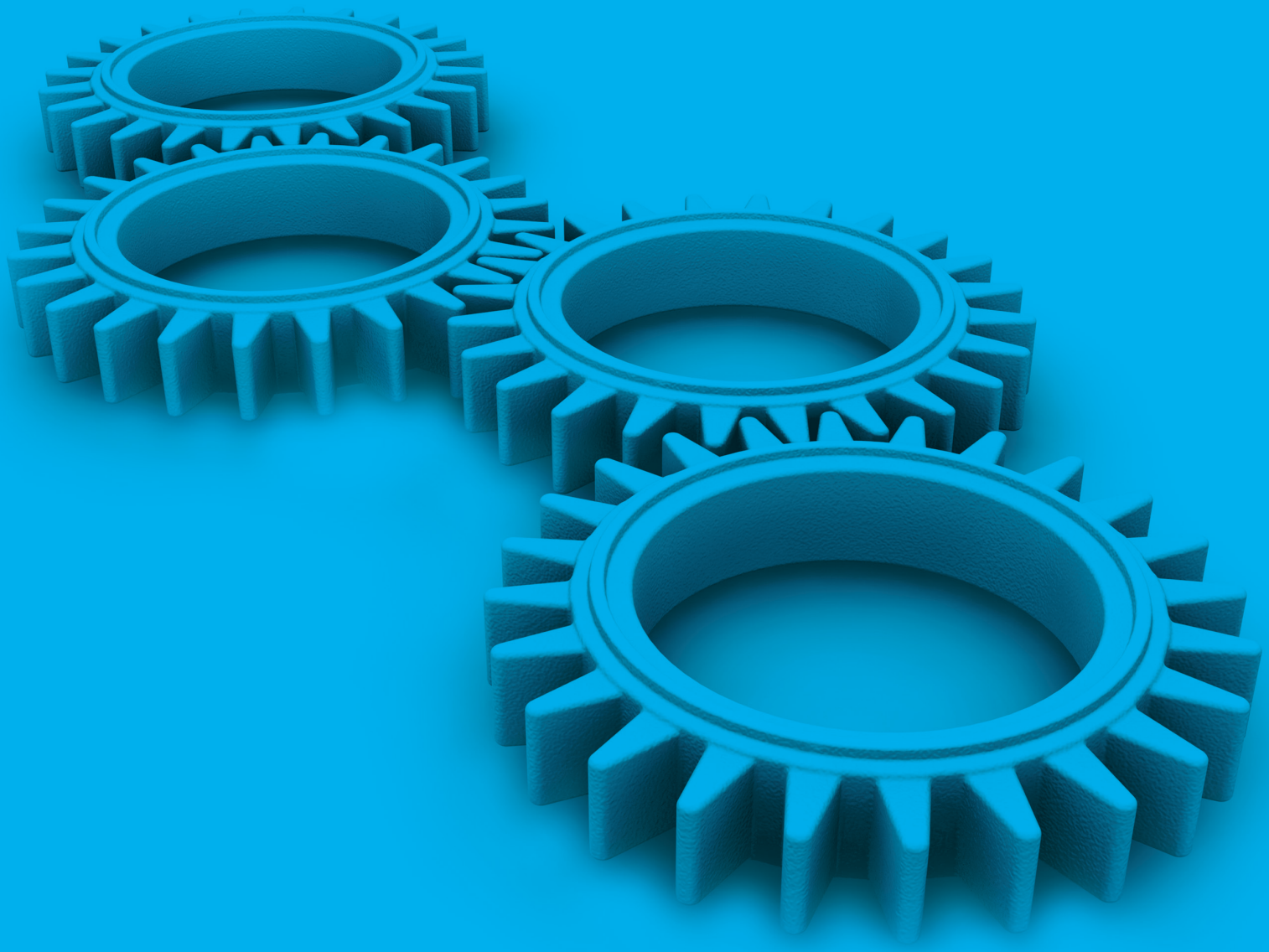
ADMINISTRATION MANUAL

SMALL GROUPS



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Administration Manual for Small Groups

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INTRODUCTION

Welcome to Highmark Blue Cross Blue Shield Delaware (Highmark Delaware). As the state's largest and most respected provider of a complete range of employee benefit solutions, we're here to help you to meet the comprehensive health needs of your employees.

But we don't just provide benefit plans. We also provide the support to help you administer them. That's what this manual is all about. Use it as a reference tool whenever you need to:

- Learn about our administrative policies and procedures.
- Get information about our enrollment processes and billing guidelines.
- Review forms as well as instructions for completing them.
- Prepare documentation to send to us.
- Understand documentation we send to you.
- Answer questions from your employees.

Please keep in mind, this manual is not a contract. Therefore, if a conflict exists between the Diamond State Group Insurance Trust (DSGIT) contract and the content of this manual, the terms of the contract will always govern.

HOW TO USE THIS MANUAL

This manual is divided into ten sections so that you can quickly find the information you need. For specific page numbers, please see the table of contents.

Section 1: Introduction
Section 2: Service Information
Section 3: Eligibility & Enrollment
Section 4: Changes in Coverage
Section 5: Billing & Payment
Section 6: Claims Procedures
Section 7: Laws & Regulations
Section 8: Medicare Part D and Prescription Drug Coverage
Section 9: Notice of Privacy Practices
Section 10: Definitions

As things change, we will provide you with revisions and updates to keep your information current.

To make this manual as easy to use as possible, we have avoided as much insurance terminology and jargon as possible. Unfortunately, some of this is unavoidable due to the nature of the business.

As always, our representatives are ready to provide any assistance you need or to answer any questions you may have.

YOUR RESPONSIBILITIES

As Account Administrator for your company's benefit program, you're responsible for many important tasks, including communicating with your employees about their benefits as well as reporting and coordinating various activities with us.

Communicating with Employees

You'll need to know and communicate to your employees:

- The types of benefit options and coverage that your company offers.
- How to complete the *Member Enrollment/Change Application* when an employee and his or her dependent(s) enroll for health coverage.
- What to do if there is a change in an employee's family status or coverage and how to follow COBRA continuation of benefits procedures, if applicable.
- How to complete a claim form and what to do to appeal a claim.

Reporting and Coordination with Highmark Delaware

You'll need to know and coordinate:

- Where to send *Member Enrollment/Change Application* forms after you have verified their completion.
- How to complete the *Account Transmittal Report* indicating employee and dependent additions, changes and cancellations.
- How to interpret your billing statement.
- How and where to remit premiums.
- What to do to certify and recertify disabled dependents.

Employee Responsibilities

To help your employees get the most value from their Highmark Delaware benefit program, they need to know and understand the following responsibilities:

- Employees must accurately complete a *Member Enrollment/Change Application* to apply for coverage.
- Employees who elect coverage that requires the selection of a primary care physician (PCP) must select a valid PCP at the time of application.
- Employees and covered dependents must present their identification card to providers at the time services are rendered.
- Employees and covered dependents must pay their provider any applicable copayments at the time services are rendered.
- Following receipt of an *Explanation of Benefits* (EOB) from Highmark Delaware and a bill from their provider, employees and covered dependents must make reasonably prompt payment of any applicable deductible and coinsurance amounts, and/or any other amounts the provider indicates employees are responsible for paying. In the case of Coordination of Benefits, these payments should be made only after all appropriate benefit programs are applied.

- Employees covered under any managed care benefit program should educate themselves regarding their obligations under these programs. In order to receive benefits, they need to follow these guidelines and work in cooperation with their providers as well as with Highmark Delaware's referral center and case management center. Included among these responsibilities are:
  - Consulting the PCP for all health care under IPA plans.
  - Using network providers under EPO plans.
  - Keeping appointments or giving timely notice when they need to cancel.
  - Treating the PCP and other providers with respect.
  - Giving truthful information to the PCP and other providers.
  - Telling providers when they don't understand the care or advice provided.

SERVICE INFORMATION

This section provides important phone numbers and addresses for various departments at Highmark Delaware, along with a description of their services. You'll also learn how to order the various forms and supplies discussed in this manual.

YOUR BLUECONNECTION

Highmark Delaware provides multiple Internet inquiry services and immediate access to information through our website, **highmarkbcbsde.com.**

Highmarkbcbsde.com Registration

Employees should visit **highmarkbcbsde.com** and click on *Customers,* then complete the *Online Registration Form*. Employees will need their Highmark Delaware ID card to complete the form. After registering, a log on password will be assigned and sent to the employee via U.S. mail to ensure privacy.

Internet Inquiries

The following are some of the services that can be accessed by logging onto the Highmark Delaware website:

- Check on Claim Status
- Customer Service Inquiry
- Check on Eligibility & Benefits
- Order a New ID Card
- Prior Authorization Status
- Provider Directory
- Request a Change of Address
- Change PCP

SERVICE INFORMATION continued

CUSTOMER SERVICE ASSISTANCE FOR EMPLOYEES

Employees can usually find answers to their benefit questions in their benefit booklet. If they need additional information, they can contact Customer Service by phone at the number on their customer ID card, by mail, or on our website, **highmarkbcbsde.com**.

Some of the topics and questions our Customer Service team can help your employees with include:

- Services covered/not covered
- Deductible status
- Coinsurance expense limits
- Explanation of claim payments and denials
- Explanation of Benefits (EOB)
- Appeal of denied claims
- Changing addresses
- Requesting ID cards
- Questions about managed care guidelines and network providers

Web Site

When submitting an inquiry online, employees should go to the *Customers* section of **highmarkbcbsde.com** and click on *Contact Customer Service*.

www.highmarkbcbsde.com

To find providers in the national BlueCard® PPO network, click on *Find a Doctor, Lab or Hospital*, then choose the *Nationwide BCBS Network*.

Customer Service Phone Numbers

Employees should have their customer ID card ready when they call. When calling for assistance, customers may use the automated response options or speak directly with a customer service representative.

Northern DE: 302.429.0260 *Other locations:* 800.633.2563

Customer Service Phone Hours

8:30 AM to 7:00 PM, Eastern Time, Monday through Friday

More Customer Service Options:

Call Highmark Delaware's Voice Response System — 24 hours a day

Customer Service Mailing Address

Employees should include their member ID number in all correspondence as well as relevant claim numbers, provider names, and dates of service.

Customer Service Department
Highmark Blue Cross Blue Shield Delaware
DelCode 1-6-48
PO Box 1991
Wilmington, DE 19899-1991

THE REFERRAL CENTER

For Authorization of Surgical and Medical Managed Care

Employees covered under managed care programs and/or their physicians are required to contact the Referral Center to request authorization for certain medical and surgical services.

The Referral Center is staffed by specially trained Registered Nurses who will help ensure that only medically necessary care is being delivered and in the most appropriate setting.

Referral Center Phone Numbers

Employees will reach the Automatic Authorization System, an audio-response telephone system that will guide the caller through the proper steps.

Northern Delaware: 302.421.3333
Other locations: 800.572.2872

Referral Center Mailing Address:

The Referral Center
Highmark Blue Cross Blue Shield Delaware
DelCode 1-8-30
PO Box 1991
Wilmington, DE 19899-1991

THE BEHAVIORAL HEALTH CASE MANAGEMENT CENTER

For Authorization of Mental Health and Substance Abuse Managed Care

Employees covered under Mental Health and Substance Abuse managed care programs or their providers are required to contact the Behavioral Health Case Management Center to request authorization for mental health and substance abuse services.

The Behavioral Health Case Management Center is staffed by specially trained mental health professionals who will help determine an effective treatment plan for employees and/or their covered dependents.

Behavioral Health Case Management Center Phone Numbers:

Northern Delaware: 302.421.2500
Other locations: 800.421.4577

Behavioral Health Case Management Center Mailing Address:

The Case Management Center
Highmark Blue Cross Blue Shield Delaware
DelCode 1-8-62
PO Box 1991
Wilmington, DE 19899-1991

Claims

Employees should submit claims to the following address:

Customer Claims Department
Highmark Blue Cross Blue Shield Delaware
PO Box 8831
Wilmington, DE 19899-8831

Please note: There may be a separate address for prescription drug claims. Please consult your company's prescription drug program for information.

ASSISTANCE FOR THE ACCOUNT ADMINISTRATOR

Claims Questions

Due to HIPAA Regulations, Account Administrators should have their employees contact Highmark Delaware's Customer Service Department directly if they have questions about their claims.

Billing and Premium Questions

Please direct questions concerning billing and premium payments to the Billing Representative noted on your bill. If you are unable to reach your Billing Representative, you may also call us at the general number below.

Billing Dept. Phone Number

302.421.3132

Billing Dept. Fax Number

302.421.8934

Billing Dept. Mailing Address

Billing Department
Highmark Blue Cross Blue Shield Delaware
PO Box 1557
Wilmington, DE 19899-1557

SERVICE INFORMATION continued

ENROLLMENT AND ELIGIBILITY QUESTIONS

Please direct questions concerning either eligibility or enrollment to the Enrollment Services Department. Our team is available to you, and can be contacted in these ways:

Enrollment Services
Phone Numbers

302.421.3400 or 866.835.8977

Our phones are staffed from 8:00 am until 5:00 pm Monday through Friday, Eastern Time.

Enrollment Services
Fax Number

302.421.8948

Enrollment Services
Email Address

enrollserv@highmarkbcbsde.com

Enrollment Services
Mailing Address

PO Box 8868
Wilmington, DE 19899-8868

To make additions, changes or cancellations to enrollment information by phone, please refer to Section 3.

SERVICE INFORMATION continued

FOR OTHER QUESTIONS

For any questions other than those related to claims, billing of premiums and eligibility and enrollment, please contact a member of your account team at the numbers below. You may also fax any member of your account team at: 302.421.3354.

Your account team includes:

Account Executive (AE)
(for accounts with 25 or more covered employees)

Your AE is responsible for providing you with all of the financial information you need to renew or change your benefit plan. Your AE will also coordinate with your Agent Broker, if applicable, and is ultimately responsible for the service your account receives.

Your AE's Name:_____

Your AE's Phone Number: _____

Account Service Representative (ASR)
(for accounts with 1-24 covered employees)

Your ASR can answer most of your day-to-day administrative questions, including questions about benefits, completing forms, or rates.

Your ASR's Name: _____

Your ASR's Phone Number:_____

GENERAL MAILING ADDRESS

If, for any reason, you are unable to get an answer to your question or get the information you need through one of the contacts noted in this section, please write to us at:

Highmark Blue Cross Blue Shield Delaware
PO Box 1991
Wilmington, Delaware 19899-1991

HOW TO REQUEST SUPPLIES

When you need forms or other supplies from Highmark Delaware, many can be downloaded from our website, **highmarkbcbsde.com**. Or, you can complete a *Request for Supplies* postcard (see below). For a stock of *Request for Supplies* postcards, simply call our Sales Department at 800.572.4400. You may also fax us your request at 302.421.3354.

REQUEST FOR SUPPLIES

_____
Account Number

Contact Name _____
Account Name _____
Address _____

FORM	QUANTITY
☐ Member Enrollment/Change Application	_____
☐ Account Transmittal Report	_____
☐ Underwriting Address Labels	_____
☐ Customer Claim Form	_____
☐ Provider Network Directory	_____
☐ Other (describe) _____	_____

_____

You can download many forms from our website: **highmarkbcbsde.com**

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ELIGIBILITY & ENROLLMENT

In this section, you'll find a summary of Highmark Delaware's eligibility requirements and enrollment procedures, as well as guidelines that will help you administer your health care benefit program.

At the end of this section, we've included samples of the different forms you'll need to use when sending enrollment information to Highmark Delaware. There are also instructions for completing and submitting these forms.

Please take some time to thoroughly review the information in this section. Take care to understand and to follow all eligibility guidelines. We rely heavily on you to educate employees about which life events have a possible impact on eligibility and enrollment. As Account Administrator, you will need to talk with employees about how and when to communicate with Highmark Delaware. You will also need to provide assistance to employees as needed.

Also, please act in a timely manner and report eligibility information quickly to help Highmark Delaware maintain an accurate and updated eligibility database. In doing so, you will assure continuity of coverage for your employees, help facilitate the proper processing of claims and simplify the administration of your health care benefits. An accurate and updated enrollment database can also reduce exposure to undue risk from ineligible individuals.

ELIGIBLE EMPLOYEES

To substantiate the eligibility of your company and its employees, you must maintain applicable payroll/personnel records of hours worked and wages/salaries paid, in accordance with state and federal laws and regulations. Upon request, you must permit Highmark Delaware to review business, personnel, and payroll records to verify eligibility.

Employees are eligible for health and dental benefits offered by your plan when they meet ALL of the following requirements:

- They must be part of an eligible class of employees for your company.
- They must satisfy the eligibility waiting period established by your company.

While it is up to your company to determine classes of employees for eligibility purposes, these classes must be nondiscriminatory in definition and administration. In addition, Highmark Delaware must approve your written eligibility classes and waiting period requirements.

Please note: Payment of an employee's health care premium alone does not constitute compensation for purposes of determining eligibility.

In general, Highmark Delaware defines eligible employees as follows:

Full-Time Active Employees

An active full-time employee works 30 or more hours per week. Employees must be receiving salary/wages that reflect full-time employment.

OPTIONAL CLASSES OF PERSONNEL

In addition to Full-Time Active Employees, your company may also offer coverage to the following optional classes of personnel:

Officers, Directors and Owners

These individuals can be covered if ALL of the following standards are met:

- They engage in the daily operation of the business.
- They receive a salary reflective of full-time status OR they receive a salary reflective of part-time status (at least 20 hours per week) AND your company also covers other part-time employees.

Deviations from this standard must be presented in writing for review by Highmark Delaware. Approval is at Highmark Delaware's discretion.

Part-Time Active Employees

These employees can be covered if ALL of following standards are met:

- The employer must contributions at least 50% of the health care premium.
- They work at least 20 hours per week, or meet your company's definition of a part-time employee (working 20–29 hours a week).
- They receive salary/wages reflective of part-time status.

Deviations from this standard must be presented in writing for review by Highmark Delaware. Approval is at Highmark Delaware's discretion.

Retired Employees

These individuals can be covered if they meet ALL of the following standards:

- They were covered as active employees.
- They satisfy your company's written requirements for receiving such benefits, including any age and service requirements for health benefits.

Deviations from this standard must be presented in writing for approval by Highmark Delaware. We may periodically require a signed document from your company to show that the individuals in your retired employee class are consistently covered.

Disabled Employees

These employees are defined as those who are unable to work as a result of disability AND were covered by your health care plan before becoming disabled. Disabled employees may be covered under your Highmark Delaware benefit plan if ALL of the following standards are met:

- They are eligible for and receiving employer contributions at the same level as active full-time employees.
- They satisfy your company's written requirements for receiving such benefits.
- They must be receiving disability compensation (e.g., Workers Compensation) under the terms of your group disability program. Payment of the employee's health care premium alone does not constitute compensation. Once the employee's eligibility for disability compensation ends, they must be terminated from your group health benefits program unless they have returned to the prior level of active employment with your company. This requirement is waived for short term disabilities not exceeding eight weeks.

A disabled employee's eligibility for group health benefits expires when their eligibility for your company's disability compensation expires, but in no case will exceed 26 weeks. At such time, disabled employees must be canceled from the group and may be offered Direct Billed non-group health insurance, or, if eligible, COBRA continuation coverage. Highmark Delaware may require a copy of your company's disability compensation program and policy.

Seasonal Employees

Your company may elect to cover its seasonal employees all year if the following standard is met:

- They work the same number of hours per week as full-time employees for at least nine consecutive months in a 12-month period.

ELIGIBILITY & ENROLLMENT continued

Former Owners

Former owners may retain coverage under your company as retired employees if ALL of the following standards are met:

- They retired at the time of sale.
- They were eligible for and covered by your company's health benefits programs during their term of ownership.
- They satisfy the eligibility requirements for retired employees under your company's written health benefits policy, including, but not limited to, any age and length of service requirements.

Independent Contractors

Your company may elect to cover its full-time independent contractors provided they work for your company at least the same number of hours as its eligible full-time employees. The salary requirement is the same as defined for full-time employees. Your company may not cover its part-time independent contractors unless it has also elected to cover its part-time employees.

Surviving Spouses or Dependents

This is NOT AN ELIGIBLE CLASS. Surviving spouses or dependents of deceased employees are not permitted to retain coverage under your company. Some surviving spouses or dependents may be covered up to 36 months as allowed by federal COBRA regulations, but only if your company is obligated by COBRA regulations and only for the time period allotted by COBRA. The COBRA coverage is continuation coverage and is not employee coverage.

Employees with Additional Jobs

An individual employed by or associated through ownership or holding office with more than one business entity can only enroll in the entity which represents his or her primary occupation. Typically, this is the entity that is the **primary source of income** and the activity where the individual spends the most time.

ELIGIBLE DEPENDENTS

An employee's eligible dependents are defined as a spouse and dependent children.

A spouse is defined as a person to whom an employee is legally married.

An employee's dependent child is defined as an individual who meets ALL of the following criteria:

- He/she is under the dependent child age limit of 26.
- He/she is the employee's natural child, stepchild, legally adopted child, or child placed in the employee's home for adoption.
- He/she is unmarried.*
- He/she is dependent upon the employee or the employee's spouse for more than half of his or her support and maintenance.*
- He/she is not working full-time.*

A dependent child who fails to meet any of these criteria is no longer eligible for coverage and must be canceled. See Section 4 for determining the effective date of the cancellation.

A dependent child, as defined above, is eligible for coverage until the end of the month in which he/she reaches the age limit of 26.

Highmark Delaware may request and examine copies of tax returns and other documentation to verify dependent eligibility.

*As federal Health Care Reform provisions become effective for groups as they enroll or renew after September 23, 2010, these criteria will no longer apply.

DEPENDENT DISABLED CHILDREN

An employee's dependent disabled child may continue coverage beyond the dependent age limit of 26 if ALL of the following requirements are met:

- Prior to reaching the dependent age limit, the child has had continuous Highmark Delaware coverage OR the child has been continuously and previously covered by the parent.
- The child is unmarried.
- The child is **incapable of self-support** because of a physical or mental disability that commenced prior to reaching the maximum child age limit.
- The child is dependent upon the employee for his or her support.
- The child is expected to be disabled for a long and indefinite period of time.
- Not eligible for Medicare.
- Proof of disability is submitted to Highmark Delaware on a completed and original copy of the *Disabled Child Application*.
- Highmark Delaware approves the application.

Highmark Delaware should receive the *Disabled Child Application* at least 30 days prior to the end of the year, month or day in which the disabled child reaches the dependent age limit of 26 (or upon initial eligibility of the employee if the child's age is already beyond the age limit upon first enrollment with Highmark Delaware).

Any other health care coverage information for the disabled dependent must be disclosed. If approved by Highmark Delaware Underwriting, the dependent's coverage under the parent's contract is extended at full contract benefits. Approval for coverage is subject to periodic review, and the employee may be asked to reapply at a later date.

INDIVIDUALS NOT ELIGIBLE FOR COVERAGE

Coverage is not available to friends, relatives, former employees, co-mortgagees, temporary employees, consultants, unpaid workers, volunteers, or others who are not actually employed by or retired from your company.

Persons not eligible as dependents include common law spouses (in states where this is not recognized as a legal marriage), life partners, household dependents and other friends or persons that may be living in the household unless approved by Highmark Delaware.

Coverage of a company or an individual can be terminated immediately by Highmark Delaware for cause. Such cases include, but are not limited to, ineligibility, misrepresentation, fraud or misconduct. Highmark Delaware will recover from your company expenses incurred for benefits paid for ineligible persons including claims and administrative expenses.

For questions concerning eligibility requirements, please contact Enrollment Services:

Phone: 302.421.3400 or 866.835.8977
Fax: 302.421.8948
Hours: 8:00AM–5:00PM, Monday through Friday

TYPES OF COVERAGE

An employee may enroll under one of the following standard types of coverage:

Self—Provides coverage for the employee only. Also referred to as Individual coverage.

Self and Spouse—Provides coverage for the employee and his/her spouse. Also referred to as Employee and Spouse coverage.

Self and Child(ren)—Provides coverage for the employee and his/her eligible child(ren), but does not include the spouse. Also referred to as Employee and Child(ren) coverage.

Family—Provides coverage for the employee, his or her spouse and eligible child(ren).

WHEN COVERAGE BEGINS

The date coverage actually begins is based on **all** of the following:

- The date an employee or dependent(s) becomes eligible for coverage or for company contribution to the premium.
- The date an employee completes, signs and dates a *Member Enrollment/Change Application*.
- The Effective Date of Coverage practice your company chooses.
- The date enrollment notification is sent to Highmark Delaware.

It is imperative that you and your employees understand the many factors that can impact the effective date of coverage, as detailed in this section.

In general, we advise you to apply early and send your written request to Highmark Delaware **before** the effective date that is being requested. If outstanding pieces of information are needed, Highmark Delaware will work with you to secure that data once the initial request is reviewed. The date your initial request is sent to us will be used as the Date of Notification when outstanding information needs to be collected.

Please note: Initial request paperwork must be sent in no later than 10 days following the requested effective date. If this paperwork is not sent in on time, Highmark Delaware will decline coverage or move the effective date of coverage.

When Employees Become Eligible for Coverage

Your company may elect to impose an enrollment eligibility waiting period before offering benefits. This waiting period, also known as a probationary period for enrollment, is a predetermined number of days after the hire date. Per Delaware law, this cannot exceed 60 days.

In addition, your company may have a period of time during which an employee is eligible for coverage before your company contributes towards the premium; this is called a contribution waiting period. This contribution waiting period is different from the initial eligibility waiting period for an employee and can be up to 12 months.

Depending on the administrative policy of your company, an employee's initial eligibility for enrollment can be any one of the following times:

- Date of hire.
- First of the month following the date of hire.
- Date following the satisfaction of the enrollment eligibility waiting period.
- First of the month following satisfaction of the enrollment eligibility waiting period.
- Date following satisfaction of the contribution waiting period.
- First of the month following satisfaction of the contribution waiting period.

ENROLLMENT CATEGORIES

As defined by the portability portion of the HIPAA law, there are three categories of enrollees based on when the employee applies for coverage (e.g. at initial eligibility, following a life event that causes a special eligibility opportunity, or during a renewal period):

Timely Enrollee—This is an employee who enrolls within 30 days from the date he or she first became eligible for coverage as a new hire.

Late Enrollee—This is an employee or dependent who does not enroll as a Timely Enrollee or does not qualify as a Special Enrollee. Employees who wait until the contribution waiting period to enroll will be considered Late Enrollees. Otherwise, Late Enrollees must wait until your company's next renewal period to enroll.

Special Enrollee—This is an employee or dependent who did not enroll when first eligible; and subsequently becomes eligible for any of the following reasons:

- Marriage.
- Birth or adoption of a child.
- Placement of a child in the home for adoption.
- Involuntary loss of prior coverage under the following circumstances:
  - Employee or dependent waived Highmark Delaware coverage at the time he/she originally became eligible as a new hire or when your company commenced coverage through Highmark Delaware because he/she had existing health coverage.
  - The other coverage was either COBRA continuation coverage that has now expired, or other non-COBRA coverage is now lost because he/she is no longer eligible or the employer stopped contributions to the health plan.
  - The individual can prove the loss of the other coverage with documentation such as a *Certificate of Coverage*.

Please note: Most of the time, eligibility can be determined without a *Certificate of Coverage*. Please do not wait for the *Certificate* before applying to Highmark Delaware, as it is important that the individual apply within 30 days relative to the event that caused the coverage loss.

Special Enrollees and/or their dependents must apply for coverage within 30 days of the qualifying event. This time period is known as the Special Enrollment Period. If the employee was not originally enrolled, he/she must enroll during the Special Enrollment Period in order to obtain coverage for now-eligible dependents.

Also, any other dependents not originally enrolled may apply for coverage during the Special Enrollment Period.

Please note: An individual does not have Special Enrollment rights if he/she loses other coverage as the result of failure to pay premiums or for fraud.

PRE-EXISTING CONDITION WAITING PERIOD

All three types of enrollees will need to satisfy a pre-existing condition waiting period before they can obtain benefits for a pre-existing condition. HIPAA limits the maximum waiting period for pre-existing condition limitations to 12 months for timely and special enrollees (from the date of hire into an employer class eligible for coverage) and 18 months for late enrollees. Highmark Delaware applies a 12 month waiting period for Timely, Special and Untimely Enrollees.

***Please note**:* Highmark Delaware can typically determine eligibility for enrollment without evaluating the pre-existing waiting period for an employee and/or dependents. Please do not hold a Member Enrollment/Change Application to get a ruling on the disposition of the pre-existing waiting period, since failure to apply within a time limit could result in the application being declined.

EFFECTIVE DATE OF ENROLLMENT/ CANCELLATION PRACTICE OPTIONS

We offer employers two effective date practice options for enrolling and canceling employees and their dependents:

- First of The Month Practice (FOM)
- Other Than First of The Month Practice (OTFOM)

As the Account Administrator, you will use the FOM or OTFOM option to determine what date you will request for an effective date.

FOM Accounts—All requested dates for additions, deletions and changes should be FOM. For enrollments, you may request an effective date that is within or just after the eligibility time period. *Exception*: If the contract type is Employee and Child(ren) or Family and an additional child is being added due to birth or adoption, then the date of the eligibility event will be the effective date since there is no change in the premium to include the additional dependent. The employee will still need to follow eligibility rules regarding applying on time.

OTFOM Accounts—For enrollments, the requested effective date may be any date within the 30 day eligibility time period, which begins with the eligibility event and ends 30 days after the event. Effective enrollment dates may not extend past the eligibility time period as they do for FOM.
With both the FOM and OTFOM enrollment practice options, employees must apply for coverage before or during their 30-day eligibility time period, which begins with any of the eligibility events.

Whenever possible, encourage employees to apply before the eligibility time period. If the employee does not apply before or during this time period, he or she must wait until your company's next renewal period to reapply for coverage.

Please remember it is also important that you apply your chosen enrollment practice option consistently, since a failure to do so may cause adjustments to the effective date of coverage or a decline of an employee's *Member Enrollment/Change Application*.

Your company may change its enrollment/cancellation practice option only during the renewal period.

Following are several examples of FOM and OTFOM enrollment and cancellation practice options.

First of The Month (FOM) Enrollment Practice

New Hires— Highmark Delaware processes enrollments of new employees and their dependents with an effective date of the first of the month following satisfaction of the eligibility requirements, provided the Date of Notification is no later than 10 days after the requested effective date.

The formula used to calculate the eligibility time period for new hires is:

- *Start* of eligibility time period = date of hire + enrollment or contribution waiting period
- *End* of the eligibility time period = date of hire + enrollment or contribution waiting period + 30 days

The effective date of coverage for FOM accounts can be either:

- The FOM following the start of the eligibility time period *OR*
- The FOM following the end of the eligibility time period.

Life Events—With the exception of a birth or adoption, Highmark Delaware processes enrollments for life events with an effective date of the first of the month following the life event, provided the Date of Notification is no later than 10 days after the requested effective date.

The formula used to calculate the eligibility time period for life events is:

- *Start* of the eligibility time period = date of life event.
- *End* of the eligibility time period = date of life event + 30 days.

The effective date of coverage for FOM accounts is either:

- The FOM following the start of the eligibility period.
- The FOM following the end of the eligibility time period.

In some instances, a company may request the FOM before the eligibility time period. The company would pay premiums from the FOM prior to the eligibility time period, but not effect coverage until the actual day the eligibility time period begins.

Example: An employee who already has individual coverage is being married on May 12. Application is made before the marriage and the company asks for an effective date of May 1. The premium for the employee and spouse will be collected from May 1, however, the spouse will not have coverage until May 12 because that is when the spouse becomes an eligible dependent.

Newborns and Adoptions—Newborns and adopted children are covered from the date of birth/adoption, as long as the proper premium is received and Highmark Delaware receives written notification from your company of the employee's desire to have the child enrolled. A *Member Enrollment/Change Application* for the child must be completed within 30 days of the birth/adoption.

For a birth or adoption life event, your company may request the FOM before the event occurs. The company would pay premiums from the FOM prior to the event, but not effect coverage until the actual birth or adoption.

Example: An employee that already has coverage is expecting a baby on July 7. Application is made before the baby is born and the company asks for an effective date of July 1. The premium for the dependent child will be collected from July 1; however, the dependent child will not have coverage until the actual date of birth.

First of The Month (FOM) Cancellation Practice

Cancellations for employees and/or their dependents are effective the last day of the month in which the employee and/or dependent becomes ineligible for coverage.

Exceptions to FOM Cancellations— Highmark Delaware reserves the right to cancel coverage for intentional misrepresentation and misconduct on the date Highmark Delaware becomes aware of the situation. We may also retroactively cancel coverage back to the date coverage began.

Other Than First of The Month (OTFOM) Enrollment Practice

New Hires— Highmark Delaware processes enrollments of new employees and their dependents with an effective date of whatever date the eligibility requirements are satisfied, provided that the Date of Notification is no later than 10 days after the requested effective date.
The formula used to calculate the eligibility time period for new hires is:

- *Start* of eligibility time period = date of hire + enrollment or contribution waiting period.
- *End* of the eligibility time period = date of hire + enrollment or contribution waiting period + 30 days.

The effective date of coverage can be any date within the eligibility time period.

Life Events— Highmark Delaware processes enrollments for life events with an effective date of the life event, provided the Date of Notification is received no later than 10 days after the requested effective date (which is the date of the life event).
The formula used to calculate the eligibility time period for **life events** is:

- *Start* of the eligibility time period = date of life event.
- *End* of the eligibility time period = date of life event + 30 days.

The effective date of coverage can be any date within the eligibility time period.

Other Than First Of The Month (OTFOM) Cancellation Practice

Cancellations for employees and/or their dependents are effective the actual day the employee and/or dependent becomes ineligible for coverage.

Exceptions to OTFOM Cancellations— Highmark Delaware reserves the right to cancel coverage for intentional misrepresentation and misconduct on the date Highmark Delaware becomes aware of the situation. We may also retroactively cancel coverage back to the date coverage began.

Please note: As described at the beginning of this section, it is important to keep in mind that the effective date of coverage is based on a combination of four factors: eligibility or contribution waiting period, when application is made, when paperwork is sent to Highmark Delaware, and the enrollment/cancellation practice used by your company. Do not look at any one factor in isolation of the others when determining an effective date.

EFFECTIVE DATE POLICY

Highmark Delaware uses the Date of Notification to determine if paperwork and enrollment requests are sent on time. The Date of Notification is the date that Highmark Delaware is informed that there is an enrollment request. This date can be any one of the following:

- The date an item is U.S. postmarked.
- The date an item is faxed.
- The date you make a phone-in request as recorded by Enrollment Services.

When paperwork for an enrollment request is sent in on time, you can expect that coverage will take effect on the requested Effective Date, if eligibility is approved. To be considered on time, the Date of Notification must be no later than 10 days following the requested effective date.

Any request with a Date of Notification which is more than 10 days after the requested effective date will be given an Assigned Effective Date equal to the Date of Notification for the request. Keep in mind that eligibility requirements must always be met, and take precedence over the Effective Date Policy in determining whether or not Highmark Delaware will accept the enrollment request.

When an Assigned Effective Date moves the enrollment date outside of the eligibility time period, then the application will be declined.

Example: Involuntary loss of prior coverage occurs June 12. The employee signs an *Application for Group Coverage* on July 10. The requested effective date is August 1. The paperwork is U.S. postmarked on August 15. Since the Date of Notification (August 15) is more than 10 days after the requested effective date (August 1), the Date of Notification becomes the Assigned Effective Date. However, the Assigned Effective Date (August 15) falls outside of the eligibility time period that ended on July 12 (30 days from the eligibility event), so the application will be declined. The employee will need to wait until the renewal period to apply for coverage.

HOW TO ENROLL

To add, change or cancel an employee and/or dependents, you must make an enrollment request in writing. You will probably find that our *Member Enrollment/Change Application* form is the easiest way to make an enrollment request for most situations. Newly hired applicants and employees enrolling for the first time MUST use this form. For additions, changes and cancellations, you can also use the *Account Transmittal Form*.

We prefer that all requests, except employee cancellations, include the employee's signature as an indication that the employee was part of the decision to make an enrollment change, and is aware of the request.

Enrollment requests must include the employee's Highmark Delaware ID number, your account number, company name and the requested effective date. Be sure the employee is aware of the requested effective date.

When the *Member Enrollment/Change Application* and/or *Account Transmittal Form* are ready to send in to Highmark Delaware, please verify that:

- The date of hire is in line with the enrollment window for a new hire.
- The benefit selection is clear.
- The level of coverage matches the individuals listed on the form.
- All information is legible.
- The application is signed and dated by the employee.
- Any certifcate(s) of coverage for the employee or dependents are included with the application.

Please send enrollment requests to Highmark Delaware as soon as they are completed and signed. Do not wait until the end of the month or until you receive your billing.

Also, it is only necessary to send an enrollment request by one method (mail, fax or phone-in).

To serve all of our customers as fairly as possible, Enrollment Services typically processes enrollment requests in order of receipt. You can expect a 5 to 7 day turnaround.

For enrollment questions, please contact our Enrollment Services department at: 302.421.3400 or 866.835.8977

Representatives are available from 8:00 AM to 5:00 PM Eastern Time, Monday through Friday, except holidays.

You can also contact us by emailing **enrollserv@highmarkbcbsde.com**.

HOW TO SEND ENROLLMENT REQUESTS TO HIGHMARK DELAWARE

Mail your enrollment request 7 to 10 days before the effective date (U.S. Mail takes about 2 days). This is usually the easiest way to communicate enrollment information. Our mailing address is:

Highmark Blue Cross Blue Shield Delaware
PO Box 8868
Wilmington, DE 19899-8868

Fax your enrollment request to 302.421.8948. Please use this method only if there are a few pages and/or the need for service is urgent. If there is an urgent service need, please make note of it and explain the kind of service needed.

Phone-In your enrollment request only if the required paperwork will not be ready by the requested effective date, but you need to record the request in order to reserve the effective date you prefer.

Phone-in service is available Monday through Friday from 8:00 AM. to 5:00 PM, Eastern Time. Our phone numbers are:

Northern Delaware: 302.421.3400
All other locations: 866.835.8977

Please keep in mind, Highmark Delaware will not take any enrollment action on a phone-in request until the paperwork is received. Phone-in requests will not receive priority treatment and are not considered received on the date of the call. The phone-in simply alerts us that an enrollment request is being made, but the paperwork is not ready yet. As with any other request, phone-in paperwork is processed in order of receipt.

The phone-in date will be the Date of Notification for all items included on the phone-in call. All phone-in requests must be followed up with a signed *Member Enrollment/Change Application* form (for additions or changes) and/or the *Account Transmittal Report* (for additions, changes and cancellations) within five business days of your phone call. These documents constitute the official request for coverage and are subject to approval by Highmark Delaware's underwriters.

If the paperwork for the phone-in is not U.S. postmarked and to sent to Highmark Delaware within 5 days of the phone-in date, we reserve the right to void the phone-in request and use the U.S. postmark as the Date of Notification instead of the phone-in date.

Calling the Phone-In Service

1. Gather all coverage information before you call. Your *Account Transmittal Report* and *Application for Group Coverage* will typically have the information you need. Please speak slowly so our phone-in representative can transcribe the information you provide. The representative will help you to ensure that all necessary information is collected.
2. Provide the phone-in representative with your company name, your 10-digit account number as well as your name and telephone number.

3. Please follow these guidelines when reporting information:

   Addition—To add an employee, you will need to provide the employee's social security number and date of hire.

   Change—To change an employee's coverage, you will need to provide the employee's identification number, and the change(s) to be made, the reason for the change, and the date of the event causing the change.

   Cancel—To cancel an employee's coverage, provide the employee's identification number. Indicate the cancel reason code and the requested effective date of cancellation.

Once you have finished your series of transactions, the phone-in representative will verify the total number of transactions. Next, you will be given an authorization number, which you should write in the upper right corner of the *Account Transmittal Report* that you will be mailing within five business days. Please verify the authorization code by repeating it back to the phone-in representative.

When your paperwork is received by Highmark Delaware, we will use the authorization number to match the paperwork to our record of the request. Only those enrollment requests made during the phone-in call will be given a Date of Notification that matches the phone-in date. All other requests on the *Account Transmittal* will be given a Date of Notification that matches the date your paperwork is sent to us.

What Paperwork Must Be Sent with an Enrollment Request

New Hire: You will need to send a *Member Enrollment/Change Application* along with certificate(s) of coverage, if applicable, and any relevant dependent information, such as custody papers, marriage certificate or birth certificate(s).

Birth/Adoption: The *Member Enrollment/Change Application* should be completed to request the enrollment of a new child. Highmark Delaware reserves the right to request a copy of the birth certificate.

An expected child may be pre-enrolled before birth. This is not required, but is a good idea since we often receive claims for newborn children as early as the night they are born. Use the *Member Enrollment/Change Application* to make the request. Once the child is born, send us a written update about the gender, birth date and name of the child so we can update the enrollment database.

Marriage: The *Member Enrollment/Change Application* should be completed to request the enrollment of a new spouse. This enrollment request can be made prior to the marriage, with a requested effective date that matches the date of marriage. Highmark Delaware reserves the right to request a copy of the marriage certificate.

Custody or Court Order: The *Member Enrollment/Change Application* should be completed to request the enrollment of a custody case or court ordered dependent. If there is a custody agreement or court order that applies to dependent children for whom an enrollment request is being made, Highmark Delaware requires that you send a copy for our review.

ELIGIBILITY & ENROLLMENT continued

Loss of Coverage: A *Member Enrollment/Change Application* should be completed to request the enrollment. You will also need to provide us with the date of the coverage loss, reason for loss, the ID number with the other carrier and the employer group number with the other carrier. Include any *Certificate(s) of Coverage* as well.

Renewal Period: A *Member Enrollment/Change Application* should be completed to request a change to enrollment for the upcoming plan year. Paperwork should be completed and sent to Highmark Delaware at least 30 days prior to the beginning of the plan year.

Loss of Dependent Eligibility: Often the loss of eligibility for a dependent can be anticipated. The request can be sent in advance of children reaching the age limit, or getting married. A simple written request signed by the employee can communicate this type of request.

Special Enrollment: If your company allows for special enrollment events that are not covered by the preceding list, then Highmark Delaware may request a copy of your Plan Document or Premium Only Plan (POP) to verify the situation is listed in your documents and permits the requested enrollment. A *Member Enrollment/Change Application* is typically the easiest way to request the enrollment.

BECOMING ELIGIBLE FOR MEDICARE

To facilitate the correct processing of claims, it is imperative that your company put processes in place to discover when someone is eligible for Medicare and to ensure that the enrollment is correct. This is especially important in light of Medicare Secondary Payer Rules (MSP) and Highmark Delaware Underwriting Regulations.

Highmark Delaware will assist you in this effort by sending you lists in advance of covered persons attaining age 65, and by sending an annual statement in November of individuals whose enrollment shows some relation to Medicare.

Unless the employee's employment status and federal regulations require otherwise, **individuals eligible for Medicare must apply for and retain both Parts A and B of Medicare when they are first eligible to do so in order to remain eligible for Highmark Delaware benefits.**

Medicare and Working Individuals Age 65 and Over

Employees and/or spouses usually become eligible for Medicare at age 65. Because Medicare is the primary payer, in order to remain eligible for Highmark Delaware benefits an individual must have and retain enrollment for both Part A and B of Medicare. At this time, employees and dependents will need to consider possible changes to their Highmark Delaware coverage. As Account Administrator, it is important that you take action one or two months in advance of an employee and/or spouse attaining age 65. Encourage the individual to make an appointment with the Medicare Office or Social Security Administration to verify that their records are accurate and current.

If you are an employer group subject to TEFRA, your aged, benefits-eligible active employee must decide if he/she wants to retain employer benefits or have Medicare be the primary payer. **If the individual chooses Medicare as the primary payer, then he/she must be disenrolled from your account.** If the aged person chooses the employer group to be primary payer, please notify Highmark Delaware to code the person as TEFRA on our database. For more information on TEFRA, see Section 7.

Medicare and Working Individuals Under Age 65

For employees and dependents under age 65 who are Medicare eligible due to a disability, Medicare is considered the primary payer. The exception to this rule is if your employer group is a Large Group Health Plan (i.e. has 100 or more full-time and part-time employees). In this case, notify Highmark Delaware to code the individual as OBRA (Omnibus Budget Reconciliation Act) in our database. For more information on OBRA, see Section 7.

When Medicare is the primary payer, the employee or dependent must apply for and retain both Part A and Part B of Medicare to remain eligible for Highmark Delaware benefits. The employee should also complete a Highmark Delaware *Member Enrollment/Change Application* and include Medicare information. Highmark Delaware will enroll the individual in a Medicare Primary Payer benefit. **Without both parts of Medicare, the individual is ineligible for Highmark Delaware benefits**.

Medicare and End Stage Renal Dialysis (ESRD)

For individuals affected by ESRD, there are federal guidelines regarding primary and secondary payer. Many times, an employer is not aware that someone is being treated for ESRD. If it comes to your attention that someone enrolled in your account is an ESRD patient, please notify Highmark Delaware so we can work with the individual. We will coordinate with Medicare on claims payments as required by Medicare Secondary Payer guidelines.

Medicare and the Retired

When a person is no longer working, TEFRA and OBRA rules no longer apply. Anyone who is enrolled in your account as a retiree and who is Medicare eligible must have both Part A and Part B of Medicare. The individual will be enrolled in a Medicare Primary Payer benefit. If the individual does not have both Part A and Part B of Medicare then he/she is not eligible for Highmark Delaware benefits.

Medicare and COBRA

When a person is enrolled through COBRA continuation coverage, he/she is no longer an employee and TEFRA and OBRA do not apply. **Medicare eligible COBRA individuals must have both Part A and Part B of Medicare**. The enrollment will be in a Medicare Primary Payer benefit. For more information on COBRA, see Section 7.

PRE-EXISTING CONDITIONS

A pre-existing condition is a condition for which medical advice, diagnosis or treatment was received within the six months before the date an employee or dependent became eligible for your company's plan. Pregnancy is not considered a pre-existing condition.

The pre-existing condition waiting period is the period of time beginning with the first date of eligibility, during which services related to pre-existing conditions are not covered. The waiting period is 12 months for Timely, Special and Late Enrollees.

For Timely Enrollees, the pre-existing condition waiting period begins the same day as any eligibility waiting period that may apply for your company.

For Special Enrollees, the same rule applies with the following exception: newborns, adopted children and children placed in the home are excluded from pre-existing condition limitations if enrolled during a Special Renewal Period or within 62 days after coverage ended under a previous plan.

For Late Enrollees, the waiting period begins on the first day of coverage.

Effect on Benefits

Employees and dependents subject to pre-existing condition limits cannot obtain benefits for services related to any pre-existing condition during the pre-existing condition waiting period. Pre-existing condition limits do not apply to dependants up to age 19.

Certificates of Coverage

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employees and dependents are provided with a *Certificate of Coverage* when they lose coverage or move from one plan to another. This certificate provides proof of coverage over the previous 18 months, and may be used to obtain credit towards a pre-existing condition waiting period under any new plan for which the individual may become eligible.

A *Certificate of Coverage* must be given by the employer (or the health plan, if requested by the employer) to the individual under any one of the following circumstances:

- When the individual loses coverage
- When the individual exhausts the COBRA benefit
- On request, within 24 months from losing coverage

A *Certificate of Coverage* applies only for "creditable coverage" as defined by HIPAA. Examples of "creditable coverage" include:

- A group plan through an employer
- An individual (or Direct Billed) plan
- Part A or Part B of Medicare
- Medicaid

Credit for the Pre-existing Condition Waiting Period

The pre-existing condition waiting period may be reduced by the number of days the employee or dependent was covered under the prior "creditable coverage."

Under HIPAA, to be eligible for a credit, the lapse in coverage between the new plan and the prior plan cannot exceed 62 days. The 62-day period begins on the day after the prior "creditable coverage" ended and ends:

- For *Timely Enrollees*, on the date of hire into an employee class eligible for coverage.
- For *Special Enrollees* and *Late Enrollees*, on the date of coverage.

Credit is determined and applied separately to each employee and dependent.

For more information about the Health Insurance Portability and Accountability Act of 1996 (HIPAA), please refer to Section 7.

Examples of How Pre-existing Condition Limitations Work

12-month Pre-Existing Condition Waiting Period—John Doe is hired on January 15, 2004. Your company's eligibility requirements make John eligible for coverage the first of the month following satisfaction of a 30-day eligibility waiting period. Therefore, John is eligible for and obtains coverage for himself and his dependents effective March 1, 2004. The 12-month pre-existing condition waiting period commences on January 15, 2004 and lasts through January 14, 2005.

During this time, John and his dependents are only covered for medical treatment of conditions which were *not* pre-existing.

On April 5, 2004, John has an office visit for treatment of high blood pressure. High blood pressure is considered a pre-existing condition. Therefore, any treatment for high blood pressure rendered prior to January 15, 2005 would not be covered.

If John's spouse discovers during an OB/GYN exam on May 2, 2005 that she is two months pregnant, the pregnancy would **not** be considered a pre-existing condition since pregnancy is excluded from the pre-existing condition limitation.

Credit for the Pre-existing Condition Waiting Period—Fred Smith is hired on July 1, 2004. Fred's company has Highmark Delaware coverage and does not have an eligibility waiting period. Before coming to his new company, Fred had coverage through his old company through a different insurance carrier. The prior employer provided Fred with a Certificate of Coverage detailing his prior coverage, and Fred submits this to his new company, who then submits it to Highmark Delaware with Fred's application.

Highmark Delaware determines the prior coverage is "creditable coverage" under the terms of HIPAA and is eligible for credit towards the pre-existing condition waiting period.

Fred has been continuously covered under his old company's group plan since January 1, 2004—six months before coming to his new company and becoming eligible for benefits with Highmark Delaware. Therefore, Fred receives a six-month credit towards the satisfaction of the 12-month pre-existing condition waiting period. Highmark Delaware will cover services rendered to Fred on or after January 1, 2005 for treatment of any pre-existing conditions.

How Pre-existing Condition Limitations Apply to Your Company

Please be sure to refer to your *Employee Health Benefits Booklet* for details on the application of pre-existing condition waiting periods.

Renewal Period

The Renewal Period usually occurs during the one-month period immediately prior to your company's contract renewal date. The purpose of the Renewal Period is to provide an opportunity for:

- Late Enrollees to enroll if they wish to apply for coverage.
- Employees to renew their existing benefits.
- Employees to change benefit plans (for example from a Highmark Delaware Traditional program to a Highmark Delaware PPO program) if your company makes more than one plan available.
- Employees to add, change, or cancel coverage for dependents.
- Accounts to change eligibility criteria for future activity.

To request new enrollments, changes in coverage or changes in dependents, employees must complete and sign a *Member Enrollment/Change Application* before the new plan year begins, or the request will be declined.

It is important that you submit *Member Enrollment/Change Application* forms and the *Account Transmittal Reports* to Highmark Delaware as soon as possible before the end of the Renewal Period. This will give us time to make enrollment updates to our database and to send new ID cards to employees prior to the new plan year taking effect.

DENTAL COVERAGE AND THE RENEWAL PERIOD

Your company can offer either Traditional dental coverage, or a combination of dental HMO and PPO plans. While your company may add Traditional dental coverage at any time, coverage may only be cancelled during the Renewal Period.

Your employees may add or cancel Traditional Dental or Dental HMO or PPO coverage only during the Renewal Period.

VISION COVERAGE AND THE RENEWAL PERIOD

Your company can offer vision coverage. While your company may add vision coverage at any time, coverage may only be cancelled during the Renewal Period.

Your employees may add or cancel vision coverage only during the Renewal Period.

Please note: If you need enrollment materials, such as the *Member Enrollment/Change Application* or additional booklets, please complete and send us a Request for Supplies card well ahead of time or contact your Field Service Representative.

For more information, see How to Request Supplies on page 13.

ENROLLMENT FORMS

The enrollment forms we provide are designed to gather the information Highmark Delaware needs from the applicant in order to verify eligibility and complete the enrollment. In most cases, these forms will be the quickest, easiest way for you to communicate enrollment information to us. However, we know there will be times when you'll need to supplement this information with an additional form or other documentation.

These forms are designed so you and your employees can complete them quickly and accurately. It is our intent that each form be easy enough to complete the first time through.

Please take some time to familiarize yourself with our enrollment forms so you can help your employees with any questions they may have.

> ***An important note about fraud:*** Under Delaware law, Highmark Delaware is required to report to the Delaware Insurance Fraud Prevention Bureau any act of insurance fraud which Highmark Delaware has a reasonable belief has been committed. The law defines fraud as any act to prepare, present, assist, abet, solicit or conspire with another to cause to be presented any oral or written statement containing false, incomplete or misleading information concerning any fact that is material to a claim for payment or benefit or application for issuance of an insurance policy.

The Account Transmittal Form

The *Account Transmittal* form has several important purposes:

- Serves as a summary of all enrollment requests being submitted in a single batch.
- Allows Highmark Delaware to assure that the proper information is received for each request.
- Serves as a record of all requested effective dates.

While using the *Account Transmittal* form is recommended, you may also submit information in your own format. Please be sure to include the following information:

- Account name, account number, name of the person submitting the request, account phone number and account fax number
- Whether the request is to ADD an employee, make a CHANGE to an existing enrollment or to CANCEL an employee
- Employee's first initial and last name
- Highmark Delaware ID number for the employee (or the SSN for a new enrollee)
- Requested effective date for each request
- Any comments you may want to make in order to clarify the request

- A signature from a member of the company benefits staff to authorize the requests

Please mail or fax the *Account Transmittal* form along with any relevant application forms to our Enrollment Services department.

The Member Change/Enrollment Application

The *Member Change/Enrollment Application* form is used to:

- Enroll a new applicant
- Change (select or cancel) coverage
- Change dependents

The following is a description of the various sections of this form:

Section 1 **Reason for Application/Change**—In this section we would like the employee to indicate why he/she is completing the application. More than one reason may apply.

Please note: This section of the application is also a reminder to COBRA enrollees that they will need to submit a COBRA election form instead of the *Member Enrollment/Change Application*.

Section 2 **About You**—Here, the employee records information about him or herself. Please guide the employee about whether or not your company needs department and/or employee numbers recorded. If so, we can load this information into our system in order to make our billing statements easier for your company to use.

If a Primary Care Physician (PCP) is required for the benefit selected by the employee, the physician's name and ID number must be entered. Be sure your employee checks one of the boxes in the "Is this your current physician?" field. For "yes" answers, this will help us avoid assigning the employee to another PCP if the physician's practice is closed to new patients.

Section 3 **Health and Dental Coverage Choices**—As the Account Administrator, you will need to know what coverage choices are available to your employees. You may want to include a description of these benefits in an employee information packet distributed upon hire or prior to the Renewal Period. That same packet could be useful during the plan year for employees experiencing life events. Please contact our Marketing Department for available benefit materials.

In this section of the application, the employee will need to indicate:

- If he/she is continuing, selecting (starting) or canceling health and/or dental coverage, if offered.
- Who the coverage is for so that we can assign the Type of Coverage (Self, Self & Spouse, Self & Child(ren) or Family).

- Which of the benefits offered is being selected by writing the name of the health plan in the space.
- Type of dental coverage being chosen and the name of the dental provider if Dental HMO or PPO is chosen.

Section 4 **Enrolling Your Dependents**—For each dependent to be enrolled, the employee will need to complete the block of fields that begins with the "Add" and "Cancel" boxes. The information provided will be used to validate information for eligibility and claims processing. **It is very important that the information is accurate**. If the employee has more than three dependents, he/she can use a separate piece of paper or a copy of page 2 from the application to enroll additional dependents.

The employee should provide as much information as possible for each dependent. While we would like to collect all dependent social security numbers, if possible, please do not hold back an application for that information.

When an employee indicates a PCP choice, be sure to include the PCP's ID number with Highmark Delaware. Also, be sure your employee checks one of the boxes in the "Is this the dependent's current physician?" field. For "yes" answers, this will help us avoid assigning the dependent to another PCP if the physician's practice is closed to new patients. A list of PCPs can be found on **highmarkbcbsde.com**.

If the "disabled" box is checked for a dependent, then the employee will also need to submit a *Disabled Child Application,* along with their *Member Enrollment/Change Application*. Remember that a dependent child cannot be classified as disabled for the purposes of eligibility and health care coverage until he/she is older than the child age limit of 25.

Section 5 **Coordination of Benefits Information**—An employee or dependent who has other health or dental coverage will need to complete this section so claims may be coordinated with those carriers. This will help us avoid overpayment of benefits.

Section 6 **Medicare Eligible Applicants**—The employee should indicate if any of the listed statements is true for any individual named on the application (self or dependent) or anyone else who is currently enrolled as a dependent with this employee. This information is used to assure that Highmark Delaware coordinates correctly with Medicare for payment of claims.

As a reminder, both Highmark Delaware and your employer group can be heavily fined if we do not follow the Medicare Secondary Payer (MSP) guidelines.

Section 7 **Terms of Agreement**—These are the terms that govern the agreement between Highmark Delaware and the applicant.

Section 8 **Signature**—When an employee signs and dates the *Member Enrollment/Change Application* form, he/she is confirming an understanding of the terms of agreement, and that all information is accurate. **Only the employee can sign the application.** Unsigned applications will be returned.

Hints for Avoiding Common Errors

Please review each application to assure that:

- The employee's name and Social Security number (or Highmark Delaware ID number) are included.
- The application is signed and dated by the employee.
- The health care plan choice is clearly written, and the type of coverage clearly marked (employee only, family, etc.).
- The name of the PCP and the Highmark Delaware PCP ID number is included when a PCP is chosen.
- The appropriate box is checked if an applicant is a current patient of the PCP.
- Any supplemental forms have been included, such as the *Disabled Child Application*, custody papers, court orders, loss of coverage information etc.

Please Note: *When an applicant's situation is difficult to explain through the application or when additional information will help us to better understand the enrollment request, we encourage you to submit a brief note of explanation.*

The Disabled Child Application

The *Disabled Child Application* is used to enroll a dependent disabled child either when an employee initially enrolls or when a child ages out of the child category and into the disabled child category.

The following is a description of the fields on this form:

Front of Application—The employee completes the front of the application by providing information about himself or herself as well as the disabled child, the child's employment situation and residence. The employee will also need to provide information about any Medicare coverage and sign the application. The employee's signature confirms that the information provided is accurate, and that the child's physician is free to share information about the child's condition with Highmark Delaware.

Back of Application—The reverse side of the application must be completed by the disabled child's physician, who will need to provide information on the health condition and prognosis for the child. The employee is responsible for having the physician complete the back of the application. Only a Highmark Delaware Underwriter can decide upon eligibility for a disabled child. Until this decision has been made, the child will not be eligible for benefits. The application process to verify whether or a not a child qualifies as a disabled child should be started at least 30 days prior to the child aging out of the child category.

Please note: Highmark Delaware will only accept an original copy of the *Disabled Child Application*.

CONTRACT RENEWAL

At least 30 days prior to the expiration of the contract year, your company will receive a Rate Renewal Notice containing rate and benefit information.

> **Rate information** indicates the renewal rates for the 12-month period beginning with your company's next contract renewal date. Your company must meet minimum participation requirements at all times.
>
> **Benefit information** describes amendments to benefits (if any) that will take effect on your renewal date.

Your annual renewal is the time when you can make changes in your benefit program options or payment levels, eligibility and contribution waiting periods, etc. Changes to eligibility definitions can only be made at renewal, and only for future activity.

Employee Participation

Before renewing your contract, you will need to calculate the percentage of eligible employees who are actually enrolled in the program.

It is important for Highmark Delaware to know your company's employee participation so we can determine if your company meets our minimum participation requirements and is therefore eligible for coverage.

Highmark Delaware considers your full-time employees and full-time salaried owners as eligible employees. In addition, if your company has elected to offer coverage to any optional classes as defined in Section 3, we will include all personnel who meet your eligibility requirements among those classes.

Calculating Your Company's Participation Rate

When determining participation percentages, your company must count all eligible employees as defined earlier in this section, excluding the following:

- Individuals covered under their spouse's employer's health plan
- Individuals who have not satisfied your company's eligibility waiting period

Your company may not terminate, reduce the hours or otherwise alter an employee's work arrangements for the primary purpose of making that person ineligible for health insurance benefits in order to satisfy Highmark Delaware's minimum participation requirements.

Minimum Participation Requirements

Your company must meet the following percentage of *Participation Requirements* for health benefits (and Traditional dental benefits—if offered by your company):

Eligible Employees	Minimum Percentage of Who Must Enroll
1 to 5	100%
6 to 9	100%, less one employee
10 to 50	75%

To determine the above percentage, your company must count as eligible all persons who have completed your eligibility waiting period in the classes you have selected, unless they are covered under their spouse's or parent's health care plan or have other qualifying coverage.

Participation Rates and Dental Coverage

The same participation rules apply if your company is applying for traditional dental coverage. In addition, 85% of all employees who have eligible dependents must enroll their dependents in the traditional dental plan.

Dental HMO and PPO plans do not require a minimum participation percentage.

Highmark Delaware does not provide "stand alone" dental coverage. If a person has medical coverage with Highmark Delaware or another carrier, they are eligible for Highmark Delaware Traditional Dental. If they are eligible for medical coverage but decline it, they are not eligible for Highmark Delaware Traditional Dental.

Common Ownership and Close Affiliations

Highmark Delaware considers commonly-owned and/or closely-affiliated companies as one entity for purposes of calculating the minimum percentage participation requirement.

Common ownership exists where one or more business entities are eligible to file a combined tax return, or where a common owner or group of owners owns at least 80% of two or more business entities.

Close affiliation exists where there are overlapping indications of ownership or control of similar or interdependent entities, or where facilities or Employees are shared.

CHANGES IN COVERAGE

This section covers the reasons an employee or dependent may lose coverage, options for transferring coverage to a non-group health plan (Direct Billed coverage) as well as changes in coverage for Medicare-eligible individuals. There is also a brief discussion on COBRA continuation of coverage benefits.

WHEN ELIGIBILITY FOR GROUP COVERAGE ENDS

Canceling Employee Coverage

When an employee is no longer eligible for benefits, coverage will end. Employees become ineligible if:

- They move to an ineligible class of employees, e.g. full-time to part-time, or active to retired (see Section 3 for eligibility guidelines).
- They leave your employment.
- Your company ceases to be eligible as a group with Highmark Delaware (voluntarily leaving or no longer qualifies for group coverage).
- There is evidence of intentional misrepresentation or misconduct (insurance fraud).

As Account Administrator, you will need to report cancellations immediately. If you are a *First Of The Month* (FOM) account, you will need to cancel the employee with an effective date of the FOM after he/she becomes ineligible.

If you are an *Other Than First Of The Month* (OTFOM) account, you will need to cancel the employee with an effective date of the last day of work or eligibility, plus one day. Please note that the Highmark Delaware system considers an enrollee eligible through the end of the day before the date entered in the system. For example, if May 6 is entered in the system, the individual is covered through midnight on May 5.

Please see Section 3 for more information on FOM and OTFOM practices.

If a cancellation request is reported late, Highmark Delaware will apply an Assigned Effective Date, and your company will be charged the premium for the extra days of coverage. See Section 3 for more information on our Effective Date policy.

At our discretion, we may cancel the ineligible individual when eligibility is lost and/or charge your company the costs incurred for benefits paid for the ineligible person.

Canceling Dependent Coverage

When an employee becomes ineligible for group coverage, all of his or her previously eligible dependents (spouse and/or children) will also lose coverage.

Coverage will end for a dependent when any one of the criteria for eligibility as stated in Section 3 is lost. A *Member Enrollment/Change Application* must be completed and signed by the employee.

As Account Administrator, you'll need to report cancellations immediately. If you are a *First Of The Month* (FOM) account, you will need to cancel the dependent with an effective date of the FOM after he/she becomes ineligible.

CHANGES IN COVERAGE continued

If you are an *Other Than First Of The Month* (OTFOM) account, you will need to cancel the dependent with an effective date of the last day of eligibility, plus one day. Please note that the Highmark Delaware system considers an enrollee eligible through the end of the day before the date entered in the system. For example, if May 6 is entered in the system, the individual is covered through midnight on May 5.

Please see Section 3 for more information on FOM and OTFOM practices.

Exception: A dependent child meeting all eligibility criteria may be eligible for coverage through the end of the month in which he/she reaches the maximum child age limit of 26.

WHEN A COMPANY TERMINATES COVERAGE

Voluntary Termination

If your company voluntarily terminates its Highmark Delaware benefit program, Highmark Delaware must be notified 60 days prior to the cancellation. The notification should specify the effective date that the group coverage ends.

Involuntary Termination

Non-Payment of Premium—Highmark Delaware has the right to cancel a company for non-payment of premium. (Please see Section 5 for more information.)

If a payment is not received by the date specified in your contract, coverage is canceled. A cancellation notice is mailed to your company at the most recent address Highmark Delaware has on file. The cancellation is effective on the date specified in the notice.

If your company is canceled for non-payment of premium, we may, at our sole discretion, allow reinstatement.

Decrease in Participation—If your company's participation drops below the minimum level required, Highmark Delaware may cancel coverage. We will, however, offer your employees the opportunity to convert to a Direct Billed program, provided that other group coverage is not obtained for any employees of your company.

For more information on participation requirements, see Section 5.

Termination For Cause—The coverage of your company or an individual may be terminated immediately for cause, including but not limited to ineligibility, misrepresentation, fraud, misconduct and/or, in the case of IPA programs, failure to comply with IPA policies.

Termination of an employee's coverage because of such conduct will result in termination of coverage for all family members, and there will be no entitlement to convert to Direct Billed coverage.

Where your company knew or had reason to know of its ineligible status, or the ineligibility, fraud, misrepresentation or misconduct of any individual covered through the company, Highmark Delaware may recover the difference between any claims paid and premiums received for such ineligible persons, plus any related administrative costs.

Highmark Delaware may cancel the coverage of the company, or the coverage of the Account Administrator and any other person involved in maintaining ineligible membership. Actual cancellation could be retroactive to the date of the fraud or misrepresentation.

CHANGES IN COVERAGE continued

Benefits After Coverage Ends

If your company cancels Highmark Delaware coverage, and an employee or dependent is an inpatient in a hospital, skilled nursing facility or specialized care facility on the date coverage terminates, Highmark Delaware will continue to provide the benefits of your account's health plan for 10 days, unless such benefits are exhausted or until the day the employee is discharged from the facility, whichever occurs first.

All other benefits terminate on the date group coverage terminates.

WHEN EMPLOYEES TRANSFER COVERAGE

Transfers to a Non-Group Health Plan (Individual Coverage)

If an employee or dependent is no longer eligible for group coverage, he or she may apply to Highmark Delaware for a non-group health plan, called *Individual* coverage. *Individual* programs are billed to and paid for by the individual rather than through an employer.

Applications for *Individual* programs must be submitted to Highmark Delaware within 30 days after group coverage ends. Members transferring to a HIPAA plan have 63 days to apply after group coverage ends.

An employee or dependent may apply for *Individual* coverage when he or she:

- Has left employment.
- Becomes divorced from the employee.
- Is the surviving spouse of a deceased employee.
- Is no longer a dependent child as defined by requirements on age, marital status or financial support.
- Has been enrolled for continuation of coverage under COBRA, and the time period has ended.

Restrictions on Individual Products

An employee or dependent is not eligible for *Individual* coverage if:

- Another health insurance program (except COBRA continuation coverage) is available at the individual's place of employment or from an organization with which the individual is affiliated, regardless of the other program's pre-existing condition waiting period.
- The employee or dependent was terminated from group coverage because of fraud, misrepresentation or intentional misuse of benefits.
- The company is cancelled because of misrepresentation, etc. Only those employees who were not involved in the misrepresentation are eligible for Individual coverage. (Coverage is conditional upon Highmark Delaware's acceptance of the application.)

Individual Products

Individual Conversion Programs—Highmark Delaware offers an Individual Conversion product that is not medically underwritten. The premiums are likely to be much higher than the rates for group coverage. In addition, the conversion contract offered is likely to provide fewer benefits and/or a lower benefit payment level than your company's group coverage.

Medically Underwritten Programs—An employee or dependent who is no longer eligible for group coverage may apply for coverage under a Medically Underwritten program. These programs generally have a higher benefit level and a lower premium than the Individual Conversion programs.

CHANGES IN COVERAGE continued

To determine if the employee or dependent is eligible for a Medically Underwritten program, he or she submits a health statement as evidence of insurability to Highmark Delaware.

If not approved for a Medically Underwritten program, the employee or dependent may still be eligible to receive Individual Conversion coverage.

Coverage may also be available through Highmark Delaware's HIPAA Portability programs. The applicant must have had 18 months of prior creditable coverage, and enroll no later than 63 days after group coverage ends.

Employees may contact a Highmark Delaware Customer Service Representative for more information on how to apply for *Individual* coverage and for an explanation of the premiums and benefit options available.

COBRA CONTINUATION OF COVERAGE

Companies with 20 or more full-time and part-time employees are subject to regulations under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These companies will need to offer continuation of group health benefits to employees and their dependents for anywhere from 18 to 36 months after their group coverage would typically end, depending on the qualifying event. For additional information about your responsibilities under COBRA and the individuals affected by this legislation, please refer to Section 7.

CHANGES IN COVERAGE FOR MEDICARE-ELIGIBLE PERSONS

When employees or their spouses reach age 65, they may have several options for coverage, depending on the size of your company and whether the employee retires or remains an active employee.

Retiring Employees

If an employee is eligible for retirement and your company has a formal written health insurance program for retirees, the retiree can enroll in a Medicare Primary Payer benefit if he or she has both Medicare Part A and Part B. These programs supplement Medicare and are designed to coordinate with full (both Parts A and B) coverage. This coverage also applies to the spouse of a retiring employee (although Individual coverage is issued to the spouse).

If your company does not have a formal written health program for retired employees, the retiree is not eligible for group coverage, but may apply for Individual coverage.

A retiring employee or the spouse of a retired employee age 65 or older will need to complete a *Member Enrollment/Change Application*. Be sure the applicant completes all applicable information in Section 6 (Medicare Eligible Dependents).

Active Employees

If your company has 20 or more full-time and part-time employees, TEFRA/DEFRA law and regulations apply. For a description of TEFRA/DEFRA, please refer to Section 7.

If a covered employee remains actively at work as an eligible full-time or part-time employee upon reaching age 65, you should complete an *Account Transmittal Report* to request a change from regular to TEFRA contract type.

The *Account Transmittal Report* sent to Highmark Delaware should designate the employee as "TEFRA," meaning he or she will continue to be enrolled for the regular health program, and not a Medicare Secondary Payer program. Premiums for the employee will not change from the Under 65 coverage premium.

Please note: This explanation is not presented as advice concerning your legal obligations. For questions concerning your legal obligations under TEFRA/DEFRA, you should contact your legal counsel.

If your company has fewer than 20 full- and part-time employees, then TEFRA/DEFRA laws do not apply.

If a covered employee remains actively at work upon reaching age 65, he or she should complete a *Member Enrollment/Change Application for Group Coverage* requesting a change to the appropriate Medicare Secondary Payer program. He or she must be enroll and maintain coverage in Medicare Parts A and B.

CHANGES IN COVERAGE FOR DISABLED EMPLOYEES

Companies with 100 or more total full-time and part-time employees are required to provide the same coverage for Medicare eligible disabled individuals (employees and dependents) as they offer to all active employees. Please refer to Section 7 for a more detailed description of OBRA.

If your company has disabled employees or covered dependents who are not yet eligible for Medicare, these enrolled individuals should also be provided the same coverage as offered to all active employees.

If your company has fewer than 100 employees, OBRA does not apply, and the individual is eligible for a Medicare Secondary Payer program—but only **if** your company's formal written health benefits program stipulates that your company provides coverage for disabled employees and dependents. In addition, the disabled individual must be enrolled in and maintain both Part A and Part B of Medicare. (Please see Section 3 for more information.)

When individuals are eligible for Medicare, they must complete the *Member Enrollment/Change Application* and check the appropriate box (5, 6 or 7) in Section 7 (Medicare Eligible Applicants).

BILLING & PAYMENT

This section describes the types of bills you will receive from us as well as variations among those bills. It also covers how to report and pay the premiums for your Highmark Delaware benefit programs. At the end of this section, you will find information on renewing your contract with us.

If you need any assistance with billing and payment issues, please call one of our representatives at the phone number listed on your bill.

PREMIUM BILLING

If your company has more than 20 subscribers, you will receive a multi-page *Account Billing Detail* statement with a summary of your company's account and activity on the first page, and your company's per subscriber detail on subsequent pages.

If your company has 20 or less subscribers, your bill will list the prior month's billing activity, and covered subscribers.

PREMIUM BILLING SCHEDULE

Highmark Delaware will mail your bill in the middle of each month. Your premium payment is due on or before the first of the following month, i.e., the month in which coverage is effective. For example, we will bill you in the middle of April for coverage in May. Your payment is due on or before May 1st.

Exception: If you have made a late payment, we will adjust your billing schedule from that noted above. Your next bill will allow ten days for payment, but based on the date of your bill, we may request payment for more than one month.

SUMMARY OF ACCOUNT ACTIVITY

Here you will find your account number and name, the billing date, due date, and amount due. You will need to remit this portion of the notice with your payment.

Account Activity Detail

This portion of your statement shows premium activity since your last billing.

1. *Previous Amount Billed* is the prior month's billing.
2. *Membership Activity Processed After Billing* is a calculation of activity that occurred after the prior month's bill was produced. It can include additions, cancellations and changes.
3. *Adjusted Amount Due* is calculated by adding or subtracting line 2 from line 1.
4. *Payment Received* is the amount we received for the prior month on the date indicated.
5. *Late Payment Charge* (if applicable) is the fee for delinquent premium payment.
6. *Balance Forward* is the difference between the payment received (line 4) and the adjusted amount due (line 3).
7. *Current Billing* represents premiums for the current month, plus or minus any amounts being billed or credited for prior months, which can be seen in the adjustments column on the detail portion of the bill.
8. *Please Pay this Amount* is the amount you should pay based on line 7, after adding or subtracting line 6.
9. *Explanation of Balance Forward* documents membership activity noted in line 2 and/or balance forward noted in line 6. It can also be used to communicate other important information.

Payment Discrepancies

On the back of your *Notice of Payment Due* statement, you'll find a form for telling us about any payment discrepancies you may have. Reasons for this might include membership additions, changes or cancellations.

Late Payments

If your premium is not received by the first of the month in which coverage is effective, we will mail you a reminder 10 days after the due date. If payment is still not received, we will mail you a second reminder 20 days after the due date.

BILLING & PAYMENT continued

If your premium has not posted within 30 days of the due date, your pharmacy benefits will be suspended.

If your premium has not posted within 32 days of the due date, your group coverage will be canceled.

Keep in mind that until your current bill is paid, we will not bill you for subsequent months.

Reinstatement Policy

If your group coverage gets canceled for the first time in the most recent 12 months, you will need to:

- Call us to confirm your eligibility for reinstatement.
- Remit payment for the delinquent months, current month, and a reinstatement fee with a guaranteed payment (e.g. cashier's check).

Once we receive your full payment as noted above, we will reinstate your coverage the next business day. Your group will have access to full benefits within three business days.

Please note: *Group coverage may only be reinstated twice in a 12-month period.*

OTHER BILLING DETAILS

In addition to a *Notice of Payment Due* statement, the bill for 20 plus size groups will include:

- *A Current Billing* form, which lists covered employees
- *A Coverage Summary* form
- *A Line of Business Summary* form

Current Billing Form

Employee Information includes employee name, identification number, contract type (Individual, Family, etc.) and coverage date (the effective date of coverage or beginning of the billing period).

Current Coverage includes the premium due for each employee for the current billing period by type of coverage, e.g. Blue Classic, Blue Care, Blue Choice, etc.

Adjustments are the amounts shown on the bill, if any, for an employee who is eligible for coverage, had a change in coverage, or was terminated before the beginning of the billing period.

Amount Due is the total premium due per covered Employee. The page total is at the bottom of each column.

Coverage Summary Form

Contract Type is the type of coverage the Employee has (self, self and child or family).

Package is the number that represents your specific account benefit plans. For example, package number 001 may be "PPO and Dental" for your account. If you do not know these codes, call our Billing Representative for assistance.

Contracts is the number of covered Employees in a package of a specific benefit type.

Premium is the cumulative premium by contract type according to the number of contracts.

Totals matches the premium due from the Current Billing listing. The Total is carried forward to the Notice of Payment Due.

Line of Business Summary

This form illustrates the cumulative premium by type of coverage, e.g. Blue Classic, Blue Care, Blue Choice, etc.

CLAIMS PROCEDURES

This section explains the way Highmark Delaware administers claims for our health and dental products. To ensure that claims are filed correctly and promptly, your employees should always carry and present their identification card whenever they receive services.

If your company offers prescription drug benefits, there may be separate identification cards and claims procedures. Please consult your prescription drug program information for instructions on claims.

FILING CLAIMS

Participating Provider Claims

For most services rendered by a Highmark Delaware Participating Provider, the Provider typically submits a claim to us. This includes claims for hospital and surgical services and most medical services.

While Providers are encouraged to submit claims as soon as possible following the date services are rendered, they may take up to six months from the date of service to file claims. If a claim is not filed within this period, Highmark Delaware may deny payment of the claim, and the Provider may not bill the patient for the claim.

Once a claim is processed, Highmark Delaware makes payment directly to the Participating Provider. An *Explanation of Benefits* is sent to the employee indicating what amounts have been paid by Highmark Delaware, and what amounts the patient may owe the provider (including coinsurance and deductible amounts, or charges not covered by the employee's benefit program).

Employee Claims

An employee or covered dependent may need to file a claim in the following situations:

A Non-Participating Provider is used—Providers who are non-participating with Highmark Delaware typically bill the patient at the time of service. The employee will then need to submit the itemized receipt with a completed *Customer Claim Form* to Highmark Delaware.

Charges are for employee-submitted services—In some benefit programs, claims for some services are submitted by the employee rather than the Provider. This may include prescription drugs, doctor office visits, durable medical equipment, etc. In these instances, the employee should submit the itemized receipt with a completed *Customer Claim Form* to Highmark Delaware.

While employees and dependents are encouraged to submit claims as soon as possible following the date of service, they have up to two years to file the claim.

Once the claim is processed, Highmark Delaware will make payment directly to the employee. A *Notice of Benefits* is sent along with the check to explain what amounts have been paid and what amounts may not have been paid due to any coinsurance amounts, deductible amounts or charges not covered under the employee's benefit plan.

Dental Services—In many cases, claims for dental services are submitted by the employee on a *Dental Claim Form*. Payment may be made to the employee or the provider.

Special Claims Situations

When Services are Received Outside of Delaware—When an employee or covered dependent receives services outside of Delaware, in most cases, the Provider will submit the claim. This is accomplished through the Blue Cross Blue Shield BlueCard national provider network. Here's how this process works:

- The Provider submits the claim to the local Blue Cross Blue Shield plan.
- The local Blue Cross Blue Shield plan electronically sends the claim to Highmark Delaware.
- Highmark Delaware determines the appropriate pay-ment amount and electronically notifies the local Blue Cross Blue Shield plan.
- The local Blue Cross Blue Shield plan pays the provider accordingly. Highmark Delaware sends a *Notice of Benefits* to the Employee.

Please keep in mind, the employee or dependent is responsible for any coinsurance and/or deductible requirements, and for charges for services not covered under your account's health plan.

When submitting claims for services received outside of Delaware, it is especially important to make sure that either the Provider or the employee includes the three-digit alpha prefix to the employee's identification number from the member's ID card. The three-digit alpha prefix lets Blue Cross Blue Shield companies know that the employee is covered through Highmark Delaware.

When Medicare is Primary—When Medicare is the patient's primary carrier, Highmark Delaware cannot process the claim until Medicare has processed it.

For most Medicare claims for services rendered locally, the Medicare system automatically forwards the claim to Highmark Delaware after Medicare processing. Highmark Delaware can then apply any applicable Medicare Secondary Payer benefits. This process may take several weeks from the time Medicare processed the claim.

When Medicare claims are not automatically forwarded to Highmark Delaware, the provider or the employee may submit the claim to Highmark Delaware (after Medicare has processed it) along with a completed *Customer Claim Form*. The *Explanation of Medicare Benefits (EOMB)* form must be attached so that any available coverage may be applied correctly.

THE CUSTOMER CLAIM FORM

The *Customer Claim Form* is completed by the employee when submitting claims for covered services, such as prescription drugs, doctor office visits, durable medical equipment, etc., under certain health care benefit programs. Because there may be separate procedures and identification cards for your company's prescription drug benefits, please be sure to reference the appropriate materials for information.

The following is a description of each section on this form:

Section 1 **Customer Information**—In this section, the employee will enter his or her name, address and phone number.

Section 2 **Other Coverage Information**—If the employee or any covered dependent has health care coverage under another plan, information about such coverage should be entered here.

Section 3 **Patient Information**—This section is used to enter basic information about the patient, including name, address, gender, date of birth, member ID number, etc.

Section 4: **Accident or Injury Indication**—If the care provided was for the treatment of an accident or injury, information about the accident or injury will need to be entered here. This will help Highmark Delaware determine if payment for the services may be the responsibility of another party, e.g. worker's compensation.

Section 5 **Diagnosis**—The employee or dependent will use this section to describe the condition or symptoms for which treatment was provided.

Section 6 **Category**—This section includes a listing of categories into which certain medical services fall. The employee or dependent should check the appropriate boxes to indicate category of service provided.

In each category there is a reminder of the information needed on the itemized statement in order to process the charges. A total dollar amount for each category should be entered, and the cumulative total for all categories should be included.

Section 7 **Employee Signature**—The form must be signed by the employee in order to be processed by Highmark Delaware. No one else may sign for the employee.

Submitting the Customer Claim Form for Processing

To be processed, an itemized receipt from the Provider, on the Provider's professional letterhead or billing form, must be included with the *Customer Claim* form. This itemized receipt should include all of the following:

- The date of each service
- The charge for each service
- The diagnosis
- A description of each service, drug or durable equipment charged

CLAIMS PROCEDURES continued

The completed *Customer Claim* form and itemized receipt should be sent to:

Customer Claims Department
Highmark Blue Cross Blue Shield Delaware
PO Box 8831
Wilmington, DE 19899

Hints for Avoiding Common Errors

- To avoid payment delays, an employee must provide all of the attachments specified in Section 6 of the form.
- The employee should check to be sure the total charges for all categories are the exact sum of the individual categories and match the receipts submitted.
- No receipts should be sent to Highmark Delaware without a completed and signed claim form, or there may be a delay in processing the claim.
- Employees should keep a copy of the claim and receipts for their records. Highmark Delaware does not retain the originals and cannot return them to the employee.
- If services were received in another country, Section B on the back of the form should be used to provide additional information about the nature of the illness and subsequent treatment.

ATTENDING DENTIST'S STATEMENT (DENTAL CLAIM FORM)

The *Attending Dentist's Statement* is used to submit claims for covered services under a Traditional Dental Plan.

Typically, the dentist completes the *Attending Dentist's Statement* and forwards it directly to Highmark Delaware for payment. However, if an employee's dentist does not submit the form, then the employee should obtain an itemized statement from the dentist that lists the services rendered and the corresponding charges. The employee should complete the top portion of the form and submit it, along with the itemized receipt, to the Dental Claims Section at the address noted at the bottom of the form. The employee will be paid benefits according to your company's dental care plan.

The following is a description of each section on this form:

> **Customer Information**—Information about the patient and employee will need to be entered in boxes 1 through 14, including name, address, birth date, etc. Box 15 pertains to coverage by another dental plan. If the employee or dependent is also covered by another dental plan, the information should be entered here.

Predetermination of Benefits

The employee and dentist have the option of submitting a treatment plan on the dental claim form before services are actually rendered. This *predetermination of benefits* allows Highmark Delaware to consider the necessity of the treatment proposed and to give the employee information on the allowable charges and any deductibles or coinsurance amounts that will apply to the services.

The results of the predetermination are returned to the dentist so he or she may review this information with the patient.

Hints for Avoiding Common Errors:

- No receipts should be sent to Highmark Delaware without a completed and signed claim form or a delay in processing the claim may occur.
- Employees should keep a copy of the claim and receipts for their records. Highmark Delaware does not retain the originals and cannot return them to the employee.

EXPLANATION OF BENEFITS (EOB) FORM

The *Explanation of Benefits (EOB)* form is used to communicate claims information to the employee. This includes information about what services the employee's benefit plan has covered and what obligations the patient may have in paying any non-covered amounts to the provider.

On the front of the form, employees will find the following information:

- Claim number
- Name of the provider who delivered the service
- Dates of service and service description
- Explanation of applicable deductibles, coinsurances, copayments and sanctions
- Explanation of non-covered services, including amounts the employee may be responsible for paying the provider
- Instructions concerning non-covered amounts which should NOT be billed by the provider and therefore should not be paid by the employee, e.g. amounts in excess of the Allowable Charge, any applicable provider sanctions for not following Managed Care guidelines, reductions due to Claim Policies, etc.
- Payment amount, payment date, and payee
- If the payee is the employee, the check number
- The Customer Service address and telephone number, where Employees may direct their inquiries

The back of the *EOB* form provides information about Claim Appeal procedures.

When a claim is processed, the employee's *EOB* for the claim is produced at the same time as the *Provider Voucher*. Generally, the *Provider Voucher* and the *EOB* are mailed on the same date.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision of a health or dental benefit plan applies when members and/or their dependents are covered by more than one health or dental plan.

All Highmark Delaware members are required to provide on their *Application for Coverage*, information about potential coverage from other sources that may be available to the member and his or her dependents.

COB ensures that members receive the maximum amount of benefits to which they are entitled. It also prevents the total amount paid for the claim from exceeding 100% of the allowable expenses (i.e. any necessary, reasonable and customary health or dental care expense that is covered at least in part by a plan that covers the individual).

Benefit payments are based on which plan is the primary plan and which is the secondary plan. The primary plan is the plan under which benefits are determined before those of the other plan, without considering the other plan's benefits. The secondary plan is the plan under which benefits are determined after those of the primary plan. Benefits under a secondary plan may be reduced due to the primary plan's benefits.

Order of Benefits Determination

Primary and secondary plan payments are based on the following rules:

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

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

- If the above rules do not establish which plan is primary, the plan covering the individual longer is primary.
- If there are two or more secondary plans, these rules repeat until the obligation for benefits is set.
- Health care benefit plans exempt through ERISA may follow different guidelines. Final determination regarding primary and secondary coverage is done through investigation by Highmark Delaware once a claim has been submitted.

An Example of COB

Assume a member incurs allowable charges of $1000, and the services are covered at 80% of the allowable charges. If Highmark Delaware is the **primary plan**, then our payment would be $800. If Highmark Delaware is the **secondary plan**, and the primary plan paid $800, then our payment would be $200.

COB and ERISA

The guidelines noted above are consistent with ERISA. Therefore, health care benefit plans which are ERISA exempt may follow a different set of guidelines. In any event, final determination regarding primary and secondary coverage is done through investigation by Highmark Delaware once a claim has been submitted. For more information on ERISA, please refer to Section 7.

SUBROGATION—RIGHT OF RECOVERY

If Highmark Delaware paid more than our share due to COB, we may recover the excess from:

- The member or any person to or for whom such payments were made.
- Any insurance plan involved.
- Other organizations involved.

The member is required to cooperate with Highmark Delaware by completing and delivering any requested documents. If a member refuses to cooperate or if he or she settles without our written consent, Highmark Delaware reserves the right to terminate his or her coverage and that of all family members.

CLAIM APPEALS

If a claim for a benefit is denied, whether in whole or in part, the employee will receive an explanation of the reason for the denial on the *Explanation of Benefits (EOB)* form. If the employee needs further explanation of the decision or additional information regarding the claim, he or she may contact a Highmark Delaware Customer Service Representative.

Claim appeals should be made in writing, and should include a copy of any documents, written comments, or other information relevant to the appeal.

Highmark Delaware will carefully review all of the available information and will evaluate its original decision. Most appeal decisions will be made within 60 days, but Highmark Delaware may extend the review period when necessary to adequately review the case. The member will be notified of the outcome, along with an explanation, once a decision is made.

For more information on the appeal procedure for claims, please read *How to Appeal a Decision* following this section.

HOW TO APPEAL A CLAIM DECISION

You have the right to a full and fair review of all claim decisions. Here's how the appeal process works:

HIGHMARK DELAWARE'S APPEAL PROCESS

- To appeal a Highmark Delaware decision, you or your representative must contact Customer Service ***within 180 days*** from the date you received the decision. You may call us or you may use the Highmark Delaware Appeal Form on our website, **highmarkbcbsde.com**. There is no cost to appeal. Please explain why you believe the decision was wrong and provide any additional relevant information. *If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.*
- A qualified reviewer, who did not participate in the initial decision, will be appointed to conduct the appeal.
- **Pre-service decision:** For appeals relating to a service you have not received (Highmark Delaware denied authorization and you have not received the service or treatment), you will be notified of the appeal decision within 30 days of your request. You may request an **expedited** appeal for coverage relating to an emergency medical treatment or a life-threatening illness. We will make an expedited appeal decision and notify you and your provider within 72 hours of your request.
- **Post-service decision:** For appeals relating to a service you have already received, you will be notified of the decision within 45 to 60 days of your request for an appeal.

AFTER THE HIGHMARK DELAWARE APPEAL

For health benefit plans regulated by Delaware insurance law:

- If you have appealed a decision and are not satisfied with the outcome, you are eligible for an independent review coordinated by the Delaware Department of Insurance (DOI). As required by law, you must request an independent review within ***60 days*** of the date you received Highmark Delaware's appeal decision.
    - For decisions involving medical judgment or necessity, you must contact Highmark Delaware Customer Service to initiate the review.
    - For reviews of all other decisions, you must contact the DOI directly at **302.739.4251**.
- The DOI provides free, informal mediation services which are in addition to, but do not replace, your right to appeal. For information about an appeal or mediation, you can call the DOI Consumer Services Division at **302.739.4251** or **800.282.8611**, or visit the DOI office at: The Rodney Building, 841 Silver Lake Boulevard, Dover, Delaware. Office hours are 8:30 AM – 4:00 PM, Monday – Friday. **To preserve your appeal rights, all requests for appeals and independent reviews must be made within the given timeframes. Please note that these deadlines will still apply if you choose mediation services.**
- If you request, Highmark Delaware will provide copies of all records relevant to the Highmark Delaware appeal decision.

For health benefit plans regulated by ERISA:

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

If you are not sure which of the above processes to follow or would like more information, please contact Highmark Delaware.

HIGHMARK DELAWARE CUSTOMER SERVICE APPEALS TEAM CONTACT INFORMATION		
INTERNET: Visit our internet Customer Service Center at **highmarkbcbsde.com**	**TELEPHONE:** 302.429.0260 *northern Delaware* 800.633.2563 *all other locations*	**MAIL:** Highmark Blue Cross Blue Shield Delaware

	302.421.3411 *for the hearing impaired* 302.421.2593 *fax*	PO Box 8832 Wilmington, DE 19899-8832

LAWS & REGULATIONS

There are many federal and state laws and regulations that can affect your health benefit programs. In this section, we'll provide a summary of several key laws and regulations, including:

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Omnibus Budget Reconciliation Acts of 1986, 1989, and 1993 (OBRA '86, OBRA '89, and OBRA '93)
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and Deficit Reduction Act of 1984 (DEFRA)
- Employee Retirement Income Security Act of 1974 (ERISA) and State Mandated Benefits
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Please Note: *This section is not intended as legal advice. For questions concerning your legal obligations under these laws, you should contact your company's legal counsel.*

CONSOLIDATED OMNIBUS RECONCILIATION ACT OF 1985 (COBRA)

COBRA regulations require an employer with 20 or more full and part-time employees working 20 or more weeks in the preceding calendar year to offer continuation of group health benefits to employees and dependents for a limited period of time after their coverage would normally end.

Benefits Affected—The legislation includes all group health plans including Traditional, EPO, PPO, POS, IPA and dental programs. Continuation of coverage is only applicable to those specific benefits an employee carried on the day before the qualifying event.

Companies Excluded—COBRA laws do not apply to church related groups or the federal government.

Individuals Affected—COBRA extends coverage for 18 months to individuals who lose coverage through the following qualifying events:

- A reduction in work hours (e.g. full-time to part-time)
- Voluntary resignation
- Layoff
- Involuntary termination (other than for gross misconduct)

COBRA extends coverage for 36 months to individuals who lose coverage through the following qualified events:

- Surviving dependents of a deceased employee
- Legally separated or divorced spouses and their dependents
- Spouses (not themselves eligible for Medicare) of employees losing coverage due to becoming eligible for Medicare
- Dependents of employees who lose eligibility

COBRA extends coverage for an additional 11 months (up to 29 months in total) for individuals who are disabled under Title II or Title XVI of the Social Security Act at the time they terminated employment (or had a reduction in the number of hours of employment) or within 60 days of becoming eligible for COBRA. Such COBRA beneficiaries will be eligible for COBRA continuation coverage until they are eligible for Medicare.

Responsibilities under COBRA

Employer Responsibilities—Under COBRA, the employer must:

- Notify all employees and dependents regarding COBRA when they first become covered under your plan(s).
- Determine if an employee or dependent is no longer eligible for benefits under the company's health program and notify the employee or dependent accordingly.
- Assure that all eligible beneficiaries and/or dependents who elect continuation of coverage are properly enrolled for coverage.
- Collect premiums from individuals who have elected continuation of coverage (102% of the plan cost for active employees with similar coverage or 150% for disabled COBRA continuants for months 19 through 29).
- Monitor the time period, including the expiration of the 18-, 29- or 36-month period or the early termination of coverage, which can occur when:
  - The company terminates health coverage for all employees.
  - The individual does not pay the premium on time.
  - The individual becomes entitled to Medicare.
  - The individual joins another group health plan through re-employment, marriage or Medicare participation. (An exception may apply when the other group health program contains a pre-existing condition limitation or exclusion. In such case, the employee may be eligible to be covered under both COBRA continuation coverage and the other group health program.)
  - Permit the individual to make changes to the benefits elected at open enrollment.

Please note that many of the employer responsibilities listed above can be administered through Highmark Delaware with our COBRA administrator.

Employee Responsibilities—Under COBRA, the COBRA continuant must:

- Notify the employer of legal separation, divorce, disability, or change in dependent status within 60 days of the event.
- Pay premiums to the employer (or the employer's designated agency) if he or she elects continuation of coverage.
- Provide notification to the employer within 30 days of Social Security's final determination that the employee is no longer disabled.

Highmark Delaware Responsibilities—Under COBRA, Highmark Delaware must provide coverage and pay claims for those COBRA eligible individuals on whose behalf we receive proper premium payment for continuation of coverage under COBRA.

Consequences of Noncompliance

Administrators of plans subject to ERISA are subject to penalties for failure to provide required COBRA notices. (Note that "administrator" is defined by COBRA to mean the ERISA plan administrator who is the employer or the person specifically designated as administrator by the documents under which the plan operates.)

An excise tax of $100 per day applies during any period of noncompliance with the COBRA rules with respect to each qualified beneficiary. Where a failure occurs with respect to more than one qualified beneficiary under the plan for members of the same family, the amount of the excise tax is capped at $200 per day.

COBRA Administration Services

Keeping up with all of the requirements under COBRA can be difficult and time-consuming. That's why Highmark Delaware works with a national organization specializing in the administration of COBRA continuation of coverage. Through this arrangement, we can offer your company the following services:

Elections

- Respond to all inquiries from your qualified beneficiaries regarding COBRA continuation of coverage.
- Respond to inquiries from you or employees through a toll-free help hotline.
- Determine whether elections received by the administrator were made within the allowable 60-day period.
- Provide 24 hour-a-day, 365 day-a-year premium inquiry service.

Billing

- Administer initial 45-day and ongoing 30-day premium grace periods.
- Send a detailed monthly bill and payment envelope with request for ongoing certification of continuant eligibility.
- Send grace letters to those who do not pay within 15 days of the due date.
- Adjudicate any late payments, accepting only full and timely premium payments.
- Return via First Class mail checks that are not negotiable, if received by the administrator more than 10 days before grace expiration date.
- Call and Express Mail to continuants who send an unacceptable check within 10 days of expiration of grace period.
- Archive all correspondence, envelopes, copies of bills/checks for seven years to resolve potential disputes.
- Send cancellation notices to those who do not pay within the grace period.

Reporting

- Provide daily reports to your company whenever a continuant makes the initial COBRA premium payment or has been canceled, or a dependent has been added or canceled.
- Provide monthly reports to your company on the current status of all continuants, along with a full accounting of all premiums collected and a consolidated check.

Additional Services

- Adjudicate and process disability extension requests.
- Update policies, procedures and forms to comply with changes in COBRA law.
- Provide you with mailing labels for all COBRA continuants to assist in open enrollment communications.
- Handle multiple qualifying events (termination of employment followed by divorce, etc.).
- Mail an administration kit to the employer at time of implementation with current forms and procedures.

If you would like Highmark Delaware and our COBRA administrator to administer your COBRA benefits, contact your Account Executive.

OMNIBUS BUDGET RECONCILIATION ACTS OF 1986, 1989, AND 1993 (OBRA '86, OBRA '89, AND OBRA '93)

OBRA legislation applies to large group health plans that cover at least 100 full-time and part-time employees. OBRA made these health plans the primary payer in situations where employees or their dependents who are disabled and under the age of 65 are covered by both the company's health plan and Medicare. This means that the company's health plan pays benefits first and then Medicare supplements the company's health plan.

Applicability—If your company normally employed at least 100 full-time and/or part-time employees on a typical business day in the previous calendar year, then it is subject to OBRA.

Benefits Affected—The legislation includes group health plans such as Traditional, PPO, POS and IPA programs and prescription drug programs.

Individuals Affected—OBRA applies to:

- Disabled employees who participate in the employer's written health plan by reason of a direct employment relationship.
- Disabled dependents who participated in the employer's health plan by reason of an indirect employment relationship (that is, satisfying the company's requirements for dependent status).

OBRA does not apply to:

- Individuals who are entitled to Medicare benefits because of end-stage renal disease.
- Retired or former employees and family members of retired or former employees.
- Individuals who are eligible and enrolled in Medicare as a result of age.

Responsibilities Under OBRA

Employer Responsibilities—Under OBRA, you must:

- Determine whether your company must satisfy OBRA requirements by calculating employees working on a typical business day during the previous calendar year.
- Pay premiums equal to the amount paid for non-disabled, under-age-65 employees subject to OBRA legislation.

Employee Responsibilities—Under OBRA, the employee must:

- Notify you that he or she (or a dependent) is disabled and approved for Medicare.

Highmark Delaware Responsibilities—Under OBRA, Highmark Delaware must:

- Provide coverage and pay claims, as primary payer, for those disabled employees and dependents who are covered for health benefits because of OBRA legislation, and for whom we have received the appropriate premium.

Consequences of Noncompliance

A claimant, including an individual who received services, the provider or supplier of service, or the government, may sue a large group health plan for failure to pay primary benefits. Double damages may be imposed for noncompliance. If sued and/or found liable, Highmark Delaware reserves the right to pay and collect either the appropriate premium or the appropriate claim amount from the company and to adjust premium, if necessary, in such cases.

Companies that do not comply may have to pay an excise tax of 25% of the company's expenses incurred during the calendar year for each large group health plan to which the company contributes.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) AND DEFICIT REDUCTION ACT OF 1984 (DEFRA)

TEFRA/DEFRA legislation requires that employers with 20 or more employees make available to active employees or their spouses age 65 through 69 the same health coverage as that offered to employees under age 65. COBRA later amended these rules to extend the provision to apply to employees or their spouses over age 69.

Companies Affected—If your company normally employs at least 20 full-time and/or part-time Employees for each working day in at least 20 calendar weeks in the current or previous year, then it is subject to TEFRA/DEFRA.

Benefits Affected—The legislation encompasses all group health plans such as Traditional, PPO, POS and HMO programs as well as dental, vision and prescription drug plans.

Companies Excluded—TEFRA/DEFRA do not apply to the federal government.

Individuals Affected—TEFRA/DEFRA applies to:
- Active employees age 65 and over
- Spouses age 65 or older of active employees

TEFRA/DEFRA does not apply to:
- Retired employees
- Spouses of retired employees (unless the spouse is an active employee of a company to which TEFRA applies)

Responsibilities Under TEFRA/DEFRA

Employer Responsibilities:

Under TEFRA/DEFRA, you will need to determine if TEFRA/DEFRA legislation applies to your company. If so, your company must:

- Notify employees, in writing, of the opportunity for them to choose Medicare or the health plan as the primary payer of health coverage.
- Complete an Account Trasmittal Report to request a change from Regular to TEFRA contract type.

Please note: *The law prohibits a covered employer from offering employees Medicare supplementary coverage or Carveout coverage.*

Employees who choose Medicare as their Primary payer are not eligible to retain group coverage under your company. They may obtain supplementary coverage on their own on an individual (non-group) basis.

Employee Responsibilities:

Under TEFRA/DEFRA, the employee must:

- Notify the employer that he or she is eligible for Medicare.
- Choose his or her primary payer, either Medicare or your company's health plan.

Highmark Delaware Responsibilities:

Under TEFRA/DEFRA, Highmark Delaware must:

- Provide coverage and pays claims as primary payer for those employees electing your company's health plan as primary payer, provided we have received the appropriate premium.

Consequences of Noncompliance

If your company provides Medicare Supplement coverage or Carveout coverage in violation of Federal law, Highmark Delaware may collect from your company the difference between the amount of premium paid and the amount that should have been paid for primary coverage for the entire period during which the prohibited coverage was provided.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) AND STATE MANDATED BENEFITS

ERISA is part of the Federal Internal Revenue Code that provides laws that govern virtually all private sector employee pension and welfare benefit plans. The passage of ERISA displaced state laws that governed such benefit plans.

For the purposes of health care benefit programs, benefit plans offered by employers who are covered by ERISA are subject to certain guidelines that promote the rights of participants. Such plans are required to offer certain health care benefits that may be mandated by state governments.

Who is not covered by ERISA

- Church Plans
- Government Agencies

State Mandates

Delaware, like other states, has enacted laws that require health benefit programs to cover certain specific benefits. These laws may "mandate" that plans pay for a particular service, reimburse a type of specialty, and so on. They usually apply to all programs complying with this type of state law.

The following mandates apply to employee benefit programs unless the program is exempted by ERISA (i.e. self funded):

Please note: There may be limitations, such as copays and deductibles, on what is covered under the mandates. Please check your benefits manual.

- Assistant at Surgery Services
- Breast Reconstruction after Mastectomy
- Cervical Cancer Screening (Pap Smear)
- Childhood Immunizations
- Chiropractor Services
- Clinical Trials
- Colorectal Cancer Screening
- Contraceptives by Prescription
- Coordination of Benefits Guidelines
- Dependent child coverage to age 24
- Diabetic Supplies and Equipment
- Direct Access to Network OB/GYN
- Extension of Benefits Regulations
- Hearing Aids for Dependant Children to Age 24
- Lead Poisoning Screening
- Mammography Screening
- Mental Health Parity
- Midwife Services
- Minimum Maternity Hospital Stays
- Multiple Surgical Procedures
- Nurse Practitioner Services
- Ovarian Cancer Monitoring
- Patient's Bill of Rights
- Pharmacy: (Any Willing Provider)
- Prostate Cancer Screening (PSA Test)
- Substance Abuse Parity

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains health insurance reforms intended to increase portability of health coverage.

HIPAA established a number of new requirements of health plans and employers. These are described below.

Privacy and Security of Health Information

The HIPAA Administrative Simplification rules address the privacy and security of your employees' Protected Health Information (PHI). We may use or disclose PHI only as permitted or required by the rules or with employees' authorization. We are also required to have in place physical, technical and administrative safeguards for the protection of your information. For more information on our Privacy Practices, please refer to our *Notice of Privacy Practices*.

Standard Transactions

HIPAA also created rules relating to the electronic transfer of information. Certain transactions that are done electronically, such as claims submissions and eligibility inquires, must be in a standardized format throughout the health care industry. This provision of HIPAA was intended to reduce costs and simplify the process of payment for health care.

Enrollment Portability Categories

As described in Section 3: Eligibility & Enrollment, HIPAA defines potential enrollees as either Timely Enrollees, Late Enrollees, or Special Enrollees. These categories indicate when an enrollee can apply for coverage.

Pre-existing Condition Waiting Periods

HIPAA limits the maximum waiting period for pre-existing condition limitations to 12 months for Timely Enrollees and Special Enrollees (from the date of hire into an employee class eligible for coverage) and 18 months for Late Enrollees. See Section 3: Eligibility & Enrollment for more information about pre-existing condition waiting periods.

Crediting Prior Coverage

The length of any pre-existing condition waiting period may be reduced or satisfied by crediting prior "creditable coverage" which the employee or dependent had with another health plan. Credit for prior coverage may be granted provided the lapse in coverage between plans does not exceed 62 days. For more information, see Section 3: Eligibility & Enrollment.

Certificates of Coverage

Under HIPAA, employers are required to provide employees with a Certificate of Coverage when canceling coverage, when COBRA continuation of benefits has been exhausted, and upon request in the 24 months following cancellation of coverage. The Certificate of Coverage describes the health benefits under which the employee and his or her dependents were enrolled for the 18 months prior to the date of cancellation of the health policy.

Individuals may present the Certificate of Coverage when applying for a new health plan to obtain credit towards any pre-existing condition waiting period. For more information, see Section 3: Eligibility & Enrollment.

COBRA Changes

Individuals disabled within the first 60 days of COBRA continuation of benefits qualify for an extension to 29 months of coverage. Previously, the extension to 29 months was granted only if the individual was disabled when first becoming eligible for COBRA.

In addition, dependents may be enrolled for COBRA coverage in the event of birth, adoption, or placement in the home for adoption. Enrollment must be made within 30 days of the event.

A Certificate of Coverage must be provided when COBRA benefits are exhausted. COBRA benefits are considered "creditable coverage" towards a preexisting condition waiting period with a new plan.

HIPAA Enforcement

Penalties of $100 per day per aggrieved person will be applied against the employer for failing to meet the portability requirements.

What Highmark Delaware Can Provide

Highmark Delaware has modified benefit offerings to be compliant with HIPAA requirements.

We can provide the Certificate of Coverage for your employees and dependents when their coverage with Highmark Delaware ends. Please call your Account Executive to discuss arrangements and fees.

Nondiscrimination Requirements

HIPAA provides that employers and insurers cannot base eligibility or continued eligibility on health status, medical condition, claims experience, medical history, receipt of health care, genetic information, evidence of insurability, or disability.

MEDICARE PART D
AND PRESCRIPTION DRUG COVERAGE

On December 8, 2003, President Bush signed the Medicare Prescription Drug Improvement and Modernization Act (MMA) into law, significantly expanding Medicare by adding voluntary prescription drug coverage under a new Medicare Prescription Drug Program called Part D. Part D was effective on January 1, 2006, and is offered by either a stand-alone prescription drug plan or through a Medicare Advantage plan that includes prescription drug coverage.

The MMA requires all group accounts who offer a prescription drug benefit to determine if that coverage is "creditable."

Creditable Coverage

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) will provide all group accounts with information about the status of their prescription drug coverage each fall. This will indicate whether your drug program is "creditable" ("as good or better" than that being offered through Part D) or "not creditable" ("not as good" as that being offered through Part D) as determined by Highmark Delaware based on Medicare Guidelines.

A group account that covers Medicare-eligible persons and offers prescription drug coverage must notify the Centers for Medicare & Medicaid Services (CMS) of whether the coverage they offer is "creditable" or "not creditable." They must also notify each Medicare-eligible subscriber as to whether his or her current prescription drug coverage qualifies as "creditable" under the Part D rules. If the coverage is "not creditable," the notice must also explain that there are limits on when the individual may enroll in a Part D plan during the year, and that he or she may be subject to a late enrollment penalty under Part D should he or she choose to enroll at a later date.

Based on the information that you provide, these individuals must then decide whether to enroll in Part D.

Notices must be provided to Medicare-eligible active employees, retirees and dependents annually **before November 15 of each year**. The notice must also be provided:

a. before each individual's initial enrollment period for Part D,
b. before the effective date of enrollment in the prescription drug coverage offered by the employer,
c. upon any change that affects whether the coverage is creditable and
d. upon request.

The present guidelines and notice format are available at the following website:
www.cms.hhs.gov/CreditableCoverage/
(Select "Creditable Coverage Guidance and Notices for Use After May 15, 2006" from the left side of the screen.) Please note that there are specific government directives about what must be included in this notice.

If you have specific questions regarding your Part D obligations, Highmark Delaware encourages you to consult with legal and tax advisors who are familiar with your particular business needs. For additional information regarding the MMA and how it affects employers, please refer to the following CMS website: www.cms.hhs.gov/EmplUnionPlanSponsorInfo/

NOTICE OF PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

This notice applies to members of fully insured groups and individual policies only. If you are a member of a self-insured group, while we continue to safeguard your protected health information with the same safety mechanisms, you will be getting a Notice of Privacy Practices from your group health plan. If you are unsure if you are a fully insured or self-insured member, please contact your group administrator.

This notice applies to the privacy practices of Highmark Blue Cross Blue Shield Delaware (Highmark Delaware). We might share your protected health information and the protected health information of others on your insurance policy as needed for payment or health care operations.

Our Legal Duty

This notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle and protect our members' protected health information. Protected health information includes facts that identify you personally, such as your name and social security number, as well as information regarding your health care, including diagnoses, doctors who have treated you, etc.

The federal government regulates health care privacy primarily under the HIPAA Privacy Regulations. In this notice, we will call those HIPAA rules the "federal Privacy Regulations."

We are required by law to maintain the privacy of your protected health information. We also are required to give you this notice about our privacy practices, our legal duties and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers within 60 days of the effective date of the change.

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.

Uses and Disclosures of Medical Information

Primary Uses and Disclosures of Protected Health Information—We use and disclose protected health information about you for payment and health care operations. The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example,

where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment: We might use and disclose your protected health information for all activities that are included within the definition of "payment" as written in the federal Privacy Regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others that are covered by your health plan. We also might use your information to determine your eligibility for benefits, coordinate benefits, examine medical necessity, obtain premiums and issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We might use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the federal Privacy Regulations. For example, we might use and disclose your protected health information to determine our premiums for your health plan, conduct quality assessment and improvement activities, engage in care coordination or case management, and manage our business.

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, our 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.

Other Covered Entities: We might 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 components of their health care operations. For example, we might disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might 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.

NOTICE OF PRIVACY PRACTICES continued

Other Possible Uses and Disclosures of Protected Health Information—The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information:

To You or With Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we might not use or disclose your protected health information for any reason except those described in this notice.

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 (DHHS) when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.

To Plan Sponsors: Where permitted by law, 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 seeking information to evaluate future changes to your benefit plan. We also may disclose summary health information (this type of information is defined in the federal Privacy Regulations) 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.

To Family and Friends: If you agree (or if you are unavailable to agree), such as in a medical emergency situation, we might disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care.

Underwriting: We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

NOTICE OF PRIVACY PRACTICES continued

Health Oversight Activities: We might 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.

Abuse or Neglect: We might disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.

To Prevent a Serious Threat to Health or Safety: Consistent with certain federal and state laws, we might 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.

Coroners, Medical Examiners, Funeral Directors and Organ Donation: We might disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye or tissue donation and transplantation.

Research: We might disclose your protected health information to re-searchers 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.

Inmates: If you are an inmate of a correctional institution, we might 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.

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

Public Health and Safety: We might disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required By Law: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to DHHS upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings: We might disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we might disclose your protected health information to law enforcement officials.

Law Enforcement: We might disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We might disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful counterintelligence, intelligence and other national security activities.

Other Uses and Disclosures of Your Protected Health Information: 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 in reliance on your authorization.

Individual Rights

Access: You have the right to look at or get copies of the protected health information contained in what the federal Privacy Regulations define as a "designated record set," with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You also may request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we might 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, but we might charge a fee to do so.

We might deny your request to inspect and copy your protected health information in certain limited circumstances. 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. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your re-quest and the denial. The person performing this review will not be the same person who denied your initial request.

NOTICE OF PRIVACY PRACTICES continued

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to six years before the date of your request, but in no event for disclosures made before April 14, 2003.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication: 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. This means that you may request that we send you information by alternative means, or to an alternate location. We may accommodate your request if it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a confidential communication by writing to us using the information listed at the end of this notice.

Amendment: 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 with 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.

Electronic Notice: Even if you agree to receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the e-mail transmission has failed, and Highmark Delaware is aware of the failure, then we will provide a paper copy of the notice to you.

NOTICE OF PRIVACY PRACTICES continued

Questions and Complaints

Information on Highmark Delaware Privacy Practices—If you want more information about our privacy practices or have questions or concerns, please call the Customer Service number on your card.

Filing a Complaint—If you are concerned that we might have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to DHHS. We will provide you with the contact information for DHHS 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 DHHS.

Highmark Delaware Contact Information

Privacy Office
Highmark Blue Cross Blue Shield Delaware
PO Box 8835
Wilmington, DE 19899-8835

DEFINITIONS

Account or Group: An entity providing benefit plans to a group of employees.

Account Administrator: You, the person named by your employer to manage the program and answer questions about program details.

Account Contract: A legal agreement which describes the relationship between an account and Highmark Delaware and which expresses financial arrangements, premium, eligibility, benefits and other provisions of the coverage for a group of employees.

Account Executive: The Highmark Delaware employee who is the liaison between the account and Highmark Delaware.

Account Number: Number assigned to your account by Highmark Delaware to distinguish it from other accounts.

Account Transmittal Report: The form submitted by the Account to Highmark Delaware showing employee and dependent additions, changes and cancellations.

Allowable Charge: The price Highmark Delaware determines is reasonable for care and supplies.

Allowable Expenses: For the purpose of interpretation of the Coordination of Benefits provision, it means a necessary, reasonable and customary health care expense when the expense is covered at least in part by one or more contracts covering the individual for whom the claim is made.

Highmark Delaware: Highmark Blue Cross Blue Shield Delaware.

Billing Representative: The person at Highmark Delaware who handles questions and concerns regarding premium, billing, late payment policy, and coverage changes for accounts.

Carveout Coverage: A health benefits approach designed to supplement Medicare coverage after an employee (or his or her spouse) has reached age 65 and is enrolled in Medicare Parts A and B. It is designed to provide the same level of health benefits the individual had before he or she became eligible for Medicare. Medicare is the primary payer; Highmark Delaware is the secondary payer.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): A program administered by the Department of Defense, which pays for care delivered by civilian health providers to retired members, and dependents of active and retired members, of the uniformed services of the United States.

Claim: A request for payment for benefits received or services rendered.

Coinsurance: The percent of allowable charges the customer pays. If Highmark Delaware pays a benefit at 80%, the customer's coinsurance is 20%.

Coinsurance Expense Limit: The total amount of coinsurance the customer pays. When the limit is reached, Highmark Delaware payments increase to 100% of allowable charges for the remainder of the plan year. The limit does not include the deductible, co-payments, amounts over the allowable charge, or charges for non-covered care.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): COBRA rules pertain to accounts with 20 or more full and/or part-time employees and provide for the continuation of coverage option to employees or dependents for a limited period if group coverage is lost due to death, termination, divorce, or other specified events.

Contract Renewal Date: The date of the beginning of a contract term, usually 12 months in duration.

Contribution Waiting Period: The length of time the employee must wait from his or her date of employment to the date the employer begins making contributions to the health or dental care plan.

Conversion Privilege: The privilege granted by a group health plan to convert to an individual (Direct Billed) health plan upon termination of group coverage. Highmark Delaware offers 3 types of Direct Billed plans:

- Medically Underwritten—the applicant must satisfy Evidence of Insurability.
- Conversion—the applicant does not need to satisfy Evidence of Insurability.
- Portability—the applicant must have 18 months of prior Creditable Coverage and enroll no later than 63 days after the group plan ends.

Coordination of Benefits (COB): The non-duplication contract provision which establishes the order in which plans pay benefits, when two or more group benefit plans provide coverage. The amount of benefits payable under all plans are coordinated so the aggregate amount paid will not exceed 100% of Allowable Expenses.

Co-payment: The flat dollar amount the insured pays to the provider at the time of service in return for the provision of certain specified services.

Customer Service Representative: The person at Highmark Delaware who handles benefit questions and concerns for Employees regarding their Health and Dental plans.

Date of Notification: The date an enrollment request is US Postmarked, faxed, or phoned in to Highmark Delaware.

Deductible: The amount paid by the customer before benefits are applied.

Dependent: An employee's spouse to whom he/she is legally married. Dependent also means an unmarried child born to or legally adopted by the employee and his/her spouse, who is placed in the home for adoption, or for whom health care coverage is provided because of a qualified medical child support court order. For a child to be an eligible dependent, he/she must be unmarried, dependent upon the employee or the employee's spouse for at least 50% of support, and under the maximum age limit established by the employer.

Direct-Billed Coverage: An individual (non-group) health plan which is billed directly to and paid by the individual.

Disability: Physical or mental handicap resulting from sickness or injury.

Duplication of Benefits: Overlapping or identical coverage for the same individual under two or more health plans, often the result of contracts with different insurance companies, or pre-payment plans; also known as multiple coverage.

Durable Medical Equipment: 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.

Effective Date: The date on which the coverage under a benefit plan begins or terminates.

Effective Date of Coverage Enrollment/Cancellation Practice: The method used by an account to determine which effective dates to request when enrolling and canceling employees and their dependents. There are two practice options: First Of The Month (FOM) practice and Other Than First Of The Month (OTFOM) practice.

Effective Date Policy: A set of procedures and time requirements for submissions of account changes, additions and cancellations. This policy determines the effective date of employee and dependent enrollments, cancellations and changes based on existing contract provisions and the notice date of specified information from the account.

Eligible Employees: Those members of an account who have met the eligibility requirements under a group benefit plan.

Eligibility Waiting Period: The length of time the employee must wait from his or her date of employment to the date the employee's coverage becomes effective. Sometimes called "Probationary Period."

Employee Booklet: A booklet for the employee that contains a general explanation of benefits and related provisions of the plan.

Employee Retirement Income Security Act of 1974 (ERISA): ERISA contains provisions to protect the interests of group insurance plan participants and beneficiaries. It requires, among other things, that insurance plans be established pursuant to a written instrument that describes the benefits provided under the plan, names the persons responsible for the operation of the plan, and spells out the arrangements for funding and amending the plan.

Evidence of Insurability: Statement of an employee's or dependent's physical condition and/or other factual information affecting his or her acceptance for health insurance.

Family Coverage: Coverage for the employee, the spouse of the employee, and any eligible dependent children of the employee.

Family Deductible: A deductible that is satisfied by the combined expenses of covered family members.

Fee-For-Service: A means of billing by health or dental providers for each service performed, referring to payment in specific amounts for specific services rendered (as opposed to capitation, retainer, salary or other contract arrangements).

Field Service Representative: The Highmark Delaware employee who handles the administration for an account and who, along with the Account Executive, is available to answer questions.

First Of The Month (FOM) Practice: The Effective Date of Coverage Enrollment/ Cancellation Practice where initial enrollment of employees (and their dependents) and subsequent enrollment of dependents are requested by the account with an effective date of the first of the month following the event, and cancellations of employees and/or dependents are requested by the account with an effective date of the last day of the month.

Group: See **Account**.

Health Maintenance Organization (HMO) Plan: A plan to deliver health or dental care through a panel of primary care physicians (PCP) or primary care dentists (PCD). The PCP or PCD in conjunction with Highmark Delaware is the manager of the patient's health or dental needs. Referrals to other providers (such as a hospital or specialist) must have PCP or PCD approval. There is no coverage when the customer fails to get PCP or PCD authorization for care. Highmark Delaware's health HMO plan is called "Blue Care"; the dental HMO plan is called "Dental Health Plus."

Identification Card: The card issued by Highmark Delaware to the employee as evidence of enrollment. It shows the name and number of both the account or association, and the Employee.

Indemnity Schedule: Predetermined allowances for each medical, surgical, or dental procedure where the maximum payment is made in accordance with the schedule.

Individual and Child(ren) Coverage: Coverage that provides benefits for the employee and (an) eligible child(ren). Also referred to as "Employee and Child(ren)" coverage.

Individual Coverage: Coverage that provides benefits only for the employee. Also referred to as "Employee" coverage.

Inside Sales Specialist: The Highmark Delaware employee who handles account administration.

Late Payment Policy: The set of procedures established by Highmark Delaware to determine claims suspension, late interest charges and account cancellation when premiums are not paid by the due date.

Line of Business: The different types of benefit plans provided to the employees. For example, PPO health coverage is one line of business; Traditional dental, another.

Marketing Representative: The Highmark Delaware Account Executive who is the liaison between your account and Highmark Delaware.

Medicare: Medicare is the U.S. federal government plan for paying certain hospital and medical expenses for those who qualify, primarily those 65 and over. Part A is compulsory insurance pertaining to hospital expenses. Part B covers certain other medical expenses. Enrollment under Part B is voluntary, and requires payment of a premium. The employee or dependent is not eligible for Medicare Supplement coverage with Highmark Delaware unless he or she is enrolled in and retains Medicare Parts A and B.

Medicare Supplement Coverage: Highmark Delaware's health insurance plan designed to supplement Medicare coverage after an Employee has retired or has become eligible for Medicare as a result of disability. Medicare is the primary payer; Medicare Supplement is the secondary payer. An employee or dependent must be enrolled in and retain Medicare Parts A and B to be eligible for Medicare Supplement coverage.

Member Enrollment/Change Application: A form required by Highmark Delaware and completed by the employee to initiate coverage in a health/dental plan, to change coverage (such as Traditional to HMO), to change contract type (such as individual to family or to add/cancel dependents), or to change personal information.

Nonparticipating Provider: A provider who has not entered into a contract with Highmark Delaware, and who can bill the member for any difference between full charges and the Highmark Delaware allowable charge.

Notice of Benefits (NOB): A form sent to the employee after a claim for payment has been processed by Highmark Delaware that explains the action taken on that claim. This explanation might include the amount paid, the benefits available, reasons for deny payment, the claims appeal process, and so forth.

Omnibus Budget Reconciliation Act of 1986 (OBRA): OBRA rules pertain to accounts with at least 100 full- or part-time employees. OBRA provisions make group health benefit plans the primary payer where disabled Employees or disabled dependents under age 65 are covered by both the group's health plans and Medicare.

Other Than First of the Month Practice (OTFOM): The Effective Date of Coverage Enrollment/Cancellation Practice where initial enrollment/cancellation of employees (and their dependents) and subsequent enrollment of dependents are requested by the account with an effective date equal to the date of the event.

Paid to Date: The date corresponding to the last day of the period for which premium has been paid.

Participating Provider: A provider with a Highmark Delaware participating contract. Participating providers may not bill the customer over the allowable charge for a covered service. Not all participating providers are preferred providers.

Participation Percentage: The percentage of eligible employees who are actually enrolled in Highmark Delaware's combined health programs.

Pre-existing Condition: A condition the customer had before the enrollment date. The condition includes any disease, disorder, illness, or injury for which a health care provider made a diagnosis or advised Treatment, or for which the customer had care or Treatment within the six-month period prior to the enrollment date. Pregnancy is not considered a pre-existing condition under group, or conversion or medically underwritten Direct Billed plans. Under Direct Billed portability plans, pregnancy is considered a pre-existing condition.

Preferred Provider: A provider with a contract to participate in Highmark Delaware's preferred network.

Primary Care Physician (PCP): A physician who has entered into a contract with Highmark Delaware to provide health care to HMO or POS customers.

Primary Payer: Under the Coordination of Benefits provision, the plan under which benefits are determined before those of the other plan and without considering the other plan's benefits.

Probationary Period: The Eligibility Waiting Period or Contribution Waiting Period.

Provider: The organization or person performing or supplying health or dental services. Providers include hospitals, doctors, pharmacies, physical therapists, etc.

Reinstatement: The resumption of coverage under a contract which has been cancelled due to nonpayment of premium.

Reopening Period: A period, usually annually, during which employees in a health or dental

benefit program have an opportunity to select an alternate health or dental plan being offered to them, such as changing from a Traditional plan to a PPO program. The Reopening Period also provides an opportunity for eligible employees (and dependents) to enroll if they did not do so previously.

Secondary Payer: Under the Coordination of Benefits provision, the plan under which benefits are determined after those of the other plan.

Subrogation: If the employee has a right to recovery against any person or organization based upon a legal claim (whether or not he or she asserts that claim), and if the legal action or claim involves medical expenses or services which Highmark Delaware paid for or provided under any of its benefit programs, Highmark Delaware is subrogated to all the employee's rights of recovery against that person or organization. This means that Highmark Delaware is entitled to reimbursement from that person or organization.

Tax Equity and Fiscal Responsibility Act of 1982 and Deficit Reduction Act of 1984 (TEFRA/DEFRA): TEFRA was enacted to prevent discrimination against elderly employees with regard to health insurance. It amended the Age Discrimination in Employment Act to make Medicare secondary to employer group health plans for active employees aged 65 through 69. DEFRA extended the provisions of TEFRA to include employee's dependents aged 65 through 69. COBRA removed the age 69 cap for employees and dependents. TEFRA/DEFRA requires accounts with 20 or more Employees to offer employees and dependents aged 65 and over the same coverage as that available to younger employees.

Traditional Dental Insurance: A fee-for-service insurance plan to cover some of the expenses resulting from dental care treatment.

Traditional Plan: A health plan where the customer may go to any provider he or she chooses. It is sometimes called an "Indemnity" plan. Highmark Delaware's traditional health plan is called "Blue Classic."

Waiver of Pre-existing Condition Limitation: A waiver whereby employees are not required to observe a waiting period in order to claim benefits for a pre-existing condition. The waiver can apply to all employees, including new hires, or to only those employees enrolled on the original effective date of the plan.

We, Us, Our: Highmark Blue Cross Blue Shield Delaware (Highmark Delaware).

Written Health Plan: For Highmark Delaware's administrative and auditing purposes, an account's written plan which defines the classes of eligible employees, eligibility requirements and waiting periods, types of coverage, benefit descriptions, and any other information pertinent to the plan.

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