



A Guide To Your Benefits



**BlueCross BlueShield
of Delaware**

Working well together.

bcbsde.com



**STATE OF DELAWARE
BLUE CARE[®] HMO PLAN**

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 Blue Cross Blue Shield of Delaware (BCBSD).

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

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

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

- **BCBSD** means Blue Cross Blue Shield of Delaware
- **PCP** means Primary Care Physician
- **HMO** means health maintenance organization

PLEASE NOTE: In the Blue Care plan, you select a PCP. To receive benefits, your PCP manages all of your health care needs. It is important to contact your PCP when you need care.

If you do not use your PCP, BCBSD will not pay for your care.

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

This booklet is not a contract. It explains your plan for easy reference. The benefits and terms and conditions of your plan are in an Account Contract on file with the Statewide Benefits Office, OMB. The Account Contract is the final determination of the benefits and rules of your plan.

This booklet describes your plan in effect as of January 1, 2009. It replaces all previous booklets.

HINTS TO GET THE MOST FROM YOUR BCBSD HEALTH CARE PLAN

- Always show your BCBSD ID card when you need care.
- Always contact your PCP before seeing another provider.
- Always follow BCBSD Managed Care Requirements.
- Read this booklet.
- Call us if you have any questions.

Remember! Your PCP manages your health care needs. See your PCP when you need care.

Get your PCP's authorization before seeing a specialist or going to the hospital.

Without your PCP's prior authorization, your care is not covered!

WHEN YOU HAVE QUESTIONS

BCBSD welcomes questions, comments, suggestions or complaints. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about BCBSD'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:

- choosing a PCP
- changing to a new PCP
- asking about your plan
- obtaining information about providers
- reporting a lost or stolen ID card
- ordering a new ID card
- checking on the status of approvals from the Referral Center
- asking about a claim

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

To Reach Us By Phone

Local Calls: (302) 429-0260

Long Distance Calls: (800) 633-2563

To talk to a Customer Service Representative, call 8:30 a.m. to 7:00 p.m., 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 for:

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

You may also use the automated system 24/7 to access our Help Library.

To Reach Us By Letter

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

To Reach Us In Person

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

To Reach Us on the Internet

Internet Address: www.bcbsde.com

To Reach the Referral Center (for Managed Care)

Referral Center
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: (302) 421-3333
Long Distance Calls: (800) 572-2872

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

Behavioral Health Care Department
Blue Cross Blue Shield of Delaware
One Brandywine Gateway
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: (302) 421-2500
Long Distance Calls: (800) 421-4577

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BLUE CARE SCHEDULE OF BENEFITS

Your PCP manages all your health care needs. Always contact your PCP when you need care. BCBSD will not pay for care that your PCP has not approved.

Many services have limits, copayments or coinsurance. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the following pages. Please read the following pages.

All payments are based on the allowable charge. BCBSD determines the allowable charge.

Preexisting conditions are covered.

SERVICE	BENEFIT
Primary Care and Preventive Care Programs	
■ Well Baby Care	\$10 Copayment per visit
■ Routine Physical Exams	\$10 Copayment per visit
■ Routine Immunizations	\$10 Copayment per visit
■ Routine GYN Exams (one per year)	\$10 Copayment with PCP or OB/GYN
■ Lab Charges for Pap Smears	\$5 Copayment per visit
■ Hemoglobin Tests	\$5 Copayment per visit
■ Cholesterol Tests	\$5 Copayment per visit
■ Blood Sugar Tests	\$5 Copayment per visit
■ Prostate Specific Antigen Tests	\$5 Copayment per visit
■ Lead Poison Screening Tests	\$5 Copayment per visit
■ Blood Occult	\$5 Copayment per visit
■ Flexible Sigmoidoscopy	100% Covered.
■ Colonoscopy	100% Covered.
■ Barium Enema	\$15 Copayment per visit
■ Routine Mammograms	\$15 Copayment per visit
■ Routine Vision Exams	\$15 Copayment per visit
■ Routine Hearing Exams by PCP	\$5 Copayment per visit
■ Doctor's Office Visits to PCP	\$10 Copayment per visit
■ Doctor's Home Visits	\$25 Copayment per visit
■ Doctor's Nursing Home Visits	100% Covered for up to 120 days per plan year
■ Diabetes Education	100% Covered
Hospital and Other Facility Benefits	
■ Inpatient Hospital Care	\$100 Copayment per day for the first 2 days per admission, then 100% covered for unlimited days.
■ Outpatient Surgical Facilities	\$75 Copayment per day.
■ Ambulatory Surgical Center	\$30 Copayment per day.
■ Skilled Nursing Facilities	100% Covered; 120 day limit; benefits renew after 180 days without care.
Surgical-Medical Benefits	
■ Surgical and Anesthesia Benefits	100% Covered.
■ Inpatient Medical and Consultation Benefits	100% Covered.
■ In Vitro Fertilization	See benefit description; limited to \$30,000 per member's lifetime.
■ Artificial Insemination	See benefit description; limited to \$600 per member's

SERVICE

- Organ Transplants

Maternity Benefits

- Prenatal and Postnatal Care
- Inpatient Hospital Care
- Birthing Center
- Obstetric and Newborn Care

Emergency Services

- Emergency Ambulance and Paramedic Services
- Emergency Room
- Urgent Care Facility
- Emergency Services (Doctor's Services at Emergency Room)

Therapeutic & Diagnostic Services

Outpatient Services

- Chemotherapy, Radiation and Respiratory Therapy, Dialysis
- Physical Therapy
- Speech Therapy and Occupational Therapy
- Cognitive Therapy
- Cardiac Therapy
- Lab Tests
- Imaging Services – such as x-rays (except MRI, CAT and PET scans)
- MRIs, CAT scans and PET scans
- Machine Tests (such as EKGs & EEGs)

Inpatient Services

- Therapeutic Services
- Diagnostic Services

Other Covered Services

- Hospice
- Home Health Care
- Home Infusion Services
- Inpatient Private Duty Nursing Services
- Specialist/Referral Care
- Surgical Procedures in a Physician's Office

BENEFIT

lifetime.

See benefit description; limited to \$1,000,000 per covered organ type per member's lifetime.

\$20 Copayment for initial pre-natal visit to obstetrician, birthing center or midwife, then 100% Covered.

Same as *Inpatient Hospital Care*, above

100% Covered.

100% Covered.

\$50 Copayment per service.

\$135 Copayment per visit (waived if admitted).

\$20 Copayment per visit.

100% Covered.

100% Covered.

80% Covered for up to 45 visits per medical condition.

80% Covered for up to 60 days from onset of therapy per acute condition.

80% Covered for 30 consecutive days, beginning on the first day of treatment.

80% Covered for up to 3 sessions per week and 3 months of treatment.

\$5 Copayment per visit

\$15 Copayment per visit

\$25 Copayment per visit

100% Covered.

100% Covered.

100% Covered.

100% Covered for up to 240 days.

100% Covered.

100% Covered.

100% Covered.

\$20 Copayment per visit.

\$20 Copayment per visit.

SERVICE

- Allergy Testing
- Allergy Treatment
- Second Surgical Opinion
- Durable Medical Equipment
- Chiropractic Services

- Care for Weight Loss

BENEFIT

\$20 Copayment per visit with PCP or specialist.
\$5 Copayment per visit with PCP or specialist.
\$20 Copayment
80% Covered.
\$20 Copayment for initial consultation, then 80% Covered for subsequent visits; limited to one visit per day and 60 consecutive days per acute condition.
See benefit description.

Mental Health and Substance Abuse Benefits

(Does not include authorized care for Serious Mental Illness.)

- Inpatient Mental Health and Partial Hospital Care
80% Covered for up to 31 days per plan year.
One inpatient day reduces partial hospital days by one day and vice versa.
- Outpatient Mental Health Care
\$20 Copayment per visit for up to 20 visits per plan year.
- Substance Abuse Treatment - Inpatient Care
\$100 Copayment per day for the first 2 days per admission, then 100% covered for unlimited days.
- Substance Abuse Treatment - Intensive Outpatient Care
\$100 Copayment per day for the first 2 days per plan year, then 100% covered for unlimited days.
- Substance Abuse Treatment - Outpatient Care (Office Visits)
\$20 Copayment per visit

COPAYMENTS

Copayments are amounts you pay at the time you have care. After the copayment, care is paid at 100%. Copayments apply only to certain services. See the *Schedule of Benefits* for a list of services with copayments.

Here's how copayments work:

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

Copayments should be paid at the time you receive care.

COINSURANCE

Some of your benefits are paid at 80% of the allowable charge. The 20% difference is your coinsurance. This is the amount you pay.

YOUR PRIMARY CARE PHYSICIAN (PCP)

To join the Blue Care plan, you must choose a Primary Care Physician (PCP). Each family member may choose a different PCP. Your PCP is the first step in receiving care. BCBSD's PCPs are:

- internists
- family practitioners
- pediatricians
- general practitioners

THE ROLE OF THE PCP

Your PCP's goal is to help you keep well. Your PCP manages all of your health care needs. This assures all the care you receive is coordinated.

When you need care, see your PCP. Your PCP will provide your care or refer you for specialist care. Your PCP also provides routine exams and immunizations.

If you don't see your PCP or have a referral from your PCP for specialist care that is approved by BCBSD, your care is not covered. You will have to pay for your care.

REFERRALS

Usually you'll see your PCP when you need care. When necessary your PCP will refer you to a specialist or hospital. Your PCP will work with BCBSD to assure that the referral is medically necessary for your condition. See *Managed Care Requirements* for more information.

If you don't have referrals from your PCP that are approved by BCBSD, your care is not covered.

CHANGING YOUR PCP

Choosing a PCP is important. Staying with your PCP can result in the best care for you. However, we realize you may have personal reasons to change your PCP.

To change your PCP, call Customer Service. We can help you choose a new PCP, or send you a list of PCPs from which to choose.

The change is effective 3 working days after we receive the request. We do not count the date of the request as one of the 3 working days. Some examples are:

- if we get the request on a Monday, the effective date would be the next Thursday.
- if we get the request on a Friday, the effective date would be the next Wednesday.

Call BCBSD's Customer Service Department if you need help choosing a doctor who will meet your cultural or language needs.

BENEFITS WITHOUT PCP AUTHORIZATION

In a few cases, you can get care without a PCP referral. You don't need a PCP referral for:

- Medical emergencies (but you should contact your PCP within 48 hours of an emergency)
- One routine GYN examination by your PCP or network OB/GYN every 12 months
- Non-routine OB/GYN services by network OB/GYNs
- One routine eye exam every 24 months by network optometrists or network ophthalmologists. (This applies to adults only. Children under 18 must have PCP authorization.)
- Non-routine eye exams by network optometrists or network ophthalmologists.
- Lab services by network lab providers
- Imaging services by network imaging providers (However, you need BCBSD's authorization to have a PET scan.)
- Mental health and substance abuse care (However, you must have authorization from BCBSD. This is described in more detail later in this booklet.)
- Other situations as approved by BCBSD, such as referrals to a cardiologist or oncologist. Call Customer Service for more information on specialties that don't require PCP authorization.

AWAY FROM HOME CARE[®] PROGRAM

TAKING YOUR BENEFITS ON THE ROAD

Most plans provide coverage through an emergency room if you need care when you travel. Many Blue Cross and Blue Shield Plans go a step further by offering a Guest Membership through the Away From Home Care Program. A Guest Membership is a courtesy enrollment for members who are temporarily residing outside of their Home HMO service area for at least 90 days. The Away From Home Care Program is available in most states and the District of Columbia.

This benefit is designed to bring you peace of mind if you have one of the following situations:

- Students – Dependents attending school out-of-state
- Families Apart – Family members living in different HMO service areas
- Long-Term Traveler – Long term work assignment in another state, or retirees with a dual residence.

To learn more about the Away From Home Care Program, contact us at the phone number listed at the front of this booklet or on your ID card.

MANAGED CARE REQUIREMENTS

In this section, we describe the Managed Care requirements. The requirements are administered by BCBSD's Referral Center. The Referral Center helps you and your doctor make sure that care you receive is appropriate for your condition. Please read these requirements carefully. Call us if you have any questions.

Note: You do not need to follow managed care requirements if this plan is secondary (see the section, *Coordination of Benefits*).

Your PCP will arrange your care when you are referred to another provider. Your PCP must call BCBSD's Referral Center **before** you:

- go to a specialist,
- go into a hospital or Skilled Nursing Facility (SNF) for a non-emergency
- remain in the hospital or SNF beyond the date we authorized
- receive home health care
- receive home infusion
- have a PET scan

These requirements are explained in more detail below. Always check with your PCP to see if he or she has followed the requirements.

The Referral Center can be reached at:

Local Calls: 421-3333
Long Distance Calls: (800) 572-2872

There are also special requirements for mental health and substance abuse care. These requirements are described later in this booklet.

AUTHORIZATION FOR SPECIALIST REFERRALS

When your PCP refers you to a **network** doctor in a specialty requiring authorization,

- your PCP will send the referral request to BCBSD
- BCBSD will review the referral
- if the request is medically necessary, BCBSD will authorize the request
- you, your doctor and the specialist will be notified of the authorization and the number of approved visits.

In rare cases, your PCP may refer you to a **non-network** specialist.

- If there is a doctor in BCBSD's network for that particular specialty, BCBSD will generally not authorize a medically necessary referral to a non-network specialist. Always ask your PCP if the referral doctor is a network doctor.
- If there is no network provider available, BCBSD will authorize a medically necessary referral to the non-network provider. However, you may be billed amounts over BCBSD's allowable charge if the non-network provider does not participate with BCBSD.

If a specialist refers you to another doctor, you must first contact your PCP. Only your PCP can refer you to a specialist.

If these requirements are not followed, BCBSD will deny payment.

AUTHORIZATION FOR HOSPITAL ADMISSIONS

For elective admissions into a hospital, your PCP will call BCBSD at least two days before the admission. (This doesn't apply to maternity or emergency cases.) BCBSD will review your case. From the review, BCBSD may

- find that care can be best provided as an outpatient, or
- authorize the admission and the number of approved inpatient days, or
- not authorize the admission.

For emergency admissions, you or your doctor must call us within 48 hours of admission. The Referral Center reviews the admission. If the admission is authorized, BCBSD will also determine the number of approved days.

If these requirements are not followed, BCBSD will deny payment for all services.

AUTHORIZATIONS FOR OTHER SERVICES

These requirements apply to:

- Skilled Nursing Facility admissions
- home health care
- home infusion
- PET scans

Your PCP must call the Referral Center for authorization at least two days before you begin having care. The Referral Center reviews the request. If authorized, BCBSD will also determine the number and type of approved services.

If these requirements are not followed, BCBSD will deny payment for all services.

AUTHORIZATIONS TO EXTEND YOUR CARE

Sometimes your hospital or Skilled Nursing Facility stay will need to be extended. Or, you may need more visits to a specialist. Your doctor must call for authorization before the last approved day or visit. The Referral Center reviews the request. If authorized, BCBSD will determine the additional days or visits.

If these requirements are not followed, BCBSD will deny payment for the additional days or visits.

CASE MANAGEMENT

When you need certain care, BCBSD may choose to provide optional benefits not normally included under your plan. These optional benefits will replace or minimize the need for existing health care plan benefits. Such benefits may include modification to copayments, coinsurance, deductibles or covered services. We work with you and your doctor when considering optional benefits.

Optional benefits may include

- coordinating care when you leave the hospital
- providing care in your home
- providing educational materials

BCBSD offers case managed optional benefits only as long as the benefits are medically necessary, and the total benefits paid aren't more than the plan benefits. When we provide optional benefits for you, it doesn't mean we need to provide optional benefits for you or anyone else at any other time or in any other situation.

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

PROVIDER RESPONSIBILITIES

Your PCP has agreed to follow BCBSD's Managed Care Requirements. He or she **may not** bill you for amounts denied, if:

- they didn't follow the requirements.

They **may** bill you for amounts denied, if:

- they did follow the requirements, and
- the Referral Center did not authorize services, and
- you chose to have them anyway.

GENERAL CONDITIONS

- If you do not comply with the requirements, BCBSD will deny payment.
- We do not pay for services that are not covered, even when the Referral Center authorizes them, except for expanded case managed care. When authorizing a service, the Referral Center only determines the medical necessity of the service, not whether the member's plan provides coverage for the service.
- You don't need to follow managed care requirements if this plan is secondary (see the section, *Coordination of Benefits*).

APPEALS

You may disagree with a decision the Referral Center makes. If so, you may file a written appeal with us. See the section, *Grievance and Appeals - How to Appeal a Claim Decision*, for more information.

EVALUATING NEW TECHNOLOGY AND TREATMENT

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

OUR EVALUATION PROCESS

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

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

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

The Committee uses the following evaluation criteria:

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

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

EMERGENCY AND URGENT CARE

EMERGENCY CARE

If you have a life-threatening emergency, go directly to the nearest emergency provider whether you're at home or traveling. Call your PCP as soon as possible. We cover the emergency facility and ancillary services when:

- the condition is serious enough to cause a prudent person to seek emergency care,
- a delay in care might cause permanent damage to your health, and
- you have care within 48 hours from the onset of the condition.

Some examples are:

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

COVERAGE FOR EMERGENCIES:

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

Emergency care is not paid if:

- you didn't have a life-threatening emergency, or
- your PCP didn't authorize your care in an emergency facility

Follow up care to an emergency also needs PCP authorization.

URGENT CARE

Urgent care is for an injury or sudden illness that isn't life threatening, but you need care within a day or two to avoid a serious problem. For urgent care you can either

- see your regular doctor, or
- seek care at an urgent care center.

An urgent care center is a medical facility staffed by physicians and other medical personnel equipped to provide treatment of minor illnesses and injuries of an urgent nature which require prompt, but not emergency treatment.

WHEN YOU'RE HOME

When you're home or anywhere in Delaware and need urgent care, call your PCP or go to an urgent care facility. You may call your PCP 24 hours a day, 7 days a week. Your PCP will

arrange the care you need. **Your PCP must provide or authorize in-area urgent care. Without PCP authorization, payment is denied.**

WHEN YOU'RE TRAVELING

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

Step 1

Find a provider. You can call (800) 810-BLUE [(800) 810-2583] to get connected to a 24-hour referral service. You can also use the BCBS.com website to find a provider. This service helps you find doctors who participate with the local Blue Cross Blue Shield plan where you're traveling. If a doctor is found, you're given the doctor's name, office address and phone number.

Step 2

Contact your PCP to get authorization for care. Your PCP will let BCBSD know that your care is authorized.

Step 3

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

Step 4

If you need follow-up care, find a provider by following Step 1. Then call BCBSD to get authorization.

PRIMARY CARE AND PREVENTIVE CARE PROGRAMS

Check the *Schedule of Benefits* for limits and payments.
Care must be given by or authorized by your PCP!

PRIMARY CARE SERVICES

DOCTOR VISITS

Visits are covered with your PCP, at home or at the PCP's office.

PREVENTIVE CARE

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

Please note: BCBSD has the right to change these benefits at any time. We will send written communication of our preventive updates.

EXAMINATIONS

Benefits are provided for:

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

TESTS AND SCREENINGS

Some examples of covered routine tests 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 BCBSD to be experimental in nature are not covered.

PERIODIC VISION EXAMS

For adults age 18 and older:

- One routine eye exam is covered every 24 months

For children:

- Routine eye exams are covered as part of routine physical exams. Children need PCP authorization to see an optometrist or ophthalmologist.

PERIODIC HEARING EXAMS

Periodic hearing exams are covered as part of PCP office visits. Visits to specialists or audiologists are covered under *Specialist Care*.

DIABETES EDUCATION

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

NUTRITIONAL COUNSELING

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

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

HOSPITAL AND OTHER FACILITY BENEFITS

Check the *Schedule of Benefits* for limits and payments.

Follow managed care requirements and PCP rules to get the highest benefit!

INPATIENT HOSPITAL CARE

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

Room And Board

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

Other Hospital Care

When medically necessary, we cover:

- use of operating room and recovery room
- drugs listed in the U.S. Pharmacopoeia or National Formulary
- therapy:
 - chemotherapy by a doctor
 - occupational therapy as called for in your doctor's treatment plan when:
 - needed to help your condition in a reasonable and predictable time, or
 - needed to establish an effective home exercise program
 - physical therapy as called for in your doctor's treatment plan when:
 - done by a doctor or licensed physical therapist, and
 - needed to help your condition in a reasonable and predictable time, or
 - needed to establish an effective home exercise program
 - radiation therapy for cancer and neoplastic diseases
 - inhalation therapy by a doctor or registered inhalation therapist
 - speech therapy, when
 - done by a licensed or state certified speech therapist; and
 - ordered by a doctor; and
 - done to improve speech impairment caused by:
 - disease
 - trauma
 - congenital defect
 - recent surgery
 - cognitive therapy done by an approved provider. There's a 30 consecutive day limit that begins on the first day of treatment. The diagnoses eligible for coverage are
 - stroke with cognitive impairment, or
 - head injury or trauma.
 - cardiac therapy. There's a limit of 3 sessions per week and 3 months of treatment. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.

- surgical dressings
- administration of blood or blood plasma (but not blood itself)
- machine tests
- imaging exams (such as X-rays)
- durable medical equipment
- lab exams
- dialysis

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy
- childbirth
- miscarriage

There are no time limits for childbirth admissions. This plan complies with the Newborns' and Mother's Health Protection Act of 1996, which states that group health plans may not restrict mothers' and newborns' benefits for a childbirth admission to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Maternity admissions may be less than the 48 or 96 hours only if both you and your doctor agree.

See the section, *Early Maternity Discharge Program*, for information about more maternity benefits.

CARE OF NEWBORNS

Infants are covered for the first 31 days after the infant's birth. There is no coverage for the child after the 31 days unless:

- a parent has coverage that includes children, or has requested that enrollment change within the first 31-day period by notifying their Human Resources/Benefits Office, and
- the baby is added to the coverage, and
- if applicable, pays any additional premium.

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

OUTPATIENT SURGICAL FACILITIES

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

- hospitals
- approved ambulatory surgical centers

Dental surgery is normally only covered when done in the dentist's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by BCBSD. Please refer to the Dental Surgery description in the section entitled *Surgical and Medical Benefits*, below.

EMERGENCY ROOM

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

SKILLED NURSING FACILITIES (SNFs)

You're covered for up to 120 days per confinement in a SNF. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient SNF care.

The plan covers:

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

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

SURGICAL AND MEDICAL BENEFITS

Check the *Schedule of Benefits* for limits and payments.

Follow managed care requirements and PCP rules to get the highest benefit!

SURGICAL BENEFITS

Surgical services include:

- cutting and operative procedures (including reconstructive surgery following a mastectomy)
- treatment of fractures and dislocations
- delivery of newborns

These services can be done:

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

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

Dental Surgery

Dental surgery is only covered for:

- extracting bony impacted teeth; or
- correcting accidental injuries (to the jaws, cheeks, lips, tongue, roof and floor of mouth).
Coverage is not provided for the extraction of normal, abscessed or diseased teeth or for the removal, repair or replacement of teeth damaged due to accidental injuries or disease even if such services are necessary to correct other injuries suffered as a result of accident or disease.

Such surgery is covered when done in a dentist's office. We must approve dental surgery done in a hospital outpatient department or ambulatory surgical center.

Multiple Surgical Procedures

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

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

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

- we cover the entire procedure as one stage.

ANESTHESIA

Anesthesiologist services are covered when medically necessary.

ORGAN TRANSPLANTS

The benefits described below apply to transplants for:

- heart
- combined heart and lung
- lung/lobar lung
- pancreas
- small bowel
- liver
- small bowel and liver
- multivisceral
- kidney
- cornea
- Autologous bone marrow transplant/stem cell
- Allogenic bone marrow transplant/stem cell

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

- Transplants performed at a Blue Distinction Centers for Transplant (BDCT) are covered at the level of the member's inpatient facility benefit for network providers. Copayments, deductibles and coinsurance, if any, will apply. Pricing is at a global rate established by the Blue Cross Blue Shield Association based on the BDCT contract with the individual facility, and includes payment of the organ acquisition.
- Transplants performed at non-BDCT, but participating hospitals are covered with a 20 percentage point reduction of the benefit level for inpatient, outpatient facility or professional services.
- For the period January through December 2009, this sanction will not apply to claims for transplant services provided at The Nemours Foundation, Children's Hospital of Philadelphia or Christiana Care Health Systems. Starting in January 2010, claims for services provided at these facilities will be subject to the sanction.
- Except for kidney and cornea transplants, the maximum benefit for organ harvesting and procurement is \$10,000 for each cadaveric organ and up to \$45,000 for each organ procured from a living donor. Maximums are subject to copayments, deductibles and coinsurance, if any. Maximums for kidney and cornea transplants are determined by BCBSD.
- Transplants performed at non-participating hospitals are not covered.
- Travel/Lodging/Meal Reimbursement Benefits
 - Benefit begins 5 days prior to transplant event
 - Coverage is for the recipient and one other person. If the recipient is a minor, the cost for two other people is covered.
 - Covers travel to and from the transplant site (ground or air travel, mileage (based on IRS guidelines), tolls and parking
 - Reasonable lodging and meal costs are covered. There is a \$150 per day limit.
 - The aggregate benefit may not exceed \$10,000 nor extend more than 3 months after the date of the transplant.

ARTIFICIAL INSEMINATION (AI)

Artificial insemination (AI) procedures are covered when done as an outpatient. The following limits apply:

- dependent children aren't covered for AI procedures
- there's a proven infertility problem
- infertility isn't due to voluntary sterilization
- donor services aren't paid

There's a \$600 lifetime payment limit. Charges are paid at the same benefit level as other similar services. The \$600 limit includes only approved AI procedures. The \$600 limit applies even when you switch to another BCBSD plan or to another plan offered by the State of Delaware. If pregnancy results, your maternity benefits are then applied.

IN VITRO FERTILIZATION (IVF)

The following procedures are covered when done as an outpatient:

- In vitro fertilization (IVF)
- gamete intrafallopian transfer (GIFT)
- zygote intrafallopian transfer (ZIFT)

The following limits apply:

- dependent children aren't covered for any of the above procedures
- women must be at least age 18 and must not have reached their 45th birthday
- there is a proven infertility problem
- infertility isn't due to a voluntary sterilization
- other infertility methods must have been tried (this includes artificial insemination)
- a pretreatment plan must be approved by BCBSD.

There's a \$30,000 lifetime payment limit. Charges are paid at the same benefit level as outpatient surgery. The \$30,000 limit applies even when you switch to another BCBSD plan or to another plan offered by the State of Delaware. If pregnancy results, your maternity benefits are then applied.

Services included in the \$30,000 maximum are:

- office visits
- surgical services
- hospital outpatient services
- anesthesia
- lab exams
- prescription drugs

Donor services are not covered.

INPATIENT MEDICAL SERVICES

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

We normally cover one doctor visit per day. Usually this is your attending doctor. If another specialist visits you, we may cover the visit. Visits must be medically necessary.

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

INPATIENT CONSULTATION SERVICES

Inpatient consultation services are covered when:

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

Only one consultation per specialty per admission is covered.

EMERGENCY CARE

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

OBSTETRIC CARE

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

- prenatal care
- anesthesia
- delivery
- postnatal care

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

Remember, you may see a network OB/GYN for OB/GYN care without your PCP's authorization.

There are no time limits for childbirth admissions. This plan complies with the Newborns' and Mothers' Health Protection Act of 1996, which states that group health plans may not restrict mothers' and newborns' benefits for a childbirth admission to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Maternity admissions may be less than the 48 or 96 hours only if both you and your doctor agree.

See the section, *Early Maternity Discharge Program*, for information about more maternity benefits.

NEWBORN CARE

Infants are covered for the first 31 days after the infant's birth: There is no coverage for the child after the 31 days unless:

- a parent has coverage that includes children, or has requested that enrollment change within the first 31-day period by notifying their Human Resources/Benefits Office, and
- the baby is added to the coverage, and
- if applicable, pays any additional premium.

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

THERAPEUTIC AND DIAGNOSTIC SERVICES

Check the *Schedule of Benefits* for limits and payments.

Follow managed care requirements and PCP rules to get the highest benefit!

INPATIENT THERAPEUTIC AND DIAGNOSTIC CARE

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

OUTPATIENT THERAPEUTIC AND DIAGNOSTIC CARE

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

- a provider's office
- an approved lab
- a hospital's outpatient department

THERAPY SERVICES

Covered care includes:

- chemotherapy by a doctor
- occupational therapy as called for in your doctor's treatment plan. There's a 60 consecutive day limit per acute condition. Only the facility charge is covered. Therapy must be:
 - needed to help your condition in a reasonable and predictable time, or
 - needed to establish an effective home exercise program.
- physical therapy as called for in your doctor's treatment plan. There's a 45 visit limit per acute condition. Therapy must be:
 - done by a doctor or licensed physical therapist, and
 - needed to help your condition in a reasonable and predictable time, or
 - needed to establish an effective home exercise program.
- radiation therapy for cancer and neoplastic diseases
- inhalation therapy by a doctor or registered inhalation therapist
- speech therapy. There's a 60 consecutive day limit per acute condition. Therapy must be:
 - done by a licensed or state certified speech therapist
 - ordered by a doctor
 - needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery
- dialysis
- cognitive therapy done by an approved provider. There's a 30 consecutive day limit that begins on the first day of treatment. The diagnoses eligible for coverage are
 - stroke with cognitive impairment, or
 - head injury or trauma.
- cardiac therapy. There's a limit of 3 sessions per week and 3 months of treatment. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures

DIAGNOSTIC SERVICES

Covered care includes:

- imaging services
- lab tests
- machine tests

OTHER COVERED SERVICES

Check the *Schedule of Benefits* for limits and payments.

Follow managed care requirements and PCP rules to get the highest benefit!

HOSPICE

Hospice provides palliative and support care to terminally ill patients and their families. Hospice is covered up to 240 consecutive days from the first day of care. BCBSD must authorize the hospice care.

You may have hospice care at home, in an inpatient hospice facility or a nursing home.

What Is Covered Under Hospice:

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

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

- care by a non-hospice doctor
- prescription drugs
- durable medical equipment (DME)
- imaging and lab tests
- inhalation therapy

What's Not Covered Under Hospice:

- respite care
- private duty nursing
- care not prescribed in the approved treatment plan
- chemotherapy or radiation therapy (except when needed to manage the illness)
- financial, legal or estate planning
- hospice care in an acute care facility

HOME HEALTH CARE

Home health care is covered. The provider must be approved by BCBSD. BCBSD must authorize the treatment plan. BCBSD may review the plan every 30 days.

Guidelines:

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

What Is Covered Under Home Health:

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

What's Not Covered Under Home Health:

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

HOME INFUSION

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

What Is Covered Under Home Infusion:

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

What's Not Covered Under Home Infusion:

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

INPATIENT PRIVATE DUTY NURSING

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

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

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

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

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

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

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

When you can travel by private car, the ambulance isn't covered. Only one-way travel to the hospital is covered. Air ambulance is covered only when no other means of travel is appropriate.

When billed separately, these items are not paid:

- patient care equipment
- reusable devices
- first aid supplies

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

SPECIALIST/REFERRAL CARE

Home and office visits with specialists are covered.

ALLERGY TESTING AND TREATMENT

Allergy testing and treatment are covered.

SECOND SURGICAL OPINION

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

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

Elective surgery is surgery that

- is covered under this plan, and
- is not an emergency

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

CHIROPRACTIC CARE

The following care is covered when done by a licensed chiropractor:

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

The following limits apply:

- three modalities per visit
- one visit per day
- 60 consecutive days per acute condition
- treatment must:
 - help your condition in a reasonable and predictable time, or
 - be needed for an effective maintenance program.

X-rays of the spine ordered by a chiropractor are covered under your outpatient imaging benefit. You must use the network imaging provider. X-rays by chiropractors aren't covered.

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

Machine tests are covered. They are covered under your Machine Testing benefit.

DURABLE MEDICAL EQUIPMENT

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

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

Some examples of DME are:

- prosthetic devices including wigs for hair loss caused by chemotherapy or alopecia areata resulting from an autoimmune disease.
- orthopedic braces

- wheel chairs
- hospital beds

We also pay to replace or repair prosthetic devices.

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

We also pay for medical foods and formula for the treatment of inherited metabolic disorders.

Hearing Aid Benefit

Hearing Aids are covered for members under age 24. One hearing aid and one replacement per member are covered within a 36-month period; replacement at a greater frequency requires a medical necessity determination. Repairs and replacement of batteries are not covered.

DME Not Covered:

- items for comfort or convenience
- dental prosthetics
- orthotics
- diabetic supplies covered through your pharmacy benefits provider.

CARE FOR WEIGHT LOSS

All weight loss care must be approved by BCBSD and under the care of a doctor. Weight loss coverage includes:

- office visits
- lab tests
- drug therapy, if the patient's Body Mass Index (BMI) is 30 or greater, or 27 or greater with one or more chronic, weight-related diseases

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

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

SURGERY FOR MORBID OBESITY

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

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

You must:

- have achieved full growth and be 18 years or older, and
- have no specific, treatable, correctable cause for the morbid obesity (e.g., endocrine disorder), and
- have completed a structured diet program in the 2-year period that immediately precedes the request for the surgery, and

- have received a psychological evaluation specifically for the diagnosis of obesity or morbid obesity, and
- meet any of the following criteria:
 - you weigh at least 100 pounds above or are twice the ideal body weight; or
 - have a BMI of at least 40; or
 - have a BMI equal or greater than 35, in conjunction with one or more of the following co-morbid conditions: degenerative joint disease, hypertension, coronary artery disease, diabetes, sleep apnea, lower extremity venous/lymphatic obstruction, or obesity related pulmonary hypertension.

Benefits for surgery for morbid obesity are paid like other surgical procedures.

MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE

Your plan has Mental Health and Substance Abuse Managed Care Requirements. The requirements help assure the care you receive is appropriate. If you don't follow these requirements, payment is denied.

WHAT YOU MUST DO

When you need mental health or substance abuse care, follow these steps:

- **Call the Behavioral Health Care Department.** The Behavioral Health Care Department is staffed by trained professionals. They review your needs and approve your care. If you can't call yourself, your provider or a friend may call us. Make sure we're called before having care. You may reach the Behavioral Health Care Department at:

Local Calls: (302) 421-2500

Long Distance Calls: (800) 421-4577

- **Use the approved network provider.** The Behavioral Health Care Department refers you to a network provider. You must use the network provider.
- **Follow the approved treatment plan.** The Behavioral Health Care Department works with your provider to set up a treatment plan. Follow the treatment plan to get coverage.

IF YOU ARE ALREADY RECEIVING CARE

If you were receiving care before this health care plan began, let us know right away. The Behavioral Health Care Department will work out a transition treatment plan. You must notify us within 30 days after this health care plan begins.

IN AN EMERGENCY

If you need emergency care and are unable to contact us, seek care right away. You must call us within 24 hours of receiving emergency care. If you can't call yourself, your provider or a friend may call us.

HOW BENEFITS MAY BE DENIED

If you don't follow the requirements, payment is denied.

PROVIDER RESPONSIBILITIES

All mental health and substance abuse network providers agree to follow these requirements. They may not bill you for amounts reduced or denied if they didn't follow the requirements.

Non-network providers may not know about the requirements. If you see a non-network provider, you may be billed the full charge.

APPEALS

You may disagree with a decision the Case Manager makes. If so, you may file a written appeal with us.

See the section, *Grievance and Appeals-How To Appeal A Claims Decision* for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Refer to the *Schedule of Benefits* for limits and payments.
Also, refer to the requirements for Mental Health and Substance Abuse Managed Care.

SERIOUS MENTAL ILLNESS

You may get more information about coverage for Serious Mental Illness by referencing Title 18, Chapter 33, Section 3343, of the Delaware Code.

Definition

"Serious Mental Illness" means any mental health disorder that is in one of the following categories:

- schizophrenia
- bipolar disorder
- obsessive-compulsive disorder
- major depressive disorder
- panic disorder
- anorexia nervosa
- bulimia nervosa
- schizo-affective disorder
- delusional disorder

How the Law Affects Your Coverage

A health benefit plan may condition coverage of services provided in the diagnosis and treatment of a serious mental illness on the further requirements that the service(s):

- must be rendered
 - by a mental health professional licensed or certified by the State Board of Licensing, or
 - in a mental health facility licensed by the State or substantially similar licensing entities in other states; and
- must be medically necessary; and
- must be covered services subject to any administrative requirements of the health benefit plan.

A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a serious mental illness in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned.

HOW MENTAL HEALTH BENEFITS ARE PAID

Payment of mental health benefits depends upon whether you have care for

- Serious Mental Illness, or
- other mental health disorders

Benefits for Serious Mental Illness

When managed care requirements are met, benefits for a Serious Mental Illness are paid at the same level as any other illness. For example, inpatient hospital benefits for a Serious Mental Illness are the same as inpatient hospital benefits for having a surgical procedure.

Benefits for Other Mental Health Disorders

You are covered for other mental health disorders. You must follow managed care requirements or your benefits will be reduced. The *Schedule of Benefits* shows how benefits are paid when you have care for other mental health disorders.

MENTAL HEALTH BENEFITS

The following describes benefits for all mental health care, including care for Serious Mental Illness.

INPATIENT CARE

You're covered for inpatient mental health care for approved diagnoses. This benefit covers doctor and facility costs. Electroconvulsive therapy by a doctor is also covered.

PARTIAL HOSPITAL CARE PROGRAM

Partial Hospital Care is a program for patients who:

- are not confined to a facility, and
- need intensive care not available as an outpatient.

Care is provided for 8 or fewer hours per day.

OUTPATIENT CARE

Outpatient care covers:

- brief crisis intervention psychotherapy
- psychiatric consultations
- supportive psychotherapeutic treatment
- psychological tests (limit of 8 hours of tests per year)

Outpatient care includes:

- attention deficit disorder (ADD), and
- attention deficit hyperactivity disorder (ADHD).

Care must be by a network provider such as a

- doctor, or
- licensed clinical psychologist, or
- licensed clinical social worker.

Care must be done in the provider's office or as a hospital outpatient. Such care must first be reviewed by a doctor.

What's Not Covered

- aptitude tests
- learning disabilities
- personality disorders
- care past the time needed to determine mental deficiency or retardation
- mental disorders not likely to improve

SUBSTANCE ABUSE BENEFITS

Care is covered for treatment of alcoholism and drug addiction. Care is covered as an inpatient, intensive outpatient, or office visit. The program, and for inpatient/intensive outpatient care, the hospital or specialized care facility, must be approved by BCBSD.

HOW AUTHORIZED SUBSTANCE ABUSE BENEFITS ARE PAID

Benefits for Substance Abuse Treatment

When managed care requirements are met, benefits for substance abuse treatment are paid at the same level as any other illness. For example, inpatient hospital benefits for substance abuse are the same as inpatient hospital benefits for having a surgical procedure.

The benefits are subject to the same plan copayments, deductibles or coinsurance, if any, as other non-substance abuse care benefits.

Unauthorized or Out-of-Network substance abuse care is not covered.

WHAT IS NOT COVERED

The following services and items are not covered. They aren't covered even if authorized by your PCP.

- Injury or illness on the job. This includes any care normally covered under Workers' Compensation or occupational disease laws.
- Care given by institutions or agencies owned or operated by the government, unless the law requires otherwise. This includes the Veteran's Administration.
- Care needed through an act of war. This applies if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care as a result of any criminal act in which you conspired or took part. One example is BCBSD does not pay for the court mandated instruction course or rehabilitation program resulting from driving under the influence of alcohol or drugs.
- Care given by a family member. This includes parents, children, spouse or siblings.
- Care given by any person living with you.
- Care you can have without charge in the absence of insurance.
- Rest cures, custodial care or homelike care. This applies even if prescribed by a doctor.
- Exams or tests done as inpatient for convenience. This applies when such care could be done as outpatient.
- Dental care, except certain dental care noted in the *Medical and Surgical Benefits* section.
- Eyeglasses, contact lenses and all procedures for refractive correction.
- Hearing aids for members age 24 and over.
- Eye or hearing exams, unless noted elsewhere in this booklet.
- Treatment of Temporomandibular Joint (TMJ) Dysfunction Syndrome. This includes exams, fittings, nutrition counseling and occlusal adjustment. However, you do have coverage for the treatment of TMJ Dysfunction caused by
 - Documented organic joint disease, or
 - Joint damage as a result of physical trauma.Benefits for a TMJ appliance are not covered.
- Routine foot care.
- Orthotic equipment and devices, such as:
 - foot inserts
 - arch supports
 - lifts
 - corrective shoes
- Blood, blood components and donor service.

- Care for cosmetic reasons. This includes routine care of acne and hair loss.
- Care not directly related to diagnosis or treatment of illness or injury. Care must:
 - be consistent with the symptom or treatment of the condition
 - meet the standard of accepted professional practice
 - not be solely for anyone's convenience
 - be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient.
- Routine exams, unless noted elsewhere in this booklet. Excluded are exams for:
 - potential employers
 - insurers
 - schools
 - camps
 - marriage physicals
 - any other third party
- Computerized gait analysis or electrodiagnostic tests.
- Care for vision therapy or orthoptics.
- Immunization or inoculations that are not considered routine childhood immunizations and/or immunizations that are not listed in the current Preventive Health Guidelines. Immunizations or inoculations for travel are not covered.
- Care given by your employer's health department.
- Care we consider to be experimental or investigational. This includes care we consider not to be accepted medical practice. This also includes care that requires government agency approval, and the approval hasn't been granted.
- Prescription drugs, even if your doctor writes you a prescription. Prescriptions are covered through the prescription vendor contracted with the State of Delaware.
- We cover one service per day by a professional provider. If more than one service is done, we cover only the service with the greater allowable charge.
- Care by:
 - a school infirmary
 - a student health center
 - staff working at the above
- Drugs or care received in violation of law.
- Speech therapy for:
 - attention disorders
 - behavior problems
 - conceptual handicaps
 - learning disabilities
 - developmental delays
- Occupational or physical therapy for developmental delay.

- Change of sex surgery, except to correct congenital defect.
- Surgery to reverse voluntary sterilization.
- Thermography.
- Acupuncture.
- Massage Therapy.
- Nutritional Counseling, except when a patient is diagnosed with certain conditions that render such counseling medically necessary.
- Enteral nutrition ingested or administered orally, even if it is the sole nutritional source. The only exceptions are certain medical foods prescribed for inherited metabolic disorders.
- Convenience items, including:
 - phones
 - TVs
 - radios
 - other personal items

VALUE ADDED FEATURES

BCBSD offers Value Added Features. These features include Eyewear Discounts and Discount Programs. These features are described briefly below.

The Value Added Features program is subject to all terms and conditions of this Contract. Value Added Features are administered only as specified in the BCBSD Value Added Features materials.

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

EYEWEAR DISCOUNTS

Your BCBSD coverage includes an eyewear discount program. You and your family 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 (800) 424-1155.

To get more information about this program, please contact the Statewide Benefits Office, OMB or call BCBSD Customer Service at (302) 429-0260 or (800) 633-2563.

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

DISCOUNT PROGRAMS

Valuable discounts on a variety of services are available to BCBSD members. Some of these services are health-related (for example involving fitness, nutrition and weight management as well as alternative therapies and wellness services) and others are not (for example, financial consulting). Health-related discounts include such services as acupuncture, massage therapy, chiropractic care, fitness club memberships, laser vision correction, mail order contact lenses, hearing aids, and eldercare management when receiving care from one of the program's participating providers. For more information on the Discount Programs, please call BCBSD Customer Service or visit our website at bcbsde.com.

A GUIDE TO CLAIMS

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

HOW TO FILE CLAIMS

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

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

WHEN YOU USE A PARTICIPATING PROVIDER

A provider participating with BCBSD files claims for you. The provider also accepts BCBSD's allowable charge as full payment for covered services. You still pay your share (any copayment or coinsurance). BCBSD pays participating providers for your care.

WHEN YOU USE A NONPARTICIPATING PROVIDER

Some providers don't participate with BCBSD. These providers may ask you to pay full cost for your care.

You may need to submit a claim for your care. We'll pay the allowable charge to you, less any copayment or coinsurance. This is the same payment we make to participating providers.

You must pay any balance over our payment.

WHEN YOU'RE OUT OF AREA

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

If the local plan is in the BlueCard® Program:

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

If the local plan isn't in the BlueCard Program:

- you must file the claim with BCBSD

IF YOU NEED TO FILE A CLAIM

To file a claim, you'll need a claim form. To obtain a form, call Customer Service. Let us know how many forms you need. We'll send your forms right away. Please follow the instructions on the form. Attach an itemized receipt from the provider. Send your claim to this address:

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

GRIEVANCE AND APPEALS - 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:

APPEAL PROCESS

- To appeal a decision, you or your representative must contact BCBSD's Customer Service Department within 180 days from the date you received the decision. You may call BCBSD or you may use the Appeal Form on the BCBSD website, bcbsd.com. There is no cost to appeal. Please explain why you believe the decision was wrong, provide any additional relevant information, and submit this to BCBSD. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.

- Call or write BCBSD at:

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

Local Calls: (302) 429-0260
Long Distance: (800) 633-2563

- A qualified reviewer, who did not participate in the initial decision, will be appointed to conduct the appeal.
- Pre-service decision: For appeals relating to a service you have not received (BCBSD denied authorization and you have not received the service or treatment), you will be notified of the appeal decision within 30 days of your request. You may request an expedited appeal for coverage relating to an emergency medical treatment or a life-threatening illness. BCBSD will make an expedited appeal decision and notify you and your provider within 72 hours of your request.
- Post-service decision: For appeals relating to a service you have already received, you will be notified of the decision within 30 to 60 days of your request for an appeal.

AFTER THE APPEAL

- If you have appealed a decision involving medical judgment, experimental or investigational care and are not satisfied with the outcome, you are eligible for an independent review. You must contact BCBSD Customer Service Department in writing within 60 days of the date you received the appeal decision. Please include the appeal decision letter and all pertinent information that supports your request for review. BCBSD will arrange for a review by a medical provider who practices in the same or similar specialty at issue and who has not been involved in the initial decision or the appeal. There is no cost to you for this independent review. You will receive a written decision within 30 to 45 days.
- An expedited review is available if your physician certifies that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3 to 5 calendar days after receipt by BCBSD.
- If you request, BCBSD will provide copies of all records relevant to the appeal decision.

If you would like more information, please contact BCBSD Customer Service.

COORDINATION OF BENEFITS

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

Your spouse's benefits will be sanctioned, and we will pay 20% for your spouse's benefits if:

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

TERMS

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

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

ORDER OF BENEFITS DETERMINATION

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

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

This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

EFFECT ON BENEFITS

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if
 - the State's plan is secondary, and
 - the other plan had paid the normal payment.

HOW COB WORKS WITH MANAGED CARE

The rules below will apply to you, your spouse and your dependent children.

COB When This Plan is Primary

The State's managed care rules must be followed. If you don't, benefits are coordinated by applying the penalties of this plan.

COB When This Plan is Secondary

BCBSD will never pay more than what we would pay if this plan were primary.

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

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

We will coordinate benefits if the primary plan:

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

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

Exceptions are:

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

A GUIDE TO ENROLLMENT INFORMATION

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You
- Your spouse
- Your unmarried children

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

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

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

YOU ARE ELIGIBLE TO BE COVERED IF:

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

CHILDREN

To be covered, a child must be

- unmarried, and
- under age 21, and

- either
 - born to you or your spouse,
 - adopted by you or your spouse,
 - placed in your home for adoption, or
 - living in your home in a parent/child relationship (however, if the child's parent also lives in your home, the child is not eligible for coverage)

The State will require proof of dependency, such as a birth certificate, adoption papers or court order.

FULL-TIME STUDENTS

Full-time Students can be covered up to age 24. You must submit a *Student Certification Form* each year to receive coverage. We must receive the form before August 1. You may get the form from us.

The child must take a minimum of 12 credit hours every semester. However, only 9 credit hours are necessary if the student is in the semester before graduation. A student nurse must be enrolled in a degree program.

The school must have

- a regular faculty, and
- a set curriculum, and
- a regular student body attending.

The school may be a

- prep school, or
- junior college, or
- seminary, or
- university

DISABLED CHILDREN

Disabled children can be covered after age 21 (or age 24 for students). They may be covered if:

- they were covered by BCBSD before reaching age 21 (or age 24 for students), and
- they are not married, and
- they cannot support themselves because of a disability, and
- their disability happened before age 21 (or age 24 for students), and
- they depend on you for support.

You must file a *Disabled Child Application* form with BCBSD. You may get the form from us.

THE ADULT DEPENDENT PROGRAM

The Adult Dependent Program is designed to provide health care coverage to an employee's or a pensioner's adult dependent child(ren), biologically or by law, who meet(s) all of the following eligibility requirements. The adult dependent must:

- be less than 24 years of age;
- be unmarried;
- have no dependents of his/her own;
- be either a resident of the State of Delaware or enrolled as a full-time student at an accredited institution of higher learning; and

- not be provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under Medicare.

Members who enroll in the Adult Dependent Program are not eligible for some services described in this booklet. Additionally, enrollment and appeal rights are different. These differences will be clarified for those members enrolling in the program.

Contact BCBSD Customer Service for more information about the Adult Dependent Program.

SPOUSE'S BENEFITS

This is how we pay benefits for spouses enrolled under this plan:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse
 - is eligible for, and
 - **is** enrolled in his/her employer's plan.
- We pay 20% of allowable covered charges if your spouse
 - is eligible for, and
 - **is not** enrolled in his/her employer's plan.

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

The above will not apply if your spouse is not enrolled in his/her employer's plan because your spouse

- doesn't work full-time, or
- isn't eligible because he/she doesn't work enough hours to be eligible, or
- isn't eligible because he/she hasn't completed a waiting period, or
- has to pay more than 50% of the plan's cost (including flexible credits), or
- doesn't have health coverage at work.

ENROLLMENT

ENROLLMENT DATE

Your enrollment date is the later of

- your date of hire for Timely Enrollees (if you're in an employee class eligible for health coverage), or
- the date you move to an employee class that is eligible for health coverage (such as going from part-time to full-time employee), or
- the date coverage begins if you're a Special Enrollee or a Late Enrollee.

HOW TO ENROLL

You may enroll yourself and your dependents when you are first eligible or at Open Enrollment by completing an enrollment form/application and returning it to your Human Resources/Benefits Office (with any premium owed). If you want to cover your spouse, you'll need to complete the *Spousal Coordination of Benefits Form*. You can get both the enrollment form/application and Spousal COB form from your Human Resources/Benefits Office.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You will need to complete an enrollment form/application indicating you are waiving coverage and return it to your Human Resources/Benefits Office.

WHEN COVERAGE BEGINS

When your coverage begins is determined by

- when you are eligible for coverage, and
- when you enroll for coverage.

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

- Timely Enrollee, or
- Special Enrollee, or
- Late Enrollee

TIMELY ENROLLEES

Who Can be a Timely Enrollee

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

When Coverage Begins

Coverage for new employees (and their dependents) begins

- on the first of the month following the employee's hire date, or
- on the first of the month following the date of enrollment when an employee moves to a class that is eligible for health coverage.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

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

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

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

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

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

Loss Of Other Coverage

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

- you were covered under another group or individual health plan when coverage was previously offered under this plan (when first eligible or during Open Enrollment), and
- when this plan was previously offered, you declined coverage under this plan because you had other coverage, and
- the other coverage was either:
 - COBRA continuation coverage that is exhausted, or
 - other (non-COBRA) coverage that was lost because
 - you are no longer eligible, or
 - the lifetime limits under the other coverage were reached, or
 - the employer stopped contributing, and
- you enrolled within 30 days of the date the other coverage was lost, and
- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*.

New Dependents

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

- marriage, or
- birth, or
- adoption, or
- placement of a child in the home for adoption, or
- court ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows if the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted:

- *Employees*: the first day of the month after the loss of coverage
- *Spouses*: either the date of the marriage or the first day of the month after the marriage
- *Children*: either
 - the date of birth, adoption or placement in the home for adoption; or
 - the first day of the month after you request enrollment if
 - you lost coverage under a prior plan, or
 - your parent got married.

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

Don't forget, when you get married and add your spouse, you'll also need to complete the *Spousal Coordination of Benefits Form*.

LATE ENROLLEES

Who Can Be A Late Enrollee

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

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

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

When Coverage Begins

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

CHANGES IN ENROLLMENT

You can change your enrollment because of one of the reasons described below.

MARRIAGE

You may add your spouse when you get married. You must request enrollment within 30 days after the marriage. If added premium is due, you must pay when you request enrollment. If you request enrollment within the 30-day period, your spouse will be a Special Enrollee. If you don't request enrollment within the 30-day period, your spouse will be a Late Enrollee.

Don't forget, when you get married you'll also need to complete the *Spousal Coordination of Benefits Form* and **provide a copy of your marriage certificate to your Human Resources/Benefits Office.**

NEWBORNS

You may add your newborn child. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. The baby is covered for the first 31 days after the infant's birth. There is no coverage after that 31-period unless:

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

If you request enrollment within the 31-day period, the newborn will be a Special Enrollee. If you don't request enrollment within the 31-day period, the child will be a Late Enrollee.

ADOPTED CHILDREN

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date of adoption or placement in the home in order for the child to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

OTHER CHILDREN

You may add a child other than a newborn or adopted child, such as a stepchild. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment for your child within 30 days of the date the child became eligible in order to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

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

When your COBRA continuation coverage is exhausted, you may request enrollment in this plan within 30 days. If you request enrollment within the 30-day period, you will be a Special Enrollee. If you don't request enrollment within the 30-day period, you will be a Late Enrollee.

MEDICARE ELIGIBILITY

At age 65 you become eligible for Medicare. Medicare is provided by the Federal Government. It is not part of this health care plan.

If you are an active employee working at age 65, you have a choice of benefit plans:

- you can continue coverage in this plan until you retire. This plan will be primary.
- you can be covered under Medicare. Medicare will be primary. You won't have any other coverage through the State. You can buy Medicare Supplemental coverage directly from BCBSD.

About three months before you reach age 65, contact

- your Human Resources Office, and
- Social Security Administration Office

Follow the same guidelines when your spouse reaches age 65.

You have to be an active, full-time employee

- to be covered under this plan when you reach age 65.
- for your spouse to be covered under this plan when he or she reaches age 65.

Please note: If your option is Medicare Supplemental coverage with BCBSD, you must be enrolled in and keep both Parts A and B of Medicare to be covered.

HIPAA CERTIFICATE OF CREDITABLE COVERAGE

A federal law called HIPAA requires that the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. A certificate will also be automatically issued on the termination of any individuals covered under the Plan, whether or not a request is made. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new health plan in which the individual enrolls to request a Certificate from this Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to your organization's Human Resources Office.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- Where a certificate is requested for a dependent individual, the name of the participant who enrolled in the Plan; and
- The name of the participant who enrolled the individual in the Plan; and
- A telephone number to reach the individual for whom the Certificate is requested or the participant who enrolled the individual, in the event of any difficulties or questions.
- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, your organization's Human Resources Office will send a request to the State of Delaware COBRA/HIPAA Administrator to provide the Certificate as soon as administratively feasible.

WHEN COVERAGE ENDS

The State of Delaware COBRA Administrator will provide you and your dependents with a standard *Certificate of Coverage* when you lose coverage under this plan. Also, you have up to 24 months following the loss of coverage to request a certificate. The *Certificate of Coverage* will show how long you were covered under this plan.

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

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

DIVORCE

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. State "divorce" as the reason for the change.

Coverage ends on the date of the divorce.

LEAVE YOUR JOB

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

DEATH

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

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

CHANGE IN YOUR JOB STATUS

Coverage ends when you're no longer eligible through your job. This might happen if you begin to work fewer hours, etc. Please refer to the section, *You Are Eligible To Be Covered If*, above.

CHANGE IN CHILD'S STATUS

Your child's coverage ends the earlier of:

- December 31 of the year the child reaches age 21
- when the child marries
- the end of the month that the child is no longer a full-time student (such as when he or she graduates)
- the end of the month in which a full-time student reaches age 24

THE PLAN IS CANCELED

Coverage ends the day your employer's contract with BCBSD ends.

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when you lose coverage, except:

- if your employer cancels the plan, and
- if you are an inpatient on the date the plan ends.

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

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

CONTINUING YOUR COVERAGE UNDER COBRA

You may continue your coverage after you lose coverage under this plan. This right is provided under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

EMPLOYEE

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

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

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

- are disabled when you become eligible for COBRA coverage, and
- are considered disabled under Social Security.

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

SPOUSE OF EMPLOYEE

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

- you die, or
- you divorce from your spouse, or
- you become eligible for Medicare.

DEPENDENT CHILD OF EMPLOYEE

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

- you die, or
- you and your spouse are divorced or legally separated, or
- you become eligible for Medicare, or
- the child is no longer considered a dependent under this plan.

NOTIFYING THE STATE

You need to let your Human Resources/Benefits Office know within 30 days of

- a divorce, or
- a child losing dependent status, or
- disability determination by Social Security.

Notify your Human Resources/Benefits Office within 30 days if Social Security determines you are no longer disabled.

After you notify your Human Resources/Benefits Office or the State of Delaware's COBRA Administrator, you will be sent information about COBRA and how much it costs. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this plan ends.

You should contact State of Delaware's COBRA Administrator if you have any questions. The phone number is: (800) 877-7994.

WHEN YOUR COVERAGE UNDER COBRA ENDS

You can lose the coverage you continued under COBRA if:

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

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

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

DIRECT BILLED PLAN

If your group plan ends, you may apply to BCBSD for a Direct Billed Plan. With a Direct Billed Plan, BCBSD bills you directly for your coverage. BCBSD offers three types of Direct Billed plans:

- Medically Underwritten
- Conversion
- Portability

You may apply for one of the three Direct Billed plans if:

- you left your employer
- you become divorced from a covered employee
- you lost coverage because you began to work fewer hours
- you were covered under your spouse, and your spouse died
- you no longer meet the dependent child or student requirements on age, marriage status, or financial support
- you chose COBRA continuation coverage, but the coverage time limit is exhausted

The Direct Billed Plan may have different benefits from your group plan. It may cover fewer items and pay a lower amount. Direct Billed Plans cover dependent children through December 31 of the year they reach age 19. Some Direct Billed Plans cover full-time students beyond age 19. Dependents over age 19 can apply for a Direct Billed Plan of their own.

MORE ABOUT YOUR DIRECT BILLED PLAN OPTIONS

Medically Underwritten and Conversion Plans

The following information applies to the Medically Underwritten and Conversion Plans:

- You must apply within 30 days after your group plan ends.
- You cannot be eligible for any other group plan. This applies if you're eligible through you or your spouse's employer or any organization. It applies even if:
 - the other plan has a preexisting condition limit, or
 - the other plan denied your application.
- You cannot be eligible for Medicare.
- The applicant must satisfy medical underwriting for Medically Underwritten Plans.
- There is no medical underwriting for the Conversion Plan.

There is a 12-month preexisting condition waiting period for the employee and his or her covered dependents. However, you can get credit for prior coverage under a Blue Cross Blue Shield plan if there is no lapse period between coverage.

Portability Plans

The following information applies to the Portability Plans:

- You, the applicant, must have 18 months of prior "creditable coverage."
- You must enroll no later than 63 days after the group plan ends.
- You are not eligible if you were most recently covered by a Direct Billed plan or other non-group coverage.

- You cannot be eligible for coverage under Medicare, Medicaid or another group plan.
- You do not have other health insurance coverage.
- Your most recent health insurance coverage was not cancelled for your nonpayment of premium or fraud.
- You must have elected and exhausted COBRA continuation coverage available under the group plan
- Your coverage is not retroactive. The earliest effective date would be the day after you post or deliver you application to BCBSD.

There will be no preexisting condition waiting period for the applicant if you apply within 63 days after your group coverage ends. Eligible family members who have prior coverage under a Blue Cross Blue Shield plan will get credit towards a 12-month preexisting condition waiting period if there's no lapse period between coverage.

For more information about Direct Billed Plans, call BCBSD's Customer Service department at the number listed in the front of your booklet.

GENERAL CONDITIONS

RELEASING NEEDED RECORDS

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

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

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

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

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

DUAL ENROLLMENT

You may have two or more benefit plans with BCBSD. If so, we'll coordinate benefits. However, you may not have more than one benefit plan through the State of Delaware.

TIME LIMITS

Claims must be filed within two years after you receive care. We won't pay claims filed past the two-year limit.

DENIAL OF LIABILITY

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

NON-ASSIGNABILITY

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

SUBROGATION 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 BCBSD's rights include:

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

LEGAL ACTION

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

POLICIES AND PROCEDURES

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

- policies,
- procedures,
- rules, and
- interpretations.

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

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

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

MANAGED CARE PROGRAMS

These rules apply to the Managed Care Programs:

- We cut or deny payment if you don't follow managed care requirements. You pay the balance. The balance doesn't go to your coinsurance.
- We don't pay for non-covered services. This applies even if services are authorized by BCBSD.

FOLLOWING PCP ADVICE

- **If** you fail to follow a course of treatment advised by your PCP, and
- **If** your PCP decides there is no other effective course of treatment, then:

your PCP will advise you in writing. If you still fail to follow the advice, your PCP may stop treating you for the condition. Your PCP doesn't have to provide further care for that condition or any related condition.

ALLOWABLE CHARGE CALCULATIONS UNDER THE BLUECARD PROGRAM

When you obtain health care services through BlueCard outside the geographic area BCBSD serves, the amount you pay for covered services, if not covered by a flat dollar copayment, is calculated as the **lower** of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (Host Blue) passes on to us.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in some states may require the Host Blue to use a basis for calculating insured liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim, or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, BCBSD would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

YOUR RIGHTS AND RESPONSIBILITIES

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

You have the RIGHT to:

- Be treated with respect and dignity.
- Have your health records kept confidential. The only exception is when their release is required by law.
- See your health records in accordance with the law.
- Privacy during office visits and treatment.
- Choose your PCP
- Know the professional background of anyone giving you treatment.
- Discuss your health problems with your PCP or health care professional.
- Discuss the appropriateness or medical necessity of treatments for your conditions, regardless of cost or benefit coverage.
- Information about your care and charges for your care.
- Information about diagnoses, treatments and expected results.
- Information about Blue Cross Blue Shield of Delaware, its services, its practitioners and providers, and members' rights and responsibilities.
- Play an active part in decisions about your health care.
- Have access to providers without regard to race, color, sex, country of origin, or disability.
- Complain about or appeal claims and managed care decisions.
- Complain about services received from your providers or BCBSD.
- Make recommendations regarding BCBSD's members' rights and responsibilities policies.
- Receive communications about how a covered entity (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) uses and discloses your Protected Health Information (PHI).
- Receive a Notice of Privacy Practices, which is a communication about how a covered entity (as defined by HIPAA) uses and discloses your PHI.
- Request restrictions on certain uses and disclosures of your PHI.
- Receive confidential communications of PHI.
- Inspect, amend and get a copy of certain PHI.
- An accounting of disclosures of PHI.
- File a complaint regarding violation of privacy rights. Members may file a complaint either directly with BCBSD or with the Secretary of the U.S. Department of Health and Human Services.

You have the RESPONSIBILITY to:

- Consult your PCP for all health care. This includes emergencies, except in life-threatening cases.
- Show your ID card to all caregivers before having care.
- Keep your appointments. If you will be late or need to cancel, give timely notice.
- Treat your PCP and other providers with respect.
- Give truthful information about your health to your PCP and other providers.
- Follow the advice of your PCP for medicine, diet, exercise and referrals.
- Follow the plans and instructions for care you have agreed on with your providers.
- Tell your PCP if you don't understand the care he or she gives you.
- Pay all fees in a timely manner.
- Maintain your BCBSD eligibility. Notify us of any change in your family size, address or phone number. You should also notify your Human Resources/Benefits Office of any changes.

- Tell BCBSD and your PCP about any other insurance you may have.
- Cooperate with BCBSD's administration of this health benefit plan; some examples include notifying and assisting BCBSD when a third party may be responsible for an accident.

HOW BCBSD PROTECTS YOUR CONFIDENTIAL INFORMATION

It is necessary for BCBSD 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 BCBSD protects the confidentiality of your Personal Identifiable Health Information.

YOUR RIGHT TO CONSENT OR DENY RELEASE OF INFORMATION

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

- medical cost experience
- claims volume
- cost savings.

This information helps your employer and BCBSD to determine future premium rates. This information is also used to monitor BCBSD'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 BCBSD. 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 BCBSD's Customer Service Department.

HOW BCBSD PROTECTS YOUR PRIVACY

All BCBSD 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. BCBSD'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.

BCBSD 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.

BCBSD sometimes uses outside agencies to conduct surveys and studies. BCBSD 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 BCBSD's Customer Service Department at:

Local Calls: 429-0260

Long Distance Calls: (800) 633-2563

SUGGESTIONS AND COMPLAINTS

BCBSD 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 BCBSD'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 network 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

BCBSD's Address

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

BCBSD's Customer Service Telephone Numbers

Local Calls: 429-0260
Long Distance Calls: (800) 633-2563

BCBSD's Internet Address:

www.bcbsde.com

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

DEFINITIONS

Account Contract: The agreement between the State and BCBSD which, for eligible employees and their dependents, provides for

- the provision of health care services and benefits, and
- administration of the health program.

Admission: The time you're an inpatient in a

- hospital
- skilled nursing home
- other facility

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

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

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

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

BCBSD: Blue Cross Blue Shield of Delaware.

Coinsurance: The percent of allowable charges you pay.

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

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

Confinement: For skilled nursing facilities, a confinement is one admission. It's also successive admissions if you're readmitted within 180 days. A new confinement begins when you're readmitted after 180 days after discharge.

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

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

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist, chiropractor, or dentist. Such a provider must be acting within the scope of his or her license. (Coverage for dental care is limited. See *Surgical Care* description.)

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.

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

Hospital:

- *Acute Hospital:* An institution or division of an institution. On an inpatient basis, it primarily provides diagnostic and therapeutic facilities for:

- surgical and medical diagnosis and treatment
- care of obstetric cases

Acute hospitals must be approved by:

- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- the American Osteopathic Association (AOA)

Such hospitals charge for their care and receive payments from patients. Facilities and care are supervised or rendered by a staff of licensed doctors. Such hospitals provide 24-hour-a-day nursing care. The nursing care is under the supervision of registered graduate nurses.

- *Non-Acute Hospital:* An institution that provides care distinct from care usually received in an Acute Hospital. It may be a division, section or part of an Acute Hospital. Non-Acute Hospitals must be approved by:

- BCBSD
- the appropriate state or local agency (if required by law)

Such hospitals charge for their care and receive payments from patients.

- The term **Hospital** does not include the following:

- nursing homes
- rest homes
- health resorts
- homes for aged
- infirmaries or places solely for domiciliary care, custodial care, care of drug addition or alcoholism
- similar facilities that provide mostly non-medical services

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

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

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

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

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

Network Provider: A provider with a contract to participate in the BCBSD Blue Care HMO network.

Open Enrollment: The time when you may initially enroll for or make changes to your coverage.

Outpatient: A person receiving care while not an inpatient in a hospital or other facility.

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

Prescription Drugs: Drugs that are:

- obtained only through a doctor's prescription
- listed in the U.S. Pharmacopoeia or National Formulary
- approved by the Food & Drug Administration

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

Semiprivate Room: A room with at least two beds.

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

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

State: State of Delaware.

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

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

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service:

(For questions about benefits, claims and membership)

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

Local Calls: (302) 429-0260
Long Distance Calls: (800) 633-2563

Behavioral Health Care Department:

(For Mental Health and Substance Abuse Managed Care Program)

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

Local Calls: (302) 421-2500
Long Distance Calls: (800) 421-4577

Your PCP:

(Write down your PCP's Name and Phone Number for all family members)

Member's Name	PCP's Name	PCP's Phone Number
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Referral Center:

(For Managed Care)

Referral Center
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: (302) 421-3333
Long Distance Calls: (800) 572-2872

Claims:

(For sending in your health care claims)

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

State of DE Blue Care HMO
Print Date: 01/13/09

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