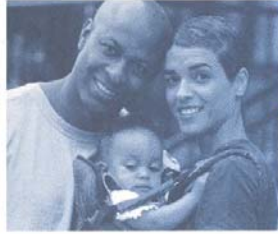

A Guide To Your Benefits

BlueCross BlueShield of Delaware

Working well together.

bcbsde.com

STATE OF DELAWARE
COMPREHENSIVE PPO 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 booklet carefully and keep it handy.

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

- **BCBSD** means Blue Cross Blue Shield of Delaware.
- **SNF** means Skilled Nursing Facilities.
- **DME** means Durable Medical Equipment.
- **PPO** means Preferred Provider Organization

This 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 explains the benefits 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 follow BCBSD Managed Care Requirements.
- Read this booklet.
- Call BCBSD if you have any questions.

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

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:

- asking about your plan
- obtaining information about providers
- reporting a lost or stolen ID card
- ordering a new ID card
- letting us know when you have a new address
- asking about a claim

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

Write to:

Customer Services
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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COMPREHENSIVE
PREFERRED PROVIDER ORGANIZATION (PPO)
SCHEDULE OF BENEFITS

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

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

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

Pre-existing conditions are covered.

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

DEDUCTIBLE/ COINSURANCE	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan Year Deductible	None	$300 per person $600 per family
Plan Year Coinsurance (excludes Deductible)	None	$1,500 per person $3,000 per family

Note: For an explanation how Plan Year Deductibles and Plan Year Coinsurance apply to your Out-of-Network benefits, please see the section *Copayments, Deductibles and Coinsurance*, page 4, below.

SERVICE	**IN-NETWORK BENEFIT**	**OUT-OF-NETWORK BENEFIT**
Preventive Care		
■ Well Baby Care	$15 Copayment per visit	80% Covered
■ Routine Physical Exams	$15 Copayment per visit	80% Covered
■ Routine GYN Exams	$15 Copayment per visit	80% Covered
■ Hemoglobin Tests	$5 Copayment per visit	80% Covered
■ Cholesterol Tests	$5 Copayment per visit	80% Covered
■ Blood Sugar Tests	$5 Copayment per visit	80% Covered
■ Blood Antigen Tests	$5 Copayment per visit	80% Covered
■ Lead Poison Screening Tests	$5 Copayment per visit	80% Covered
■ Lab Charges for Pap Smear	$5 Copayment per visit	80% Covered
■ Blood Occult	$5 Copayment per visit	80% Covered
■ Routine Sigmoidoscopy	100% Covered	80% Covered
■ Colonoscopy	100% Covered	80% Covered
■ Barium Enema	$15 Copayment per visit	80% Covered
■ Routine Mammogram	$15 Copayment per visit	80% Covered
■ Routine Immunizations	$15 Copayment per visit	80% Covered
■ Vision Exams	Not Covered	Not Covered
■ Hearing Exams	100% Covered	80% Covered
■ Diabetic Education (limited to 6 visits within a three-year period)	$25 Copayment per visit	80% Covered

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
■ Nutritional Counseling (limited to 6 visits per condition per plan year)	$25 Copayment per visit	80% Covered
Hospital and Other Facility Benefits		
■ Inpatient Hospital Care for Unlimited Days	$100 Copayment per day for the first 2 days per admission, then 100% covered for unlimited days.	80% Covered
■ Surgical Facility Care	100% Covered	80% Covered
■ Skilled Nursing Facilities	100% Covered; 120 day limit, benefits renew after 180 days without care.	80% Covered; 120 day limit, benefits renew after 180 days without care.
Surgical - Medical Benefits		
■ Surgical Care (excluding care in an office setting, see below)	100% Covered	80% Covered
■ Anesthesia	100% Covered	80% Covered
■ Inpatient Medical Care	100% Covered	80% Covered
■ Inpatient Consultant Care	100% Covered	80% Covered
■ In-Vitro Fertilization (limited to $30,000 per member's lifetime)	See Benefit Description	See Benefit Description
■ Artificial Insemination (limited to $600 per member's lifetime)	See Benefit Description	See Benefit Description
■ Organ Transplants (limited to $1,000,000 per covered organ type per person's lifetime)	See Benefit Description	See Benefit Description
Maternity Benefits		
■ Prenatal and Postnatal Care	100% Covered	80% Covered
■ Inpatient Hospital Care	Same as *Inpatient Hospital Care*, above	Same as *Inpatient Hospital Care*, above
■ Birthing Center	100% Covered	80% Covered
■ Obstetric Care	100% Covered	80% Covered
Emergency Services		
■ Emergency Ambulance and Paramedic Services	100% Covered	100% Covered, no deductible
■ Emergency Facility	$125 Copayment per visit (waived if admitted).	$125 Copayment per visit (waived if admitted).
■ Medical Emergency Care (doctor's care in an emergency facility)	100% Covered	100% Covered; no deductible

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Therapeutic & Diagnostic Services		
Outpatient Care		
■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis	100% Covered	80% Covered
■ Physical and Speech Therapy	85% Covered	80% Covered
■ Occupational Therapy	85% Covered	80% Covered
■ Cognitive Therapy	85% Covered for 30 consecutive days, beginning on the first day of treatment.	80% Covered for 30 consecutive days, beginning on the first day of treatment.
■ Cardiac Therapy	85% Covered for up to 3 sessions per week and 3 months of treatment.	80% Covered for up to 3 sessions per week and 3 months of treatment.
■ Lab Tests	$5 Copayment per visit	80% Covered
■ Diagnostic Imaging	$15 Copayment per visit	80% Covered
■ Machine Tests	100% Covered	80% Covered
Inpatient Care		
■ Therapeutic Services	100% Covered	80% Covered
■ Diagnostic Services	100% Covered	80% Covered
Other Covered Services		
■ Hospice	100% Covered for up to 240 days	80% Covered for up to 240 days
■ Home Health Care	100% Covered for up to 240 visits per plan year	80% Covered for up to 240 visits per plan year
■ Home Infusion	100% Covered	80% Covered
■ Inpatient Private Duty Nursing	100% Covered	80% Covered
■ Doctor's Home/Office Visits (includes surgery performed in the doctor's office)	$15 Copayment per visit	80% Covered
■ Doctor's Nursing Home Visits	100% Covered for up to 120 days per plan year	80% Covered for up to 120 days per plan year
■ Specialist/Referral Care (includes surgery performed in the specialist's office)	$25 Copayment per visit	80% Covered
■ Allergy Tests	$25 Copayment per visit	80% Covered
■ Allergy Treatment	$5 Copayment per visit	80% Covered
■ Chiropractic Care	85% Covered for up to 30 visits per plan year	80% Covered for up to 30 visits per plan year
■ Durable Medical Equipment	100% Covered	80% Covered
■ Care for Morbid Obesity	See Benefit Description	See Benefit Description

Mental Health and Substance Abuse Care
(Does not include authorized care for Serious Mental Illness.)

	AUTHORIZED CARE	UNAUTHORIZED CARE
■ Inpatient Mental Health and Partial Hospital Care	$100 Copayment per day for the first two days per admission, then 100% Covered for up to 60 inpatient days and 120 partial	80% Covered for up to 60 inpatient days and 120 partial hospital days per plan year. One inpatient day reduces partial

	AUTHORIZED CARE	UNAUTHORIZED CARE
	hospital days per plan year. One inpatient day reduces partial hospital days by two days. Two days of partial hospital care reduce inpatient days by one day.	hospital days by two days. Two days of partial hospital care reduce inpatient days by one day.
▪ Outpatient Mental Health Care	$25 Copayment per visit	80% Covered
▪ Substance Abuse Treatment – Inpatient	$100 Copayment per day for the first two days per admission, then 100% covered for unlimited days.	80% Covered for up to 30 days inpatient care or 60 days intensive outpatient care per Treatment Period and two 270-day Treatment Periods per lifetime, separated by 365 days without care. Two intensive outpatient days reduce inpatient days by one day. One inpatient day reduces intensive outpatient days by two days.
▪ Substance Abuse Treatment – Intensive Outpatient	$100 Copayment per day for the first 2 days, then 100% covered for unlimited days per plan year.	
▪ Substance Abuse Treatment – Outpatient Office Visit Care	$25 Copayment per visit	Not Covered

COPAYMENTS, DEDUCTIBLES AND COINSURANCE

In the Schedule *of Benefits*, we refer to copayments, deductibles and coinsurance. These amounts are your share of payment. These terms are described below.

COPAYMENTS

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

Here's how copayments work:

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

Copayments should be paid to the provider at the time you receive care.

OUT-OF-NETWORK DEDUCTIBLE AND COINSURANCE EXPENSE LIMITS

Your Out-of-Network (and unauthorized Mental Health and Substance Abuse) benefits have a $300 plan year deductible per person. You must pay the first $300 of allowable charges for services.

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

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

Your Out-of-Network benefits have a $1,500 plan year coinsurance expense limit per person. This applies when the coinsurance adds up to $1,500. Then, we pay 100% for the rest of the year. The 100% is based on the BCBSD allowable charge.

You have a $3,000 plan year family coinsurance expense limit. This applies when two enrolled family members each meet their $1,500 coinsurance expense limit (totaling $3,000). Then, we pay 100% for all enrolled members for the rest of the year. The 100% is based on the BCBSD allowable charge.

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

HOW THE DEDUCTIBLE AND COINSURANCE WORK

Example #1:

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

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

Example #2:

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

Your Out-of-Network coinsurance expense limit is $1,500
Less: Your coinsurance times the medical expenses (20% X $500) $100
Equals: The amount of coinsurance you still have to pay to meet
your Out-of-Network coinsurance expense limit:..$1,400

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

Example # 3

When you use a non-participating provider, benefits are paid at the out-of-network benefit level. Since the doctor does not participate with the BCBSD, benefits are limited at BCBSD's allowable charge. The amount above BCBSD's allowable charge is your responsibility, and the doctor can balance bill you directly.

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

Blue Cross Blue Shield of Delaware Allowable Charge for this service:...............$2,000
Less Your Deductible: 300
Equals: 1,700
Less Your Coinsurance amount (20% x $1700) 340
Equals the amount that Blue Cross Blue Shield of Delaware will pay:.................$1,360

Your Total Liability:
Deductible:..$ 300
Coinsurance Amount: 340
Amount above Blue Cross Allowable for this service:...6,000
Equals: $6,640

WHAT'S NOT INCLUDED IN THE COINSURANCE EXPENSE LIMIT

The coinsurance expense limit does not include:

- copayments
- deductible amounts

CARRYOVER

There is no carryover into a subsequent plan year of any copayments, deductibles, or coinsurance from a previous plan year.

HOW TO USE YOUR COMPREHENSIVE PPO BENEFITS

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

TWO LEVELS OF BENEFITS

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

- With In-Network benefits, your care is covered at the highest level.
- With Out-of-Network benefits, coverage is reduced. The amount you pay is greater.

HOW TO RECEIVE IN-NETWORK BENEFITS

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

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

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

HOW TO RECEIVE OUT-OF-NETWORK BENEFITS

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

When choosing a provider, there are ways to save money. Many doctors and other providers contract with BCBSD or local BCBS plans outside of Delaware. These providers agree to accept the BCBS allowable charge as full payment. They are called "participating providers." They cannot bill you more than the allowable charge, even if their normal charge is higher. And, these providers file claims for you with BCBSD or the local BCBS plan. So, you don't need to complete claim forms.

Non-participating providers don't have contracts with BCBSD or BCBS plans outside of Delaware. They may bill for amounts over our allowable charge. **Be sure to ask if your provider participates with BCBSD or the local BCBS plan before you receive the service.**

EXCEPTIONS TO THE COMPREHENSIVE PPO RULES

Here are some instances when you don't have to use a network provider. You'll still get benefits at the In-Network level. Please read the following carefully. It's important that you understand the exceptions.

EMERGENCY CARE

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

OUTPATIENT LAB AND IMAGING TESTS

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

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

OUT OF AREA SERVICES

You can use other Blue Cross Blue Shield provider networks when you have care outside BCBSD's provider area. If you use an Out-of-Area network provider, your benefits will be paid In-Network. When you need out-of-area care, call (800) 810-BLUE [(800) 810-2583] to find out which providers are in the network.

THE BLUECARD® PROGRAM

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

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

After you receive care:

- You should not have to complete any claim forms.
- Your should not have to pay up front for medical services, other than the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance)
- BCBSD will send you a complete explanation of benefits.

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).*

Under the Managed Care Requirements, you must call BCBSD **before** you:

- go into a hospital or Skilled Nursing Facility (SNF) for a non-emergency
- remain in the hospital or SNF beyond the date we first approved
- receive home health care
- receive home infusion

The Referral Center can be reached at:

Local Calls: (302) 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 HOSPITAL ADMISSIONS

For elective admissions to a hospital, you must have BCBSD's authorization. You or your doctor should call us at least two days before 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, BDBSD 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

You or the provider must call the Referral Center for authorization at least two days before you begin having care. The Referral Center reviews the request. If approved, they decide the number and type of services authorized.

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. You or your doctor must call BCBSD 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 charges 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 expanded 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

Participating providers agree to follow BCBSD's Managed Care Requirements. They **may not** bill you for amounts reduced, if:

- they didn't follow the requirements.

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

- they did follow the requirements, and
- the Referral Center denied services, and
- you choose to have them anyway.

Non-participating providers may not know about the requirements. It's up to you to call the Referral Center. If the requirements aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- If you do not comply with the requirements, BCBSD will reduce or 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.
- Penalties you pay are not credited toward any deductible or coinsurance requirement.
- 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. We cover the emergency facility, ancillary services and physician care when:

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

Some examples are:

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

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.

URGENT CARE

WHEN YOU'RE HOME

Urgent care is for an injury or sudden illness that isn't life threatening, but you need care within a day or two to avoid 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 that require prompt, but not emergency treatment.

WHEN YOU'RE TRAVELING

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

Step 1

Find a provider. You can call 800.810.BLUE (800.810.2583) to get connected to a 24-hour referral service. This service helps you find doctors who participate with the local Blue Cross

Blue Shield plan where you're traveling. If a doctor is found, you're given the doctor's name, office address and phone number.

You can also use the **bcbsde.com** website to find a provider. The website can access the names, office addresses and phone numbers of network providers nationwide.

Step 2

Call the doctor's office for an appointment and tell them that you're a 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, if any. The doctor's office will then bill the local Blue Cross Blue Shield plan, and the claim will be forwarded to us.

PREVENTIVE CARE PROGRAMS

Check the *Schedule of Benefits* for limits and payments.
Follow managed care rules to get the highest benefit!

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. Please refer to your Preventive Health Guidelines for all terms and conditions.

PERIODIC HEARING EXAMS

Periodic hearing exams are covered as part of routine 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 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.

Inpatient hospital stays must be precertified prior to admission.

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 mother's 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 if both you and your doctor agree.

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 the 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 pre-approved by BCBSD.

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. BCBSD must pre-approve your stay. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient 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 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. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be pre-approved by us.

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 at the out-of-network inpatient, outpatient facility or professional service benefit level. Copayments, deductibles and coinsurance, if any, will apply.
- For the period January through December 2009 claims for transplant services provided at The Nemours Foundation, Children's Hospital of Philadelphia or Christiana Care Health Systems will be paid the same as for a BDCT. Starting in January 2010, claims for services provided at these facilities will be paid the same as other non-BDCT facilities.
- 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 outpatient surgery care. The $600 limit includes only approved AI procedures. The $600 limit applies even when you switch to another State of Delaware medical plan. 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. The $30,000 limit applies even when you switch to another BCBSD plan or another plan offered by the State of Delaware. If pregnancy results, your maternity benefits are then applied.

The following services are included in the $30,000 maximum. They are paid at the same level as other services in the same category.

- office visits
- surgical services
- hospital outpatient services
- radiology exams
- 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.

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 the 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 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. 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. 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. 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 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 for up to 240 visits per plan year. 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 aide count as one specialty for this benefit.)
- Care must be under the direction of a doctor.
- The patient must be home bound and medically unable to get care as an outpatient.
- Care must be in lieu of inpatient care.

What Is Covered Under Home Health:

- skilled nursing care by an RN or LPN
- therapy by licensed or state certified therapists for:
  - physical therapy
  - speech therapy
  - occupational therapy
- medical and surgical supplies
- social service guidance by a licensed or state certified social worker
- 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 that 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 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.

DOCTOR'S VISITS

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

- injury or illness
- allergy treatment
- visits to a specialist

Services for routine foot care are not paid.

CHIROPRACTIC CARE

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

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

The following limits apply:

- three modalities per visit
- one visit per day
- 30 visits per plan year
- 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.

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 MORBID OBESITY

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

If you are morbidly obese, we cover the following:

- office visits
- lab tests

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

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

SURGERY FOR MORBID OBESITY

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

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

You must:

- have achieved full growth and be 18 years or older, 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/lypmphatic 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. Follow these requirements to avoid benefit reductions.

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 REDUCED

If you don't follow the requirements, payment is reduced to the “Unauthorized Care” level. This means you'll be responsible for the rest of the charges.

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.

CALCULATION OF BENEFIT REDUCTIONS

If you do not meet the requirements, your payment is reduced. Here is how the payment due will be calculated:

From the allowable charge:

- First, we will subtract the deductible amount, if any, then
- Second, we will subtract the managed care program reduction, then
- Third, we will apply any plan year and lifetime maximums, and then
- Finally, we will reduce payment due to coordination of benefits if necessary.

The balance then left, if any, will be the amount we pay. If the penalty is denial of payment, we pay nothing.

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 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.

The benefits are subject to the same plan deductible, if any, as other non-mental health care benefits.

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. Benefits may be subject to the deductible. The *Schedule of Benefits* shows how benefits are paid 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)
- 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.

HOW UNAUTHORIZED SUBSTANCE ABUSE BENEFITS ARE PAID

Service Day Maximum

The *Schedule of Benefits* shows the day limits **for unauthorized care.** This is called your **Service Day Maximum**. Inpatient and Outpatient day limits are combined as follows:

- One inpatient day used reduces your available outpatient days by two days.
- Two days of outpatient care reduces your available inpatient days by one day.

Treatment Period

The *Schedule of Benefits* may use the phrase **Treatment Period** for unauthorized care. A **Treatment Period** ends the earlier of:

- 270 days from the first day you had substance abuse care; or
- the day you reach your **Service Day Maximum**.

Unauthorized office visits for substance abuse treatment are not covered.

WHAT IS NOT COVERED

The following services and items are not covered.

- Injury or illness on the job. One example is 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. One example is care given by the Veteran's Administration.
- Care needed through an act of war if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care 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. "Family" means parents, children, spouses 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 even when prescribed by a doctor.
- Exams or tests done as inpatient for convenience 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 prescribed for an approved diagnosis are limited to $350.
- Routine foot care.
- Care for weight loss, unless co-morbid conditions are present.
- Orthotic equipment and devices. Some examples are:
  - foot inserts
  - arch supports
  - lifts
  - corrective shoes
- Blood, blood components and donor service.

- Care for cosmetic reasons. Some examples are 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, such as exams for:
  - potential employers
  - insurers
  - schools
  - camps
  - marriage physicals
  - any other third party

- Computerized gait analysis or electrodynographic 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. Some examples are:
  - care we consider not to be accepted medical practice, and
  - care that requires government agency approval, and the approval hasn't been granted.

- 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, unless the patient is diagnosed with a condition that renders such counseling medically necessary.
- Convenience items. Some examples are:
    - 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, bcbsde.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 or 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.

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.

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.

HOW COB WORKS WITH PROVIDER NETWORKS

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

When This Plan is Primary

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

When This Plan is Secondary

If the primary (other) plan has managed care requirements or a provider network, you must follow those requirements to get maximum payment for both the primary and secondary (State) programs. If you followed the other plan's managed care requirements, you don't have to follow the State's managed care requirements.

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

Exceptions are:

- If the primary plan doesn't cover the services and the secondary (State) plan does, the secondary plan becomes primary for the particular services. Benefits will then be paid according to the State's network and managed care requirements.

- If you've met the primary plan's benefit maximum and the benefit is covered under the secondary (State) plan, the secondary plan becomes primary for the particular service. Benefits will then be paid according to the State's network and managed care requirements (until you can again get coverage under the other plan for the particular benefit).

You'll need to send BCBSD 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 network penalties were, if any.

EFFECT ON BENEFITS

- When this plan is primary, we pay without regard to any secondary plan.

- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.

- When this plan is secondary, you don't need authorization from us as long as you follow the primary carrier's managed care requirements. However, if you meet the maximum (either day or dollar) for a particular benefit covered by the primary carrier, you must follow BCBSD's managed care requirements to get the highest coverage under this plan for that particular benefit.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed 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 11of 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 half 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 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 the Spousal COB 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 were 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 date of hire, 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, coverage begins for:

- *Employees*: the first day of the month after the loss of coverage
- *Spouses*: either the date of 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 request enrollment after the 30-day enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be A Late Enrollee

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

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

- birth,
- adoption, 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; a copy of your marriage certificate is required by your State of Delaware Human Resources/Benefits Office. 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*.

NEWBORNS

You may add your newborn child. A birth certificate or legal documentation needs to be supplied to your State of Delaware 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-day period unless:

- You have coverage that already covers dependent children. You still must request enrollment 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 State of Delaware 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 step-child. A birth certificate or legal documentation needs to be supplied to your State of Delaware Human Resources/Benefits Office. You must request enrollment 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 3 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 retain both Parts A and B of Medicare to be eligible for coverage.

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 upon 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 is enrolled 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 sections below regarding each), coverage ends the last day of the month in which you lose eligibility because of one of the events below.

DIVORCE

Former spouses are not eligible for coverage under this program. 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 terminates 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
- end of the month when 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, or
- become disabled within the first 60 days of 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 or legally separate 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 your 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
  - *Medically Underwritten*: satisfy medical underwriting.
  - *Conversion*: There is no medical underwriting.

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 coverages.

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 canceled 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 your 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 coverages.

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.

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.

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

You have the RIGHT to:

- Be treated with respect and dignity.
- Have your health records kept confidential except when the laws allow or require release of information.
- See your health records in accordance with law.
- Receive privacy during office visits and treatment.
- Know the professional background of anyone giving you treatment.
- Discuss your health problems with your health care professional.
- Discuss the appropriateness or medical necessity of treatment options for your condition, regardless of cost or benefit coverage for those options.
- Receive information about your care and charges for your care.
- Receive information about your diagnoses, treatments and expected results.
- Receive information about BCBSD, its services, practitioners and providers, and members' rights and responsibilities.
- Play an active part in decisions about your health care.
- Receive benefits and care without regard to race, color, gender, country of origin, or disability.
- Register complaints or appeals about BCBSD or the quality of care given by your providers.
- Make recommendations regarding BCBSD's members' rights and responsibilities policies.
- Receive communications about how a covered entity (as defined by the Health Insurance Portability 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 the Health Insurance Portability Act of 1996 [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:

- 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 health care providers with respect.
- Supply information (to the extent possible) that BCBSD or your health care provider needs.
- Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Tell your health care provider if you don't understand the care given to you.
- Follow the advice of your health care provider for medicine, diet, exercise and referrals.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Pay all fees in a timely manner.
- Maintain your 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 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 providers
- 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.

BlueCard Program: A national BCBS program whereby members have access to physicians and healthcare facilities outside their local provider's geographic area.

BCBS: Blue Cross Blue Shield

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
- the deductible

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, 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, that 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 that 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 Comprehensive PPO 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

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

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

Claims:
(For sending in your health care claims)

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

Your Doctors:

(Write down your doctors' names and phone numbers for all family members)

Member's Name	Doctor's Name	Doctor's Phone Number

State of DE Comprehensive PPO
Print Date: 01/13/09

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