A GUIDE TO YOUR BENEFITS

Highmark Delaware

KENT COUNTY LEVY COURT
GROUP SPECIAL MEDICFILL®

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WELCOME

This booklet summarizes benefits of the Group Special Medicfill Health Care Plan that helps fill many of the gaps in Medicare coverage. For your convenience, technical terms have been defined in the *Definitions* section at the back of the booklet.

This booklet is not a contract. It is designed to provide a summary of benefits for easy reference. The benefits and the terms and conditions of your Medicfill Health Care Plan are contained in a group contract between your employer and Highmark Blue Cross Blue Shield Delaware. A copy of the group contract is held by your employer.

This booklet describes the Medicfill Health Care Plan in effect as of July 1, 2016 and replaces all previous booklets.

KEEP THIS BOOKLET HANDY FOR REFERENCE WHEN YOU NEED IT.

WHEN YOU HAVE QUESTIONS OR COMMENTS

Highmark Delaware welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Member Service anytime you have a concern about Highmark Delaware's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

Here are reasons you may need to call us:

- asking about your plan
- reporting a lost or stolen ID card
- ordering a new ID card
- letting us know when you have a new address
- asking about a claim
- getting language assistance

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

To Reach Us By Phone

All Calls: 800.633.2563

To talk to a Member Service Representative, call 8:00 AM to 8:00 PM Eastern Standard Time (EST), Monday through Friday.

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

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

To Reach Us By Letter

Write to:

Member Services
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

To Reach Us In Person

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

To Reach Us On The Internet

Internet Address: **highmarkbcbsde.com**

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SPECIAL MEDICFILL HEALTH CARE PLAN
BENEFIT HIGHLIGHTS

The following highlights your Special Medicfill benefits and how these benefits supplement your Medicare Coverage.

THESE BENEFIT HIGHLIGHTS ONLY BRIEFLY DESCRIBE THE BENEFITS AVAILABLE TO YOU FROM MEDICARE. FOR A COMPLETE DESCRIPTION OF YOUR MEDICAL BENEFITS UNDER MEDICARE AND ANY LIMITATIONS ON THOSE BENEFITS, CONSULT MEDICARE PUBLICATIONS OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS).

This booklet describes the benefits, terms and conditions of your Special Medicfill Health Care Plan. This Health Care Plan is designed to supplement Medicare. Unless otherwise indicated, we will pay the benefits described in this booklet only after Medicare pays its full amount.

INPATIENT HOSPITAL & OTHER FACILITY BENEFITS

Benefit:		Medicare Covers:	Special Medicfill Covers:	You Pay:
Inpatient Days in Acute Hospitals; Semi-Private Room and Ancillary Services (for covered expenses each benefit period)	Days 1-60	Medicare pays all but the Medicare Part A deductible.	This plan covers the Medicare Part A deductible.	You pay nothing.
	Days 61-90	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan covers a specified dollar amount of coinsurance.	You pay nothing.
	Days 91-120	Medicare pays nothing. (There are 60 Lifetime Reserve Days* with all but the daily coinsurance amount covered. These days may be used at the patient's discretion.)	This plan covers inpatient care for days 91 through 120 in a general hospital except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	You pay nothing.
	Days 121-365	Medicare pays nothing.	This plan covers inpatient care for days 121 through 365, except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	You pay nothing.

*Medicare's 60 Lifetime Reserve Days may be used only once; they are not renewable.

INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)

Benefit:		Medicare Covers:	Special Medicfill Covers:	You Pay:
Treatment for Mental or Nervous Disorders (in a Psychiatric Hospital)		Benefits are limited to 190 days for your lifetime. Medicare covers all but the Medicare Part A deductible and the specified coinsurance for days 61-120	This plan covers the Medicare Part A deductible and the specified dollar amount of coinsurance for up to the 190 lifetime days approved by Medicare.	You pay nothing while Medicare is paying. You pay all charges thereafter.
Inpatient Dental Surgery		Medicare covers hospital services for surgery related to the jaw or reduction of any fracture of the jaw or facial bone.	This plan covers the Medicare Part A deductible and specified dollar amount of coinsurance when Medicare standards are met.	You pay nothing.
Services in a Medicare Approved Skilled Nursing Facility	Days 1-20	Medicare pays 100% of eligible expenses.	This plan pays nothing.	You pay nothing.
	Days 21-100	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan pays a specified dollar amount of coinsurance per day.	You pay nothing

INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare standards are met, and Medicare pays, this plan covers the Part A deductible and coinsurance for the first 90 days and then 100% of the allowable charge for days 91-120.	You pay nothing.
		If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States, we will pay for services as defined by Medicare Law for 120 days of inpatient care.	You pay nothing for the first 120 days if the hospital confinement is approved for payment by Highmark Delaware. You pay all charges thereafter.

OUTPATIENT HOSPITAL BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
■ Anesthesia ■ Clinical Services ■ Emergency Accident ■ Dialysis ■ Injections (except most routine immunizations) ■ Laboratory ■ Machine Testing ■ Medical Emergency ■ Minor Surgery ■ Physical Therapy ■ Radiation Therapy ■ Imagining Services	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges**.	You pay nothing.
Home Health Visits	Covered at 100% of the Reasonable Charge**, subject to Medicare criteria.	There is no coverage under this plan for Home Health Visits.	You pay charges, if any, for services not covered by Medicare.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers hospital benefits equivalent to Medicare hospital benefits in the U.S., including the payment of the deductible and coinsurance amounts.	You pay nothing.
		When Medicare does not pay, payment will be made for those covered services as defined by Medicare. Payment must be approved by Highmark Delaware	You pay nothing if the care is approved for payment by Highmark Delaware.

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

SURGICAL-MEDICAL BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
■ Ambulance ■ Anesthesia ■ Appliances ■ Chiropractic Services (subject to Medicare criteria) ■ Clinic Visits ■ Durable Medical Equipment ■ Home & Office Visits ■ Imaging Services ■ Inpatient Consultants ■ Inpatient Medical Visits ■ Inpatient Professional Services ■ Inpatient Skilled Nursing Facility Visits ■ Laboratory ■ Machine Testing ■ Medical Emergency Care ■ Physical Therapy ■ Radiation Therapy ■ Surgery	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**	You pay nothing.

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

SURGICAL-MEDICAL BENEFITS (CON'T)

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Outpatient Treatment for Mental and Nervous Disorders	Medicare covers 50% of the Reasonable Charges** accepted by Medicare after the Medicare Part B deductible. If services are rendered in a partial hospitalization program or in the outpatient department of a hospital, Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 50% or 20% of the Reasonable Charges**, whichever is applicable.	You pay nothing.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	You pay nothing.
		When Medicare does not pay, benefits are covered as stipulated in the Blue Shield Limited Indemnity Schedule.	You pay all charges over those approved in the Blue Shield Limited Indemnity Schedule.

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

CANCER SCREENING BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Annual Routine Mammogram	Medicare pays 80% of Medicare Eligible expenses, with no Part B deductible requirement, for annual mammograms for females age 40 and over.	This plan covers 20% of Medicare Eligible expenses.	You pay nothing.
Pap Smear	Medicare pays 80% of Medicare Eligible expenses, with no Part B deductible requirement, for Pap smears once every three calendar years for women at average risk, and once a calendar year for women at high risk.	When Pap smears for cancer screening are covered by Medicare, this plan covers 20% of Medicare Eligible expenses. When not covered by Medicare, this plan will pay 100% of our allowable charges for one Pap smear every 12 months.	You pay nothing.
Colorectal Cancer Screening	Medicare pays 80% of Medicare Eligible expenses after the Part B deductible for: ■ fecal-occult blood test every 12 months; ■ flexible sigmoidoscopy every 3 years for covered persons age 50 and over who are at average risk; and ■ colonoscopy every 2 years for those covered persons who are at high risk.	When services are covered by Medicare, this plan covers 20% of Medicare Eligible expenses.	You pay nothing.

OTHER COVERED BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Outpatient Prescription Drugs	Medicare covers 80% of the reasonable charges for immunosuppressive drugs during the first year following a covered transplant (after the Medicare Part B deductible).	During a calendar year, drugs prescribed by the attending doctor are covered at 80% of Highmark Delaware's allowable charges after you pay a $100 deductible for prescription drugs. This program also pays the 20% coinsurance for immunosuppressive drugs during the first year following a covered transplant.	You pay the copayment per prescription or refill as follows: <u>Retail:</u> Generic: $10.00 Preferred Brand: $20.00 Non-Preferred Brand: $50.00 <u>Mail Order:</u> Generic: $20.00 Preferred Brand: $50.00 Non-Preferred Brand: $100.00 NOTE: If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. See the section, *Prescription Drug Benefits*, to learn how to calculate your payment.
	Medicare covers 80% of the reasonable charges for immunosuppressive drugs during the first year following a covered transplant (after the Medicare Part B deductible).	This program also pays the 20% coinsurance for immunosuppressive drugs during the first year following a covered transplant.	You pay nothing for immunosuppressive drugs during the first year following a covered transplant.

OTHER COVERED BENEFITS (CON'T)

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Private Duty Nursing	No coverage under Medicare.	This plan covers the services of a Registered Professional Nurse (RN) for care provided in an acute care facility at 80% of Highmark Delaware's allowable charge, up to a maximum of 240 hours during any 12-month period. If an RN is not available, at our discretion, benefits may be provided for the services of a Licensed Practice Nurse (LPN).	You pay 20% of the allowable charges. You also pay any charges incurred after the 240-hour maximum has been met.

HUMAN ORGAN TRANSPLANT BENEFIT

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Human organ transplants	Benefits are provided on the same basis and at the same level as Inpatient Hospital Benefits, Outpatient Hospital Benefits, and Physician Services, subject to the Medicare Part A and Part B deductibles and coinsurance.	When Medicare pays for an Organ Transplant, this plan provides benefits on the same basis and at the same level as other Special Medicfill benefits.	You pay any charges not covered by Medicare or Special Medicfill.

HOSPITAL AND OTHER FACILITY BENEFITS

INPATIENT HOSPITAL SERVICES

Benefits are provided for covered expenses for inpatient hospital care for each benefit period as follows:

- For days 1 through 60, we will pay the Medicare Part A deductible.
- For days 61 through 90, we will pay the specified daily coinsurance.
- For days 91 through 120, we will pay for hospital services for all admissions except for treatment of mental and nervous disorders. You may use these days before you use your 60 Medicare lifetime reserve days. If you use your Medicare lifetime reserve days, we will pay the coinsurance amount.
- For days 121 through 365, we will pay for hospital services except for treatment of mental and nervous disorders.

Covered services include:

- Semi-private room and board and ancillary services. If a private room is medically necessary, benefits are provided at the private room rate.
- Medicare limits coverage to 190 days for admissions for treatment of mental and nervous disorders. We will pay the Part A deductible and specified daily coinsurance for days approved by Medicare.
- When you are admitted to the hospital for dental surgical services approved by Medicare, we will pay the Medicare Part A deductible and the daily coinsurance amount. Dental services are limited to surgery related to the jaw or reduction of any fracture of the jaw or facial bone.

SKILLED NURSING FACILITY

When you are admitted to a Skilled Nursing Facility for a stay approved by Medicare, we will pay the applicable daily coinsurance for days 21 through 100.

SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES

The Medicare program places certain restrictions on payments for admissions outside the United States. If Medicare approves payment for the admission, we will pay the Part A deductible and the daily coinsurance for the first 90 days. We will then pay 100% of the allowable charges for days 91-120.

If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States and we approve the admission, we will pay for covered services as defined by Medicare law at 100% of the allowable charge for 120 days of inpatient care.

OUTPATIENT HOSPITAL SERVICES

We pay the Medicare Part B deductible and then we pay 20% of the reasonable charge for covered services for care in the outpatient department of the hospital. If care is rendered in a freestanding facility and Medicare pays, then we will pay the deductible, if any, and the coinsurance amount.

Covered services include:

- Emergency Treatment that is treatment for accidental injury or for sudden and serious medical conditions. These services must be rendered within 72 hours after the accident or onset of the emergency condition.
- Minor Surgery.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Diagnostic imaging services, laboratory and machine testing.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Hemodialysis.
- Clinical Services.
- Injections (not including routine immunizations except for influenza, pneumococcal and hepatitis B vaccines which are fully covered by Medicare).
- Coverage Outside the United States-In those cases where Medicare will pay, we will pay the deductible and coinsurance amounts. In those cases where Medicare does not pay, we will pay for those covered services as defined by Medicare at 100% of the allowable charge.

SURGICAL-MEDICAL BENEFITS

We pay the Medicare Part B deductible, and then we pay 20% of the Medicare reasonable charge for covered professional services provided or ordered by a physician.

COVERED SERVICES

Covered services are as defined by Medicare and include:

- Appliances and Durable Medical Equipment.
- Ambulance Services.
- Home and Office Visits (excluding routine physical examinations).
- Inpatient Hospital Medical Visits.
- Surgery.
- Imaging Services.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Inpatient Consultations.
- Inpatient Skilled Nursing Facility medical visits.
- Medical Emergency Care in the outpatient department of a hospital or other facility approved by us.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Laboratory and machine testing.
- Injections (not including routine immunizations).
- Clinic Visits.
- Chiropractic Services limited to manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray.

OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS DISORDERS

We will pay the Medicare Part B deductible and then 50% of the reasonable charge for outpatient treatment of mental and nervous disorders. If you receive outpatient care in a partial hospitalization program or in the outpatient department of a hospital, we will pay 20% of the reasonable charge.

SERVICES OUTSIDE THE UNITED STATES

- For services outside of the United States, in those cases where Medicare will pay, we will pay the Part B deductible and coinsurance amounts.
- In those cases where Medicare will not pay, benefits for services outside the United States are provided at 20% of Medicare's Resource-Based Relative Value Scale (RBRVS).

CANCER SCREENING BENEFITS

ANNUAL ROUTINE MAMMOGRAM

We will pay 20% of Medicare Eligible expenses, with no Part B deductible requirement, for an annual routine mammogram for females age 40 and over.

ROUTINE PELVIC EXAM AND PAP SMEAR

When a routine Pap smear for cancer screening is covered by Medicare, we will pay 20% of Medicare Eligible expenses. When a routine Pap smear for cancer screening is not covered by Medicare, we will pay 100% of our allowable charge for one Pap smear every 12 months.

COLORECTAL CANCER SCREENING

When colorectal cancer screening tests are covered by Medicare, we will pay 20% of the Medicare Eligible expense.

OTHER COVERED BENEFITS

The following benefits are provided in addition to those in the Hospital and Surgical-Medical Benefits section of this booklet. Covered services include:

OUTPATIENT PRESCRIPTION DRUGS

After you pay a $100 calendar year deductible for prescription drugs (including injectable insulin, needles and syringes), we will pay 80% of the allowable charge for prescription drugs for the remainder of the calendar year. No hospitalization is required.

You may carry over into a new calendar year any allowable charges which were incurred and applied towards the deductible in October, November and December of the preceding year. The deductible carryover will be permitted only for the period in which coverage is continuous. If your coverage terminates and you later re-enroll, we will begin counting expenses as of the effective date of the latest coverage.

Certain prescription drugs may

- require Highmark Delaware's approval prior to dispensing, and
- be subject to our dispensing limits.

PRIVATE DUTY NURSING - INPATIENT

When you are an inpatient in an acute hospital (‘hospital’ is defined in the Definitions section of this booklet), benefits are provided for the medically necessary services of a Registered Professional Nurse (R.N.) at 80% of Highmark Delaware’s allowable charge, up to a maximum of 240 hours during a 12-month period.

This benefit is provided only when all of the following conditions are met:

- The nursing service is available;
- The service is prescribed by the attending doctor;
- The service is connected with the condition for which hospital care and treatment are being rendered;
- The service is medically necessary; and
- The service is approved by the hospital.

Private duty nursing is not covered when it is provided as a convenience for you, whether or not prescribed by your doctor, or when it is provided at your request or your family's request.

If an R.N. is not available, then at our discretion, benefits may be provided for a Licensed Practical Nurse (L.P.N.) at 80% of Highmark Delaware's allowable charge.

HUMAN ORGAN TRANSPLANT BENEFIT

The benefits listed in this section are only available for services related to certain medically necessary human organ transplants. If Medicare covers these services, services related to kidney, cornea and bone marrow transplants are covered on the same basis and at the same level as other surgical benefits under this benefit plan and are not subject to the benefits and limitations of this section.

Benefits for human organ transplants are available only when Medicare pays for an organ transplant.

Benefits Available

Subject to all the terms and conditions of this benefit plan, when a heart, heart-lung, liver or pancreas transplant is medically necessary, the following benefits are available for that transplant:

- If Medicare covers these services, covered Hospital and Surgical-Medical services as specified under this benefit plan. Benefits are payable on the same basis and at the same level as other similar benefits under this benefit plan.
- If Medicare covers these services, surgical, storage and transportation costs incurred and directly related to the donation of a human organ used in a covered transplant procedure.
- If Medicare covers these services, transportation to and from the site of the covered transplant procedure is covered for the transplant recipient and one other person. If the recipient is a minor, transportation costs for two other persons accompanying the recipient are covered.
- If Medicare covers these services, reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of $150, by those individuals accompanying the recipient.

Benefit Limitations

- The benefits for transportation, lodging and meal expenses are subject to an aggregate maximum of $10,000 per covered transplant procedure. All covered transportation costs, lodging and meal expenses incurred are paid at the same level as outpatient doctor's visits.
- The organ transplant benefits specified in this section are available only during the applicable benefit period. For purposes of this Human Organ Transplant Benefit, the Benefit Period shall mean 5 days immediately prior to and one year immediately following a covered Organ Transplant Procedure.
- Benefits under this section are payable only for those services that Medicare will pay, with the exception of those non-Medicare covered services specified in the *Other Covered Benefits* section of this booklet.

EXCLUSIONS

The following services and other items are excluded from your coverage under this Medicfill plan:

- Services and supplies covered by Medicare Part A and Part B benefits, except those items and services expressly provided in this plan.
- Unless otherwise specified in this health care plan, charges for covered services that are over the Medicare reasonable charge for that service.
- Any service or benefit provided or available, to any extent, to you under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job related injuries or conditions.
- Unless federal law requires otherwise, any services or supplies furnished by the Veterans' Administration or by any institution owned or operated by the United States, any corporation, agency or bureau thereof, or any state, county or municipal government; services or supplies available, in whole or in part under the laws of the United States (including Medicare) or under the laws of any state or political subdivision thereof or furnished or available pursuant to any law hereinafter enacted.
- Any service necessitated by an act of war declared or undeclared which occurs after the effective date of this plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
- Services rendered by any member of your immediate family or any person living with you. For purpose of this paragraph only, family includes parents, spouses, siblings, and natural or adopted children of whatever age.
- Services for which no charge would normally be made in the absence of insurance.
- Rest cures, custodial care or homelike care, whether or not recommended by your doctor.
- Dental X-rays and appliances and the services of a dentist, except Medicare covered surgery involving the bone of the jaw or facial bone.
- Eyeglasses, contact lenses, the examination, prescription or fitting of same, and all procedures for refractive correction.
- Hearing aids and the examination, prescription or fitting of same,
- All procedures for refractive correction.
- Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
- Routine foot care.
- Blood or blood donor services, including blood components.
- Supplies or services for cosmetic purposes, including routine treatment of acne and treatment for hair loss restoration.

- Unless specified otherwise, services for routine physical examinations or other examinations or treatments including, but not limited to, those procured by you to satisfy requirements of any third party including those required or ordered by a potential employer, licensing authority, insurer, educational institution, court, or legal representative, unless specified otherwise. School, camp, and pre-marital physicals are also excluded.

- Services not directly related to or medically necessary for the diagnosis or treatment of an illness or injury. Medical necessity is defined by us as: medically necessary services or supplies provided by a hospital, doctor or other provider to identify or treat an illness or injury and which, as determined by us are:

  - Consistent with the symptom or diagnosis and treatment of a condition, disease or injury;
  - Appropriate with regard to standards of accepted professional practice;
  - Not solely for your convenience, your doctor's convenience or any other provider's convenience; and,
  - The most appropriate supply or level of service which can safely be provided to you. When applied to an inpatient it further means that your medical symptoms or condition require that the service or supplies cannot be safely provided to you as an outpatient.

  We may base payment upon Medicare's determination of medical necessity.

- Computerized gait analysis or electrodynographic testing.

- Services and supplies for or related to visual therapy or orthoptics.

- Services by a medical department maintained by your employer.

- Services and supplies which are experimental or investigational in nature meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any of such items requiring federal or other government agency approval not granted at the time services were rendered.

- Any service or supply specified as an exclusion under the Medicare program or denied by Medicare except any service or supply expressly covered as a benefit by this plan.

- Services, supplies, or drugs obtained in violation of applicable law.

HOW TO CLAIM BENEFITS

Claims must be filed within 2 years from the time you receive care. Claims filed beyond 2 years will not be paid.

HOW TO CLAIM HOSPITAL AND SURGICAL-MEDICAL BENEFITS

Since this program supplements Medicare benefits, claims for benefits must first be submitted for coverage through Medicare.

A *Request for Medicare Payment Form*, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All Social Security offices, and most doctors' offices, have copies of this form. Instructions on how to fill it out are on the back of the form.

When Medicare has paid for the services of doctors and suppliers which are covered by your medical insurance, you will receive an *Explanation of Benefits* notice explaining what coverage has been provided.

INSIDE DELAWARE

When you receive care inside Delaware, put your Blue Cross Blue Shield Identification Number on your *Request for Medicare Payment Form.* Payment will be made to the provider of services.

OUTSIDE DELAWARE

Medicare Part A Hospital Services

If you are hospitalized outside of Delaware, supply the hospital with your Blue Cross Blue Shield Identification Number. The hospital or Skilled Nursing Facility which provides you service will submit a Medicare Claim Form to the Medicare Part A Intermediary in the area where you receive care. Payment will be made to the provider of services.

Medicare Part B Doctor's Services

If you receive surgical-medical care outside of Delaware, supply the doctor or provider with your Blue Cross Blue Shield Identification Number. The doctor or provider will submit the claim to Medicare in the area where you receive care. Payment will be made to the provider of services.

OUTSIDE THE UNITED STATES

Send a copy of the *Explanation of Benefits* form you received from Medicare to:

Highmark Blue Cross Blue Shield Delaware
P.O. Box 8830
Wilmington, DE 19899-8830

Highmark Delaware will pay you directly for benefits in accordance with this health care plan.

HOW TO CLAIM OTHER COVERED BENEFITS

PRIVATE DUTY NURSING

For private duty nursing inpatient benefits, please submit the following information to us:

- Name of the hospital.
- Date of admission to the hospital.
- Date of discharge from the hospital.
- Diagnosis.
- Attending physician's signature.
- Either a completed Claim Form CL-65, which may be obtained in any Delaware hospital, or the nurse's receipt showing the nurse's registration number. If the nurse's receipt is submitted without Form CL-65, you must also include the signed authorization of the attending physician.
- Your name, address, and Blue Cross Blue Shield Identification Number (referred to in some cases as 'contract' or 'certificate' Identification Number).

PRESCRIPTION DRUG BENEFITS

For prescription drug claims, please complete the Extended Benefits Claim Form, and attach your drug receipts. If receipts are not available, the doctor, pharmacist or technician must complete the back portion of this claim form, and must include his or her signature. Send the claim form to:

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

BENEFITS APPEAL

Here are the steps you need to follow if you disagree with how we processed a claim:

HOW TO APPEAL A DECISION

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) members have the right to a full and fair review of all benefit denials, reductions or terminations. If you wish to appeal a decision, you may represent yourself or appoint someone else, including your physician or provider, to represent you. At any time during the appeal process, you may submit written comments, documents or other information relevant to the appeal. You may submit your appeal by calling or writing Member Service at:

Highmark Blue Cross Blue Shield Delaware
Customer Service Department
PO Box 1991
Wilmington, DE 19899
(302) 429-0260 or (800) 633-2563

You may also submit your appeal using the Highmark Delaware Appeal Form, which is available on our website, bcbsde.com. Here's how the Highmark Delaware appeal process works:

HIGHMARK DELAWARE'S APPEAL PROCESS

- To appeal a Highmark Delaware decision, contact Member Service within 180 calendar days from the date you received the benefit decision. There is no cost to you to appeal. Please explain why the claim was not paid correctly and provide any additional information relevant to the decision.
- A Highmark Delaware representative or qualified reviewer who did not participate in the initial decision will be appointed to conduct the review. A qualified physician reviewer will participate in all decisions involving issues of medical judgment.
- You will be notified of the outcome, along with an explanation, within 45 to 60 days of your request for an appeal.

POST-APPEAL OPTIONS

- If your health plan is subject to Employee Retirement Income Security Act (ERISA) and you have already completed the Highmark Delaware appeal process, you have the right to file a civil action under Section 502(A) of ERISA. To determine whether ERISA applies to your plan, please contact your employer or plan administrator.
- If you would like more information, please call Highmark Delaware Member Service.

IMPORTANT NOTE

PLEASE READ YOUR MEDICARE HANDBOOK, SENT TO YOU BY YOUR SOCIAL SECURITY ADMINISTRATION, TO LET YOU KNOW WHAT BENEFITS YOU CAN RECEIVE FROM THE TWO PARTS OF THE MEDICARE PROGRAM.

COORDINATION OF BENEFITS

We reserve the right to coordinate available benefits for you so that duplication of payment of the same benefits will not occur and so that all parties having responsibility for payment for covered services perform in accordance with their benefit plan obligations. If you are entitled to benefits under any other plan as defined herein, to which you are a party or beneficiary, the amount of benefits payable under this plan and any other plan will be coordinated so that the aggregate amount paid will not exceed one hundred percent of the Allowable Expenses.

DEFINITIONS

For the purpose of interpretation of this provision, the following definitions will apply:

Allowable Expenses means a necessary, reasonable and customary health care expense when the expense is covered at least in part by one or more health benefit plans covering the individual for whom the claim is made.

Coordination of Benefits Provision means any provision of any plan which establishes the order in which plans pay benefits when an individual is insured under two or more plans.

Other Plan means any arrangement providing health care benefits or services, including but not limited to benefits or services through:

- Any form of health or other insurance, including nonprofit health service, or any other form of prepayment of insurance coverage including individual, group, blanket, franchise, fraternal, no-fault insurance or personal injury protection coverage;
- Any health maintenance organization or similar coverage;
- Coverage under any labor management trusteed plan, union welfare plan, or employee benefit organization plan;
- Coverage under any governmental or tax supported program; or
- Coverage required by statute to be offered to or procured potentially by you whether or not you have the option of declining such coverage or of purchasing such coverage subject to mandatory or optional deductibles, including but not limited to personal injury protection coverage, no-fault coverage or similar provisions of state or other statutes.

Primary Plan means the plan under which benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the plan under which benefits are determined after those of the other plan. Benefits under a secondary plan may be reduced because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan responsibility is determined according to the following rules as they apply to your Medicfill health care plan:

- A plan with no provision for coordination of benefits is primary over a plan which contains such provision.

- A plan which covers you as an employee is primary over a plan which covers you as a dependent.

- A plan which covers you as an active employee (or as that employee's dependent) is primary over a plan which covers you as a laid off or retired employee (or that employee's dependent).

- If two or more plans cover a dependent child of parents not divorced or separated, the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan which covered one parent longer is primary.

  If the other plan's Coordination of Benefits provision determines primary or secondary plan responsibility based upon the parent's gender rather than upon the parent's birthday, the gender rule will control. As a result, the plan covering the dependent child of the male parent will be primary.

- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in the following order:

  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with the custody of the child; and
  - Finally, the plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the organization providing benefits has actual knowledge of the decree, the plan of that parent is primary.

- If the above rules do not establish which plan is primary, the plan which has covered the individual for the longer time period is primary.

- When there are two or more secondary plans, this order of benefit determination will be repeated until this plan's responsibility for benefits has been determined.

EFFECT ON BENEFITS

- When this plan is primary, the benefits of the secondary plan will be ignored for the purpose of determining the benefits under this plan.

- When this plan is secondary, we will coordinate payments with those of the other plan(s) so that payments made by both (or all) plans will not exceed Allowable Expenses for covered services. In no event will we pay more than would have been paid had there been no other plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of this provision, we may release to or obtain from any organization or individual any information deemed necessary.

You, personally, are obligated to provide information necessary to implement this provision. If you refuse to cooperate with us in providing necessary information or in securing payment, then coverage under this plan for that incident is null and void and we may, at our discretion, terminate the plan and take any other action necessary to protect our rights hereunder.

FACILITY OF PAYMENT

When this plan is determined to be primary but payment was made under another plan, we have the right to reimburse the organization making such payments the amount which we determine is our liability in accordance with this provision. By making such payment, we will have satisfied the obligation under this plan.

RIGHT OF RECOVERY

When we make payments that exceed the maximum amount of covered benefits that we must pay under the coordination of benefits rules, we have the right to recover the excess from any one of the following:

- Any person to or for whom such payments were made;
- Any insurance companies;
- Other organizations; or
- You.

ELIGIBILITY INFORMATION

WHO IS ELIGIBLE

This Health Care Plan is made available through your Employer who elected to provide Medicare supplementary coverage for:

- Retired employees and their spouses
- Disabled employees, spouses and dependent children
- Employees, spouses and dependent children who have permanent kidney failure.

You must be enrolled in Part A and Part B of the Medicare program. You must also continue to be covered under both Part A and Part B to keep coverage in this plan.

WHEN YOUR COVERAGE ENDS

DEATH

Coverage for your surviving spouse and any eligible dependents ends as of the last day of the month of your death.

LOSS OF BENEFITS

You can lose coverage under this plan if you do not retain coverage under both Part A and Part B of Medicare.

Also, persons under 65 can lose their Medicare eligibility by losing their Social Security disability classification. This occurs when the disabled or blind person becomes gainfully employed or, in the case of the dialysis patient, three years after a successful kidney transplant or one year after termination of dialysis.

Contact your employer for information regarding other coverage which may be available.

EMPLOYER DROPS COVERAGE

Your coverage (and your dependents coverage) ends on the date on which your employer's contract with us for the provision of benefits ends.

BENEFITS AFTER YOUR COVERAGE ENDS

If you are an inpatient in a hospital, skilled nursing facility or specialized care facility on the date your coverage terminates because your employer dropped coverage with us, we will continue to provide the benefits described in this booklet for the facility and professional charges related to that admission for up to 10 days after the coverage termination date or until the day you are discharged from the hospital, skilled nursing facility or specialized care facility, whichever occurs first.

If you lose coverage for any reason other than because your employer dropped coverage, all health care benefits under this health care plan terminate on the date your group coverage terminates.

IF GROUP COVERAGE ENDS

If your group coverage ends, you may apply directly to us for conversion to a contract under which you are billed personally (a 'direct-billed' contract) at the then current premium rate. You must apply within 31 days after your coverage under the group contract ends. You have this conversion right if:

- You have left your employer; or
- You are the ex-spouse of an employee; or
- You are the surviving spouse of a deceased employee; or
- You no longer meet the dependent child requirements on age, marital status, or financial support.

The direct-billed contract offered may provide fewer benefits and/or a lower benefit payment level than what you were eligible to receive under group coverage.

If another health insurance program is available where you are employed or in an organization with which you are affiliated, you and/or your dependents are not entitled to a group conversion direct-billed contract under this provision, regardless of whether the other health insurance program contains a preexisting condition limitation or the application is denied.

GENERAL CONDITIONS

MEDICARE AMENDMENTS

If there are changes to the Medicare Law or any other applicable law that either increase or decrease the amount of benefits or provide services not previously covered, benefits under this plan will be adjusted accordingly. We may adjust your premium at renewal time or at any other time required or permitted by applicable law to reflect these adjustments.

RELEASING NECESSARY INFORMATION

Hospitals, doctors, pharmacies and other providers have information we need to determine your eligibility for both enrollment and benefits under this plan. By applying for coverage you agree to let any doctor, hospital, pharmacy or provider give us and our agents all the medical information we may need. This may include the diagnosis and history of any illness, disease, condition or symptom you have had, or for which coverage is sought; or other information. We will keep this information confidential to the extent permitted by law. However, by applying for coverage you authorize us to furnish any and all records including complete diagnosis and medical information to an appropriate medical review board, utilization review board, utilization review organization and/or to any other insurance carrier or administrator or health maintenance organization for purposes of administration of this health benefits plan. If such information relates to fraud or other misrepresentation, we may disclose it to legal authorities or use it in legal proceedings. We reserve the right to charge a fee for the reproduction of claims records requested from us.

TIME LIMITS

Requests for benefits must be received by us within 2 years from the date you received the service.

DENIAL OF LIABILITY

We are not responsible for the quality of care received from any institution or individual. Your coverage does not give you any claim, right or cause of action against us based on an act of omission or commission of a hospital, nursing home, doctor or other provider of care or service.

RECEIPT OF BENEFITS

In order for you to receive benefits, you must identify yourself as our customer as soon as possible. When you receive services, you must show the current membership card.

DUPLICATE COVERAGE

If you have two or more benefit plans through Blue Cross Blue Shield corporations, benefits will be coordinated.

PAYMENT OF BENEFITS

If your doctor accepts Medicare assignment, payment will be made directly to the doctor. He/she cannot bill you for any balance over the Medicare reasonable charge. However, if your doctor does not accept Medicare assignment and you have not assigned benefits under this plan to your

doctor in accordance with Medicare program requirements, payment will be made directly to you and you may be responsible for any balance remaining. If you have assigned benefits under this plan to your doctor according to Medicare guidelines, we will pay benefits under this plan directly to your doctor, as required. In all other cases where benefits are payable to you, such payments shall not be assignable without our written approval.

SUBROGATION

When we pay a claim, we are subrogated to all rights you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of Highmark Delaware's rights include:

- **Constructive trust.** Accepting benefits from Highmark Delaware makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until Highmark Delaware receives payment. Failure to pay funds to Highmark Delaware will be considered a breach of your duty to the health care plan. No settlement can be made without Highmark Delaware's written permission.

- **Subrogation lien.** Accepting benefits from Highmark Delaware will result in an automatic lien by Highmark Delaware against any recovery from any third party. This means Highmark Delaware has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that Highmark Delaware has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. Highmark Delaware is entitled to recovery from any party possessing the funds.

- **Recovery from a third party.** Highmark Delaware is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying Highmark Delaware.** If you are involved in an accident or incident that results in both Highmark Delaware paying a claim and you having a claim against any third party, you must notify Highmark Delaware in writing within 30 days.

- **Cooperating with Highmark Delaware.** You are required to cooperate with Highmark Delaware and assist in the recovery from the third party.

LEGAL ACTION

No legal action may be brought against us for failure to provide benefits under this plan unless brought within 2 years from the date the service in question was rendered.

CANCELLATION FOR MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACTS

We may cancel this plan at any time if we learn:

- That the statements you made at the time you applied for coverage were untrue or incomplete; or
- That you received or attempted to receive benefits under this plan under circumstances indicating fraud or other intentional misconduct; or
- You assisted another person as specified above.

ERISA INFORMATION

This booklet is intended to be a part of the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 (ERISA), enacted by the Federal government.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the ERISA Plan, service of legal process may be made upon the ERISA Plan Administrator through your Personnel Department.

TYPE OF PLAN

The ERISA Plan is a welfare benefit plan providing the health care benefits described herein.

TYPE OF ADMINISTRATION

The Plan is administered through a group insurance policy issued by us.

YOUR ERISA RIGHTS

As a participant in the Blue Cross Blue Shield health insurance plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in covered benefit plans, such as your health insurance plan, shall be entitled to:

- Examine, without charge, at the office of the Plan Administrator (your employer or your union), all Plan documents, including insurance contracts and copies of any documents filed by the Plan with the U.S Department of Labor, such as detailed annual reports and ERISA Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Receive a written explanation of the reason for denial, if your claim for a benefit is denied, in whole or in part. You have the right to have us review and reconsider your claim.
- File suit in a state or federal court, if you have a claim for benefits which is denied or ignored, in whole or in part.
- File suit in a federal court if any materials requested are not received within 30 days of your request, unless the materials were not sent because of matters beyond the control of the administrator. The court may require the Plan Administrator to pay up to $100 for each day's delay until you receive the material.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. Called "fiduciaries," the people who operate your Plan have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor. You may also file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees.

No one may fire you or discriminate against you in any way to prevent you from obtaining a benefit under this Plan or exercising your rights under ERISA.

QUESTIONS

If you have any questions about your Plan, you should contact the ERISA Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (the address and phone are listed in your phone book), or

Division of Technical Assistance & Inquiries
Room N-5625
200 Constitution Ave., N.W.
Washington, DE 20210
Phone: (202) 219-8776

DEFINITIONS

Accident means accidental bodily injury which is sustained as the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this plan is in force.

Admission means the period from the time you enter a hospital or skilled nursing facility as an inpatient until discharge.

Allowable Charge means the fee or price Blue Cross and Blue Shield of Delaware determines to be reasonable for services and supplies.

Benefit Period means the period beginning with the first day of admission to a hospital or Skilled Nursing Facility and ending when you have gone 60 consecutive days without admission to either a hospital or Skilled Nursing Facility.

Highmark Delaware means Highmark Blue Cross Blue Shield Delaware.

Coinsurance means the portion of covered charges for services which, under Medicare, is your responsibility to pay. The coinsurance is the amount remaining after Medicare payment is made.

Deductible means a portion of covered charges for services which is payable before Medicare begins paying. The deductible amount is determined by Medicare.

Durable Medical Equipment means medically necessary equipment, prosthetic devices (artificial devices replacing body parts) and orthopedic braces used only during an illness or injury. It does not include disposable items.

Hospital means any institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and which operates pursuant to state law and which provides diagnostic and therapeutic facilities for services performed mostly on an inpatient basis. Such services must at a minimum include: surgical and medical diagnosis and treatment; and twenty-four hour a day nursing service under the direction or supervision of registered professional nurses. Hospital services must be supervised and rendered by a staff of physicians.

Indemnity Schedule means the Blue Shield Limited Indemnity Schedule maintained by us listing the maximum amount we will pay for services.

Inpatient means a person admitted to a hospital or skilled nursing facility for an overnight stay.

Licensed Practical Nurse means a person licensed as such by the state in which they practice nursing.

Medically Necessary means those services or supplies which are provided by a hospital, physician or other provider that are required to identify or treat an illness or injury and which, as determined by us, are:

- Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for your convenience, the doctor's convenience, or any other provider's convenience; and,
- The most appropriate supply or level of service which can safely be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. Medicare includes Part A Hospital Insurance Benefits; Part B Supplementary Medical Benefits; and includes rules, regulations, directives and interpretations about these programs issued by the Secretary of Health and Human Services.

Medicare Eligible Expenses means the health care expenses of the kinds covered by Medicare and to the extent recognized as reasonable by Medicare.

Mental and Nervous Disorders means emotional and personality illnesses as classified by the International Classification of Diseases. Excluded are psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation or illnesses determined by us as not amenable to favorable modification.

Outpatient means a person who is receiving services or supplies while not an inpatient in a hospital or skilled nursing facility.

Physician or Doctor means any person who is licensed to practice medicine and surgery, osteopathy, podiatry, chiropractic or dentistry and who is acting within the scope of that license.

Prescription Drugs means a substance which is used in the cure, treatment, or prevention of a disease or illness which can only be obtained upon a physician's prescription; and which Highmark Delaware has approved as prescription drugs.

Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare Program.

Registered Professional Nurse means a person licensed as such by the state in which he or she practices nursing.

Skilled Nursing Facility means extended care facilities, convalescent hospitals or rehabilitation centers providing skilled nursing care or rehabilitation services and approved by Medicare. Medicare's approval is based on the facility's guarantee of safety to the patient and effectiveness of the care rendered to the patients. These facilities provide:

- Skilled nursing and related services on an inpatient basis for patients who require continuous, 24 hour a day medical or nursing care.
- Rehabilitation for patients who require such care because of illness, disability or injury.

We, Us or Our refers to Highmark Blue Cross Blue Shield Delaware.

You and Your refers to the employee or any eligible dependents you have enrolled for coverage. You must be eligible for enrollment in the Medicare program and enter into agreement with us for supplementary coverage.

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc.