



A Guide To Your Benefits



BlueCross BlueShield
of Delaware

Working well together.

bcbsde.com

WILMINGTON UNIVERSITY SIMPLY BLUE EPO PLAN

WELCOME!

Thank you for choosing Simply Blue, Blue Cross Blue Shield of Delaware's EPO plan. Our goal is to bring you the best in health care coverage.

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.
- **DME** means Durable Medical Equipment.
- **EPO** means Exclusive 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 a group contract with your employer. Your employer holds a copy of the contract.

This booklet explains the benefits in effect as of March 1, 2010. It replaces all previous booklets.

HINTS TO GET THE MOST FROM YOUR HEALTH CARE PLAN

- Always show your ID card when you need care.
- Always follow BCBSD's Managed Care Requirements.
- Read this booklet.
- Call us if you have any questions!

Remember! If you go to a preferred provider, your services are covered. If not, with a few exceptions, services are not covered.

WHEN YOU HAVE QUESTIONS OR COMMENTS

BCBSD welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about 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 AM to 7:00 PM Eastern Standard Time (EST), Monday through Friday.

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

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

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 places 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: bcbsde.com

To Reach the Medical Management Department (for Managed Care)

Medical Management Department
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
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: 302.421.2500
Long Distance Calls: 800.421.4577

Drug Program Questions

Prescription drug benefits are administered by Argus Health Systems, Inc (Argus), an independent prescription benefits administrator.

For information about your drug plan, or to submit claims to Argus:

Argus Health Systems, Inc.
P.O. Box 419019
Kansas City, MO 64141

All calls: 800.314.9674

Website: **argushealth.com**

Mail-order prescription drug benefits are administered by Walgreens Mail Service, an independent pharmacy services administrator.

For mail order prescriptions:

Walgreens Mail Service
P.O. Box 628001
Orlando, FL 32862-8001

800.449.2356

Website: **walgreensmail.com/bcbsde**

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SIMPLY BLUE SCHEDULE OF BENEFITS

The next pages describe what's covered under your Simply Blue benefits. 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. Services that have a copayment are not subject to the deductible.

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.

DEDUCTIBLE/ COINSURANCE

Calendar Year Deductible

IN-NETWORK

\$500 per person
\$1,500 per family

SERVICE

Preventive Care

- Well Baby Care
- Routine Physical Exams
- Routine GYN Exams
- Hemoglobin Tests
- Cholesterol Tests
- Blood Sugar Tests
- Blood Antigen Tests
- Lead Poison Screening Tests
- Lab Charge for Pap Smear
- Blood Occult
- Routine Sigmoidoscopy
- Colonoscopy
- Barium Enema
- Routine Mammogram
- Routine Immunizations
- Vision Exams
- Hearing Exams

IN-NETWORK BENEFIT

\$15 Copayment per visit
\$15 Copayment per visit
\$15 Copayment per visit
100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
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100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
100% Covered, no deductible
\$15 Copayment per visit
\$15 Copayment per visit
\$15 Copayment per visit

Hospital and Other Facility Benefits

- Inpatient Hospital Care 100% Covered
- Surgical Facility Care 100% Covered
- Skilled Nursing Facilities 100% Covered; 120 day limit, benefits renew after 180 days without care

Surgical and Medical Benefits

- Surgical Care 100% Covered
- Anesthesia 100% Covered; also covered Out-of-Network
- Organ Transplants See Benefit Description
- Inpatient Medical Care 100% Covered

SERVICE

IN-NETWORK BENEFIT

Maternity Benefits

- | | |
|-------------------------------|--------------|
| ■ Prenatal and Postnatal Care | 100% Covered |
| ■ Inpatient Hospital Care | 100% Covered |
| ■ Birthing Center | 100% Covered |
| ■ Obstetric Care | 100% Covered |

Emergency Services

- | | |
|---|---|
| ■ Emergency Ambulance and Paramedic Services | \$50 Copayment per occurrence; also covered Out-of-Network |
| ■ Emergency Facility | \$100 Copayment per visit; also covered Out-of-Network (waived if admitted) |
| ■ Medical Emergency Care (doctor's care in an emergency facility) | 100% Covered, no deductible; also covered Out-of-Network |

Diagnostic & Therapeutic Services

Outpatient Care

- | | |
|--|--|
| ■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis | 100% Covered |
| ■ Physical Therapy | 100% Covered for up to 30 visits per calendar year. Visits combine with Occupational Therapy visits. |
| ■ Occupational Therapy | 100% Covered for up to 30 visits per calendar year. Visits combine with Physical Therapy visits. |
| ■ Speech Therapy | 100% Covered for up to 30 visits per calendar year. |
| ■ Cognitive Therapy | 100% Covered for up to 30 consecutive days, beginning on the first day of treatment |
| ■ Lab Tests | 100% Covered |
| ■ Machine Tests | 100% Covered |
| ■ Imaging | 100% Covered |

Inpatient Care

- | | |
|------------------------|--------------|
| ■ Therapeutic Services | 100% Covered |
| ■ Diagnostic Services | 100% Covered |

Other Covered Services

- | | |
|--|---|
| ■ Hospice | 100% Covered for up to 240 days |
| ■ Home Health Care | 100% Covered for up to 100 visits per calendar year |
| ■ Home Infusion | 100% Covered |
| ■ Inpatient Private Duty Nursing | 100% Covered for up to 240 hours in a 12-month period |
| ■ Doctor's Office Visits | \$15 Copayment per visit |
| ■ Doctor's Home and Nursing Home Visits | \$30 Copayment per visit |
| ■ Diabetic Education (limited to 6 visits within a three-year period) | \$15 Copayment per visit |
| ■ Nutritional Counseling (limited to 6 visits per condition per calendar year) | \$15 Copayment per visit |
| ■ Allergy Tests and Treatment | \$15 Copayment per visit |
| ■ Durable Medical Equipment | 100% Covered |

SERVICE

- Chiropractic Care
- Care for Morbid Obesity
 - Office Visits and Labs
 - Bariatric Surgery

IN-NETWORK BENEFIT

100% Covered for up to 30 visits per calendar year

See Benefit Description.

50% Covered. Coinsurance does not accrue to coinsurance expense limit.

Prescription Drugs

Per Prescription or Refill:

- Generic
- Preferred Brand
- Non-Preferred Brand

**34-DAY SUPPLY
RETAIL**

- \$10.00 Copayment
- \$25.00 Copayment
- \$50.00 Copayment

**90-DAY SUPPLY
MAIL ORDER**

- \$20.00 Copayment
- \$50.00 Copayment
- \$100.00 Copayment

NOTE: If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. To calculate the difference, take

- the charge for the Preferred or Non-Preferred Brand Drug
- less the charge for the Generic Drug
- plus the copayment for the Generic Drug
- which equals the amount you have to pay

Care for Mental Illness and Substance Abuse Treatment

- Inpatient and Partial Hospital/Intensive Outpatient Care 100% Covered.
- Outpatient Care (Office Visits) \$15 Copayment per visit

COPAYMENTS AND DEDUCTIBLES

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, most services are subject to the calendar year deductible, then paid at 100%. See the Schedule of Benefits for a list of services with copayments.

Here's how copayments work:

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

Copayments should be paid at the time you receive care.

DEDUCTIBLES

In addition to copayments that apply to many services, your benefits have a \$500 calendar year deductible per person. You pay the first \$500 for services.

You also have a \$1,500 calendar year family deductible. This applies when three members each meet their \$500 deductible (totaling \$1,500). Then, no more deductible is taken for all members for the rest of the year.

After the deductible is met, most benefits are paid at 100% of the allowable charge.

NOTE: An excess deductible may be taken. This can happen when more than three family members submit claims. Some claims for other family members may be applied to the deductible 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 WORKS

Example #1:

Suppose you have medical expenses of \$100 in allowable charges. Here's how your deductible would be reduced:

Your deductible is	\$500
Less: Your medical expenses	\$100
Equals: The amount you still have to pay to meet your deductible:	\$400

HOW TO USE YOUR SIMPLY BLUE BENEFITS

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

HOW TO RECEIVE IN-NETWORK BENEFITS

To receive benefits, see a preferred provider when you need care. The preferred providers are listed in the Provider Network Directory. **If you receive care without using a preferred provider, generally your services will not be covered. This means you will be responsible for all charges!**

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

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

EXCEPTIONS TO THE SIMPLY BLUE EPO RULES

Generally if you receive care from a provider that is not part of the EPO network, services will not be covered.

Here are some instances when you don't have to use a preferred provider, but will still get benefits. Please be careful when you read the following. 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 preferred lab or imaging provider. However, sometimes a preferred 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 preferred provider.
- X-rays done for oral surgery are paid In-Network if the surgeon is a preferred provider. See Surgical Benefits to see when oral surgery is paid.
- Lab and imaging tests done as part of hospice or home health care given by preferred providers are paid In-Network. These tests must be billed by the provider.
- Imaging done and billed by a preferred orthopedic doctor is paid In-Network.

IN-HOSPITAL ANESTHESIA

Inpatient services by non-preferred anesthesiologists are covered when the surgical procedure is performed in a preferred hospital.

APPROVED REFERRALS TO NON-PREFERRED PROVIDERS

In very limited situations, services may not be available through a preferred provider within a reasonable period of time. In those instances, your preferred provider may refer you to a Non-Network provider. BCBSD will approve and pay for those services at the in-network level based upon BCBSD's allowable charge. Please contact BCBSD Customer Service if you have received a referral and your claim was denied.

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. When you need out-of-area care, call 1-800-810-BLUE (1-800-810-2583) 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) Call BCBSD for pre-certification or prior authorization, if necessary (refer to the phone number on your Blue Plan ID card).
- 3) To find names and addresses of nearby doctors and hospitals, visit the Blue National Doctor and Hospital Finder (accessed through **bcbsde.com** or **bcbs.com**) or call BlueCard *Access*® at 800.810.BLUE (800.810.2583)
- 4) When you arrive at the participating doctor's office or hospital, simply present your BCBSD ID card.
- 5) In an emergency, go directly to the nearest hospital

After you receive care:

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

MANAGED CARE REQUIREMENTS

The benefits provided under this plan are subject to BCBSD's managed care requirements. These requirements are described below, and are administered by BCBSD's Medical Management and Behavioral Health Departments.

Please read these requirements carefully, and 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*).

AUTHORIZATION FOR HOSPITAL ADMISSIONS – SURGICAL OR MEDICAL

Hospital admissions for surgical or medical care must be authorized by the Medical Management Department. The Medical Management Department can be reached at:

Local Calls: 302.421.3333
Long Distance Calls: 800.572.2872

Emergency Admissions

For emergency admissions, you must call us within 48 hours of admission. If you can't call yourself, your provider, a family member or a friend may call us. BCBSD will review the admission. If approved, we'll assign an initial length of stay.

Maternity Admissions

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

Other Surgical or Medical Admissions

Your doctor should call us at least two weeks before the admission. BCBSD will review your case. From the review, BCBSD may:

- authorize the admission and assign an initial length of stay, or
- not authorize the admission because the admission is not medically necessary. For example, BCBSD may determine your care can be most appropriately provided in an alternative setting.

If these requirements are not followed, BCBSD will deny payment for the hospital charges.

AUTHORIZATION FOR HOSPITAL ADMISSIONS - MENTAL HEALTH OR SUBSTANCE ABUSE

Hospital admissions for mental health or substance abuse care must be authorized by the Behavioral Health Department. The Behavioral Health Department can be reached at:

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

Emergency Admissions

For emergency admissions, you must call us within 24 hours of admission. If you can't call yourself, your provider, a family member or a friend may call us. BCBSD will review the admission. If approved, we'll assign an initial length of stay and establish a treatment plan.

Planned Admissions

Non-emergency mental health and substance abuse inpatient, partial hospital or intensive outpatient admissions must also be authorized. Your doctor should call us before admission. BCBSD will review your case. From the review, BCBSD may:

- authorize the admission and assign an initial length of stay, or
- not authorize the admission because the admission is not medically necessary. For example, BCBSD may determine your care can be most appropriately provided in an alternative setting.

When a planned admission is authorized, you must use the approved provider and follow the approved treatment plan.

Please notify us as soon as possible, and not later than 30 days after your effective date for this health care plan, if you were receiving care prior to that date. The Behavioral Health Department will work out a transition treatment plan.

If these requirements are not followed, BCBSD will deny payment for the hospital charges.

AUTHORIZATION FOR ADVANCED RADIOLOGY SERVICES

Authorization is required for non-emergency advanced radiology services performed by providers who participate with BCBSD. Some examples of advanced radiology services are CAT and PET scans, MRIs, MRAs and nuclear cardiac studies. If these services are not authorized, BCBSD will deny payment and the provider cannot bill you unless:

- the provider followed the requirements
- the services were not authorized, and
- you chose to have them anyway.

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 Medical Management Department for authorization at least two business days before you begin receiving care. The Medical Management Department reviews the request. If approved, an authorization will be generated that includes the type of service and the number of days or visits initially approved.

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

AUTHORIZATIONS TO EXTEND YOUR CARE

Sometimes authorized care will need to be extended. Your provider must call for an authorization to extend your care before the last approved day. BCBSD reviews the request. If authorized, we will assign additional days to the initial approved length of stay and determine when a next review will occur, or will assign additional days for the other services.

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

CARE MANAGEMENT PROGRAMS

Individual Case Management

BCBSD may provide a case manager to work with you and your doctor to coordinate your care and maximize your existing benefits. The case manager may assist you with:

- coordinating care when you leave the hospital
- providing care in your home
- providing educational materials
- locating network providers
- identifying community services

You may contact the Medical Management Department to request a case manager. BCBSD will evaluate your needs and determine if you meet criteria for case management services. You may choose to decline case management services at any time.

BCBSD may also choose to provide optional benefits not normally included under your plan. These benefits will replace or minimize the need for existing health care plan benefits, and may include modification to copayments, coinsurance, deductibles, limits or covered services. Optional benefits will only be provided as long as they 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.

Disease Management

BCBSD works with independent experts to provide disease management programs that help members with certain chronic conditions better manage those illnesses.

If you are identified as having one of the specific health conditions for which a program is offered by BCBSD, you will automatically be enrolled in that program. You may choose to opt out of any disease management program at any time.

More information can be found at bcbsd.com. BCBSD reserves the right to change or discontinue these programs at any time.

USE OF PARTICIPATING PROVIDERS

All providers who participate with BCBSD have agreed to follow BCBSD's managed care requirements. In circumstances where an authorization for a service is required, the participating provider cannot bill you unless:

- BCBSD's authorization requirements were followed, and
- the service was not authorized, and
- having been informed of BCBSD's decision, you chose to have the service anyway, and agreed in writing to be responsible for payment.

Non-participating providers may not know about the requirements. It's up to you to call the Medical Management or Behavioral Health Department. If the requirements aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- BCBSD does not pay for services that are not covered, even when the Medical Management or Behavioral Health Department authorizes them, except for optional benefits authorized by BCBSD through individual case management.
- If you do not comply with the managed care requirements, BCBSD will reduce or deny payment.
- Any payments you must make because you or your provider fail to follow the managed care requirements are not credited toward any deductible or coinsurance requirement.

APPEALS

You may disagree with a decision either the Medical Management or Behavioral Health Department makes. If you disagree, you may file a written appeal with us. See the section, *A Guide To Filing Claims and Appeals*, for more information.

PREVENTIVE SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.

Follow managed care requirements to get the highest benefit!

PREVENTIVE SERVICES

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 bcbsd.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.

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:

- blood antigen test for prostate cancer
- blood occult
- blood sugar test
- cholesterol test
- colonoscopy
- electrocardiogram
- flexible sigmoidoscopy
- hemoglobin test
- lead screening
- mammogram
- osteoporosis screening
- tuberculin testing

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- DTaP and combinations (diphtheria, pertussis, tetanus)
- Hepatitis A
- Hepatitis B
- Hib (haemophilus influenza)
- Influenza
- IPV (polio)
- Meningitis
- MMR (measles, mumps, rubella)
- Pneumococcal

- Td (Tetanus)
- Varicella (chickenpox) vaccine

Immunizations considered by BCBSD to be experimental are not covered.

ROUTINE VISION EXAMS

Visual acuity tests are covered for adults and children as part of their routine physical exams.

Visits to a specialist (optometrist or ophthalmologist) for routine vision exams are covered as follows:

For adults age 18 and older:

- Routine eye exams are covered every 24 months, and only when provided by a network optometrist or ophthalmologist.

For children:

- Routine eye exams are covered as part of routine physical exams.
- The eye exam may also be given by a network optometrist or ophthalmologist.

Vision exams are covered only by a network optometrist or ophthalmologist.

ROUTINE HEARING EXAMS

Hearing exams are covered as part of a routine physical exam. Visits to a specialist or audiologist are covered under *Specialist Care*.

HOSPITAL AND OTHER FACILITY BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.

Follow managed care requirements to get the highest benefit!

INPATIENT HOSPITAL CARE

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

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. 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 improve in a reasonable and predictable time, or
 - needed to establish an effective home exercise program
 - physical therapy as called for in your doctor's treatment plan when:
 - done by a doctor or licensed physical therapist, and
 - needed to help your condition improve in a reasonable and predictable time, or
 - needed to establish an effective home exercise program
 - radiation therapy for cancer and neoplastic diseases
 - inhalation therapy by a doctor or registered inhalation therapist
 - speech therapy, when:
 - done by a licensed or state certified speech therapist; and
 - ordered by a doctor; and
 - done to improve speech impairment caused by:
 - disease
 - trauma
 - congenital defect, or
 - recent surgery
 - cognitive therapy done by an approved provider. The diagnoses eligible for coverage are:
 - stroke with cognitive impairment, or
 - head injury or trauma.
 - cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.
- surgical dressings
- administration of blood or blood plasma (but not blood itself)

- machine tests
- imaging exams (such as X-rays)
- durable medical equipment
- lab tests
- dialysis

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy
- childbirth
- miscarriage

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

This plan conforms with this federal law, which states that group health plans may not restrict mothers' and newborns' benefits for a hospital length of stay related to childbirth to less than:

- 48 hours following a vaginal delivery, and
- 96 hours following a cesarean section.

Maternity lengths of stay may be less than the 48 or 96 hours *only* if both the patient and physician agree.

NEWBORN CARE

Hospital care for a newborn child is covered, provided the newborn is enrolled. See *Changes in Enrollment, Newborns* in the Guide to Enrollment section.

OUTPATIENT SURGICAL FACILITY

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

- hospitals
- approved ambulatory surgical centers

Dental surgery is normally only covered when done in the dentist's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by BCBSD.

EMERGENCY ROOM

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

SKILLED NURSING FACILITY

You're covered for confinement in a skilled nursing facility. BCBSD must approve your stay. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient skilled nursing facility care.

The plan covers:

- skilled nursing and related care as an inpatient
- 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 benefit levels and any limits that may apply.

Follow managed care requirements to get the highest benefit!

SURGICAL BENEFITS

Surgical services include:

- cutting and operative procedures
- treatment of fractures and dislocations
- 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).

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

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

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.

Women's Health and Cancer Rights Act of 1998

This federal law requires coverage of mastectomy-related services, provided in a manner determined in consultation with the attending physician and patient. This coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and;
- Treatment of physical complications of the mastectomy, including lymph edemas.

ANESTHESIA

Anesthesiologist services are covered when medically necessary.

ORGAN TRANSPLANTS

This section describes the coverage for the following human organ transplants:

- heart
- lung/lobar lung
- combined heart and lung
- pancreas
- combined pancreas and kidney
- small bowel
- liver
- combined small bowel and liver
- multivisceral
- autologous bone marrow/stem cell
- allogenic bone marrow/stem cell
- kidney

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

- Transplants performed at a Blue Distinction Center for Transplant[®] (BDCT) are covered at the level of the member's inpatient facility benefit for network providers.
 - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
 - The benefit includes all organ acquisition costs.
- Transplants performed at non-BDCT, but participating hospitals are covered at a level that is 20 percentage points lower than the member's inpatient or outpatient facility and professional benefit level for network providers.
 - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. If there is no coinsurance expense limit associated with the member's benefits, then coinsurance is capped at \$10,000 per transplant.
 - Except for kidney and bone marrow/stem cell transplants, the maximum benefit for organ harvesting and procurement is \$10,000 for each cadaveric organ and up to \$50,000 for each organ procured from a living donor (including harvesting). Maximums are subject to copayments, deductibles and coinsurance, if any.
- There are no BDCT facilities for kidney transplants. Kidney transplants are covered at the member's benefit plan's facility and professional benefit levels.
 - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a \$10,000 coinsurance expense limit would apply.
 - Allowable charges for harvesting/procurement for kidneys are determined by BCBSD.
 - Living donor costs are limited to \$50,000 (not including harvesting).
- Bone Marrow/Stem Cell Transplants are covered at the member's benefit plan's facility and professional benefit level.
 - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a \$10,000 coinsurance expense limit would apply.

- Allowable charges for donor treatment and harvesting for bone marrow/stem cells are determined by BCBSD.
- Transplants performed at non-participating hospitals are not covered.
- Travel Reimbursement. For transplants that occur at a facility that is located greater than 50 miles from the recipient's home, the following will be covered during the reimbursement period:
 - \$150/day limit for reasonable lodging and meals.
 - Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant facility. Reimbursement is calculated using BCBSD's current mileage reimbursement rate.
 - Air travel is reimbursed at the price of the airline ticket (coach class).
 - Tolls and parking incurred while traveling between recipient's home or temporary lodging and transplant facility.
 - There is a \$10,000 aggregate limit for all travel costs.

The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered.

If you have questions about BCBSD's organ transplant policy, please contact the Medical Management Department at the number listed in the front of this booklet.

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, under the following conditions:

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

Only one consultation per specialty per admission is covered.

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

EMERGENCY CARE

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

OBSTETRIC CARE

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

- prenatal care
- anesthesia

- delivery, and
- postnatal care

Midwives 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.

One routine ultrasound per pregnancy is also covered.

NEWBORN CARE

Medical care of a newborn child by a physician is covered, provided the newborn is enrolled. See *Changes in Enrollment, Newborns* in the Guide to Enrollment section.

EMERGENCY AND URGENT CARE

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.

Follow managed care requirements to get the highest benefit!

EMERGENCY CARE

If you have a life-threatening emergency, go directly to the nearest emergency provider. 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

Mental Health and Substance Abuse Emergencies

An emergency mental health or substance abuse condition is one which requires voluntary or involuntary hospitalization because the individual patient is a danger to himself or herself, or to others.

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.

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

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

When you can travel by private car, the ambulance isn't covered. Only one-way travel to the hospital is covered, except when being transported from hospital to hospital for specialized care. In such cases round trip transportation is covered.

Air ambulance is covered only when no other means of travel is appropriate.

When billed separately, these items are not paid:

- patient care equipment
- reusable devices
- first aid supplies

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

URGENT CARE FACILITIES/MEDICAL AID UNITS

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 facility.

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

WHEN YOU'RE TRAVELING

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

Step 1

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

You can also use the **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.

DIAGNOSTIC AND THERAPEUTIC SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.

Follow managed care requirements to get the highest benefit!

INPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

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

OUTPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

DIAGNOSTIC SERVICES

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

- a provider's office,
- an approved freestanding lab, imaging or machine testing provider, or
- a hospital's outpatient department

Covered care includes:

- imaging services
- lab tests, and
- machine tests

THERAPY SERVICES

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

- a provider's office, or
- a hospital's outpatient department

Covered care includes only:

- chemotherapy by a doctor
- occupational therapy as called for in your doctor's treatment plan when:
 - needed to help your condition improve in a reasonable and predictable time, or
 - needed to establish an effective home exercise program
- physical therapy as called for in your doctor's treatment plan when:
 - done by a doctor or licensed physical therapist, and
 - needed to help your condition improve in a reasonable and predictable time, or
 - needed to establish an effective home exercise program
- radiation therapy for cancer and neoplastic diseases
- inhalation therapy by a doctor or registered inhalation therapist
- speech therapy. Therapy must be:
 - done by a licensed or state certified speech therapist
 - ordered by a doctor, and
 - needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery
- dialysis

- cognitive therapy done by a provider approved by BCBSD. The diagnoses eligible for coverage are:
 - stroke with cognitive impairment, or
 - head injury or trauma.
- cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.
- vision therapy as called for in your doctor's treatment plan, which must include the projected period of treatment.

OTHER COVERED SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.

Follow managed care requirements to get the highest benefit!

HOSPICE

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

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

What Is Covered Under Hospice:

- care by a hospice doctor
- nursing care
- home health aide supervised by a registered nurse
- social service guidance
- nutritional counseling and meal planning
- physical therapy
- speech therapy
- occupational therapy
- spiritual counseling by the hospice
- medical supplies that are needed to manage the illness
- prescription drugs related to the palliative management of the patient's terminal illness
- 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 other than those drugs used for palliative management
- durable medical equipment (DME) not related to palliative management
- palliative chemotherapy or radiation therapy when needed to manage the illness
- inhalation therapy
- imaging and lab tests

If your plan covers these benefits, they will be paid according to the coverage indicated for that specific benefit.

What's Not Covered Under Hospice:

- private duty nursing
- respite care
- care not prescribed in the approved treatment plan
- financial, legal or estate planning, and
- hospice care in an acute care facility, except when a patient in hospice care requires services in an inpatient setting for a limited time.

HOME HEALTH CARE

Home health care is covered. The provider and treatment plan must be approved by BCBSD. Medical records or a suitable summary of the progress of the treatment plan must be reviewed by the attending doctor at regular intervals, or at least every 30 days.

Guidelines:

- Care must be needed to treat or stabilize a condition. Care to maintain a chronic condition is not covered.
- There's a limit of one visit per day per specialty. (A nurse and 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, and
- home health aide when supervised by an RN (limit of 3 visits per week)

What's Not Covered Under Home Health:

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

HOME INFUSION

Home infusion is home care for receiving needed infusion medicine. It involves the use of an infusion pump with fluids, nutrients and drugs. 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, and
- needed infusion pumps, poles and supplies.

What's Not Covered Under Home Infusion:

- delivery costs
- record keeping costs
- doctor management
- other services which do not involve direct patient contact, or
- 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 when you are an inpatient in an acute hospital. We may review the case in advance. We may review the case again after 80 hours of care. Care must be:

- ordered by the attending doctor
- for the same condition you're hospitalized for, and
- approved by the hospital

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

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

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

DOCTOR'S VISITS

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

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

SPECIALIST/REFERRAL CARE

Home and office visits with specialists are covered.

DIABETIC EDUCATION

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

NUTRITIONAL COUNSELING

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

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

ALLERGY TESTING AND TREATMENT

Allergy testing and treatment are covered.

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

Chiropractic services must either provide significant improvement in your condition in a reasonable and predictable period of time or be necessary to the establishment of an effective maintenance program. Chiropractic services that are part of a maintenance program are not covered.

Chiropractic X-rays are covered only for X-rays of the spine. They are covered under your Outpatient Imaging benefit. You must use a 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 under your Therapeutic and Diagnostic Services benefit.

DURABLE MEDICAL EQUIPMENT & PROSTHETICS

Durable Medical Equipment

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

- prescribed by a doctor, 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:

- orthopedic braces
- wheel chairs
- orthotics
- hospital beds

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

Prosthetics

Covered prosthetics includes items that are

- intended to replace all or part of an organ or body part lost to disease or injury, or absent from birth, or permanently inoperative or malfunctioning
- prescribed by a qualified provider
- removable and attached externally to the body
- deemed by BCBSD to be medically necessary and appropriate

Some examples of prosthetics are:

- hair prostheses for hair loss caused by chemotherapy or alopecia areata resulting from an autoimmune disease
- limb, ear, or eye prostheses
- electro-larynx devices

We also pay to replace or repair prosthetic devices.

We also pay for:

- medical foods and formula for the treatment of inherited metabolic disorders
- hearing aids. Benefits are limited to \$1,000 per individual hearing aid, per ear, every three (3) years for children less than 24 years of age.

DME & Prosthetics Not Covered:

- items for comfort or convenience
- dental prosthetics
- foot orthotics

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

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,
- gastric banding, and
- 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
- complete a structured diet program in the 2-year period that immediately precedes the request for the surgery, and
- have received a psychological evaluation specifically for the diagnosis of obesity or morbid obesity, and
- meet any of the following criteria:
 - you weigh at least 100 pounds above or are twice the ideal body weight; or
 - have a BMI of at least 40; or
 - have a BMI equal or greater than 35, in conjunction with one or more of the following co-morbid conditions: degenerative joint disease, hypertension, coronary artery disease, diabetes, sleep apnea, lower extremity venous/lymphatic obstruction, obesity related pulmonary hypertension.

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

PRESCRIPTION DRUG BENEFITS

Check the *Schedule of Benefits* pages for limits and payments. Certain prescription drugs may require BCBSD's approval prior to dispensing.

On behalf of BCBSD, your prescription drug benefits plan is administered by Argus Health Systems, Inc. (Argus). If you have questions about your drug benefits, call Argus at 800.314.9674.

DEFINITIONS

Generic Drugs means those drugs that are copies of the Preferred or Non-Preferred Brand Drugs. They are not marketed under a specific trade name. These drugs

- contain the same active ingredients in the same strength as the Preferred or Non-Preferred Brand Drugs,
- are equally effective as the Preferred or Non-Preferred Brand Drugs at treating the medical condition, and
- meet the same Federal requirements as the Preferred or Non-Preferred Brand Drugs.

Preferred Drug List (PDL) means the list of preferred drugs for certain conditions. Several similar drugs may work equally well for a given medical condition. For various reasons, one drug may be given a preferred status over other similar drugs and placed on the PDL. We may make changes to the PDL periodically. You can check bcbsde.com or call Argus at 800.314.9674 for the current list of drugs on the PDL.

Preferred Brand Drugs means those drugs on the PDL which are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection.

Non-Preferred Brand Drugs means those drugs not on the PDL which are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection.

BENEFITS

The following are covered when prescribed for use outside the hospital:

- caution legend drugs (these require a prescription according to Federal and State laws)
- compounded prescriptions with at least one caution legend drug
- injectible insulin prescribed by your doctor
- contraceptive devices prescribed by your doctor and FDA approved
- needles and syringes up to 2cc* prescribed by your doctor

*Syringes over 2 cc are covered under your Durable Medical Equipment benefit.

DISPENSING LIMITS

Prescription drugs may also have dispensing limits. These include:

- 34-day supply through a retail pharmacy
- 90-day supply through mail order
- limit of a 3-month supply for oral contraceptives at one time
- limit of one supply per lifetime of smoking cessation drugs (supply limited to one consecutive 3-month period; the 3 months is counted from the date dispensed)
- renewals past one year from the original prescription are not accepted.

NOTE: BCBSD may apply other dispensing limits.

HOW THE RETAIL PROGRAM WORKS

PHARMACIES IN THE NETWORK

To fill or refill prescriptions, show your BCBSD ID card at the pharmacy. You'll be asked to pay any copayment, deductible and/or coinsurance that apply. (See the *Schedule of Benefits*). There's a separate copayment and/or coinsurance for each prescription. The drug store handles all other billing for you.

PHARMACIES NOT IN THE NETWORK

You must pay the pharmacy the full charge. You may then complete the *Argus Direct Reimbursement Claim Form* and send it to Argus. To receive a form, call Argus at 800.314.9674. Argus pays you the allowable charge less any deductible, copayment or coinsurance. Because the allowable charge may be less than the actual charge, you may pay more when you use a pharmacy not in the network.

To learn about pharmacies in the network, call Argus at 800.314.9674.

HOW THE MAIL SERVICE PROGRAM WORKS

Mail order services are administered by Walgreens Mail Service. You may use the program for maintenance drugs, which are drugs taken regularly to treat conditions such as:

- high blood pressure
- ulcers
- diabetes

To use the mail order program, follow the steps outlined in the Walgreens Mail Service materials or call Walgreens at 800.449.2356 for information. Prescriptions may be mailed to:

Walgreens Mail Service
P. O. Box 628001
Orlando, FL 32867-8001

WHAT'S NOT COVERED UNDER THE DRUG PROGRAM

In addition to the exclusions listed in the section *What is Not Covered*, there is no coverage for:

- drugs other than caution legend drugs and injectible insulin
- devices, other than
 - those related to diabetic care, and
 - FDA-approved contraceptives
- administration or injection of drugs
- vitamins, except those that by law need a prescription
- drugs you get while a patient in a health care facility
- drugs provided under Workers Compensation laws
- drugs covered through any government agency, unless required by law
- drugs for weight loss
- drugs that have either a generic or brand name equivalent available without a prescription.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Check the *Schedule of Benefits* for benefit levels.

Follow managed care requirements to get the highest benefit!

This plan provides benefits for the treatment of behavioral health disorders, including mental illness and substance abuse. For inpatient, partial hospital and intensive outpatient care, managed care requirements must be followed.

INPATIENT HOSPITAL CARE

Inpatient hospital care is covered on an emergency or planned basis. The following services are covered when you're in the hospital:

Room And Board

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

Other Hospital Care

When medically necessary, we cover:

- Electroconvulsive therapy by a doctor.
- Detoxification
- Drugs listed in the U.S. Pharmacopoeia or National Formulary
- Lab tests

PARTIAL HOSPITAL CARE

This plan also covers partial hospital programs. A partial hospital program provides an intermediate level of care as an alternative to inpatient hospitalization or as an option following inpatient hospitalization. Partial hospital programs generally are provided within a psychiatric hospital or behavioral health department of a hospital.

INTENSIVE OUTPATIENT CARE

Intensive outpatient care in a free-standing or hospital-based program is covered. Intensive outpatient programs provide a step down from acute inpatient or partial hospitalization, or a step up from outpatient care in office settings.

OUTPATIENT CARE – OFFICE VISITS

Outpatient care covers:

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

Care must be by a network provider such as a:

- doctor,
- licensed clinical psychologist
- licensed professional counselor of mental health (LPCMH)
- licensed clinical social worker, or
- nurse practitioner.

Care must be done in the provider's office or as a hospital outpatient.

WHAT'S NOT COVERED

The following services are excluded from coverage:

- aptitude tests
- testing and treatment for learning disabilities
- treatment for personality disorders
- care beyond that needed to determine mental deficiency or retardation
- treatment for mental disorders not likely to improve, and
- care at behavioral health facilities or in residential programs

WHAT IS NOT COVERED

The following services and items are not covered.

- Acupuncture.
- Ancillary services (including but not limited to, office visits, physician care, lab and radiology procedures and prescription drugs) in conjunction with a non-covered service.
- Artificial insemination procedures.
- Artificial reproductive technologies (ART), including, but not limited to:
 - In vitro fertilization (IVF) procedures
 - Gamete intrafallopian transfer (GIFT) procedures
 - Zygote intrafallopian transfer (ZIFT) procedures,]Any procedures, services, supplies, physician care or drugs related to ART are also not covered.
- Blood, blood components and donor service.
- 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 by:
 - a school infirmary
 - a student health center
 - staff working at the above
- Care for cosmetic reasons.
- Care for complications or consequences of services and items not covered.
- Care for weight loss, unless co-morbid conditions are present.
- Care given by a family member. "Family" means parents, children, spouses or siblings.
- Care given by any person living with you.
- Care given by institutions or agencies owned or operated by the government, unless the law requires otherwise. One example is care given by the Veteran's Administration.
- Care given by your employer's health department.
- Care needed through an act of war if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care not directly related to 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.

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

Routine care costs related to approved clinical trials, as determined by BCBSD, are covered.
- Care you can have without charge in the absence of insurance.
- Change of sex surgery, except to correct congenital defect.
- Computerized gait analysis or electrodiagnostic tests.
- Convenience items. Some examples are:
 - phones
 - TVs
 - radios
 - other personal items
- Dental care, except certain dental care noted in the *Surgical and Medical Benefits* section.
- Drugs or care received in violation of law.
- Enteral nutrition ingested or administered orally, even if it is the sole nutritional source. The only exceptions are certain medical foods prescribed for inherited metabolic disorders.
- Exams or tests done as inpatient for convenience when such care could be done as outpatient.
- Eye or hearing exams, unless noted elsewhere in this booklet.
- Eyeglasses, contact lenses and all procedures for refractive correction.
- Hearing aids for members age 24 and over.
- Immunization or inoculations, unless noted elsewhere in this booklet. Immunizations or inoculations for travel are not covered.
- Injury or illness on the job. One example is any care normally covered under Workers' Compensation or occupational disease laws.
- Items or services that can be purchased without a prescription, unless noted elsewhere in this booklet. Some examples are:
 - Blood pressure cuffs
 - Contraception, first aid and other medical supplies
 - Exercise equipment
 - Incontinence and personal hygiene supplies
- Occupational or physical therapy for developmental delay.
- Orthotic equipment and devices for feet. Some examples are:
 - foot inserts
 - arch supports
 - lifts
 - corrective shoes

- Physical exams for:
 - potential employers
 - insurers
 - schools
 - camps
 - marriage physicals
 - any other third party
- Rest cures, custodial care or homelike care even when prescribed by a doctor.
- Routine foot care.
- Services in excess of your covered benefit limits.
- Speech therapy for:
 - attention disorders
 - behavior problems
 - conceptual handicaps
 - learning disabilities
 - developmental delays
- Surgery to reverse voluntary sterilization.
- Thermography.
- Transcutaneous electrical nerve stimulation (TENS) units, replacement lead wires, other related supplies or batteries.
- Treatment of developmental delay unless there is an identifiable underlying cause.
- Treatment of Temporomandibular Joint (TMJ) Dysfunction Syndrome, unless there is documented organic joint disease, or joint damage resulting from physical trauma. This includes exams for fittings, occlusal adjustment and TMJ devices.
- 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.

VALUE ADDED FEATURES

BCBSD offers Value Added Features. They are described below.

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

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

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

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**.

WELLNESS PROGRAMS

BCBSD's online wellness programs, managed and operated by leading, independent experts in the health care field, offer you a variety of support programs designed to identify your health risk factors and proactively address your needs. Some programs may include incentives for participation.

- Online health risk assessment
- Online smoking cessation
- Online nutrition, weight, fitness and stress management
- Online health coaching
- Biometric screenings
- Telephonic health coaching
- Nicotine replacement therapy

Please note that availability of wellness programs may be dependent on your health benefits plan. Also, the online wellness programs are only available to members 18 years of age and older; however, you can access a nutrition and fitness program for children once you have logged in to the website.

SECOND OPINION PROGRAM

If you are diagnosed with one of the conditions identified as part of this program (including various cancers or pediatric heart defects) you can obtain an independent second opinion from a leading medical center with special expertise in treating that condition.

This service:

- coordinates with your attending physician,
- identifies several medical centers that have a reputation for excellence in treating your condition,
- confirms that a timely second opinion based on your medical records is available from those medical centers,
- provides this information to you and your physician so that you and s/he can choose the appropriate facility for review and evaluation of your medical records,
- assists with getting your records to the facility you select,
- arranges for the prompt independent evaluation of your diagnosis and treatment plan based on your medical records, with a detailed written opinion returned to you and your physician.

Please note: This feature provides only the administrative services listed above; it does not change the benefits you are entitled to under your health plan. Coverage for the treatment recommended in the second opinion is subject to all the normal terms and conditions of the health plan, just as any treatment would be. Some examples of limitations which would apply are preexisting condition waiting periods, experimental or investigational care exclusions, and out-of-network payment limitations.

For more information on the Second Opinion program please visit our website or call Customer Services.

YOUR RIGHTS AND RESPONSIBILITIES

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

You have the RIGHT to:

- Be treated with courtesy, consideration, respect and dignity.
- Have your protected health information (PHI) and health records kept confidential and secure, in accordance with applicable laws and regulations.
 - Receive communications about how BCBSD uses and discloses your PHI.
 - Request restrictions on certain uses and disclosures of your PHI.
 - Receive confidential communications of PHI.
 - Inspect, amend and receive a copy of certain PHI.
 - Receive an accounting of disclosures of PHI.
 - File a complaint when you feel your privacy rights have been violated.
- Available and accessible services when medically necessary, including urgent and emergent care 24 hours a day, seven days a week.
- Receive privacy during office visits and treatment.
- Refuse care from specific practitioners.
- Know the professional background of anyone giving you treatment.
- Discuss your health concerns with your health care professional.
- Discuss the appropriateness or medical necessity of treatment options for your condition, regardless of cost or benefit coverage for those options.
- Receive information about your care and charges for your care.
- Receive from your provider, in easy to understand language, information about your diagnoses, treatment options including risks, expected results and reasonable medical alternatives.
- All rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medications and treatment after possible consequences of this decision have been explained to you in your primary language.
- Receive information about BCBSD, its policies, procedures regarding its products, services, practitioners and providers, grievance procedures, and members'/enrollees' rights and responsibilities.
- Play an active part in decisions about your health care including formulating an advance directive.
- Receive benefits and care without regard to race, color, gender, country of origin, or disability.
- File a grievance with BCBSD and receive a response to the grievance within a reasonable period of time.
- Register complaints. This includes requesting an internal appeal or review by an Independent Utilization Review Organization, or filing a petition for arbitration for decisions made about your

coverage. To register a complaint or request an appeal members are instructed to call the Customer Service number listed on their ID card.

- Submit a formal complaint about the quality of care given by your providers.
- Make recommendations regarding BCBSD's members' rights and responsibilities policies.

You have the RESPONSIBILITY to:

- Double-check that any facilities from which you receive care are covered by BCBSD. Visit bcbsde.com or call the Customer Service number listed on your ID card to ask about a facility.
- Show your ID card to all caregivers before having care.
- Keep your appointments. If you will be late or need to cancel, give timely notice (in accordance with your provider's office policy).
- Treat your providers with respect.
- Provide truthful information (to the extent possible) about your health to your providers. This includes notifying your providers about any medications you are currently taking.
- Understand your health and participate in developing mutually agreed upon treatment goals.
- Tell your health care providers if you don't understand the care he or she is providing.
- Follow the advice of your health care provider for medicine, diet, exercise and referrals.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Pay all fees in a timely manner.
- Maintain your BCBSD eligibility. Notify us of any change in your family size, address or phone number.
- Tell BCBSD about any other insurance you may have.

A GUIDE TO ENROLLMENT INFORMATION

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You
- Your spouse
- Your unmarried children

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

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

CHILDREN

To be covered, a child must be:

- unmarried, and
- under age 25, 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), and
- more than 50% dependent upon you for support, unless you must provide coverage because of a qualified medical child support court order.

BCBSD may require proof of dependency.

DISABLED CHILDREN

Disabled children can be covered after age 25. They may be covered if:

- they were covered continuously as a dependent child by a group plan through their parent before reaching age 25,
- they are not married,
- they have provided 50% or less of their own support because of a disability that is expected to last more than 12-months or result in death,
- their disability occurred before age 25,
- they are not eligible for coverage under Medicare, unless federal or state law requires otherwise.

Other rules may apply in the case of divorced parents.

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

ENROLLMENT

HOW TO ENROLL

You may enroll yourself and your dependents by completing the enrollment materials and returning them to your employer (with any premium owed). You can get the enrollment materials from your employer.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You may need to complete a form and return it to your employer.

WHEN COVERAGE BEGINS

When your coverage begins is determined by:

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

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

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

TIMELY ENROLLEES

Who Can Be A Timely Enrollee

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

When Coverage Begins

Coverage for new employees (and their dependents) begins on the first day of the month after the date of hire.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

You are a Special Enrollee if you enroll 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, 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 enroll 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 (such as at the last reopening period), 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*.

Special Enrollment Rights for Loss of Medicaid or Children's Health Insurance Program (CHIP) Enrollment

Effective April 1, 2009, you may enroll within 60 days of the date your Medicaid or CHIP coverage was terminated because you were no longer eligible.

New Dependents

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

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

When Coverage Begins

Coverage for Special Enrollees begins as follows if we receive the enrollment materials and premium before the end of the 30-day enrollment period.

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

Remember, if you enroll 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 a reopening period.

Children are Late Enrollees if they were not enrolled 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. *If added premium is due, you must pay when you enroll.*

You must enroll yourself (and any dependents) within a 30-day period from the dates of the events listed below to be Special Enrollees. You and/or your dependent(s) will be Late Enrollees if you are not enrolled within the 30-day period. Newborns must be enrolled within a 31-day period.

MARRIAGE

You may add your spouse when you get married. To ensure the earliest effective date of coverage for your spouse, you must postmark or send your enrollment materials to BCBSD prior to the marriage, or no later than 10 days after the marriage (or requested effective date).

You may also add any eligible children or stepchildren when you marry.

NEWBORNS

You may add your newborn child. Care for newborns is covered from the child's date of birth if:

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

ADOPTED CHILDREN

You may add a child because of adoption or placement in your home for adoption.

OTHER CHILDREN

If you add a newborn or an adopted child, you may also add other eligible stepchildren or siblings.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

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

When your COBRA continuation coverage is exhausted, you may enroll in this plan.

MEDICARE ELIGIBILITY

Anyone covered by this plan who becomes eligible for Medicare must apply for and retain both Parts A and B of Medicare in order to remain eligible for this plan, unless:

- federal law requires the group health plan be primary, or
- through Medicare's ESRD program, he or she is not subject to a penalty for non-enrollment.

This applies to you, your spouse and your dependent children.

BCBSD will not provide primary coverage to persons eligible for primary reimbursement under Medicare.

Discuss your options under federal law with your employer.

WHEN COVERAGE ENDS

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

Your employer may be subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, you may extend coverage after one of the events noted below. You are eligible to receive a *Certificate of Coverage* after you lose coverage under COBRA. Check with your employer for more information.

Coverage ends the last day of the month in which you lose eligibility because of one of the events below:

DIVORCE

Former spouses aren't eligible to be covered. You must send an enrollment form when you become divorced.

LEAVE YOUR JOB

Coverage ends when you leave your job.

DEATH

Coverage ends for your dependents when you die.

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.

CHANGE IN CHILD'S STATUS

Your child's coverage ends the earlier of:

- December 31st of the year the child reaches age 25
- when the child marries
- when the child no longer depends on you or your spouse for support

MEDICARE ELIGIBILITY

Coverage ends when BCBSD's eligibility rules require you to have Medicare Parts A & B and you don't.

THE PLAN IS CANCELED

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

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when your coverage ends, except:

- if your employer cancels its contract with BCBSD, and
- if you are an inpatient on the date the contract ends.

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

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

DIRECT BILLED PLANS

If your coverage under a group plan with BCBSD ends, you may apply to BCBSD for a direct billed plan. You may also apply for a direct billed plan when COBRA continuation coverage is exhausted.

With a direct billed plan, BCBSD bills you directly for your coverage. BCBSD offers the following types of direct billed plans:

- Medically Underwritten
- Conversion
- Portability

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 24. Dependents over age 24 can apply for a direct billed plan of their own.

MORE ABOUT YOUR DIRECT BILLED PLAN OPTIONS

Medically Underwritten Plans

The following information applies to medically underwritten plans:

- You must apply within 30 days after the group plan ends to avoid a lapse in coverage.
- 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.
- You must satisfy 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 coverage.

Conversion Plans

The following information applies to conversion plans:

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

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

Portability Plans

The following information applies to the Portability Plans:

- You must have 18 months of prior "creditable coverage."
- You must apply 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 enrollment materials to BCBSD.

There will be no preexisting condition waiting period for the applicant. Eligible family members will get credit toward a 12-month preexisting condition waiting period if there is no lapse period between coverage.

For more information about Direct Billed Plans, call BCBSD's Customer Service department at the number listed in the front of your booklet. If you do not reside in Delaware, you may contact your local Blue Cross Blue Shield plan for more information.

A GUIDE TO FILING CLAIMS AND APPEALS

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

HOW TO FILE CLAIMS

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

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

WHEN YOU USE A PREFERRED PROVIDER

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

WHEN YOU USE A NON-PREFERRED PROVIDER

Services provided by non-preferred providers are not covered, except in the rare situations described in the section *Exceptions to the Simply Blue Rules*. Non-Preferred providers fall into two categories: those who have contracts to participate with BCBSD, and those who do not.

Many doctors and other providers contract with BCBSD. They are called "participating providers". These providers agree to accept BCBSD's allowable charge as full payment. They cannot bill you more than our allowable charge for covered services, even if their normal charge is higher. And, these providers file claims with BCBSD for you. So you don't need to complete claim forms.

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

If you receive care from a non-participating provider you may need to submit a claim for your care. If the services are covered by BCBSD, we'll pay the allowable charge to you, less any copayment, deductible 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.

Under the BlueCard® Program:

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

IF YOU NEED TO FILE A CLAIM

To obtain a form, call Customer Service. You may also get the form from the BCBSD website, **bcbsde.com**.

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

The section, *Prescription Drug Benefits*, explains how to file claims for drugs.

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:

BCBSD'S APPEAL PROCESS

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

For health benefit plans regulated by Delaware insurance law:

- If you have appealed a decision and are not satisfied with the outcome, you are eligible for an independent review coordinated by the Delaware Department of Insurance (DOI). *As required by law, you must request an independent review within 60 days of the date you received BCBSD's appeal decision.*
 - For decisions involving medical judgment or necessity, you must contact BCBSD Customer Service to initiate the review.
 - For reviews of all other decisions, you must contact the DOI directly at 302.739.4251.
- The DOI provides free, informal mediation services which are in addition to, but do not replace, your right to an independent review. For information about mediation, you can call the DOI Consumer Services Division at **302.739.4251** or **800.282.8611**, or visit the DOI office at: The Rodney Building, 841 Silver Lake Boulevard, Dover, Delaware. Office hours

are 8:30 AM – 4:00 PM Monday – Friday. **Please note that independent review deadlines will still apply if you choose mediation services.**

- If you request, BCBSD will provide copies of all records relevant to the BCBSD appeal decision.

For health benefit plans regulated by ERISA:

- If you belong to an employer-sponsored group health plan or another group health plan, your health benefits coverage may be governed by the Employee Retirement Income Security Act (ERISA). If your health plan is subject to ERISA and you have already completed the BCBSD appeal process, you have the right to file a civil action under ERISA. To determine whether ERISA applies to your plan, please contact your employer or plan administrator. If you request, BCBSD will provide copies of all records relevant to the BCBSD appeal decision.

If you are not sure which of the above processes to follow or would like more information, please call BCBSD Customer Service Appeals Team by one of the methods below.

Internet:

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

Telephone:

302.429.0260 northern Delaware
800.633.2563 all other locations
302.421.3411 for the hearing impaired

Mail:

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

COORDINATION OF BENEFITS

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

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 which covers you as an employee is primary over a plan which covers you as a dependent.
- A plan which covers you as an active employee is primary over a plan which covers you as a non-active employee. Non-active means a laid off or retired employee. This rule also applies if you're the employee's dependent.
- For a child covered by plans under both parents, these rules apply:
 - The plan of the parent whose birthday comes first in the year is primary.
 - If both parents have the same birthday, the plan that covered one parent longer is primary.
 - The other plan's COB rules may set the payment order by the parent's gender. In this case, the male parent's plan is primary.
- If the parents are divorced or separated, this order applies:
 - First, the plan of the parent with custody
 - Then, the plan of the spouse of the parent with custody; and
 - Last, the plan of the parent not having custody.

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

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

EFFECT ON BENEFITS

- When this plan is primary, 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.

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

BCBSD QUALITY INITIATIVES

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.

CURIOUS ABOUT QUALITY?

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

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

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 us. If so, we'll coordinate benefits.

TIME LIMITS

You must file a claim within 2 years after you receive care. We won't pay a claim filed past the 2 year limit.

DENIAL OF LIABILITY

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

Subrogation applies when:

- you have a right of recovery against a party (a person or organization), and
- your right of recovery is based on a legal claim, and
- the legal action involves a medical cost we paid.

When this happens, we're **subrogated** to your rights of recovery from that party. This applies whether or not you assert your claim. This means we're entitled to receive payment from that party.

You're required to assist us. This includes filling out and giving us any needed documents we request. You cannot settle or compromise your claim for medical costs without our written consent. We may cancel your coverage if you don't comply.

LEGAL ACTION

There's a 2 year time limit past which you cannot bring legal action against us for not paying a claim. The period begins on the date of service.

POLICIES AND PROCEDURES

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

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

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

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

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

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 which 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.

ERISA INFORMATION

ERISA stands for *Employee Retirement Income Security Act of 1974*. ERISA was enacted by the Federal Government. ERISA requires us to give you this description.

Type of Plan

The ERISA Plan is a fully insured welfare benefit plan. It provides the health care benefits described in this book.

Type of Administration

The Plan is administered through a group contract issued by BCBSD.

Agent for Service of Legal Process

You may have a dispute under the ERISA Plan. Service of legal process is made upon the ERISA Plan Administrator. This is done through your employer.

Your ERISA Rights

You have rights and protections under ERISA. You are entitled to:

- **Examine, without charge, all Plan documents.** You may examine documents at the Plan Administrator's office. Such documents include:
 - insurance contracts
 - copies of documents filed by the Plan with the U.S. Department of Labor, including:
 - detailed annual reports
 - ERISA Plan descriptions
- **Obtain copies of all Plan documents.** Make your request in writing to the Plan Administrator. The Plan Administrator may charge you for copies.
- **Receive a summary of the Plan's annual financial report.** The Plan Administrator must give each member a copy of a Summary Annual Report.
- **Receive a written explanation of the reason for a claim denial.** This applies if your claim is denied in whole or in part. At your request, we must reconsider your claim.
- **File suit if your claim is denied or ignored.** This applies if your claim is denied in whole or in part. You may file suit in state or federal court.
- **File suit if you do not receive materials you request within 30 days.** You may file suit in state or federal court. The court may fine the administrator. The fine may be up to \$110 for each day's delay. This does not apply if the delay is beyond the administrator's control.

ERISA also imposes duties on the people who operate the Plan. These people are called **fiduciaries**. They have a duty to operate the Plan prudently and in the interest of all Plan members.

You may seek help from the U.S. Department of Labor if:

- Plan fiduciaries misuse Plan money
- You are discriminated against for asserting your rights

You may also file suit in federal court. The court decides who pays court costs and legal fees. If you win, the court may order the person you sued to pay costs and fees. If you lose, the court may order you to pay them.

No one may fire you or discriminate against you to prevent you from:

- obtaining a benefit under this Plan
- exercising your rights under ERISA

Questions

If you have any questions about the Plan:

- contact the ERISA Plan Administrator

If you have questions about this statement or your ERISA rights, you can either:

- contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (the address and phone are listed in your phone book), or
- contact the following:

Division of Technical Assistance & Inquiries
Room N-5625
200 Constitution Ave., N.W.
Washington, DC 20210
Phone: 202.219.8776

DEFINITIONS

Admission: The time you're an inpatient in a

- hospital
- skilled nursing home
- other facility

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

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

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

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

BCBSD: Blue Cross Blue Shield of Delaware.

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

Coinsurance: The percent of allowable charges you pay.

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

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

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

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

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist or dentist. Such a provider must be acting within the scope of his or her license. (Coverage for dental care is limited. See *Surgical and Medical Benefits* and *What Is Not Covered* sections, above.)

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

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 nonmedical services

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

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

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

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

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

Network Provider: A provider with a contract to be a member of BCBSD's preferred network.

Outpatient: A person receiving care while not an inpatient.

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 which are:

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

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

Reopening Period/Open Enrollment Period: The time when you may make changes to your coverage.

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.

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

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

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service:

(For questions about benefits, claims and membership)

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

Local Calls: 302.429.0260
 Long Distance Calls: 800.633.2563

Behavioral Health Care Department:

(For Mental Health and Substance Abuse Managed Care Program)

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

Local Calls: 302.421.2500
 Long Distance Calls: 800.421.4577

Argus:

(For information about your drug plan or to submit claims)

Argus Health Systems, Inc.
 P. O. Box 419019
 Kansas City, MO 64141
 All Calls: 800.314.9674

Medical Management Department:

(For Managed Care)

Medical Management Department
 Blue Cross Blue Shield of Delaware
 P. O. Box 1991
 Wilmington, DE 19899-1991

Local Calls: 302.421.3333
 Long Distance Calls: 800.572.2872

Claims:

(For sending in your health care claims)

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

(For mail order prescriptions)

Walgreens Mail Service
 P.O. Box 628001
 Orlando, FL 32862-8001
 800.449.2356

Your Doctor(s):

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

Member's Name	Doctor's Name	Phone Number
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SG/G-U65-AHP(EPO/HSA EPO/HRA EPO)-2-09

SG/G-U65-AHP(GMF)-2-09

SG/G-U65-AHP(RX)-1-08

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