Highmark Blue Cross Blue Shield Delaware
Individual Application Checklist

Thank you for your interest in Highmark Blue Cross Blue Shield Delaware's Individual Insurance plans. To apply for coverage, please follow the instructions below.

1. Print the following application form.

2. Please complete all fields of this form in black or blue ink.

3. In Section I. of the application labeled "Applicant Information," please indicate the date that you would like the coverage to begin under the question "If you are approved, please provide the date you would like your coverage to begin." Please note that coverage can begin on the first or the fifteenth of a month provided that all paperwork is received fifteen days early (for example, to obtain a first of a month start date, paperwork must be received prior to the fifteenth of the prior month). Additionally, coverage is dependent upon health underwriting.

4. Please be certain to sign the application.

5. If you are selecting the Health Savings Account with Bancorp Bank, please complete and sign The "MyAdvantageHSA™ Health Savings Account Declaration" and "MyAdvantageHSA™ Authorization for Release of Information." Please note that these 3 pages are only necessary if you are applying for a H.S.A. plan **and also** opening the Health Savings Account with Bancorp Bank.

6. Once complete, please mail or email this application to the address or email below. At this time, Highmark Blue Cross will mail a monthly bill.

IFS Benefits, LLC
220 Continental Drive, Suite 209
Newark, DE 19713
Attention: Markie Mitchell
Email: mmitchell@ifs-benefits.com.

7. The final page to the application is an Attending Physician Statement (APS). This is a form that Blue Cross typically requests from your physician. Should you choose to, you can proactively take this form to your doctor to be completed and send a copy to us.

If you have any questions regarding the plans or the application process, please don't hesitate to contact me at 302-652-2355 x 137

HIGHMARK. Delaware

Highmark Blue Cross Blue Shield Delaware
ATTN: Underwriting Services, 1-8-10
PO Box 1991, Wilmington, DE 19899-1991
Fax: 302.421.2161

BLUE INDIVIDUAL
Application for Individual Coverage
Medically Underwritten—Subject to Approval

INSTRUCTIONS

- Complete this form and send to the address above.
- Form must be signed. An updated application will be required if the entire application process is not completed within 90 days of the date you signed this form.
- Incomplete applications will be returned. If additional information is needed from a physician, please allow four to six weeks to complete the process.
- Use a separate sheet of paper if more space is needed.
- To add a dependent or change coverage to a higher coverage level option, complete the entire application. To cancel a dependent or change to a lesser coverage level option, complete a *Change in Coverage* form.
- Make check or Money Order payable to Highmark Blue Cross Blue Shield Delaware.

IMPORTANT INFORMATION (Please read carefully.)

- **Do not cancel your current health care coverage until you have been informed of your approval.**
- Coverage is not guaranteed. Some or all persons on this application may be denied.
- The oldest applicant accepted will be the contract holder.
- **Please note:** Benefits include a 12-month preexisting waiting period. Individuals under age 19 will not be subject to a preexisting waiting period. If you have prior Blue Cross Blue Shield coverage (with no lapse), please submit your Certificate of Coverage to reduce this waiting period (with this application or send to the address above).

ELIGIBILITY

- A Delaware resident between the ages of 19 to 64;
- Not enrolled in or eligible for Medicare; and
- If a non-citizen resident of the U.S., must have resided in the U.S. for six consecutive months

I. APPLICANT INFORMATION. List all persons applying.

Last Name	First Name	M.I.	Date of Birth	Relationship	Social Security No.	Height	Weight
				Self: ☐ Male ☐ Female			
				☐ Spouse* ☐ Son ☐ Daughter			
				☐ Son ☐ Daughter			
				☐ Son ☐ Daughter			

Mailing Address: Number Street City State Zip Code

Home Phone: ( ) Business Phone: ( ) Are you married? ☐ Yes ☐ No

May we contact you by email? If yes, please provide your email address:

Employment information must be completed for you and your spouse, even if spouse is not applying for coverage.

Applicant's Employer: _____ Self-employed? ☐ Yes ☐ No Occupation: _____ ☐ Full-time ☐ Part-time

Spouse's Employer: _____ Self-employed? ☐ Yes ☐ No Occupation: _____ ☐ Full-time ☐ Part-time

If you are approved, please provide the date you would like your coverage to begin: ☐ 1st ☐ 15th

I am only interested in coverage if all persons on this application are approved: ☐ Yes ☐ No

HIGHMARK DE USE ONLY	Effective Date: ____/____/____			
GENERAL AGENT USE ONLY	Agent Name: Atlantic States United Brokerage, Inc	Agent No.: 241		
BROKER/PRODUCER USE ONLY	1). Did you review the completed application with the applicant(s)? ☐ Yes ☐ No	If No, please explain:	2). Are you aware of any undisclosed or misrepresented information on this application that would have an impact on Highmark DE's decision to approve or deny the applicant(s)? ☐ Yes ☐ No	If Yes, please explain:
Broker Name (Print): Markie Mitchell	Broker Signature:		Broker Number: 6104	Date:

*Effective January 1, 2012, Highmark DE's definition of spouse includes civil union partners for all group and individual insured policies.

II. COVERAGE LEVEL AND BILLING CYCLE. Check one option. Information shows single/family deductible amounts, and the level of coverage once the deductible is met.

Coverage level:

☐ BlueIndividual EPO $30 - $1,200/$2,400 ☐ BlueAdvantage HSA PPO - $1,800/$3,600 ☐ BlueAdvantage HSA EPO - $2,000/$6,000

☐ BlueIndividual EPO $40 - $2,400/$4,800 ☐ BlueAdvantage HSA PPO - $3,000/$6,000 ☐ BlueAdvantage HSA EPO - $3,000/$9,000

Choose billing cycle: ☐ Monthly ☐ Quarterly (Direct Billing - January, April, July, October)

III. INSURANCE INFORMATION. CHECK ANSWER THAT BEST APPLIES.

1. ☐ I have no health insurance coverage now and am applying for new coverage.
   ☐ I am an existing Highmark DE Individual customer and want to change my coverage. (See choices below).
   ☐ Add a dependent ☐ Change coverage level
   ☐ I am currently enrolled with Highmark DE through a group or association. ID Number: _____
   ☐ I am currently enrolled with another carrier. Name of carrier: _____
   ☐ I am currently enrolled with another Blue Cross and Blue Shield plan. Name of plan: _____
   My current health care coverage will end on ____/____/____. If approved, will this policy replace current coverage? ☐ Yes ☐ No
2. Is anyone listed on this application eligible for Medicare? ☐ Yes ☐ No
   If "Yes," please provide the name(s) of family member(s): _____
3. Please list below anyone on this application who:
   • has not had any health insurance for the past 12 months: _____
   • previously applied for health insurance in the past three years and was denied for medical reasons: _____

IV. HEALTH STATEMENT.

Because this coverage is medically underwritten, we need your complete and accurate answers to all of the following health questions. Highmark DE has a duty to report insurance fraud to the Fraud Bureau of the Delaware Department of Insurance. For each family member applying, list all of the information below for the last visit with his/her physician.

Applicant Name	Date of Visit	Symptom or condition	Results of Visit – Provide Details	Complete Physician Name and Address

Has any person included on this application had any known indication, diagnosis or treatment within the last seven years of any of the conditions listed below? **Please check "Yes" or "No" for each question.** If "Yes," circle the appropriate condition. Answering "Yes" will not necessarily result in rejection of your application. Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling.

	Yes	No	Relevant Person Applying
1. Any cancer, cysts, tumors or unusual growths?	☐	☐	
2. Any metabolic or endocrine conditions/disorders *(examples: diabetes, adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, chronic fatigue syndrome, AIDS or any immune disorder)*?	☐	☐	
3. Any alcohol, drug or substance abuse or dependency, or been advised to reduce alcohol or drug intake?	☐	☐	
4. Any disorder of the circulatory system or heart *(examples: aneurysm, chest pain, elevated cholesterol level, heart attack, heart murmur, high blood pressure, irregular heart beat, phlebitis, rheumatic fever, stroke or varicose veins)*?	☐	☐	
5. Any emotional or psychological disorders *(examples: adjustment disorder, anxiety, attention deficit disorder, depression, obsessive-compulsive disorder, schizophrenia or attempted suicide)*?	☐	☐	
6. Any disorder of the lungs or respiratory system *(examples: allergy, asthma, chronic obstructive pulmonary disease, emphysema or tuberculosis)*?	☐	☐	
7. Any disorder of the kidney or urinary system *(examples: cystitis, renal failure, kidney stones, nephritis, prostatitis or recurring bladder infections)*?	☐	☐	
8. Any disorder of the brain or nervous system *(examples: epilepsy, seizures, head trauma, migraines, multiple sclerosis or paralysis)*?	☐	☐	
9. Any disorder of the digestive system *(examples: cirrhosis, chronic constipation, colitis, esophagitis, gall bladder/stones, hemorrhoids, chronic acid reflux, hepatitis or ulcer)*?	☐	☐	
10. Any disorder of the muscles or skeletal system *(examples: arthritis, bursitis, carpal tunnel syndrome, gout, back or spine trouble, external deformity, osteomyelitis, osteoporosis, rheumatism, or scoliosis)*?	☐	☐	
11. Any disorder of the skin *(examples: collagen disorder, eczema or psoriasis)*?	☐	☐	
12. Any disorder of the blood *(examples: anemia, hemophilia, leukemia or sickle cell)*?	☐	☐	

	Yes	No	Relevant Person Applying
13. Any breast or gynecological disorders *(examples: endometriosis, infertility, irregular menstruation, or breast condition)*?	☐	☐	
14. Any venereal disease *(examples: gonorrhea, herpes or syphilis)*?	☐	☐	
15. Any disorders of the eye, ear, nose or throat *(examples: allergy, deafness, cataracts)*?	☐	☐	
16. Any of the following conditions or procedures: Alzheimer's disease, cystic fibrosis, Hodgkin's disease, muscular dystrophy, myasthenia gravis, palsy, Parkinson's disease or polio?	☐	☐	
17. Any congenital conditions?	☐	☐	
18. Any premature births, caesarean deliveries, or miscarriages?	☐	☐	
19. Is any person named on this application currently pregnant, expecting a baby or in the process of adoption or surrogacy? If "Yes," please fill in expected delivery or adoption date below	☐	☐	
Expected delivery or adoption date: _____ / _____ / _____			
20. Any motor vehicle accident involvement in the last three years?	☐	☐	
21. Is any applicant an organ transplant recipient or currently on a transplant waiting list?	☐	☐	
22. Any abnormal test or physical exam results, or is any applicant currently awaiting test results?	☐	☐	
23. Any advice by a physician to undergo additional testing or treatment that has not yet been sought?	☐	☐	
24. Any scheduled surgery or hospital admission within the next six months?	☐	☐	
Please list the condition: _____			
Date of scheduled surgery or hospital admission: _____ / _____ / _____			
Attending physician: _____			
25. Any tobacco use (smoked, snuffed or chewed tobacco) at any time during the past 24 months?	☐	☐	
26. Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment (including medical, surgical, hospital, emergency, or urgent care) was sought?	☐	☐	
27. Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment was not sought?	☐	☐	

- If you answered "Yes," to any of the questions above, please enter details below. (If more space is required, use a separate piece of paper.)
- All questions must be answered "Yes" or "No," or your application will be returned.
- Failure to disclose conditions may result in voiding of coverage and denial of benefits.

Applicant Name	Question No.	Illness or condition	Last Treatment	Operation	Complete Attending Physician Name and Address
			Month Year /	☐ Yes ☐ No	
			Month Year /	☐ Yes ☐ No	
			Month Year /	☐ Yes ☐ No	
			Month Year /	☐ Yes ☐ No	

- Has anyone included in this application been prescribed medications in the last 12 months? (If "Yes," please complete the information below). ☐ Yes ☐ No

Applicant Name	Drug and Daily Dosage	Illness or condition

V. AUTHORIZATION TO PROVIDE HEALTH INFORMATION TO BROKER

If you are submitting this application through a broker, complete this section to indicate if you authorize Highmark DE to discuss this application, including related health information, with that broker. Please note: This authorization applies to all applicants signing below.

____ Yes, I do want Highmark DE to discuss this application with my broker. Please write your broker's name in the blank below.

_____ No, I do not want Highmark DE to discuss this application with my broker.

I authorize Highmark BCBSD Inc. to release my Protected Health Information (PHI) to _____ (name of your broker) for any and all purposes related to this application for coverage, including discussion of Highmark DE's decision to accept or reject the application. My signature below authorizes the disclosure of all PHI in Highmark DE's possession, specifically including the following: HIV/AIDS, Substance Abuse, Behavioral Health and Genetic Testing. I understand that I may revoke this authorization at any time by notifying Highmark DE in writing. My revocation will not affect any action that Highmark DE took before receiving my notice. I understand that if the person I have authorized to receive my PHI is not subject to federal health information privacy laws, the information will no longer be protected by those laws and may be re-disclosed. I understand that giving this authorization is not a condition of eligibility for benefits, enrollment in a health plan or payment of claims.

VI. TERMS OF AGREEMENT

I hereby apply on behalf of myself, my spouse and my dependent children (if listed on this application) for a Highmark Blue Cross Blue Shield Delaware (Highmark DE) health insurance contract.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I have the authority to act for myself, my spouse and all of my dependent children; including those who have reached the age of 18.
2. The contract will be effective only for those applicants approved by Highmark DE.
3. If Highmark DE accepts this application, I will receive a copy of the contract and an identification card. The contract will state plan benefits for insureds and define the conditions under which the benefits will be available. If I am a new member, the carrier holding my ID card will specify the effective date of my coverage.
4. Highmark DE has a 12-month waiting period before preexisting conditions will be covered under this contract. Individuals under age 19 will not be subject to a preexisting waiting period. Highmark DE will apply this waiting period to any physical or mental condition of a covered person (a) for which medical advice, diagnosis, care or treatment was received within the 12 months prior to this contract being effective, or (b) that manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis or treatment within the 12 months prior to this contract being effective.
5. The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
6. I will pay the premiums to Highmark DE when due.
7. In the event there is an error made in any payment of benefits, I agree to refund to Highmark DE the amount of any overpayment of benefits to which I am not entitled.
8. I will notify Highmark DE in writing if there have been any changes to the health of any person listed on this application, that occur prior to acceptance of this application by Highmark DE.
9. All statements made on this application are complete, true, and correctly stated to the best of my knowledge. I intend for Highmark DE to rely on these representations in deciding to issue the contract, and for them to be part of this contract.
10. Failure to enter accurate and complete medical information in writing, as well as failure to update that information prior to the acceptance of the application by Highmark DE, may be a material or fraudulent misrepresentation. If so, Highmark DE may void or cancel your contract, deny benefits for the affected individual or condition, and report fraud to the Delaware Department of Insurance.
11. I authorize any medical professional, hospital, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medical-related facility, governmental agency or other person or firm, to disclose to Highmark DE or Highmark DE's authorized representative information (including copies of records) concerning advice, care or treatment provided to me and/or my dependents. That information may include, without limitation, information relating to HIV/AIDS, mental health, or abuse of drugs or alcohol. In addition, I authorize Highmark DE to use its own records for information. I understand that such information will be used by Highmark DE to evaluate my application for health coverage, to decide whether or not to offer me coverage, and to determine whether I am eligible for benefits. I understand information obtained with my authorization may be re-disclosed by Highmark DE as permitted or required by law and that upon such re-disclosure, it may no longer be protected by federal privacy laws. I understand that I, or any authorized representative, will receive a copy of this authorization upon request. This authorization is valid for two years from the date signed unless (a) revoked by me in writing, which I may do at any time, or (b) Highmark DE declines this application. Any revocation will not affect the activities of Highmark DE prior to the date such revocation is received by Highmark DE.

IF I HAVE A HEALTH SAVINGS ACCOUNT (HSA), I UNDERSTAND AND AGREE TO THE FOLLOWING ADDITIONAL STATEMENTS

12. If Highmark DE accepts this application, I accept complete and sole responsibility, and Highmark DE has no responsibility for payment of any tax obligations I may incur should any individuals I cover under a Highmark DE health insurance contract not meet the definition of spouse or dependent child under the Internal Revenue Code and IRS published rulings. Such tax obligations include, but are not limited to, federal, state and local income tax obligations, and any interest and penalties that may result from such tax obligations.
13. If Highmark DE accepts this application, the Highmark DE health insurance policy that will be issued to me is intended to qualify as a high-deductible health plan (HDHP) under Section 223 of the Internal Revenue Code and IRS published rulings. I should obtain professional legal advice before I establish or contribute to a Health Savings Account (HSA) now and in the future.

I have carefully read this application and agree to the terms and conditions specified. All applicants have signed below, except for dependent children under the age of 18.

Signature (DO NOT PRINT)	Printed Name	Date
Signature of Spouse or Child Age 18 or Older (DO NOT PRINT)	Printed Name of Spouse of Child Age 18 or Older	Date
Signature of Child Age 18 or Older (DO NOT PRINT)	Printed Name of Child Age 18 or Older	Date

HIGHMARK. Delaware

ATTENDING PHYSICIAN'S STATEMENT

Physician's Name | Number & Street | City & State | Zip Code

Dear Doctor: Highmark Blue Cross Blue Shield Delaware (Highmark DE) needs certain medical history information from you to further consider my medically underwritten application for Highmark DE health care coverage. As Highmark DE does not provide reimbursements for charges related to providing the information requested below, please contact me directly for payment if you charge a fee for responding to this request.

I authorize you to furnish Highmark DE the information requested concerning the patient listed below. Please complete this form and use the enclosed envelope to mail it to Highmark DE **within 20 days** of your receipt of this request. Thank you for your help.

Date _____ Patient's Signature _____

If patient is a spouse or child, please provide the name of the primary applicant: _____

TO BE COMPLETED BY PHYSICIAN

Patient Name: _____ **DOB:** _____

Please provide the following information:

Date of last visit: _____ Date of last physical exam: _____

Height: _____ Weight: _____

Blood Pressure: _____ Cholesterol reading(s): _____

Tobacco Usage: ☐ Yes ☐ No Alcohol intake per week: _____

Has patient ever been treated for any of the following?	Yes or No	If yes, please comment.
1. Cancer or any pre-cancerous conditions	☐ Yes ☐ No	
2. Migraine headaches, TIAs, CVAs or seizures	☐ Yes ☐ No	
3. Heart disease (coronary, congenital, structural, arrhythmia, valvular) or Hypertension	☐ Yes ☐ No	
4. Asthma, COPD or other lung and respiratory diseases	☐ Yes ☐ No	
5 Back or other musculoskeletal conditions	☐ Yes ☐ No	
6. Liver/pancreas disease, or inflammatory or other bowel diseases	☐ Yes ☐ No	
7. Diabetes or other endocrine/metabolic disorders	☐ Yes ☐ No	A1C reading _____
8. Kidney/urinary tract disease or renal failure	☐ Yes ☐ No	Creatinine clearance _____
9. Chronic skin conditions or blood disorders	☐ Yes ☐ No	
10. Behavioral health conditions	☐ Yes ☐ No	
11. Alcohol/drug abuse or dependency	☐ Yes ☐ No	

Additional doctor's notes from above or comments on any other medical condition not listed above:

Please list current medications or treatments:

Any anticipated care, treatment or surgery in the next 12 months? ☐ Yes (please explain) ☐ No

Any surgeries in the last seven years? ☐ Yes (please explain) ☐ No

Please provide the names of other doctors (including oral surgeon and chiropractor) seen in the last seven years:

Physician's signature Date Address

BLUE INDIVIDUAL

IMPORTANT LIMITATIONS, DISCLOSURES AND ENROLLMENT INFORMATION

ELIGIBILITY

To be eligible to enroll in a Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) *Blue Individual* plan, you must be a Delaware resident between the ages of 18 and 64. You must be neither enrolled in, nor eligible for, Medicare and neither enrolled in, nor eligible for, Highmark Delaware group coverage. Since these are medically underwritten plans, medical information for all individuals to be covered by the contract must be provided to Highmark Delaware.

Additional eligibility requirements apply for establishing and contributing to a health savings account (HSA). Please see the important notes for Health Savings Accounts insert for more details.*

RATING

Each subscriber's rate will be based on his or her age at the time of enrollment. Rates will be based on the age of the oldest covered adult applying. If you have more than one child, each additional child can be added to Individual and Child(ren) or Family coverage at no extra cost, subject to contract terms. A "child" must be under age 26.

MEDICAL UNDERWRITING

Highmark Delaware *Blue Individual* plans require medical underwriting and approval is not guaranteed. Medical underwriting is a systematic process that insurers use to evaluate information about a health insurance applicant.

Based on medical underwriting reviews, you may be:

- Enrolled in your selected plan at the standard rate charge
- Enrolled in your selected plan at a higher rate
- Offered a different plan
- Declined coverage

*Note: Individuals under age 19 cannot be refused coverage based on health status.

Other plans may be available to you without medical underwriting or preexisting condition waiting periods if you meet the criteria specified by HIPAA (Health Insurance Portability and Accountability Act). To find out more, please contact your broker or call Highmark Delaware at **800.633.2563.**

PREEXISTING CONDITIONS

A preexisting condition is any physical or mental condition of a covered person (a) for which medical advice, diagnosis, care or treatment was received within the 12 months prior to this contract being effective, or (b) that manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis or treatment within the 12 months prior to this contract being effective. You may receive credit toward, or waiver of, the preexisting condition period if you enroll with us directly following termination (with no lapse) of other Blue Cross and Blue Shield coverage. We do not credit coverage from other carriers.

Note: Individuals under age 19 are not subject to a preexisting condition waiting period.

INDIVIDUAL COVERAGE

Coverage selected for one person is individual coverage.

FAMILY COVERAGE

Coverage selected for more than one person is family coverage. There are three rates depending on the number of persons covered. They are:

- Individual & Child(ren): Coverage is for one adult and one or more children.
- Individual & Spouse: Coverage is for two adults who are married.
- Family: Coverage is for two adults who are married and one or more children.

(continued on the back)

BLUE INDIVIDUAL IMPORTANT LIMITATIONS, DISCLOSURES AND ENROLLMENT INFORMATION (CONTINUED)

OUT-OF-POCKET EXPENSES FOR FAMILY COVERAGE

Please remember that when you select coverage for more than one person, the deductible and coinsurance are higher than the individual amount. The deductible and coinsurance amounts combine to equal the out-of-pocket expense. Any copays are excluded from the out-of-pocket maximum.

DEDUCTIBLES

With both basic and HSA-compatible plans, there are no embedded deductibles. One or more family members must satisfy the entire family deductible in any combination before benefits will be paid for any family member.

MEDICAL LIMITATIONS AND EXCLUSIONS

Blue Individual plans do not cover all health care expenses and have exclusions and limitations. *Blue Individual* policies do not cover maternity services or bariatric surgery. Your *Blue Individual* contract (mailed at time of enrollment) determines which health care services are covered and to what extent. All payments to providers are based on Highmark Delaware's allowable charge.

Please note, all of these medical plans have certain managed care requirements, such as our program for mental health and substance abuse care, and authorization for elective hospital admissions. Other requirements, as described in your contract, vary based on the benefits plan design.

You may request a copy of the exclusions before enrolling by calling us at **888.692.5830.** The following is a partial list of services and supplies that are generally not covered. Services generally not covered:

- Non-medically necessary services or supplies
- Medical expenses for a preexisting condition are generally not covered for the first 12 months
- Care Highmark Delaware considers to be experimental or investigational
- Care for cosmetic reasons
- Any and all consequences or complications from, or related to, uncovered procedures, therapies or treatments
- Immunizations or inoculations for travel
- Infertility services, including artificial insemination or advanced reproductive technologies such as IVF, GIFT and ZIFT
- Speech, occupational or physical therapy for developmental delay
- Orthotic equipment or devices for feet
- Over-the-counter medications or supplies
- Physical exams for: potential employers, insurers, schools, camps, marriage or any other third party
- Pregnancy
- Care normally covered under Workers' Compensation
- Dental care
- Eyeglasses and all procedures for refractive correction
- Bariatric surgery

HOW TO RECEIVE IN-NETWORK BENEFITS — EPO/PPO PLANS

To receive in-network benefits, see a preferred provider when you need care. The preferred providers are listed in the Provider Network Directory online at **highmarkbcbsde.com.**

Please note that some preferred providers are not approved by Highmark Delaware to perform all health services at the in-network level. For example, a preferred hospital ,may not be approved as a preferred provider for outpatient lab tests.

You should always check the Provider Network Directory before you receive care.

There are no out-of-network benefits with an EPO plan. EPO/PPO members can access in-network providers in the national *BlueCard*® Network across the country. You can access the network by visiting **bluecares.com** and clicking 'Find a Doctor or Hospital,' or by calling a *BlueCard* customer service representative at **800.810.BLUE (2583).**

Blue Individual plans require medical underwriting and are not guaranteed issue plans.