Delaware
Attn: Director of Quality Improvement
P.O. Box 1991
Wilmington, DE 19899-1991

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. . . 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.

SUBROGATION

When we pay a claim, we are subrogated to all rights 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 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, and
- interpretations.

You agree to abide by these rules.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

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

OUT-OF-AREA SERVICES

Highmark 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; or
- 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 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 fully 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.

Highmark Delaware: Highmark Blue Cross Blue Shield Delaware.

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.

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.)

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

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, and
- 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 network.

Out-of-Pocket Maximum: The total amount of cost-sharing for an individual or family during a plan year. When you reach the Maximum, our payments increase to 100% of allowable charges. The Maximum does not include:

- amounts over the allowable charge
- charges for non-covered care

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, and
- 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.

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

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 Call: 800.421.4577

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

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

Claims:

(For sending in your health care claims)

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

For mail order prescriptions:

Medco Health Solutions of Fort Worth
P.O. Box 650022
Dallas, TX 75265-9867
All Calls: 800.473.3455

SG-SC EPO 250-500-750-1200-1500-2000_100-04/25/14
SG-QHP/OFFX-AHP(GMF)-04/25/14
05/05/14

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