

A GUIDE TO YOUR BENEFITS



STATE OF DELAWARE SPECIAL MEDICFILL®

®Medicfill is a registered trademark of Highmark Blue Cross Blue Shield Delaware.

Discrimination is Against the Law

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

- 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 Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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>.

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）。

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).

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).

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).

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).

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).

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.

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).

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

توجه 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)۔

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).

గమనిక: మీరు తెలుగు మాట్లాడతే, లాగేవేజ్ అసెస్మెంట్ సర్వీసెస్, ఛారిజి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వినుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

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).

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).

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).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (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, éi t'áá níik'eh, bee níká a'doowoł, éi bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jì' hodíilnih.

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 Blue Cross Blue Shield Delaware (Highmark Delaware).

This booklet summarizes benefits of the Special Medicfill Health Care Plan that helps fill many of the gaps in Medicare coverage. For your convenience, technical terms have been defined in the *Definitions* section at the back of the booklet.

This booklet is not a contract. It is designed to provide a summary of benefits for easy reference. The benefits and the terms and conditions of your Medicfill Health Care Plan are in an Account Contract on file with the Statewide Benefits Office, DHR. The Account Contract is the final determination of the benefits and rules of your plan.

This booklet describes the Medicfill Health Care Plan in effect as of January 1, 2022 and replaces all previous booklets.

KEEP THIS BOOKLET HANDY FOR REFERENCE WHEN YOU NEED IT.

WHEN YOU HAVE QUESTIONS OR COMMENTS

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

Here are reasons you may need to call us:

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

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

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 8:00 PM Eastern Standard Time (EST), Monday through Friday.

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

- enrollment information;
- claims status; and
- ID card requests.

To Reach Us By Letter:

Write to:

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

To Reach Us In Person:

You may also visit us at several places in New Castle, Kent and Sussex Counties. To find out the days, times and locations, call Highmark Delaware's Customer Service Department at 844-459-6452.

To Reach Us On The Internet:

Internet Address: www.highmarkbcbsde.com

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SPECIAL MEDICFILL HEALTH CARE PLAN BENEFIT HIGHLIGHTS

The following highlights your Special Medicfill benefits and how these benefits supplement your Medicare Coverage.

THESE BENEFIT HIGHLIGHTS ONLY BRIEFLY DESCRIBE THE BENEFITS AVAILABLE TO YOU FROM MEDICARE. FOR A COMPLETE DESCRIPTION OF YOUR MEDICAL BENEFITS UNDER MEDICARE, AND ANY LIMITATIONS ON THOSE BENEFITS, CONSULT MEDICARE PUBLICATIONS OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AT WWW.CMS.HHS.GOV

This booklet describes the benefits, terms and conditions of your Special Medicfill Health Care Plan. This Health Care Plan is designed to supplement Medicare. Unless otherwise indicated, we will pay the benefits described in this booklet only after Medicare pays its full amount.

PREVENTIVE BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
<p style="text-align: center;"></p> <p>Note: Services identified with this symbol in the Medicare and You handbook are preventive services, and are listed together, below.</p>			
<p>See the <i>Medicare and You</i> handbook for more information about these services. The chart below assumes you receive services from providers that accept assignment.</p>			
Abdominal aortic aneurysm screening (One-time, as part of the "Welcome to Medicare" preventive visit.)	100% of allowed charges, no deductible.	Nothing.	Nothing.
Advance Care Planning (can also be covered as part of your medical treatment)	100% of allowed charges, no deductible—when this service isn't part of your "Wellness" visit, the Part B deductible and coinsurance apply.	Nothing.	Nothing.
Alcohol Misuse Counseling (One screening, and up to 4 brief counseling sessions per year.)	100% of allowed charges, no deductible.	Nothing.	Nothing.
Bone Mass Measurement (Bone Density) - every 24 months)	100% of allowed charges, no deductible.	Nothing.	Nothing.
Breast Cancer Screening (Mammograms - women age 40 & older; one baseline b/w ages 35-39 years.)	100% of allowed charges, with no deductible for annual mammograms for women age 40 and over.	Nothing.	Nothing.
Cardiovascular Disease (behavioral therapy) – one visit per year with primary doctor	100% of allowed charges, no deductible.	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicifill Covers:	You Pay:
Cardiovascular disease screenings (once every 5 years)	100% of allowed charges, with no Part B deductible requirement for the test. 80% of allowed after the Part B deductible for the associated doctor's visit.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance for the associated doctor's visit.	Nothing.
Cervical and Vaginal Cancer Screening –Pap Smear Only (every 24 mos. except for high risk - annually)	100% of allowed charges, with no deductible requirement for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk. 80% of allowed after the Part B deductible for the associated doctor's visit.	When Pap smears for cancer screening are covered by Medicare, this plan pays nothing. When not covered by Medicare, this plan will pay 100% of our allowable charge for a Pap Smear every 12 months.	Nothing.
Cervical and Vaginal Cancer Screening - Pap Collection, Pelvic Exams and Breast Exams	100% of allowed charges, with no Part B deductible requirement, for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk.	Nothing.	Nothing.
Colorectal Cancer Screening	100% of Medicare eligible expenses with no Part B deductible requirement for: Colonoscopies covered once every 120 months, or every 24 months if high risk <ul style="list-style-type: none"> ■ (If your doctor finds and removes a polyp or other tissues during your colonoscopy, you may pay 20% of the Medicare approved amount for your doctor's services and a copay for in a hospital outpatient setting. The Part B deductible does not apply). 	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
	Fecal occult blood test is covered once every 12 months if age 50 or older.	Nothing.	Nothing.
	Flex Sigmoidoscopies covered once every 12 months if age 50 or older, or 120 months after a previous screening colonoscopy if not high risk.	Nothing.	Nothing.
	Multi target stool DNA test covered once every three years if: <ul style="list-style-type: none"> ■ Ages 50-85 ■ No symptoms of colorectal disease ■ At an average risk for colorectal cancer ■ No family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer. 	Nothing.	Nothing.
	Blood-based biomarker test covered if age 50-85, no symptoms of colorectal disease, and average risk of developing colorectal cancer.	Nothing.	Nothing.
	When barium enema tests are covered by Medicare, this plan covers the Medicare Part B deductible and 20% coins, and you pay nothing. If Medicare does not cover, this plan pays nothing.		

Benefit:	Medicare Covers:	Special Medicifill Covers:	You Pay:
Depression screening (annual in a primary care setting)	100% of allowed charges, no deductible	Nothing.	Nothing.
Diabetes screenings	100% of allowed charges, no deductible for up to two diabetes screenings per year.	Nothing.	Nothing.
Diabetes self-management training.	80% of allowed charges after the Part B deductible pursuant to doctor's written order.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	Nothing for covered services.
Flu Shots	100% of allowed charges, no deductible for one flu shot per flu season.	Nothing.	Nothing.
Glaucoma Tests	80% of allowed charges after the Part B deductible once every 12-months for glaucoma tests for persons who are at high risk for glaucoma, including diabetics and those with a family history of glaucoma.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	Nothing.
Hepatitis B vaccine/HBV screening	100% of allowed charges, no deductible for persons at risk.	Nothing.	Nothing.
Hepatitis C screening test	100% allowed charges for persons at risk.	Nothing.	Nothing.
HIV Screening (annually)	100% of allowed charges, no deductible	Nothing.	Nothing.
Lung Cancer screening	100% allowed charges once per year for a Low Dose Computed Tomography (LDCT) once per year if meet all of these conditions: <ul style="list-style-type: none"> ■ You're 55-77. ■ You're asymptomatic (don't have signs of symptoms of lung cancer). 		
Lung Cancer screening	<ul style="list-style-type: none"> ■ You're either a current smoker or have quit 		

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
(continued)	<p>smoking within the last 15 years.</p> <ul style="list-style-type: none"> ■ You have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years.) ■ You get a written order from a doctor or other qualified health care provider. ■ You generally pay nothing for this service of the health care provider. 		
Medical Nutrition Therapy Services	100% of allowed charges, no deductible provided you meet the diagnostic criteria.	Nothing.	Nothing.
Obesity Screening and Counseling	100% of allowed charges no deductible for persons with a body mass index (BMI) of 30 or more.	Nothing.	Nothing.
Pneumococcal Shot	100% of allowed charges no deductible for one shot per lifetime.	Nothing.	Nothing.
Prostate Cancer Screening (PSA and digital rectal exam – annually for men age 50)	<p>PSA - 100% of allowed charges, no deductible.</p> <p>Digital exam – 80% of allowed benefit after the Part B deductible</p>	Nothing.	Nothing.
Sexually Transmitted Infection (STI) screening and Counseling	Covered once per 12-months for persons who are pregnant or at an increased risk for a STI. Medicare also covers up to two individual, 20-30 minutes counseling sessions for sexually active adults at increased risk for STI's.	Nothing.	Nothing.
Tobacco-use Cessation Counseling – up to 8 visits in a 12-month period.	100% of allowed benefit after the Part B deductible.	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Welcome to Medicare Preventive Visit (within 12 mos. of enrollment)	100% of allowed charges with no deductible.	Nothing.	Nothing.
Yearly Wellness Visits	100% of allowed charges, no deductible	Nothing.	Nothing.

PART A - INPATIENT HOSPITAL & OTHER FACILITY BENEFITS

Benefit:		Medicare Covers:	Special Medicfill Covers:	You Pay:
Inpatient Days in Acute Hospitals; Semi-Private Room and Ancillary Services (for covered expenses each benefit period)	Days 1-60	Medicare pays all but the Medicare Part A deductible.	This plan covers the Medicare Part A deductible.	Nothing.
	Days 61-90	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan covers a specified dollar amount of coinsurance.	Nothing.
	Days 91-150	Medicare pays nothing. (There are 60 Lifetime Reserve Days* with all but the daily coinsurance amount covered. These days may be used at the patient's discretion.)	This plan covers inpatient care for days 91 through 150 in a general hospital except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	Nothing.
	Days 151-365	Medicare pays nothing.	This plan covers inpatient care for days 151 through 365, except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	Nothing.
Hospice		Medicare pays 100% of eligible expenses, subject to Medicare criteria.	Nothing.	Nothing.
		Medicare also covers 95% of the cost of up to 5 days of inpatient respite care.	5% of the Medicare approved amount.	

*Medicare's 60 Lifetime Reserve Days may be used only once; they are not renewable.

PART A - INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)

Benefit:		Medicare Covers:	Special Medicfill Covers:	You Pay:
Treatment for Mental or Nervous Disorders (in a Psychiatric Hospital)		Benefits are limited to 190 days for your lifetime. Medicare covers all but the Medicare Part A deductible and the specified coinsurance for days 61-150	This plan covers the Medicare Part A deductible and the specified dollar amount of coinsurance for up to the 190 lifetime days approved by Medicare.	Nothing while Medicare is paying. You pay all charges thereafter.
Inpatient Dental Surgery		Medicare covers hospital services for surgery related to the jaw or reduction of any fracture of the jaw or facial bone.	This plan covers the Medicare Part A deductible and specified dollar amount of coinsurance when Medicare standards are met.	Nothing.
Services in a Medicare Approved Skilled Nursing Facility	Days 1-20	Medicare pays 100% of eligible expenses.	This plan pays nothing.	Nothing.
	Days 21-100	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan pays a specified dollar amount of coinsurance per day.	Nothing
Coverage Outside of the United States		Generally, Medicare does not pay for services provided outside the U.S.	When Medicare standards are met, and Medicare pays, this plan covers the Part A deductible and coinsurance for the first 90 days and then 100% of the allowable charge for days 91-150. If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States, we will pay for services as defined by Medicare Law for 150 days of inpatient care.	Nothing. Nothing for the first 150 days if the hospital confinement is approved for payment by Highmark Delaware. You pay all charges thereafter.

PART B - OUTPATIENT HOSPITAL AND OTHER COVERED BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
<ul style="list-style-type: none"> ■ Anesthesia ■ Clinical Services ■ Emergency Accident ■ Dialysis ■ Injections (except most routine immunizations) ■ Machine Testing ■ Medical Emergency ■ Minor Surgery ■ Physical Therapy ■ Radiation Therapy ■ Imaging Services 	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges**.	Nothing.
Blood	Covered 100% of allowed charges after first 3 pints in any benefit year.	Nothing.	First 3 pints of blood in any benefit year.
Chemotherapy	Covered 80% of allowed charges, no deductible.	20%	Nothing.
Clinical Laboratory Services	Covered at 100% of the Reasonable Charge**	There is no coverage under this plan Clinical Laboratory Services.	Charges, if any, for services not covered by Medicare.
Diabetes Equipment & Supplies & Therapeutic	Covered 80% of allowed charges after the deductible for covered services.	Part B deductible, then 20%	Nothing for covered services.
Doctor and Other Health Care Provider Services	Covered 80% of allowed charges after the deductible for covered services.	Part B deductible, then 20%	Nothing for covered services.
Eyeglasses (limited to one pair glasses or contacts after cataract surgery with implanted lens)	Covered 80% of allowed charges after the deductible	Part B deductible, then 20%	Nothing.
Federally-Qualified Health Center Services	Covered 80% of allowed charges 100% of allowed charges, no deductible for most preventive services	20% or nothing for preventive services.	Nothing.
Home Health Services (doctor ordered care with a Medicare-certified provider)	Covered 100% of allowed charges, no deductible	Nothing.	Nothing.
Home Health Visits	Covered at 100% of the Reasonable Charge**, subject to Medicare criteria.	There is no coverage under this plan for Home Health Visits.	Charges, if any, for services not covered by Medicare.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Laboratory Services	100% of allowed charges, no deductible	Nothing.	Nothing.
Rural Health Clinic Services	Covered 80% of allowed charges after the deductible; Preventive Care: 100% of allowed charges , no deductible	Part B deductible, then 20% Preventive Care: Nothing	Nothing.
Surgical Dressing Services	80% of allowed charges after the deductible in a doctor's office. A copayment applies in a hospital setting.	Part B deductible, then 20%	Nothing.
Tests (other than lab tests)	80% of allowed charges after the deductible for x-rays, MRIs, CT scans, EKGs and some other diagnostic tests. A copayment may apply in hospital setting.		
Transplants and Immunosuppressive Drugs	80% of allowed charges after the deductible for eligible transplants in a Medicare-certified facility	Part B deductible, then 20%	Nothing.
Travel (health care needed when traveling outside the United States)	Medicare generally doesn't cover medical care while you're traveling outside the U.S. or its territories and possessions. If emergency care is needed and covered, payment is 80% of allowed charges after the deductible.	Out of country Surgical medical benefits: For services outside the U.S. which are covered by Medicare BCBSD will pay the Medicare Part B deductible and 20% coinsurance. Benefits for services outside the U.S. not paid by Medicare are covered at 20% of the BCBSDE traditional RBRVS allowable, if these services are defined as coverable under Medicare policy guidelines.	Nothing for services covered by Medicare. 80% for services not covered by Medicare but defined as coverable under Medicare policy guidelines.
Urgently-Needed Care	80% of allowed charges after the deductible. A copayment applies in a hospital setting.	Part B deductible, then 20%	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	<p>When Medicare pays, this plan covers hospital benefits equivalent to Medicare hospital benefits in the U.S., including the payment of the deductible and coinsurance amounts.</p> <p>When Medicare does not pay, payment will be made for those covered services as defined by Medicare. Payment must be approved by Highmark Delaware</p>	<p>Nothing.</p> <p>Nothing if the care is approved for payment by Highmark Delaware.</p>

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

PART B - SURGICAL-MEDICAL BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
<ul style="list-style-type: none"> ■ Acupuncture for back pain ■ Ambulance ■ Ambulatory Surgical Centers ■ Anesthesia ■ Appliances ■ Behavioral Health Integration Services ■ Cardiac Rehabilitation ■ Chiropractic Services (limited to correction of subluxation of the spine) ■ Chronic Care Management Services ■ Clinical Research Studies ■ Cognitive assessment and care plan services ■ Clinic Visits ■ Continuous Positive Airway Pressure (CPAP therapy) ■ Defibrillator (Implantable Automatic) ■ Durable Medical Equipment ■ EKG (once for screening; otherwise diagnostic) ■ Emergency Department Services ■ Foot Exams and Treatment ■ Hearing and Balance Exams ■ Home & Office Visits ■ Imaging Services ■ Inpatient Consultants 	<p>Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.</p>	<p>This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**</p>	<p>Nothing.</p>

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
<ul style="list-style-type: none"> ■ Inpatient Medical Visits ■ Inpatient Professional Services ■ Inpatient Skilled Nursing Facility Visits ■ Kidney Dialysis Services and Supplies ■ Kidney Disease Education Services ■ Machine Testing ■ Medical Emergency Care ■ Mental Health Care (Outpatient) ■ Occupational Therapy ■ Opioid use Disorder Treatment Services ■ Outpatient Medical and Surgical Services and Supplies ■ Physical Therapy ■ Prescription Drugs (limited) ■ Prosthetic/Orthotic Items ■ Pulmonary Rehabilitation ■ Radiation Therapy ■ Screening, Brief Intervention & Referral to Treatment ■ Second Surgical Opinions ■ Speech-Language Pathology Services ■ Surgery ■ Telehealth (limited) & other virtual visits—E-Visits and Virtual Check-ins 	<p>Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.</p>	<p>This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**</p>	<p>Nothing.</p>

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
<ul style="list-style-type: none">■ Tobacco Use Cessation Counseling (with diagnosis of tobacco- related illness)■ Transitional Care Management Services			

SURGICAL-MEDICAL BENEFITS (CON'T)

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Outpatient Treatment for Mental and Nervous Disorders	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**	Nothing.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance. When Medicare does not pay, benefits are covered as are covered under this contract at 20% of the Highmark Delaware traditional Resource Based Relative Value Scale (RBRVS) allowable.	Nothing. All charges over 20% of the Highmark Delaware traditional Resource Based Relative Value Scale (RBRVS) allowable.

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

OTHER COVERED BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Outpatient Prescription Drugs	Medicare Part B covers 80% of the reasonable charges for a very limited number of drugs (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See medicare.gov for more information.	This program pays the 20% coinsurance for these drugs.	Nothing.
Private Duty Nursing	No coverage under Medicare.	This plan covers the services of a Registered Professional Nurse (RN) for care provided in an acute care facility at 80% of Highmark Delaware's allowable charge, up to a maximum of 240 hours during any 12-month period. If an RN is not available, at our discretion, benefits may be provided for the services of a Licensed Practice Nurse (LPN).	Twenty percent (20%) of the allowable charges. You also pay any charges incurred after the 240-hour maximum has been met.

HUMAN ORGAN TRANSPLANT BENEFIT

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Human organ transplants	Benefits are provided on the same basis and at the same level as Inpatient Hospital Benefits, Outpatient Hospital Benefits, and Physician Services, subject to the Medicare Part A and Part B deductibles and coinsurance.	When Medicare pays for an organ transplant, this plan provides benefits on the same basis and at the same level as other Special Medicfill benefits. See the benefit description on page 15 for more information about organ transplants, including benefit limits.	Any charges not covered by Medicare or Special Medicfill, and any charges over the maximum limits of this plan.

PREVENTIVE CARE

Benefits for the following preventive care and wellness programs are paid at 100% of Highmark Delaware's allowable charge. If Medicare pays any portion, Highmark Delaware will pay the balance up to 100% of the allowable charge.

PREVENTIVE CARE

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

Please note: Highmark Delaware has the right to change these benefits at any time. This plan does not cover the women's preventive services required by the Patient Protection and Affordable Care Act (PPACA).

EXAMINATIONS

Benefits are provided for:

- routine physical exam
- routine GYN exam and Pap smear

TESTS AND SCREENINGS

Some examples of covered routine tests and screenings are:

- hemoglobin test
- cholesterol test
- blood sugar test
- blood antigen test for prostate cancer
- blood occult
- lead screening test
- mammogram
- flexible sigmoidoscopy

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- Hepatitis A
- Hepatitis B
- Varicella (chickenpox) vaccine
- DTaP (diphtheria, pertussis, tetanus)
- Td (Tetanus)
- MMR (measles, mumps, rubella)
- IPV (polio)
- Hib (haemophilus influenza)
- Influenza
- Pneumococcal

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

HOSPITAL AND OTHER FACILITY BENEFITS

INPATIENT HOSPITAL SERVICES

Benefits are provided for covered expenses for inpatient hospital care for each benefit period as follows:

- For days 1 through 60, we will pay the Medicare Part A deductible.
- For days 61 through 90, we will pay the specified daily coinsurance.
- For days 91 through 150, we will pay for hospital services for all admissions except for treatment of mental and nervous disorders. You may use these days before you use your 60 Medicare lifetime reserve days. If you use your Medicare lifetime reserve days, we will pay the coinsurance amount.
- For days 151 through 365, we will pay for hospital services except for treatment of mental and nervous disorders.

Covered services include:

- Semi-private room and board and ancillary services. If a private room is medically necessary, benefits are provided at the private room rate.
- Medicare limits coverage to 190 days for admissions for treatment of mental and nervous disorders. We will pay the Part A deductible and specified daily coinsurance for days approved by Medicare.
- When you are admitted to the hospital for dental surgical services approved by Medicare, we will pay the Medicare Part A deductible and the daily coinsurance amount. Dental services are limited to surgery related to the jaw or reduction of any fracture of the jaw or facial bone.

SKILLED NURSING FACILITY

When you are admitted to a Skilled Nursing Facility for a stay approved by Medicare, we will pay the applicable daily coinsurance for days 21 through 100.

HOSPICE

To qualify for hospice care, your doctor must certify that you're terminally ill and have 6 months or less to live. Coverage includes drugs for pain relief and symptom management, nursing, some durable medical equipment and spiritual and grief counseling.

A Medicare-approved hospice usually gives hospice care in your home or other facility where you live such as a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home.

Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care.

You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.

This plan will pay 5% of the Medicare-approved amount for inpatient respite care.

SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES

The Medicare program places certain restrictions on payments for admissions outside the United States. If Medicare approves payment for the admission, we will pay the Part A deductible and the daily coinsurance for the first 90 days. We will then pay 100% of the allowable charges for days 91-150.

If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States and we approve the admission, we will pay for covered services as defined by Medicare law at 100% of the allowable charge for 150 days of inpatient care.

OUTPATIENT HOSPITAL SERVICES

We pay the Medicare Part B deductible and then we pay 20% of the reasonable charge for covered services for care in the outpatient department of the hospital. If care is rendered in a free-standing facility and Medicare pays, then we will pay the deductible, if any, and the coinsurance amount.

Covered services include:

- Emergency Treatment that is treatment for accidental injury or for sudden and serious medical conditions. These services must be rendered within 72 hours after the accident or onset of the emergency condition.
- Minor Surgery.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Diagnostic imaging services, laboratory and machine testing.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Hemodialysis.
- Clinical Services.
- Injections (not including routine immunizations except for influenza, pneumococcal and hepatitis B vaccines which are fully covered by Medicare).
- Coverage Outside the United States - In those cases where Medicare will pay, we will pay the deductible and coinsurance amounts. In those cases where Medicare does not pay, we will pay for those covered services as defined by Medicare at 100% of the allowable charge.

SURGICAL-MEDICAL BENEFITS

We pay the Medicare Part B deductible, and then we pay 20% of the Medicare reasonable charge for covered professional services provided or ordered by a physician.

COVERED SERVICES

Covered services are as defined by Medicare and include:

- Acupuncture for back pain
- Ambulance Services.
- Ambulatory Surgical Centers
- Anesthesia.
- Appliances and Durable Medical Equipment.
- Behavioral Health Integration Services
- Cardiac Rehabilitation
- Chiropractic Services (limited to correction of subluxation of the spine)
- Chiropractic Services limited to manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray.
- Chronic Care Management Services
- Clinic Visits.
- Clinical Research Studies
- Continuous Positive Airway Pressure (CPAP therapy)
- Defibrillator (Implantable Automatic)
- EKG (once for screening; otherwise diagnostic)
- Emergency Department Services
- Foot Exams and Treatment
- Hearing and Balance Exams
- Home and Office Visits.
- Imaging Services.
- Injections (not including routine immunizations – See *Preventive Benefits*).
- Inpatient Consultations.
- Inpatient Hospital Medical Visits.
- Inpatient Skilled Nursing Facility medical visits.
- Kidney Dialysis Services and Supplies

- Kidney Disease Education Services
- Laboratory and machine testing.
- Medical Emergency Care in the outpatient department of a hospital or other facility approved by us.
- Mental Health Care (Outpatient)
- Occupational Therapy
- Opioid use Disorder Treatment Services
- Outpatient Medical and Surgical Services and Supplies
- Physical Therapy (subject to Medicare criteria).
- Prescription Drugs (limited)
- Prosthetic/Orthotic Items
- Pulmonary Rehabilitation
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Screening, Brief Intervention & Referral to Treatment
- Second Surgical Opinions
- Speech-Language Pathology Services
- Surgery.
- Telehealth (limited) & other virtual visits—E-Visits and Virtual Check-ins
- Tobacco Use Cessation Counseling (with diagnosis of tobacco-related illness)
- Transitional Care Management Services

OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS DISORDERS

We will pay the Medicare Part B deductible and then 20% of the reasonable charge for outpatient treatment of mental and nervous disorders. If you receive outpatient care in a partial hospitalization program or in the outpatient department of a hospital, we will pay 20% of the reasonable charge.

SERVICES OUTSIDE THE UNITED STATES

- For services outside of the United States, in those cases where Medicare will pay, we will pay the Part B deductible and coinsurance amounts.
- In those cases where Medicare will not pay, benefits for services outside the United States are provided at 20% of Medicare's Resource-Based Relative Value Scale (RBRVS).

OTHER COVERED BENEFITS

The following benefits are provided in addition to those in the Hospital and Surgical-Medical Benefits section of this booklet. Covered services include:

OUTPATIENT PRESCRIPTION DRUGS

Medicare Part B covers 80% of the reasonable charges for a **very limited number of drugs** (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See www.medicare.gov for more information.

PRIVATE DUTY NURSING - INPATIENT

When you are an inpatient in an acute hospital ('hospital' is defined in the Definitions section of this booklet), benefits are provided for the medically necessary services of a Registered Professional Nurse (R.N.) at 80% of Highmark Delaware's allowable charge, up to a maximum of 240 hours during a 12-month period.

This benefit is provided only when all of the following conditions are met:

- The nursing service is available;
- The service is prescribed by the attending doctor;
- The service is connected with the condition for which hospital care and treatment are being rendered;
- The service is medically necessary; and
- The service is approved by the hospital.

Private duty nursing is not covered when it is provided as a convenience for you, whether or not prescribed by your doctor, or when it is provided at your request or your family's request.

If an R.N. is not available, then at our discretion, benefits may be provided for a Licensed Practical Nurse (L.P.N.) at 80% of Highmark Delaware's allowable charge.

HUMAN ORGAN TRANSPLANT BENEFIT

The benefits listed in this section are only available for services related to medically necessary human organ transplants. If Medicare covers these services, services related to kidney, cornea and bone marrow transplants are covered on the same basis and at the same level as other surgical benefits under this benefit plan and are not subject to the benefits and limitations of this section.

Benefits for human organ transplants are available only when Medicare pays for an organ transplant.

Benefits Available

Subject to all the terms and conditions of this benefit plan, when a human organ transplant is medically necessary, the following benefits are available for that transplant:

- If Medicare covers these services, covered Hospital and Surgical-Medical services as specified under this benefit plan. Benefits are payable on the same basis and at the same level as other similar benefits under this benefit plan.
- If Medicare covers these services, surgical, storage and transportation costs incurred and directly related to the donation of a human organ used in a covered transplant procedure. The maximum amount payable for this benefit is \$10,000 for each cadaveric organ and up to \$45,000 for each organ procured from a living donor (including harvesting)..
- If Medicare covers these services, transportation to and from the site of the covered transplant procedure is covered for the transplant recipient and one other person. If the recipient is a minor, transportation costs for two other persons accompanying the recipient are covered.
- If Medicare covers these services, reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of \$150, by those individuals accompanying the recipient.

Benefit Limitations

- The benefits for transportation, lodging and meal expenses are subject to an aggregate maximum of \$10,000 per covered transplant procedure. All covered transportation costs, lodging and meal expenses incurred are paid at the same level as outpatient doctor's visits.
- The organ transplant benefits specified in this section are available only during the applicable benefit period. For purposes of this Human Organ Transplant Benefit, the Benefit Period shall mean 5 days immediately prior to and one year immediately following a covered Organ Transplant Procedure.
- Benefits under this section are payable only for those services that Medicare will pay, with the exception of those non-Medicare covered services specified in the *Other Covered Benefits* section of this booklet.

EXCLUSIONS

The following services and other items are excluded from your coverage under this Medicfill plan:

- Services and supplies covered by Medicare Part A and Part B benefits, except those items and services expressly provided in this plan.
- Unless otherwise specified in this health care plan, charges for covered services that are over the Medicare reasonable charge for that service.
- Any service or benefit provided or available, to any extent, to you under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job related injuries or conditions.
- Unless federal law requires otherwise, any services or supplies furnished by the Veterans' Administration or by any institution owned or operated by the United States, any corporation, agency or bureau thereof, or any state, county or municipal government; services or supplies available, in whole or in part under the laws of the United States (including Medicare) or under the laws of any state or political subdivision thereof or furnished or available pursuant to any law hereinafter enacted.
- Any service necessitated by an act of war declared or undeclared which occurs after the effective date of this plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
- Services rendered by any member of your immediate family or any person living with you. For purpose of this paragraph only, family includes parents, spouses, siblings, and natural or adopted children of whatever age.
- Services for which no charge would normally be made in the absence of insurance.
- Rest cures, custodial care or homelike care, whether or not recommended by your doctor.
- Dental X-rays and appliances and the services of a dentist, except Medicare covered surgery involving the bone of the jaw or facial bone.
 - Eyeglasses, contact lenses, the examination, prescription or fitting of same, and all procedures for refractive correction.
 - Hearing aids and the examination, prescription or fitting of same,
 - All procedures for refractive correction.
- Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
- Routine foot care.
- Blood or blood donor services, including blood components.
- Supplies or services for cosmetic purposes, including routine treatment of acne and treatment for hair loss restoration.

- Unless specified otherwise, services for routine physical examinations or other examinations or treatments including, but not limited to, those procured by you to satisfy requirements of any third party including those required or ordered by a potential employer, licensing authority, insurer, educational institution, court, or legal representative, unless specified otherwise. School, camp, and pre-marital physicals are also excluded.
- Services not directly related to or medically necessary for the diagnosis or treatment of an illness or injury. Medical necessity is defined by us as: medically necessary services or supplies provided by a hospital, doctor or other provider to identify or treat an illness or injury and which, as determined by us are:
 - Consistent with the symptom or diagnosis and treatment of a condition, disease or injury;
 - Appropriate with regard to standards of accepted professional practice;
 - Not solely for your convenience, your doctor's convenience or any other provider's convenience; and,
 - The most appropriate supply or level of service which can safely be provided to you. When applied to an inpatient it further means that your medical symptoms or condition require that the service or supplies cannot be safely provided to you as an outpatient.

We may base payment upon Medicare's determination of medical necessity.

- Computerized gait analysis or electrodiagnostic testing.
- Services and supplies for or related to visual therapy or orthoptics.
- Services by a medical department maintained by your employer.
- Services and supplies which are experimental or investigational in nature meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any of such items requiring federal or other government agency approval not granted at the time services were rendered.
- Any service or supply specified as an exclusion under the Medicare program or denied by Medicare except any service or supply expressly covered as a benefit by this plan.
- Services, supplies, or drugs obtained in violation of applicable law.
- Prescription drugs (except for the limited number of drugs covered by Medicare Part B) for use outside the hospital, even if your doctor writes you a prescription. Prescriptions are provided through the State of Delaware's CVS Caremark/Silver Scripts Medicare Retiree Prescription Plan. Contact the State of Delaware Office of Pensions for additional information

VALUE ADDED FEATURES

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

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

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

EYEWEAR DISCOUNTS

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

You can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 888.235.3119 (TTY: 800.523.2847) or visit www.davisvision.com. The client code is 2722.

DISCOUNT PROGRAMS

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

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

For a full listing of our discounts go to www.highmarkbcbsde.com or call us at 844-459-6452.

HOW TO CLAIM BENEFITS

Claims must be filed within 2 years from the time you receive care. Claims filed beyond 2 years will not be paid.

HOW TO CLAIM HOSPITAL AND SURGICAL-MEDICAL BENEFITS

Since this program supplements Medicare benefits, claims for benefits must first be submitted for coverage through Medicare.

A *Request for Medicare Payment Form*, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All Social Security offices, and most doctors' offices, have copies of this form. Instructions on how to fill it out are on the back of the form.

When Medicare has paid for the services of doctors and suppliers that are covered by your medical insurance, you will receive an *Explanation of Benefits* notice explaining what coverage has been provided.

INSIDE DELAWARE

When you receive care inside Delaware, put your Highmark Delaware Identification Number on your *Request for Medicare Payment Form*. Payment will be made to the provider of services.

OUTSIDE DELAWARE

Medicare Part A Hospital Services

If you are hospitalized outside of Delaware, supply the hospital with your Highmark Delaware Identification Number. The hospital or Skilled Nursing Facility that provides you service will submit a Medicare Claim Form to the Medicare Part A Intermediary in the area where you receive care. Payment will be made to the provider of services.

Medicare Part B Doctor's Services

If you receive surgical-medical care outside of Delaware, supply the doctor or provider with your Highmark Delaware Identification Number. The doctor or provider will submit the claim to Medicare in the area where you receive care. Payment will be made to the provider of services.

OUTSIDE THE UNITED STATES

For claims incurred while on a cruise ship:

Send a copy of the *Explanation of Benefits* form you received from Medicare to:

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

Highmark Delaware will pay you directly for benefits in accordance with this health care plan.

For all other international claims:

Use the BlueCard Worldwide® International Claim Form available at www.highmarkbcbsde.com, and send the form to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

HOW TO CLAIM OTHER COVERED BENEFITS

PRIVATE DUTY NURSING

For private duty nursing inpatient benefits, please submit the following information to us:

- Name of the hospital.
- Date of admission to the hospital.
- Date of discharge from the hospital.
- Diagnosis.
- Attending physician's signature.
- Either a completed Claim Form CL-65, which may be obtained in any Delaware hospital, or the nurse's receipt showing the nurse's registration number. If the nurse's receipt is submitted without Form CL-65, you must also include the signed authorization of the attending physician.
- Your name, address, and Highmark Delaware Identification Number (referred to in some cases as 'contract' or 'certificate' Identification Number).

HOW TO APPEAL A CLAIM DECISION

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

HIGHMARK DELAWARE'S APPEAL PROCESS

- To appeal a Highmark Delaware decision, you or your representative must contact Customer Service *within 180 days* from the date you received the decision. You may call us or you may use the Highmark Delaware *Appeal Form*, available at <https://www.highmarkbcbsde.com/downloads/forms/AppealForm.pdf>. There is no cost to appeal, and Highmark Delaware will provide copies of records relevant to your claim upon written request. Members should use the *Designation of Personal Representative for Appeal Purposes* form to designate a personal representative for purposes of an appeal, available at https://www.highmarkbcbsde.com/downloads/forms/Designation_of_Personal_Representative_for_Appeal_Purposes.pdf
- Please explain why you believe the decision was wrong and provide any additional relevant information. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.
- You will be notified of the decision within 30 to 60 days of your request for an appeal.

AFTER THE HIGHMARK DELAWARE APPEAL

- If you have appealed a decision and are not satisfied with the outcome, you may be eligible for an external review coordinated by the Delaware Department of Insurance (DOI). As

required by law, you must request an external review within four months of the date you received Highmark Delaware's appeal decision.

- For decisions involving medical judgment or necessity, you must contact Highmark Delaware Customer Service to initiate the review.
- For reviews of all other decisions, you must contact the DOI directly at 800.282.8611.
- The DOI provides free, informal mediation services which are in addition to, but do not replace, your right to an independent review. For information about mediation, you can call the DOI Consumer Services Division at **800.282.8611**, or visit the DOI office at: The Rodney Building, 841 Silver Lake Boulevard, Dover, Delaware. Office hours are 8:30 AM – 4:00 PM Monday – Friday. **Please note that the four month external review deadline will still apply if you choose mediation services.**

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; www.highmarkbcbsde.com; www.cms.gov

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

www.s-https:

Internet:

Visit our internet Customer Service Center at www.highmarkbcbsde.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

IMPORTANT NOTE

PLEASE READ A *GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, PROVIDED BY THE FEDERAL GOVERNMENT'S CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) TO FIND OUT WHAT BENEFITS YOU CAN RECEIVE FROM THE MEDICARE PROGRAM AT www.cms.gov.

COORDINATION OF BENEFITS

We reserve the right to coordinate available benefits for you so that duplication of payment of the same benefits will not occur and so that all parties having responsibility for payment for covered services perform in accordance with their benefit plan obligations. If you are entitled to benefits under any other plan as defined herein, to which you are a party or beneficiary, the amount of benefits payable under this plan and any other plan will be coordinated so that the aggregate amount paid will not exceed one hundred percent of the Allowable Expenses.

DEFINITIONS

For the purpose of interpretation of this provision, the following definitions will apply:

Allowable Expenses means a necessary, reasonable and customary health care expense when the expense is covered at least in part by one or more health benefit plans covering the individual for whom the claim is made.

Coordination of Benefits Provision means any provision of any plan that establishes the order in which plans pay benefits when an individual is insured under two or more plans.

Other Plan means any arrangement providing health care benefits or services, including but not limited to benefits or services through:

- Any form of health or other insurance, including nonprofit health service, or any other form of prepayment of insurance coverage including individual, group, blanket, franchise, fraternal, no-fault insurance or personal injury protection coverage;
- Any health maintenance organization or similar coverage;
- Coverage under any labor management trusteed plan, union welfare plan, or employee benefit organization plan;
- Coverage under any governmental or tax supported program; or
- Coverage required by statute to be offered to or procured potentially by you whether or not you have the option of declining such coverage or of purchasing such coverage subject to mandatory or optional deductibles, including but not limited to personal injury protection coverage, no-fault coverage or similar provisions of state or other statutes.

Primary Plan means the plan under which benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the plan under which benefits are determined after those of the other plan. Benefits under a secondary plan may be reduced because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan responsibility is determined according to the following rules as they apply to your Medicfill health care plan:

- A plan with no provision for coordination of benefits is primary over a plan that contains such provision.
- A plan that covers you as an employee is primary over a plan that covers you as a dependent.

- A plan that covers you as an active employee (or as that employee's dependent) is primary over a plan that covers you as a laid off or retired employee (or that employee's dependent).
- If two or more plans cover a dependent child of parents not divorced or separated, the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered one parent longer is primary.
- If the other plan's Coordination of Benefits provision determines primary or secondary plan responsibility based upon the parent's gender rather than upon the parent's birthday, the gender rule will control. As a result, the plan covering the dependent child of the male parent will be primary.
- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
 - First, the plan of the parent with custody of the child;
 - Then, the plan of the spouse of the parent with the custody of the child; and
 - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the organization providing benefits has actual knowledge of the decree, the plan of that parent is primary.

- If the above rules do not establish which plan is primary, the plan that has covered the individual for the longer time period is primary.
- When there are two or more secondary plans, this order of benefit determination will be repeated until this plan's responsibility for benefits has been determined.

EFFECT ON BENEFITS

- When this plan is primary, the benefits of the secondary plan will be ignored for the purpose of determining the benefits under this plan.
- When this plan is secondary, we will coordinate payments with those of the other plan(s) so that payments made by both (or all) plans will not exceed Allowable Expenses for covered services. In no event will we pay more than would have been paid had there been no other plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of this provision, we may release to or obtain from any organization or individual any information deemed necessary.

You, personally, are obligated to provide information necessary to implement this provision. If you refuse to cooperate with us in providing necessary information or in securing payment, then coverage under this plan for that incident is null and void and we may, at our discretion, terminate the plan and take any other action necessary to protect our rights hereunder.

FACILITY OF PAYMENT

When this plan is determined to be primary but payment was made under another plan, we have the right to reimburse the organization making such payments the amount that we determine is our liability in accordance with this provision. By making such payment, we will have satisfied the obligation under this plan.

RIGHT OF RECOVERY

When we make payments that exceed the maximum amount of covered benefits that we must pay under the coordination of benefits rules, we have the right to recover the excess from any one of the following:

- Any person to or for whom such payments were made;
- Any insurance companies;
- Other organizations; or
- You.

ELIGIBILITY INFORMATION

WHO IS ELIGIBLE

This Health Care Plan is made available through the State of Delaware who elected to provide Medicare supplementary coverage for:

- Retired employees and their spouses
- Disabled employees, spouses and dependent children
- Employees, spouses and dependent children who have permanent kidney failure.

You must be enrolled in Part A and Part B of the Medicare program. You must also continue to be covered under both Part A and Part B to keep coverage in this plan.

WHEN YOUR COVERAGE ENDS

DEATH

Coverage for your surviving spouse and any eligible dependents ends as of the last day of the month of your death.

LOSS OF BENEFITS

You can lose coverage under this plan if you do not retain coverage under both Part A and Part B of Medicare.

Also, persons under 65 can lose their Medicare eligibility by losing their Social Security disability classification. This occurs when the disabled or blind person becomes gainfully employed or, in the case of the dialysis patient, three years after a successful kidney transplant or one year after termination of dialysis.

Contact your Pension Office for information regarding other coverage that may be available.

STATE DROPS COVERAGE

Your coverage (and your dependents coverage) ends on the date on which the State's contract with us for the provision of benefits ends.

BENEFITS AFTER YOUR COVERAGE ENDS

If you are an inpatient in a hospital, skilled nursing facility or specialized care facility on the date your coverage terminates because your employer dropped coverage with us, we will continue to provide the benefits described in this booklet for the facility and professional charges related to that admission for up to 10 days after the coverage termination date or until the day you are discharged from the hospital, skilled nursing facility or specialized care facility, whichever occurs first.

If you lose coverage for any reason other than because your employer dropped coverage, all health care benefits under this health care plan terminate on the date your group coverage terminates.

IF GROUP COVERAGE ENDS

If your group coverage ends, you may apply directly to us for conversion to a contract under which you are billed personally (a 'direct-billed' contract) at the then current premium rate. You must apply within 31 days after your coverage under the group contract ends. You have this conversion right if:

- You have left your employer; or
- You are the ex-spouse of an employee; or
- You are the surviving spouse of a deceased employee; or
- You no longer meet the dependent child requirements on age, marital status, or financial support.

The direct-billed contract offered may provide fewer benefits and/or a lower benefit payment level than what you were eligible to receive under group coverage.

If another health insurance program is available where you are employed or in an organization with which you are affiliated, you and/or your dependents are not entitled to a group conversion direct-billed contract under this provision, regardless of whether the other health insurance program contains a preexisting condition limitation or the application is denied.

GENERAL CONDITIONS

MEDICARE AMENDMENTS

If there are changes to the Medicare Law or any other applicable law that either increase or decrease the amount of benefits or provide services not previously covered, benefits under this plan will be adjusted accordingly.

RELEASING NECESSARY INFORMATION

Hospitals, doctors, pharmacies and other providers have information we need to determine your eligibility for both enrollment and benefits under this plan. By applying for coverage you agree to let any doctor, hospital, pharmacy or provider give us and our agents all the medical information we may need. This may include the diagnosis and history of any illness, disease, condition or symptom you have had, or for which coverage is sought; or other information. We will keep this information confidential to the extent permitted by law. However, by applying for coverage you authorize us to furnish any and all records including complete diagnosis and medical information to an appropriate medical review board, utilization review board, utilization review organization and/or to any other insurance carrier or administrator or health maintenance organization for purposes of administration of this health benefits plan. If such information relates to fraud or other misrepresentation, we may disclose it to legal authorities or use it in legal proceedings. We reserve the right to charge a fee for the reproduction of claims records requested from us.

TIME LIMITS

Requests for benefits must be received by us within 2 years from the date you received the service.

DENIAL OF LIABILITY

We are not responsible for the quality of care received from any institution or individual. Your coverage does not give you any claim, right or cause of action against us based on an act of omission or commission of a hospital, nursing home, doctor or other provider of care or service.

RECEIPT OF BENEFITS

In order for you to receive benefits, you must identify yourself as our customer as soon as possible. When you receive services, you must show the current membership card.

DUPLICATE COVERAGE

If you have two or more benefit plans through Blue Cross Blue Shield corporations, benefits will be coordinated.

PAYMENT OF BENEFITS

If your doctor accepts Medicare assignment, payment will be made directly to the doctor. He/she cannot bill you for any balance over the Medicare reasonable charge. However, if your doctor does not accept Medicare assignment and you have not assigned benefits under this plan to your doctor in accordance with Medicare program requirements, payment will be made directly to you and you may be responsible for any balance remaining. If you have assigned benefits under this plan to your doctor according to Medicare guidelines, we will pay benefits under this plan directly to your doctor, as required. In all other cases where benefits are payable to you, such payments shall not be assignable without our written approval.

SUBROGATION AND RIGHT OF REIMBURSEMENT:

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

Some examples of Highmark Delaware's rights include:

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

Some examples of your responsibilities include:

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

LEGAL ACTION

No legal action may be brought against us for failure to provide benefits under this plan unless brought within 3 years from the date the service in question was rendered.

CANCELLATION FOR MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACTS

We may cancel this plan at any time if we learn:

- That the statements you made at the time you applied for coverage were untrue or incomplete; or
- That you received or attempted to receive benefits under this plan under circumstances indicating fraud or other intentional misconduct; or
- You assisted another person as specified above.

HOW HIGHMARK DELAWARE PROTECTS YOUR CONFIDENTIAL INFORMATION

It is necessary for Highmark Delaware to receive information about you and your health to properly administer your plan benefits. This information is called "Personal Identifiable Health Information" and includes items such as your

- provider's name,
- tests that were done,
- diagnosis, or
- costs of treatment.

The following explains how Highmark Delaware protects the confidentiality of your Personal Identifiable Health Information.

YOUR RIGHT TO CONSENT OR DENY RELEASE OF INFORMATION

By enrolling with Highmark Delaware, you agree that we can receive information from your providers about care that you received. You also permit Highmark Delaware to release your Personal Identifiable Health Information to business associates outside Highmark Delaware, such as

- organizations that process claims,
- people who help coordinate services, or
- auditors.

We may need to release your Personal Identifiable Health Information to:

- process and pay claims,
- coordinate benefits when you're covered under another health plan,
- monitor care,
- help manage a chronic illness, such as diabetes or congestive heart failure,
- measure satisfaction through customer surveys, or
- conduct studies to measure our performance and our providers' performance.

In situations other than our routine business practice, Highmark Delaware will only release Personal Identifiable Health Information if you sign the *Notice of Specific Consent* form. The form will contain information such as what is being released, who is getting the information and why the information is needed.

WITHDRAWING CONSENT

If you signed a *Notice of Specific Consent* form, you may withdraw that consent by calling or writing Highmark Delaware's Customer Service Department. When you call, please specify which information indicated on the *Notice of Specific Consent* form you don't want released. However, if you withdraw that consent, the withdrawal will not affect any Personal Identifiable Health Information that Highmark Delaware has already released based on your signing the *Notice of Specific Consent* form.

SHARING YOUR INFORMATION WITH YOUR EMPLOYER

At times it may be necessary for Highmark Delaware to provide your employer with information such as

- medical cost experience

- claims volume
- cost savings.

This information helps your employer and Highmark Delaware to determine future premium rates. This information is also used to monitor Highmark Delaware's performance.

We do not release your Personal Identifiable Health Information to your employer without your signing a *Notice of Specific Consent* form, unless we are required to do so by law. The consent form will contain information such as what is being released, who is getting the information and why the information is needed.

YOUR RIGHT TO ACCESS MEDICAL RECORDS

You have the right to access the medical records that were originated by Highmark Delaware. Some examples of such records are the *Explanation of Benefits* and authorization of service forms. You can request your records by either writing or calling Highmark Delaware's Customer Service Department.

HOW HIGHMARK DELAWARE PROTECTS YOUR PRIVACY

All Highmark Delaware Employees are required to sign confidentiality statements when they're hired. Employees are then trained to follow certain guidelines to protect your confidential information. However, employees need to discuss your information with other employees when performing routine business practices, such as when they

- process claims,
- resolve disputes,
- answer inquiries, or
- coordinate care or benefits.

Much of your Personal Identifiable Health Information is on our computer network. Our employees are granted access to the network only on a need-to-know basis. Highmark Delaware's management determines the level of access that employees need to perform their job. Our systems are password protected. Passwords are periodically changed to prevent unauthorized access.

Highmark Delaware also requires that your providers follow confidentiality policies. We periodically audit providers to ensure that your medical records are kept private and that their staff has received confidentiality training.

USE OF MEASUREMENT DATA

We conduct surveys and health studies to measure customer satisfaction to help us improve our services. Health studies help us measure our performance and our providers' performance. Information collected during these studies is reported for the entire group rather than for one person. Your Personal Identifiable Health Information is not identified.

Highmark Delaware sometimes uses outside agencies to conduct surveys and studies. Highmark Delaware requires these agencies to sign a confidentiality agreement and to train their employees about confidentiality.

COMPLAINTS AND QUESTIONS

You have the right to file a complaint with us at anytime you feel that we have not maintained your privacy. You also have the right to ask questions about our confidential policy. To do either, please call Highmark Delaware's Customer Service Department at:

Long Distance Calls: 844-459-6452

SUGGESTIONS AND COMPLAINTS

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

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

- access to your PCP or other provider
- the care you received

Highmark Delaware's Address

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

Highmark Delaware's Customer Service Telephone Numbers

Long Distance Calls: 844-459-6452

Highmark Delaware's Internet Address:

www.highmarkbcbsde.com

To learn how to appeal benefits, see "Benefits Appeal" in the section, *A Guide to Claims*.

DEFINITIONS

Accident means accidental bodily injury that is sustained as the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this plan is in force.

Admission means the period from the time you enter a hospital or skilled nursing facility as an inpatient until discharge.

Allowable Charge means the fee or price Blue Cross and Blue Shield of Delaware determines to be reasonable for services and supplies.

Benefit Period means the period beginning with the first day of admission to a hospital or Skilled Nursing Facility and ending when you have gone 60 consecutive days without admission to either a hospital or Skilled Nursing Facility.

Coinsurance means the portion of covered charges for services that, under Medicare, is your responsibility to pay. The coinsurance is the amount remaining after Medicare payment is made.

Deductible means a portion of covered charges for services which is payable before Medicare begins paying. The deductible amount is determined by Medicare.

Durable Medical Equipment means medically necessary equipment, prosthetic devices (artificial devices replacing body parts) and orthopedic braces used only during an illness or injury. It does not include disposable items.

Explanation of Benefits (EOB): A written statement issued to a member that provides detail concerning processing and payment of a claim for benefits, including the member's financial responsibility for services rendered.

Highmark Delaware means Highmark Blue Cross Blue Shield Delaware.

Hospital means any institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and which operates pursuant to state law and which provides diagnostic and therapeutic facilities for services performed mostly on an inpatient basis. Such services must at a minimum include: surgical and medical diagnosis and treatment; and twenty-four hour a day nursing service under the direction or supervision of registered professional nurses. Hospital services must be supervised and rendered by a staff of physicians.

Inpatient means a person admitted to a hospital or skilled nursing facility for an overnight stay.

Licensed Practical Nurse means a person licensed as such by the state in which they practice nursing.

Medically Necessary means those services or supplies which are provided by a hospital, physician or other provider that are required to identify or treat an illness or injury and which, as determined by us, are:

- Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for your convenience, the doctor's convenience, or any other provider's convenience; and,
- The most appropriate supply or level of service that can safely be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. Medicare includes Part A Hospital Insurance Benefits; Part B Supplementary Medical Benefits; and includes rules, regulations, directives and interpretations about these programs issued by the Secretary of Health and Human Services.

Medicare Eligible Expenses means the health care expenses of the kinds covered by Medicare and to the extent recognized as reasonable by Medicare.

Mental and Nervous Disorders means emotional and personality illnesses as classified by the International Classification of Diseases. Excluded are psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation or illnesses determined by us as not amenable to favorable modification.

Outpatient means a person who is receiving services or supplies while not an inpatient in a hospital or skilled nursing facility.

Physician or Doctor means any person who is licensed to practice medicine and surgery, osteopathy, podiatry, chiropractic or dentistry and who is acting within the scope of that license.

Prescription Drugs means a substance which is used in the cure, treatment, or prevention of a disease or illness which can only be obtained upon a physician's prescription.

Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare Program.

Registered Professional Nurse means a person licensed as such by the state in which he or she practices nursing.

Resource Based Relative Value Scale – a schedule established by the federal government to standardize physician payments as determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance, each of which is resource-based. Payments are adjusted for geographical differences in resource costs.

Skilled Nursing Facility means extended care facilities, convalescent hospitals or rehabilitation centers providing skilled nursing care or rehabilitation services and approved by Medicare. Medicare's approval is based on the facility's guarantee of safety to the patient and effectiveness of the care rendered to the patients. These facilities provide:

- Skilled nursing and related services on an inpatient basis for patients who require continuous, 24 hour a day medical or nursing care.
- Rehabilitation for patients who require such care because of illness, disability or injury.

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

You and Your refers to the employee or any eligible dependents you have enrolled for coverage. You must be eligible for enrollment in the Medicare program and enter into agreement with us for supplementary coverage.

HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
NOTICE OF PRIVACY PRACTICES
PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

► For example:

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

Health Care Operations

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

► For example:

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

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

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

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

P. Health Information Exchange

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

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

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

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may “opt-out.”

In order to opt-out, you must call 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 practically do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

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

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

B. Right to an Accounting

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

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Delaware Privacy Office, P. O. Box 8835, Wilmington, DE 19899-8835. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

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

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

D. Right to Request Confidential Communications

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

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Delaware Privacy Office
Telephone: 1-866-568-3790 (toll free)
Fax: 1-877-750-2364
Address: P. O. Box 1991 Wilmington, DE 19899-8835

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

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

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

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

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

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

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

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

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Delaware Privacy Office
Telephone: 1-866-568-3790 (toll free)
Fax: 1-877-750-2364
Address: P. O. Box 1991
Wilmington, DE 19899-8835

State of DE Special Medicfill
Revised: 09/21/21

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