YOUR 2020
BENEFIT BOOKLET

SHARED COST BLUE EPO Bronze 7900

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Thank You for Choosing Highmark Delaware

Welcome to Highmark Delaware. We appreciate your choosing us for your health coverage.

Take the time to review this booklet; it contains important information about your health insurance, including:

- How to use your member ID card
- The importance of selecting a provider of record
- Getting quality care and service
- Definitions of common health care insurance terms
- The Outline of Coverage and Member Agreement for your plan

If you have any questions regarding your plan, please call the Member Service toll-free telephone number on the back of your ID card. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

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Your Identification Card Is Your Key to Care

You will receive your identification (ID) card in a separate mailing. Your ID card is your key to letting providers know that you have health coverage. You should carry your card with you. You can also view and fax it to a provider by logging in to **www.HighmarkBCBSDE.com** with your web-enabled phone.

Show your card to the health care provider when you need care. Use it at the pharmacy when you buy prescription drugs. You can even use your ID card nationwide for emergency and urgent care.

Your ID card is your source for important information. It includes:

- Your name and/or dependent's name (when applicable)
- Your identification number
- Your group number
- Effective date of your plan
- Pediatric vision network and pediatric dental network information
- Office visit, specialist visit, and emergency room copayment amounts (if applicable)
- Pharmacy network
- Toll-free Member Service phone number
- Member website address
- Blues On Call℠ nurse line
- Toll-free phone numbers for authorizing services
- Addresses for filing claims for emergency and urgent care that is provided out of the network or out of the coverage area

If your ID card is lost or stolen, please contact Member Service immediately. You can order a replacement ID card on **www.HighmarkBCBSDE.com**. It's illegal to lend your ID card to anyone who is not eligible to use your benefits.

Select a Physician of Record (POR)

A physician of record (also called a primary care provider or PCP) is the provider or practice that you visit for your primary and routine health care services. This could be an internal medicine physician, general practitioner, family practitioner, certified registered nurse practitioner, or pediatrician.

Often your least costly option for getting care, your POR can deliver routine services, such as physicals and immunizations, and can recommend and help you select appropriate specialist care when you need it. Physicians of record, or their covering providers, are on call 24 hours a day, seven days a week. This includes specialists for behavioral health and preventive care. You are not required to select a POR, but we encourage you to do so.

A physician of record can help you to:

- Achieve health goals.
- Monitor chronic health conditions and care maintenance.
- Make sure you receive preventive services, like annual exams.
- Coordinate the care you receive from other providers, such as specialists, labs, and imaging centers. This prevents gaps or overlaps in service.
- Improve your patient experience.

How to Obtain Information Regarding Your Provider

To learn more about a provider or to find a physician of record:

1. Visit **www.HighmarkBCBSDE.com.**
    a. Select **Find a Doctor or Pharmacy**.
    b. Select **Find a Doctor, Hospital or other Medical Provider**.
    c. Enter the name of your plan by entering the first three letters of your member ID and selecting the appropriate plan from the **Select a Plan** menu.
    d. Enter **"primary care"** into the search field.
    e. Click on the **SEARCH** button to locate providers near you who participate in your network.
    f. Select **See More** to learn more about a specific provider.
    g. Click **More Details** then select Physician Details to locate the physician of record's nine-digit Physician ID number.

2. Call Member Service at the number on the back of your Member ID card to ask for help in locating a physician of record with an office near you.

When you search for a provider at **www.HighmarkBCBSDE.com**, you can view the following information:

- Physician name
- Location/Office Hours/Phone numbers
- Whether the provider is accepting new patients
- Professional qualifications
- Clinical specialties
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations
- Medical group affiliations
- Patient ratings
- Performance in 13 categories of care
- Parking and public transit nearby
- Handicap accessibility
- Languages spoken
- Gender

You may also obtain more information on network providers by calling Member Service at the number on the back of your member ID card.

To select a Physician of Record:

- Log in to the member website.
- Go to **Settings**.
- Select **Physician Information** to update your physician of record.

Selecting a physician of record is optional and does not impact your benefits or claims payments in any way.

How to Use Your Plan

Your Highmark Delaware plan gives you more value than ever before by offering in-network access to a network of high-quality providers that includes PCPs, specialists, imaging centers, hospitals, and other facilities and allowing you to select any in-network facility of your choice.

Benefits Included with Your Plan

Free Preventive Vaccines

To help you and your family stay healthy, preventive vaccines are included with your plan when given at participating providers' offices and pharmacies. These vaccines require no copay or coinsurance, and you do not have to have met your deductible to take advantage of these visits. Visit www.HighmarkBCBSDE.com to find participating providers and pharmacies near you.

Preventive vaccines available at participating pharmacies are for members who meet all necessary state requirements that apply to the administration of vaccines in a retail pharmacy (such as specific vaccines that are allowed in the retail setting, age of patient, prescription requirements, etc.). These regulations vary by state. Check with your pharmacy for any such restrictions.

Telemedicine Services

Speak with a doctor in just 5 – 10 minutes using your mobile phone, tablet, or laptop to get help with a variety of minor illnesses, such as colds, sore throats, pink eye, allergies, and rashes. Visit AmWell.com to set up your account so that you can visit a doctor from the comfort of your home.

Two Free Mental Health and Two Free Substance Abuse Office Visits

Your plan includes two mental health and two substance abuse office visits with in-network providers with no cost-sharing. These visits require no copay or coinsurance, and you do not have to have met your deductible to take advantage of these visits. If you receive additional services during the office visit, you may be responsible for the cost of the additional services.

In-network Care

Before you see a provider, it's always important to make sure they are in-network. By keeping care in-network, **medically necessary and appropriate services** specified in the Member Agreement will be covered, and you will pay the least out of pocket. There is no coverage for out-of-network care except in emergency medical situations or when urgent care is needed.

Find In-network Providers, Hospitals, and Facilities

To check a provider's participation and confirm that your providers participate in your plan's network, search **Find a Doctor** on **www.HighmarkBCBSDE.com.** To learn more about searching for a provider, refer to the Select a Provider of Record section in this booklet.

Out-of-Network, Out-of-Area, and BlueCard Coverage

Care can be delivered in a variety of settings for various situations. To understand how care will be covered, it is helpful to know the types of care that are available:

Emergency Care - Emergency care is needed for the treatment of serious or life-threatening medical conditions that require immediate care. **In a medical emergency, call 911 or go immediately to the nearest emergency room.** The hospital will provide needed care, and it will be covered at in-network rates — even if that hospital is out-of-network.

Urgent Care - Urgent care is care needed for an unexpected illness or injury that is not life threatening but must be treated and cannot reasonably be postponed.

Out-of-Network Care - Care received from non-participating providers or at non-participating facilities.

Out-of-network coverage is available for emergency care services, ambulance, urgent care, and anesthesia only. If an out-of-network provider or facility is selected for non-emergency care, you are responsible for all costs associated with that care, including an admission that results from an emergency department visit.

Out-of-Area Care with BlueCard – Subject to the terms of your benefit agreement, BlueCard® is a program that allows you to obtain certain health care services from BlueCard participating providers while traveling outside of Highmark Delaware's service area. The program links participating health care providers with the independent Blue Cross Blue Shield Plans across the country and allows providers to submit claims for processing and reimbursement so you don't have to. Please refer to your contract to determine benefits covered by BlueCard for your plan.

You can find BlueCard participating providers by calling BlueCard Access at 1-800-810-BLUE. You can also search on the member website for a BlueCard provider by ZIP code and provider specialty, or by city and state. Or visit the BlueCard Doctor and National Hospital Finder website at **bcbs.com**.

Preventive Schedule

Preventive care helps you to stay well or find problems early, when they may be easier to treat. The preventive guidelines in the schedule on the next few pages depend upon your age, gender, health, and family history and can be an important part of your overall health and well-being. Take some time to review the preventive schedule and discuss it with your doctor.

The following preventive schedule is current as of January 1, 2020. Periodic updates may be made to the schedule. Visit the Highmark Delaware website at **www.HighmarkBCBSDE.com** to view the current schedule.

2020 Preventive Schedule

Effective 1/1/2020

PLAN YOUR CARE: KNOW WHAT YOU NEED AND WHEN TO GET IT

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you. CHIP Members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

QUESTIONS?

- Call Member Service
- Ask your doctor
- Log in to your account

Adults: Ages 19+ Male Female

General Health Care	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Pelvic, Breast Exam	Once a year
Screenings/Procedures	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (including Colonoscopy)	• Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Certain Colonoscopy Preps With Prescription	• Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk
Hepatitis C Screening	High-risk
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years

* Routine checkup could include health history; physical; height, weight and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age woman.

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Adults: Ages 19+

Screenings/Procedures	
Mammogram	Ages 40 and older: Once a year including 3-D; baseline mammogram can be performed on women ages 35 to 39 based on Delaware state mandate
Osteoporosis (Bone Mineral Density) Screening	Age 65 and older: once every 2 years. Younger if at risk as recommended by physician
Pap Test	• Ages 21 to 65: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females
Immunizations**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	• One-time Tdap • Td booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2 or 3 dose series
Hepatitis B	At-risk or per doctor's advice: One 2 or 3 dose series
Human Papillomavirus (HPV)	To age 26: One 3-dose series
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles	• Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses
Preventive Drug Measures That Require a Doctor's Prescription	
Aspirin	• Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Raloxifene Tamoxifen	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products

* Meningococcal B vaccine per doctor's advice.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Preventive Drug Measures That Require a Doctor's Prescription

Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.

Preventive Care for Pregnant Women

Screenings and Procedures

- Gestational diabetes screening
- Hepatitis B screening and immunization, if needed
- HIV screening
- Syphilis screening
- Smoking cessation counseling
- Depression screening during pregnancy and postpartum
- Depression prevention counseling during pregnancy and postpartum
- Rh typing at first visit
- Rh antibody testing for Rh-negative women
- Tdap with every pregnancy
- Urine culture and sensitivity at first visit
- Alcohol misuse screening and counseling

Prevention of Obesity, Heart Disease and Diabetes

Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:

- Additional annual preventive office visits specifically for obesity and blood pressure measurement
- Additional nutritional counseling visits specifically for obesity
- Recommended lab tests:
  - ALT
  - AST
  - Hemoglobin A1c or fasting glucose
  - Cholesterol screening

Adult Diabetes Prevention Program (DPP)

Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

2020 Preventive Schedule

PLAN YOUR CHILD'S CARE: KNOW WHAT YOUR CHILD NEEDS AND WHEN TO GET IT

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations depends on what the doctor thinks is right for your child.

QUESTIONS?

- Call Member Service
- Ask your doctor
- Log in to you account

Children: Birth to 30 Months[1]

General Health Care	Birth	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
Screenings											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Screening							●				
Lead Screening						●	●			●	
Newborn Blood Screening and Bilirubin	●										
Immunizations											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)**					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2				Dose 3					
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional instrument vision screening to assess risk for ages 1 and 2 years. ** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

General Health Care	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	●
Screenings												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
Immunizations												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
Care for Patients With Risk Factors												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									• For all sexually active individuals • HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

*Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17 and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4 and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years[1]

Preventive Drug Measures That Require a Doctor's Prescription	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride
Prevention of Obesity and Heart Disease	
Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Adult Diabetes Prevention Program (DPP) Age 18	
Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

Women's Health Preventive Schedule

Services	
Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for age and developmentally appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy
Screenings/Procedures	
Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without Diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One form of contraception in each of the 18 FDA-approved methods is covered without cost sharing. If the doctor recommends a clinical service or FDA-approved item based on medical necessity, there will be no cost sharing.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations or your benefit coverage, please call the Member Service number on the back of your member ID card.

[1]Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grand-fathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association.

Discrimination is Against the Law

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

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Komirike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY：711）。

ترجمه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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HIGHMARK. DELAWARE

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HIGHMARKBCBSDE.COM

Using Your Prescription Drug Coverage

Your benefits include prescription drug coverage. You can fill prescriptions at pharmacies in your plan's pharmacy network. To locate a network pharmacy, go to your member website, **www.HighmarkBCBSDE.com**, log in, and click the **Prescriptions** tab. Scroll down to **Find a Pharmacy** and click on **Search Pharmacies**. Or call Member Service at the number on the back of your ID card. You may save money on medications that you take on an ongoing basis by choosing the convenient home delivery option. You can arrange for home delivery from the Express Scripts Pharmacy by calling 1-800-903-6228.

For maintenance prescription drugs, you have two choices:

- Your prescriptions can be conveniently delivered to your home.
- You can pick up your prescriptions at a retail pharmacy.

To choose the mail order option, simply let Express Scripts know that you would like mail order delivery of your medications by calling 1-855-686-9786. You can change your preference for retail or mail order delivery at any time by contacting Express Scripts.

Prescription Drug Management for Your Formulary

Your formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It covers products in every major treatment category. Your drug formulary may limit coverage of certain drugs to the generic formulation(s) or it may prefer generic formulations by assigning a lower cost share to those products as compared to the brand name formulations. Generic drugs have been determined by the FDA to be equivalent to the brand name drug. A list of drugs included on your formulary is on the Highmark Delaware member website. You can also call Member Service at the number on the back of your member ID card for more information. Please note that formulary changes may occur throughout a plan year, so be sure to check the Highmark Delaware website often.

Highmark Delaware may impose quantity level limits on certain prescription drugs. Limits are based on the manufacturer's recommended dosage and Highmark Delaware's determination. The limits control the quantity the pharmacy provider gives you for each new prescription or refill. Additional quantity restrictions may be imposed on your first prescription for certain covered drugs. This means that the quantity you get will be reduced as necessary while it is established that you can tolerate the drug.

Additional quantity restrictions may be imposed which limit the duration of therapy for a medication to ensure it's used for an appropriate length of time. The prescribing physician may contact Highmark Delaware if an additional quantity of the drug is medically necessary and appropriate. If Highmark Delaware determines that it is medically necessary and appropriate, additional quantities of the drug will be covered.

Certain drugs that your physician may prescribe require a prior authorization from Highmark Delaware. You can find out what specific drugs or drug classifications require prior

authorization by simply calling the Member Service number on your ID card or visiting www.HighmarkBCBSDE.com. Once the prescription is written, the provider or the member must request prior authorization from Highmark Delaware.

To obtain a prescription medication that is not included in the formulary, or to request prior authorization, your physician must complete the "Prescription Drug Medication Request Form" and return it to Highmark Delaware using either the fax number or the address as shown on the form for clinical review.

To print a copy of the "Prescription Drug Medication Request Form" for your provider to complete, log in to **www.HighmarkBCBSDE.com**, click on the **Coverage** tab, and then click on **Prescriptions Summary & Drug List**. Scroll down to the **Drugs Coverage** section and then click on the **Prescription Drug Medication Request Form** link.

You may also initiate this process yourself by following these steps: Log in to **www.HighmarkBCBSDE.com**, click on the **Coverage** tab, and then click on **Prescriptions Summary & Drug List**. Scroll down to the **Drugs Coverages** section and then click on **"Submit an online request."** Complete the form and click **Submit**.

Once a clinical decision has been made, a decision letter will be mailed to you and your provider. If your request for an exception is not granted, you can ask for a review of Highmark Delaware's decision by making an appeal.

See your Member Agreement for more details about your prescription drug benefits.

Women's Health and Cancer Rights Act of 1998

A diagnosis of breast cancer can be devastating. And while we hope you never face such a situation, we want you to know that Highmark Blue Cross Blue Shield Delaware will be there if you need us.

Our health plans are in compliance with the Women's Health and Cancer Rights Act of 1998. The federal act requires group health plans that cover mastectomies to also cover all stages of reconstruction and surgery of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. The act also requires such plans to offer coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedema. Coverage may be subject to deductibles and coinsurance. If you have any questions, please call Member Service at the number on the back of your ID card.

Info Is a Call Away

If you are facing decisions about breast cancer, you can discuss your options or concerns with a Blues On Call health coach anytime, day or night, by calling 1-888-BLUE-428.

Paying Your Monthly Premium

It's important to pay your monthly premiums to ensure that your coverage is active when you seek medical care. There are several ways to pay your premium, just pick the one that's right for you!

e-Bill
When you sign up online for e-Bill, your monthly premium is automatically deducted from your checking or savings account on the first day of each month – saving you time and eliminating the need to write checks. Set up recurring payments or pay month-by-month.

Set up your safe, secure and convenient e-Bill account today!

1. Visit **HighmarkBCBSDE.com**
2. Select **Pay Premium**
3. Select **Log In** if you have already set up your online account and follow the prompts.
4. Select **Pay as a Guest** to make a payment without logging in and follow the prompts.
5. Select **Register Here** to set up your online account.*
6. Once registered, select Pay Premium and follow the prompts.

*By registering, you'll gain full access to your member website in addition to e-Bill. Your member website allows you to view claims, keep track of your prescriptions and request refills, learn more about your coverage and benefits, locate doctors, hospitals, and other providers, and find a variety of wellness tools.

Electronic Funds Transfer (EFT)
EFT is a convenient way to pay your premiums by having them automatically withdrawn from your bank account each month. To set up EFT payments:

1. Go to **HighmarkBCBSDE.com**
2. Scroll down to **Helpful Links**
3. Select **Forms Library**
4. Select **Automatic Premium Payment**
5. Download the PDF file
6. Complete the form and mail it with a voided check and your bill to the address indicated

Please note that it takes 6 – 8 weeks for EFT set up and you must continue to pay your premium payments by another method during this time.

Mail
To pay your premium by mail, just include a check with your invoice and mail both to the address on the invoice.

Pay by Phone
To make your payment by phone, just call the Member Service number on the back of your member ID card. Be sure to have your account number and the bank's routing number available when you call.

Changes That Affect Your Premium

Here are three things that can change your premium amount that you need to report to us:

1. **Changes in Membership Status**
   You must report when you or any of your dependents have a change that can affect your enrollment, such as:

   - Marriage or divorce
   - Adding or removing a domestic partner or dependent
   - Termination or death of a dependent or policyholder
   - Eligibility for employer group health insurance coverage*
   - Eligibility for Medicare*

   To report a change for coverage you bought directly from Highmark Delaware, call the Member Service number on the back of your ID card. For coverage purchased on the Health Insurance Marketplace, call 1-800-318-2596 or visit **www.healthcare.gov**.

   *These situations won't affect your premium, but they should be reported.

2. **Changes in Household Income**
   If you bought your health coverage from the Health Insurance Marketplace, you must report changes in your household income. Increases or decreases in your income can affect your eligibility for the federal Advance Premium Tax Credit and/or cost-sharing reductions. To report changes, you must call 1-800-318-2596 or visit **www.healthcare.gov.**

   You can also check for increased or reduced premium credits or cost-sharing reductions on **healthcare.gov.**

3. **Changes in Tobacco Use**
   Tobacco use means that you used tobacco products on average four or more times per week within the past six months. If you indicated that you are a tobacco user when you enrolled for health coverage, your premium includes a tobacco surcharge. This means you pay a higher rate.

   If you are tobacco-free for six months, the new health care law no longer considers you to be a tobacco user. You are then eligible for an adjustment in your health insurance premium rate. After you have stopped using tobacco for six months, let us know so that we can adjust your rate. Simply call the Member Service number on the back of your ID card.

If You Need to Cancel or Terminate this Plan or Your EFT/eBill Payments

This section applies only to plans purchased directly from Highmark Delaware and does not affect those purchased through Healthcare.gov.

If you purchased your plan directly from Highmark Delaware and you would like to cancel or terminate coverage under this Plan, the Subscriber must contact the Plan to request cancellation/termination of your individual policy. The Subscriber must provide notice by calling the Member Service number on the ID Card prior to the requested termination date. Member requested cancellation/termination effective dates can only occur on the first of the month. Coverage will be canceled/terminated as of the first of the month following receipt of notification or as of your account paid to date (whichever is earlier). Cancellations will void the coverage and must be requested prior to the coverage effective date or no later than ten (10) days after receipt of the Member Agreement. Member Service can instruct you on cancellation/termination procedures. Please do **not** send policy change requests back with your monthly premium payment/invoice coupon. Contact Member Service instead.

In the event you plan to enroll in other coverage, the Subscriber must contact the Plan to request cancellation/termination of the individual policy. If applicable, it is the Subscriber's responsibility to notify any third party that is paying the premium on the Subscriber's behalf (the Plan will not refund premium payments because the Subscriber's request to the Plan or the third party payer was not provided in a timely fashion).

You are solely responsible for payment setup and cancellation for any EFT/eBill recurring payments, even when a third party payer is paying your premium on your behalf. Requesting cancellation/termination of your policy will cancel the recurring payment/EFT payments; however, you must first contact Member Service to request cancellation/ termination of your policy. Member Service can explain how recurring payments are done and can provide the date the next payment is scheduled to be withdrawn.

Highmark Delaware will communicate renewal, enrollment discontinuation and premium information to you using the billing/correspondence addresses you have provided. Communications sent to a third party address provided by you or your Agent/Broker acting on your behalf do not relieve you of the responsibility for providing payment and timely requests for cancellation/termination to the Plan.

Additional information can be found in the Member Agreement located in this booklet.

Paying for Your Care

Paying in the Provider's Office

A copayment, or copay, is a fixed amount you pay for a health service, such as a doctor's visit. If you owe a copayment, you need to pay it when you check in for your visit. Coinsurance is a percentage of the total cost of care that you also may need to pay. Network providers may have online tools to estimate your coinsurance costs. They can do this at the time of your visit. This lets you talk about costs with your provider before getting services. It also allows you to pay your share of the cost for services before leaving the office. Please note that copayments and coinsurance may not be required for some covered services.

The Explanation of Benefits

Once your claim is processed, you may receive an Explanation of Benefits (EOB) from us. The EOB is not a bill. It's a statement that gives you information about services you received. Services can be from physicians, facilities, or other professional providers. The EOB also includes costs you may owe for these services.

The EOB includes:

- The provider's charge
- The allowable amount
- The copayment, deductible, and coinsurance amounts, if applicable, that you're required to pay
- The total benefits payable
- The total amount you owe

You can get your EOB online by simply registering on the member website. Your EOB can also be mailed to you if that is your preference. If you do not owe a payment to the provider, you may not receive an EOB.

Filing Claims

A claim is a request you make for payment of the charges or costs for a covered service you received. If you receive services from a network provider, you do not have to file a claim. Your network provider takes care of that for you. If you go to an out-of-network provider, you may have to file the claim yourself. It is important to note that if you have an EPO or HMO plan you only have coverage for emergency and urgent care when out-of-network. If you have to file the claim yourself, simply follow these easy steps:

1. Know your benefits. Review your Member Agreement to see if the services you received are eligible under your plan.

2. Get a detailed bill that includes:
    - The name and address of the service provider
    - The patient's full name
    - Date of service
    - Description of the service/supply
    - Amount charged
    - Diagnosis or nature of illness
    - Doctor's certification for durable medical equipment
    - Nurse's license number and shift worked for private duty nursing
    - Total mileage for ambulance services

    Canceled checks, cash register receipts, or personal lists are not acceptable as bills.

3. Copy bills for your records. You must submit original bills. Once your claim is received, we cannot return bills.

4. Complete a claim form. Make sure all information is completed properly. Date the form. To download claim forms, go to **www.HighmarkBCBSDE.com,** click **Spending**, then **Forms Library**. You can also get a claim form by calling Member Service.

After you complete steps 1 through 4, attach all detailed bills to the claim form. Mail the form to the address on the form.

You can file multiple services for the same family member with one claim form. However, you must complete a separate claim form for each covered member. You must submit your claim no later than 12 months after the date you received services.

How to Submit a Complaint

You can submit a complaint if you are not satisfied with:

- Any part of your health care benefits
- A participating health care provider
- Coverage
- Operations
- Management policies

Please contact Member Service at the number on the back of your member ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

For plans purchased on the Health Insurance Marketplace:
Highmark Blue Cross Blue Shield Delaware
Member Grievance
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For all other plans:
Highmark Blue Cross Blue Shield Delaware
Member Grievance
Attn: Review Committee
P.O. Box 8832
Wilmington, DE 19899-8832

If this process does not meet your needs, your objection can be reviewed through an appeal process. Please refer to your Member Agreement in the back of this booklet for more details regarding your appeal rights. You may also call Member Service at the number on your member ID card.

Appeal Procedure

If you receive notification that your coverage has been rescinded or that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. You can file an appeal in writing or on the phone by calling the Member Service number on the back of your member ID card. If you file in writing, please include your identification and group numbers as displayed on your ID card. Mail your appeal to:

For plans purchased on the Health Insurance Marketplace:
Highmark Blue Cross Blue Shield Delaware
Member Grievance and Appeals
Attn: Review Committee
P.O. Box 1988
Parkersburg, WV 26102-1988

For all other plans:
Highmark Blue Cross Blue Shield Delaware
Member Grievance and Appeals
Attn: Review Committee
P.O. Box 8832
Wilmington, DE 19899-8832

If you decide to appeal by calling, you can call Member Service at the number on the back of your ID card. You must submit this appeal no later than 180 days from the date we notified you of the decision in order for your appeal to be reviewed. You should submit information to support your appeal.

We will review your appeal. You will be notified in writing of the appeal decision. Please refer to your Member Agreement in the back of this booklet for more details regarding your appeal rights.

Get Quality Care

Your plan pays for covered services, supplies, or medications that are medically necessary and appropriate. These might be to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. They must:

- Be generally accepted standards of medical practice
- Be clinically appropriate in type, frequency, extent, site, and duration
- Be considered effective for your illness, injury, or disease
- Not be for your or your provider's convenience
- Not be more costly than another service that may give you similar results

If your care requires prior authorization, your in-network provider will need to contact our Utilization Management (UM) team in Clinical Services to review the medical necessity of the service being requested. This includes inpatient and outpatient non-emergency care. This review helps to determine if a service, supplies, or medication are medically necessary and appropriate. For requests related to planned or non-emergency care, this review is done before the care is given. This must be done before your plan pays benefits. Your plan will not pay benefits if our team of doctors and nurses determine that the service, supplies, or medication are not medically necessary and appropriate.

Out-of-network Services

Your plan does not include coverage for out-of-network services except in the case of emergencies or urgently needed care. If you choose to receive care from an out-of-network provider for a non-emergent or non-urgent situation, you will be responsible for all costs associated with that care. If there are no in-network practitioners to provide the specialty care you need or located within a certain driving distance from you, we may consider approving that out-of-network care on a case-by-case basis before it is provided to you.

Out-of-network providers are not obligated to contact UM. If they do, they do not have to accept UM's decision, if not approved. As a result, you may receive services that are considered not medically necessary and appropriate under your plan and therefore not covered. You could be responsible for the cost of those services so it is important to understand your health plan coverage.

You or your designated representative should ask the out-of-network provider to request an authorization for these services. However, if your provider refuses that request, you or your designated representative should contact Highmark Delaware at the Member Service number on the back of your ID card.

Out-of-network emergency care services

In a medical emergency when you think you need immediate treatment, go directly to a hospital emergency room or call 911. Emergency care is care needed for the treatment of serious or life-threatening medical conditions that require immediate care. Emergency care is covered. You or your designated representative should contact Highmark Delaware Member Service at the number on the back of your member ID card and your PCP after the crisis has passed.

Please note: If you seek emergency care from an out-of-network provider, Highmark Delaware will ensure that you are not responsible for any amounts in excess of the Highmark Delaware payment, except for applicable deductible, coinsurance, and/or copayment required by your plan (i.e., pre-defined member responsibility). Providers may not balance bill you for charges beyond pre-defined member responsibility amounts, as required by your plan. If you should receive such a balance bill from an out-of-network provider for emergency care services, please contact Highmark Delaware immediately.

Out-of-network urgent care services

If you have a condition that is not life threatening but must be treated and cannot reasonably be postponed, your care that is medically necessary and appropriate will be covered – even if that provider is out-of-network. However, if the service or treatment requires authorization, the out-of-network provider will need to contact UM for medical necessity review.

You or your designated representative must contact Highmark Blue Cross Blue Shield Delaware to confirm the procedure, treatment, or covered service is medically necessary and appropriate. If the procedure, treatment, or covered service is not medically necessary and appropriate, the member will be financially responsible for the full amount of the out-of-network provider's charges.

Get Quality Service

How We Decide if a Technology or Drug Is Experimental

Medical researchers constantly experiment with new medical equipment, drugs, and other technologies. They also look for new applications for existing technologies. These could be for medical and behavioral health procedures, drugs, and devices.

A panel of medical professionals must evaluate these new technologies and new applications for existing technologies for:

- Safety
- Effectiveness
- Product efficiency

After these evaluations are completed, Highmark Delaware may recommend that the technology be considered a medical practice and a covered benefit. Or the technology may be considered "experimental or investigative." This technology is not generally covered. We may also re-evaluate it in the future.

Evaluating New Drugs

A Pharmacy and Therapeutics (P&T) Committee composed of pharmacists and physicians evaluates new drugs based on items such as:

- National and international data
- Current research
- Opinions from leading clinicians

The review process addresses factors such as:

- Safety
- Drug effectiveness
- Unique value
- Patient compliance
- Local physician and specialist input
- Financial impact of the drug

The P&T Committee then makes a recommendation on the new drug.

You may decide to pursue an experimental or investigative treatment. If a service you are going to receive may be experimental or investigational, find out if it's covered. You, the hospital, or a professional provider can call Member Service about coverage for experimental or investigational medications.

If You Suspect Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include, but are not limited to, the following:

- Submitting claims for services that you did not get
- Adding extra charges for services that you did not get
- Giving you treatment for services you did not need

Please call the toll-free Fraud Hotline at 1-800-438-2478.

Your Rights and Responsibilities

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

You have the right to:

1. Be treated with courtesy, consideration, respect, and dignity.
2. Receive privacy during office visits and treatment.
3. Refuse care from specific practitioners.
4. Know the professional background of anyone giving you treatment.
5. Discuss your health concerns with your health care professional.
6. Discuss the appropriateness or medical necessity of treatment options for your condition, regardless of cost or benefit coverage for those options.
7. Receive information about your care and charges for your care.
8. Receive from your provider, in easy-to-understand language, information about your diagnoses, treatment options, including risks, expected results, and reasonable medical alternatives.
9. 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.
10. Receive information about Highmark Delaware, its policies, procedures regarding its products, services, practitioners and providers, grievance procedures, and members'/enrollees' rights and responsibilities.
11. Play an active part in decisions about your health care, including formulating an advance directive.
12. Receive benefits and care without regard to race, color, gender, country of origin, or disability.
13. File a complaint with Highmark Delaware and receive a response to the complaint.
14. Submit a formal complaint about the quality of care given by your providers.
15. Make recommendations regarding Highmark Delaware's members' rights and responsibilities policies.

You have the responsibility to:

1. Double check that any facilities from which you receive care are covered by Highmark Delaware. Visit highmarkbcbsde.com or call the Customer Service number listed on your ID card to ask about a facility.
2. Show your ID card to all caregivers before having care.
3. Keep your appointments. If you will be late or need to cancel, give timely notice (in accordance with your provider's office policy). You may be responsible for charges for missed appointments.
4. Treat your providers with respect.

How We Protect Your Right to Privacy

We have policies and procedures to protect your privacy. This includes your Protected Health Information (PHI). PHI may be oral, written, or electronic.

- We do not discuss PHI outside of our offices.
- We confirm who you are before we discuss PHI on the phone.
- Our employees sign privacy agreements.
- Our employees use computer passwords to limit PHI access.
- We include privacy language in our provider contracts.

Highmark Notice of Privacy Practices

The Notice of Privacy Practices describes:

- How your medical information may be used and disclosed.
- How you can get access to this information.
- How we collect, use, and disclose non-public personal financial information.

To review our complete notice of privacy practices, please see the next page.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark Delaware al número al réves de su tarjeta de identificación de Highmark Delaware. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00.

HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE

NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

- **Our Legal Duties**

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

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

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

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

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

I. Uses and Disclosures of Protected Health Information

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

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

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

- **Payment**

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

►For example:

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

Health Care Operations

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

►For example:

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

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

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

(i) Business Associates.

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

(ii) Other Covered Entities.

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

B. Required by Law

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

C. Public Health Activities

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

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions.

Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

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

F. Legal Proceedings

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

G. Law Enforcement

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

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

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

I. Research

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

J. To Prevent a Serious Threat to Health or Safety

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

K. Military Activity and National Security, Protective Services

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

L. Inmates

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

M. Workers' Compensation

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

N. Others Involved in Your Health Care

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

O. Underwriting

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

P. Health Information Exchange

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange

patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

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

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

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

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

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

a. Used by the person who created the psychotherapy note for treatment purposes, or

b. Used or disclosed for the following purposes:

(i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;

(ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
(iii) if required for enforcement purposes;
(iv) if mandated by law;
(v) if permitted for oversight of the provider that created the note,
(vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
(vi) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

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

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

B. Right to an Accounting

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

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

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

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

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we

may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

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

D. Right to Request Confidential Communications

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

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

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

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

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

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

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

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark Delaware, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

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

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

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

For questions about this Privacy Notice, please contact:

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

RCD-030 (12-18)

HIGHMARK BCBSD INC. d/b/a

HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE

A wholly owned Subsidiary of Highmark Inc.
An independent licensee of the Blue Cross and Blue Shield Association

800 Delaware Avenue
Wilmington, DE 19801

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT IDENTIFIED AS SHARED COST BLUE EPO Bronze 7900

Required Outline of Coverage

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

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CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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I. **READ YOUR AGREEMENT CAREFULLY** - This outline provides a very brief description of the important features of your Agreement. This is not the insurance contract and only the actual Agreement provisions will control. The Agreement itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR AGREEMENT CAREFULLY!

II. **COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER EXPENSE COVERAGE** - Agreements of this category are designed to provide coverage for hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided at one network level of benefits with cost-sharing options such as deductibles, copayments, coinsurance amounts and benefit maximums.

Most Services are covered only when they are received from a network provider. Exceptions for Emergency Care Services, Ambulance Services, Urgent Care and Anesthesia, where benefits are provided for out-of-network providers, are noted in **SECTION SB – SCHEDULE OF BENEFITS** of the Agreement. Network services are limited to the Highmark Blue Cross Blue Shield Delaware Participating Provider Network and/or the Local PPO Network, depending upon where the member receives services. Covered pediatric dental services are limited to the United Concordia Advantage Plus 2.0 Provider Network and vision care services are limited to the Davis Vision Health Care Reform Provider Network. A gatekeeper is not required to access benefits. This program includes individual and family deductibles, coinsurance and copayment amounts. Benefits are subject to the Health Care Management Services provisions with possible loss of benefits for non-compliance.

III. **RENEWABILITY AND CHANGE OF PREMIUM**

Coverage under the Agreement continues until the end of the Benefit Period, and for each Benefit Period thereafter until terminated in accordance with this Agreement. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement. Subject to the right of the Plan to terminate coverage and to any amendment permitted under applicable law, this Agreement will remain in effect continually until terminated by the Subscriber or the Plan in accordance with Subsection T. **TERMINATION OF THE MEMBER'S COVERAGE UNDER THE AGREEMENT** of **SECTION GP - GENERAL PROVISIONS**.

Subject to the approval of the Delaware Department of Insurance, the Plan may adjust premiums on a class basis. Any change in the premium shall become applicable for Subscribers (and any dependents) upon the expiration of the Benefit Period. This Agreement will renew at the beginning of a Benefit Period at the premium for the age which the Subscriber (and any dependents) has then attained.

IV. A BRIEF DESCRIPTION OF THE BENEFITS CONTAINED IN THE AGREEMENT IS AS FOLLOWS:

A. **Daily Hospital Room and Board** - including a room with two (2) or more beds or a private room, when medically necessary and appropriate, and general nursing services.

B. **Miscellaneous Hospital Services** - including the use of medical equipment and specialty rooms, transplant services, services related to surgery and other usual and customary covered services such as drugs and medicines, diagnostic services, habilitative and rehabilitative services and therapy services not specifically excluded by the Agreement.

C. **Surgical Services** - including pre- and post-operative services, assistant at surgery, second surgical opinion and special surgical procedures which include oral surgery and mastectomy and breast cancer reconstruction.

D. **Anesthesia Services** - including the administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery. Benefits are provided for the administration of anesthesia for oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

E. **In-Hospital Medical Services** - including inpatient medical care visits, intensive medical care, concurrent care, consultation and routine newborn care.

F. **Out-of-Hospital Care** - including outpatient medical care visits and telemedicine services and specialist virtual visits; surgery of a non-dental nature; diagnostic services; chemotherapy; radiation therapy; physical medicine; speech therapy; occupational therapy; infusion therapy; oral surgery; routine adult and pediatric care; pediatric immunizations; routine gynecological examinations and papanicolaou smears; annual screening mammograms for members age forty (40) and over, and for any physician recommended mammograms for members under age forty (40); well-woman care; services for mastectomy and breast cancer reconstructive surgery; diabetes treatment for all types of diabetes; preventive medications, prescription drugs, certain immunizations, and specific devices when purchased from a participating pharmacy provider.

G. **Prosthetic Appliances** - including the purchase, fitting, adjustments, repairs and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses); initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof; the purchase, fitting, adjustments, repairs and replacement of supportive device which restricts or eliminates motion of a weak or diseased body part; and the rental purchase, adjustment, repairs and replacement of durable medical equipment.

H. **Other Benefits** - including home health agency covered services for eligible members; inpatient care in a skilled nursing facility; fertility care services; birthing center coverage for prenatal, labor, delivery and postpartum care, vision care services when provided by a participating vision provider; orthodontic treatment for congenital cleft palates; dental services related to accidental injury; and general anesthesia and associated services normally related to the administration of general anesthesia rendered in connection with covered and non-covered dental procedures or non-covered oral surgery as mandated by law.

I. **Emergency Care Services** - including the treatment of bodily injuries resulting from an accident, following the sudden onset of a medical condition or, following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following: 1) placing the member's health, or with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy, 2) causing serious impairment to bodily functions, 3) causing serious dysfunction of any bodily organ or part and for which care is sought as soon as possible after the medical condition becomes evident to the member or the member's parent or guardian.

Transportation and related emergency services provided by an ambulance service shall constitute emergency ambulance services if the injury or the condition satisfies the criteria above.

Use of an ambulance as transportation to an emergency room of a facility provider for an injury or condition that does not satisfy the criteria above will not be covered as emergency ambulance services.

In the event that the member requires emergency services, benefits will be provided at the network services benefit levels. The member will not be responsible for any difference between the Plan payment and the provider's charge. Once a Member is stabilized, the Plan reserves the right to transfer the Member's care from an out-of-network provider to a network provider. In connection with such transfer, the Plan will arrange for transport to the network provider without cost to the Member.

Treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law is not covered.

J. **Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement**

1. Benefit Period - the specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. For this program, the benefit period is a calendar year. A member's effective date is the date on which coverage under this program commences for the member.

2. Payment of Benefits - Benefit amounts are determined based on the plan allowance for covered services. The plan allowance is the allowance that the Plan utilizes to represent the value of covered services provided to a member based on the type of service and the provider who renders such service, or as required by law. The plan allowance is the portion of the provider's billed charge that is used by the Plan to calculate the Plan's payment to that provider and the member's liability.

   Benefit amounts for outpatient prescription drugs are determined based on the provider's allowable price for covered medications. The provider's allowable price is the amount at which the participating pharmacy provider has agreed with the Plan to provide covered medications, covered maintenance prescription drugs, and specific devices to members covered under the Agreement.

3. Schedule of Benefits

   Please see **SECTION SE – SCHEDULE OF BENEFITS** of the **INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT IDENTIFIED AS SHARED COST BLUE EPO Bronze 7900** for more information about what services this program covers and associated cost sharing.

V. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE AGREEMENT

A. **Medically Necessary and Appropriate** - "Medically necessary and appropriate" means services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Benefits under the Agreement for services or supplies will be provided only when the Plan, utilizing the criteria set forth in the paragraph above, determines that such service or supply is medically necessary and appropriate. "Dentally necessary" means dental services determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. This determination will be made by the dentist in accordance with guidelines established by the Plan.

B. **Experimental/Investigative Treatments** - The Plan does not cover services which it determines are experimental or investigative in nature because those services are not accepted by the medical community as effective treatments.

C. **Health Care Management Services** - A complete Health Care Management Service (HMS) Program requires review prior to non-emergency inpatient admissions and outpatient procedures or services to determine the medical necessity and appropriateness of the admission, place of services, or covered services ("precertification").

D. **Plan Payment and Member Liability**

The Plan uses the plan allowance to calculate the benefit payable and the financial liability of the member for medically necessary and appropriate services covered under the Agreement. In the case of outpatient prescription drug benefits, the Plan uses the provider's allowable price. Plan allowance and the provider's allowable price are set forth in Section III, Subsection J. ***Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement***.

1. Plan Payment

   The Plan's payment is determined by first subtracting any deductible and/or copayment liability from the plan allowance. The coinsurance percentage of the plan allowance set forth in Section III., Subsection J. ***Benefit Amounts, Durations, Limits, Deductibles and Coinsurance for Benefits Under the Agreement*** is then applied to that amount. This amount represents the Plan's payment. Any remaining coinsurance amount is the member's responsibility.

2. Member Liability

   The member's total liability is the sum of any deductible, copayment and/or member coinsurance obligation. Network providers will accept the Plan's payment plus the member's total liability as payment in full for the covered services provided to the member. However, out-of-network providers are not required to accept the Plan's payment as payment in full. When a member receives covered services from an out-of-network provider, the out-of-network provider may bill the member for the difference between the out-of-network provider's billed amount and the Plan's payment. This is in addition to any member coinsurance, deductible and/or copayment obligations. If a member receives services which are not covered under the Agreement, the member is responsible for all charges associated with those services.

   In certain circumstances, the Plan may have an agreement with a provider located within the Plan service area that is not participating in the Highmark Delaware Network for negotiated rates that are less than the provider's billed amount. When the member receives covered services from such an out-of-network provider, the provider will accept the Plan's negotiated rate as payment in full for covered services. The member will be responsible for any out-of-network service deductible, copayment and/or coinsurance amounts.

   In the event that a member requires non-emergency covered services that are not available within the network, the Plan may refer the member to a provider who is not a network provider. In such cases, services will be covered at the network service benefit level and the liability of the member will be limited to the network coinsurance amount plus any network deductible and/or copayment obligations. The member will not be responsible for any difference between the Plan payment and the provider's charge. Additionally, there are some instances where a member may not have the opportunity to make a provider selection. In such cases, claims for covered

services will be processed to apply network cost-sharing amounts and the Plan will prohibit provider balance billing to the member.

3. Outpatient Prescription Drug Benefits

   The Plan's payment for covered medications and specific devices purchased from a participating pharmacy provider is determined by first subtracting any deductible liability from the provider's allowable price. The coinsurance percentage as set forth in **SECTION SB - SCHEDULE OF BENEFITS** is then applied to that amount once the deductible, if any, has been satisfied. Any remaining coinsurance amount is the member's responsibility. The member's total liability for covered medications is the sum of any deductible and coinsurance obligations, if any. However, until the member has satisfied their deductible, the participating pharmacy provider is entitled to collect from the member 100% of the provider's allowable price for the covered medication at the time of purchase. Preventive medications are exempt from any deductible, and/or coinsurance obligation. No benefits are payable for covered medications purchased from a non-participating pharmacy provider. Coverage is not provided for prescription drugs and over-the-counter drugs not appearing on the formulary, unless an exception has been granted pursuant to the prescription drug exceptions process referenced in Section HC - Health Care Management Services of the Agreement.

4. Plan Payment for Vision Care Services

   The plan allowance for participating vision providers within or outside of Delaware is the amount agreed to by the participating vision provider as payment in full, as set forth in the agreement between the participating vision provider and the Plan.

5. Plan Payment for Pediatric Dental Services

   The plan allowance for participating dental providers within or outside Delaware is the amount agreed to by the participating dental provider as payment in full, as set forth in the agreement between the participating dental provider and the Plan.

E. **Exclusions**

Please see **SECTION EX – EXCLUSIONS** of the **INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT IDENTIFIED AS SHARED COST BLUE EPO Bronze 7900.**

HIGHMARK BCBSD INC. d/b/a
HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE

A wholly owned Subsidiary of Highmark Inc.
An independent licensee of the Blue Cross and Blue Shield Association

800 Delaware Avenue
Wilmington, DE 19801

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL EXCLUSIVE PROVIDER SUBSCRIPTION AGREEMENT IDENTIFIED AS SHARED COST BLUE EPO Bronze 7900

("Agreement")

GUARANTEED RENEWABLE

PREMIUM SUBJECT TO CHANGE ON A CLASS BASIS
(see Page 55 of this Agreement)

DESCRIPTION OF COVERAGE: This Agreement sets forth a comprehensive program of inpatient and outpatient facility, professional and ancillary provider benefits provided at network benefit levels with cost-sharing options such as deductible and/or coinsurance. Most Services are covered only when they are received from a network provider. Exceptions for Emergency Care Services, Ambulance Services, Urgent Care and Anesthesia, where benefits are provided for out-of-network providers, are noted in **SECTION SB – SCHEDULE OF BENEFITS**. Network services are limited to the Highmark Blue Cross Blue Shield Delaware Participating Provider Network and/or the Local PPO Network, depending upon where the member receives services. Covered pediatric dental services are limited to the United Concordia Advantage Plus 2.0 Provider Network and vision care services are limited to the Davis Vision Health Care Reform Network. A gatekeeper is not required to access benefits. This program includes individual and family deductibles, and coinsurance amounts. Benefits are subject to the Health Care Management Services provisions with possible loss of benefits for non-compliance. This Agreement is non-participating in any divisible surplus of premium.

Subscriber's Right to Examine Agreement for Ten (10) Days

The Subscriber shall have the right to return the Agreement within ten (10) days of its delivery and to have the premium rate refunded if, after examination of the Agreement, the Subscriber is not satisfied for any reason.

HIGHMARK. Delaware

Nicholas Moriello, Market President

*An independent licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

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

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

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ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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Highmark Blue Cross Blue Shield Delaware

(hereinafter called "the Plan")

Individual Comprehensive Major Medical
Exclusive Provider Subscription Agreement
Identified As
SHARED COST BLUE EPO Bronze 7900

In consideration for and upon payment of the appropriate premium, the persons covered under this Agreement are entitled to health care benefits set forth herein in accordance with the terms and conditions of this Agreement. A newborn child of a Member, whether natural born, adopted, or placed for adoption will also be entitled to health care benefits set forth herein in accordance with the terms and conditions of this Agreement from the moment of birth to a maximum of thirty-one (31) days from the date of birth.

Guaranteed Renewable
Premium Subject to Change on a Class Basis

Subject to the approval of the Delaware Department of Insurance, the Plan may adjust premiums on a class basis. Any change in the premium shall become applicable for Subscribers (and any dependents) upon the expiration of the Benefit Period. This Agreement will renew at the beginning of a Benefit Period at the premium for the age which the Subscriber (and any dependents) has then attained. Premiums are payable in advance on a monthly basis. Members may submit amounts in excess of the specific premium amount. However, such excess amounts will be applied on a monthly basis and the application of such excess amounts will not guarantee the continuation of coverage in the event of the loss of eligibility in accordance with **SECTION SE - SCHEDULE OF ELIGIBILITY**. Coverage will be subject to premium increases on the date the increase becomes effective.

Coverage continues until the end of the Benefit Period, and for each Benefit Period thereafter until terminated in accordance with this Agreement. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement. Subject to the right of the Plan to terminate coverage and to any amendment permitted under applicable law, this Agreement will remain in effect continually until terminated by the Subscriber or the Plan in accordance with Subsection T. **TERMINATION OF THE MEMBER'S COVERAGE UNDER THE AGREEMENT** of **SECTION GP - GENERAL PROVISIONS**.

IMPORTANT NOTICE

Regarding Treatment Which the Plan Determines Is Not Medically Necessary and Appropriate

The Plan only provides benefits for Covered Services which it determines to be Medically Necessary and Appropriate. Medical Necessity and Appropriateness of Covered Services may be determined either prior to the service being rendered or after the service has been rendered.

A Network Provider in the Plan Service Area will accept the Plan's determination of Medical Necessity and Appropriateness, and not bill the Member for Covered Services that require Highmark Delaware's prior authorization and that the Plan determines are not Medically Necessary and Appropriate, except when the Member elects to receive the Services after being advised that the Services have been determined not to be Medically Necessary and Appropriate. An Out-of-Network Provider is not obligated to accept the Plan's determination and, therefore, may bill the Member for Services determined not to be Medically Necessary and Appropriate. The Member is solely responsible for payment of such Services. The Member can avoid this responsibility by choosing a Network Provider. If a Member has a concern about a Service being covered, he/she should contact the Plan prior to the Service being rendered.

A Participating Dentist or a Participating Vision Provider will accept the Plan's determination of Medical Necessity and Appropriateness and not bill the Member for Covered Services that the Plan determines are not Medically Necessary and Appropriate, except when the Member elects to receive the Services after being advised that the Services have been determined not to be Medically Necessary and Appropriate. An Out-of-Network Dentist or Vision Provider is not obligated to accept the Plan's determination and, therefore, may bill the Member for Services determined not to be Medically Necessary and Appropriate. The Member is solely responsible for payment of such Services. The Member can avoid this responsibility by choosing a Network Provider. If a Member has a concern about a Service being covered, he/she should contact the Plan prior to the Service being rendered.

For any questions regarding the Medical Necessity and Appropriateness of a service, the Member may contact the Plan at the toll-free telephone number on the Member Identification Card.

See **SECTION DE - DEFINITIONS** for the definition of Medically Necessary and Appropriate and **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** for additional information.

Regarding Experimental/Investigative Treatments

The Plan does not cover services which it determines are Experimental or Investigative in nature because those services are not accepted by the medical community as effective treatments. However, the Plan acknowledges that situations exist when a patient and his or her Professional Provider agree to pursue an Experimental treatment. If the Member's Provider performs an Experimental procedure, the Member is responsible for the charges. The Member or the Member's Professional Provider may contact the Plan to determine whether a service is considered Experimental or Investigative.

See **SECTION DE - DEFINITIONS** for the definition of Experimental/Investigative.

SECTION DE - DEFINITIONS

1. **ADVANCE PAYMENT OF PREMIUM TAX CREDITS (APTCs)** - tax credit payments made on behalf of the Member to the Plan, on an advance basis and in amounts as determined by the Exchange, which are applied to the premium amounts due under this Agreement.

2. **AFFORDABLE CARE ACT (ACA)** - the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and its implementing regulations.

3. **AGREEMENT** - this Agreement, including the application and endorsements, if any, between the Plan and the Subscriber, the Member's enrollment confirmation letter, the Member's current Identification Card, and the Highmark Preventive Schedule, as amended from time to time.

4. **AMBULANCE SERVICE** - an Ancillary Provider licensed by the state which, for compensation from its patients, provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

5. **AMBULATORY SURGICAL FACILITY** - a Facility Provider, with an organized staff of Physicians, which is licensed as required by the state, and which, for compensation from its patients:

   a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

   b. provides treatment by or under the supervision of Physicians and nursing Services whenever the patient is in the facility;

   c. does not provide Inpatient accommodations; and

   d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

6. **ANCILLARY PROVIDER** - a person or entity licensed where required and performing services within the scope of such licensure. Ancillary Providers include:

Ambulance Service	Independent Diagnostic Testing Facility (IDTF)
Clinical Laboratory	Suite Infusion Therapy Provider
Diabetes Prevention Provider	Suppliers
Home Infusion Therapy Provider	

   For purposes of this Agreement, Ancillary Providers that have an agreement, either directly or indirectly, with the Plan pertaining to payment as a participant in the Highmark Delaware Network for Covered Services rendered to a Member, or have an agreement, either directly or indirectly with Highmark Delaware or with any licensee of

the Blue Cross Blue Shield Association located Out-of-Area pertaining to payment as a network participant for Covered Services rendered to Members shall be considered a Network Provider when calculating the Provider/Supplier reimbursement and Member liability.

7. **ANESTHESIA** - the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

8. **ANNUAL OPEN ENROLLMENT PERIOD** - the annual period from November 1st through December 15th during which an eligible individual may enroll under this Agreement.

9. **ARTIFICIAL INSEMINATION** - a procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

10. **AUTISM SPECTRUM DISORDERS** - any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

11. **BARIATRIC SURGERY** - an operation on the stomach and/or intestines intended to help promote weight loss including, but not limited to, vertical banded gastroplasty, gastric stapling, laparoscopic adjustable gastric banding, mini-gastric bypass, gastric bypass with Roux-en-Y, biliopancreatic diversion, biliopancreatic diversion with duodenal switch, long-limb gastric bypass, intestinal gastric bypass, or any other surgical procedure designed to restrict an individual's ability to assimilate food.

12. **BENEFIT PERIOD** - the specified period of time during which this Agreement provides health care coverage for Members, and during which charges for Covered Services must be Incurred in order to be eligible for payment by the Plan. For purposes of this Agreement, a Benefit Period is a calendar year.

13. **BIRTHING FACILITY** - a Facility Provider licensed by the state which, for compensation from its patients, is primarily organized and staffed to provide maternity care and is under the supervision of a Nurse-Midwife.

14. **BLUECARD PARTICIPATING PROVIDER** - an Ancillary Provider, Professional Provider or Facility Provider located Out-of-Area that has an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association pertaining to payment as a participant in that licensee's PPO network for Covered Services rendered to a Member under this Agreement.

15. **BLUES ON CALL (Health Education and Support Program)** - a program administered by the Plan's Designated Agent through which the Member receives health education and support services, including assistance in the self-management of certain health conditions.

16. **BRAND DRUG** - a recognized trade name drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name drug for multi-source drugs and noted as such in the pharmacy database used by the Plan.

17. **CERTIFIED REGISTERED NURSE** - a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the state Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

18. **CLAIM** - a request made by or on behalf of a Member for Precertification or prior approval of a Covered Service, as required under this Agreement, or for the payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Member. Claims for benefits provided under this Agreement include:

    a. Pre-service Claim - a request for Precertification or prior approval of a Covered Service which, as a condition to the payment of benefits under this Agreement, must be approved by the Plan before the Covered Service is received by the Member.

    b. Urgent Care Claim - a Pre-service Claim which, if decided within the time periods established by the Plan for making non-urgent care Pre-service Claim decisions, could seriously jeopardize the life or health of the Member, the ability of the Member to regain maximum function or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the Service requested. Whether a request involves an Urgent Care Claim will be determined by the Member's attending Physician or Provider.

    c. Post-service Claim - a request for payment or reimbursement of the charges or costs associated with a Covered Service that has been received by a Member.

    For purposes of the Claim determination and appeal procedure provisions of this Agreement, whether a Claim or an appeal of a denied Claim involves a Pre-service Claim, an Urgent Care Claim or a Post-service Claim will be determined at the time that the Claim or appeal is filed with the Plan in accordance with its procedures for filing Claims and appeals.

19. **CLINICAL LABORATORY** - a medical laboratory licensed where required, performing within the scope of such licensure, and is not affiliated or associated with a Hospital or Physician.

20. **CLINICAL SOCIAL WORKER** - a licensed Clinical Social Worker performing within the scope of such licensure. Where there is no licensure law, the Clinical Social Worker must be certified by the appropriate professional body.

21. **CLINICAL TRIAL** - a research project that is approved or funded by use of the following entities:

    a. One of the National Institutes of Health (NIH);

    b. An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approval peer review program operating within the group, including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

    c. The federal Departments of Veterans' Affairs or Defense;

    d. An institutional review board of an institution in Delaware that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; and

    e. A qualified research entity that meets the criteria for NIH Center Support grant eligibility.

22. **COINSURANCE** - the percentage of the Plan Allowance for Covered Services that is the responsibility of the Member. The remaining percentage is the responsibility of the Plan, subject to the provisions of the Agreement.

23. **CONTRACTING SUPPLIER** - a Supplier who has an agreement with any licensee of the Blue Cross Blue Shield Association located Out-of-Area, either directly or indirectly, pertaining to payment for the sale or lease of Durable Medical Equipment, supplies, prosthetics, and orthotics to a Member.

24. **COPAYMENT** - a specified dollar amount of eligible expenses which the Member is required to pay for a specified Covered Service and which will be deducted from the Plan Allowance before the determination of the benefits payable under this Agreement is made.

25. **COST-SHARING REDUCTIONS** - reductions as determined by the Exchange in the cost-sharing amounts for which the Member is otherwise responsible to pay under this Agreement.

26. **COVERED MEDICATIONS** - Prescription Drugs and Over-the-Counter Drugs ordered by a Professional Provider by means of a valid Prescription Order which the Plan is contractually obligated to pay or provide as a benefit to a Member.

27. **COVERED SERVICE** - a Service or supply, including Vision Care Services, specified in this Agreement which is eligible for payment when rendered by a Provider or Supplier.

28. **CUSTODIAL CARE** - care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Multiple non-Skilled Nursing Services/non-Skilled Rehabilitation Services in the aggregate do not constitute Skilled Nursing

Services/Skilled Rehabilitation Services. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparing special diets and supervising the administration of medications not requiring Skilled Nursing Services/Skilled Rehabilitation Services provided by trained and licensed medical personnel.

29. **DAY/NIGHT PSYCHIATRIC FACILITY** - a Facility Provider licensed by the state which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness only during the day or only during the night.

30. **DEDUCTIBLE** - a specified dollar amount of liability for Covered Services that must be Incurred before the Plan will assume any liability for all or part of the remaining Covered Services.

31. **DENTALLY NECESSARY** - dental services determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. This determination will be made by the Dentist in accordance with guidelines established by the Plan.

32. **DENTIST** - a person who is a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

33. **DEPENDENT** - a Member other than the Subscriber as specified in **SECTION SE - SCHEDULE OF ELIGIBILITY**.

34. **DESIGNATED AGENT** - an entity that has contracted with the Plan, either directly or indirectly, to perform a function and/or Service in the administration of this Agreement. Such function and/or Service may include, but is not limited to, medical management.

35. **DESIGNATED TELEMEDICINE PROVIDER** - a Physician, licensed where required and performing within the scope of such licensure, who limits his or her practice to family, general or internal medicine and who has an agreement with a vendor that has contracted with the Plan to provide Telemedicine Services.

36. **DIABETES EDUCATION PROGRAM** - an Outpatient program of self-management training and education, including medical nutrition therapy, for the treatment of diabetes. Such Outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education Services will be covered subject to the criteria of the Plan. These criteria are based on the certification programs for Outpatient diabetes education developed by the American Diabetes Association and other appropriate bodies.

37. **DIABETES PREVENTION PROGRAM** - a twelve (12) month program utilizing a curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for individuals at high risk of developing type 2 diabetes. The Diabetes Prevention Program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

38. **DIABETES PREVENTION PROVIDER** - an entity that offers a Diabetes Prevention Program.

39. **DIAGNOSTIC SERVICE** - a testing procedure ordered by a Professional Provider because of specific symptoms to determine a definite condition or disease or for the purpose of routine screening. Diagnostic Services covered under this Agreement are set forth in **SECTION DB - DESCRIPTION OF BENEFITS**.

40. **DIETICIAN-NUTRITIONIST** - a licensed dietician-nutritionist performing within the scope of such licensure. Where there is no licensure law, the dietician-nutritionist must be certified by the appropriate professional body.

41. **DOMESTIC PARTNER** - a member of a Domestic Partnership consisting of two (2) partners, who meet all of the following:

    a. is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;

    b. is not related to the other partner by adoption or blood;

    c. is the sole Domestic Partner of the other partner and has been a member of this Domestic Partnership for the last six (6) months;

    d. agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and

    e. meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships which are currently enacted, or which may be enacted in the future.

42. **DOMESTIC PARTNERSHIP** - a voluntary relationship between two (2) Domestic Partners.

43. **DURABLE MEDICAL EQUIPMENT** - items which can withstand repeated use, are primarily and customarily used to serve a productive medical purpose, are generally not useful to a person in the absence of illness, injury or disease, are appropriate for use in the home and do not serve as comfort or convenience items.

44. **EFFECTIVE DATE** - according to **SECTION SE - SCHEDULE OF ELIGIBILITY**, the date on which coverage for a Member begins under this Agreement.

45. **EMERGENCY CARE SERVICES** - the treatment:

    a. of bodily injuries resulting from an accident;

    b. following the sudden onset of a medical condition; or

c. following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:

i) placing the Member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

ii) causing serious impairment to bodily functions; or

iii) causing serious dysfunction of any bodily organ or part;

and for which care is sought as soon as possible after the medical condition becomes evident to the Member, or the Member's parent or guardian.

Transportation and related emergency services provided by an Ambulance Service shall constitute Emergency Ambulance Services if the injury or the condition satisfies the criteria above.

Use of an ambulance as transportation to an emergency room of a Facility Provider for an injury or condition that does not satisfy the criteria above will not be covered as Emergency Ambulance Services.

Treatment for any occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law is not covered.

46. **ENTERAL FOODS** - a liquid source of nutrition administered under the direction of a Physician which may contain some or all nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

47. **EXCHANGE (HEALTH INSURANCE MARKETPLACE)** - the approved governmental agency or non-profit entity performing required public exchange functions as set forth in the Affordable Care Act. This term refers to State Exchanges, State-Federal Partnership Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

48. **EXCLUSIVE PHARMACY PROVIDER** - a Pharmacy Provider performing within the scope of its license that has an agreement, either directly or indirectly, with the Plan pertaining to the payment and exclusive dispensing of selected Prescription Drugs provided to a Member, as set forth in this Agreement and where allowed by law.

49. **EXPERIMENTAL/INVESTIGATIVE** - the use of any treatment, Service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Plan to be medically effective for the condition being treated.

The Plan will consider an intervention to be Experimental/Investigative if:

a. the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or

b. available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or

c. the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or

d. the intervention does not improve health outcomes; or

e. the intervention is not proven to be applicable outside the research setting.

If an intervention as defined above is determined to be Experimental/Investigative at the time of Service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date.

50. **FACILITY PROVIDER** - an entity which is licensed, where required, to render Covered Services. Facility Providers include:

Ambulatory Surgical Facility
Birthing Facility
Day/Night Psychiatric Facility
Freestanding Dialysis Facility
Freestanding Nuclear Magnetic Resonance Facility/Magnetic Resonance Imaging Facility
Home Health Care Agency
Hospice
Hospital
Outpatient Physical Rehabilitation Facility
Outpatient Psychiatric Facility
Outpatient Substance Abuse Treatment Facility
Pharmacy Provider
Psychiatric Hospital
Rehabilitation Hospital
Residential Treatment Facility
Skilled Nursing Facility
State-Owned Psychiatric Hospital
Substance Abuse Treatment Facility

51. **FAMILY COUNSELING** - counseling with family members in the assessment of the patient's diagnosis and treatment. Such counseling may assist family members to gain insight into the patient's illness and serve as an adjunct of the treatment regimen. Nevertheless, the Services must primarily relate to the management of the patient's illness.

52. **FAMILY COVERAGE** - coverage for the Subscriber and one (1) or more Dependents.

53. **FAMILY DEDUCTIBLE** - a specified dollar amount of liability for Covered Services that must be Incurred in the manner set forth in **SECTION SB** of this Agreement. Once the Family Deductible is met, no further Deductible amounts must be satisfied by any covered family member.

54. **FORMULARY** - a listing of Prescription Drugs and Over-the-Counter Drugs selected by the Plan based on an analysis of clinical efficacy, unique value, safety, and pharmacoeconomic impact. This listing is subject to periodic review and modification by the Plan or a designated committee of Physicians or pharmacists.

55. **FREESTANDING DIALYSIS FACILITY** - a Facility Provider licensed and approved by the appropriate governmental agency which, for compensation from its patients, is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

56. **FREESTANDING NUCLEAR MAGNETIC RESONANCE FACILITY/ MAGNETIC RESONANCE IMAGING FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing, through an organized professional staff, nuclear magnetic resonance/magnetic resonance imaging scanning. These facilities do not include Inpatient beds, medical or health-related Services.

57. **GENERIC DRUG** - a drug that is available from more than one (1) manufacturing source, accepted by the Federal Food and Drug Administration ("FDA") as a substitute for those products having the same active ingredients as a Brand Drug, and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations", otherwise known as the Orangebook, and noted as such in the pharmacy database used by the Plan.

58. **HABILITATIVE OR REHABILITATIVE SERVICES** - the following Services or supplies ordered by a Professional Provider to promote the restoration, maintenance or improvement in the level of function following disease, illness or injury. This also includes therapies to achieve functions or skills never acquired due to congenital and developmental anomalies. Habilitative and Rehabilitative Services are covered to the extent specified in **SECTION SB - SCHEDULE OF BENEFITS**.

    a. Applied Behavior Analysis (ABA) Services - means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

    b. Cardiac Rehabilitation - the physiological rehabilitation of patients with cardiac conditions through regulated exercise, diet and other lifestyle modification programs.

    c. Occupational Therapy - the treatment by means of constructive activities designed and adapted to promote the ability to satisfactorily accomplish the ordinary tasks of daily living and those required by a particular occupational role. Occupational Therapy includes Cognitive Rehabilitation: therapeutic activities designed to improve cognitive function and retrain an individual's ability to think, use judgment and make decisions. The focus of these therapeutic activities is to improve deficits in memory, attention, perception, visual processing, language, reasoning, learning, planning, judgment, and problem-solving resulting from traumatic and acquired brain injury caused by brain hemorrhage, cerebral thrombosis, concussion, fractured skull, encephalopathy, and anoxic brain damage.

d. Physical Medicine - the treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities.

e. Speech Therapy - the treatment for the correction of a speech impairment.

59. **HEALTH CARE MANAGEMENT SERVICES** - a program which integrates all activity related to managing a Member's medical care from the time that an admission, surgical or diagnostic procedure, or certain services become necessary. The program consists of any applicable Pre-admission Certification, Admission Certification of Emergency Admissions, Outpatient Procedure or Covered Service Precertification, Continued Stay Review, Discharge Planning, and Individual Case Management.

60. **HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE** - an independent licensee of the Blue Cross Blue Shield Association. Any reference to Highmark Blue Cross Blue Shield Delaware may also include its designated agents with whom Highmark Blue Cross Blue Shield Delaware has contracted to perform a function or service.

61. **HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE PARTICIPATING PROVIDER** - a Facility Provider that has a Highmark Blue Cross Shield Delaware Participating Facility Provider agreement, either directly or indirectly, with the Plan pertaining to payment as a participant in the Plan's network for Covered Services rendered to a Member.

62. **HOME HEALTH CARE AGENCY** - a Facility Provider or Hospital program for home health care, licensed by the state and certified by Medicare which, for compensation from its patients:

a. provides skilled nursing and other services on a visiting basis in the Member's home, and

b. is responsible for supervising the delivery of such services under a plan prescribed by the attending Physician.

63. **HOME INFUSION THERAPY PROVIDER** - an Ancillary Provider, licensed by the state, accredited by The Joint Commission, if appropriate, and is organized to provide Infusion Therapy to patients at their place of residence.

64. **HOSPICE** - a Facility Provider, licensed by the state which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

65. **HOSPICE CARE** - a program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice Services are centrally coordinated through an interdisciplinary team directed by a Physician.

66. **HOSPITAL** - a duly licensed Facility Provider that is a general or special Hospital which has been approved by Medicare, The Joint Commission or by the American Osteopathic Hospital Association, and which, for compensation from its patients:

    a. is primarily engaged in providing Inpatient Diagnostic and therapeutic Services for the diagnosis, treatment, and care of injured and sick persons; and

    b. provides twenty-four (24)-hour nursing services by or under the supervision of Registered Nurses.

67. **IDENTIFICATION CARD** - the currently effective card issued to the Member by the Plan.

68. **IMMEDIATE FAMILY** - the Member's spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in- law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

69. **IN-AREA** - the geographic area covering the Plan Service Area.

70. **INCURRED** - a charge is considered Incurred on the date a Member receives the Service or supply for which the charge is made.

71. **INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)** - an Ancillary Provider operating from a fixed or mobile location, which performs diagnostic testing services, other than clinical laboratory or pathology testing, using diagnostic testing and imaging equipment including, but not limited to, sleep centers/home sleep testing providers, mobile x-ray providers and cardiac event monitoring providers, and other diagnostic imaging providers. Such technical services do not include the interpretation of test results by a Professional Provider.

72. **INFERTILITY –** a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth.

73. **INFUSION THERAPY** - the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein to patients.

74. **INPATIENT** - a Member who is a registered bed patient in a Facility Provider and for whom a room and board charge is made.

75. **IATROGENIC INFERTILITY** – an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.

76. **LIMITED OPEN ENROLLMENT PERIOD** - a period during which an eligible individual who experiences certain qualifying events may enroll or change enrollment in the coverage provided under this Agreement when such coverage is not provided pursuant to enrollment through the Exchange. Limited Open Enrollment Periods are provided to individuals who experience qualifying events, which applicable federal law, regulations and guidance have determined result in limited open enrollment period rights.

77. **LOCAL PPO NETWORK** - all Ancillary Providers, Facility Providers, Professional Providers and Suppliers who have an agreement, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association located Out-of-Area pertaining to payment as a participant in that licensee's PPO network for Covered Services rendered to a Member under this Agreement.

78. **MAINTENANCE PRESCRIPTION DRUG** - a Prescription Drug ordered by a Physician by means of a valid Prescription Order for control of a chronic disease or illness or to alleviate the pain and discomfort associated with a chronic disease or illness.

79. **MARRIAGE AND FAMILY THERAPIST** - a licensed Marriage and Family Therapist performing within the scope of such licensure. Where there is no licensure law, the Marriage and Family Therapist must be certified by the appropriate professional body.

80. **MAXIMUM** - the greatest amount for which the Plan may be liable for Covered Services within a prescribed period of time. This could be expressed in number of days or number of Services.

81. **MEDICAL CARE** - professional services rendered by a Professional Provider or Professional Other Provider for the treatment of an illness or injury.

82. **MEDICALLY NECESSARY AND APPROPRIATE (MEDICAL NECESSITY AND APPROPRIATENESS)** - Services or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

    a. in accordance with generally accepted standards of medical practice;

    b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

    c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

    The Plan reserves the right, utilizing the criteria set forth in this Definition, to render the final determination as to whether a Service or supply is Medically Necessary and Appropriate. No benefits hereunder will be provided unless the Plan determines that the Service or supply is Medically Necessary and Appropriate.

83. **MEDICARE** - the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

84. **MEMBER** - an individual who meets the eligibility requirements specified in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement.

85. **MENTAL ILLNESS** - an emotional or mental disorder characterized by a neurosis, psychoneurosis, psychopathy, or psychosis without demonstrable organic origin.

86. **NETWORK** - depending on where the Member receives Services, the Network is designated as one (1) of the following:

    a. When the Member receives Services within the Plan Service Area, the designated network for Professional Providers, Facility Providers and Ancillary Providers, is the Highmark Blue Cross Blue Shield Delaware Participating Provider Network. All other Providers located within the Plan Service Area, are not considered Network Providers.

    b. When the Member receives Services Out-of-Area outside Delaware, the designated network for Professional Providers, Facility Providers and Ancillary Providers is the Local PPO Network. All other Providers located Out-of-Area and outside of Delaware who have not signed an agreement pertaining to payment as a Local PPO Network participant are not considered Network Providers.

87. **NETWORK DIABETES PREVENTION PROVIDER** - a Diabetes Prevention Provider that contracts with:

    a. the Plan to offer a Diabetes Prevention Program based on a digital model; or

    b. the Plan or the local licensee of the Blue Cross Blue Shield Association to offer a Diabetes Prevention Program based on an in-person/onsite model.

88. **NETWORK FACILITY PROVIDER** - a Facility Provider located within the Network Service Area, that has an agreement with the Plan, either directly or indirectly, pertaining to payment as a Network participant for Covered Services rendered to a Member.

89. **NETWORK PROVIDER** - an Ancillary Provider, Professional Provider or Facility Provider who has an agreement, either directly or indirectly, with the Plan pertaining to payment as a Network participant for Covered Services rendered to Members.

90. **NETWORK SERVICE** - a Service, treatment or care that is provided by a Network Provider or Supplier. For purposes of this Agreement this includes Covered Medications provided by a Participating Pharmacy Provider.

91. **NETWORK SERVICE AREA** - the geographic area consisting of the State of Delaware and contiguous counties in the States of Maryland and New Jersey and in the Commonwealth of Pennsylvania.

92. **NON-FORMULARY PRESCRIPTION DRUG** - any Prescription Drug not designated in a formulary listing as a Formulary Prescription Drug by the Plan as amended from time to time.

93. **NON-PARTICIPATING DENTIST** - a Dentist who does not have an agreement, directly or indirectly, with the Plan pertaining to payment as a participant in the United Concordia Advantage Provider Network for Covered Services rendered to a Member.

94. **NON-PARTICIPATING PHARMACY PROVIDER** - a Pharmacy Provider licensed where required and performing within the scope of its license that does not have an agreement, either directly or indirectly, with the Plan pertaining to the payment for Covered Medications provided to a Member.

95. **NURSE-MIDWIFE** - a licensed Nurse-Midwife. Where there is no licensure law, the Nurse-Midwife must be certified by the appropriate professional body.

96. **OCCUPATIONAL THERAPIST** - a licensed Occupational Therapist performing within the scope of such licensure. Where there is no licensure law, the Occupational Therapist must be certified by the appropriate professional body.

97. **OUT-OF-AREA** - the geographic area outside the Plan Service Area. Certain Ancillary Providers, Professional Providers and Facility Providers that are located Out of Area will be BlueCard Participating Providers that have agreements, either directly or indirectly, with any licensee of the Blue Cross Blue Shield Association pertaining to payment as a participant in that licensee's PPO network for Covered Services rendered to a Member under this Agreement.

98. **OUT-OF-NETWORK PROVIDER** - a Provider who does not have an agreement, either directly or indirectly, with the Plan, or with any licensee of the Blue Cross Blue Shield Association located Out-of-Area, pertaining to payment as a Network participant for Covered Services provided to a Member.

99. **OUT-OF-NETWORK SERVICE** - a Service, treatment or care that is provided by an Out-of-Network Provider.

100. **OUT-OF-POCKET MAXIMUM** - a specified dollar amount of Deductible, Copayment and Coinsurance expenses Incurred by a Member for Covered Services in a Benefit Period, after which the level of benefits payable by the Plan is increased to one hundred percent (100%) of the Plan Allowance such that the Member will not be liable for any additional Deductible, Copayment or Coinsurance expenses in that Benefit Period.

101. **OUTPATIENT** - a Member who receives Services or supplies while not an Inpatient

102. **OUTPATIENT PHYSICAL REHABILITATION FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing a variety of Habilitative and Rehabilitative services on an Outpatient basis.

103. **OUTPATIENT PSYCHIATRIC FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing Diagnostic and Therapeutic Services for the treatment of Mental Illness on an Outpatient basis.

104. **OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing rehabilitative counseling services for the treatment of Substance Abuse and Diagnostic and Therapeutic Services for the treatment of Substance Abuse on an Outpatient basis. This facility must also meet the minimum standards set by the Delaware Department of

Health and Social Services, Division of Substance Abuse and Mental Health, or another appropriate governmental agency.

105. **OVER-THE-COUNTER DRUG** - a select non-prescription Brand or Generic Drug which is therapeutically similar to available federal legend products or such non-prescription drug that the Plan deems clinically appropriate.

106. **PARTIAL HOSPITALIZATION** - the provision of medical, nursing, counseling or therapeutic Mental Health Care Services or Substance Abuse Services on a planned and regularly scheduled basis in a Facility Provider, designed for a patient or client who would benefit from more intensive services than are generally offered through Outpatient treatment but who does not require Inpatient care.

107. **PARTICIPATING DENTIST** - a Dentist who has an agreement with the Plan, either directly or indirectly, pertaining to payment as a participant in the United Concordia Advantage Provider Network for Covered Services rendered to a Member.

108. **PARTICIPATING PHARMACY PROVIDER** - a Pharmacy Provider licensed where required and performing within the scope of its license that has an agreement, either directly or indirectly, with the Plan pertaining to the payment of Covered Medications or specific devices provided to a Member. To the extent permitted by state and federal law, Participating Pharmacy Providers with capability to provide certain immunizations may also receive payment pertaining to such immunizations, and the administration thereof, when provided to Members.

109. **PARTICIPATING VISION PROVIDER** - a Vision Provider who has an agreement with the Plan, either directly or indirectly, pertaining to payment as a participant in the Davis Vision Network for the payment of Covered Services rendered to a Member.

110. **PHARMACY PROVIDER** - a Facility Provider licensed by the state which is engaged in dispensing Prescription Drugs through a licensed pharmacist.

111. **PHYSICAL THERAPIST** - a licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

112. **PHYSICIAN** - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and dispense drugs.

113. **PLAN** - refers to Highmark Blue Cross Blue Shield Delaware (Highmark Delaware), which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the Plan may also include its Designated Agent as defined herein and with whom the Plan has contracted to perform a function or service in the administration of this Agreement.

114. **PLAN ALLOWANCE** - the amount used to determine payment by the Plan for Covered Services provided to a Member as set forth in **SECTION SB - SCHEDULE OF BENEFITS**, and to determine Member liability. Plan Allowance is based on the type of Provider who renders such Services or as required by law.

In the case of a Network Provider, Participating Dentist or Participating Vision Provider, the Plan Allowance is the contractual allowance for Covered Services rendered by a Network Provider in a specific geographic region. A Network Provider, Participating Dentist or Participating Vision Provider will accept the Plan Allowance, plus any Member liability, as payment-in-full for Covered Services.

The Plan Allowance for a Facility Provider that is a State-Owned Psychiatric Hospital is what is required by law.

The Plan Allowance for a VA Provider is what is required by law.

In the case of an In-Area Out-of-Network Provider the Plan Allowance shall be based on an adjusted contractual allowance for like services rendered by a Network Provider in the same geographic region. The Member will be responsible for any difference between the Provider's billed charges and the Plan's payment, except as otherwise required by law.

In the case of an Out-of-Area Provider, whether or not such Out-of-Area Provider has an agreement with the local licensee of the Blue Cross Blue Shield Association, the Plan Allowance shall be determined, for other than pediatric dental and vision care Covered Services, based on prices received from the local licensee in accordance with the Plan's participation in the INTER-PLAN PROGRAMS as set forth in **SECTION GP - GENERAL PROVISIONS**.

When a Member receives covered Telemedicine Services from a Designated Telemedicine Provider located within Delaware, the Plan Allowance shall be based on the negotiated rate established with the Designated Telemedicine Provider.

When a Member receives covered Telemedicine Services from a Designated Telemedicine Provider located outside Delaware, that has an agreement, either directly or indirectly, with the local licensee of the Blue Cross Blue Shield Association, the Plan Allowance shall be determined based on the price received from the local licensee of the Blue Cross Blue Shield Association in accordance with the Plan's participation in the INTER-PLAN PROGRAMS as set forth in **SECTION GP - GENERAL PROVISIONS**.

When a Member receives covered Telemedicine Services from a Designated Telemedicine Provider located outside Delaware, that does not have an agreement, either directly or indirectly, with the local licensee of the Blue Cross Blue Shield Association, the Plan Allowance shall be based on the negotiated rate established with the Designated Telemedicine Provider.

115. **PLAN SERVICE AREA** - the geographic area consisting of the State of Delaware and contiguous counties in the States of Maryland and New Jersey and in the Commonwealth of Pennsylvania.

116. **PRECERTIFICATION (CERTIFICATION)** - a process whereby the Medical Necessity and Appropriateness of Inpatient admissions, Services or place of Services is determined by the Plan prior to, or after, an admission or the performance of a procedure or Service.

117. **PRESCRIPTION DRUG** - any drugs or medications ordered by a Professional Provider by means of a valid prescription order, bearing the Federal legend: "Caution - Federal law prohibits dispensing without a prescription," or legend drugs under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed insulin and other pharmacological agents used to control blood sugar, diabetic supplies and insulin syringes.

118. **PRESCRIPTION ORDER** - the request for medication issued by a Professional Provider.

119. **PRIMARY CARE PROVIDER (PCP)** - a Physician whose practice is limited to family, general, internal, pediatric medicine, an obstetrician/gynecologist, or a certified registered nurse practitioner each of whom has an agreement with the Plan pertaining to payment as a Network participant and has specifically contracted with the Plan to: a) be designated as a PCP; b) supervise, coordinate and provide specific basic medical services to Members; and c) maintain continuity of patient care.

120. **PROFESSIONAL COUNSELOR** - a licensed Professional Counselor performing within the scope of such licensure. Where there is no licensure law, the Professional Counselor must be certified by the appropriate professional body.

121. **PROFESSIONAL OTHER PROVIDER** - a person or entity other than a Facility Provider or Professional Provider who is licensed, where required, to render Covered Services as prescribed by a Professional Provider within the scope of such licensure or under the supervision of a Professional Provider within the scope of such licensure. Professional Other Providers include:

Autism Services Provider (Board Certified Behavior Analyst-Doctoral® (BCBA-D), Board Certified Behavior Analyst® (BCBA), Board Certified Assistant Behavior Analyst® (BCaBA)	Registered Nurse
Licensed Practical Nurse	Respiratory Therapist*

*Covered Services must be prescribed by a Physician and services of a respiratory therapist are only reimbursable through a Facility Provider.

122. **PROFESSIONAL PROVIDER** - a person or practitioner licensed where required and performing Services within the scope of such licensure. The Professional Providers are:

Audiologist	Optometrist
Autism Services Provider (Board Certified Behavior Analyst-Doctoral® (BCBA-D), Board Certified Behavior	Physical Therapist

Analyst® (BCBA), Board Certified
Assistant Behavior Analyst® (BCaBA)
Certified Registered Nurse
Chiropractor
Clinical Social Worker
Dentist
Dietician-Nutritionist
Marriage and Family Therapist
Nurse-Midwife
Occupational Therapist
Physician
Physician Assistant
Podiatrist
Licensed Professional Counselor of Mental Health
Psychologist
Speech-Language Pathologist
Teacher of the Hearing Impaired

123. **PROVIDER** - an Ancillary Provider, Facility Provider, Professional Provider or Professional Other Provider, licensed where required and performing within the scope of such licensure.

124. **PROVIDER'S ALLOWABLE PRICE (PAP)** - the amount at which the Participating Pharmacy Provider has agreed with the Plan, either directly or indirectly, to provide Covered Medications to Members covered under this Agreement.

125. **PSYCHIATRIC HOSPITAL** - a Facility Provider approved by The Joint Commission or by the American Osteopathic Hospital Association which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Continuous nursing services are provided under the supervision of a Registered Nurse.

126. **PSYCHOLOGIST** - a licensed Psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.

127. **QUALIFIED HEALTH PLAN** - a health plan, including coverage provided under this Agreement, which has been certified by the Exchange as meeting the standards of a qualified health plan as defined under the Affordable Care Act.

128. **REHABILITATION HOSPITAL** - a Facility Provider approved by The Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities or certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Rehabilitation Services on an Inpatient basis. Skilled Habilitative and Rehabilitative Services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by congenital or developmental anomalies, disease or injury to achieve the highest possible level of functional ability. Skilled Habilitative and Rehabilitative Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

129. **RESIDENTIAL TREATMENT FACILITY** - a Facility Provider which, for compensation from its patients, is primarily engaged in providing intensive, structured psychological services either directly by, or under the supervision of, a medical professional for the treatment of behavioral, emotional, mental or psychological conditions. The Facility Provider must also meet the minimum standards of the Plan's

credentialing criteria for this facility as well as those standards required by the appropriate governmental agencies.

130. **RESPITE CARE** - short-term care for a terminally ill Member provided by a Facility Provider when necessary to relieve a person (caregiver) who is caring for the Member at home free of charge.

131. **RETAIL CLINIC** - a retail-based clinic that provides basic and preventive health care services seven (7) days a week, including evenings and weekends. A Retail Clinic is generally staffed by Certified Registered Nurses that diagnose and treat minor health problems and triage patients to appropriate levels of care.

132. **ROUTINE PATIENT CARE FOR CLINICAL TRIALS** - means all Covered Services that are otherwise generally available to a Member that are provided in the Clinical Trial except:

    a. The investigational items or service itself;

    b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients; and

    c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

133. **SERVICE** - each treatment rendered by an Ancillary Provider, Facility Provider, Professional Provider, or Professional Other Provider to a Member for a Covered Service.

134. **SKILLED NURSING FACILITY** - a Facility Provider approved by the state, certified by Medicare which, for compensation from its patients, is primarily engaged in providing Skilled Nursing Services on an Inpatient basis to patients requiring twenty-four (24)-hour Skilled Nursing Services but not requiring confinement in an acute care general hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

    a. minimal care, Custodial Care, ambulatory care, or part-time care services; or

    b. care or treatment of Mental Illness, Substance Abuse or pulmonary tuberculosis.

135. **SKILLED NURSING SERVICES/ SKILLED REHABILITATION SERVICES** - Services which have been ordered by and under the direction of a Physician or Member's PCP, and are provided either directly by or under the supervision of a medical professional: e.g., Registered Nurse, Licensed Practical Nurse, Occupational Therapist, Speech Pathologist or Audiologist with the treatment described and documented in the patient's medical records. Unless otherwise determined in the sole discretion of the Plan, Skilled Nursing Services/Skilled Rehabilitation Services shall be subject to the following:

    a. the Skilled Nursing Services/Skilled Rehabilitation Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified licensed medical

professional and must be such that the care could not be performed by a non-medical individual instructed to deliver such Services.

b. the Skilled Rehabilitation Services must be provided with the expectation that the patient has restorative potential and that the condition will improve materially in a reasonable and generally predictable period of time. Once a maintenance level has been established or no further progress is attained, the Services are no longer classified as Skilled Rehabilitation and will be classified as Custodial Care.

The mere fact that a Physician has ordered or prescribed a therapeutic regimen does not, in itself, determine whether a Service is a Skilled Nursing Service or a Skilled Rehabilitation Service.

136. **SKILLED REHABILITATION SERVICES** - the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Skilled Rehabilitation Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

137. **SPECIAL ENROLLMENT PERIOD** - the period during which an eligible individual who experiences certain qualifying events may enroll in, or change enrollment in this Agreement. Special enrollment periods also apply to individuals eligible to enroll during a Limited Open Enrollment Period or who experience such other events in connection with which applicable federal laws, regulations and guidance have determined results in special enrollment rights.

138. **SPECIALIST** - a Physician, other than a Primary Care Provider whose practice is limited to a particular branch of medicine or Surgery.

139. **SPECIALIST VIRTUAL VISIT** - a real-time office Visit with a Specialist at a remote location, conducted via interactive audio and streaming video telecommunications.

140. **SPECIALTY PRESCRIPTION DRUGS** - selected Prescription Drugs which are typically used to treat rare or complex conditions and which may require special handling, monitoring, and/or special limited distribution systems, including dispensing through an Exclusive Pharmacy Provider.

141. **STATE-OWNED PSYCHIATRIC HOSPITAL** - a Facility Provider, that is owned and operated by the State of Delaware, which has been approved by Medicare, The Joint Commission or the American Osteopathic Hospital Association and which, for compensation from its patients, is primarily engaged in providing treatment and/or care for the Inpatient treatment of Mental Illness for individuals aged eighteen (18) and older whose hospitalization is ordered by a court of competent jurisdiction through a civil commitment proceeding.

142. **SUBSCRIBER** - an applicant who has satisfied the specifications of **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement, signed the Application, and with whom the Plan has this Agreement.

143. **SUBSTANCE ABUSE** - any use of alcohol or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

144. **SUBSTANCE ABUSE TREATMENT FACILITY** - a Facility Provider licensed by the state and approved by The Joint Commission which, for compensation from its patients, is primarily engaged in providing detoxification and/or rehabilitation treatment for alcohol abuse and/or drug abuse. This facility must also meet the minimum standards set by the Delaware Department of Health & Social Services, Division of Substance Abuse and Mental Health, or another appropriate governmental agency.

145. **SUITE INFUSION THERAPY PROVIDER** - an Ancillary Provider licensed by the state, accredited by The Joint Commission, if appropriate, and organized to provide Infusion Therapy to patients at an infusion suite.

146. **SUPPLIER** - an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies. Suppliers include, but are not limited to, the following: Durable Medical Equipment Suppliers, vendors/fitters, orthotic and prosthetic Suppliers, pharmacy/Durable Medical Equipment Suppliers.

147. **SURGERY** -

a. the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures;

b. the correction of fractures and dislocations; or

c. usual and related Inpatient pre-operative and post-operative care.

148. **TELEMEDICINE SERVICE** – a realtime interaction between a Member and a Telemedicine Provider who is a Network Provider, conducted by means of telephonic or audio and video communications, for the purpose of providing specific Outpatient Covered services.

149. **THERAPY SERVICES** - the following Services or supplies ordered by a Professional Provider to promote the recovery of the Member. Therapy Services are covered to the extent specified in **SECTION SB - SCHEDULE OF BENEFITS**.

a. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.

b. Dialysis Treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

c. Infusion Therapy – the treatment of disease by the administration of Medically Necessary and Appropriate fluid or medication via a central or peripheral vein.

d. Pulmonary Therapy - the treatment of chronic pulmonary diseases through a multidisciplinary program which combines Physical Medicine with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

e. Radiation Therapy - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

f. Respiratory Therapy - the introduction of dry or moist gases into the lungs for treatment purposes.

150. **URGENT CARE CENTER** - a formally structured hospital-based or freestanding full-service, walk-in health care clinic, outside of a hospital-based emergency room, that is open twelve (12) hours a day, Monday through Friday and eight (8) hours a day on Saturdays and Sundays, that primarily treats patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. An Urgent Care Center can also provide the same services as a family Physician or Primary Care Provider, such as treatment of minor illnesses and injuries, physicals, x-rays and immunizations.

151. **VISION CARE SERVICES** - vision care services as specified in this Agreement rendered by a Participating Vision Provider which the Plan is contractually obligated to pay or provide as a benefit to a Member.

152. **VISION PROVIDER** - a Physician or Professional Provider licensed, where required, and performing services related to the examination, diagnosis and treatment of conditions of the eye and associated structures.

153. **VISIT** -

a. the physical presence of a Member at a location designated by the Provider for the purpose of providing Covered Services;

b. an interaction between a Member and a PCP or Retail Clinic for the purpose of providing Outpatient Covered Services for treatment of a condition not related to Surgery or pregnancy conducted by means of an audio and video telecommunications system; or

c. an interaction between a Member and a Specialist for the purpose of providing Outpatient Covered Services conducted by means of:

i. an audio and video telecommunications system for the treatment of Mental Illness or Substance Abuse; or

ii. the internet or similar electronic communications for the treatment of skin conditions or diseases.

SECTION SE - SCHEDULE OF ELIGIBILITY

A. **ELIGIBILITY**

1. Eligible Subscriber

   To be eligible to enroll as a Subscriber under this Agreement, an individual must:

   a. be a U.S. citizen, national or other individual lawfully present in the United States;

   b. not be entitled for benefits under Medicare Part A or be enrolled in Medicare Part B, Medicaid or CHIP;

   c. not be incarcerated (Incarcerated individuals are limited to those serving a prison or jail term, but do not include those persons not convicted of a crime); and

   d. reside in the Plan Service Area.

2. Eligible Dependent

   An eligible Dependent is a U.S. citizen, national or other individual lawfully present in the United States:

   a. not entitled for benefits under Medicare Part A or enrolled in Medicare Part B, Medicaid or CHIP;

   b. not incarcerated (Incarcerated individuals are limited to those serving a prison or jail term, but do not include those persons not convicted of a crime.);

   c. a person who has been identified by the Subscriber through the appropriate enrollment process or on an application form accepted by the Plan who is:

      i) the Subscriber's spouse under a legally valid existing marriage; or

      ii) The Subscriber's Domestic Partner for the duration of the Domestic Partnership. In addition, the child(ren) of the Domestic Partner shall be considered, for eligibility purposes, as if they were the child(ren) of the Subscriber as long as the Domestic Partnership exists; or

      iii) the Subscriber's child, including a newborn child, step-child, child legally placed for adoption, child awarded coverage pursuant to an order of court, and legally adopted child of the Subscriber or Subscriber's spouse or civil union or domestic partner. The limiting age for a covered child is twenty-six (26), unless the period of eligibility for such Dependent is otherwise extended pursuant to applicable state or federal law.

Eligibility will be continued past the date that a Dependent child turns age twenty-six (26) for the Subscriber's unmarried child who, as medically certified by a Physician, is totally disabled and incapable of self-support due to intellectual disability or physical disability, mental illness or developmental disability that started before age twenty-six (26). The Plan may require proof of such Dependent's disability from time to time.

3. Newborn Children

A newborn child, whether natural born, adopted, or placed for adoption, of the Subscriber or eligible Dependent is covered under this Agreement from the moment of birth to a maximum of thirty-one (31) days from the date of birth. To be covered as a Dependent beyond the thirty-one (31) day period, the newborn child must be enrolled as a Dependent under this Agreement and appropriate premium payment must be received within such period. In the event that a newborn child is not eligible for continuing coverage as a Dependent under this Agreement, the eligible Dependent may enroll or apply for a separate Agreement to be issued by the Plan.

B. NOTICE OF INELIGIBILITY

It shall be the responsibility of the Member to notify the Plan of any changes that will affect his or her eligibility for coverage under this Agreement. The Member must immediately notify the Plan or the Exchange, if applicable, of any changes that will affect his or her eligibility for coverage

C. ENROLLMENT

Subject to the terms and conditions of this Agreement, the Plan must receive, within the applicable enrollment period, a completed application for or other appropriate request for enrollment, documentation of eligibility, if required, and the applicable premium payment by the Member before coverage will be provided under this Agreement.
Eligible individuals may enroll in coverage under this Agreement during the Annual Open Enrollment Period. When applicable, enrollment is also permitted during a Limited Open Enrollment Period or Special Enrollment Period.

Coverage under this Agreement shall become effective on the date established by the ACA or, when appropriate, as determined by the Plan.

The Effective Date of coverage under this Agreement shall appear on the Member's enrollment confirmation letter and Identification Card. A Member may also obtain confirmation of the Effective Date of his or her coverage by contacting the Member Service Department of the Plan at the toll-free telephone number listed on the Member's Identification Card.

D. OPEN ENROLLMENT

Subject to the terms and conditions of this Agreement, the Plan must receive, within the applicable enrollment period, a completed application for or other appropriate request for enrollment, documentation of eligibility, if required, and the applicable premium payment by the Member before coverage will be provided under this Agreement.

Eligible individuals may enroll in coverage under this Agreement during the Annual Open Enrollment Period. When applicable, enrollment is also permitted during a Limited Open Enrollment Period or period of special enrollment as described in Subsection D. **SPECIAL ENROLLMENT** of this Section.

Unless otherwise required by applicable law or regulation, coverage under this Agreement shall for the 2018 and subsequent Benefit Periods become effective as follows:

Coverage:

For individuals who enroll during an Annual Open Enrollment Period, coverage shall begin on the first day of the following Benefit Period. For enrollment requests made during an applicable Limited Open Enrollment Period, coverage shall begin on the effective date of coverage established under the Affordable Care Act.

The Effective Date of coverage under this Agreement shall appear on the Member's enrollment confirmation letter and Identification Card. A Member may also obtain confirmation of the Effective Date of his or her coverage by contacting the Member Service Department of the Plan at the toll-free telephone number listed on the Member's Identification Card.

E. SPECIAL ENROLLMENT

1. Eligible individuals may enroll in coverage provided under this Agreement pursuant to his or her special enrollment rights.

   To be eligible for coverage as a special enrollee, the individual must have, within the sixty (60) day period prior to requesting enrollment:

   a. lost other coverage in which he or she was enrolled for reasons other than nonpayment of premium;

   b. moved into and established a new permanent residence within the Plan Service Area; or

   c. experienced such other event in connection with which applicable federal and state laws and regulation has determined results in special enrollment rights.

2. Coverage pursuant to a special enrollment request shall be effective the first day of the following month, when the request has been made between the first (1st) and the fifteenth (15th) of the month or the first day of the second following month when made between the sixteenth (16th) of the month or later, except when the special enrollment involves the loss of other minimum essential coverage in which event coverage shall be effective the first day of the month following the request.

3. Nothing in this Agreement shall prohibit or restrict the right of an eligible individual to exercise special enrollment rights during an open enrollment period.

SECTION HC - HEALTH CARE MANAGEMENT SERVICES

This program provides Network Services for most Covered Services. Out-of-Network services are generally not covered, unless otherwise noted in **SECTION SB – SCHEDULE OF BENEFITS**.

Specific payment provisions are outlined in **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement, as well as in this Section. Members may contact the Plan at the toll-free telephone number or the website appearing on the back of the Member's Identification Card to locate a Network Provider or to obtain a Provider Directory.

A. BLUES ON CALL (Health Education and Support Program)

The Blues On Call Program addresses the total health care needs of Members rather than focusing on one (1) specific disease, condition or illness through interaction with both the patient and the Physician. Blues On Call promotes the philosophy of shared decision-making by helping Members work with their Physicians in the task of choosing treatment options that take into account the Member's values and preferences. The Program provides Members with health care support services, including assistance in the self-management of certain health conditions. Members have twenty-four (24) hour access, seven (7) days a week, to health information and personalized support for health decisions.

Support services may include:

1. assessment of the Member's functional and health status, including co-morbidities, risk factors, motivation and confidence in managing their health, and receptivity for change;

2. assessment of the Member's knowledge of their particular condition and their understanding and adherence to the recommendations and instructions of his/her health care Provider;

3. Member education and training on health-related topics that can be helpful in improving the Member's overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and

4. ongoing monitoring (coaching) to optimize the Member's health status, ensuring adherence to the Physician's treatment plan, identifying and addressing barriers preventing or hindering adherence to the Physician's treatment plan, and assessing the need for case management services.

Members may contact Blues On Call at the toll-free telephone number listed on the Member's Identification Card.

B. EMERGENCY CARE SERVICES - NO PRIOR APPROVAL REQUIREMENT

No prior approval or Precertification is required for a Member to receive Emergency Care Services.

When the Member requires Emergency Care Services, all benefits for such Covered Services will be provided at the Network Services benefit levels. The Member will not be responsible for any difference between the Plan Allowance and the Provider's charge. In the event of an Inpatient admission, either the Member, Provider, or a family member must notify the Plan within forty-eight (48) hours of the admission, or as soon as reasonably possible. Once a Member is stabilized, the Plan reserves the right to transfer the Member's care from an Out-of-Network Provider to a Network Provider. In connection with such transfer, the Plan will arrange for transport to the Network Provider without cost to the Member.

C. SUBSTANCE ABUSE TREATMENT - NO PRIOR APPROVAL REQUIREMENT

In the event that a Member requires treatment for Substance Abuse requiring admission to a Facility Provider, the admission will not be subject to prior authorization or Precertification.

D. HEALTH CARE MANAGEMENT SERVICES

A Member is entitled to benefits for Covered Services under this Agreement, subject to exclusions, conditions and limitations of this Agreement, and subject to Health Care Management Services administered by the Plan.

When Precertification, as set forth in this Agreement, is required, Medical Necessity and Appropriateness for Covered Services will be determined prior to the Covered Service being rendered. However, when Precertification is not required, the Plan may determine that a Covered Service was not Medically Necessary and Appropriate after the Covered Service has been rendered.

When a Member seeks Covered Services outside the Plan Service Area, the Member is required to call the Precertification toll-free number on the back of his/her Identification Card, prior to the receipt of the Covered Services, to determine what, if any, Precertification requirements he/she must follow.

1. Pre-Admission Certification

When a Member requires Hospital, Psychiatric Hospital, Rehabilitation Hospital, Residential Treatment Facility, Substance Abuse Treatment Facility, or Skilled Nursing Facility care, benefits for Covered Services will be provided subject to the following:

a. Network Services

In the event of a proposed Inpatient stay for other than an emergency or the treatment of Substance Abuse, it shall be the responsibility of the Network Provider to contact the Plan prior to a proposed admission, in accordance with procedures established by the Plan, to determine if the proposed admission is Medically Necessary and Appropriate.

The Member will be held harmless and will not be financially responsible for payment for admissions which have been determined not to be Medically Necessary and Appropriate, except when the Plan provides prior written notice to the Member that the admission will not be covered. In such cases, the Member will be financially responsible for charges for such admission.

b. Out-of-Area Network Services

In the event of a proposed Inpatient stay to a Network Facility Provider located Out-of-Area, for other than an emergency or the treatment of Substance Abuse, it shall be the responsibility of the Network Facility Provider to contact the Plan prior to a proposed admission to obtain Precertification of the admission. In addition, the Member must contact the Plan to confirm the Plan's determination of Medical Necessity and Appropriateness prior to the admission.

i) If Precertification for a Medically Necessary and Appropriate Inpatient admission has been obtained, as required under this Agreement, benefits will be paid in accordance with this Agreement.

ii) If a Member elects to be admitted after receiving written notification from the Plan that any portion of the proposed admission is not Medically Necessary and Appropriate, the Member will be financially responsible for all charges associated with care that has been determined not to be Medically Necessary and Appropriate.

iii) If the Facility and the Member DO NOT CONTACT the Plan for Precertification, as required under this Agreement, any claim for benefits will be reviewed for Medical Necessity and Appropriateness.

If the admission is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement. The Member will be financially responsible for the difference between the payment by this Agreement and the full amount of the Out-of-Area Network Provider's charge.

If such admission is determined not to be Medically Necessary and Appropriate, no benefits will be provided, and the Member will be financially responsible for the full amount of the Out-of-Area Network Provider's charge.

2. **Certification of Emergency and the Treatment of Substance Abuse Admissions**

When a Member requires an emergency admission or an admission for the treatment of Substance Abuse to a Hospital, Psychiatric Hospital, Rehabilitation Hospital, Residential Treatment Facility or Substance Abuse Treatment Facility, benefits for Covered Services will be provided subject to the following:

a. In-Area Network Services

In the event of an emergency admission, or of an admission for the treatment of Substance Abuse, it shall be the responsibility of the Network Provider to contact the Plan within forty-eight (48) hours, or as soon as reasonably possible, after such admission to determine if the admission is Medically Necessary and Appropriate. Additionally, for admissions for the treatment of Substance Abuse, an initial treatment plan must be provided to the Plan within 48 hours of the admission.

The Member will be held harmless and will not be financially responsible for payment for admissions which are determined not to be Medically Necessary and Appropriate, except when the Plan provides prior written notice to the Member that any portion of the Inpatient admission will not be covered. In such case, the Member will assume financial responsibility for such Inpatient charges.

b. Out-of-Area Network Services

In the event of an emergency admission or of an admission for the treatment of Substance Abuse, which is located Out-of-Area, the Facility and the Member must contact the Plan within forty-eight (48) hours, or as soon as reasonably possible, after such admission to determine if the admission is Medically Necessary and Appropriate. Additionally, for admissions for the treatment of Substance Abuse, an initial treatment plan must be provided to the Plan at the time of the notice of the admission.

i) If certification for a Medically Necessary and Appropriate emergency admission has been obtained, as required under this Agreement, and the admission has been determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement.

ii) If a Member elects to remain hospitalized after receiving written certification from the Plan that such level of care is no longer Medically Necessary and Appropriate, the Member will be financially responsible for the full amount of the Provider's charges from the date appearing on the written notification.

iii) If the Facility and the Member DO NOT CONTACT the Plan for certification, as required under this Agreement, any claim for benefits will be reviewed for Medical Necessity and Appropriateness. If the admission is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement.

If such admission or Services are determined not to be Medically Necessary and Appropriate, no benefits will be provided, and the Member will be financially responsible for the full amount of the Provider's charge.

c. Out-of-Network Services

In the event of an emergency admission that is Out-of-Network, the Member must contact the Plan within forty-eight (48) hours, or as soon as reasonably possible, after such admission to determine if the admission is Medically Necessary and Appropriate.

i) If Admission Certification for a Medically Necessary and Appropriate emergency admission has been obtained, as required under this Agreement, and the admission has been determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement.

ii) If a Member elects to remain hospitalized after receiving written notification from the Plan that such level of care is no longer Medically Necessary and Appropriate, the Member will be financially responsible for the full amount of the Provider's charges from the date appearing on the written notification.

iii) If a Member DOES NOT CONTACT the Plan for certification, as required under this Agreement, any claim for benefits will be reviewed for Medical Necessity and Appropriateness. If the admission is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement. The Member will be financially responsible for the difference between the payment by this Agreement and the full amount of the Out-of-Network Provider's charge.

If such admission or Services are determined not to be Medically Necessary and Appropriate, no benefits will be provided, and the Member will be financially responsible for the full amount of the Out-of-Network Provider's charge.

3. **Outpatient Procedure or Covered Service Precertification Requirements**

Precertification may be required to determine the Medical Necessity and Appropriateness of certain Outpatient procedures or Covered Services (including Covered Medications) as determined by the Plan prior to the receipt of services. Precertification is not required for an emergency or the treatment of Substance Abuse.

a. In-Area Network Services

The In-Area Network Provider is responsible for the Precertification of such procedure or Covered Service. The Member will not be financially responsible whenever certification for such procedure or Covered Service is not obtained by the Network Provider. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, the Member will not be financially responsible, except when the Plan provides prior written notice to the Member that charges for the procedure or Covered Service will not be covered. In such case, the Member will be financially responsible for such procedure or Covered Service.

b. Out-of-Area Network Services

Whenever a Member utilizes an Out-of-Area Network Provider, it is the responsibility of the Member to contact the Plan prior to the receipt of a procedure or Covered Service to confirm the Medical Necessity and Appropriateness and/or obtain Precertification of the procedure or Covered Service.

If the Member DOES NOT CONTACT the Plan for Certification, that procedure or Covered Service may be reviewed after it is received to determine Medical Necessity and Appropriateness.

If the procedure or Covered Service is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Agreement. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, no benefits will be provided. The Member will be financially responsible for the full amount of the Out-of-Area Network Provider's charge.

c. Out-of-Network Services

Whenever a Member utilizes an Out-of-Network Provider, it is the responsibility of the Member to first contact the Plan to confirm the Medical Necessity and Appropriateness of such procedures or Covered Services.

If the Member DOES NOT CONTACT the Plan for Certification, those procedures or Covered Services may be reviewed after they are received to determine Medical Necessity and Appropriateness.

If the procedure or Covered Service is determined to be Medically Necessary and Appropriate, benefits will be paid in accordance with this Contract. The Member will be financially responsible for the difference between what is covered by the Contract and the full amount of the Out-of-Network Provider's charge. If the procedure or Covered Service is determined not to be Medically Necessary and Appropriate, no benefits will be provided. The Member will be financially responsible for the full amount of the Out-of-Network Provider's charge.

4. **Continued Stay Review**

Network and Out-of-Network Services

The medical progress of patients is reviewed to identify the continued Medical Necessity and Appropriateness of the Inpatient stay.

If a Member elects to continue to receive Inpatient Services after receipt of written notification from the Plan that such level of care is no longer Medically Necessary and Appropriate, the Member will be financially responsible for the full amount of the Provider's charges from the date appearing on the written notification.

Benefits provided in inpatient or residential settings for the diagnosis and treatment of Substance Abuse are not subject to concurrent utilization review for the first 14 days of an admission, provided the Facility Provider notifies the plan of both the admission and the initial treatment Plan within forty-eight (48) hours of the admission.

5. **Discharge Planning**

Discharge Planning is a collaborative effort on the part of the Plan, the Facility Provider, the Professional Provider, the Member, and their family to assure that the patient receives safe and uninterrupted care when needed at the time of discharge.

6. **Individual Case Management**

Case Management is the process by which the Plan, in its sole discretion, identifies alternative treatment modalities commensurate with the Member's diagnosis profile and consults with the patient and attending Professional Provider(s). Notwithstanding the foregoing, all decisions regarding the treatment to be provided to a Member shall remain the responsibility of the treating Professional Provider(s) and the Member working with the Plan.

The Plan shall provide such alternative benefits, in its sole discretion, only when, and for so long as, it determines that the procedures/Services are Medically Necessary and Appropriate, cost effective, and that the total benefits paid for such procedures/Services do not exceed the total benefits to which the Member would otherwise be entitled under this Agreement in the absence of alternative benefits.

Such alternative benefits may include offering the Member a home recovery care option so that treatment for specific medical conditions can be provided in the Member's home when it is determined that the Member can be safely treated for such condition in that setting. In connection with the home recovery care option, case management will largely focus on stepped-up care coordination services and may include, in the Plan's sole discretion, non-emergency transportation to provider locations.

The Plan will provide Individual Case Management Services for those Members identified by the Plan as falling into one (1) or more of the following diagnosis profiles of illnesses or injuries, or such other diagnosis profiles as deemed appropriate from time to time by the Plan:

<u>Illnesses</u>

Acquired Immune Deficiency Syndrome
Amyotrophic Lateral Sclerosis
Autism Spectrum Disorders
Carcinoma
Cardiac Surgery
Cerebral Palsy
Cerebrovascular Accident
Chronic Obstructive Pulmonary Disease
Complications of Chronic Disease Processes
Cystic Fibrosis
Diabetes Mellitus
Multiple Sclerosis
Muscular Dystrophy
Neonatal High Risk Infants
Osteomyelitis
Psychiatric Diagnoses
Sickle Cell Anemia
Spina Bifida

Injuries

Amputations	Paralytic Syndromes
Major Head Trauma	Severe Burns
Multiple Fractures	Spinal Cord Injury

7. **Authorized Representative**

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Precertification request or other Pre-service Claim on behalf of a Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a Professional Provider or Professional Other Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

8. **Notification of Precertification and Other Pre-Service Claim Determinations**

Precertification of Covered Services, when required under this Agreement, and all other Pre-service Claims including requests to extend a previously approved course of treatment will be processed and notice of the Plan's determination, whether adverse or not, will be given to the Member within the following time frames unless otherwise extended by the Plan for reasons beyond its control:

a. In the case of an Urgent Care Claim, as soon as possible, taking into account the medical exigencies involved, but not later than seventy-two (72) hours following the Plan's receipt of the Urgent Care Claim. Similarly, when the Urgent Care Claim seeks to extend a previously approved course of treatment and the request is made at least twenty-four (24) hours prior to the expiration of such previously approved course of treatment, notice of the Plan's determination will be given to the Member as soon as possible, taking into account the medical exigencies involved, but no later than twenty-four (24) hours following receipt of the request; and

b. In the case of a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days following the Plan's receipt of the non-urgent care Pre-service Claim.

   Notice of the Plan's approval of a Pre-service Claim will include information sufficient to apprise the Member that the request has been approved. In the event that the Plan renders an adverse determination on a Pre-service Claim, the notification shall include, among other items, the specific reason or reasons for the adverse determination and a statement describing the right of the Member to file an internal appeal or request an external review.

9. **Prescription Drug Precertification**

Certain Covered Medications, as designated by the Plan, may require Precertification to ensure the Medical Necessity and Appropriateness of the Prescription Order. The Member's Physician must obtain Certification from the Plan prior to the dispensing of the

drug at a Participating Pharmacy Provider or through mail-order, if applicable. If it is determined by the Plan that the Covered Medication is Medically Necessary and Appropriate, the Covered Medication will then be dispensed by the Participating Pharmacy Provider or through mail-order, if applicable.

10. **Prescription Drug Exceptions**

Coverage is not provided for Prescription Drugs and Over-the-Counter Drugs not appearing on the Formulary, unless an exception has been granted by the Plan pursuant to the Step Therapy Program described in Subsection Q. Outpatient Prescription Drugs of **Section DB – DESCRIPTION OF BENEFITS**. The Member, the Member's authorized representative or the Member's prescribing physician may request coverage of a Prescription Drug not appearing on the Formulary. The Plan will review the exception request and notify the Member of its determination within seventy-two (72) hours of receiving sufficient information to begin its review of the request.

If the Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-formulary drug, the Member, the Member's authorized representative, or the Member's prescribing physician may request an expedited review based on exigent circumstances. In the case of such an exigent circumstance, the Plan will notify the Member, the Member's authorized representative, or the Member's prescribing physician of its coverage determination within twenty-four (24) hours of receiving sufficient information to begin its review of the request.

In the event that the Plan denies a request for exception, the Member, the Member's authorized representative, or the Member's prescribing physician may request that the exception request and subsequent denial of the request be reviewed by an independent review organization. Plan must make its determination on the external exception request and notify the Member, Member's authorized representative or the Member's prescribing physician of its coverage determination no later than seventy-two (72) hours following its receipt of sufficient information to begin its review or the request, or if the request was an expedited exception request, no later than twenty-four (24) hours following its receipt of sufficient information to begin its review of the request.

If the Plan grants the request for an exception, the Prescription Drug will be covered for the duration of the prescription, or if pursuant to an expedited exception request, for the duration of the exigency. Coverage will be provided in accordance with the Outpatient Prescription Drugs schedule of benefits in Section SB – Schedule of Benefits.

E. SELECTION OF PROVIDERS

A Member covered under this Agreement must use a Network Provider for Covered Services, except for Emergency Care Services, Ambulance Services, Urgent Care and Anesthesia. Covered Services may also be rendered by a Contracting Supplier, a Participating Pharmacy Provider, a Designated Telemedicine Provider, a Participating Dentist or a Participating Vision Provider. However, services are not covered when rendered by a Non-Participating Pharmacy Provider, a non-Designated Telemedicine Provider, a Non-Participating Dentist or a non-Participating Vision Provider.

In the event that a Member requires non-emergency Covered Services that are not available within the Network, the Plan may refer the Member to a Provider who is not a Network Provider. The Member must notify the Plan prior to receiving a Covered Service from an Out-of-Network Provider in order for the Plan to facilitate this arrangement. In such cases, Services will be covered so that the Member will not be responsible for any greater out-of-pocket amount than if Services had been rendered by a Network Provider. The Member will not be responsible for any difference between the Plan payment and the Provider's billed charge. Additionally, there are some instances where a Member may not have the opportunity to make a provider selection. In such cases, Claims for Covered Services will be processed to apply the Network cost-sharing amounts and the Plan will prohibit provider balance billing to the Member.

Payment for Covered Services is specified in **SECTION SB - SCHEDULE OF BENEFITS**, Subsection IV. **PLAN PAYMENT AND MEMBER LIABILITY** and Subsection V. **COVERED SERVICES**.

Members may contact the Plan at the toll-free telephone number or the website appearing on the back of the Member's Identification Card to locate a Network Provider or to obtain a Provider Directory.

F. BENEFITS AFTER PROVIDER TERMINATION FROM THE NETWORK

If, at the time a Member is receiving medical care from a Network Provider, notice is received from the Plan that it intends to terminate or has terminated the contract of that Network Provider for reasons other than cause, the Member may, at his/her option, continue an active course of treatment with that Provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this Subsection, active course of treatment means:

1. an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

2. an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy or post-operative visits;

3. the second or third trimester of pregnancy, through the postpartum period; or

4. an ongoing course of treatment for a health condition for which a treating Physician or health care provider attests that discontinuing care by that Physician or health care provider would worsen the condition or interfere with anticipated outcomes.

If, however, the Network Provider is terminated for cause and a Member continues to seek treatment from that Provider, the Plan will not be liable for payment for health care services provided to the Member following the date of termination.

Any Services authorized under this Subsection will be covered in accordance with the same terms and conditions as applicable to a Network Provider. Nothing in this Subsection shall require the Plan to pay benefits for health care services that are not otherwise provided under the terms and conditions of this Agreement.

G. WELLNESS PROGRAMS

The Plan may offer Members the opportunity to participate in programs of health promotion and/or disease prevention. When offered, these programs will be available to Members without regard to health status. Whether or not Members decide to participate in such programs will not affect their continued eligibility, benefits, premiums, or cost-sharing obligations under this Agreement.

At times, the Plan may offer rewards for Member participation in certain of these programs. Any reward provided by the Plan in connection with these programs will not be offered or conditioned upon the Member satisfying a standard that is based on a health related factor.

H. VALUE PROGRAMS

The Plan may offer Members the opportunity to participate in programs which create incentives to use lower cost services. At times, these incentives may offer rewards to Members. Such rewards may take the form of cash or cash equivalents and, therefore, may be subject to taxation as miscellaneous income. Any such programs will be offered to all Members. Whether or not Members decide to participate in such programs will not affect their continued eligibility, their premium, or reduce their benefits under this Agreement.

Highmark Delaware reserves the right to modify or discontinue any such program at any time.

SECTION SB - SCHEDULE OF BENEFITS

Subject to the exclusions, conditions, and limitations of this Agreement, and subject to **SECTION HC - HEALTH CARE MANAGEMENT SERVICES** in this Agreement, a Member is entitled to benefits for Covered Services as set forth in this **SECTION SB - SCHEDULE OF BENEFITS** during a Benefit Period. Benefits are subject to the Deductible and Coinsurance, if any, and in the amounts as specified in this Section. Out-of-Network Services are not covered except for Emergency Care Services, Ambulance, Urgent Care and Anesthesia.

I. BENEFIT PERIOD

Calendar year.

II. DEDUCTIBLE/OUT-OF-POCKET MAXIMUM

NETWORK SERVICES

INDIVIDUAL $7,900

FAMILY $15,800

A. Unless otherwise indicated, Deductible amounts are applicable to Covered Services furnished to a Member per Benefit Period.

B. The Deductible applies to all Covered Services, except where exempted by law or indicated in Subsection V. **COVERED SERVICES** of this Section. The Deductible represents the total Out-of-Pocket Maximum during the benefit period.

C. The Plan will begin to pay benefits for each Member who satisfies his or her own individual Deductible whether or not the entire Family Deductible has been satisfied. The entire Family Deductible must be satisfied in one (1) Benefit Period by two (2) or more family members in order for the family to satisfy the Family Deductible. No individual Member may satisfy the entire Family Deductible. Once the entire Family Deductible amount has been satisfied, the Plan will pay benefits for all remaining family members.

D. The dollar amount specified shall not include amounts in excess of the Plan Allowance.

III. PLAN PAYMENT AND MEMBER LIABILITY

The Plan uses the Plan Allowance to calculate the benefit payable and the financial liability of the Member for Medically Necessary and Appropriate Services covered under this Agreement. In the case of Outpatient Prescription Drug benefits, the Plan uses the Provider's Allowable Price for this calculation. See **SECTION DE - DEFINITIONS** of this Agreement for the definitions of "Plan Allowance" and "Provider's Allowable Price".

1. **Plan Payment**

   The Plan's payment is determined by first subtracting any Deductible and/or Copayment liability from the Plan Allowance. The Coinsurance percentage of the Plan Allowance set forth in **SECTION SB - SCHEDULE OF BENEFITS** is then applied to that amount. This amount represents the Plan's payment.

2. **Member Liability**

   The Member's total liability is the sum of any applicable Deductible. Network Providers, Designated Telemedicine Providers and Participating Pharmacy Providers will accept the Plan's payment plus the Member's total liability as payment in full for the Covered Services provided to the Member. However, Out-of-Network Providers are not required to accept the Plan's payment as payment in full. When a Member receives Covered Services from an Out-of-Network Provider, the Out-of-Network Provider may bill the Member for the difference between the Out-of-Network Provider's billed amount and the Plan's payment. This is in addition to any Member Deductible obligations. If a Member receives services which are not covered under this Agreement, the Member is responsible for all charges associated with those services.

   In the event that a Member requires non-emergency Covered Services that are not available within the Network, the Plan may refer the Member to a Provider who is not a Network Provider. In such cases, Services will be covered at the Network Service benefit level and the liability of the Member will be limited to the Network Coinsurance amount plus any Network Deductible obligations.

3. **Plan Payment and Member Liability for Covered Medications**

   The Plan's payment for Covered Medications purchased from a Participating Pharmacy Provider is determined by first subtracting any Deductible liability from the Provider's Allowable Price. The Coinsurance percentage as set forth in **SECTION SB - SCHEDULE OF BENEFITS** is then applied to that amount once the Deductible, if any, has been satisfied. The Member's total liability for Covered Medications is the sum of any Deductible and Coinsurance obligations, if any. However, until the Member has satisfied their Deductible, the Participating Pharmacy Provider is entitled to collect from the Member 100% of the Provider's Allowable Price for the Covered Medication at the time of purchase. However, Preventive Covered Medications are exempt from any Deductible obligation. No benefits are payable for Covered Medications purchased from a Non-Participating Pharmacy Provider. Coverage is not provided for prescription drugs and over-the-counter drugs not appearing on the formulary, unless an exception has been granted pursuant to the prescription drug exceptions process described in Section HC - Health Care Management Services.

4. **Plan Payment for Vision Care Services**

   The Plan Allowance for Participating Vision Providers within or outside Delaware is the amount agreed to by the Participating Vision Provider as payment in full, as set forth in the agreement between the Participating Vision Provider and the Plan.

5. **Plan Payment for Dental Services**

The Plan Allowance for Participating Dentists within or outside Delaware is the amount agreed to by the Participating Dentist as payment in full, as set forth in the agreement between the Participating Dentist and the Plan.

IV. COVERED SERVICES

Benefits are payable for those Covered Services listed in this schedule or otherwise specified in this Agreement. See **SECTION DB - DESCRIPTION OF BENEFITS** in this Agreement for further explanation and additional limitations.

The Deductible applies to all Covered Services, except where exempted by law or as otherwise indicated in this Section. Subject to the provisions of this Agreement, a Member is responsible for payment of any cost-sharing amounts due to the Provider after the amounts paid by the Plan hereunder. The payment amount is based on the Plan Allowance at the time Services are rendered. The payments to a Hospital or Facility Provider may be adjusted from time to time based on settlements with the Providers. Such adjustments will not affect the Member's Deductible obligation.

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
A. AMBULANCE SERVICE		
Ambulance Service (emergency and non-emergency)	100% Plan Allowance	Same as Network Services

Benefits for Ambulance Services rendered by an Out-of-Network Provider will be paid at the Network Services level. The Plan will pay the Plan Allowance after Member cost-sharing (Deductible and/or Coinsurance, if any) and except as required by law, the Member will be responsible for any remaining charges if the provider does not participate with Highmark Delaware or the local BCBS plan.

B. DENTAL SERVICES		
Services for Accidental Injury and Covered and Non-Covered Dental Services	100% Plan Allowance	Not Covered

Pediatric Dental Services
All services must be provided by a United Concordia Advantage Plus 2.0 Network Provider.

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Routine pediatric oral examination, x-rays, prophylaxis, fluoride treatments, sealants, space maintainers, emergency palliative care, consultations	100% Plan Allowance Limited to one (1) exam every six (6) months. Not subject to Deductible	Not Covered
All other Covered Services listed in **SECTION DB - DESCRIPTION OF BENEFITS**, Subsection B. **DENTAL SERVICES**, Paragraph 3. **Pediatric Dental Services**	50% Plan Allowance Not subject to Deductible	Not Covered

Important: See **SECTION DB - DESCRIPTION OF BENEFITS**, Subsection B. **DENTAL SERVICES**, Paragraph 3. **Pediatric Dental Services** for the orthodontic treatment conditions and limitations which affect a Member's pediatric dental coverage.

C. **DIABETES TREATMENT**

Equipment and Supplies	100% Plan Allowance	Not Covered
Diabetes Education Program	100% Plan Allowance	Not Covered
Outpatient Prescription Drugs required for the treatment of Diabetes	Prescription Drugs are covered in accordance with Paragraph R. **OUTPATIENT PRESCRIPTION DRUGS** in this Subsection.	

D. **DIAGNOSTIC SERVICES**

Advanced Imaging Services	100% Plan Allowance	Not Covered
Diagnostic Medical Services	100% Plan Allowance	Not Covered
Laboratory/Pathology Services/Allergy Testing	100% Plan Allowance	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Standard Imaging Services	100% Plan Allowance	Not Covered

The Network Deductible, Copayment and Coinsurance obligations do not apply to Basic Diagnostic Services provided for preventive purposes in accordance with a predefined schedule based on age and sex described in **SECTION DB - DESCRIPTION OF BENEFITS**, Subsection Q. **PREVENTIVE SERVICES**.

E. **DURABLE MEDICAL EQUIPMENT**	100% Plan Allowance	Not Covered
F. **EMERGENCY CARE SERVICES**	100% Plan Allowance	Same as Network Services

Benefits for Emergency Care Services rendered by an Out-of-Network provider will be paid at the Network Services level. The Plan will pay 100% of the Plan Allowance after the Network Deductible. The Member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the Plan Allowance.

G. **ENTERAL FOODS**	100% Plan Allowance	Not Covered
H. **FERTILITY CARE SERVICES**	100% Plan Allowance	Not Covered
I. **HABILITATIVE AND REHABILITATIVE SERVICES**		
Applied Behavior Analysis	100% Plan Allowance	Not Covered
Cardiac Rehabilitation	100% Plan Allowance	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Occupational Therapy (including Cognitive Rehabilitation) and Physical Medicine	100% Plan Allowance Limited to thirty (30) Visits per Benefit Period for Habilitative Services and thirty (30) Visits per Benefit Period for Rehabilitative Services. This limit does not apply to Services for the treatment of back pain by chiropractors or physical therapists, or to habilitative Services prescribed for the treatment of Mental Illness or Substance Abuse.	Not Covered
Speech Therapy	100% Plan Allowance Limited to thirty (30) Visits per Benefit Period for Habilitative Services and thirty (30) Visits per Benefit Period for Rehabilitative Services. This limit does not apply when Services for habilitative purposes are prescribed for the treatment of Mental Illness or Substance Abuse.	Not Covered
J. **HEARING SERVICES**		
Routine Hearing Screenings	100% Plan Allowance Not subject to Deductible; limited to age parameters listed in the Highmark Delaware Preventive Schedule	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Hearing Exams	100% Plan Allowance	Not Covered
Hearing Aids	100% Plan Allowance Limited to one (1) hearing aid per ear, every three (3) years per Member under age 24.	Not Covered
K. **HOME HEALTH CARE SERVICES**	100% Plan Allowance Limited to 100 Visits per Benefit Period.	Not Covered
L. **HOSPICE CARE SERVICES**	100% Plan Allowance	Not Covered
M. **HOSPITAL SERVICES**		
Inpatient Services	100% Plan Allowance Unlimited days per Benefit Period.	Not Covered
Private Room Allowance	100% Plan Allowance for the most common semiprivate room charge. Private Room covered when Medically Necessary and Appropriate.	Not Covered
Surgery	100% Plan Allowance	Not Covered
Bariatric Surgery	100% Plan Allowance	Not Covered
Outpatient Services	100% Plan Allowance	Not Covered
Pre-Admission Testing	Same as other Outpatient Diagnostic Services	Not Covered
Surgery	100% Plan Allowance	Not Covered
Bariatric Surgery	100% Plan Allowance	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
N. **MATERNITY SERVICES**		
Facility	100% Plan Allowance	Not Covered
Professional Services	100% Plan Allowance	Not Covered
Maternity Home Health Care Visit	One (1) maternity home health care visit within forty-eight (48) hours of discharge when discharge occurs prior to (a) forty-eight (48) hours of Inpatient care following a normal vaginal delivery; or (b) ninety-six (96) hours of Inpatient care following a Caesarean delivery.	
O. **MEDICAL SERVICES**		
Inpatient Medical Care Services		
Inpatient Medical Care Visits and Intensive Medical Care	100% Plan Allowance	Not Covered
Concurrent Care	100% Plan Allowance	Not Covered
Consultation	100% Plan Allowance	Not Covered
Newborn Care	100% Plan Allowance	Not Covered
Private Duty Nursing	100% Plan Allowance Limited to 240 hours per Benefit Period – Inpatient Only.	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Outpatient Medical Care Services		
Members may be responsible for a facility or clinic based Coinsurance amount in addition to the Professional Provider charge if an office Visit or Service is provided at a Hospital, Facility Provider, Ancillary Provider, Retail Clinic or Urgent Care Center.		
Allergy Extract & Injections	100% Plan Allowance	Not Covered
Medical Care Visits		
Primary Care Provider	100% Plan Allowance	Not Covered
Retail Clinic	100% Plan Allowance	Not Covered
Specialist	100% Plan Allowance	Not Covered
Specialist Virtual Visit	100% Plan Allowance	Not Covered
Specialist Virtual Visit Originating Site Fee	100% Plan Allowance	Not Covered
Urgent Care Center	100% Plan Allowance	Same as Network Services
Benefits for Urgent Care Services rendered by an Out-of-Network Provider will be paid at the Network Services level. The Plan will pay 100% of the Plan Allowance after any Deductible. The Member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the Plan Allowance		
Telemedicine Services (Designated Telemedicine Provider)	100% Plan Allowance	Not Covered
Therapeutic Injections	100% Plan Allowance	Not Covered
Surgical Services		
Anesthesia	100% Plan Allowance	Same as Network Services

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Benefits for Anesthesia rendered by an Out-of-Network Provider will be paid at the Network Services level. The Plan will pay the Plan Allowance after Member cost-sharing (Deductible, Coinsurance or Copayment, if any) and the Member will be responsible for any remaining charges if the provider does not participate with Highmark Delaware or the local BCBS plan.		
Assistant at Surgery	100% Plan Allowance	Not Covered
Bariatric Surgery	100% Plan Allowance	Not Covered
Second Surgical Opinion Services	100% Plan Allowance	Not Covered
Special Surgery	100% Plan Allowance	Not Covered
Surgery	100% Plan Allowance	Not Covered
P. **MENTAL HEALTH CARE SERVICES**		
Inpatient Services	100% Plan Allowance Unlimited days per Benefit Period.	Not Covered
Outpatient Services	100% Plan Allowance First two (2) visits are not subject to Deductible.	Not Covered
Q. **ORTHOTIC DEVICES**	100% Plan Allowance	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES

R. **OUTPATIENT PRESCRIPTION DRUGS**

Covered Medications	100% of the PAP	Not Covered

Notes:

1. Certain retail Participating Pharmacy Providers may have agreed to make Maintenance Prescription Drugs available pursuant to the same terms and conditions, including cost-sharing and quantity limits, as the mail service coverage set forth in this Agreement. Members may contact the Plan at the toll-free number or the website appearing on the back of the Member's Identification Card for a listing of those retail Participating Pharmacy Providers who have agreed to do so.
2. No Member cost sharing will apply to self-administered Chemotherapy Medications including oral Chemotherapy Medications.
3. Continuous Glucose Monitors are subject to Tier 3 cost-sharing at retail or mail order from Participating Pharmacy Providers. See SECTION DB - DESCRIPTION OF BENEFITS in this Agreement for further explanation and additional limitations.

Preventive Covered Medications	100% of the PAP	Not Covered

Preventive Covered Medications are exempt from Deductibles, Copayments and Coinsurance.

Important: See **SECTION DB - DESCRIPTION OF BENEFITS** for conditions and limitations which affect a Member's Outpatient Prescription Drug coverage.

S. **PREVENTIVE SERVICES**

Benefits are provided in accordance with a predefined schedule which is reviewed and updated periodically by the Plan based on the requirements of the Affordable Care Act and the advice of the American Academy of Pediatrics, U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Accordingly, the frequency and eligibility of services is subject to change. Network Preventive Services benefits are exempt from Deductibles, Coinsurance, and Copayments.

Adult Care	100% Plan Allowance	Not Covered
Adult Immunizations	100% Plan Allowance	Not Covered
Diabetes Prevention Program	100% Plan Allowance	Not Covered
Mammographic Screenings	100% Plan Allowance	Not Covered
Pediatric Care	100% Plan Allowance	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Pediatric Immunizations	100% Plan Allowance	Not Covered
Routine Gynecological Examination and Papanicolaou Smear	100% Plan Allowance	Not Covered
Well-Woman Care	100% Plan Allowance	Not Covered
T. **PROSTHETIC APPLIANCES**	100% Plan Allowance	Not Covered
U. **ROUTINE CARE FOR CLINICAL TRIALS**	Refer to Benefit for Network Service required.	Not Covered
V. **SKILLED NURSING FACILITY SERVICES**	100% Plan Allowance Limited to 120 days per Benefit Period. Benefits renew after 180 days without care.	Not Covered
W. **SPINAL MANIPULATIONS**	100% Plan Allowance Limited to thirty (30) Visits per Benefit Period, except for the treatment of back pain.	Not Covered
X. **SUBSTANCE ABUSE SERVICES**		
Inpatient Services	100% Plan Allowance Unlimited days per Benefit Period.	Not Covered
Outpatient Services	100% Plan Allowance First two (2) visits are not subject to Deductible.	Not Covered

COVERED SERVICES	NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Y. **THERAPY SERVICES**		
Chemotherapy	100% Plan Allowance	Not Covered
Dialysis Treatment	100% Plan Allowance	Not Covered
Infusion Therapy	100% Plan Allowance	Not Covered
Radiation Therapy	100% Plan Allowance	Not Covered
Respiratory Therapy	100% Plan Allowance	Not Covered
Z. **TRANSPLANT SERVICES**	100% Plan Allowance; See Benefit Description.	Not Covered
AA. **VISION CARE SERVICES**		
Services must be provided by a Davis Vision Health Care Reform Network Provider.		
Pediatric Vision Care Services (for members under age 19)	100% Plan Allowance; not subject to Deductible	Not Covered
a. Comprehensive routine eye examination	One (1) every twelve (12) consecutive months.	Not Covered
b. Eyeglass Frames	One (1) every twelve (12) consecutive months.	Not Covered
c. Eyeglass Lenses	One (1) every twelve (12) consecutive months.	Not Covered

SECTION DB - DESCRIPTION OF BENEFITS

Subject to the exclusions, conditions, and limitations of this Agreement, and subject to **SECTION HC - HEALTH CARE MANAGEMENT SERVICES**, a Member is entitled to the benefits described in this Section for Medically Necessary and Appropriate Services rendered by a Provider and/or Supplier in the amounts specified in **SECTION SB - SCHEDULE OF BENEFITS**. A different level of benefits may be provided based on the place of treatment as set forth in **SECTION SB - SCHEDULE OF BENEFITS** of this Agreement.

A. **AMBULANCE SERVICE**

1. Ambulance Service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

   a. from a Member's home or the scene of an accident or medical emergency to a Hospital, or Skilled Nursing Facility;

   b. between Hospitals; or

   c. between a Hospital and a Skilled Nursing Facility

   when such facility is the closest institution that can provide Covered Services appropriate to the Member's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Member's condition, then Ambulance Service means transportation to the closest facility outside the local area that can provide the necessary service.

   Transportation and related emergency services provided by an Ambulance Service shall constitute Emergency Ambulance Services if the injury or the condition satisfies the criteria as described in the EMERGENCY CARE SERVICES Definition of **SECTION DE - DEFINITIONS** of this Agreement.

   Use of an ambulance as transportation to an emergency room of a Facility Provider for an injury or condition that does not satisfy the criteria set forth in the EMERGENCY CARE SERVICES Definition will not be covered as Emergency Ambulance Services.

2. Ambulance Service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

   a. from a Hospital to the Member's home; or

   b. from a Skilled Nursing Facility to the Member's home.

B. DENTAL SERVICES

1. Related to Accidental Injury

Dental Services rendered by a Physician or Dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth, or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

2. Services Related to Covered and Non-Covered Dental Procedures

General Anesthesia and associated Hospital and medical Services normally related to the administration of general Anesthesia which are rendered in connection with:

a. non-covered dental procedures or non-covered oral surgery; and

b. Pediatric Dental Services to the extent such anesthesia services are not covered under Paragraph 3 below.

Benefits are provided for Members age seven (7) or under and for developmentally disabled Members when determined by the Plan to be Medically Necessary and Appropriate and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

3. Pediatric Dental Services

Benefits are provided for Members to age nineteen (19) for the following when rendered by a Dentist who is a Network Provider:

a. Oral Evaluations:

i) Comprehensive, periodic and limited problem focused - one (1) of these services per six (6) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).

ii) Consultations - one (1) of these services per Dentist per patient per twelve (12) months for a consultant other than a Pedodontist or Orthodontist.

iii) Detailed problem focused - one (1) per Dentist per patient per twelve (12) months per eligible diagnosis.

b. Radiographs - Full mouth x-rays - one (1) every five (5) year(s). Bitewing x-rays - four (4) bitewings(s) per six (6) months to age nineteen (19).

c. Prophylaxis - one (1) per six (6) months. One (1) additional for Members under the care of a medical professional during pregnancy.

d. Fluoride treatments:

   i) Topical fluoride treatment - one (1) per six (6) months to age nineteen (19).

   ii) Fluoride varnish - one (1) per six (6) months to age nineteen (19).

e. Palliative treatment (Emergency)

f. Sealants - one (1) per tooth per five (5) years.

g. Space maintainers - one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

h. Preventive resin restorations - one (1) per tooth per five (5) years.

i. Basic restorations - amalgam or composite.

j. Prefabricated stainless steel crowns - one (1) per tooth per five (5) years.

k. Crowns - ceramic, porcelain-fused to metal, and metal alloy - one (1) every five (5) years.

l. Periodontal Services:

   i) Full mouth debridement - one (1) per three (3) years.

   ii) Periodontal maintenance following active periodontal therapy - one (1) per three (3) months in addition to routine prophylaxis.

   iii) Periodontal scaling and root planing - one (1) per two (2) years per area of the mouth.

   iv) Surgical periodontal procedures - one (1) per thirty-six (36) months per area of the mouth.

   v) Guided tissue regeneration - one (1) per tooth per lifetime.

m. Replacement of restorative services only when they are not, and cannot be made, serviceable:

   i) Basic restorations - not within twenty-four (24) months of previous placement.

   ii) Crowns (including but not limited to prefabricated stainless steel crown) - not within five (5) years of previous placement.

   iii) Buildups and post and cores - not within five (5) years of previous placement.

iv) Replacement of natural tooth/teeth in an arch - not within five (5) years of a fixed or three (3) years with partial denture.

n. Oral and maxillofacial surgical services:

i) Simple Extractions

ii) Surgical Extractions

iii) Oral Surgery

iv) Apicoectomy/Periradicular Surgery

o. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

p. Pulpal therapy - one (1) per eligible tooth per lifetime for members under age nine (9). Eligible teeth limited to those with no secondary permanent tooth to replace the primary tooth.

q. Root canal retreatment - one (1) per tooth per lifetime.

r. Recementation - one (1) per five (5) years. Recementation during the first twelve (12) months following insertion by the same Dentist is included in the prosthetic service benefit.

s. Administration of I.V. sedation, nitrous oxide or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bone or complete bony impactions.

t. Therapeutic drug injections - only covered in unusual circumstances, by report.

u. Occlusal Guard

v. Orthodontics

Covered Services which are intended to treat a severe dentofacial abnormality and are the only method capable of preventing irreversible damage to the Member's teeth or their supporting structures, and restoring the Member's oral structure to health and function.

Limitations

a. Orthodontic treatment limitations:

i) All pediatric orthodontic treatment is subject to Precertification by the Plan, and must be part of an approved written plan of care.

ii) To be eligible for pediatric orthodontic treatment, a Member must have a fully erupted set of permanent teeth.

b. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Provider choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

c. Coverage terminates for Pediatric Dental Services at the end of the Benefit Period in which the Member reaches age nineteen (19).

C. DIABETES TREATMENT

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a Physician legally authorized to prescribe such items under the law:

1. **Equipment and Supplies**

   Blood Glucose Monitors, monitor supplies, injection aids, and insulin infusion devices.

2. **Diabetes Education Program**

   When the Member's Physician certifies that a Member requires diabetes education as an Outpatient, coverage is provided for the following when rendered through a Diabetes Education Program:

   a. Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and

   b. Subsequent Visits under circumstances whereby a Member's physician:

      i) identifies or diagnoses a significant change in the Member's symptoms or conditions that necessitates changes in a Member's self-management; or

      ii) identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the Member's treatment and/or management of diabetes.

3. Prescription Drugs required for the treatment of diabetes are covered in accordance with Paragraph Q. **OUTPATIENT PRESCRIPTION DRUGS** in this Section.

D. DIAGNOSTIC SERVICES

Benefits will be provided for the following Covered Services on an Inpatient or Outpatient basis only when such Covered Services are ordered by a Professional Provider:

1. **Advanced Imaging Services**

   Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

2. **Basic Diagnostic Services**

   a. Standard Imaging Services - procedures such as skeletal x-rays, ultrasound and fluoroscopy;

   b. Laboratory and Pathology Services - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures;

   c. Diagnostic Medical Services - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing; and

   d. Allergy Testing Services - allergy testing procedures such as percutaneous, intracutaneous, and patch tests. If you have allergy testing services during an office visit, you will pay separate copayments for the allergy testing services and the office visit.

   Basic Diagnostic Services provided for preventive purposes in accordance with a predefined schedule based on age and sex described in **SECTION DB - DESCRIPTION OF BENEFITS**, Subsection R. **PREVENTIVE SERVICES** are exempt from Deductibles, Copayments and Coinsurance.

E. DURABLE MEDICAL EQUIPMENT

The rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase, adjustment, repairs and replacement of Durable Medical Equipment when prescribed by a Professional Provider within the scope of their license and required for therapeutic use.

F. EMERGENCY CARE SERVICES

Services and Supplies for the Outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition, as described in the **EMERGENCY CARE SERVICES** Definition of **SECTION DE - DEFINITIONS** of this Agreement, including a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition, and such further medical examination and treatment as required to stabilize the patient.

Transportation and related emergency services provided by an Ambulance Service shall constitute Emergency Ambulance Services if the injury or the condition satisfies the criteria as described in the **EMERGENCY CARE SERVICES** Definition of **SECTION DE - DEFINITIONS** of this Agreement.

G. ENTERAL FOODS

Coverage is provided for Enteral Foods, as defined in this Agreement, when administered on an Outpatient basis for the following:

1. Amino acid-based elemental medical formulae ordered by a Physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome.

2. Nutritional supplements administered under the direction of a Physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

H. FERTILITY CARE SERVICES

Pursuant to Delaware law, this plan provides fertility care services and fertility preservation services for individuals diagnosed with infertility or at risk of infertility due to surgery, radiation, chemotherapy or other medical treatment.

Covered services include artificial insemination, in vitro fertilization and related technologies, cryopreservation of cells and tissue, and reversal of voluntary sterilization (under limited circumstances).

1. **Artificial Insemination (AI, IUI, ICI)**

   Artificial Insemination is a procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

2 **In Vitro Fertilization (IVF, GIFT, ZIFT)**

   IVF (or related technologies, including, but not limited to: gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)) may be considered medically necessary when the following criteria are met:

   - Individual has a congenital absence or anomaly of reproductive organ(s); or

   - Individual fulfills one of the following definitions of infertility:

     - Individual is less than the age of 35 years and has not achieved a successful pregnancy after at least twelve (12) months of appropriately timed unprotected

vaginal intercourse or intrauterine insemination; or

- Individual is 35 years of age or older and has not achieved a successful pregnancy after at least six (6) months of appropriately timed unprotected vaginal intercourse or intrauterine insemination.

and

- In the absence of known tubal disease and/or severe male factor problems (contraindications to insemination cycles), the individual has not achieved a successful pregnancy as described above, which includes up to three (3) intrauterine insemination cycles; and
- Individual has at least one risk factor that includes, but is not limited to the following:
  - Tubal disease that cannot be corrected surgically; or
  - Diminished ovarian reserve; or
  - Irreparable distortion of the uterine cavity or other uterine anomaly (when using a gestational carrier); or
  - Male partner with severe male factor infertility; or
  - Unexplained infertility; or
  - Stage 4 endometriosis as defined by the American Society of Reproductive Medicine;

and

- Individual does not have either of the following contraindications:
  - Ovarian failure: premature (i.e., ovaries stop working before age 40) or menopause (i.e., absence of menstrual periods for 1 year); or
  - Contraindication to pregnancy

For IVF services, retrievals must be completed before the individual is 45 years old and transfers must be completed before the individual is 50 years old. The benefit is limited to six (6) completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (SET) when recommended and medically appropriate.

3. **Gestational Carrier/Surrogate**

   Medical services or supplies rendered to a gestational carrier or surrogate may be considered medically necessary if the member has ANY of the following indications:

- Congenital absence of a uterus; or
- Uterine anomalies that cannot be repaired; or
- A medical condition for which pregnancy may pose a life-threatening risk.

4. **Exclusions:**

   The following related services to reproductive technologies/techniques are considered not medically necessary:

   - Reversal of voluntary sterilization (tuboplasty or vasoplasty) undergone after the covered individual successfully procreated with the covered individual's partner at the time the reversal is desired; or
   - Payment for surrogate service fees for purposes of child birth; or
   - Living expenses; or
   - Travel expenses.

I. HABILITATIVE AND REHABILITATIVE SERVICES

Benefits will be provided for the following Covered Services only when such Services are ordered by a Physician, Professional Provider, or Professional Other Provider.

1. Applied Behavior Analysis
2. Cardiac Rehabilitation
3. Occupational Therapy, including Cognitive Rehabilitation
4. Physical Medicine
5. Speech Therapy

J. HEARING CARE SERVICES

Benefits will be provided for the following Covered Services only when such Services are ordered by a Physician or Professional Other Provider.

1. Hearing Screenings - Routine hearing screenings are covered as part of a routine physical exam, subject to the limitations described in Subsection R. **PREVENTIVE SERVICES**, below.
2. Diagnostic Hearing Exams - Visits to a specialist or audiologist are covered as specialist care. Benefit excludes coverage for hearing aid exams and fittings.

3. Hearing Aids - Limited to one (1) hearing aid, per person, per ear, every three (3) years for Members under age twenty-four (24).

K. HOME HEALTH CARE SERVICES

Services rendered by a Home Health Care Agency or a Hospital program for Home Health Care for which benefits are available as follows:

1. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*;

2. Physical Medicine, Speech Therapy and Occupational Therapy Services;

3. Medical and surgical supplies provided by the Home Health Care Agency or Hospital Program for Home Health Care;

4. Oxygen and its administration;

5. Medical social service consultations; and

6. Health aide Services to a Member who is receiving covered nursing Services, or Habilitative and Rehabilitative Services or Therapy Services.

7. No Home Health Care benefits will be provided for:

   a. Dietitian Services;

   b. Homemaker Services;

   c. Maintenance therapy;

   d. Dialysis treatment;

   e. Custodial Care; and

   f. Food or home delivered meals.

L. HOSPICE CARE SERVICES

Services rendered by an Agency or a Hospital program for Hospice Care for which benefits are available as follows:

1. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)*;

*The services of a Licensed Practical Nurse (LPN) shall be made available only when the services of a Registered Nurse are not available and only when Medically Necessary and Appropriate. Services of a LPN are only reimbursable through a Facility Provider.

2. Physical Medicine, Speech Therapy and Occupational Therapy Services;

3. Medical and surgical supplies provided by the Home Health Care Agency or Hospital Program for Hospice Care;

4. Oxygen and its administration;

5. Medical social service consultations;

6. Health aide Services to a Member who is receiving covered nursing Services, or Habilitative and Rehabilitative Services or Therapy Services;

7. Family Counseling related to the Member's terminal condition; and

8. Hospice Care Services will be provided to Members with a life expectancy of one hundred eighty (180) days or less, as certified by a Physician.

9. No Hospice Care benefits will be provided for:

   a. Dietitian Services;

   b. Homemaker Services;

   c. Maintenance therapy;

   d. Dialysis treatment;

   e. Custodial Care; and

   f. Food or home delivered meals.

M. **HOSPITAL SERVICES**

1. **Inpatient Services**

   a. Bed, board and general nursing Services in a Facility Provider when the Member occupies:

      i) a room with two (2) or more beds;

      ii) a private room; or

      iii) a bed in a Special Care Unit - a designated unit which has concentrated all facilities, equipment, and supportive Services for the provision of an intensive level of care for critically ill patients.

   b. Ancillary Services

      Hospital services and supplies including, but not restricted to:

i) Use of operating and treatment rooms and equipment;

ii) Drugs and medicines provided to a Member who is an Inpatient in a Facility Provider;

iii) Whole blood, administration of blood, blood processing, and blood derivatives;

iv) Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider. Administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;

v) Medical and surgical dressings, supplies, casts, and splints;

vi) Diagnostic Services;

vii) Habilitative and Rehabilitative Services; and

viii) Therapy Services.

2. **Outpatient Services**

a. Ancillary Services

Hospital services and supplies including, but not restricted to:

i) Use of operating and treatment rooms and equipment;

ii) Drugs and medicines provided to a Member who is an Outpatient in a Facility Provider. However, benefits for certain therapeutic injectables and Infusion Therapy Prescription Drugs as identified by the Plan and which are appropriate for self-administration will be provided only when received from a Participating Pharmacy Provider as set forth under Subsection Q. **OUTPATIENT PRESCRIPTION DRUGS** of this section;

iii) Whole blood, administration of blood, blood processing, and blood derivatives;

iv) Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider, including the administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;

v) Medical and surgical dressings, supplies, casts, and splints;

vi) Diagnostic Services;

vii) Habilitative and Rehabilitative Services; and

viii) Therapy Services. However, benefits for certain Infusion Therapy Services as identified by the Plan will only be provided when performed by an Ancillary Provider.

b. Pre-Admission Testing

Tests and studies, including those set forth in the Basic Diagnostic Services paragraph of Subsection D. **DIAGNOSTIC SERVICES** in this Section, when such Services are required in connection with the Member's admission and are rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

c. Surgery

Hospital services and supplies for Outpatient Surgery including removal of sutures, Anesthesia, Anesthesia supplies and Services rendered by an employee of the Facility Provider other than the surgeon or assistant at Surgery.

d. Bariatric Surgery

If the Member is morbidly obese, the following surgical procedures are covered:

i) gastric bypass;

ii) gastric stapling;

iii) biliopancreatic bypass with duodenal switch;

iv) gastric banding; and

v) sleeve gastrectomy.

The Member must:

i) have achieved full growth and be eighteen (18) years or older (Members under age eighteen (18) may also qualify under certain circumstances);

ii) have no specific, treatable, correctable cause for the morbid obesity (e.g., endocrine disorder);

iii) complete a structured diet program in the two (2)-year period that immediately precedes the request for the surgery;

iv) have received a psychological evaluation specifically for the diagnosis of obesity or morbid obesity;

v) have received appropriate medical (including cardiac and pulmonary) clearances from the Member's Physician;

vi) meet any of the following criteria:

1. weigh at least one-hundred (100) pounds above or are twice the ideal body weight;

2. have a BMI of at least forty (40) (at least fifty (50) for sleeve gastrectomy and biliopancreatic bypass with duodenal switch); or

3. have a BMI equal or greater than thirty-five (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.

N. MATERNITY SERVICES

Hospital Services and medical/surgical services rendered by a Facility Provider, Professional Provider or Professional Other Provider for:

1. Complications of Pregnancy

Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

2. Maternity Home Health Care Visit

Benefits for one (1) maternity home health care visit will be provided at the Member's home within forty-eight (48) hours of discharge when the discharge occurs prior to: (a) forty-eight (48) hours of Inpatient care following a normal vaginal delivery; or (b) ninety-six (96) hours of Inpatient care following a caesarean delivery. This visit shall be made by a Professional Provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at the mother's sole discretion, occur at a Facility Provider. The maternity home health care visit is subject to all the terms of this Agreement.

3. Newborn Care

Covered Services will be provided to the newborn child of a Member from the moment of birth and shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes Inpatient medical visits by a Professional Provider. Such Benefits shall continue for a maximum of thirty-one (31) days from birth, subject to the termination provisions set forth in Subsection B. **BENEFITS AFTER TERMINATION OF COVERAGE** of **SECTION GP - GENERAL PROVISIONS**.

4. **Normal Pregnancy**

Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

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

This plan does not restrict mothers' and newborns' benefits for a hospital length of stay related to childbirth to less than:

- forty-eight (48) hours following a vaginal delivery; and
- ninety-six (96) hours following a cesarean section.

Maternity lengths of stay may be less than the forty-eight (48) or ninety-six (96) hours *only* if both the patient and physician agree.

O. MEDICAL SERVICES

1. **Inpatient Medical Services**

Medical Care rendered by a Professional Provider to a Member who is an Inpatient for a condition not related to Surgery, pregnancy, Mental Illness or Substance Abuse, except as specifically provided.

a. Inpatient Medical Care Visits

b. Intensive Medical Care

Medical care rendered to a Member whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

c. Concurrent Care

i) Medical care rendered concurrently with Surgery during one (1) Inpatient stay by a Professional Provider other than the operating surgeon for treatment of a medical condition separate from the condition for which Surgery was performed.

ii) Medical care by two (2) or more Professional Providers rendered concurrently during one (1) Inpatient stay when the nature or severity of the Member's condition requires the skills of separate physicians.

d. Consultation

Consultation Services rendered to an Inpatient by another Professional Provider at the request of the attending Professional Provider. Consultation does not include staff consultations which are required by the Facility Provider's rules and regulations.

e. Routine Nursery Care

Professional Provider visits to examine the newborn.

f. Private Duty Nursing

Private duty nursing Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a Physician, providing such nurse does not ordinarily reside in the Member's home or is not member of the Member's immediate family. Private duty nursing Services are provided only when the plan determines that the nursing Services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.

2. **Outpatient Medical Care Services**

Medical care rendered by a Professional Provider to a Member who is an Outpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specifically provided, including allergy extracts, allergy injections, medical care Visits, Telemedicine Services, therapeutic injections and consultations for the examination, diagnosis and treatment of an injury or illness, and Covered Services provided by Professional Providers at a Retail Clinic or Urgent Care Center. However, benefits for certain therapeutic injectables as identified by the Plan and which are appropriate for self-administration will be provided only when received from a Participating Pharmacy Provider as set forth under Subsection Q. **OUTPATIENT PRESCRIPTION DRUGS** of this Section.

Medical nutrition therapy (MNT) is covered for certain conditions, including but not limited to diabetes mellitus, nutritional deficiencies, morbid obesity, anorexia nervosa and eating disorders, cardiovascular disease, congenital anomalies of the kidneys and digestive system and gastric bypass and other ulcers.

Benefits are also provided for a Specialist Virtual Visit when a Member communicates with the Specialist from any location such as their home, office or another mobile location, or the Member travels to a Provider based location referred to as the "Provider originating site". If the Member communicates with the Specialist from a Provider originating site, the Member will be responsible for the Specialist Virtual Visit Provider Originating Site Fee Coinsurance amount specified in the Schedule of Benefits.

Benefits are also provided for Teledermatology and Virtual Behavioral Health.

Benefits for Outpatient Medical Care Services will be provided in the amounts specified in **SECTION SB - SCHEDULE OF BENEFITS** and are subject to additional limitations outlined in that Section.

3. **Surgical Services**

a. Anesthesia

Administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery. Benefits are also provided for the administration of Anesthesia for oral surgical procedures in an Outpatient setting when ordered and administered by the attending Professional Provider.

b. Assistant at Surgery

Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant at surgery only if an intern, resident, or house staff member is not available.

c. Second Surgical Opinion

i) Services

A consulting opinion and directly related Diagnostic Services to confirm the need for recommended elective Surgery.

ii) Specifications

(a) The second opinion consultant must not be the Physician who first recommended elective Surgery.

(b) Elective Surgery is covered Surgery that may be deferred and is not an emergency.

(c) Use of a second surgical opinion is at the Member's option.

(d) If the first opinion for elective Surgery and the second opinion conflict, then a third opinion and directly related Diagnostic Services are Covered Services.

(e) If the consulting opinion is against elective Surgery and the Member decides to have the elective Surgery, the Surgery is a Covered Service. In such instances, the Member will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

d. Special Surgery

i) Oral Surgery

Benefits are provided for limited oral surgical procedures in an Outpatient setting when Preauthorized by the Plan or in an Inpatient setting if determined to be Medically Necessary and Appropriate.

(a) Extraction of impacted third molars when partially or totally covered by bone;

(b) Extraction of teeth in preparation for cardiac Surgery, organ transplantation or radiation therapy;

(c) Mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;

(d) Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie) and mandibular frenectomy;

(e) Facility Provider and Anesthesia services rendered in conjunction with non-covered dental procedures when determined by the Plan to be Medically Necessary and Appropriate due to the age and/or medical condition of the Member;

(f) Accidental injury to the jaw or structures contiguous to the jaw;

(g) The correction of a non-dental physiological condition which has resulted in a severe functional impairment;

(h) Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of mouth; and

(i) Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

ii) Mastectomy and Breast Cancer Reconstruction

Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis for the following:

(a) Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;

(b) Initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and

(c) Physical complications of all stages of mastectomy, including lymphedemas.

Benefits are also provided for one (1) home health care visit, as determined by the Member's Physician, when received within forty-eight (48) hours after discharge, if such discharge occurred within forty-eight (48) hours after an admission for a mastectomy.

iii) Abortions

Benefits are provided for abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which Federal funding is allowed).

e. Surgery

i) Surgery performed by a Professional Provider. Separate payment will not be made for pre- and post-operative Services.

ii) If more than one (1) surgical procedure is performed by the same Professional Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, plus fifty percent (50%) of the amount that would have been payable for each of the additional procedures, had those procedures been performed alone.

P. MENTAL HEALTH CARE SERVICES

1. Inpatient Facility Services

Hospital Services are provided for the Inpatient treatment of illness by a Facility Provider.

2. Inpatient Medical Services

The following Services are provided for the Inpatient treatment of Mental Illness by a Professional Provider:

a. individual psychotherapy;

b. group psychotherapy;

c. psychological testing;

d. Family Counseling; and

Counseling with family members to assist in the Member patient's diagnosis and treatment.

e. convulsive therapy treatment.

Electroshock treatment or convulsive drug therapy including Anesthesia when administered concurrently with the treatment by the same Professional Provider.

3. **Partial Hospitalization Mental Health Care Services**

   Benefits are only available for Mental Health Care Services provided on a Partial Hospitalization basis when received through a Partial Hospitalization program. A Mental Health Care Service provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts.

4. **Outpatient Mental Health Care Services**

   Inpatient Facility Services and Inpatient Medical Services Benefits as described in this Subsection are also available when provided for the Outpatient treatment of Mental Illness by a Facility Provider, a Professional Provider or a Professional Other Provider.

Benefits are subject to provisions set forth in **SECTION HC - HEALTH CARE MANAGEMENT SERVICES**, Subsection C. **HEALTH CARE MANAGEMENT SERVICES**.

Q. ORTHOTIC DEVICES

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

R. OUTPATIENT PRESCRIPTION DRUGS

1. Benefits are provided for Covered Medications appearing on the Formulary when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Participating Pharmacy Provider upon presentation of a valid Identification Card and when dispensed on or after the Member's Effective Date for Outpatient use. Benefits for Covered Medications are provided in the amounts specified in **SECTION SB - SCHEDULE OF BENEFITS.**

   Coverage is provided for:

   a. Prescription Drugs appearing on the Formulary, including those obtained from a Participating Pharmacy Provider; and

   b. Maintenance Prescription Drugs obtained through a mail service program or from a retail Participating Pharmacy Provider for up to a ninety (90)-day supply;

   c. Preventive Covered Medications and Over-the-Counter Drugs set forth in a predefined schedule* and which are prescribed for preventive purposes, upon presentation of a written Prescription Order; and

*This schedule is reviewed and updated periodically by the Plan based on the requirements of the Affordable Care Act and the advice of the American Academy of Pediatrics, U.S. Preventive Services Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

d. Selected Prescription Drugs within, but not limited to, the following drug classifications only when such drugs are Covered Medications and when dispensed through an Exclusive Pharmacy Provider:

i) Oncology related therapies;

ii) Interferons;

iii) Agents for multiple sclerosis and neurological related therapies;

iv) Antiarthritic therapies;

v) Anticoagulants;

vi) Hematinic agents;

vii) Immunomodulators;

viii) Growth Hormones; and

ix) Hemophilia related therapies.

These selected Prescription Drugs may be ordered by a Physician or other healthcare Provider on behalf of the Member, or the Member may submit the Prescription Order directly to the Exclusive Pharmacy Provider. In either situation, the Exclusive Pharmacy Provider will deliver the Prescription Drug to the Member.

Members may contact the Plan at the toll-free telephone number or the website appearing on the back of the Member's Identification Card to verify whether a particular Prescription Drug may be purchased from a Participating Pharmacy Provider or must be obtained through an Exclusive Pharmacy Provider.

2. Benefits are provided for continuous glucose monitoring devices when prescribed by a Professional Provider in connection with a Covered Service, when purchased at a Participating Pharmacy Provider upon presentation of a valid Identification Card, and when dispensed on or after the Member's Effective Date for Outpatient use.

3. Limitations

a. No coverage is provided for Covered Medications purchased at a Non-Participating Pharmacy Provider.

b. Each Covered Medication from a retail Participating Pharmacy Provider or through a mail service Participating Pharmacy Provider is limited to a ninety (90)-day supply. Certain Specialty Prescription Drugs, including those which must be obtained from an Exclusive Pharmacy Provider, are limited to a thirty-four (34)-day supply.

NOTE:Certain retail Participating Pharmacy Providers may have agreed to make Maintenance Prescription Drugs available pursuant to the same terms and conditions, including cost-sharing and quantity limits, as the mail service coverage set forth in this Agreement. Members may contact the Plan at the toll-free number or the website appearing on the back of the Member'sIdentification Card for a listing of those retail Participating Pharmacy Providers who have agreed to do so.

c. No coverage is provided for any refill of a Covered Medication that is dispensed before the date of the Member's predicted use of at least ninety percent (90%) of the days' supply of the previously dispensed Covered Medication, unless the Member's Physician obtains Precertification from the Plan for an earlier refill.

d. Quantity level limits may be imposed on certain Prescription Drugs by the Plan. Such limits are based on the manufacturer's recommended daily dosage or as determined by the Plan. Quantity level limits control the quantity covered each time a new Prescription Order or refill is dispensed for selected Prescription Drugs. Each time a Prescription Order or refill is dispensed, the Participating Pharmacy may limit the amount dispensed.

e. Insulin syringes, needles, and/or disposable diabetic testing materials will be covered by the same payment as the insulin, if dispensed in a day supply corresponding to the amount of insulin dispensed. Insulin syringes, needles, and/or disposable diabetic testing material dispensed without insulin will require a payment when dispensed.

f. The quantity level limit of Covered Medications for which benefits are payable hereunder for each initial Prescription Order may be reduced, dependent upon the particular medication, to a quantity level necessary to establish that the Member can tolerate the Covered Medication. Consequently, the amounts set forth in **SECTION SB - SCHEDULE OF BENEFITS** will be prorated based upon the initial quantity dispensed. If the Member is able to tolerate the Covered Medication, the remainder of the available day supply for the initial Prescription Order will be filled and the Member will be charged the balance of the amount applicable to the initial Prescription Order.

g. The selected Prescription Drugs dispensed through an Exclusive Pharmacy Provider are subject to the cost-sharing provisions set forth in the Outline of Coverage, and to the day supply quantity limitations for non-Maintenance Prescription Drugs as set forth in this Paragraph 2. Limitations, Subparagraph b.

h. Continuous glucose monitoring devices are available from a retail Particiapting Pharmacy Provider or a mail service Participating Pharmacy Provider. Receiver kits are limited to one (1) per Benefit Period. Sensor kits are limitned to one (1) refill every thirty (30) days. Transmitter kits are limited to one (1) refill every ninety (90) days.

i. Benefits are provided for certain specified drugs when dispensed to Members on a "stepped basis," referred to as the "Step Therapy" Program. Within selected drug categories, benefits are only provided for specified Prescription Drugs when one of the following criteria is met:

i) Individual has previously tried and failed two (2) preferred products (when available), one of which must be in the same therapeutic class/category as the specified Prescription Drug, the other product may be in a different therapeutic class/category, however it must have the same indication as the specified Prescription Drug; or

ii) For combination products: Individual has previously tried and failed two (2) preferred products (when available), one of which must be in the same therapeutic class/category as at least one ingredient in a non-formulary combination product; or

iii) For antibiotics, anti-virals, and anti-fungals: Individual has previously tried and failed one preferred antibiotic, anti-viral, or anti-fungal product within the same route of administration; or

iv) Individual has a documented drug interaction with the preferred drug; or

v) Individual has documented adverse drug experiences with the preferred drug or the prescriber attests that the individual would have adverse drug reactions with the preferred drug; or

vi) The individual is currently stable on the specified Prescription Drug and the prescriber attests that a change to another preferred product would not be in the individual's best interest because of a likely adverse event or mental harm to the individual; or

vii) The preferred drug is expected to be ineffective or less effective based on known, relevant physical or mental characteristics of the individual and the known characteristics of the prescription drug regimen.

viii) Any request for an exception that does not meet the criteria above will be subject to medical necessity review.

ix) If any of the criteria are met, the Participating Pharmacy Provider will dispense the specified Prescription Drug to the Member. The Member shall be responsible for any costsharing amounts and will be subject to any quantity limit requirements or other limitations set forth in this Agreement. When these criteria are not met, the treating Physician may submit a request for authorization to dispense a specified Prescription Drug to the Member for the Plan's consideration.

j. Benefits provided under this Subsection are not subject to the provisions of Subsection F. **COORDINATION OF BENEFITS** of **SECTION GP - GENERAL PROVISIONS** in this Agreement.

Important: See **SECTION EX - EXCLUSIONS** for additional conditions, limitations, and exclusions which affect a Member's Outpatient Prescription Drug coverage.

S. PREVENTIVE SERVICES

Benefits are provided for the following Covered Services and Covered medications in the amounts specified in **SECTION SB - SCHEDULE OF BENEFITS**, in accordance with a predefined schedule* based on age and sex, and are exempt from Deductible, Coinsurance and Copayment amounts.

1. Adult Care

Benefits are provided for routine physical examinations regardless of Medical Necessity and Appropriateness, including a complete medical history, and other items and Services.

2. Adult Immunizations

Benefits are provided for adult immunizations, including the immunizing agent, required for the prevention of disease. Adult immunizations are covered when obtained at a doctor's office and certain vaccines are also covered when obtained at a Highmark network pharmacy vaccination provider or Participating Pharmacy Provider. Contact Member Services for a list of Highmark network pharmacy vaccination providers and Participating Pharmacy Providers. Adult immunizations required by an employer are subject to any Deductible and/or Coinsurance.

3. Colorectal Cancer Screenings

a. Benefits will be provided for the following Covered Services in the amounts specified in **SECTION SB - SCHEDULE OF BENEFITS:**

i) pathology and laboratory screening services such as fecal-occult blood or fecal immunochemical test;

ii) x-ray screening services such as barium enema;

iii) surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services; and

iv) such other pathology and laboratory, x-ray, surgical screening tests and medical screening services consistent with approved medical standards and practices for the detection of colon cancer.

*This schedule is reviewed and updated periodically by the Plan based on the requirements of the Affordable Care Act and the advice of the American Academy of Pediatrics, U.S. Preventive Services Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

b. Colorectal Cancer Screenings will be covered as follows:

i) For all Members beginning at age fifty (50) as follows:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five (5) years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five (5) years
- A colonoscopy every ten (10) years

ii) For Members determined to be at high or increased risk, regardless of age:

A colonoscopy or any other combination of Covered Services related to Colorectal Cancer Screening prescribed by a Physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

Colorectal cancer screening services which are otherwise not described in this **Colorectal Cancer Screenings** Paragraph or which are prescribed by a Physician for a symptomatic Member are not considered Preventive Care Services. These Services will be paid under this Contract consistent with similarly Medically Necessary and Appropriate Covered Services.

4. **Diabetes Prevention Program**

Benefits are provided for those Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled in a Diabetes Prevention Program that is offered through a Network Diabetes Prevention Provider. Coverage is limited to one (1) enrollment in a Diabetes Prevention Program per year, regardless of whether the Member completes the Diabetes Prevention Program.

5. **Mammographic Screenings**

Benefits are provided for the following Covered Services in amounts specified in **SECTION SB - SCHEDULE OF BENEFITS**:

a. One (1) annual routine mammographic screening starting at forty (40) years of age or older; and

b. Mammographic screenings for all Members, regardless of age, when such Services are prescribed by a Physician.

Benefits for mammographic screenings are payable only if performed by a mammography service provider who is properly certified by the Office of Radiation Control, Delaware Division of Public Health.

6. **Pediatric Care**

   Benefits are provided for routine physical examinations and diagnostic Services regardless of Medical Necessity and Appropriateness, and other items and Services

7. **Pediatric Immunizations**

   Benefits are provided to Members under twenty-one (21) years of age as defined in **SECTION SE - SCHEDULE OF ELIGIBILITY** of this Agreement, for those pediatric immunizations, including the immunizing agents which, as determined by the Delaware Division of Public Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, and the U. S. Department of Health and Human Services. Pediatric immunizations are covered when obtained at a doctor's office and certain vaccinations are also covered when obtained at a Highmark network pharmacy vaccination provider or Participating Pharmacy Provider. Contact Member Services for a list of Highmark network pharmacy vaccination providers and Participating Pharmacy Providers.

8. **Preventive Covered Medications**

   Coverage will be provided for Prescription Drugs and Over-the-Counter Drugs set forth in a predefined schedule* and which are prescribed for preventive purposes, upon presentation of a written Prescription Order. Preventive Covered Medications include all Food and Drug Administration approved tobacco cessation medications. Preventive Covered Medications are subject to the terms and conditions set forth in the OUTPATIENT PRESCRIPTION DRUGS Subsection of this **SECTION DB - DESCRIPTION OF BENEFITS.**

9. **Routine Gynecological Examination and Papanicolaou Smear**

   Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou smear per year.

10. **Tobacco Use Counseling and Intervention**

    Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two (2) tobacco cessation attempts per year. A tobacco cessation attempt includes four (4) tobacco cessation counseling sessions and Covered Medications as set forth in the Paragraph 76. Preventive Covered Medications of this Subsection.

11. **Well-Woman Care**

    Benefits are provided for items and services including but not limited to an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling for all Members capable of pregnancy, and breastfeeding support and counseling.

T. PROSTHETIC APPLIANCES

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered. Wigs hair prostheses for hair loss caused by chemotherapy or alopecia areata resulting from an autoimmune disease.

U. ROUTINE PATIENT CARE FOR CLINICAL TRIALS

Benefits will be provided for routine patient care associated with approved clinical trials, and will be paid at the same benefit level as for other patient care. See the **SECTION DE – DEFINITIONS** for more information about Clinic Trials and Routine Patient Care for Clinical Trials.

V. SKILLED NURSING FACILITY SERVICES

1. Services rendered in a Skilled Nursing Facility to the same extent benefits are available to an Inpatient of a Hospital.

   Benefits for Skilled Nursing Facility Services cannot exceed the Maximum number of days shown in **SECTION SB - SCHEDULE OF BENEFITS**.

2. No benefits are payable:

   a. after the Member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care;

   b. when confinement in a Skilled Nursing Facility is intended solely to assist the Member with the activities of daily living or to provide an institutional environment for the convenience of a Member; and

   c. for the treatment of Substance Abuse or Mental Illness.

W. SPINAL MANIPULATIONS

Benefits will be provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

X. SUBSTANCE ABUSE SERVICES

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and Family Counseling for the treatment of Substance Abuse when rendered to a Member by a Facility Provider or Professional Provider and include the following:

1. Detoxification services rendered;

   a. on an Inpatient basis; or

   b. on an Outpatient basis;

2. Substance Abuse Treatment Facility Services for non-Hospital Inpatient residential treatment and rehabilitation Services; and

3. Outpatient Hospital or Substance Abuse Treatment Facility or Outpatient Substance Abuse Treatment Facility Services for rehabilitation therapy. For purposes of this benefit, a Substance Abuse Service provided on a Partial Hospitalization basis shall be deemed an Outpatient care Visit subject to Outpatient care cost-sharing amounts.

Benefits are subject to provisions set forth in **SECTION HC - HEALTH CARE MANAGEMENT SERVICES**, Subsection C. **HEALTH CARE MANAGEMENT SERVICES**.

Y. THERAPY SERVICES

Benefits will be provided for the following Covered Services only when such Services are ordered by a Physician or Professional Other Provider.

1. Chemotherapy

2. Dialysis Treatment

3. Infusion Therapy

   Benefits will be provided when Covered Services are performed by a Provider on an Outpatient basis or if the components are furnished and billed by a Provider. Covered Services include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Infusion Therapy. Benefits for certain Infusion Therapy Prescription Drugs as identified by the Plan and which are appropriate for self-administration, will be provided only when received from a Participating Pharmacy Provider as set forth under Subsection Q. OUTPATIENT PRESCRIPTION DRUGS of this Section.

4. Radiation Therapy

5. Respiratory Therapy

Z. **TRANSPLANT SERVICES**

Subject to the provisions of this Agreement, benefits will be provided for Covered Services furnished by a Hospital which are directly and specifically related to transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

1. When both the recipient and the donor are Members, each is entitled to the benefits of this Agreement;

2. When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of this Agreement subject to the following additional limitations:

    a. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross or Blue Shield coverage or any government program; and

    b. Benefits provided to the donor will be charged against the recipient's coverage under this Agreement to the extent that benefits remain and are available under this Agreement after benefits for the recipient's own expenses have been paid;

3. When only the donor is a Member, the donor is entitled to the benefits of this Agreement, subject to the following additional limitations:

    a. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Agreement; and

    b. No benefits will be provided to the non-Member transplant recipient;

4. If any organ, tissue or blood stem cell is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Member recipient's Agreement limit.

- 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 Highmark Delaware'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 five (5) days prior to a transplant and ends twelve (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.

AA. VISION CARE SERVICES

Pediatric Vision Care Services

Benefits are provided for Members under age nineteen (19) every twelve (12) consecutive months for the following when rendered by a Participating Vision Provider:

a. one (1) comprehensive eye examination (including dilation as professionally indicated);

b. one (1) pair of single vision, bifocal, trifocal or lenticular lenses (including glass, plastic or oversized lenses); and

c. one (1) pair of frames from a selection designated by the Plan.

Coverage for Pediatric Vision Care Services terminates at the end of the month in which the Member reaches age nineteen (19).

Benefits provided under this Subsection are not subject to the provisions of Subsection F. **COORDINATION OF BENEFITS** of **SECTION GP - GENERAL PROVISIONS** in this Agreement.

SECTION EX - EXCLUSIONS

Except as specifically provided in this Agreement, or as the Plan is mandated or required to pay based on state or federal law, no benefits will be provided for Services, supplies, Prescription Drugs or charges:

1. Which are not Medically necessary and Appropriate as determined by the Plan;

2. Which are not prescribed by or performed by or upon the direction of a Professional Provider;

3. Rendered by other than Providers and Suppliers identified herein;

4. Which are Experimental/Investigative in nature;

5. Rendered prior to the Member's Effective Date;

6. Incurred after the date of termination of the Member's coverage except as provided in **SECTION GP - GENERAL PROVISIONS**, **BENEFITS AFTER TERMINATION OF COVERAGE** Subsection;

7. For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared;

8. For which a Member would have no legal obligation to pay;

9. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

10. To the extent payment has been made under Medicare when Medicare is primary;

11. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the Member files a claim for said benefits or compensation;

12. To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Member has a legal obligation to pay;

13. For nicotine cessation support programs and classes for nicotine cessation purposes, except as otherwise set forth in the predefined schedule described in Subsection R. PREVENTIVE SERVICES of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

14. Which are submitted by a Certified Registered Nurse and another Professional Provider or Professional Other Provider for the same services performed on the same date for the same Member;

15. Rendered by a Provider who is a member of the Member's Immediate Family;

16. Performed by a Professional Provider or Professional Other Provider enrolled in an education or training program when such services are related to the education or training program;

17. For ambulance services, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS**;

18. For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: as otherwise required by law; or except a) as otherwise provided when necessitated by a covered sickness or injury; when required to correct a condition directly resulting from an accident; or b) to correct a congenital birth defect;

19. For telephone consultations which do not involve Telemedicine Services, charges for failure to keep a scheduled Visit, or charges for completion of a claim form;

20. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a Professional Provider or Professional Other Provider;

21. For Inpatient admissions which are primarily for diagnostic studies or for Physical Medicine;

22. For Custodial Care, domiciliary care, protective and supportive cares including educational services, rest cures and convalescent care;

23. For Respite Care, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS**;

24. Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental services, orthodontic treatment for congenital cleft palates, or Pediatric Dental Services as provided in **SECTION DB - DESCRIPTION OF BENEFITS**;

25. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

26. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone Surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;

27. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, except for hearing aids as provided in **SECTION DB - DESCRIPTION OF BENEFITS**;

28. For experimental fertility care services;

29. For reversal of sterilization undergone after the Member successfully procreated with the Member's partner at the time reversal is desired;

30. For contraceptive services including contraceptive Prescription Drugs, contraceptive devices, implants and injections and all related services, except when provided for purposes other than birth control, or as set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection;

31. For the following drugs or services, except for Preventive Covered Medications set forth in a predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS, PREVENTIVE SERVICES** Subsection and which are prescribed for preventive purposes:

    a. Prescription Drugs that are not FDA approved;

    b. Drugs and supplies that can be purchased without a Prescription Order;

    c. Charges for administration of Prescription Drugs and/or injectable insulin whether by a Physician or other person;

    d. Compounded medications;

    e. Over-the-Counter Drugs which are not set forth in a predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection and are not prescribed for preventive purposes;

    f. Topical acne retinoid products when prescribed for cosmetic purposes such as to minimize the appearance of facial wrinkles, facial mottles hyperpigmentation, hypopigmentation associated with photoaging, and facial skin roughness;

    g. Hair growth stimulants;

32. For services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and prenatal/delivery/postnatal services;

33. For weight control drugs and services intended to produce weight loss, except as otherwise set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection;

34. For weight reduction programs, including all diagnostic testing related to weight reduction programs, except as otherwise set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection;

35. For the treatment of obesity, except as provided in **SECTION SB-SCHEDULE OF BENEFITS** and **SECTION DB - DESCRIPTION OF BENEFITS**;

36. For prescription vitamins, except vitamins prescribed during pregnancy, and fluoride legend vitamins, or as otherwise set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection;

37. For any eye examinations or vision care services, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS**, or as mandated by law, and for any eye examinations or vision care services rendered by a Physician or Professional Provider who is not a Participating Vision Provider;

38. For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services;

39. For any food including, but not limited to, Enteral Foods, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an Outpatient basis, except as provided in the **ENTERAL FOODS** Subsection of **SECTION DB - DESCRIPTION OF BENEFITS** of this Agreement;

40. For preventive care services, wellness services or programs, except as otherwise set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection;

41. For allergy testing, except as provided in **SECTION DB - DESCRIPTION OF BENEFITS**, or as mandated by law;

42. For routine or periodic physical examinations, except as otherwise set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, except as mandated by law;

43. For immunizations required for foreign travel or employment, except as otherwise set forth in the predefined schedule described in **SECTION DB - DESCRIPTION OF BENEFITS**, **PREVENTIVE SERVICES** Subsection;

44. For Outpatient Habilitative and Rehabilitative Services for which there is no reasonable expectation of acquiring, restoring, improving or maintaining a level of function;

45. For treatment of sexual dysfunction not related to organic disease or injury;

46. For any care that is related to conditions such as autism spectrum disorders, learning disabilities, behavioral problems or intellectual disabilities which extends beyond traditional medical management or medically necessary inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change or for Respite Care;

47. For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services Program;

48. For any care, treatment or service for any loss sustained or contracted in consequence of the Member's being intoxicated, or under the influence of any narcotic unless administered on the advice of a Physician;

49. For any care, treatment or service for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member's being engaged in an illegal occupation;

50. For otherwise Covered Services ordered by a court or other tribunal unless Medically Necessary and Appropriate or if the reimbursement of such services is required by law;

51. For acupuncture services;

52. For procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed;

53. Care, unless required by law, by a school infirmary, a student health center or staff working at either type of facility;

54. Routine eye examinations (including, but not limited to, eye refraction, glaucoma testing and dilated fundus examinations) for Members age nineteen (19) and over;

55. For the following Services or charges related to pediatric dental services, except as specifically provided in this Agreement:

    a. For treatment started prior to the Member's Effective Date or after the termination date of coverage under this Agreement, (for example but not limited to: multi-visit procedures such as endodontics, crowns, fixed partial dentures (bridges), inlays, onlays, and dentures);

    b. For house or Hospital calls for dental services and for hospitalization costs (e.g. facility-use fees);

    c. For charges that are the responsibility of Worker's Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy;

    d. For Prescription and non-Prescription Drugs, vitamins or dietary supplements;

    e. Cosmetic in nature as determined by the Plan (for example, but not limited to: bleaching, veneer facings, personalization or characterization of crowns, fixed partial dentures (bridges), and/or dentures);

    f. Elective procedures (for example, but not limited to: the prophylactic extraction of third molars);

    g. For congenital mouth malformations or skeletal imbalances (including, but not limited to: treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn child or newly adopted children, regardless of age;

    h. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically indicated in **SECTION DB - DESCRIPTION OF BENEFITS**;

    i. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under this Agreement. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint;

    j. For treatment of fractures and dislocations of the jaw;

    k. For treatment of malignancies or neoplasms;

    l. Services and/or appliances that alter the vertical dimension (for example, but not limited to: full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method;

m. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances;

n. Periodontal splinting of teeth by any method;

o. For duplicate dentures, prosthetic devices or any other duplicative device;

p. Maxillofacial prosthetics;

q. For which in the absence of insurance the Member would incur no charge;

r. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions;

s. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority;

t. For any claims submitted to the Plan by the Member or on behalf of the Member in excess of twelve (12) months after the date of service;

u. Incomplete treatment (for example, but not limited to: patient does not return to complete treatment) and temporary services (for example, but not limited to: temporary restorations);

v. Procedures that are:

i) part of a service but are reported as separate Services;

ii) reported in a treatment sequence that is not appropriate; or

iii) misreported or which represent a procedure other than the one reported.

w. Specialized procedures and techniques (for example, but not limited to: precision attachments, copings and intentional root canal treatment);

x. Service not Dentally Necessary and Appropriate or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan will apply;

y. For implantology services to replace one (1) or more teeth missing prior to the Member's effective date of coverage;

z. For other pediatric dental services not set forth in **SECTION DB - DESCRIPTION OF BENEFITS**;

aa. Fees for broken appointments;

bb. For the following orthodontic services:

i) Treatments that are primarily for cosmetic reasons;

ii) Treatments for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment);

56. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint;

57. For any other medical or dental service or treatment except as provided in **SECTION DB - DESCRIPTION OF BENEFITS** or as mandated by law.

58. For Prescription Drugs and Over-the-Counter Drugs not appearing on the Formulary, except where an exception has been granted pursuant to the procedure set forth in SECTION HC - HEALTH CARE MANAGEMENT SERVICES, Subsection D. HEALTH CARE MANAGEMENT SERVICES, Paragraph 9. Prescription Drug Exceptions;

59. For a Diabetes Prevention Program offered by other than a Network Diabetes Prevention Provider.

SECTION GP - GENERAL PROVISIONS

A. APPEAL PROCEDURE

1. Internal Appeal Process

a. The Plan maintains an internal appeal process involving one (1) level of review.

b. At any time during the appeal process, a Member may choose to designate an authorized representative to participate in the appeal process on the Member's behalf. The Member or the Member's authorized representative shall notify the Plan, in writing, of the designation. For purposes of the appeal process, authorized representative includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member. Such procedures as adopted by the Plan shall, in the case of an Urgent Care Claim, permit a Professional Provider or Professional Other Provider with knowledge of the Member's medical condition to act as the Member's authorized representative.

   At any time during the appeal process, a Member may contact the Member Service Department at the toll-free telephone number listed on the Member's Identification Card to inquire about the filing or status of an appeal.

c. If a Member has received notification that a Claim has been denied by the Plan, in whole or in part, the Member may appeal the decision. For purposes of this Subsection, determinations made by the Plan to rescind a Member's coverage, not to continue coverage of an Eligible Dependent child past the limiting age based on a disability, or to deny the enrollment request of an individual that the Plan has determined is ineligible for coverage under this Agreement, can also be appealed in accordance with the procedures set forth in this Subsection. The Member's appeal must be submitted within one hundred eighty (180) days from the date of the Member's receipt of notification of the adverse decision.

d. The Member, upon request to the Plan, may review all documents, records and other information relevant to the appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of the appeal.

e. The appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Claim or matter which is the subject of the Member's appeal. In rendering a decision on the appeal, the Member Grievance and Appeals Department will take into account all evidence, comments, testimony, documents, records and other information submitted by the Member without regard to whether such information was previously

submitted to or considered by the Plan. The Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the Claim which is the subject of the appeal.

f. Each appeal will be promptly investigated and the Plan will provide written notification of its decision within the following time frames:

i) When the appeal involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the appeal;

ii) When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or

iii) When the appeal involves a Post-service Claim, or a decision by the Plan to rescind coverage or deny an enrollment request because the individual is not eligible for coverage, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

g. If the Plan fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, the Member shall be permitted to request an external review and/or pursue any applicable legal action.

h. In the event that the Plan renders an adverse decision on the internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding the right of the Member to request an external review and/or pursue any applicable legal action.

2. **External Review Process**

A Member shall have four (4) months from the receipt of notice of the Plan's decision to appeal the denial resulting from the Internal Appeal Process by requesting external review of the decision. To be eligible for external review, the decision of the Plan to be reviewed must involve:

i) a Claim that was denied involving medical judgment, including application of the Plan's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Service or a determination that the treatment is experimental or investigational; or

ii) a determination made by the Plan to rescind a Member's coverage or to deny the enrollment request of an individual due to ineligibility for coverage under this Agreement.

In the case of a denied Claim, the request for external review may be filed by either the Member or a health care Provider, with the written consent of the Member in the format required by or acceptable to the Plan. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

a. Preliminary Review and Notification

Within five (5) business days from receipt of the request for external review, the Plan will complete a preliminary review of the external review request to determine:

i) in the case of a denied Claim, whether the Member is or was covered under this Agreement at the time the Covered Service which is the subject of the denied Claim was or would have been received;

ii) whether the Member has exhausted the Plan's Internal Appeal Process, unless otherwise not required to exhaust that process; and

iii) whether the Member has provided all of the information and any applicable forms required by the Plan to process the external review request.

Within one (1) business day following completion of its preliminary review of the request, the Plan shall notify the Member, or health care Provider filing the external review request on behalf of the Member, of its determination.

In the event that the external review request is not complete, the notification will describe the information or materials needed to complete the request in which case the Member, or health care Provider filing the external review request on behalf of the Member, must correct and/or complete the external review request no later than the end of the four (4) month period in which the Member was required to initiate an external review of the Plan's decision or, alternatively, forty-eight (48) hours following receipt of the Plan's notice of its preliminary review, whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by the Plan will include the reasons why the request is ineligible for external review and contact information that the Member may use to receive additional information and assistance.

b. Final Review and Notification

Requests that are complete and eligible for external review will be assigned to an Independent Review Organization (IRO) to conduct the external review. The assigned IRO will notify the Member, or health care Provider filing the external review request on behalf of the Member, that the request has been accepted and is eligible for external review. The notice will further state that the IRO has been assigned to conduct the external review and that any additional information which the Member or health care Provider may have in support of the request must be submitted, in writing, within ten (10) business days following receipt of the notice. Any additional information timely submitted by the Member or health care Provider

and received by the assigned IRO will be forwarded to the Plan. Upon receipt of the information, the Plan shall be permitted an opportunity to reconsider its prior decision regarding the Claim that was denied or the matter which is the subject of the external review request.

The assigned IRO will review all of the information and documents that it timely received and make a decision on the external review request. The decision shall be made without regard or deference to the decision that was made in the Plan's Internal Appeal Process. The assigned IRO shall provide written notice of its final external review decision to the Plan and Member, or the health care Provider filing the external review request on behalf of the Member, within forty-five (45) days from receipt by the IRO of the external review request. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO, as well as other relevant information.

c. Expedited External Review
(Applies to Urgent Care Claims only)

If the initial decision of the Plan or the denial resulting from the Plan's Internal Appeal Process involves an Urgent Care Claim, a Member or health care Provider on behalf of the Member may request an expedited external review of the Plan's decision. Requests for expedited external review are subject to review by the Plan to determine whether they are timely, complete and eligible for external review. When the request involves a denied Urgent Care Claim, the Plan must complete the preliminary review and provide notice of its eligibility determination immediately upon receipt of the request for expedited external review. If the request is eligible for expedited external review, the Plan must then transmit all necessary documents and information that was considered in denying the Urgent Care Claim involved to an assigned IRO in an expeditious manner. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as the Member's medical condition or circumstances require, but in no event more than seventy-two (72) hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provided in writing, the IRO must provide within forty-eight (48) hours following initial notice of its final external review decision written confirmation of that decision to the Plan and the Member, or health care Provider filing the expedited external review request on behalf of the Member.

3. **Member Assistance Services**

Members may obtain assistance with the Plan's claim and internal appeal and external review procedures set forth in this Section by contacting the Delaware Department of Insurance or such other applicable office of health insurance consumer assistance or ombudsman. Please note that in the preparation of an appeal of an adverse determination involving treatment for substance abuse, legal assistance may be available to you from attorneys working for the Delaware Department of Justice.

B. **BENEFITS AFTER TERMINATION OF COVERAGE**

1. If a Member is an Inpatient in a Facility Provider on the day this Agreement is terminated by the Plan, for reasons other than non-payment of premium, and the Member incurs charges while the Member remains an inpatient, the Member shall be entitled to benefits under the terms of this Agreement.

   Benefits will be provided, for charges Incurred for the inpatient confinement, until the earlier of:

   a. ten (10) days after the Agreement terminates; or

   b. the end of the Benefit Period.

   Any such continuation of benefits after the date this Agreement is terminated is conditioned upon the continuous inpatient confinement of the Member and the providing of documentation as required by the Plan which evidences such continued inpatient confinement.

2. If a newborn child is not otherwise eligible for continuing benefits beyond the first thirty-one (31) days as a Dependent under this or any other current agreement, benefits may be continued for such child if, within said thirty-one (31) day period, the Member applies for and is issued an Agreement for said newborn either individually or as a Dependent, subject to Paragraph B.1. of this Subsection.

3. If this Agreement terminates as the result of non-payment of premiums, fraud or intentional misrepresentation of a material fact, the liability of the Plan shall cease as of the date of such termination, and no benefits will be provided for newborn care Incurred after that date, subject to Paragraph 1 of this Subsection.

C. **BENEFITS TO WHICH MEMBERS ARE ENTITLED**

1. The benefit liability of the Plan is limited to the benefits specified in this Agreement.

2. Except as provided in Subsection W. **TRANSPLANT SERVICES** of **SECTION DB - DESCRIPTION OF BENEFITS** no person other than a Member is entitled to receive benefits under this Agreement. Such right to benefits and coverage is not transferable.

3. Benefits for Covered Services specified in this Agreement will be provided only for Services and supplies rendered by a Provider as defined in **SECTION DE - DEFINITIONS** of this Agreement and regularly included in such Provider's charges.

D. **COMPLIANCE WITH THE LAW; AMENDMENT**

Anything contained herein to the contrary notwithstanding, the Plan shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Agreement, including any endorsements hereto, or to increase, reduce or eliminate any of the benefits provided for in this Agreement for any one (1) or

more eligible Members enrolled under this Agreement, and each party hereby agrees to any amendment of this Agreement which is necessary in order to accomplish such purpose.

E. CONTINUATION UPON DEATH OF SUBSCRIBER OR TERMINATION OF SUBSCRIBER'S COVERAGE

Unless coverage under this Agreement is provided pursuant to enrollment through the Exchange, coverage may continue under this Agreement for the covered Dependents upon termination of the Subscriber's coverage under this Agreement due to enrollment in a Medicare Supplemental or Medicare Advantage plan, or due to the death of the Subscriber, for any period for which premium has already been paid. The Subscriber's spouse, if covered under this Agreement, shall thereafter become the Subscriber upon notice to the Plan of the termination of the Subscriber's coverage or the Subscriber's death. If the Subscriber's spouse was not covered under this Agreement, a Dependent child may become a Subscriber but only under his or her own agreement.

F. COORDINATION OF BENEFITS

Except as otherwise stated, all benefits provided under this Agreement are subject to the following provisions of this Subsection and will not be increased by virtue of this Subsection.

1. Definitions

In addition to the Definitions of this Agreement, the following definitions apply to this Subsection:

a. Other Agreement - any individual, group or group-type coverage, whether insured or uninsured, providing health care benefits or Services, other than school/student accident-type coverage, or a group or group-type hospital indemnity Agreement of one hundred dollars ($100) per day or less, including:

   i) Blue Cross, Blue Shield, health maintenance organization and other prepayment coverage;

   ii) coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

   iii) coverage under any tax-supported or government program to the extent permitted by law.

   "Other Agreement" shall be applied separately with respect to each arrangement for benefits or Services and separately with respect to that portion of any arrangement which reserves the right to take the benefits or Services of Other Agreements into consideration in determining its benefits and that portion which does not.

b. Dependent - for any Other Agreement, any person who qualifies as a Dependent under that Agreement.

c. Allowable Expense - a health care expense, including any Deductibles and Coinsurance for a Service or supply specified in this Agreement, to the extent that such Service or supply is covered by this and/or the Other Agreement. When benefits are provided in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by this and/or the Other Agreement is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

i) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless this or the Other Agreement provides coverage for private hospital room expenses.

ii) If a Member is covered by this and one (1) or more Other Agreements that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

iii) If a Member is covered by this and one (1) or more Other Agreements that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

iv) If a Member is covered by this and an Other Agreement, one (1) of which calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and the other of which provides its benefits or services on the basis of negotiated fees, the payment arrangement of the Primary Agreement will be deemed the Allowable Expense. However, if a provider under the Secondary Agreement provides benefits or services for a specific negotiated fee or payment amount that is different than the payment arrangement under the Primary Agreement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Agreement to determine its benefits.

v) The amount of any benefit reduction under the Primary Agreement because a Member has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of provisions include, but are not limited to, second surgical opinions, precertification of admissions, and preferred provider arrangements.

d. Primary/Secondary Agreement - the order of benefit determination rules state whether this Agreement is a Primary Agreement or a Secondary Agreement.

i) When this Agreement is a Primary Agreement, its benefits are determined before those of the Other Agreement and without considering the Other Agreement's benefits.

ii) When this Agreement is a Secondary Agreement, its benefits are determined after those of the Other Agreement and may be reduced because of the benefits of the Other Agreement.

iii) When there are more than two (2) Other Agreements covering the person, this Agreement may be a Primary Agreement as to one (1) or more Other Agreements, and may be a Secondary Agreement as to a different agreement or agreements.

2. **Effect on Benefits**

a. This Subsection shall apply in determining the benefits payable under this Agreement if, for the Covered Services received, the sum of the benefits payable under this Agreement and the benefits payable under Other Agreements would exceed the total Allowable Expense.

b. Except as provided in Paragraph 2c. of this Subsection, when this Agreement is a Secondary Agreement, benefits will be calculated based on what the Plan would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under this Agreement that is unpaid under the Primary Agreement. The Plan may reduce its payment by the amount so that, when combined with the amount paid under the Primary Agreement, the total benefits paid or provided under all agreements for the claim do not exceed the total Allowable Expense for that claim. In addition, the Plan shall credit to the applicable Deductible any amounts it would have credited to that Deductible in the absence of other health care coverage. Benefits payable under Other Agreements include the benefits that would have been payable had claim been made.

c. If,

i) an Other Agreement contains a provision coordinating its benefits with those of this Agreement and its rules require the benefits of this Agreement to be determined first, and

ii) the rules set forth in Paragraph 2.d. of this Subsection require the benefits of this Agreement to be determined first,

then the benefits of the Other Agreement will be ignored in determining the benefits under this Agreement.

d. This Agreement determines its order of benefits using the first of the following rules which applies:

i) The benefits of an agreement which covers the person as other than a Dependent shall be determined first,

ii) When this Agreement and an Other Agreement cover the person as a Dependent of different parents:

(a) the benefits of the agreement which covers the person as a Dependent of the parent whose birthday (excluding year of birth) falls earliest in the year shall be determined first; but,

(b) if both parents have the same birthday, the benefits of the agreement which covered the parent longer are determined before those of the Agreement which covered the other parent for a shorter period of time.

However, if the Other Agreement does not have the rule described in item (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the agreements do not agree on the order of benefits, the rule in the Other Agreement will determine the order of benefits.

iii) If two (2) or more agreements cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the agreement covering the parent with custody of the child;

(b) then, the agreement of the spouse of the parent with custody of the child; and

(c) finally, the agreement of the parent not having custody of the child.

However, if there is a court decree which establishes a parent's financial responsibility for the child's health care expenses, the benefits of the agreement which covers the child as a Dependent of that parent shall be determined first. This paragraph does not apply with respect to any Benefit Period during which any benefits are actually paid or provided before the entity obligated to pay or to provide benefits under that parent's agreement has actual knowledge of the court decree.

iv) The benefits of the agreement covering the person as an employee other than a laid-off or retired employee or as a Dependent of such person shall be determined before the benefits of the agreement covering the person as a laid-off or retired employee or as a Dependent of such person. If the Other Agreement does not have this provision regarding laid-off or retired employees and, as a result, the agreements do not agree on the order of benefits, then this rule is disregarded.

v) If none of the above rules determines the order of benefits, the benefits of the agreement which has covered the person for the longest period of time shall be determined first.

e. If an Other Agreement does not contain provisions establishing the same order of benefit determination rules, the benefits under that agreement will be determined before the benefits under this Agreement.

3. **Facility of Payment**

Whenever payments should have been made under this Agreement in accordance with this Subsection, but the payments have been made under any Other Agreement, the Plan has the right to pay to any organization that has made such payment any amount it

determines to be warranted to satisfy the intent of this Subsection. Amounts so paid shall be deemed to be benefits paid under this Agreement and, to the extent of the payments for Covered Services, the Plan shall be fully discharged from liability under this Agreement.

4. **Right of Recovery**

   a. Whenever payments have been made by the Plan for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Subsection, irrespective of to whom paid, the Plan shall have the right to recover the excess from among the following, as the Plan shall determine: any person to or for whom such payments were made, any insurance company, or any other organization.

   b. The Member and the Plan will cooperate fully to make every reasonable effort under the circumstances, to help secure the Plan's rights to recover these excess payments.

5. **Benefits Payable**

   The Plan shall not be required to determine the existence of any Other Agreement or amount of benefits payable under any Other Agreement except this Agreement. The payment of benefits under this Agreement shall be affected by the benefits payable under any and all Other Agreements only to the extent that the Plan is furnished with information relative to such Other Agreements by the Member or any other insurance company or organization or person.

G. GOVERNING LAW

This Agreement is entered into and is subject to the laws of the State of Delaware. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

H. IDENTIFICATION CARDS

The Plan shall furnish to the Member an Identification Card to be presented to Providers when a service is requested.

I. INTER-PLAN ARRANGEMENTS

1. **Out-of-Area Services**

   The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access health care services outside the geographic area the Plan serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area the Plan serves, Members obtain care from health care providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. The Plan remains responsible for fulfilling our contractual obligations to you. The Plan payment practices in both instances are described below.

2. **BlueCard® Program**

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area the Plan serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to the Plan by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to the Plan by the Host Blue may be represented by one of the following:

i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases;

ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

iii) an average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e. prospective adjustment may mean that a current price reflects additional amounts or

credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by the Plan in determining your premiums.

3. **Special Cases: Value-Based Programs**

   The Plan has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under this Agreement additional information is available upon request.

4. **Return of Overpayments**

   Recoveries of overpayments/from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Plan, they will be credited to your account. In comes cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

5. **Non-Participating Providers Outside of the Plan Service Area**

   a. Member Liability Calculation

      When Covered Services are provided outside of the Plan service area by non-participating providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this Subsection. Payments for out-of-network emergency services are governed by applicable federal and state law.

   b. Exceptions

      In some exception cases, the Plan may pay claims from non-participating health care providers outside of the Plan service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to the participating provider, as determined by the Plan in the Plan's sole and absolute discretion or by applicable law. In other exception cases, the Plan may pay such claims based on the payment the Plan would make if the Plan were paying a non-participating provider inside the Plan service area. This may occur where the Host Blue's corresponding payment would be more than the Plan in-service area non-participating provider payment. The Plan may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating health care provider bills and payment the Plan will make for the Covered Services as set for in this Subsection.

6. **BlueCard Global Core® Program**

a. General Information

If Members are outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of the BlueCard Global Core Program when accessing Covered Services. The BlueCard Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Global Core Program assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

b. Inpatient Out-of-Area Covered Services

In most cases, if Members contact the Service Center for assistance, hospitals will not require Members to pay for Out-of-Area covered inpatient services, except for their cost-sharing amounts. In such cases, the Blue Cross Blue Shield Global Core contracting hospital will submit Member claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Out-of-Area Covered Services. **Members must contact the Plan to obtain precertification for non-emergency inpatient services.**

c. Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Out-of-Area Covered Services.

d. Submitting a BlueCard Global Care Claim

When Members pay for Out-of-Area Covered Services outside the Blue Card service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Care International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the service center at 1-(800)-810-BLUE (2583) or call collect at 1-(804)-673-1177, 24 hours a day, seven days a week.

J. MEMBER/PROVIDER RELATIONSHIP

1. The choice of a Provider and Supplier is solely that of the Member.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Plan is not liable for any act or omission of any Provider and Supplier. The Plan has no responsibility for a Provider's and Supplier's failure or refusal to render Covered Services to a Member.

3. The use or non-use of an adjective such as Ancillary, Network, Out-of-Network, Participating or Non-Participating in modifying any Provider is not a statement as to the ability of the Provider. Similarly, the use or non-use of an adjective such as Contracting or Non-Contracting in modifying any Supplier is not a statement as to the ability of the Supplier.

4. Network Professional Providers maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services. The relationship between the Plan and any Network Provider is an independent contract relationship. Network Providers are not agents or employees of the Plan, nor is any employee of the Plan an employee or agent of a Network Provider. The Plan shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Professional Provider, or from any Provider to whom the Member has been referred.

K. OVERPAYMENT OF PLAN BENEFITS

The Plan and the Member will cooperate fully to make every reasonable effort under the circumstances, considering the chances of successful recovery and costs thereof, to recover any payment made to a Member or Provider which is in excess of the amount entitled to be received under the Plan.

L. PARTICIPATING PLAN

The Plan may make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Members.

Wherever the phrase Blue Cross Blue Shield plan is used in this Agreement, it includes participating plan(s) outside the Plan Service Area unless the context clearly indicates to the contrary.

M. PAYMENT OF BENEFITS

1. The Plan is authorized by the Member to make payments directly to Providers and Suppliers furnishing Covered Services for which benefits are provided under this Agreement. However, the Plan reserves the right to make the payments directly to the Member.

When covered Telemedicine Services are provided by a Designated Telemedicine Provider located outside Delaware that does not have a direct or indirect contractual agreement with the local licensee of the Blue Cross Blue Shield Association, the Plan will make payments directly to the Designated Telemedicine Provider.

The right of a Member to receive payment is not assignable, except to the extent required by law, nor may benefits of this Agreement be transferred either before or after Covered Services are rendered.

2. Once Covered Services are rendered by a Provider and Supplier, the Plan will not honor the Member's requests not to pay the claims submitted by the Provider and Supplier. The Plan will have no liability to any person because of its rejection of the request.

N. PREMIUM/MODIFICATION

1. Each Agreement is maintained at a premium for which the Subscriber and the Subscriber's enrolled Dependents, if applicable, are eligible.

2. The amount of the premium for the Subscriber, and the Subscriber's Dependents, if applicable, at any time is the rate set forth in the schedule of rates on file with the Delaware Department of Insurance.

3. Coverage under this Agreement begins on the Effective Date and continues until the end of the calendar year. Thereafter, this coverage renews annually. The premium is payable in advance directly to the Plan on a monthly basis. Members may, for their convenience, submit amounts in excess of the specific monthly premium. However, such excess amounts will only be applied on a monthly basis by the Plan. Acceptance of the excess remittance by the Plan does not convert the term of this Agreement from a month-to-month term to some other term.

4. The Plan, subject to the approval of the Delaware Department of Insurance, may alter or revise the terms of this Agreement or the premiums. Any such alteration or revision of the terms of this Agreement shall become effective for all Members on the effective date of the alteration or revision whether or not the Subscriber has paid the premium in advance.

   Any change in the premiums shall become applicable for Members upon the expiration of the period covered by the Subscriber's current payment at the time of such change. In the event of such alteration or revision of the premium, the Subscriber shall be notified in advance of the new premium and the Effective Date, and payment of the new premium shall be considered receipt of notice and acceptance of the change in premium.

   Any notice shall be considered to have been given when mailed to the Subscriber at the address on the records of the Plan.

O. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Subscriber is hereby notified:

This Agreement is between the Subscriber and the Plan only. Highmark Blue Cross Blue Shield Delaware is an independent Corporation operating under a license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield plans throughout the United States. Although all of these independent Blue Cross and Blue Shield plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows the Plan to use the familiar Blue names and symbols. The Plan, upon entering into this Agreement, is not contracting as an agent of the national Association. Only the Plan shall be liable to the Subscriber for any of the Plan's obligations under this Agreement. This paragraph does not add any obligations to this Agreement.

P. RELEASE AND PROTECTION OF MEMBER INFORMATION

All personally identifiable information about individual Members ("Protected Health Information") is subject to various statutory privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, the Plan may use and disclose Protected Health Information to facilitate payment, treatment and health care operations as described in the Plan's Notice of Privacy Practices (NPP). Copies of Highmark's current NPP are available on Highmark's internet site, or from Highmark's Privacy Office.

At its sole discretion, the Plan may make available, either directly or through a designated vendor, Member identity theft protection services. Any decision to accept or not accept such services will not affect the continued eligibility, benefits, premiums or cost-sharing of the Member under this Contract. The Plan shall not be liable for, and the Member shall hold the Plan harmless from, any matters arising from or relating to such services.

Q. REPORTS AND RECORDS

Each Member, in connection with the administration of, or delivery or receipt of benefits under this Agreement a) authorizes any insurer, employer, organization and health care service Provider to release to the Plan all personal health information relating to past, present and future health care examinations, treatments and diagnoses and b) authorizes the Plan to release the personal health information described above, including medical records, claims, benefits and other administrative data to insurers, health care service providers, and outside vendors. The information will only be released in connection with the following purposes: treatment decisions, appeals, complaints and grievances, coordination of care, quality assessment and measurement, quality improvement, preventive measures, audits, utilization management, case management, pharmacy management, physician review, research, fraud investigations, reviews by regulatory and accrediting bodies, claims processing, billing and reimbursement.

Each Member further agrees that approval by the Plan of benefits for any services rendered under this Agreement is contingent upon the furnishing of such information or records or copies of records.

The Member is responsible for maintaining all claims information and correspondence. If the Member requests claims information from the Plan with an incurred date of more than twelve (12) months prior to the request, it will be the Member's responsibility to pay for the cost of retrieval of such information.

R. REQUIRED PROVISIONS

1. Entire Agreement; Changes

This Agreement, the Subscriber's application and any Endorsements and/or Schedules, the Member's enrollment confirmation letter, the Subscriber's current Identification Card and the Highmark Preventive Schedule, as amended from time to time, constitute the entire Agreement between the Member and the Plan. No change in this benefit agreement shall be valid until approved by an executive officer of the Plan and unless such approval be endorsed hereon or attached hereto. No agent or representative of the Plan, other than a Plan officer, may otherwise change this Agreement or waive any of its provisions. All statements made by a Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Agreement, unless it is contained in a written instrument signed by and furnished to the Subscriber.

2. Time Limit On Certain Defenses

After two (2) years from the date of issue of this Agreement, no misstatements, except intentional misrepresentations of material fact or fraudulent misstatements, made by the Subscriber in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability commencing after the expiration of such two (2)-year period. No claim for loss Incurred after two (2) years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this Agreement.

Intentional misrepresentations of material fact or fraudulent misstatements will, at the option of the Plan, render this Agreement void from inception, provided such material misrepresentations or misstatements are discovered by the Plan within two (2) years of the Effective Date. In the event the Plan elects to void this Agreement, the Subscriber will be given at least thirty (30) days advance written notice and will forfeit any charges paid to the extent of any liability incurred by the Plan.

3. Grace Period

A grace period of thirty-one (31) days from the due date will be granted for the payment of each premium. During the grace period, the Agreement will stay in force; however, no benefits will be paid for services Incurred subsequent to the Agreement's then current paid date, subject to Subsection B. **BENEFITS AFTER TERMINATION OF**

COVERAGE of this Section. If appropriate payment is not received at the end of thirty-one (31) days, this Agreement automatically terminates as of the then current paid date without written notification to the Member.

When coverage under this Agreement is provided pursuant to enrollment through the Exchange and the Subscriber:

a. is receiving Advance Payment of Premium Tax Credits (APTCs); and

b. has made payment of at least one full monthly premium;

a grace period of three (3) consecutive months shall be provided under this Agreement for the payment of premium. Benefits will only be provided by the Plan under this Agreement for Covered Services received during the first month of the three (3) month grace period if payment of the appropriate premium amount by the Member is not received prior to the end of the grace period. Failure of the Plan to receive Advance Payment of Premium Tax Credits shall not be grounds for termination of this Agreement.

4. **Reinstatement**

If this Agreement is terminated due solely to nonpayment of the premium, coverage will be reinstated if the Subscriber, within thirty-six (36) days from the end of the Grace Period, tenders and the Plan receives payment of the premium required for reinstatement. The Member(s) and the Plan have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted premium. The right of the Subscriber to have this Agreement reinstated is limited to one (1) reinstatement during any twelve (12)-month period and to two (2) reinstatements during the Subscriber's lifetime. When coverage under this Agreement is provided pursuant to enrollment through the Exchange, the right to reinstate coverage shall not apply.

5. **Notice of Claim and Proof of Loss**
(Applies to Post-service Claims Only)

Network Providers have an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network Provider, it is the responsibility of the Network Provider to submit its claim to the Plan in accordance with the terms of its participation agreement, but not later than six (6) months after the date of service. Should the Network Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan's requirements as they relate to the filing of claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member.

When Covered Services are received from other than a Network Provider, the Member is responsible for submitting the claim to the Plan. In such instances, the Member must submit the claim in accordance with the following procedures:

a. Notice of Claim

The Plan will not be liable for any claims under this Agreement unless proper notice is furnished to the Plan that Covered Services in this Agreement have been rendered to a Member. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Service Department. The address of the Member Service Department can be found on the Member's Identification Card. A charge shall be considered Incurred on the date a Member receives the Service or supply for which the charge is made.

b. Claim Forms

Proof of loss for benefits under this Agreement must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Paragraph as to filing a proof of loss upon submitting, within the time fixed in this Paragraph for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

c. Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than one (1) year from the time proof is otherwise required.

d. Submission of Claim Forms

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Agreement.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

- Person or organization providing the Service or supply
- Type of Service or supply
- Date of Service or supply
- Amount charged
- Name of patient

Professional Provider bills must show specific treatment dates. Drug and medicine bills must show prescription number, date of purchase, and the patient's name. The Member's attending Professional Provider must certify that he/she prescribed all Services by signing his/her name on all bills, except doctor bills, Hospital bills, or Prescription Drug bills. (Some bills requiring a signature of the Professional Provider include ambulance, prosthetic devices, rental of Durable Medical Equipment, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Notice of the Plan's claim determination will be issued within a reasonable period of time following the receipt of a proper proof of loss.

In the event that the Plan renders an adverse decision on the claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file an appeal.

e. Time of Payment of Claims

Claim payments for benefits payable under this Agreement will be processed immediately upon receipt of a proper proof of loss.

f. Authorized Representative

Nothing in this Paragraph shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

6. **Physical Examinations**

   The Plan, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

7. **Legal Actions**

   No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

8. **Misstatement of Age**

   If the age of the Member has been misstated, all amounts payable under the Agreement shall be such as the premium paid would have purchased at the correct age.

S. SUBROGATION

1. To the extent that benefits for Covered Services are provided or paid under this Agreement, the Plan shall be subrogated and succeed to any rights of recovery of a Member as permitted by law for expenses Incurred against any person, firm or organization except insurers on policies or health insurance issued to and in the name of the Member.

2. The Member shall execute and deliver such instruments and take such other reasonable action as the Plan may require to secure such rights, as permitted by law. The Member shall do nothing to prejudice the rights given the Plan by this paragraph without its consent.

3. These provisions shall not apply where subrogation is specifically prohibited by law.

T. TERMINATION OF COVERAGE UNDER THE AGREEMENT

1. This Agreement may be terminated by the Subscriber by giving appropriate written notice to the Plan. In such case, the termination effective date shall be the first of the month following the date of the request for termination. Notice shall be given no less than fourteen (14) days prior to the requested termination date.

2. This Agreement is guaranteed renewable and cannot be terminated without consent of the Subscriber except in the following instances:

   a. If payment of the appropriate premium is not made when due, or during the grace period, coverage will terminate on the last day of the grace period.

      When coverage under this Agreement is provided pursuant to enrollment through the Exchange and the Subscriber receives Advance Payments of Premium Tax Credits

(APTCs), failure of the Plan to receive payment of APTCs would not be grounds for terminating this Agreement when the Subscriber has made payment of his or her portion of the premium when due.

b. If a Subscriber in obtaining coverage, or in connection with coverage hereunder, has performed an act or practice constituting fraud or intentional misrepresentation of a material fact (e.g., misuse of the Member Identification Card), coverage will terminate immediately. However, the Plan will not terminate this Agreement because of a Subscriber's Medically Necessary and Appropriate utilization of services covered under this Agreement.

c. Coverage will terminate upon ninety (90) days notice to the Subscriber when the Plan discontinues this coverage, and offers to each individual the option to purchase any other individual health insurance coverage currently being offered by the Plan to individuals within the Plan Service Area, or upon one hundred eighty (180) days notice to the Subscriber when the Plan discontinues all individual coverage within the Plan Service Area.

d. In the event the Subscriber no longer lives in the Plan Service Area, coverage will terminate on the last day of the month for which the premium has been accepted.

3. If the coverage provided under this Agreement is a qualified health plan offered through the Exchange, coverage will terminate in the following additional circumstances:

   a. The Subscriber is no longer eligible for coverage in a qualified health plan through the Exchange in which case coverage will terminate effective:

      i) the last day of the month following the month in which notice of ineligibility is sent by the Exchange, unless an earlier termination date is requested by the Subscriber; or

      ii) in the case where the Subscriber is determined to be newly eligible for Medicaid, CHIP or basic health plan coverage, the last day of coverage under this Agreement shall be the day before such new coverage begins.

   b. The qualified health plan through which coverage under this Agreement is provided terminates or is decertified.

   c. The Subscriber elects to enroll in a different qualified health plan during an applicable open enrollment or Special Enrollment Period in which case coverage under this Agreement will terminate the day before coverage under the new qualified health plan begins.

4. If this Agreement is terminated at the option of either party, the Plan shall refund to the Subscriber the amount of any unearned prepaid premium held by the Plan. Unearned prepaid premium in any amount less than one ($1.00) dollar shall not be refunded unless specifically requested by the Subscriber.