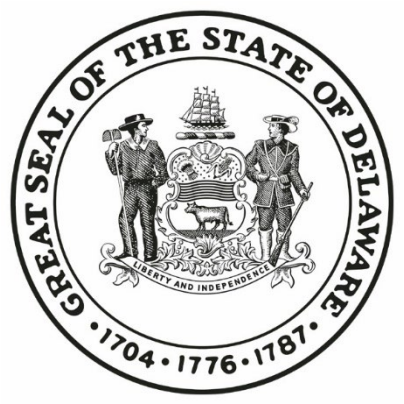
HIGHMARK®



STATE OF DELAWARE
COMPREHENSIVE PPO PLAN

Discrimination is Against the Law

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

The claims administrator:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WELCOME!

This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are funded by the State of Delaware and are administered by Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield (Highmark). Highmark does not assume any financial risk or obligation with respect to claims.

Highmark's Comprehensive PPO plan provides the freedom of choice you experience with a Preferred Provider Organization (PPO) that allows you to receive both in-network and out-of-network benefits. This plan allows you access to Blue Cross Blue Shield's nationwide network of providers. A list of these providers is available at **http://bcbs.com/**.

Using in-network providers you will pay a small copay/coinsurance with no deductible. The in-network plan year total maximum out-of-pocket (TMOOP) is $4,500 per employee and $9,000 per family. Coinsurance and copays accrue toward the TMOOP. If you use out-of-network providers, you must meet a $300 per person/$600 per family plan year deductible, unless otherwise noted. The out-of-network total maximum out-of-pocket (TMOOP) is $7,500 per person/$15,000 per family per plan year. Deductibles, coinsurance and copays accrue toward the TMOOP.

The Comprehensive PPO Plan includes coverage for services such as inpatient care, prenatal and postnatal care, emergency services, mental health and substance abuse treatment, and many outpatient services, including, but not limited to: labs, x-rays and other imaging services, vision care, chiropractic and other therapy benefits. For additional information contact Highmark's Customer Service staff at 844.459.6452.

This booklet may be viewed at: https://de.gov/statewidebenefits

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

Use the *Table of Contents* to find topics. A list of terms is given at the back of the booklet.

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

- **PPO** means Preferred Provider Organization

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

This booklet is not a contract. It provides a description of the benefits provided under your health care plan.

This booklet explains the benefits in effect as of July 1, 2026. 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's Managed Care Requirements.
- Read this booklet.
- Information about claims, including Explanation of Benefits (EOBs) is available at **myhighmark.com**.
- Call us if you have any questions!

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

WHEN YOU HAVE QUESTIONS OR COMMENTS

Highmark 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'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;
- reporting a lost or stolen ID card;
- ordering a new ID card;
- checking on the status of an approval from the Medical Management and Policy Department;
- asking about a claim; and
- getting language assistance

- obtaining information about providers. You can also obtain information about your providers on our website. When you search for a provider at myhighmark.com, you can view the following information:

  - *Name*
  - *Location/Office Hours/Phone numbers*
  - *Whether the provider is accepting new patients*
  - *Professional qualifications*
  - *Clinical specialties*
  - *Medical school attended*
  - *Residency completion*
  - *Board certification status*
  - *Hospital affiliations*
  - *Medical group affiliations*
  - *Patient ratings*
  - *Performance in 13 categories of care*
  - *Parking and public transit nearby*
  - *Handicap accessibility*
  - *Languages spoken*
  - *Gender*
  - *You may also obtain more information on network providers by calling Member Service at the number on the back of your member ID card.*

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

- access to providers; and
- the care you received.

To Reach Us By Phone:

All Calls: 844.459.6452

Fax: 877.544.8726

To talk to a Customer Service Representative, call 8:00 AM to 7:00 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; and
- ID card requests.

To Reach Us By Letter:

Write to:

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

To Reach Us On The Internet:

Internet Address: **myhighmark.com**

To Reach the Medical Management and Policy Department (for Managed Care):

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

All Calls: 800.572.2872

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

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

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

All Calls: 800.421.4577

We do not provide services. We only pay for covered services you receive from Providers. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give services to you. Any decision to receive care is solely between you and your Provider. Any action by us pursuant to any utilization management, referral management, discharge planning, Medical Necessity and Appropriateness determination or other functions in no way absolves the Provider of the responsibility to provide appropriate medical care to you.

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AMENDMENTS TO YOUR BENEFIT BOOKLET

1. **The following shall apply to Emergency Care Services Rendered by an Out-of-Network Provider*:**

   In the event that you receive emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from your injury or emergency medical condition, and upon stabilization:

   − you are unable to travel using nonmedical transportation or nonemergency medical transportation; or
   − you do not consent to be transferred,

   covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network services level of benefits as set forth in the Hospital Services benefit in the Summary of Benefits section of this booklet. You will not be subject to any balance billing amounts.

2. **The following shall replace the Specialist Virtual Visit description under Outpatient Mental Health Care*:**

   A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

3. **The following shall be added if autism spectrum disorder benefits are covered[#]**

   Benefits are provided to members regardless of age for the following:

   Autism Spectrum Disorders

   Diagnostic Assessment of Autism Spectrum Disorders
   Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist, or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

   Treatment of Autism Spectrum Disorders

   Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

4. **The "Learning Disabilities" provision under What is not Covered shall be replaced with the following if autism spectrum disorders are covered[#]:**

For any care that is related to conditions such as learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change; or for respite care.

For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

5. **The following shall be removed from under What Is Not Covered[#]**:

   a. Any limitation on methadone hydrochloride treatment for mental health/substance abuse services.
   b. Any limitation on nutritional counseling for mental health/substance abuse services.

6. **The following shall be added under What is Not Covered[+]:**

   Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.

7. **The following shall replace the description of Provider Reimbursement and Member Liability, as well as under Health Care Management[*^]**:

   When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services. However, the following covered services when received from an out-of-network provider will be provided at the applicable network level of benefits and you will not be responsible for such difference:

   1. Emergency care services provided in a hospital or freestanding emergency room; and
   2. Air Ambulance services

   Additionally, in very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are not part of the network. A network facility provider may have an arrangement with a professional provider or ancillary provider who is not part of the network to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology, or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be liable, except for applicable network deductible, copayment, or coinsurance obligations, for the charges of that professional provider or ancillary provider.

   Please review the Booklet's schedule of benefits for further details on cost sharing for Emergency Services.

   No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.

8. **The following shall be added under General Information*:**

Benefits After Provider Termination from the Network

If at the time you are receiving medical care from a network provider, notice is received from Highmark that: Highmark intends to terminate or has terminated all or portions of the contract of that network provider for reasons other than cause; or the contract of that network provider will not be renewed, or the participation status of that network provider is changing; you may, at your option, continue an active course of treatment with that provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means: (i) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (iii) confirmed pregnancy, through the postpartum period; (iv) scheduled nonelective surgery, through postoperative care; (v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

9. **The Appeal Procedures and External Review Procedures shall Include the Review of Claims that Highmark Determined were not Subject to Legal Prohibitions Against Balance Billing.***

10. **The Following Shall be Added to Terms You Should Know when Reference-Based Pricing Applies*:**

Plan Allowance - The amount used to determine payment by your program for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law.

In-Network Benefits
When covered medical services are received from a network provider, then the plan allowance is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Out-of-Network Benefits
When covered medical services are received from an out-of-network provider as described below, the plan allowance is determined as follows:

Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians
For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (iii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).
For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by an Out-of-Network Provider
For emergency services provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the reference price (as defined below) if out-of-area; (ii) recognized amount (as defined below) if out of area; (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by an Out-of-Network Provider
For Air Ambulance transportation provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the recognized amount (as defined below); (ii) the amount subsequently agreed to by the out-of-network provider and Highmark; or (iii) the amount determined by Independent Dispute Resolution (IDR).
Your cost-sharing for each of the above out-of-network providers will be based on the recognized amount.

In All Other Cases
If you receive covered medical services from an out-of-network provider, the plan allowance for an out-of-network provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment.
The plan allowance for an out-of-area network state-owned psychiatric hospital is what is required by law.

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Recognized Amount – Except as otherwise provided, the plan allowance and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by: (i) out-of-network emergency service providers; and (ii) non-emergency service received at certain in-network facilities by non-network providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center), as defined in federal law and regulation. The Recognized Amount is based on: (i) an all-payer model agreement, if adopted; (ii) state law; or (iii) the lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside of the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

Reference Price – means a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Highmark uses the price determined by a nationally recognized database or if no such price available, then 50% off billed charges.

**** Applicable to Plan Years Commencing on and after January 1, 2022.***
+ Applicable on and after January 1, 2023.
 # Applicable following the first quarter of 2023.
^ This language updates and supersedes previously issued benefit booklet language.

COMPREHENSIVE
PREFERRED PROVIDER ORGANIZATION (PPO)
SCHEDULE OF BENEFITS

The next pages describe what's covered under your Comprehensive Preferred Provider Organization (PPO) benefit plan. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

Many services have limits, copayments, deductibles, coinsurance or total maximum out-of-pocket (TMOOP). The limits indicated refer to a maximum benefit available for a service, not necessarily the number of days or visits determined to be medically necessary and appropriate to a particular condition.
Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.

All payments are based on Highmark's allowable charge. Highmark determines the allowable charge.

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described in this booklet, you will be responsible for the difference between your plan's payment and the provider's billed charge. Your plan's payments are based on Highmark's allowable charge. Highmark determines the allowable charge. The amount above Highmark's allowable charge is your responsibility, and the out-of-network provider can balance bill you directly. If you need help obtaining information about Highmark network providers, you can call Member Service at the number on the back of your member ID card or search for a provider at myhighmark.com.

Preexisting conditions are covered.

Any limits (such as days or dollar amounts) are combined for In-Network and Out-of-Network care. The combined limits determine when you reach the maximum.

DEDUCTIBLE/ COINSURANCE	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan year Deductible	None	$300 per person $600 per family
Plan year Coinsurance	None	None
Plan year **Total Maximum Out-of-Pocket** (**TMOOP** includes deductibles and coinsurance and copays). Once met, plan pays 100% of covered services for the rest of the benefit period.	$4,500 per person $9,000 per family	$7,500 per person $15,000 per family

Note: For an explanation how Plan Year Deductibles, Coinsurance and TMOOP apply to your Out-of-Network benefits, please see the section *Copayments, Deductibles, Coinsurance and TMOOP*, below.

SERVICE	**IN-NETWORK BENEFIT**	**OUT-OF-NETWORK BENEFIT**
Preventive Care		
■ Well Baby Care	100% Covered	80% Covered
■ Routine Physical Exams	100% Covered	80% Covered

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
■ Annual Behavioral Health Well Check	100% Covered	80% Covered
■ Routine Gynecological Exams	100% Covered	80% Covered
■ Hemoglobin Tests	100% Covered	80% Covered
■ Cholesterol Tests	100% Covered	80% Covered
■ Blood Sugar Tests	100% Covered	80% Covered
■ Blood Antigen Tests	100% Covered	80% Covered
■ Lead Poison Screening Tests	100% Covered	80% Covered
■ Lab Charges for Pap Smear	100% Covered	80% Covered
■ Blood Occult	100% Covered	80% Covered
■ Routine Sigmoidoscopy	100% Covered	80% Covered
■ Routine Colon Cancer Screening*	100% Covered	80% Covered
■ Barium Enema	100% Covered	80% Covered
■ Routine Mammogram (3D mammograms are covered as a routine screening)	100% Covered	80% Covered
■ Routine Immunizations	100% Covered	80% Covered
■ Routine Vision Exams	Not Covered	Not Covered
■ Hearing Exams	100% Covered	80% Covered
Hospital and Other Facility Benefits		
■ **Inpatient Hospital**	$100 Copayment per day ($200 maximum per admission) then covered at 100%.	80% Covered
■ Organ Transplants	See Benefit Description	See Benefit Description
■ Knee and Hip replacement and Spine Surgery	See Benefit Description	See Benefit Description
■ Outpatient Surgery - Hospital	$150 copay per visit, then payable at 100%. Not subject to deductible.	80% Covered
■ Outpatient Surgery - Ambulatory Surgery Center	$50 copay per visit, then payable at 100%. Not subject to deductible.	
■ Surgical Facility Care	100% Covered	80% Covered
■ Skilled Nursing Facility Care	100% Covered 120 day limit, benefits renew after 180 days without care.	80% Covered

*In network Colorectal screenings that are scheduled as routine and follow the preventive schedule parameters, are covered at 100%. However, should the performing provider find polyps and remove them at the time of the procedure, the screening may change to diagnostic. Therefore, diagnostic benefits, instead of preventive/routine benefits, will be applied to all claims related to this procedure submitted as diagnostic.

Surgical - Medical Benefits		
■ Surgical Care	100% Covered	80% Covered
■ Anesthesia	100% Covered	80% Covered (covered in-network at network facilities)
■ Inpatient Medical /Consultation Care	100% Covered	80% Covered
■ Fertility Services (limited to $30,000 per member's lifetime)	100% Covered; coinsurance does not accrue toward the TMOOP	80% Covered; coinsurance does not accrue toward the TMOOP
Maternity Benefits		
■ Prenatal and Postnatal Care	100% Covered	80% Covered
■ Inpatient Hospital Care	$100 Copayment per day ($200 maximum per admission) then covered at 100%.	80% Covered
■ Birthing Center	100% Covered	80% Covered
■ Obstetric Care	100% Covered	80% Covered
Emergency Services		
■ Emergency Ambulance and Paramedic Services	$50 copay air ambulance per occurrence; ground ambulance no copay	$50 copay air ambulance per occurrence; ground ambulance no copay; deductible does not apply
■ Emergency Facility	$200 Copayment per visit (waived if admitted)	$200 Copayment per visit (waived if admitted)
■ Medical Emergency Care (doctor's care in an emergency facility)	100% Covered	100% Covered; no deductible
■ Urgent Care Center Visits	$20 Copayment per visit	80% Covered
Therapeutic and Diagnostic Services		
<u>Outpatient Care</u>		
■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis	100% Covered	80% Covered
■ Occupational Therapy	85% Covered.	80% Covered
■ Physical Therapy	85% Covered.	80% Covered
■ Speech Therapy	85% Covered.	80% Covered
	Physical, Occupational and Speech Therapies: The maximum number of visits allowed for a specific diagnosis is determined by medical necessity. Physical, Occupational and Speech Therapies: In network services related to a mental health disorder or substance use diagnoses do not apply a member copay or coinsurance.	
■ Cognitive Therapy	85% Covered	80% Covered
■ Cardiac Therapy	85% Covered	80% Covered
	Limited to 3 sessions per week and 12 weeks of treatment. Care beyond this limit requires medical review and approval.	
■ Applied Behavior Analysis	100% Covered	80% Covered

■ Lab Tests (Blood Work)	Non-Hospital Affiliated Freestanding Facility: $10 Copayment per visit Hospital Affiliated Facility: $50 Copayment per visit No charge for services with a mental health disorder or substance use diagnosis at any lab/facility for lab tests and imaging. Drug testing for pain management and substance abuse treatment benefits are subject to the guidelines outlined in our medical policy L-102 which is found at: https://securecms.highmark.com/content/medpolicy/en/highmark/de/commercial/policies/Laboratory/L-102/L-102-020.html	80% Covered
■ Imaging Services – such as x-rays and ultrasounds	Non-Hospital Affiliated Freestanding Facility: No Charge Hospital Affiliated Facility: $50 Copayment per visit	80% Covered
■ MRIs, MRAs, CAT scans and PET scans	Non-Hospital Affiliated Freestanding Facility: No Charge Hospital Affiliated Facility: $100 Copayment per visit	80% Covered
■ Nuclear cardiac imaging.	$50 Copayment per visit	80% Covered
■ Machine Tests	100% Covered	80% Covered
Inpatient Care		
■ Therapeutic Services	100% Covered	80% Covered
■ Diagnostic Services	100% Covered	80% Covered
Other Covered Services		
■ Hospice	100% Covered for up to 365 days	80% Covered for up to 365 days.
■ Home Health Care	100% Covered	80% Covered
	Limited to 240 visits per plan year.	
■ Home Infusion	100% Covered	80% Covered
■ Inpatient Private Duty Nursing	100% Covered	80% Covered
	Limited to 240 hours in a 12-month period.	
■ Doctor's Home/Office Visits	$20 Copayment per visit	80% Covered
■ Doctor's Nursing Home Visits	100% Covered	80% Covered
■ Telemedicine Services (Through Amwell)	100% Covered	Not Applicable
■ Specialist/Referral Care (including eye care and refractions for medical treatment and management of eye conditions or diseases, as well as vision training)	$30 Copayment per visit Vision Training: The maximum number of visits allowed for a specific diagnosis is determined by medical necessity.	80% Covered
■ Diabetic Education	$30 Copayment per visit	80% Covered

■ Nutritional Counseling	$30 Copayment per visit In network services related to a mental health disorder or substance use diagnoses do not apply a member copay or coinsurance.	80% Covered
■ Allergy Tests	$30 Copayment per visit	80% Covered
■ Allergy Treatment	$5 Copayment per visit	80% Covered
■ Chiropractic Care	85% Covered In network services related to a mental health disorder or substance use diagnoses do not apply a member copay or coinsurance.	80% Covered
■ Durable Medical Equipment	100% Covered The deductible and cost sharing amount, if any, does not apply to insulin pumps purchased through in network providers. The deductible and cost sharing amount, if any, for the following diabetes equipment and supplies purchased through in network providers will not exceed $35.00 per month: covered blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies	80% Covered
▪ Hearing aids	Limited to one hearing aid per ear every 3 years for children less than 24 years of age. This limitation does not apply to Bone Anchored Hearing Devices (BAHA) and Cochlear Implants.	
▪ Cooling Caps	Covered at the durable medical equipment benefit levels for both in and out of network providers for members undergoing chemotherapy treatment with a benefit plan year benefit maximum of $1000.	
▪ Mastectomy Bras	Covered at the durable medical equipment benefit levels for both in and out of network providers for up to six bras in the first 12 months following a mastectomy, then up to four bras every 12 months afterwards.	
▪ Wig/Hair Piece	Covered at the durable medical equipment benefit levels for both in and out of network providers for any illness or injury resulting in hair loss with a plan year benefit maximum of $1000.	

■ Care for Morbid Obesity ▪ Office Visits and Labs ▪ Bariatric Surgery	See Benefit Description Not eligible under your Highmark medical plan as these services are administered through Lantern[1], an independent company that does not provide Highmark services. For more information, please contact Lantern at 855.200.2034.	See Benefit Description Not eligible under your Highmark medical plan as these services are administered through Lantern[1], an independent company that does not provide Highmark services. For more information, please contact Lantern at 855.200.2034.

Mental Health Care and Substance Abuse Treatment

■ Inpatient Hospital Care	$100 Copayment per day ($200 maximum per admission) then covered at 100%.	80% Covered
■ Partial Hospital/Intensive Outpatient Care	100% Covered	80% Covered
■ Office Visits	$20 Copayment per visit	80% Covered
■ Telemedicine	Mental health services performed by the telemedicine vendor, Amwell are 100% covered.	

[1] Lantern is solely responsible for the subject non-Highmark products or services it is providing.

COPAYMENTS, DEDUCTIBLES, COINSURANCE AND TMOOP

In the *Schedule of Benefits*, we refer to copayments, deductibles, coinsurance and TMOOP. 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 per visit per day.
- If you see more than one provider during the visit the same day, you pay only one copayment. Copayments should be paid at the time you receive care.

Copayments should be paid at the time you receive care.

IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET

Your In-Network benefits have a $4,500 plan year total maximum out-of-pocket (TMOOP) per person. This applies when the out-of-pocket maximum adds up to $4,500. Then, the plan pays 100% for all enrolled members for the rest of the year. The 100% is based on the Highmark allowable charge.

You also have a $9,000 plan year family TMOOP. This applies when two family members each meet their $4,500 TMOOP (totaling $9,000). Then, the plan pays 100% for all enrolled members for the rest of the year. The 100% is based on the Highmark allowable charge.

OUT-OF-NETWORK DEDUCTIBLE AND TMOOP

Your Out-of-Network benefits have a $300 plan year deductible per person. You must pay the first $300 of allowable charges for services.

You also have a $600 plan year family deductible. This applies when two family members each meet their $300 deductible (totaling $600). Then, no more deductible is taken for all enrolled family members for the rest of the year.

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

Your Out-of-Network benefits have a $7,500 plan year TMOOP per person. This applies when the TMOOP adds up to $7,500. Then, the plan pays 100% for the rest of the year. The 100% is based on the Highmark allowable charge.

You have a $15,000 plan year family TMOOP. This applies when two enrolled family members each meet their $7,500 TMOOP (totaling $15,000). Then, the plan pays 100% for all enrolled members for the rest of the year. The 100% is based on the Highmark allowable charge.

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described in this booklet, **you will be responsible for the difference between your plan's payment and the provider's billed charge.** Your plan's payments are based on Highmark's **allowable charge**. Highmark determines the allowable charge. The amount above Highmark's allowable charge is your responsibility, and the out-of-network provider can balance bill you directly. If you need help obtaining information about Highmark network providers, you can call Member Service at the number on the back of your member ID card or search for a provider at myhighmark.com

NOTE: An excess deductible or TMOOP may be taken. This can happen when more than two family members submit claims. Some claims for other family members may have been applied to the deductible or coinsurance before the family limits were met. If you think this has happened, call Customer Service. We'll research your case. If needed, we'll correct your claims.

TMOOP

The total maximum out-of-pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance and copays incurred for network covered services in a benefit period. Please note that coinsurance for fertility services does not apply towards this TMOOP.

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

HOW THE DEDUCTIBLE AND COINSURANCE WORK

Example #1:

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

Your Out-of-Network deductible is $300
Less: Your medical expenses $50
Equals: The amount you still have to pay to meet your Out-of-Network deductible: $250

Example #2:

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

Your Out-of-Network TMOOP is $7,500
Less: Your coinsurance times the medical expenses (20% X $500) $100
Equals: The amount of coinsurance you still have to pay to meet
your Out-of-Network TMOOP: $7,400

When you meet your Out-of-Network TMOOP, Out-of-Network benefits are paid at 100% of allowable charges for the rest of the plan year.

Example # 3

When you use a non-participating provider, benefits are paid at the out-of-network benefit level.

Since the doctor does not participate with Highmark, benefits are limited to Highmark's allowable charge. The amount above Highmark's allowable charge is your responsibility, and the doctor can balance bill you directly.

Suppose an out-of-network, non-participating surgeon charges $8,000. Since he does not participate with Highmark, the claim will be subject to the $300 deductible, and the plan will pay 80% of the Highmark allowable charge:

Highmark's allowable charge for this service:	$2,000
Less your deductible:	300
Equals:	1,700
Less your coinsurance amount (20% x $1700)	340
Equals the amount that Highmark will pay:	$1,360

Your total liability:	
Deductible:	$ 300
Coinsurance amount:	340
Amount above Highmark allowable charge for this service:	6,000
Equals:	$6,640

NOTE: When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described in this booklet, you will be responsible for the difference between your plan's payment and the provider's billed charge. Your plan's payments are based on Highmark's allowable charge. Highmark determines the allowable charge. The amount above Highmark's allowable charge is your responsibility, and the out-of-network provider can balance bill you directly. If you need help obtaining information about Highmark network providers, you can call Member Service at the number on the back of your member ID card or search for a provider at myhighmark.com.

WHAT'S NOT INCLUDED IN THE TMOOP

The TMOOP does not include:

- coinsurance you pay for assisted reproductive technologies and fertility care services (in-network or out-of-network)

CARRYOVER AND PRO-RATION

There is no carryover into a subsequent plan year of any copayments, deductibles, or TMOOP from a previous plan year. There is no pro-ration of deductibles or TMOOP if you are enrolled in the plan for part of the year.

MEMBER SERVICES

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

HIGHMARK WEBSITE

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

Go to **myhighmark.com** tab and log in to your homepage to take advantage of these resources.

BLUES ON CALL℠ - 24/7 HEALTH DECISION SUPPORT

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

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

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

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

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

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

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself. You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions. Highmark also offers a diabetes management program if you have Type 1 or Type 2 diabetes to help you manage this chronic condition.

BABY BLUEPRINTS®

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

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

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

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

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

HOW TO USE YOUR COMPREHENSIVE PPO BENEFITS

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

TWO LEVELS OF BENEFITS

With the Comprehensive PPO plan, you can receive two levels of benefits:

- With In-Network benefits, your care is covered at the highest level.
- With Out-of-Network benefits, coverage is reduced. The amount you pay is greater. When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described in this booklet, **you will be responsible for the difference between your plan's payment and the provider's billed charge.** Your plan's payments are based on Highmark's **allowable charge**. Highmark determines the allowable charge. The amount above Highmark's allowable charge is your responsibility, and the out-of-network provider can balance bill you directly. If you need help obtaining information about Highmark network providers, you can call Member Service at the number on the back of your member ID card or search for a provider at myhighmark.com.

HOW TO RECEIVE IN-NETWORK BENEFITS

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

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

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

HOW TO RECEIVE OUT-OF-NETWORK BENEFITS

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

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

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

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described in this booklet, you will be responsible for the difference between your plan's payment and the provider's billed charge. Your plan's payments are based on Highmark's allowable charge. Highmark determines the allowable charge. The amount above Highmark's allowable charge is your responsibility, and the out-of-network provider can balance bill you directly. If you need help obtaining information about Highmark network providers, you can call Member Service at the number on the back of your member ID card or search for a provider at myhighmark.com.

EXCEPTIONS TO THE COMPREHENSIVE PPO RULES

Here are some instances when you don't have to use a network provider. You'll still get benefits at the In-Network level. Please be careful when you read the following. It's important that you understand the exceptions. Call Customer Service at 1-800-633-2563 if you have questions.

EMERGENCY CARE

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

OUTPATIENT LAB AND IMAGING TESTS

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

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

Use of Provider for Laboratory Services

Labcorp and Quest Diagnostics are the designated freestanding network providers for out-patient laboratory services in Delaware. Highmark members, hospitals, and physicians must use the designated network provider of laboratory services for claims to process at the in-network level. As is the case for any service, members may be responsible for the difference between the billed amount and the amount paid by Highmark when an out-of-network provider is utilized. If the ordering physician is located in another state, for benefits to be paid, the member must use a lab provider that contracts directly with the Blue Cross Blue Shield plan in whose state the ordering physician is located..

Members who present multiple lab slips from providers who are in network with Highmark during the same lab visit will only be responsible for one copay. If you have lab slips from multiple providers with one or more providers who are out state, please contact a Highmark Customer Care Advocate at 1-844-459-6452 for assistance.

OUT OF AREA SERVICES

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

THE BLUECARD® PROGRAM

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

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

After you receive care:

- If you've used a participating provider, you should not have to complete any claim forms.
- You should not have to pay up front for medical services, other than the usual out-of-pocket expenses (non-covered services, deductible, copayment, coinsurance and TMOOP).
- If your claim is subject to out-of-pocket expenses, Highmark will send you an EOB showing these amounts. If there are no out-of-pocket expenses, the EOB will be available at **myhighmark.com**.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

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

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

1) Always carry your Blue Cross and Blue Shield ID card.
2) Contact your Blue Plan before leaving as your health care benefits may be different outside the U.S., Puerto Rico and U.S. Virgin Islands.
3) In an emergency, go directly to the nearest hospital or doctor. Call the BlueCard Worldwide Service Center if hospitalized.
4) If you need to locate a doctor or hospital, or need medical assistance services, call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
5) Call the Blue Cross Blue Shield Global Core service center at 1.800.810.2583 or collect at 1.804.673.1177 when you need inpatient care. In most cases, if you contact the Blue Cross Blue Shield Global Core service center for assistance, hospitals will not request members to pay for covered inpatient services, except for cost-sharing amounts. In such cases the Blue Cross Blue Shield contracting hospital will submit your claim to the service center on your behalf to initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for Covered Services. **Members must contact Highmark to obtain precertification for non-emergency inpatient services.**

6) Call your Blue Plan for precertification or prior authorization, if necessary. Refer to the phone number on the back of your ID card.

Claims Filing and Payment Information

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

The Medical Assistance vendor offers the following services:

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

MANAGED CARE REQUIREMENTS

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

MEDICAL MANAGEMENT SERVICES

Determining Care Coverage

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

Highmark'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'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, and mental health) and for skilled nursing facility care.

Out-of-Network Care

When you use an *out-of-network facility provider*, **you are responsible for notifying Highmark prior to your proposed admission** to obtain pre-authorization of the inpatient admission and our determination of Medical Necessity and Appropriateness. This includes admissions for medical, mental health, and substance abuse diagnoses. Pre-authorization approval does not change the applicable out-of-network benefit and how Out-of-Network services are paid.

Remember:

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

After receiving the request for inpatient hospital or 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, Maternity, and Substance Abuse 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 will review the admission. If approved, we'll assign an initial length of stay.

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

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

In the event that a Member requires treatment for Substance Abuse requiring admission to a facility provider, the admission will not be subject to prior authorization or pre-certification. The facility provider must contact Highmark within 48 hours of the admission, and an initial treatment plan must be provided to us at the time of the notice of the admission. The prior authorization waiver for substance abuse diagnoses applies only to Highmark network and out-of-area network providers.

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.

    - Benefits provided in inpatient or residential settings for the diagnosis and treatment of substance abuse are not subject to concurrent utilization review for the first 14 days of an admission, provided the facility provider notifies Highmark of both the admission and the initial treatment plan within forty-eight (48) hours of the admission.

    - Benefits provided in inpatient settings for Inpatient Withdrawal Management are not subject to concurrent utilization review for the first 5 days of Inpatient Withdrawal Management, provided the facility provider notifies Highmark of both the admission and the initial treatment plan within forty-eight (48) hours of the admission.

    - Benefits provided in inpatient settings for Inpatient Withdrawal Management are not subject to concurrent utilization review for the first 5 days of Inpatient Withdrawal Management, provided the facility provider notifies Highmark of both the admission and the initial treatment plan within forty-eight (48) hours of the admission.

The facility must perform daily clinical review and periodically consult with Highmark to ensure that the facility is using the evidence-based and peer reviewed clinical review tool used by Highmark and designated by the American Society of Addiction Medicine (ASAM) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient to ensure that the inpatient treatment is medically necessary for the patient.

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.

For admissions for the treatment of substance abuse, Highmark may deny coverage for any portion of the initial 14-day inpatient or residential treatment on the basis that the treatment was not medically necessary only if the treatment was contrary to the evidence-based and peer reviewed clinical review tool used by Highmark and designated by ASAM or any state-specific ASAM criteria.

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. These include, but are not limited to:

- Radiation oncology services;
- certain outpatient hospital surgical procedures, including hysterectomy and laminectomy (lower back surgery)
- advanced radiology (Some examples include: CAT and PET scans, MRIs, and MRAs)
- assisted reproductive technologies, and
- partial hospitalization and intensive outpatient psychiatric services
- Certain outpatient goods and services, including certain medical injection drugs (a list of these that are authorized directly by Highmark is available at **myhighmark.com**).

Prior authorization is not required for the diagnosis and medically necessary partial hospitalization or intensive outpatient treatment of drug and alcohol dependencies by Highmark network or out-of-area network participating providers. Drug and alcohol dependencies are defined as a substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Delaware law.

In addition, concurrent utilization review is prohibited for these services during the first thirty (30) days of a partial hospitalization or intensive outpatient program treatment.

Network Care: The member's primary physician or any other network specialist is responsible for obtaining preauthorization for any service that requires it.

Out-of-Area Network Care: For outpatient services provided by out-of-area providers, preauthorization will not be obtained by the provider. Whenever you utilize a Network Provider located in another Blue Cross Blue Shield service area for other than an emergency, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness of such procedures or covered services. If you do not contact Highmark for certification, those procedures or covered services may be reviewed after they are received to determine medical necessity and appropriateness. If the procedure or covered service is determined to be medically necessary and appropriate, benefits will be paid in accordance with the plan. If the procedure or covered service is determined not to be medically necessary and appropriate, no benefits will be provided. In such case you will be financially responsible for the full amount of the out-of-area provider's charge.

Out-of-Network Care: For outpatient services provided by out-of-network providers, preauthorization will not be obtained by the provider. Whenever you utilize an Out-of-Network Provider for other than an emergency, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness of such procedures or covered services. If you do not contact Highmark for certification, those procedures or covered services may be reviewed after they are received to determine medical necessity and appropriateness. If the procedure or covered service is determined to be medically necessary and appropriate, benefits will be paid in accordance with the plan. You will be financially responsible for the difference between what is covered by the plan and the full amount of the Out-of-Network Provider's charge. If such procedure or covered service is determined not to be medically necessary and appropriate, no benefits will be provided. In such case, you will be financially responsible for the full amount of the Out-of-Network Provider's charge.

If you have any questions regarding procedures and services subject to precertification or Highmark's precertification determination of a procedure or service for medical necessity and appropriateness of certain outpatient procedures or covered services, you can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card or check the member website.

AUTHORIZATION FOR URGENT CARE SERVICES

You do not need to obtain prior authorization (for those services that require it) from Highmark, for services that your physician considers to be urgent, if these services are obtained outside of Highmark'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 for post-service authorization for these services within two business days following your care.

Care in an urgent care center/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 have agreed to follow Highmark's managed care requirements. In circumstances where an authorization for a service is required, the participating provider cannot bill you unless:

- Highmark's authorization requirements were followed,
- the service was not authorized, and
- having been informed of Highmark'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 Highmark service area may not know about the requirements. It's up to you to call Highmark at 844.459.6452 if you have care that requires authorization. If the requirements aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- Highmark does not pay for services that are not covered, even when the Medical Management and Policy or Behavioral Health Department authorizes, for example, an inpatient admission, except for optional benefits authorized by Highmark through individual case management.
- If you do not comply with the managed care requirements, Highmark will reduce or deny payment. However, upon appeal Highmark 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, coinsurance or TMOOP requirement.
- You don't need to follow Highmark'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 and Policy 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 promotes preventive care to help you stay well. We administer these benefits according to Highmark's Preventive Health Guidelines materials. These materials contain details of when the plan pays for preventive care, and they are available online at **myhighmark.com**. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

In-network preventive care is provided at 100% of the allowable charge.

The Highmark Preventive Schedule is a list of general care guidelines. We encourage you to take a copy of the schedule with you when you or a family member visits your medical provider.

The schedule includes tests that are performed for both routine and diagnostic reasons. If you are seeing your doctor and have not been diagnosed with a medical condition, you should expect the services to be performed for routine/preventive care. Only those procedures that are listed on the Preventive Schedule are covered during a preventive exam. If your doctor orders other tests, those tests may be subject to your deductible and/or coinsurance or they may be denied in certain instances. If you have a medical condition and the tests are being done to monitor the condition, then the services would be performed for diagnostic reasons and subject to your program's deductible, coinsurance and copay as applicable.

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

A routine preventive wellness visit focuses on maintaining your overall health and preventing future health problems. A routine preventive visit typically includes:

- **Review of your health history**
- **Physical examination**
- **Height, weight, and blood pressure measurements**
- **Body Mass Index (BMI) assessment**
- **Counseling on topics such as obesity prevention, fall prevention, skin cancer prevention, safety, and depression screening**
- **Assessment of alcohol and drug abuse, and tobacco use**
- **Age-appropriate health guidance**
- **Intimate partner violence screening and counseling for women of reproductive age**

Important Note: If during your preventive visit you present with a specific health concern or condition requiring further evaluation, such as diagnostic testing (e.g., X-rays, blood work) or the prescribing of medication or additional services, this may transition the visit from a preventive wellness visit to a diagnostic office visit, and the PCP office visit copay will apply.

EXAMINATIONS

Benefits are provided for:

- well baby care;
- routine physical exams; and
- routine GYN exams and Pap smears.

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;
- colon cancer screening;
- ovarian cancer screening;
  - Includes two (2) annual ovarian cancer screening tests for women at risk for ovarian cancer using any of the following methods that are recommended by a member's physician:
    - Tumor marker tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.
    - Transvaginal ultrasound.
    - Pelvic examination.
    - Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.
- flexible sigmoidoscopy;
- hemoglobin test;
- lead screening;
- mammogram, including a routine 3D mammogram;
  - An annual routine mammographic screening starting at 40 years of age or older.
  - Mammographic screenings for all members regardless of age when such services are prescribed by a physician.
- supplemental breast screenings (Breast MRI, Breast Ultrasound, Mammogram, Breast Biopsy, Breast Pathology Services);
  - An annual supplemental breast screening examination starting at forty (40) years of age or older. Supplemental breast screening examination means a medically necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, mammogram, breast biopsy, and breast pathology services that is used for either of the following: (1) to screen for breast cancer when there is no abnormality seen or suspected in the breast; or (2) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.
- osteoporosis screening;
- alcohol misuse, and tobacco use and tobacco-caused disease counseling;
- Intimate Partner and Domestic Violence Screening and Counseling;
- Navigation Services for Cervical and Breast Cancer Screening
- depression screening for adolescents and adults; and
- 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); and
- Varicella (chickenpox) vaccine;

Immunizations considered by Highmark to be experimental are not covered.

PREVENTIVE COVERAGE FOR WOMEN

Certain benefits will be covered with no cost sharing to the member, including:

- contraceptives covered under the medical/surgical benefit, including:
- injections, such as Depo-Provera.
- implantable intra-tubal occlusion devices, IUDs, cervical caps and diaphragms
- sterilization procedures, such as tubal ligation, by a physician.
- well women visits: two preventive visits and two OB/GYN visits per year.
- HPV Test: covered once every 3 years for women age 30 and older, or annually if Pap test yields other than normal results.
- screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation, and at the first prenatal visit for pregnant women at high risk for diabetes.
- two counseling session per plan year for sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV)
- breastfeeding Supplies: Breastfeeding equipment in conjunction with each birth. Breastfeeding equipment includes breast pumps and supplies.
- Postpartum diabetes screening for those with gestational diabetes.

For more information about these and other preventive services, please refer to Highmark's Preventive Health Guidelines at **myhighmark.com**.

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*.

DIABETES PREVENTION PROGRAM

Benefits are provided for those Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled in a Diabetes Prevention Program that is delivered by a Diabetes Prevention Provider. Coverage is limited to one (1) enrollment in a Diabetes Prevention Program per year, regardless of whether the Member completes the Diabetes Prevention Program.

To participate in the DPP program, members need to meet the following eligibility criteria:

- 18 years of age or older;

- Not diagnosed with Type 1 or Type 2 diabetes or ESRD (End Stage Renal Disease);
- Overweight (BMI ≥25; BMI ≥23 for Asian individuals); and
- Have **ONE** of the following:
  - Diagnosed with pre-diabetes by qualifying blood test values;
  - Previous diagnosis of gestational diabetes; or
  - Qualifying Risk Score as determined by the online Risk Assessment

To learn more about these program options, log in to your member website at myhighmark.com

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. The plan covers private rooms only when medically necessary. The plan also covers intensive care when medically necessary.

Other Hospital Care

When medically necessary, the plan covers:

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

- durable medical equipment;
- lab tests; and
- dialysis.

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy;
- childbirth; and
- 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, from the moment of birth to a maximum of thirty-one (31) days from the date of birth. To be covered as a dependent beyond the thirty-one (31) days period, the newborn child must be enrolled as a dependent and appropriate premium paid within such period.

See the section entitled "A Guide to Enrollment", *Changes in Enrollment (Newborns)* for more information.

OUTPATIENT SURGICAL FACILITY

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

- hospitals; or
- 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. Please refer to the Dental Surgery description in the section entitled *Surgical and Medical Benefits*, below.

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 must approve your stay. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient skilled nursing facility care.

The plan covers:

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

The plan doesn't cover intermediate care, rest and homelike care, or custodial 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; and
- delivery of newborns.

These services can be done:

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

The allowable charge includes pre- and post- operative care done by surgeons. The plan does note pay separate charges for such care.

Second Surgical

Second opinions are covered for members that are having surgery and want to seek another specialist's opinion prior to the surgery. To be eligible, the second provider would need to be outside of the provider's practice that gave the first consult.

A benefit is also paid for charges made for a third surgical opinion. This will be done when the second opinion does not confirm the recommendation of the first physician who proposed to perform the surgery and where all three physicians providing opinions are from different practices.

A surgical opinion includes and exam, tests and a written report by the physician.

Dental Surgery

Dental surgery is only covered for:

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

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

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

When it is medical 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, the plan will cover the anesthesia and facility charges. Highmark must approve such care at least two business days prior to services being performed.

Multiple Surgical Procedures

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

- the plan provides full contract benefits for the procedure with the highest allowable charge; and
- we determine plan 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:

- the plan covers the entire procedure as one stage.

Reconstructive Surgery

Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem are excluded. However, the Plan covers the following:

- reconstructive surgery to correct the results of an injury.
- surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
- surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.

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 lymph edemas.

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; and
- 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 TMOOP apply.
- The benefit includes all organ acquisition costs.

- Transplants performed at non-BDCT, but participating hospitals are covered at the out-of-network inpatient or outpatient facility and professional service benefit levels.
  - Any copayments, deductibles, coinsurance and TMOOP 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, coinsurance and TMOOP, 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 TMOOP apply.
  - Allowable charges for harvesting/procurement for kidneys are determined by Highmark.
  - 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 TMOOP apply.
  - Allowable charges for donor treatment and harvesting for bone marrow/stem cells are determined by Highmark.

- 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:
  - $50/night for lodging for each person, with a maximum of $100/night, for the recipient of services and one other person.
  - Meals are not included in this reimbursement.
  - 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'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 transplant and ends 12 months after transplant. Reimbursement applies to recipient and one other person. If the recipient is a minor, two adults are covered.

KNEE, HIP, AND SPINE SURGERY

This section describes the coverage for the following procedures:

- total knee replacement;
- total hip replacement;
- cervical and lumbar fusion;
- cervical laminectomy;
- lumbar laminectomy/discectomy procedures

The level of coverage for the above surgeries depends upon the facility where they are performed:

- The above knee, hip, and spine surgeries performed at a Blue Distinction Center® (BDC) are covered at the level of the member's inpatient facility benefit for network providers.
  - Any copayments, deductibles, coinsurance and TMOOP apply.

- The above knee, hip, and spine surgeries performed at non-BDC, but participating hospitals are covered in network inpatient or outpatient facility and professional service benefit levels.
  - A $500 inpatient facility applies to any inpatient facility services.

- Travel Reimbursement for the knee, hip and spine procedures listed above and performed at a BDC facility, the following will be covered during the reimbursement period:
  - $50/night for lodging for each person, with a maximum of $100/night, for the recipient of services and one other person.
  - Meals are not included in this reimbursement.

  The reimbursement period begins 1 day prior to surgery and ends 6 months after surgery and applies when the facility is more than 100 miles from the recipient's home.

If you have questions about Highmark's BDC programs, please contact the Customer Service Department at the number listed in the front of this booklet.

To view a list of BDCTs, use the Blue Distinction Center Finder at **bcbs.com**.

DIAGNOSTIC BREAST EXAMINATION

This section describes the coverage for the following procedures:

- Includes coverage at 100% for one (1) annual medically necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either: (1) to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or (2) to evaluate an abnormality detected by another means of examination.

OVARIAN CANCER MONITORING TESTS

Includes coverage at 100% for two (2) annual ovarian cancer monitoring tests which are tests and examinations subsequent to treatment for ovarian cancer using any of the following methods that are recommended by a member's physician.

- Tumor marker tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.
- Transvaginal ultrasound.
- Pelvic examination.
- Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

ASSISTED REPRODUCTIVE TECHNOLOGIES AND FERTILITY CARE SERVICES

This plan provides fertility care services and fertility preservation services for individuals diagnosed with infertility or at risk of infertility due to surgery, radiation, chemotherapy or other medical treatment.

Covered services include artificial insemination, in vitro fertilization and related technologies, and cryopreservation of cells and tissue.

Artificial Insemination (AI, IUI, ICI)
Artificial Insemination is a procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

In Vitro Fertilization (IVF, GIFT, ZIFT) IVF (or related technologies, including, but not limited to: gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)) may be considered medically necessary when the following criteria are met:

- Individual has a congenital absence or anomaly of reproductive organ(s); or
- Individual fulfills one of the following definitions of infertility:
  - Individual is less than the age of 35 years and has not achieved a successful pregnancy after at least twelve (12) months of appropriately timed unprotected vaginal intercourse or intrauterine insemination; or
  - Individual is 35 years of age or older and has not achieved a successful pregnancy after at least six (6) months of appropriately timed unprotected vaginal intercourse or intrauterine insemination.

AND

- In the absence of known tubal disease and/or severe male factor problems (contraindications to insemination cycles), the individual has not achieved a successful pregnancy as described above, which includes up to three (3) intrauterine insemination cycles; and
- Individual has at least one risk factor that includes, but is not limited to the following:
  - Tubal disease that cannot be corrected surgically; or
  - Diminished ovarian reserve; or
  - Irreparable distortion of the uterine cavity or other uterine anomaly (when using a gestational carrier); or
  - Male partner with severe male factor infertility; or
  - Unexplained infertility; or
  - Stage 4 endometriosis as defined by the American Society of Reproductive Medicine;

AND

- Individual does not have **either** of the following contraindications:
  - Ovarian failure: premature (i.e., ovaries stop working before age 40) or
  - menopause (i.e., absence of menstrual periods for 1 year); or
  - Contraindication to pregnancy

For IVF services, retrievals must be completed before the individual is 45 years old and transfers must be completed before the individual is 50 years old.
The benefit is limited to six (6) completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (SET) when recommended and medically appropriate.

Gestational Carrier/Surrogate

Medical services or supplies rendered to a gestational carrier or surrogate may be considered medically necessary if the member has ANY of the following indications:

- Congenital absence of a uterus; or
- Uterine anomalies that cannot be repaired; or
- A medical condition for which pregnancy may pose a life-threatening risk.

Benefit Limits

There's a $30,000 lifetime payment limit for services related to assisted reproductive surgical procedures. The $30,000 limit applies even when you switch to another State of Delaware plan. If pregnancy results, your maternity benefits are then applied.

Note: Drugs are covered under your prescription drug benefit and are subject to a separate $15,000 limit.

Exclusions

The following related services to reproductive technologies/techniques are considered not medically necessary:

- Infertility that is a result of voluntary sterilization of either partner. (In situations where the female partner has a diagnosis of infertility and the male partner has had a voluntary sterilization, IVF coverage may still be reviewed and approved based on the female partner's infertility condition); or
- Reversal of voluntary sterilization (tuboplasty or vasoplasty); or
- Payment for surrogate service fees for purposes of child birth; or
- Living expenses; or
- Travel expenses.

GENDER AFFIRMATION SURGERY

Gender affirmation surgery, either as a male-to-female (MTF) transition or as a female-to-male (FTM) transition, consists of medical and surgical treatments that change primary sex characteristics for individuals with gender dysphoria or gender identity disorder who wish to make a permanent transition.

Gender Identity is defined as an individual's gender appearance, expression or behavior regardless of the individual's assigned sex at birth. Determinations of medical necessity, eligibility and prior authorization requirements for diagnoses related to an insured's gender identity must be based on current medical standards established by nationally recognized transgender health medical experts.

Gender affirmation surgery may be considered medically necessary when ALL of the following are met:

- The individual is greater than or equal to 18 years of age; **and**
- The individual has the capacity to make a fully informed decision and to consent for treatment; **and**
- The individual has been diagnosed with the gender dysphoria, including **ALL** of the following:
    - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make their body as congruent as possible with the preferred sex through surgery and hormone treatment; **and**
    - The individual's transgender identity has been present persistently for at least two (2) years; **and**

- The dysphoria is not a symptom of another mental disorder or a chromosomal abnormality; **and**
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The individual is an active participant in a recognized gender identity treatment program and demonstrates **ALL** of the following conditions:
  - The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender; **and**
  - For breast surgery
    - Initiation of hormonal therapy (unless medically contraindicated or individual is unable or unwilling to take hormones); **and**
    - One referral from a qualified mental health professional with written documentation submitted to the physician performing the breast surgery**; and**
  - For genital surgery
    - Documentation of at least 12 months of continuous hormonal sex reassignment therapy, unless medically contraindicated or individual is unable or unwilling to take hormones) (may be simultaneous with real life experience); **and**
    - Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent; **and**
  - Separate evaluation by the physician performing the genital surgery.

When **ALL** of the above criteria are met, the following breast/genital surgeries may be considered medically necessary for the following indications:

MTF:

- Breast augmentation
- Orchiectomy
- Clitoroplasty
- Colovaginoplasty
- Labiaplasty
- Orchiectomy
- Penectomy
- Vaginoplasty

Note: Although not a requirement, it is recommended that MTF undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

FTM:

- Breast reconstruction (e.g., mastectomy)
- Colpectomy/Vaginectomy
- Hysterectomy
- Metoidioplasty
- Penile prosthesis
- Phalloplasty
- Reduction mammoplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular prosthesis implantation
- Urethroplasty

Note: Penile prosthesis surgery is typically performed at stage two (2) or three (3) of a multi-stage phalloplasty (a minimum of nine (9) months following stage one (1)).

The following services are considered cosmetic and not covered, unless they are determined medically necessary to treat the member's condition based on scientific, medical literature and standards recognized by transgender health medical experts and are not primarily for aesthetic purposes or to reverse natural signs of aging (this is not an all-inclusive list):

- Blepharoplasty
- Blepharoptosis
- Chin augmentation
- Collagen injections
- Cricothyroid approximation
- Facial bone reduction-facial feminizing
- Hair removal – electrolysis or laser hair removal
- Hair transplantation
- Laryngoplasty
- Lip reduction/enhancement
- Liposuction
- Mastopexy
- Nipple/areola reconstruction
- Removal of redundant skin
- Rhinoplasty
- Rhytidectomy
- Trachea shave/reduction thyroid chondroplasty

NOTE: When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described in this booklet, you will be responsible for the difference between your plan's payment and the provider's billed charge. Your plan's payments are based on Highmark's allowable charge. Highmark determines the allowable charge. The amount above Highmark's allowable charge is your responsibility, and the out-of-network provider can balance bill you directly. If you need help obtaining information about Highmark network providers, you can call Member Service at the number on the back of your member ID card or search for a provider at myhighmark.com

INPATIENT MEDICAL SERVICES

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

The plan normally covers one doctor visit per day. Usually this is your attending doctor. If another specialist visits you, the plan 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.

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 asre licensed and certified nurses. They must be practicing within the scope of their license. When the plan covers midwife care, the plan does not cover a doctor's care for the same services.

One diagnostic ultrasound per pregancy is also covered.

NEWBORN CARE

Medical care for a newborn child is covered, from the moment of birth to a maximum of thirty-one (31) days from the date of birth. To be covered as a dependent beyond the thirty-one (31) days period, the newborn child must be enrolled as a dependent and appropriate premium paid within such period.

See the section entitled "A Guide to Enrollment", *Changes in Enrollment (Newborns)* for more information.

ABORTIONS

Elective and non-elective abortions are covered to the extent permitted by state law. Non-elective abortions are abortions performed where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the member in danger unless an abortion is performed. Coverage includes services related to the termination of pregnancy to the extent permitted by state law.

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. The plan covers 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; and
- severe burns.

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; and
- 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

Remember: If you go to an Urgent Care facility instead of the Emergency Room, your copayment or out-of-pocket costs would be lower.

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 facility.

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

WHEN YOU'RE TRAVELING

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

Step 1

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

You can also use the **myhighmark.com** website to find a provider, which may include a medical aid/urgent care facility. 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 customer. **To get the highest benefit, be sure the provider participates with the local Blue Cross Blue Shield plan.** The doctor's office will check your enrollment. When you receive care, you will be charged the copayment listed on your I.D. card, if any. The doctor's office will then bill the local Blue Cross Blue Shield plan, and the claim will be forwarded to us.

DIAGNOSTIC AND THERAPEUTIC SERVICES

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

INPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

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

OUTPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

Remember to use a network provider to get the highest benefits. If you use a non-network provider, even if your doctor refers you, your benefits will be reduced.

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. Remember: If you go to an Independent Provider (free-standing facility) instead of Hospital Based facility for your tests, there is no charge to you. See *Managed Care Requirements* for information about authorization requirements for these services.

PREADMISSION TESTING

The plan covers 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 by a doctor;
- infusion therapy;
- 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,
  - the maximum number of visits allowed for a specific diagnosis is determined by medical necessity;
- 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,
  - the maximum number of visits allowed for a specific diagnosis is determined by medical necessity;
- 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,
  - the maximum number of visits allowed for a specific diagnosis is determined by medical necessity;
- dialysis;
- cognitive therapy done by a provider approved by Highmark. The diagnoses eligible for coverage are:
  - stroke with cognitive impairment, or
  - head injury or trauma;
- cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.

Please note: Your health plan benefit for physical, occupational and speech therapy services includes visit limitations. The maximum number of visits allowed for a specific diagnosis is determined by medical necessity as provided to Highmark by your treating physician. Highmark will process the therapy claims according to your benefits, until you reach the visit limitation that is determined to be medically appropriate for your diagnosis. It is important to note that if you exceed the maximum number of visits, your claim(s) will be denied. You will then be responsible for the entire cost associated with the therapy service(s) received.

APPLIED BEHAVIOR ANALYSIS

Benefits are provided for Applied Behavior Analysis for the treatment of autism spectrum disorders. 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!

GENETIC TESTING

Benefits are provided only for certain genetic testing, subject to medical necessity and appropriateness. Please refer to the guidelines in Highmark's medical policies for additional information on coverage for genetic testing.

HOSPICE

Hospice provides palliative and support care to terminally ill patients and their families. Highmark must authorize the hospice care.

You may have hospice care at home, in an inpatient hospice facility or a short or long term nursing facility for up to 365 days.

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; and
- 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;
- durable medical equipment (DME) not related to palliative management;
- palliative chemotherapy or radiation therapy when needed to manage the illness;
- inhalation therapy; and
- imaging and lab tests.

What's Not Covered Under Hospice:

- private duty nursing;
- respite care;
- care not prescribed in the approved treatment plan;
- financial, legal or estate planning;
- outpatient prescription drugs other than those for palliative management; 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. 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 a 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; or
  - 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

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

What Is Covered Under Home Infusion:

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

What's Not Covered Under Home Infusion:

- delivery costs;
- record keeping costs;
- doctor management;
- other services which do not involve direct patient contact; and
- drugs normally covered under a drug program.

INPATIENT PRIVATE DUTY NURSING

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

- ordered by the attending doctor;
- for the same condition you're hospitalized for; 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; and
- intensive care units.

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

DOCTOR'S VISITS

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

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

OTHER PRACTITIONER VISITS

Physician visits - covered medical expenses include charges made by a physician or other licensed health care practitioner during a visit to treat an illness or injury. The visit may be at the physician’s office, in your home, in a hospital or other facility during your stay or in an outpatient facility.

TELEMEDICINE SERVICES

Highmark’s telemedicine service benefit is an affordable and convenient alternative to urgent care centers and emergency rooms. Members may now obtain follow up care or resolve many of their minor illness issues without an actual office visit through the convenience of audiovisual consultations.

Telemedicine provided by designated Highmark vendors includes a national network of physicians who can diagnose, treat and prescribe medication, when appropriate, for many medical issues. All physicians are Board Certified and licensed to practice medicine in the state in which the member is located.

This plan provides coverage for the telemedicine services of physicians and many other providers.

SPECIALIST/REFERRAL CARE

Home and office visits with specialists are covered. This includes visits for injury or illness.

DIABETIC EDUCATION

Diabetic education provides instruction on the care and treatment of diabetes, including foot care, eye exams for diabetic retinopathy, blood sugar monitoring, medication management and diabetic nutritional counseling. Diabetic education can be performed by either physicians or Certified Diabetic Educators, either on an individual basis or in a group setting.

NUTRITIONAL COUNSELING

Services are provided for the assessment and guidance of members at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness. Nutritional counseling is indicated for certain diagnoses, including diabetes, malnutrition, eating disorders and cardiovascular disease.

Nutritional counseling benefits are not provided for weight loss in the absence of co-morbid conditions, or for conditions that have not been shown to be nutritionally related, including, but not limited to, chronic fatigue syndrome and hyperactivity.

ALLERGY TESTING AND TREATMENT

Allergy testing and treatment are covered.

SPINAL MANIPULATIONS

Please note: Your health plan benefit for chiropractic services includes visit limitations. The maximum number of visits allowed for a specific diagnosis is determined by medical necessity as provided to Highmark by your treating physician. **In addition, services are limited to 30 days per plan year regardless of medical necessity** except for visits for the purpose of treating back pain. Highmark will process the chiropractic claims according to your benefits, until you reach the visit limitation that is determined to be medically appropriate for your diagnosis or the plan year limit for the diagnosis, whichever is less. It is important to note that if you exceed the maximum number of visits, your claim(s) will be denied. You will then be responsible for the entire cost associated with the chiropractic service(s) received.

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

- office visit for initial evaluation;
- manual manipulation of the spine, head, rib cage, abdomen and upper and lower extremities;
- physical therapy, including ultrasound, traction therapy, and electrotherapy; and
- chiropractic supportive care, which is continuous, interval-based treatment where there is a diagnosis of chronic pain or disease and which maintains function or prevents or slows deterioration.

Chiropractic coverage is limited to three modalities per visit and one visit per day. Other limits are listed on the *Schedule of Benefits*.

Chiropractic services must either provide significant improvement in your condition in a reasonable and predictable period of time or be necessary to establish an effective home exercise 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. Cervical x-rays and thoracic x-rays are covered; full spine x-rays are not covered.

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

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

DURABLE MEDICAL EQUIPMENT & PROSTHETICS

Durable Medical Equipment

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

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

Some examples of DME are:

- orthopedic braces;
- wheel chairs;
- orthotics; and
- hospital beds.

The plan may pay for rent or purchase. If we rent the equipment, the plan's 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; and
- deemed by Highmark 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; and
- electro-larynx devices.

The plan also pays to replace or repair prosthetic devices.

The plan also pays for:

- medical foods and formula for the treatment of inherited metabolic disorders; and
- hearing aids. Benefits are limited to one hearing aid, per ear, every three (3) years for children less than 24 years of age. This limitation does not apply to Bone Anchored Hearing Devices (BAHA) and Cochlear Implants.

DME & Prosthetics Not Covered:

- items for comfort or convenience;
- dental prosthetics; and
- foot orthotics, unless deemed to be medically necessary and appropriate.

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, the plan covers the following:

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

Surgical treatment of morbid obesity is not eligible under your Highmark medical plan as the benefit for these services is administered through **Lantern**, an independent company that does not provide Highmark services. For more information, please contact Lantern at 855.200.2034.

* Lantern is solely responsible for the subject non-Highmark products or services it is providing.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
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. Managed care requirements must be followed, 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. The plan covers private rooms only when medically necessary.

Other Hospital Care

When medically necessary, the plan covers:

- electroconvulsive therapy by a doctor
- detoxification and inpatient withdrawal management
- drugs listed in the U.S. Pharmacopoeia or National Formulary
- lab tests

  Drug testing for pain management and substance abuse treatment benefits are subject to the guidelines outlined in our medical policy
  L-102 which is found at:
  https://securecms.highmark.com/content/medpolicy/en/highmark/de/commercial/policies/Laboratory/L-102/L-102-020.html

The plan also covers treatment and rehabilitation services for behavioral health disorders in accredited residential and substance abuse treatment facilities.

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.

RESIDENTIAL TREATMENT

This plan also covers substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services.

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.

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.

- Biofeedback, unless there is a medically necessary diagnosis.

- Blood, blood components and donor service.

- Care as a result of any criminal act in which you conspired or took part. One example is Highmark 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; or
  - 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 parents, your children, your spouse or your siblings.

- 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, and 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; and
  - 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, are covered.

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

- Marriage counseling or other relationship counseling or advisory services. Except marriage counseling, marital therapy, couples counseling covered when rendered by a licensed behavioral health provider when at least 1 party in the relationship has a diagnosed behavioral health disorder, such as:

  - Adjustment disorder
  - Alcoholism
  - Anxiety
  - Depression

- Computerized gait analysis or electrodynographic tests.

- Convenience items. Some examples are:

  - phones;
  - TVs;
  - radios; and
  - 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 certain dental care noted in the *Surgical and Medical Benefits* section.

- Drugs or care received in violation of law.

- Enteral nutrition ingested or administered orally, even if it is the sole nutritional source. The only exceptions are certain medical foods prescribed for inherited metabolic disorders.

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

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

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

- Hearing aids for members age 24 and over. This limitation does not apply to Bone Anchored Hearing Devices (BAHA) and Cochlear Implants.

- 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; and
  - Incontinence and personal hygiene supplies.

- Occupational or physical therapy for developmental delay.

- Orthotic equipment and devices for feet, unless noted elsewhere in this booklet. Some examples are:

  - foot inserts;
  - arch supports;
  - lifts; and
  - corrective shoes.

- Any health examinations or treatment including laboratory and imaging testing to obtain or maintain employment or to attend a school, camp or sporting or other recreational events. Any special medical reports not directly related to treatment except when provided as part of a covered services. Examples of non-covered services includes:

  - Screening examinations for infectious disease, including laboratory or x-ray tests
  - Drug testing
  - Hearing or vision examinations
  - Vocational rehabilitation
  - Employment counseling

- Prescription drugs, even if your doctor writes you a prescription.

- Rest cures, custodial care or homelike care even when prescribed by a doctor.

- Routine foot care, unless there is a medically necessary diagnosis.

- Services in excess of your covered benefit limits.

- Speech therapy for:

  - attention disorders;
  - behavior problems;
  - conceptual handicaps;
  - learning disabilities; and
  - 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, the plan covers one service per day by a professional provider. If more than one service is done, the plan covers only the service with the greater allowable charge.

VALUE ADDED FEATURES

Highmark offers Value Added Features. They are described below.

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

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

EYEWEAR DISCOUNTS

On behalf of Highmark, 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**. The client number is 2722.

DISCOUNT PROGRAMS

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

- Fitness clubs
- Laser vision corrective surgery
- Hearing aids

For a full listing of our discounts go to **myhighmark.com** or call us at 844.459.6452.

YOUR RIGHTS AND RESPONSIBILITIES

As a Highmark 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 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's medical policies, products, services, network practitioners and providers, complaint and appeal procedures, and members'/enrollees' rights and responsibilities.
- 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 and receive a response to the complaint within a reasonable period of time.
  - This includes requesting an internal appeal or review by an Independent Utilization Review Organization. To register a complaint or request an appeal members are instructed to call the Customer Service number listed on their ID card.
- Submit a formal complaint about the quality of care given by your providers.
- Make recommendations regarding Highmark's members' rights and responsibilities policies.

You have the RESPONSIBILITY to:

- Double-check that any facilities from which you receive care are in network with Highmark or the local BCBS plan. Visit **myhighmark.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 they are 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 eligibility. Notify us of any change in your family size, address or phone number.
- Tell Highmark about any other insurance you may have.

A GUIDE TO ENROLLMENT INFORMATION

The information presented in this section is subordinate to Delaware Code and the Group Health Plan Eligibility and Enrollment Rules. In the event of conflict, Delaware Code and the Group Health Plan Eligiblilty and Enrollment Rules are controlling.

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You;
- Your spouse; and
- Your children.

NOTE: The State of Delaware requires proof of dependency. See the section *Changes in Enrollment,* below, for the documentation required to enroll dependents. Highmark will require proof of disability through the completion of the *Disabled Child Application* available at **myhighmark.com**.

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

- **Employee** for you only;
- **Employee and Child(ren)** for you and your children;
- **Employee and Spouse** for you and your spouse; or
- **Family** for you, your spouse and your children.

YOU ARE ELIGIBLE TO BE COVERED IF:

- you are a regular officer or employee of the State;
- you are a regular officer or employee of a State agency or school district;
- you are a pensioner already receiving a State pension;
- you are a pensioner eligible to receive a State pension;
- you are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- you are a regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group Health Insurance Program;
- you are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- you are a paid employee of any volunteer fire or volunteer ambulance company participating in the State's Group Health Insurance Program;
- you are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the State's Group Health Insurance Program;
- you are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code.

As used throughout this booklet, the term *employee* refers to any person described in the above list. The only exceptions to this are found in the section *Coordination of Benefits,* where, in limited context, the term may refer to a spouse.

SPOUSE

You may enroll your spouse. A *spouse* is one of two persons united together in either:

- a marriage; or
- a civil union;

that is recognized by and valid under Delaware law.

Information on civil unions, including Frequently Asked Questions (FAQ), tax dependent status, coverage codes, health plan rates and enrollment is available at:

https://de.gov/statewidebenefits

SPOUSE'S BENEFITS

This is how the plan pays benefits for spouses enrolled under this Plan:

- The plan pays normal plan benefits if your spouse isn't employed.
- The plan pays after your spouse's plan pays if your spouse:
  - is eligible for; and
  - **is enrolled** in a plan sponsored by their employer or by an organization from which they are collecting a pension benefit; or
  - is eligible for; and
  - **is enrolled** in an individual health plan through the Health Insurance Marketplace.
- The plan pays 20% of allowable covered charges if your spouse:
  - is eligible for; and
  - **is not enrolled** in a plan sponsored by their employer or by an organization from which they are collecting a pension benefit; or
  - is eligible for a cash benefit in lieu of a plan sponsored by their employer or by an organization from which they are collecting a pension benefit; and
  - **is not enrolled** in an individual health plan through the Health Insurance Marketplace.

The combined payments can't be more than 100% of covered charges. For more details, see the section, *Coordination of Benefits*.

The above will not apply if your spouse is not enrolled in the plan sponsored by their employer or by an organization from which they are collecting a pension benefit, because your spouse:

- doesn't work full-time;
- isn't eligible because they don’t work enough hours to be eligible;
- isn't eligible because they haven’t completed a waiting period;
- has to pay more than half of the plan's cost (including flexible credits);
- doesn't meet the underwriting requirements of the sponsored plan; or
- the employer or sponsoring organization doesn't offer active or retiree health coverage.

Members are responsible for completing a *Spousal Coordination of Benefits* form each year, or at any time a spouse's job or health coverage status changes. The electronic *Spousal Coordination of Benefits* form is available at https://de.gov/statewidebenefits**. This form must be completed and submitted online.**

CHILDREN

To be covered, a child must be

- age 26 or younger, and
- either
  - born to the employee or their spouse,
  - adopted by the employee or their spouse,

- placed in the home of the employee or their spouse for adoption, or
- someone for whom health care coverage is the employee's or their spouse's responsibility under the terms of a qualified medical child support order. A copy of the order must be provided to your Human Resources/Benefits Office.

You are required to submit proof of relationship, such as a birth certificate or adoption papers.

Coverage for Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- unmarried; and
- living with you in a regular parent-child relationship; and
- dependent upon you for support, and qualifies as your dependent under Internal Revenue Code §105 and §152; and
- is under age 19; or
- is under age 24 if a full-time student.

For each child, you are required to show proof of dependency, such as a birth certificate, court order, or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a *Statement of Support* form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The *Statement of Support* form is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a *Full-Time Student Certification* form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The *Full-Time Student Certification* form is available at https://de.gov/statewidebenefits Please print the form, complete it, and provide to your Human Resources/Benefits Office.

DISABLED CHILDREN

A Disabled child can be covered after the dependent child age limits. They may be covered if:

- They were covered continuously as a dependent child by a group plan through their parent before reaching the dependent child age limit;
- They are not married;
- They provided 50% or less of their own support because of a disability that is expected to last more than 12-months or result in death;
- Their disability occurred before they reached the dependent child age limit;
- They are not eligible for coverage under Medicare, 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. You may get the form online at https://de.gov/statewidebenefits **or at myhighmark.com.** You must print the form, complete it, obtain physician's information and signature, and mail the form to Highmark at the address provided on the form.

ENROLLMENT

HOW TO ENROLL

You may enroll yourself and your dependents when you are first eligible or at Open Enrollment by completing the enrollment process as designated by your Human Resources/Benefits Office. If you want to cover your spouse, you'll need to complete the *Spousal Coordination of Benefits Form*. Access to the Spousal Coordination of Benefits form and policy is available at https://de.gov/statewidebenefits. This form must be completed and submitted online.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You will need to complete the enrollment process indicating you are waiving coverage as designated by your Human Resources/Benefits Office.

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) begins:

- on the date of hire; or
- on the first of the month of any month following date of hire up to the first of the month when eligible for State/Employer Share when an employee moves to a class that is eligible for health coverage.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

Please also refer to the section *Changes in Enrollment*, below, for qualifying events that trigger Special Enrollment status.

You are a Special Enrollee if you enroll within the 30-day enrollment period. The enrollment period is measured from the date of the qualifying event, such as:

- losing other health coverage under certain conditions; or
- obtaining a new dependent because of marriage, civil union, birth, 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 request enrollment within the 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 (when first eligible or during Open Enrollment); 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

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;
- 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 the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted, coverage begins for:

- Employees: the first day of the month after the loss of coverage.
- Spouses: either the date of marriage or civil union or the first day of the month after the marriage or civil union.
- Children: either:
  - the date of birth, adoption or placement in the home for adoption; or
  - the first day of the month after you request enrollment if:

- you lost coverage under a prior plan; or
- your parent got married or entered into a civil union.

Remember, if you request enrollment after the enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be A Late Enrollee

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

Children are Late Enrollees if enrollment was not requested within 30 days of:

- birth;
- adoption;
- placement in the home for adoption; or
- marriage or civil union.

When Coverage Begins

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

CHANGES IN ENROLLMENT (ALSO SEE *WHEN COVERAGE ENDS*)

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. A newborn child is covered from the moment of birth to a maximum of thirty-one (31) days from the date of birth. To be covered as a dependent beyond the thirty-one (31) day period, the newborn child must be enrolled. See your Human Resources/Benefits Office.

MARRIAGE OR CIVIL UNION

You may add your spouse when you get married or enter into a civil union. You must request enrollment within 30-days after the marriage or civil union; a copy of your marriage or civil union certificate is required by your Human Resources/Benefits Office. If added premium is due, you must pay when you request enrollment.

Don't forget, when you cover your spouse you'll also need to complete the *Spousal Coordination of Benefits Form.* The form is available at https://de.gov/statewidebenefits . This form must be completed and submitted on-line each year, or anytime a spouse's job or health coverage status changes.

You may also add any stepchildren you acquire when you marry or enter into a civil union. See section describing coverage for *Other Children*, below.

DIVORCE

Former spouses aren't eligible for coverage under this program. See the section, *When Coverage Ends*, below for information about disenrolling a former spouse.

NEWBORNS

You may add your newborn child. Coverage for a child born to regular officer, employee, eligible pensioner or spouse will begin from the moment of birth to a maximum of thirty-one (31) day from the date of birth. To be covered as a dependent beyond the thirty-one (31) days period, you must:

- request enrollment of the newborn child within 31-days of the date of birth; and
- complete the necessary paperwork and provide a valid copy of the child's birth certificate to the Human Resource/Benefits Office within 31-days of the enrollment request; and
- if applicable, you must change your coverage to a type that includes children and pay any additional premium.

Where an employee has existing coverage that includes children, you must enroll the newborn child in order for the newborn child to be covered as a dependent and for claims to be paid beyond the thirty-one (31) day period.

ADOPTED CHILDREN

You may add a child because of adoption or placement in the home of a regular officer, employee, eligible pensioner, or their spouse for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date the child became eligible.

OTHER CHILDREN

You may add a child other than a newborn or adopted child, such as a step-child. For each child, you are required to show proof of dependency, such as a birth certificate, court order, or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a *Statement of Support* form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The *Statement of Support form* is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a *Full-Time Student Certification* form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. *The Full-Time Student Certification* form is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

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 AND ENROLLMENT

You are eligible to enroll in Medicare Parts A and B when you turn age 65, or earlier if you become disabled. Your spouse is similarly eligible. In accordance with 29 Delaware Code § 5203(b) and the State of Delaware's Group Health Insurance Program's Eligibility and Enrollment Rule 4.12, you and your spouse must enroll in Medicare upon eligibility. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. The following information is for you and your spouse.

Medicare Part A helps cover inpatient care in hospitals and is provided at no charge to you. Medicare Part B helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care, and is provided at a monthly cost to you as determined by the Social Security Administration.

Active Employees and Spouses

If you are a benefit eligible active employee, or the spouse of a benefit eligible active employee, about three months before turning age 65:

- Contact your local Social Security Administration Office and apply for Medicare Part A;
- Advise your Human Resources/Benefits Office that you have applied;
- When you receive your Medicare Part A identification card, provide your Human Resources/Benefits Office with a copy.

Active employees and their spouses who are age 65 or older have a right to decide which medical plan will be their primary insurer: either the employer health plan or Medicare. If you or your spouse selects Medicare as primary, the State cannot offer or subsidize a health plan to supplement Medicare's benefits. If you choose, Highmark may remain your primary plan while you are an active employee.

Important note: When you retire you will be required to have Medicare Part B in addition to Part A. Therefore, you should apply for Medicare Part B about three months before retirement.

Retiring or Retired Employees and Spouses

You must apply for Medicare Part B about three months before you retire for it to be effective upon retirement.

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, about three months before turning age 65:

- Contact your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B identification card, provide the State's Office of Pensions with a copy. The Office of Pensions will enroll you in a Medicare Supplement plan, *Special Medicfill*, to help cover costs not covered by Medicare Parts A and B.

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, and are disabled or become disabled, even though you are not age 65:

- Contact your local Social Security Administration Office and apply for Medicare Parts A and B;

- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B identification card, provide the State's Office of Pensions with a copy. The Office of Pensions will enroll you in a Medicare Supplement plan, *Special Medicfill*, to help cover costs not covered by Medicare Parts A and B.

If you are denied enrollment in Medicare Parts A and/or B, you are required to appeal, and provide both a copy of the denial and your appeal to the State's Office of Pensions. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. Should Medicare deny your appeal, and you provide a copy of the denial to the State's Office of Pensions, then you will continue to be covered under your Highmark plan with the State's Group Health Insurance Program.

Other Considerations – Disability, ESRD and ALS

The classification of being "disabled" by the State of Delaware as it relates to your ability to perform your job for the State of Delaware (or another employer for a spouse) may differ from the classification of being "disabled" by the Social Security Administration. It is always your responsibility to provide the State's Office of Pensions with your current classification by the Social Security Administration.

There are special Medicare rules regarding some health conditions, such as End Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease). Generally, you may apply to have the standard 24-month Medicare eligibility waiting period waived if you have been diagnosed with either of these conditions. Upon receiving a diagnosis of either of these conditions, whether you are an active employee, pensioner or spouse, you should contact your local Social Security Administration Office or visit ssa.gov for more information.

WHEN COVERAGE ENDS

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

Except in cases of divorce or a change in a child's status (see sections below regarding each), coverage ends the last day of the month in which you lose eligibility because of one of the events below.

DIVORCE

Former spouses are not eligible for coverage under this program; coverage of a former spouse terminates on the day following the date of the divorce. You must notify your Human Resources/Benefits Office or Office of Pensions, if you are a pensioner, of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. You should state "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources/Benefits Office or Office of Pensions, if you are a pensioner, will result in your being held financially responsible for the cost of premium, health care and prescription services provided to your former spouse and their children.

LEAVE YOUR JOB

Coverage terminates at the end of the month in which you leave your job.

DEATH

Your coverage ends on the day of your death. Coverage ends for your dependents at the end of the month in which you die, except for dependents of pensioners. Coverage for dependents of pensioners ends either:

- the last day of the month of your death; or
- if contributions have already been made, the last day of the following month; or
- when the dependent no longer meets eligibility conditions.

Dependents of pensioner, upon the pensioner's death, should contact the State's Office of Pensions to discuss options of continued coverage.

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. Please refer to the section, *You Are Eligible To Be Covered If*, above.

CHANGE IN CHILD'S STATUS

Unless covered as a disabled child, your child's coverage ends at the end of the month in which they reach:

- age 26, if your natural or adoptive child;
- age 19, if eligible under the terms described in Coverage for Other Children;
- age 24, if similarly eligible and a student.

THE PLAN IS CANCELED

Coverage ends the day the State of Delaware's contract with Highmark ends.

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when your coverage ends, except:

- if the State of Delaware cancels its contract with Highmark; and
- if you are an inpatient on the date the contract ends.

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; or
- until you are discharged

CONTINUING YOUR COVERAGE UNDER COBRA

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

EMPLOYEE

You (and your dependents) 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 gross 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 the Social Security Administration.

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 your spouse; or
- you become eligible for Medicare.

DEPENDENT CHILD OF EMPLOYEE

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

- you die;
- you divorce your spouse;
- you become eligible for Medicare; or
- the child is no longer considered a dependent under this Plan.

NOTIFYING YOUR EMPLOYER

You need to notify your Human Resources/Benefits Office, or Office of Pensions if you are a pensioner, within 30 days of a:

- divorce; or
- child losing dependent status; or
- disability determination by the Social Security Administration.

Notify your Human Resources/Benefits Office, or Office of Pensions if you are a pensioner, within 30 days if the Social Security Administration determines you are no longer disabled.

Your Human Resources/Benefits Office, or Office of Pensions if you are a pensioner, will have information about COBRA and how much it costs mailed to you. 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.

You should contact State of Delaware's COBRA Administrator if you have any questions. The phone number is: 800.877.7994.

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.

DIRECT BILLED PLANS

If your coverage under a group plan with Highmark ends, you may apply to Highmark 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 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's Customer Service department at the number listed in the front of your booklet. If you do not reside in Delaware, you may contact your local Blue Cross Blue Shield plan for more information.

A GUIDE TO FILING CLAIMS AND APPEALS

Always be sure to show your Highmark 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.**

WHEN YOU USE A NETWORK PROVIDER

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

WHEN YOU USE A NON-NETWORK PROVIDER

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

Many doctors and other providers contract with Highmark. They are called "participating providers". These providers agree to accept our 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 for you. So you don't need to complete claim forms.

Some providers don't have a contract with us. They may ask you to pay the full cost for your care, and they may bill you for amounts over our allowable charge.

If you receive care from a non-participating provider you may need to submit a claim for your care. If the plan covers the service, the plan will pay the allowable charge to you, less any copayment, deductible or coinsurance. This is the same payment the plan makes to participating providers. You must pay any balance over the plan's payment.

WHEN YOU'RE OUT OF AREA

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

Under the BlueCard® Program:

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

IF YOU NEED TO FILE A CLAIM

To obtain a form, call Customer Service. You may also get the form from the Highmark website, **myhighmark.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
P. O. Box 8831
Wilmington, DE 19899-8831

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:

THE PLAN'S APPEAL PROCESS

INITIAL SERVICE

Employee receives service and a claim is filed by the employee (or by provider on employee's behalf) with Highmark.

IF DENIED and employee has potential liability to provider,

LEVEL I APPEAL – ADMINISTERED BY HIGHMARK

Employee may file an appeal with Highmark within 180 days from receipt of the notice of denial to request a review of the initial claim decision,

- Highmark will review the appeal and provide a written decision to the employee

  a) Within 15 days for Pre-Service requests

  b) Within 30 days for Post-Service requests

Expedited appeals may be requested for a denial relating to urgent care; Highmark will notify the employee and provider within 72 hours. In the event that the denial of an expedited appeal is upheld, or if the care requested is now considered urgent, the employee would skip the Level II Appeal and move directly to a Level III Appeal.

IF DENIAL IS UPHELD,

LEVEL II APPEAL – ADMINISTERED BY HIGHMARK

Employee must file a Level II appeal within 60 days from receipt of the Level I appeal decision.

Note: If denial is related to urgent care, employee would skip the Level II appeal and move directly to a Level III Appeal.

- Highmark will review the appeal and provide a written decision to the employee

  a) Within 15 days for Pre-Service requests

  b) Within 30 days for Post-Service requests

IF DENIAL IS UPHELD,

LEVEL III APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATEWIDE BENEFITS OFFICE (SBO) AND/OR HIGHMARK

For medical judgment or necessity, including care that is cosmetic or experimental, the employee may choose to file a Level III voluntary appeal to the SBO and/or an appeal administered by Highmark.

VOLUNTARY APPEAL TO THE STATEWIDE BENEFITS OFFICE

a) Employee may file an appeal of the denial in writing to SBO within 20 days of the postmark date of the notice of denial of the Level II appeal (or within 20 days of the postmark date of the notice of denial of an expedited Level I appeal). The appeal must contain employee contact information (mailing address, telephone number, etc.), a written summary of events, applicable Explanations of Benefits (EOBs), a copy of the employee's Identification Card or the plan name and employee's identification number (as on Identification Card), any additional documentation employee desires to provide to support their position. Additionally, employee must sign and submit with the appeal, the State of Delaware's Authorization for Release of Protected Health Information Form to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark and the SBO's Health Plan Appeal Form and Checklist, both of which are available at https://de.gov/statewidebenefits.

   Employees submitting an appeal without a signed Authorization Form and/or completed Health Plan Appeal Form and Checklist will be requested, in writing, to submit the forms. Statewide Benefits Office will not begin to review the appeal until the Authorization Form and the Appeal Form and Checklist are received. The Appeals Administrator from the Statewide Benefits Office (or their designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and Highmark within 30 days of receiving the appeal. The request for appeal should be sent to:

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
841 Silver Lake Boulevard, Suite 100
Dover, DE 19904

INDEPENDENT EXTERNAL REVIEW FACILITATED BY HIGHMARK

b) Employee may file a Level III appeal for an external review for decisions involving medical judgment or necessity, including care considered to be cosmetic or experimental care, to Highmark DE in writing within 4 months from the receipt of Highmark appeal notice. Please include the Highmark DE appeal decision letter and all relevant information. Highmark DE will initiate an independent review through an Independent Review Organization (IRO). The IRO will provide a written decision within 45 days of assignment to the IRO. If the treating physician certifies that a delay in receiving the services would jeopardize the health of the employee, the IRO will provide the employee with a written decision within 72 hours.

Appeal must contain how the employee may be contacted (mailing address, telephone number, etc.) a written summary of events, applicable Explanation of Benefits (EOBs), a copy of the employee's Identification Card or the plan name and employee's identification number (as on Identification Card) and any additional documentation employee desires to provide to support their position. Additionally, employee must sign and submit with appeal the State of Delaware's Authorization for Release of Protected Health Information to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark. This form is available at www.ben.omb.delaware.gov/medical/bcbs. Employees submitting an appeal without signed form will be requested, in writing, to submit form. Statewide Benefits Office will not begin to review the appeal until State of Delaware's Authorization for Release of Protected Health Information form is received.

- The Appeals Administrator from the Statewide Benefits Office (or their designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and Highmark within 30 days of receiving the appeal.

IF DENIAL IS UPHELD,

LEVEL IV (FINAL) APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATE EMPLOYEE BENEFITS COMMITTEE (SEBC)

Employee may file a written appeal to the State Employee Benefits Committee (SEBC) within 20 days of the postmark date of the notice of denial from the Level III Appeal.

Co-Chair, State Employee Benefits Committee (SEBC)
RE: APPEAL
Department of Human Resources
Haslet Armory, Second Floor
122 Martin Luther King, Jr. Boulevard South
Dover, DE 19901

The SEBC receives the appeal and:

a) Identifies a Hearing Officer (Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report to the SEBC within 60 days of the date of the hearing. The SEBC accepts or modifies the report, and notice of the decision is postmarked to the employee within 60 days; OR

b) Hears the appeal, and notice of the decision is postmarked to the employee within 60 days of the hearing.

ADDITIONAL LEVELS OF APPEALS

For information on additional levels of appeal availability, please see https://de.gov/statewidebenefits or telephone the State of Delaware's Benefits Office at 800.489.8933 or 302.739.8331.

You may call Highmark or you may use the Highmark *Appeal Form*, available at **https://www.highmarkbcbsde.com/downloads/forms/AppealForm.pdf**. There is no cost to appeal, and Highmark will provide copies of records relevant to your claim upon written request. Members should use the *Designation of Personal Representative for Appeal Purposes* form (available at **https://www.highmarkbcbsde.com/downloads/forms/Designation_of_Personal_Representative_for_Appeal_Purposes.pdf**) to designate a personal representative for purposes of an appeal.

If you would like more information, please contact Highmark's Customer Service Appeals Team by one of the methods below.

Internet:

Visit our internet Customer Service Center at **myhighmark.com**.

Telephone:

844.459.6452
800.232.5460 for the hearing impaired

Mail:

Highmark Blue Cross Blue Shield Delaware
PO Box 8832
Wilmington, DE 19899-8832

COORDINATION OF BENEFITS

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

Please note: In order to keep our records current we may periodically reach out to you via mail to determine primacy of benefits for your covered dependents.

SPOUSAL BENEFITS

The plan will pay 20% for your spouse if:

- your spouse's employer has a benefit plan; and
- your spouse is eligible; and
- your spouse didn't join the plan.

See the section, *A Guide to Enrollment Information*, for special rules about enrolling your spouse.

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. Note: A member may not be covered more than once under the State of Delaware's Group Health Insurance Program.
- *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, the plan pays 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. The plan's payment will never be more than if the plan was primary.
- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if:
  - the State's plan is secondary, and
  - the other plan had paid the normal payment.

COORDINATION OF BENEFITS EXAMPLE

When Other Insurance (OI) Payment is **Equal To** what Highmark would have paid as Primary.

Other Insurance (OI) Primary Carrier		**Calculate Highmark (HMK) as Primary**	
Charge:	$5,500.00	Charge:	$5,500.00
Allowance:	$4,500.00	Allowance:	$4,500.00
Copay:	$ 0.00	Copay:	$ 0.00
Deductible:	$ 0.00	Deductible:	$ 0.00
Payment (80%):	$3,600.00	Payment (80%):	$3,600.00
Coinsurance:	$ 900.00	Coinsurance:	$ 900.00
Member Liability:	$ 900.00	Member Liability:	$ 900.00

Note: The Eligible Amount below represents the amount *eligible for consideration of payment* based on the COB Method.

SOD COB Method

Highmark compares the amount it would have paid $3,600) to the OI Member Liability ($900). Since $900 is less than $3,600, the $900 is paid at 100%.

Highmark secondary claim coordinated:

Eligible Amount:	$ 900.00
(Deductible):	$ 0.00
Payment (100%):	$ 20.00
Member Liability:	$ 0.00
Savings:	$2,700.00

COB AND MANAGED CARE REQUIREMENTS

The rules below will apply to you, your spouse and your dependent children. Please also refer to the section *Managed Care Requirements*.

COB When This Plan is Primary

The State's managed care requirements must be followed. If they are not followed, benefits are coordinated by applying the penalties of this plan.

COB When This Plan is Secondary

This plan will never pay more than what the plan would pay if this plan were primary.

You don't have to follow the State's managed care requirements when this plan is secondary. However, you should follow the primary plan's managed care requirements.

- If you do, both plans will pay up to the maximum.
- If you don't, we'll apply the other plan's penalties when calculating your benefit payment.

We will coordinate benefits if the primary plan:

- Has a Preferred Provider Network;
- Is a Point of Service Plan.

You will have to follow the primary plan's In-Network or Out-of-Network managed care requirements to get the maximum payment.

Exceptions are:

- This plan may cover care that the other plan doesn't cover. If this happens, the plan will pay benefits as if this plan were primary. You must follow the State's managed care rules to receive maximum payment.
- The other plan may have a day or dollar maximum on a particular benefit. This plan will pay benefits if:
  - you've met the maximum for that benefit, and
  - this plan covers the particular benefit.

The State's plan will pay until you are again eligible for that benefit under the other plan.

To file a secondary claim, you'll need to send Highmark a completed claim form (see *A Guide to Claims*) and a copy of your Explanation of Benefits (EOB) from the other carrier. That way we'll be able to see what the primary plan paid and what the managed care penalties were, if any.

HOW COB WORKS WITH PROVIDER NETWORKS

If you are covered under both a State plan and another plan, we will coordinate benefits.

When This Plan is Primary

If this plan is primary, the State's network and managed care requirements will apply.

When This Plan is Secondary

If the primary (other) plan has managed care requirements or a provider network, you must follow those requirements and utilize the network to get maximum payment for both the primary

and secondary (State) programs. If you followed the other plan's managed care requirements, you don't have to follow the State's managed care requirements.

We will apply the other plan's out-of-network payment reductions when applicable.

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 this plan is primary, but the other plan paid a claim, this plan has the right to pay the other plan. This plan's payment will be the amount we decide is this plan's share under COB rules. Such a payment will meet this plan's obligation under the plan.

RIGHT OF RECOVERY

If the plan paid more than its 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.

Please refer to the section, **Subrogation and Right of Reimbursement**, in *General Conditions*, below.

HIGHMARK QUALITY INITIATIVES

Highmark is committed to providing 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; and
- 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.

CURIOUS ABOUT QUALITY?

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

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

GENERAL CONDITIONS

RELEASE AND PROTECTION OF MEMBER INFORMATION

All personally identifiable information about individual Members ("Protected Health Information") is subject to various statutory privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, Highmark may use and disclose Protected Health Information to facilitate payment, treatment and health care operations as described in our Notice of Privacy Practices (NPP). Copies of our current NPP are available in this booklet, at **myhighmark.com**, or from Highmark's Privacy Office.

At its sole discretion, Highmark may make available, either directly or through a designated vendor, member identity theft protection services. Any decision to accept or not accept such services will not affect a member's continued eligibility, benefits, premiums or cost-sharing as described in this booklet. Highmark shall not be liable for, and the Member shall hold Highmark harmless from, any matters arising from or relating to such services.

DUAL ENROLLMENT

You may have two or more benefit plans administered by Highmark. If so, we'll coordinate benefits. However, you may not be enrolled more than once through the State of Delaware.

TIME LIMITS

You must file a claim within 2 years after you receive care. The plan will note 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 Highmark or this plan based on care by a provider.

NON-ASSIGNABILITY

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

FINANCIAL RISK DISCLAIMER

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

SUBROGATION AND RIGHT OF REIMBURSEMENT

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

Some examples of this plan's rights include:

- **Constructive trust.** Accepting benefits from this plan makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until the plan receives payment. Failure to pay funds to the plan will be considered a breach of your duty to the health care plan. No settlement can be made without Highmark's written permission.
- **Subrogation lien.** Accepting benefits from this plan will result in an automatic lien by the plan against any recovery from any third party. This means this plan has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that this plan 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. The plan is entitled to recovery from any party possessing the funds.
- **Recovery from a third party.** The plan 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.** If you are involved in an accident or incident that results in both this plan paying a claim and you having a claim against any third party, you must notify Highmark in writing within 30 days.
- **Cooperating with Highmark.** You are required to cooperate with Highmark and the plan 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 the plan 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. If you don't, we may cancel your coverage.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

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

OUT-OF-AREA SERVICES

Highmark 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's payment practices in both instances are described below.

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

There are special rules for certain ancillary services, including independent clinical laboratories, specialty pharmacy and durable medical equipment/prosthetics, when these services are obtained outside the Highmark service area.

- If the ordering physician is located in Delaware, Labcorp and Quest Diagnostics are the designated freestanding network providers for out-patient laboratory services in Delaware. Highmark members, hospitals, and physicians must use the designated network provider of laboratory services for claims to process at the in-network level. However, if the ordering physician is located in another state, for benefits to be paid at the in-network level, the member must use a lab provider that contracts directly with the Blue Cross Blue Shield plan in whose state the ordering physician is located.

  For example, if the ordering physician is in Maryland, the lab provider must contract directly with the Maryland plan for in-network benefits to apply; if not, out-of-network benefits will apply.
- A DME provider must contract with the local Blue Cross Blue Shield plan in whose state the equipment is being shipped or delivered for benefits to be paid in-network. For example, if the DME provider is located in Delaware but is shipping to Maryland, the provider must contract directly with the Maryland plan for in-network benefits to apply; if not, out-of-network benefits will apply whether the provider contracts with Highmark or not. If a member is purchasing and picking up DME, the provider must be in-network for the BCBS service area where the retailer is located for in-network benefits to apply.

If you are unsure of the network status of a particular provider, you should contact Member Services at the number on the back of your ID card for clarification before seeking services.

THE BLUECARD® PROGRAM

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, Highmark 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'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 the plan will make for the covered services as set forth in the State of Delaware contract.

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

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

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

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

Coinsurance: The percent of allowable charges you pay.

Coinsurance Expense Limit: The total amount of coinsurance you pay. When you reach the Limit, our payments increase to 100% of allowable charges. The Limit does not include:

- copayments, if any
- amounts over the allowable charge
- charges for non-covered care

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

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

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist or dentist. Such a provider must be acting within the scope of their 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.

Highmark: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

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
  - 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.

Inpatient Withdrawal Management: Services that are provided in an appropriately licensed Residential Treatment Facility, acute care general, psychiatric or specialty hospital for the purpose of completing a medically safe withdrawal from substances. Such services must be rendered by a mental health professional licensed or certified by the State Board of Licensing or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health facility licensed by the State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse.

Intensive Outpatient Programs: Medical, nursing, and therapeutic Outpatient services delivered on a structured and predetermined schedule to those patients determined as requiring more intensive levels of treatment than those typically available through traditional outpatient alcohol and/or drug abuse programs. Such Outpatient services must be rendered by a mental health professional licensed or certified by the State Board of Licensing or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health facility licensed by the State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse.

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: An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with Highmark or a Highmark affiliate, or with any licensee of the Blue Cross Blue Shield Association located in a service area other than a Highmark or

Highmark affiliate service area, pertaining to payment as a participant in your network for covered services rendered to a member..

Outpatient: A person receiving care while not an inpatient.

Participating Provider: A provider with a Highmark 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.

Residential Treatment Facility: A Facility Provider, which for compensation by its patients, is primarily engaged in providing intensive, structured psychological services, either directly by or under the supervision of a medical professional, to treat behavioral, emotional, mental, or psychological problems. This Facility must also meet the minimum standards set by appropriate government agencies.

Semiprivate Room: A room with at least two beds.

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

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

Substance Abuse Treatment Facility: A Facility Provider which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by appropriate government agencies.

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

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

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service:

(For questions about benefits, claims and membership)

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

All Calls: 844.459.6452

Medical Management and Policy Department:

(For Managed Care)

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

All Calls: 800.572.2872

Behavioral Health Care Department:

(For Mental Health and Substance Abuse Managed Care Program)

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

All Calls: 800.421.4577

Claims:

(For sending in your health care claims)

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

Your Doctor(s):

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

Member's Name	Doctor's Name	Phone Number

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

HIGHMARK BLUE CROSS BLUE SHIELD
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

Our Legal Duties

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

- For example:

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

Health Care Operations

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

- For example:

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

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

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

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

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

P. Health Information Exchange

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

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

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

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

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:
   a. Used by the person who created the psychotherapy note for treatment purposes, or
   b. Used or disclosed for the following purposes:
      (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
      (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
      (iii) if required for enforcement purposes;
      (iv) if mandated by law;
      (v) if permitted for oversight of the provider that created the note,
      (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
      (vii) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

A. Right to Access

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

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

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

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

B. Right to an Accounting

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

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

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

C. Right to Request a Restriction

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

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

D. Right to Request Confidential Communications

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

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

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

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

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

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

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

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

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

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

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

For questions about this Privacy Notice, please contact:

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

State of Delaware Comprehensive PPO Plan

Updated: 03/31/26