Summary Benefit Booklet

State of Delaware
Available to non-Medicare Aetna and
Highmark Delaware Health Plan Members

Effective July 1, 2023

Surgery Plus
by Employer Direct Healthcare

Preface

This booklet summarizes and describes the main provisions of the SurgeryPlus benefit offering ("SurgeryPlus"). SurgeryPlus is a supplemental medical benefit offering administered by Employer Direct Healthcare. The medical benefits associated with the SurgeryPlus offering are benefits provided under the State of Delaware's Group Health Insurance Plan ("GHIP"). SurgeryPlus is made available to members enrolled in coverage in a non-Medicare Aetna or Highmark Delaware health plan provided under the GHIP. These benefits are not insured by Employer Direct Healthcare. As part of the SurgeryPlus offering, Employer Direct Healthcare will provide certain administrative services related to the medical benefits plan, but covered benefits will be paid from the Group Health Insurance Program funds. The effective date of this Booklet is July 1, 2023.

This booklet describes your rights and obligations, what benefits are covered, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this booklet. This booklet replaces and supersedes all prior documents describing coverage for the medical benefits associated with the SurgeryPlus offering that you may previously have received.

We encourage you to read this summary carefully and share it with your family members. If you have any questions about this booklet or your SurgeryPlus benefits, please contact Employer Direct Healthcare, the third party administrator of the SurgeryPlus benefit, directly at 855-200-2034 or the Statewide Benefits Office at 1-800-489-8933.

Separate summaries describing other benefits available under the GHIP are available to you and may be obtained by contacting the Statewide Benefits Office at 1-800-489-8933 or at https://dhr.delaware.gov/benefits.

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About Your Participation

This section includes important information about your participation in SurgeryPlus, including eligibility information, when to enroll, when you can make election changes, paying for coverage and when coverage ends.

Who Is Eligible For SurgeryPlus

If you are eligible for coverage under a GHIP non-Medicare Aetna or Highmark Delaware health plan, you are eligible for coverage through SurgeryPlus. For details relating to your eligibility for coverage through a non-Medicare Aetna or Highmark Delaware health plan, please refer to the applicable non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

Enrollment in SurgeryPlus

If you are enrolled for coverage under a GHIP non-Medicare Aetna or Highmark Delaware health plan, you are automatically enrolled for coverage through SurgeryPlus. For details relating to enrollment for coverage in a non-Medicare Aetna or Highmark Delaware health plan (for example, how to enroll, when coverage begins, and making enrollment changes during the year), please refer to your applicable non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

When SurgeryPlus Coverage Ends

In general, coverage under SurgeryPlus will end when your GHIP non-Medicare Aetna or Highmark Delaware health plan coverage ends. For details relating to when your GHIP health plan coverage ends, as well as information regarding continuation of coverage (pursuant to COBRA or otherwise), please refer to your applicable non-Medicare or Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

SurgeryPlus Benefits

SurgeryPlus is included with enrollment in a GHIP non-Medicare Aetna or Highmark Delaware health plan. You do not need to make a separate election to receive coverage through SurgeryPlus. You cannot elect coverage only through SurgeryPlus.

Overview

SurgeryPlus is a comprehensive program that provides access to covered benefits through a high-quality network of credentialed surgeons and facilities. Additionally, you will receive a personalized concierge experience from a team of dedicated SurgeryPlus Care Advocates. The goal of SurgeryPlus is to simplify the surgical process from start to finish – from helping you select a qualified surgeon to scheduling appointments and assisting with medical bills related to certain aspects of your care. SurgeryPlus credentialed surgeons undergo a rigorous evaluation process to ensure that you receive high quality care from specialists who excel in the area related to your needs. By using the SurgeryPlus benefit, you may also save money through reduced member cost-sharing and/or financial rewards offered through SurgeryPlus and your GHIP non-Medicare Aetna or Highmark Delaware health plan (outlined on the following pages).

SurgeryPlus Provider Network

Providers affiliated with SurgeryPlus follow a pricing agreement to provide health care services and supplies to members at negotiated rates, and are referred to as SurgeryPlus Providers. SurgeryPlus Providers include physicians, other licensed health care practitioners, hospitals, and healthcare facilities, and collectively, they are referred to as the SurgeryPlus Network. The SurgeryPlus Network is separate from the provider network associated with your non-Medicare Aetna or Highmark Delaware health plan, although SurgeryPlus Providers may also participate in one or both of the health plan networks.

The SurgeryPlus benefit is designed to lower your out-of-pocket costs when you use the SurgeryPlus Network for covered services. In other words, when you utilize the SurgeryPlus Network for covered services, you may be eligible to receive reduced member cost-sharing and/or financial incentives offered through SurgeryPlus and your GHIP non-Medicare Aetna or Highmark Delaware health plan (outlined on the following pages).

Voluntary Benefits

With the exception of bariatric surgical procedures (see following section), utilization of SurgeryPlus is voluntary. In other words, with the exception of bariatric procedures, you also have the choice to access licensed providers, hospitals and facilities outside the SurgeryPlus Network for covered benefits. However, any services received from providers outside of the SurgeryPlus Network will not be covered through SurgeryPlus. Such services provided by providers outside of the SurgeryPlus Network may be covered under your non-Medicare Aetna or Highmark Delaware health Plan, but coverage of those services would be subject to the applicable deductibles, coinsurance, and other terms applicable to your health plan, and you would not be eligible to receive the financial rewards associated with the SurgeryPlus benefit. If electing not to utilize SurgeryPlus for your surgical procedure, you should refer to the plan documents related to your GHIP non-Medicare Aetna or Highmark Delaware health plan.

Mandatory Bariatric Benefits

The SurgeryPlus benefit is the exclusive source of coverage for bariatric surgical procedures. Bariatric surgical procedures will not be covered by your GHIP non-Medicare Aetna or Highmark Delaware health plan. Accordingly, you will only be able to receive coverage for bariatric surgical procedures by utilizing the SurgeryPlus Network. Bariatrics procedures covered through the SurgeryPlus Network are not eligible for financial incentives, but are subject to reduced member cost-sharing.

How SurgeryPlus Works

SurgeryPlus works best for planned surgical procedures such as joint replacements or non-emergent cardiac care. If you choose to have a medical procedure using SurgeryPlus, you must contact SurgeryPlus and speak with a Care Advocate to schedule a consultation. To get started, you may contact SurgeryPlus at (855) 200-2034.

When you call, a Care Advocate will be assigned to your case to assist you with coordinating the medical care that is best for you. The Care Advocate will help you find a qualified SurgeryPlus Provider. The Care Advocate ensures you have access to information as you make decisions about your surgical care, providing guidance throughout the process, answering questions that arise, and handling certain logistics throughout the course of your medical treatment.

All services under the SurgeryPlus benefit must be determined to be Medically Necessary by a SurgeryPlus Provider before they are performed. Your SurgeryPlus Care Advocate will assist with coordinating this for you by scheduling a consultation with a SurgeryPlus Provider.

If your SurgeryPlus Provider determines that your requested medical procedure is not Medically Necessary, which includes a determination of whether you are a suitable candidate for the procedure, you may request SurgeryPlus provide you additional SurgeryPlus Provider options to review your case and offer a second opinion. If the second SurgeryPlus Provider determines your requested medical procedure is not Medically Necessary, you may seek coverage for the requested medical procedure through your GHIP non-Medicare Aetna or Highmark Delaware health plan outside of the SurgeryPlus benefit, with the exception of bariatric procedures.

SurgeryPlus will administer claims for services provided during your Episode of Care. Episode of Care means the period of time initiated on the first day you receive covered services through SurgeryPlus in an inpatient, outpatient, surgery center, in-office, or other health care facility setting from a SurgeryPlus Provider and ends when you are discharged from the applicable health care facility. All care received from SurgeryPlus Providers during an Episode of Care is covered by your SurgeryPlus benefit. The services typically covered during any episode of care are professional services performed by the SurgeryPlus Provider and their staff, inpatient or outpatient facility services, supplies, and equipment, and professional anesthesia services, supplies, or equipment necessary to perform your surgical procedure. For information relating to appeals of any denied SurgeryPlus claims, please see the Appeals section below.

SurgeryPlus does not cover certain medical consultations and diagnostic testing provided before or after an Episode of Care (for example, services, such as lab work or imaging, provided to determine whether or not the services are Medically Necessary Services), convenience items (for example, charges for telephone use, premium television access, guest meals, or other similar items or services furnished for your convenience/comfort), any medical procedure or medical care that is not Medically Necessary, or medical services or items that are provided by healthcare providers that are not in the SurgeryPlus Network. Additionally, SurgeryPlus does not cover services which were not coordinated by a SurgeryPlus Care Advocate. Although the foregoing excluded services would not be covered through SurgeryPlus, they might be covered by your GHIP non-Medicare Aetna or Highmark Delaware health plan

Note, if you are instructed by SurgeryPlus Provider to obtain imaging, such as an MRI, or if a SurgeryPlus Provider gives you an order for lab work in advance of your procedure, you should inform your SurgeryPlus Care Advocate of those instructions. Your SurgeryPlus Care Advocate will assist you in locating an imaging center or laboratory testing facility that is in-network under your GHIP non-Medicare Aetna or Highmark Delaware health plan, and the Care Advocate will remind you that those services are not covered through SurgeryPlus, so you should present your Aetna or Highmark Delaware ID card when obtaining those services.

SurgeryPlus Surgical Specialties

SurgeryPlus specializes in covering non-emergent surgical events in the following surgical specializations:

Orthopedic Surgery	Neurological Surgery	General Surgery	Gastroenterological Surgery
Gynecological Surgery	Thoracic Surgery	Otolaryngological Surgery	Bariatric Surgery
Interventional Pain Management	Urological Surgery	Cardiac Surgery	

Deductibles and Coinsurance

Services performed by SurgeryPlus Providers are not subject to the applicable copay, deductible and coinsurance requirements of your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan as detailed below:

Health Plan	Copay	Deductible	Coinsurance	Annual Out of Pocket Maximum
Aetna CDH Gold Plan	N/A	$0 (Waived)	0% (Waived)	$0 (Waived)
Aetna HMO Plan	$0 (Waived)	N/A	N/A	$0 (Waived)
Highmark Comprehensive PPO	$0 (Waived)	N/A	N/A	$0 (Waived)
Highmark State Basic Plan	N/A	$0 (Waived)	0% (Waived)	$0 (Waived)

As the table above illustrates, your cost share requirements are waived for services received through SurgeryPlus. All claims paid by the GHIP for SurgeryPlus benefits are considered in-network.

Financial Incentives for Voluntary Benefits (Bariatric Surgery Excluded)

The combination of the low rates negotiated by SurgeryPlus and high-quality SurgeryPlus Providers results in a savings for the GHIP. These savings are passed on to members who use the SurgeryPlus benefit to receive covered services in the form of no member cost-sharing and a financial incentive. The financial incentive amount varies based on the type of procedure you receive through SurgeryPlus, as set forth in the table below.

TIER A: $4,000 Benefit	TIER B: $2,000 Benefit	TIER C: $1,000 Benefit	TIER D: $500 Benefit
Joint Replacement/ Revision • Knee Replacement/ Revision • Hip Replacement/Revision • Shoulder Replacement • Ankle Replacement • Elbow Replacement • Wrist Replacement	**Cardiac** • Defibrillator Implant • Permanent Pacemaker Implant • Pacemaker Device Replacement • Valve Surgery • Cardiac Ablation	**Orthopedics** • Knee/Shoulder Arthroscopy • ACL/MCL/PCL Repair • Rotator Cuff Repair • Bunionectomy • Carpal Tunnel Release	**Gastroenterology (GI)** • Colonoscopy** • Endoscopy **Pain Management** • Cervical Epidural • Lumbar Epidural Steroid • Stellate Ganglion Block • Epidural Blood Patch

Preventative colonoscopies are not eligible for the financial benefits outlined above. Diagnostic colonoscopies are eligible for the corresponding financial benefit outlined above. **Note: Bariatric procedures are not eligible for the financial incentives outlined above.

TIER A: $4,000 Benefit	TIER B: $2,000 Benefit	TIER C: $1,000 Benefit	TIER D: $500 Benefit
Spine • Laminectomy/Laminotomy • Anterior Lumbar Interbody Fusion (ALIF) • Posterior Interbody Fusion (PLIF) • Anterior Cervical Disk Fusion (ACDF) • 360 Spinal Fusion • Artificial Disk	**Genitourinary (GYN)** • Hysterectomy • Bladder Repair (Anterior or Posterior) • Hysteroscopy	**General Surgery** • Hernia Repair (inguinal, ventral, umbilical, and hiatal) • Gallbladder Removal • Thyroidectomy **Ear Nose & Throat (ENT)** • Ear Tube Insertion (Ear Infection) • Septoplasty • Sinuplasty	**Other Minor Procedures** • Biopsy • Excision of Mass
Preventative colonoscopies are not eligible for the financial benefits outlined above. Diagnostic colonoscopies are eligible for the corresponding financial benefit outlined above. **Note: Bariatric procedures are not eligible for the financial incentives outlined above.			

Following completion of a procedure performed by a SurgeryPlus Provider, SurgeryPlus will transfer the applicable financial incentive amount to you. The amount of your financial incentive will be loaded onto a temporary debit cards and mailed to you. This may be several months following your SurgeryPlus procedure. If you have questions about the status of your financial incentive following your procedure, please contact your SurgeryPlus Care Advocate for information.

Your financial incentive may be treated as taxable income under applicable tax laws and regulations. Accordingly, if your incentive is greater than $600, you will receive a Form 1099 from SurgeryPlus.

If a dependent that is under the age of 18 is eligible for a financial incentive, the custodial parent will receive the financial incentive and the Form 1099 from SurgeryPlus, if applicable.

Travel Benefits Through SurgeryPlus

Generally, the SurgeryPlus Network is broad enough that significant travel is not required. If travel is required, certain travel expenses may be covered by SurgeryPlus. A summary of travel benefits available to you through SurgeryPlus is set forth below. Please direct travel questions to your SurgeryPlus Care Advocate.

Hotel	Airfare	Mileage	Per Diem
• Hotel expenses are covered for necessary travel • Hotels will typically be 3 stars or above • SurgeryPlus may be able to use a hospital-affiliated hotel that features additional care and discounted rates	• Airfare expenses are covered for necessary travel • SurgeryPlus will book flights if it appears to be the best travel option when a SurgeryPlus Provider placement is more than 125 miles away	• Mileage expenses for enrollees driving to Participating Providers will be covered in the following amounts: • 0-99 miles - $25 • 100-199 miles - $100 • 200+ miles - $100	• Expenses for other necessary expenses related to your travel for services through SurgeryPlus will be covered in the amount of $35 per person, per day

Secondary Coverage For Bariatric Procedures Only

Spouses or dependents enrolled in a GHIP non-Medicare Aetna or Highmark Delaware health plan as secondary coverage may be able to receive secondary coverage through SurgeryPlus for bariatric procedures only, as outlined below:

- If the primary health plan of the spouse or dependent **does not cover bariatric procedures**, the spouse or dependent **will be eligible** to receive coverage through SurgeryPlus for their bariatric procedure. Such coverage through SurgeryPlus will be subject to the same coverage terms and conditions applicable to SurgeryPlus as if the spouse or dependent were enrolled for primary coverage in a GHIP non-Medicare Aetna or Highmark Delaware plan.

- If the primary health plan of the spouse or dependent **covers bariatric procedures**, the spouse or dependent **will not be eligible** to receive coverage through SurgeryPlus for their bariatric procedure. Instead, the spouse or dependent must use their primary coverage for their bariatric procedure. However, if such spouse's or dependent's primary coverage is less than the amount covered under the spouse or dependent's secondary GHIP non-Medicare Aetna or Highmark Delaware plan's outpatient or inpatient surgical coverage, the spouse or dependent may be eligible to receive reimbursement for out-of-pocket costs from the GHIP (not SurgeryPlus) for the bariatric procedure. If this applies to you, contact the Statewide Benefits Office at 1-800-489-8933 for more information.

Your ID Card

All members of the GHIP non-Medicare Aetna and Highmark Delaware health plans will receive a SurgeryPlus ID card following enrollment in a non-Medicare Aetna or Highmark Delaware health plan. This ID card includes the SurgeryPlus contact information to utilize this benefit if you need non-emergent surgery. If you need replacement or additional cards (for instance, if your child is attending college out of town), you can request them by calling a SurgeryPlus Care Advocate at 855-200-2034. It is important to remember to use your SurgeryPlus ID card with the SurgeryPlus Provider rather than your health plan's insurance card.

Claims Procedures

The claims and appeals procedures described in this section do not apply to services performed by health care providers who are not in the SurgeryPlus Network. Please review the applicable plan documents for your GHIP non-Medicare Aetna or Highmark Delaware health plan for the claims and appeals procedures applicable to other benefits available under your plan for more information.

State of Delaware as Plan Sponsor has delegated final claims and appeals authority for SurgeryPlus to Employer Direct Healthcare. Employer Direct Healthcare, acting on behalf of the State of Delaware, will provide the following claims and appeals review services set forth in this section.

SurgeryPlus Claims Administrator

The Claims Administrator for the SurgeryPlus benefit is Employer Direct Healthcare and includes all references to the term “Claims Administrator” in this section.

Employer Direct Healthcare
Attn: Member Services
2100 Ross Avenue, Suite 1900
Dallas, Texas 75201

Medically Necessary

All services under the SurgeryPlus benefit must be determined to be Medically Necessary by a SurgeryPlus Provider before they are performed. Your SurgeryPlus Care Advocate will coordinate this for you.

If your SurgeryPlus Provider determines that your requested medical procedure is not Medically Necessary, which includes a determination of whether you are a suitable candidate for the procedure, you may request SurgeryPlus assign you another SurgeryPlus Provider in the SurgeryPlus Network to review your case and offer a second opinion. If no SurgeryPlus Provider determines your requested medical procedure is Medically Necessary, you may also seek coverage for the requested medical procedure through your GHIP non-Medicare Aetna or Highmark Delaware health plan (subject to the coverage terms and exclusions of your non-Medicare Aetna or Highmark Delaware health plan) except for bariatric procedures. Please review the applicable plan documents for your GHIP non-Medicare Aetna or Highmark Delaware health plan for more information about your other medical benefits available under your plan.

Please note: A determination by a SurgeryPlus Provider that a medical procedure is not Medically Necessary is a determination by the SurgeryPlus Provider that he or she will not perform the requested medical procedure and is not a denial of your benefits by and under your plan. In that situation, the appeals procedures described in the following section will not apply. The appeal procedures described in the following section apply only if and when your requested medical procedure is wholly or partially denied by the Claims Administrator acting on behalf of your plan.

Claims Submission

To receive coverage through SurgeryPlus, you must use a SurgeryPlus Provider. All claims for benefits received from a SurgeryPlus Provider for covered services will be paid by the Claims Administrator on behalf of the GHIP. Generally, no claims for payment must be filed by you.

SurgeryPlus Providers will submit your claims directly to the Claims Administrator for services provided to you or any of your covered dependents. Your SurgeryPlus Care Advocate will ensure that completed claim forms are timely filed on your behalf.

Please contact your SurgeryPlus Care Advocate or the Claims Administrator with any questions regarding filing a claim for benefits under SurgeryPlus. Additional information about your SurgeryPlus benefit is available on your member portal. Your member portal can be accessed at:

- https://de.surgeryplus.com/Client/ClientAccount/Login?returnUrl=%2F

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Claims Administrator in the proper manner and form and with all of the information required. In the event a claim is not complete, the Claims Administrator will notify you and your SurgeryPlus Provider, and your SurgeryPlus Care Advocate will work with you and the SurgeryPlus Provider to complete the claim and resubmit it to the Claims Administrator.

Your SurgeryPlus Care Advocate will work to ensure completed claim forms are timely filed on your behalf.

If approved, you will receive an explanation of benefits summary from the Claims Administrator after your medical procedure is performed. If denied, you will receive an adverse benefits determination (please see Claim Denial Notification section below).

Who Receives Payment

Benefit payments will be made directly to SurgeryPlus Providers when they bill the Claims Administrator. Except as provided elsewhere in this Booklet, rights and benefits under your plan are not assignable, either before or after services and supplies are provided. Any benefits that are or may be payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Claim Denial Notification

In the event a claim for benefits through SurgeryPlus is wholly or partially denied, the Claims Administrator shall provide you with written notification of the adverse benefit determination. The notification shall be written in a manner calculated to be understood by you and shall include the following:

1. Information necessary to identify the claim, including the date of service, healthcare provider, claim amount (if applicable), and a statement describing the availability upon request, of the diagnosis code and its meaning and the treatment code and its meaning;

2. The specific reason or reasons for the adverse determination including the denial code and its corresponding meaning as well as a description of your plan's standard, if any, that used in denying the claim;

3. Reference to the specific provision of your plan on which the determination is based;

4. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of your plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;

5. Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

6. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

7. A description of your plan's available internal appeals and external review processes, including information regarding how to initiate an appeal, and the time limits applicable to such procedures; and

8. A statement of your rights to bring a civil action under applicable law following a final adverse benefit determination after appeal, and contact information for the office of health insurance consumer assistance or ombudsman, as applicable, established to assist individuals with internal claims and appeals and external review procedures.

If your claim has been denied and you do not agree with the denial, you must submit your claim for review by following the Appeals Procedure described below.

Appeals Procedure

If you disagree with a denial of your claim, you or your duly authorized representative acting on your behalf must file an appeal in writing. All references to you for the remainder of this Appeals Procedure section also include your duly authorized representative, if any. These appeal procedures must be exhausted before you can enforce your rights under applicable law.

Appeals Administrator

The Appeals Administrator for the SurgeryPlus benefit is MCMC, LLC and includes all references to the term "Appeals Administrator" in this section.

MCMC LLC
300 Crown Colony Drive, Suite 203
Quincy, MA 02169
www.mcmcllc.com

Level 1 and Level 2 Appeals – Provided by Employer Direct Healthcare

Filing a Level 1 and Level 2 Appeal

You have 180 days from the time that you receive a claim denial from the Claims Administrator to file an appeal. There are two levels of appeal for pre- service claims for benefits under your plan's SurgeryPlus benefit:

- Level 1 appeal: You may file a level 1 appeal with the Claims Administrator within 180 days if your claim for benefits is denied and you would like to appeal that denial. Your appeal will be reviewed by the Appeals Administrator within 15 days, with no extensions.

- Level 2 appeal: If your first appeal is denied by the Appeals Administrator, you may file a level 2 appeal with the Claims Administrator within 60 days, and your appeal must be considered by the Appeals Administrator within an additional 15 days, with no extensions.

Appeals (both Level 1 and Level 2) must be filed with the Claims Administrator. The Claims Administrator will notify the Appeals Administrator of your appeal and forward your request for appeal and any information you provide described below under your rights when filing an appeal. The review periods described above begin when you file your appeal with the Claims Administrator.

You have the following rights when filing an appeal (applicable to both Level 1 and Level 2 appeals):

- You may submit written comments, documents, records and other information relating to the claim for benefits in connection with your appeal, and the review of your appeal will take into account all such comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

- You may submit additional evidence and testimony in support of your appeal.

- If any new evidence is provided by your plan or any new rationale is considered by the Appeals Administrator in making the decision, you must receive notice of such new evidence and new rationale and have an opportunity to respond. You must respond within the time period during which the Appeals Administrator is considering your appeal.

- You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

- The Appeals Administrator will not afford deference to the initial adverse benefit determination (and to the Level 1 adverse benefit determination for a Level 2 appeal), and the review will be conducted by an appropriate individual who is neither the individual who made the adverse benefit determination nor the subordinate of such individual.

- In deciding a claim for review that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental/investigational or not Medically Necessary or appropriate, the Appeals Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. Any such health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of review, nor the subordinate of any such individual.

- The Appeals Administrator will provide you with the identification of medical or vocational experts whose advice was obtained on behalf of your plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Level 1 and Level 2 Appeal Denial Notification

In the event a claim for benefits is wholly or partially denied on appeal, the Appeals Administrator shall provide you with written or electronic notification of the adverse benefit determination. The notification shall be written in a manner calculated to be understood by you and shall include the following:

1. Information necessary to identify the claim, including the date of service, healthcare provider, claim amount (if applicable), and a statement describing the availability upon request, of the diagnosis code and its meaning and the treatment code and its meaning;

2. The specific reason or reasons for the adverse determination including the denial code and its corresponding meaning as well as a description of your plan's standard, if any, that used in denying the claim;

3. Reference to the specific provision of your plan on which the determination is based;

4. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of your plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;

5. Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

6. A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

7. A description of any voluntary appeal procedure available under your plan, including information regarding how to initiate an appeal, and the time limits applicable to a voluntary appeal; and

8. A description of your plan's available external review procedure, including information regarding how to initiate an appeal, and the time limits applicable to external review;

9. A statement of your right to bring a civil action under applicable law following a final adverse benefit determination on appeal (i.e. Level 2), and contact information for the office of health insurance consumer assistance or ombudsman, as applicable, established to assist individuals with internal claims and appeals and external review procedures; and

10. A statement that reads as follows: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Level III Appeals

Members may submit a Level III appeal to either or both the State of Delaware Statewide Benefits Office (SBO) or an external review to Employer Direct Healthcare.

Level III Appeal - Administered By The Statewide Benefits Office

Employee may file an appeal of the denial in writing to the Statewide Benefits Office **within 20 days** of the postmark date of the notice of denial of the Level II appeal (or an urgent level appeal) and/or notice of the denial of the Level III external review appeal.

Please submit Level III appeals to the Statewide Benefits Office at this address:

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

Appeal must contain the employee's contact information (mailing address, email address, telephone number, etc.) a written summary of events, applicable Explanation of Benefits (EOBs), and any additional documentation employee desires to provide to support his/her position. Additionally, employee must sign and submit with appeal the State of Delaware's Authorization for Release of Protected Health Information

form to provide authorization to the Statewide Benefits Office to obtain applicable information from Employer Direct Healthcare.

This form is available at: https://de.gov/statewidebenefits (Select the ***SurgeryPlus*** tile, under "I WANT TO…" select "Appeal a Denied Claim"). Employees submitting an appeal without the signed form will be requested, in writing, to submit the form.

The Statewide Benefits Office will not begin to review the appeal until the State of Delaware's Authorization for Release of Protected Health Information form is received.

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

Level III Appeal - External Review Provided by Employer Direct Healthcare

Request for Standard External Review

If you disagree with the final adverse benefit determination of your claim on appeal, you may request an external review. External review under the SurgeryPlus benefit is available for an adverse benefit determination that involves medical judgment (including, but not limited to, those based on whether a benefit is Medically Necessary, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational), as determined by the external reviewer.

You may only file a request for external review if you file such request within four months of the date you received your plan's final adverse benefit determination on your claim for review from the Appeals Administrator.

Your request for an external appeal must be filed with the Claims Administrator. The Claims Administrator will notify the Appeals Administrator of your request for external review and forward your request for appeal and any information you provide described below under your rights when filing an appeal.

Review and Preliminary Determination of Eligibility for External Review

The Appeals Administrator must review your request and respond to you within five business days of receipt of your request with a determination of whether your claim is eligible for external review. The review period begins when you file your request for external review with the Claims Administrator. A claim is eligible for external review if it meets all of the following four requirements during the preliminary review.

1. You are or were covered by your plan at the time the health care item or service in question was provided;

2. Your claim is not based upon whether you satisfied your plan's eligibility requirements;

3. You have exhausted your plan's internal appeal process, unless you were not required to do so because of an error during the claims and appeals process by the Claims Administrator or Appeals Administrator that excuses you from completing the internal appeal process; and

4. You provided all the information and forms required to process an external review.

Preliminary Notice Regarding Eligibility

Within one business day after the Appeals Administrator completes the preliminary review, your plan must issue a written notice to you stating the reasons the claim is not eligible for external review if the request was complete but not eligible for external review and must also provide contact information for the Employee Benefit Security Administration (toll-free number 866-444-EBSA (3272)). If your request for external review was not eligible because it was incomplete, the notice must include a description of the information necessary for you to complete the request for external review and permit you to submit such information by the later of 48 hours after you receive the notice or by the end of the four month period during which external review must be requested.

External Review

Your plan must rotate its assignment of claims for external review to an independent review organization that is one of the at least three independent review organizations retained by your plan to conduct external reviews and which is due to receive the claim on your plan's rotational basis established to ensure independence. The external independent review organization must conduct a full review of the file, applicable plan provisions and any material submitted as required by applicable guidance and in compliance with the independent review organization's contract with your plan. The independent review organization shall conduct such review on a de novo basis without deference to the plan's decision.

Within four business days after the independent review organization is assigned, the Appeals Administrator, acting on behalf of your plan, shall provide the documents and information considered by your plan in making its decision. If the independent review organization receives any new evidence or information, it shall provide such information to the Appeals Administrator and the Appeals Administrator may reconsider its decision. If the Appeals Administrator changes its decision upon reconsideration, it must notify the claimant and the independent review organization of its new decision within one business day of making such decision. The independent review organization must then terminate its review.

The independent review organization shall provide the claimant and Appeals Administrator with a written notice of its decision within 45 days of the date on which the independent review organization received the request for external review. Such notice shall include all information required by applicable guidance.

Upon the Appeals Administrator's receipt of an independent review organization's final external review determination reversing the Appeals Administrator's determination, the Appeals Administrator shall promptly notify your plan, and your plan shall immediately provide coverage or payment for the claim.

Level IV (Final) Appeal – Administered by The State of Delaware – State Employee Benefits Committee (SEBC)

Employee may file a written appeal to the State Employee Benefits Committee (SEBC) **within 20 days** of the postmark date of the notice of denial for the level III appeal from the Statewide Benefits Office.

Please submit Level IV appeals to the SEBC at this address:

Co-Chair, State Employee Benefits Committee (SEBC)
RE: APPEAL
Department of Human Resources
841 Silver Lake Blvd.
Suite 100
Dover, DE 19904

The SEBC receives the appeal and:

- Identifies a Hearing Officer (Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report to the SEBC within 60 days of the date of the hearing.

The SEBC accepts or modifies the report, and notice of the decision is postmarked to employee within 60 days; **OR**

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

Additional Disclosures

Women's Health and Cancer Rights Act of 1998

For details relating to benefits under the Women's Health and Cancer Rights Act of 1998, please refer to your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

For details relating to your rights under the Newborn's and Mothers' Health Protection Act, please refer to your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

Qualified Medical Child Support Order (QMCSO)

For details relating to a Qualified Medical Child Support Order (QMCSO), please refer to your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan: https://dhr.delaware.gov/benefits/.

Subrogation and Right of Reimbursement

SurgeryPlus has a right to subrogation and reimbursement as defined in your health plan summary documents, available at https://dhr.delaware.gov/benefits/. Please refer to that summary or contact your health Plan Administrator for more information.

Circumstances That May Result in Denial, Loss, Forfeiture or Rescission of Benefit

Under certain circumstances, SurgeryPlus benefits may be denied or reduced from those described in this summary. Cancellation or discontinuance of coverage is permitted if it has only a prospective effect on coverage or is effective retroactively due to failure to pay required premiums or contributions.

Rescission of coverage is cancellation or discontinuance of coverage retroactively for reasons other than failure to pay required premiums or contributions. For example, rescission of coverage may be permitted in limited circumstances such as fraud or the intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with a written notice at least 30 days prior to the date of rescission.

Continuation of Your SurgeryPlus Coverage

Continuing Coverage Through COBRA

You may be able to continue coverage under SurgeryPlus under certain conditions if you choose to continue your GHIP non-Medicare Aetna or Highmark Delaware health plan coverage. Health plan coverage may be continued under certain circumstances under the Federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA).For details relating to continuation of coverage under COBRA, please refer to your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

SurgeryPlus is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The State of Delaware is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting the Statewide Benefits Office at 1-800-489-8933 or at https://dhr.delaware.gov/benefits.

Uniformed Services Employment and Reemployment Rights Act

For details relating to continuing your GHIP non-Medicare Aetna or Highmark Delaware health plan coverage under the Uniformed Services Employment and Reemployment Rights Act, please refer to your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

Continuation of Coverage While on Family and Medical Leave

For details relating to continuing your GHIP non-Medicare Aetna or Highmark Delaware health plan coverage under the federal Family and Medica Leave Act (FMLA), please refer to your applicable GHIP non-Medicare Aetna or Highmark Delaware health plan documents, available at: https://dhr.delaware.gov/benefits/.

Plan Administration

DETAILS ABOUT SURGERYPLUS ADMINISTRATION	
Plan Sponsor/ Plan Administrator	State of Delaware
Official Plan Name	SurgeryPlus, a component plan of the State of Delaware Group Health Insurance Plan
Plan Year	July 1 – June 30
Type of Plan	Group health plan providing supplemental medical/surgical benefits
Agent for Service of Legal Process	State of Delaware 841 Silver Lake Boulevard, Suite 100 Dover, DE 19904
Carrier/Vendor/Claims Administrator	Employer Direct Healthcare Member Services 2100 Ross Avenue, Suite 1900 Dallas, Texas 75201 855.200.2099 www.edhc.com
Plan Funding	SurgeryPlus is self-funded as part of the State of Delaware Group Health Insurance Plan. Benefits from this Plan are paid from employee contributions, as applicable, and from the general assets of the State of Delaware, as needed. State of Delaware has contracted with Employer Direct Healthcare, a third-party administrator, to administer SurgeryPlus.

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of SurgeryPlus will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to SurgeryPlus, including eligibility, coverage and benefits.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of SurgeryPlus. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

The State of Delaware's Right to Amend or Terminate the Plan

The State of Delaware reserves the right to amend, modify, suspend or terminate SurgeryPlus, in whole or in part. Any such action would be taken in writing and maintained with the records of SurgeryPlus. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of SurgeryPlus to the extent permitted by law.

State of Delaware's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, HMOs, third-party administrators, etc., at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modification to the plan.

Limitation on Assignment

Your rights and benefits under SurgeryPlus cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign your rights to payment of benefits under SurgeryPlus to the health provider who provided the medical services or supplies.

Type of Coverage

Coverage under the plan is non-occupational. Only non-occupational accidental injuries and non-occupational illnesses are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Right of Recovery

If the amount of the payments made by Employer Direct Healthcare is more than it should have paid, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Treatment Outcomes

Employer Direct Healthcare is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Employer Direct Healthcare or its affiliates.

Your Employment

This summary provides detailed information about SurgeryPlus and how it works. This summary does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under SurgeryPlus should not be interpreted as an implied or express contract or guarantee of employment. The State of Delaware's employment decisions are made without regard to benefits to which you are entitled upon.

SurgeryPlus's benefits are administered by State of Delaware, the Plan Administrator. Employer Direct Healthcare is the third-party administrator responsible for processing claims for SurgeryPlus and providing appeal services; however, Employer Direct Healthcare and the State of Delaware are not responsible for any decision you or your dependents make to receive treatment, services or supplies. Employer Direct Healthcare and the State of Delaware are neither liable nor responsible for the treatment, services or supplies provided by participating or non-participating providers.