

# VISION CARE BENEFITS

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## *Vision Program*

**Carnegie Mellon University Student Plan**

**Group 10566704**

**Effective August 01, 2026**

**This booklet relates to a Limited Policy - Read it Carefully**

**Highmark Inc.**

**d/b/a Highmark Blue Cross Blue Shield**

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

BB-VPPP-WG-NG-5



[myhighmark.com](http://myhighmark.com)

## Discrimination is Against the Law

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

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

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator  
P.O. Box 22492  
Pittsburgh, PA 15222  
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475  
Email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

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

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html)

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**ATTENTION:** If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksèsib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

**ВНИМАНИЕ:** Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

**ATTENZIONE:** se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

**ATTENTION :** si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

**ÀKÍYÈSÍ:** Tí o bá nsọ èdè Yorùbá, àwọn isẹ ìtumọ ati ògbufọ èdè wà ní àrọwọtọ lófẹ́ẹ́ fún ọ. Àwọn isẹ ìtọ́jú ati ìrànlowọ́ tó yẹ (bíi titẹwé nla, gbigbo ohùn, ati iwé afójú) lati pèsè iwífúnni ni àwọn ọna irááyè si wà pẹlu lófẹ́ẹ́. Pe nọmba tó wà lẹhin kaádì idánimọ rẹ (TTY: 711) fún irànlowọ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוויי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجاناً. تتوفر أيضاً الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的ID卡背面的号码（听障人士专用号码：711）。

ध्यान आपशो: जो तमे गुजराती बोलता होव, तो तमारा माटे निःशुल्क भाषा अनुवाद अने एन्टरप्रेटेशन सेवाओ उपलब्ध छे. सुलभ ड्रिमेंटमां माहिती पूरी पाडवा माटे योग्य सहायक साधनसामग्री अने सेवाओ (जेम डे मोटी प्रिन्ट, ऑडियो अने ब्रेल) पण निःशुल्क उपलब्ध छे. मद्दत माटे तमारा आइडी कार्डनी पाछा आपेला नंबर (TTY: 711) पर डोल करे.

**CHÚ Ý:** Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोलनुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिन्ट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

Highmark Blue Cross Blue Shield is very pleased to provide this information about your vision care program administered by Davis Vision, Inc., a leading national administrator of vision care programs.

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the group contract issued by Highmark Blue Cross Blue Shield, an Independent Licensee of the Blue Cross and Blue Shield Association. Should the information in this booklet differ from the information contained in the group contract, the terms of the group contract shall govern. This booklet is merely a description of the principal features of your program.

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### **Non-Assignment**

*Unless otherwise required by law, Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the program described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefits booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.*

# How Your Benefits Are Applied

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## **Benefit Period**

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by Highmark. A charge shall be considered incurred on the date you receive the service, product or supply for which the charge is made.

Your benefit period is a 12 consecutive months beginning on August 1.

## **Payment For Network Covered Expenses**

### ***Professional Services***

#### **Eye Examination and Refractive Services**

When a network provider is used, payment for eye examinations and refractive services is based on the plan allowance.

Payment for the eye examination is made directly to the provider and is accepted as payment in full. If the eye examination is subject to a copayment, as indicated in the Schedule of Benefits, you are responsible for paying that copayment amount to the provider.

#### **Low Vision Care Services**

When a network provider is used, payment for low vision care services is based on the amount of the provider's charge up to the program allowance.

Payment for low vision care services is also made directly to the provider. However, you are responsible for the difference between the program allowance and the provider's charge.

#### **Laser Vision Correction Services**

When a network provider is used, benefits for laser vision correction services are made available in the form of a percentage discount of the provider's charge. You are responsible for paying the entire discounted price to the provider.

#### ***Post-Refractive Products***

When a network provider is used, payment for post-refractive products is based on the plan allowance, the amount of the provider's charge up to the program allowance or the discounted price which the provider has agreed to accept in satisfaction of its charge.

Payment of the plan allowance is made directly to the provider and is accepted as payment-in-full. If the covered post-refractive product is subject to a copayment, as indicated in the Schedule of Benefits, you are responsible for paying that copayment amount to the provider.

If payment for the covered post-refractive product is made up to the program allowance, as indicated in the Schedule of Benefits, you are responsible for any difference between that amount and the provider's charge.

For those post-refractive products that are provided in the form of a discounted price, as indicated in the Schedule of Benefits, you are responsible for paying the entire discounted price to the network provider.

## **Payment For Out-of-Network Covered Expenses**

When an out-of-network provider is used, payment for covered expenses is based on the amount of the provider's charge up to the program allowance, as indicated in the Schedule of Benefits. You are responsible for the difference between the program allowance and the provider's charge.

You may "split" your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time and from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either a network or out-of-network provider.

# Schedule of Benefits: Professional and Post-Refractive

Benefits	Network	Out-of-Network 1
<p><b>FREQUENCY</b></p> <ul style="list-style-type: none"> <li>• Eye examination (including dilation as professionally indicated)</li> <li>• Eyeglass lenses</li> <li>• Frames</li> <li>• Contact lenses (in lieu of eyeglass lenses)               <ul style="list-style-type: none"> <li>• Formulary</li> <li>• Non-Formulary</li> </ul> </li> </ul>	<p>One visit every 12 months<sup>2</sup></p> <p>One pair every 12 months<sup>2</sup> One frame every 12 months<sup>2</sup></p> <p>One pair of standard daily wear or an initial supply of disposable (4 multi-packs) or planned replacement (2 multipacks) contact lenses every 12 months<sup>2</sup> Payment of the program allowance<sup>2</sup></p>	
<p><b>EYE EXAMINATION</b> (including dilation as professionally indicated)</p>	<p>Member pays \$10</p>	<p>Plan pays up to \$40</p>
<p><b>FRAMES</b></p> <ul style="list-style-type: none"> <li>• Fashion level frames from "The Collection"</li> <li>• Designer level frames from "The Collection"</li> <li>• Premier level frames from "The Collection"</li> <li>• Retail allowance toward an independent provider's frame</li> <li>• Retail allowance toward a Visionworks frame</li> </ul> <p><b>STANDARD EYEGLASS LENSES (per pair)<sup>3</sup></b></p> <ul style="list-style-type: none"> <li>• Single vision lenses</li> <li>• Bifocal vision lenses</li> <li>• Trifocal vision lenses</li> <li>• Lenticular vision lenses</li> </ul>	<p>Covered in full Covered in full Member pays \$25 Plan pays up to \$130</p> <p>Plan pays up to \$180</p> <p>Member pays \$25 Covered in full Covered in full Covered in full Covered in full</p>	<p>Plan pays up to \$65</p> <p>Plan pays up to \$0</p> <p>Plan pays up to \$40 Plan pays up to \$60 Plan pays up to \$80 Plan pays up to \$100</p>
<p><b>OPTIONAL EYEGLASS LENSES (per pair)</b></p> <ul style="list-style-type: none"> <li>• Standard progressive lenses<sup>4</sup></li> <li>• Premium progressive lenses<sup>4</sup></li> <li>• Ultra progressive lenses<sup>4</sup></li> <li>• Ultimate progressive lenses<sup>4</sup></li> <li>• Glass-Grey #3 prescription sunglasses</li> <li>• Polycarbonate lenses               <ul style="list-style-type: none"> <li>• Adult<sup>5</sup></li> <li>• Dependent children                   <ul style="list-style-type: none"> <li>• Single vision Polycarbonate lenses (in lieu of single vision eyeglass lenses)</li> <li>• Bifocal Polycarbonate lenses (in lieu of bifocal eyeglass lenses)</li> <li>• Trifocal Polycarbonate lenses (in lieu of trifocal eyeglass lenses)</li> </ul> </li> </ul> </li> </ul>	<p>Member pays \$50 Member pays \$90 Member pays \$140 Member pays \$175 Member pays \$11</p> <p>Member pays \$30</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>Not Covered Not Covered Not Covered Not Covered Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>

Benefits	Network	Out-of-Network 1
<ul style="list-style-type: none"> <li>● Blended segment lenses</li> <li>● Intermediate vision lenses</li> <li>● Glass photochromic lenses</li> <li>● Plastic photosensitive lenses</li> <li>● High-index (thinner and lighter) lenses</li> <li>● Polarized lenses</li> <li>● Blue light lenses</li> </ul>	<p>Member pays \$20 Member pays \$30 Member pays \$20 Member pays \$65 Member pays \$55 Member pays \$75 Member pays \$15</p>	<p>Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered</p>
<p><b>OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS</b></p> <ul style="list-style-type: none"> <li>● Fashion, sun or gradient tinted plastic lenses</li> <li>● Ultraviolet coating</li> <li>● Scratch-resistant coating</li> <li>● Standard ARC (anti-reflective coating)</li> <li>● Premium ARC (anti-reflective coating)</li> <li>● Ultra ARC (anti-reflective coating)</li> <li>● Ultimate ARC (anti-reflective coating)</li> <li>● Scratch protection plan</li> </ul>	<p>Covered in full</p> <p>Member pays \$12 Covered in full Member pays \$35 Member pays \$48 Member pays \$60 Member pays \$85 Member pays \$20 for single vision Member pays \$40 for multifocal</p>	<p>Not Covered</p> <p>Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered</p>
<p><b>CONTACT LENSES</b> (in lieu of eyeglass lenses - per pair or initial supply of disposable contact lenses)<sup>6</sup></p> <ul style="list-style-type: none"> <li>● Contact lens evaluation and fitting <ul style="list-style-type: none"> <li>● Daily wear</li> <li>● Extended wear</li> </ul> </li> <li>● Standard daily wear contact lenses</li> <li>● Specialty contact lenses</li> <li>● Disposable contact lenses Specialty contact lenses</li> <li>● Medically necessary contact lenses (<i>prior approval required</i>)</li> </ul>	<p>Covered in full when the performing provider dispenses formulary contact lenses</p> <p>Covered in full when the performing provider dispenses formulary contact lenses</p> <p><b>Formulary /Non-Formulary</b></p> <p>Covered in full / Plan pays up to \$105<sup>8</sup></p> <p>Covered in full / Plan pays up to 105<sup>8</sup></p> <p>Covered in full / Plan pays up to \$105<sup>8</sup></p> <p>Covered in full</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Plan pays up to \$95</p> <p>Plan pays up to \$95</p> <p>Plan pays up to \$95</p> <p>Plan pays up \$225</p>
<p><b>LASER VISION CORRECTION SERVICES DISCOUNT PROGRAM</b></p>	<p>Discount available at participating providers only.</p>	<p>Not Covered</p>

Benefits	Network	Out-of-Network 1
<b>LOW VISION SERVICES</b> <sup>9</sup> <ul style="list-style-type: none"> <li>● Initial evaluation (<i>prior approval required</i>)</li> <li>● Follow-up visits</li> <li>● Low vision aids</li> </ul>		Plan pays up to \$300 per visit Plan pays up to \$100 per visit Plan pays up to \$600 per aid Plan pays up to \$1,200 lifetime maximum

- <sup>1</sup> If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.
- <sup>2</sup> Eligibility will be determined from the date of the last similar service paid under this program or any other Highmark vision program for this group. .
- <sup>3</sup> Includes glass, plastic or oversized lenses.
- <sup>4</sup> Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses; however, the member's payment toward the progressive upgrade will not be refunded.
- <sup>5</sup> Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
- <sup>6</sup> Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses fitted, they may not be exchanged for eyeglasses.
- <sup>7</sup> Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.
- <sup>8</sup> The plan's payment is applied toward the cost of contact lenses and may or may not apply to the evaluation/fitting. The member is responsible for any remaining balance.
- <sup>9</sup> One initial low vision evaluation is eligible every five years. Up to four follow-up care visits will be covered during the five-year period.

# Description of Benefits

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## Eye Examination and Refractive Services

A comprehensive examination and evaluation of the eyes performed by a professional provider which shall include the following:

- Case history
- Assessment of current visual acuities, distance and near, using your present corrective lenses, if applicable
- External ocular examination including slit lamp examination
- Internal ocular examination including, where professionally indicated, a dilated fundus examination
- Tonometry
- Distance refraction, objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields

## Post-Refractive Products

Services and supplies consisting of, but not necessarily limited to: ordering lenses and frames (facial measurement, lens formula and other specifications), the cost of materials, where applicable, verification of the completed prescription upon return from the laboratory, and adjustment of the completed glasses to the patient's face and the subsequent servicing, (i.e., refitting, realigning, readjusting and tightening for a period not to exceed 90 days), tints and special lens treatments.

## *Eyeglasses and Frames*

Services and supplies prescribed by a professional provider, and received from a provider. Standard eyeglass lenses include prescription lenses of all sizes and diopter powers, glass or plastic and oversized, and may include any of the following:

- Single vision
- Bifocal vision
- Trifocal vision
- Lenticular vision

Optional eyeglass lenses benefits provided under this program include coverage for polycarbonate lenses. Eligibility for polycarbonate lenses benefits is limited to dependent children and members who are monocular patients or patients with prescription 6.00 diopters or greater.

Benefits also include discounted prices in connection with the following:

- Standard progressive lenses
- Premium progressive lenses
- Ultra progressive lenses
- Ultimate progressive lenses
- Glass-Grey #3 prescription sunglasses
- Polycarbonate lenses, limited to adults who are non-monocular patients with prescription less than 6.00 diopters
- Blended segment lenses
- Intermediate vision lenses
- Photochromic glass lenses
- Plastic photosensitive lenses
- High-index lenses

- Polarized lenses
- Blue light lenses

Optional lens coatings and treatment benefits provided under this program include discounted prices for the following:

- Ultraviolet coating
- Scratch-resistant coating
- Standard anti-reflective coating (ARC)
- Premium anti-reflective coating (ARC)
- Ultra anti-reflective coating (ARC)
- Ultimate anti-reflective coating (ARC)

### **Contact Lenses**

Products and services prescribed by a professional provider which may include the following:

- Contact lens evaluation and fitting

Evaluation and fitting services are only covered when the network provider performing those services also dispensed the formulary contact lenses and has been credentialed by Highmark to perform those services.

- Ordering of lenses according to specifications
- Cost of the materials
- Verification of the completed prescription
- Fitting
- Dispensing

The contact lenses covered under this program include the following:

- Standard daily wear contact lenses - Contact lenses that are placed in the eye at the beginning of the day and removed at the end of the day.
- Specialty contact lenses - Includes standard daily wear, disposable or planned replacement types of contact lenses.
- Disposable contact lenses/planned replacement contact lenses - Contact lenses that are worn for a prescribed length of time and then are discarded. Compared to conventional contact lenses, these lenses are intended to offer you better eye health, clearer vision, increased comfort and a "fresh lens feeling" on a continuous basis. There is very little to no maintenance involved with these lenses.
- Medically necessary contact lenses - A contact lens considered eligible only after cataract surgery, corneal transplant surgery or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses. Medically necessary contact lenses are a contact lens that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
  - in accordance with generally accepted standards of medical practice;
  - clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
  - not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to

produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Highmark reserves the right, utilizing the criteria set forth in this description, to render the final determination as to whether covered contact lenses are medically necessary. This benefit will not be provided unless Highmark determines that the covered contact lenses are medically necessary.

*Medically necessary contact lenses may be subject to preauthorization. If the required preauthorization is not obtained, no benefits will be paid for such lenses and the entire charge will be your responsibility.*

## **Low Vision Care Services**

Services performed by a professional provider who qualifies in evaluating the needs of individuals with low vision. Services include evaluating low vision problems, prescribing optical devices and providing training and instruction to individuals with low vision in order to maximize their remaining usable vision.

*Low vision care services may be subject to preauthorization. If the required preauthorization is not obtained, no benefits will be paid for low vision care services and the entire charge will be your responsibility.*

## **Laser Vision Correction Services Discount Program**

Discounts on services for refractive surgery to eliminate myopia by flattening the central portion of the cornea with a PRK or conventional LASIK laser vision correction rendered by a network professional provider who has specifically contracted with Highmark to provide such services.

# What Is Not Covered

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Except as specifically provided in this booklet, or as Highmark is mandated or required to pay based on state or federal law, no program payment will be provided for services, products or supplies which are:

- for examinations, materials or products which are not listed herein as a covered service;
- for medical or surgical treatment of eye disease or injury;
- for visual therapy;
- for diagnostic services, such as diagnostic x-rays, cardiographic and encephalographic examinations, and pathological or laboratory tests;
- for drugs or any other medications;
- for procedures determined by Highmark to be special or unusual, such as but not limited to, orthoptics, vision training and tonography;
- for eye examinations or materials necessitated by your employment or furnished as a condition of employment;
- for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government's workers' compensation, occupational disease or similar type of legislation. This exclusion applies whether or not you file a claim for said benefits or compensation;
- to the extent benefits are provided by any governmental unit, unless payment is required by law;
- for which you would have no legal obligation to pay;
- received from a medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- rendered prior to your effective date;
- for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- for temporary devices, appliances and services;
- for which you incur no charge;
- the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
- in a facility performed by a professional provider who is compensated by the facility for similar covered services performed for you;
- to the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you so elect this coverage as primary;
- for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits, payable in any manner under any state law governing liability for injuries arising from the maintenance or use of a motor vehicle;
- for professional services not performed by licensed personnel;
- for the cost of any insurance premiums indemnifying you against losses for lenses or frames;
- for non-prescription industrial safety glasses and safety goggles;
- for sports glasses;
- incurred after the date of termination of your coverage except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;
- for duplicate devices, appliances and services;
- for any lenses which do not require a prescription;
- for prosthetic devices and services;
- for low vision aids and services not otherwise specified herein;
- for non-prescription (Plano) lenses;
- for special lens designs or coatings not otherwise specified herein;
- for replacement of lost or stolen eyeglass lenses or frames or lost, stolen or damaged contact lenses and safety eyeglasses;

- for replacement of broken frames and eyeglass lenses that are not supplied by Davis Vision's ophthalmic laboratories;
- for replacement of lost, damaged or broken safety eyeglasses supplied by Davis Vision's ophthalmic laboratories or any other manufacturer;
- for additives for glass lenses or contact lenses not otherwise specified herein;
- for sales tax and shipping charges that may be associated with purchases of post-refractive products covered herein;
- for any tests, screenings, examinations or any other services required by; a.) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employment in a particular setting; b.) a school, college or university in order to enter onto school property or a particular location regardless of purpose; or c.) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by your attending professional provider as being medically appropriate; and
- for any other medical or vision service or treatment except as provided herein.

# How Your Program Works

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## Network Care

To receive services from a provider in the network, call the network provider of your choice and schedule an appointment. Identify yourself as a member in a vision program administered by Davis Vision, and provide the office with your ID number (located on your ID card), and the name and date of birth of any covered dependent receiving services. The provider's office will verify your eligibility for services, and no claims forms are required.

The Davis Vision provider network is being used for this vision product through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained. To find a network provider, go to [www.myHighmark.com](http://www.myHighmark.com) and click on "find a vision network provider." Click "OK" to be redirected to the Davis Vision, Inc., Web site. Enter your zip code and mile radius then click on "Search" to see the most current listing of providers that will accept your vision program. Or, you can call Member Service toll-free at 1-800-223-4795.

In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations. However, your value is comparable.

## Out-of-Network Care

You and your covered dependents may use an out-of-network provider for certain covered services, although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement. For specific details, see the "How To File A Claim" section of the benefit book.

## Eligible Providers

- Ophthalmologist
- Optician
- Optometrist
- Physician
- Retail optical dispensing firm
- Supplier

# General Information

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## Who is Eligible for Coverage

You may enroll your:

- Spouse under a legally valid existing marriage
- Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children or children for whom the member or the member's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court

An eligible dependent child's coverage automatically terminates and all benefits hereunder cease at the end of the month the dependent reaches the limiting age or ceases to be an eligible dependent as indicated above, whether or not notice to terminate is received by Highmark.

- Unmarried children over age 26 who are not able to support themselves due to intellectual disability, physical disability, mental illness or developmental disability. Highmark may require proof of such disability from time to time.

NOTE: To the extent mandated by the requirements of Pennsylvania Act 83 of 2005, eligibility will be continued past the limiting age for children who are enrolled as dependents under their parent's coverage at the time they are called or ordered into active military duty. They must be a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States, who is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or be a member of the Pennsylvania National Guard ordered to active state duty for a period of 30 or more consecutive days. If they become a full-time student for the first term or semester starting 60 or more days after their release from active duty, they shall be eligible for coverage as a dependent past the limiting age for a period equal to the duration of their service on active duty or active state duty.

For the purposes of this note, full-time student shall mean a dependent who is enrolled in, and regularly attending, an accredited school, college or university, or a licensed technical or specialized school for 15 or more credit hours per semester, or, if less than 15 credit hours per semester, the number of credit hours deemed by the school to constitute full-time student status.

A student who takes a medically necessary leave of absence from school or changes their enrollment status (such as changing from Full Time to Part Time) due to a serious illness or injury may continue coverage for one (1) year from the first day of the medically necessary leave of absence or other change in enrollment, or, if earlier, until the date the coverage would otherwise terminate under the terms of the Contract. The Plan may require a certification from the treating physician in order to continue such coverage.

- A domestic partner shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

"Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within

which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
- Is not related to the other partner by adoption or blood
- Is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future.

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

## **Changes in Membership Status**

In order for there to be consistent coverage, you must keep your benefits department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under your program for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.

## **Force Majeure**

No failure, delay or default in performance of any obligation of Highmark shall constitute an event of default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the reasonable control and not the result of the negligence of Highmark. Such events include, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental authority, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors or carriers, terrorism, disaster, strikes, civil-disorder, curtailment of transportation facilities, fire, floods, blizzards, epidemics, pandemics, viral or communicable disease outbreaks, National Emergency, quarantines, disruption of the labor force and/or any other cause which is beyond the reasonable control of Highmark (hereinafter a "Force Majeure Event"), that makes it impossible, illegal or commercially impracticable for Highmark to perform its obligations in whole or in part.

Upon the occurrence of a Force Majeure Event, Highmark shall take action to minimize the consequences of the Force Majeure Event. If Highmark relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice to the group of the facts that constitute such Force Majeure Event, when it arose and when it is expected to cease.

## **Leave of Absence or Layoff**

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your group's program may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group program has adopted such a policy.

## **Termination of Your Coverage Under the Group Contract**

Your coverage can be terminated in the following instances:

- When you cease to be a student, the group shall promptly notify Highmark that you are no longer eligible for coverage and that your coverage should be terminated as follows:

- When prompt notification is received, coverage will be terminated no earlier than the date on which you cease to be eligible.
- When a group requests a retroactive termination of coverage, coverage will be terminated no earlier than the first day of the month preceding the month in which Highmark received notice from the group.
- When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.
- Termination of the group contract automatically terminates the coverage of all the members. It is the responsibility of the group to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the group.
- If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark may, upon notice to you, terminate your coverage under the program.
- It is understood that you have an affirmative obligation to notify the group or Highmark as soon as the domestic partnership has been terminated. Upon termination of the domestic partnership, coverage of the former domestic partner and the children of the former domestic partner will terminate at the end of the month the domestic partnership terminated.

# How to File a Claim

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## NOTICE OF CLAIM AND PROOF OF LOSS

Network Providers have directly or indirectly entered into an agreement with the Plan pertaining to the payment for Covered Services rendered to a Member. When a Member receives Covered Services from a Network Provider, it is the responsibility of the Network Provider to submit its claim to the Plan in accordance with the terms of its participation agreement. Should the Network Provider fail to submit its claim in a timely manner or otherwise satisfy the Plan's requirements as they relate to the filing of claims, the Member will not be liable and the Network Provider shall hold the Member harmless relative to payment of the Covered Services received by the Member.

When Covered Services are received from other than a Network Provider, the Member is responsible for submitting the claim to the Plan. In such instances, the Member must submit the claim in accordance with the following procedures:

### 1. Notice of Claim

The Plan will not be liable for any claims under this Contract unless proper notice is furnished to the Plan that Covered Services in this Contract have been rendered to a Member. Written notice of a claim must be given to the Plan within twenty (20) days or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Plan that includes information sufficient to identify the Member that received the Covered Services shall constitute sufficient notice of a claim to the Plan. The Member can give notice to the Plan by writing to the Member Service Department. The address of the Member Service Department can be found on the Member's Identification Card. A charge shall be considered Incurred on the date a Member receives the Service for which the Charge is made.

### 2. Claim Forms

Proof of loss for benefits under this Contract must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of a notice of a Claim will, within fifteen (15) days following the date a notice of a claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. The proof of loss may be submitted to the Plan at the address appearing on the Member's Identification Card.

### 3. Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Plan. Written proof of loss must be provided to the Plan within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Plan to determine benefits. Failure to submit a proof of loss to the Plan within the time specified will not invalidate or reduce any Claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Plan be required to accept a proof of loss later than (24) months after the charge for Covered Services in this Contract is Incurred.

### 4. Submission of Claim Forms

The completed claim form, with all itemized bills attached, must be forwarded to the Plan at the address appearing on the Member's Identification Card in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Contract.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing:

Person or organization providing the Service  
Type of Service  
Date of Service  
Amount charged  
Name of patient  
Itemized bills cannot be returned.

A request for payment of a Claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the Claim form has been submitted in the manner described above. The Plan reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Notice of the Plan's claim determination will be issued within a reasonable period of time not to exceed thirty (30) days following the receipt of a proper proof of loss. This period of time may be extended one (1) time by the Plan for an additional period of time not to exceed fifteen (15) days provided the extension is due to matters outside the control of the Plan and a written explanation for the delay is provided to the Member.

In the event that the Plan renders an adverse decision on the Claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement describing the right of the Member to file an appeal.

#### 5. Time of Payment of Claims

Claim payments for benefits payable under this Contract will be processed immediately upon receipt of a proper proof of loss.

#### 6. Authorized Representative

Nothing in this Subsection shall preclude a duly authorized representative of the Member from filing or otherwise pursuing a Claim on behalf of the Member. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Member.

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you must file the claim for reimbursement to:

***Your claims must be submitted to Davis Vision within 20 days after the date of service or as soon thereafter as reasonably possible, but not later than within two years of the date of service.***

Only one claim per service may be submitted for reimbursement each benefit cycle. To file a claim, take the following steps:

- Request an itemized bill which shows:
  - the patient's name and address;
  - the date of service;
  - the type of service and diagnosis;
  - itemized charges; and
  - the provider's complete name and address.
- Make a copy of your itemized bill for your records.
- Complete a claim form. To request claim forms, please visit the Davis Vision website at [www.davisvision.com](http://www.davisvision.com) or call 1-800-999-5431.

## Your Explanation of Benefits Statement

For out-of-network services, once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. This statement lists the provider's charge and total benefits payable.

## Additional Information on How to File a Claim

### Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

### Filing Benefit Claims

- ***Authorized Representatives***

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Preauthorization and Other Pre-Service Claims***

When preauthorization is required under this program prior to receiving covered services from a network provider, the network provider will contact Davis Vision, complete any required prior approval form and submit any information necessary to request that services be preauthorized. If preauthorization is denied, your network provider will inform you, and you have the right to file an appeal. The appeal process is described in the Appeal Procedure section below.

If services requiring preauthorization are to be received from an out-of-network provider, the out-of-network provider will not initiate the preauthorization process on your behalf. In that case, you should ask the doctor to provide you with a letter explaining why the services you received were medically necessary (letter of medical necessity). Attach the letter of medical necessity and copies of the bill that you paid to your completed claim form and file that with Highmark in order to be reimbursed. You will receive written notice of any decision on a request for preauthorization or other pre-service claim within 15 days from the date Davis Vision receives your claim. However, this 15-day period of time may be extended one time by Davis Vision for an additional 15 days if additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Davis to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your pre-service claim.

If your request for preauthorization or approval of any other pre-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse determination and a statement describing your right to file an appeal.

- ***Requests for Reimbursement and Other Post-Service Claims***

When you receive services from a network provider, the provider will report the services to Davis Vision and payment will be made directly to the provider. Davis Vision will also notify the provider of any amounts that you are required to pay in the form of a copayment. If you believe that the copayment amount is not correct or that any portion of those amounts are covered under your benefit program, you may file an appeal.

## **Determinations on Benefit Claims**

### ***Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims***

If you have submitted a post-service claim for services of an out-of-network provider, Davis Vision will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time for an additional 15 days, provided that Davis Vision determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Davis Vision to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

## **Appeal Procedure**

If you receive notification that a claim has been denied, in whole or in part, you may appeal the decision. Your appeal must be submitted to Highmark within 180 days from the date of your receipt of notification of the adverse decision.

The appeal process involves one level of review. This process is mandatory and must be exhausted before you are permitted to pursue legal action.

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Highmark in writing of the designation. For purposes of the appeal process described below, "you" includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

At any time during the appeal process, you may contact the Member Services Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

Upon request, you may review all documents, records and other information relevant to your appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Services Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter which is the subject of your appeal. In rendering a decision on your appeal, the Member Services Department will take into account all evidence, comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Member Services Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, the Member Services Department will consult with a vision care professional who has appropriate training and experience and who is different from and not the subordinate to any individual who was consulted in a prior review.

Each appeal will be promptly investigated and Highmark will provide written notification of its decision within the following time frames:

- When the appeal involves a pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 days following receipt of the appeal.

In the event Highmark renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue any applicable legal action or right to arbitration.

# Member Service

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We all have questions about our vision care coverage from time to time. To help you get accurate answers to questions and up-to-date information about your vision program, please visit Highmark's Web site at [www.myHighmark.com](http://www.myHighmark.com) or call Highmark at 1-800-223-4795. You can get the following information:

- Learn about the Davis Vision company
- Find network providers and where to access the Davis Vision Frame Collection
- Verify eligibility for yourself or your dependents
- Print an enrollment confirmation from our Web site
- Request an out-of-network provider reimbursement form
- Speak with a Member Service representative
- Initiate an appeal of a benefit denial
- Ask any questions about your vision care benefits

Member Service representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. Eastern Time.

Members who use a TTY (teletypewriter) because of a hearing or speech disability may access TTY services by calling 1-800-523-2847.

## Member Services

### ***Replacement Contact Lenses by Mail***

As a member of this program, Highmark offers a contact lens replacement program. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit [www.davisvisioncontacts.com](http://www.davisvisioncontacts.com) or call 1-855-589-7911 with a current prescription.

### ***Warranty Information***

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied through the Davis Vision collection.

# How We Protect Your Right to Confidentiality

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We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with physicians, hospitals, vendors and other health care providers.

Our Privacy Department review and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices. It's all part of safeguarding the confidentiality of your protected health information.

# Terms You Should Know

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**Blended Segment Lenses** - Eyeglass lenses containing two different prescriptions, one prescribed for distance and one for near. Segment with near prescription is buffed out so as not to be noticeable to the eye.

**Blue Light Lenses** - Blue light blocking glasses have specially crafted lenses that are designed to block or filter out the blue light that is given off from digital screens (phones, tablets, computers, laptops, televisions, etc.). The lens is designed to protect your eyes from glare and can help to reduce potential damage to the retina from prolonged exposure to blue light.

**Claim** - A request for preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-Service Claim** - A request for preauthorization or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Post-Service Claim** - A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

**Copayment** - A specified dollar amount of eligible expenses which you are required to pay for a specified covered service.

**Designated Agent** - An entity that has contracted, either directly or indirectly, with the vision plan to perform a function and/or service in the administration of this program.

**Discounted Price** - The reduced amount that network providers, regardless of their actual or usual charge, have agreed to bill you and accept as payment in full for a specific service.

**Formulary Contact Lenses** - Approved contact lenses as specified by Highmark.

**Glass-Grey #3 Prescription Sunglasses** - A glass material eyeglass lens that is colored all the way through the lens that is not dyed, dipped or coated.

**High-Index Lenses** - Eyeglass lenses made with material that results in thinner and lighter lenses than normal plastic eyeglass lenses.

**Intermediate Vision Lenses** - Eyeglass lenses that are designed to correct vision at ranges intermediate to distant and near objects as typically used for occupational or computer use purposes.

**Low Vision** - A significant loss of vision but not total blindness.

**Medically Necessary Contact Lenses** - A contact lens considered eligible only after cataract surgery, corneal transplant surgery or other conditions such as, but not limited to, keratoconus or when adequate visual acuity is not attainable with eyeglasses but can be achieved through the use of contact lenses. Medically necessary contact lenses are contact lenses that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Highmark reserves the right, utilizing the criteria set forth in this description, to render the final determination as to whether covered contact lenses are medically necessary. This benefit will not be provided unless Highmark determines that the covered contact lenses are medically necessary.

**Network Provider** - A provider who has an agreement, either directly or indirectly, with Highmark pertaining to payment of covered services.

**Non-Formulary Contact Lenses** - Contact lenses that have not been approved by Highmark.

**Non-Network (Out-of-Network) Provider** - A provider who has not entered into a participation agreement, either directly or indirectly, with Highmark pertaining to payment for covered services.

**Ophthalmologist** - A physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform eye examination and refractive services.

**Optician** - A technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses upon prescription to the intended wearer. The Optician's functions include: prescription analysis and interpretation; determine of the lens forms best suited to the wearer's needs; the preparation and delivery of work orders for the grinding of lenses and the fabrication of eye wear; the verification of the finished ophthalmic products; the adjustment, replacement, repair and reproduction of previously prepared ophthalmic lenses, frames and other specially fabricated ophthalmic devices.

**Optometrist** - A professional provider, licensed where required, who examines, diagnoses, treats and manages diseases, injuries and disorders of the visual system, the eye and associated structures as well as identifies related systemic conditions affecting the eye.

**Photochromic Glass Lenses** - Eyeglass lenses that darken when exposed to intense illumination, i.e., sunlight, and which lighten in color when illumination is reduced.

**Plan** - Refers to Highmark, which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted, either directly or indirectly, to perform a function or service in the administration of this program.

**Plan Allowance** - The amount used to determine payment by Highmark for covered services provided to you and to determine your liability.

**Plastic Photosensitive Lenses** - Plastic eyeglass lenses that turn dark when exposed to the ultraviolet rays of the sun.

**Polarized Lenses** - Eyeglass lenses that are either green, gray or brown and that redirect the way light enters the lens.

**Polycarbonate Lenses** - Impact resistant and lightweight eyeglass lenses.

**Preauthorization** - The process through which selected covered services or post-refractive products are pre-approved by Highmark for medical necessity or other benefit eligibility criteria.

**Premium Anti-Reflective Coating (ARC)** - A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Crizal™, Carl Zeiss Carat Gold™, etc.)

**Premium Progressive Lenses** - All-distance lenses that have no line but progress from distance to intermediate, to near (i.e. Varilux™, etc.)

**Professional Provider** - A person or practitioner licensed where required and performing services within the scope of such licensure. The professional providers are: Doctor of Medicine, Doctor of Osteopathy, Doctor of Ophthalmology or Doctor of Optometry.

**Program Allowance** - A schedule of allowances as established by Highmark, subject to any regulatory approvals.

**Retail Optical Dispensing Firm** - An enterprise engaged in the performance of optical dispensing services and the sale of ophthalmic products to the public at large.

**Safety Eyeglasses** - Prescription eyeglasses conforming to applicable American National Standards Institute (ANSI) standards for protective eye devices as determined by the U.S. Department of Labor, Occupational Safety & Health Administration.

**Scratch-Resistant Coating** - Coating applied to eyeglass lenses to increase the scratch resistance of the lens surface.

**Standard Anti-Reflective Coating (ARC)** - A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Reflection Free™, Carl Zeiss Gold ET™, etc.)

**Standard Progressive Lenses** - All-distance eyeglass lenses that have no line but progress from distance to intermediate, to near (i.e. AO Compact™, Sola VIP™, etc.)

**Supplier** - An individual or entity that is in the business of providing or dispensing post-refractive products as provided herein. Suppliers include but are not limited to retail optical dispensing firms and opticians.

**Tinted Plastic Lenses** -

- a. Fashion tinting - Eyeglass lenses dyed or coated with pigment of uniform color and density throughout the entire lens.
- b. Gradient tinting - Eyeglass lens coating that is darker at the top of the lens, fading to light at the bottom of the lens.

**Ultimate Anti-Reflective Coating (ARC)** - A clear coating placed on eyeglass lenses that provide exceptional visual clarity and protection against glare, reflections, harmful blue light, and ultraviolet rays. Lenses repel dust and dirt for clearer lenses and less cleaning.

**Ultimate Progressive Lenses** - Eyeglass lenses designed with the widest viewing areas for both distance and reading and every distance in between. Lenses are the best in digital design and cutting edge technology.

**Ultra Anti-Reflective Coating (ARC)** - A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Alize™ with Clear Guard, Carl Zeiss Carat Advantage Gold™, etc.)

**Ultraviolet Coating** - A coating on plastic or glass eyeglass lenses that blocks ultraviolet rays.

**Ultra Progressive Lenses** - Eyeglass lenses designed with no clear line of demarcation between power changes but which progress gradually from distance to intermediate to near vision correction as needed.

Highmark is a registered mark of Highmark Inc.

You are hereby notified, your health care benefit program is between the Group, on behalf of itself and its members and Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield shall be liable to the Group, on behalf of itself and its members, for any Highmark Blue Cross Blue Shield obligations under your health care benefit program.

# NOTICE OF PRIVACY PRACTICES

Highmark Inc.



## Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW HEALTH AND FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

### Our responsibilities

At Highmark Inc., including its wholly-owned health plan subsidiaries and affiliates (Highmark), we value your privacy. When it comes to managing your information, we are required by law to maintain the privacy and security of your health and non-public personal (financial) information and to provide you with notice of your rights and our duties to keep your information safe and confidential. This Notice of Privacy Practices ("Notice") combines two required privacy notices:

- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Gramm Leach Bliley Act (GLBA) privacy notice

In the normal course of doing business, we collect information as necessary to provide you with health insurance products, help manage the treatment you receive, pay for your health services, and to run our business. The information we collect is called Protected Health Information ("PHI"). PHI is health and financial information that identifies you, or could be used to identify you, and was created or received by a health care provider, a health plan, a health care clearinghouse, or vendor performing activities on behalf of one of these organizations, or your employer (if a group health plan), and is related to one of the following:

- Your past, present, or future physical or mental health or condition;
- Providing you with health care; and,
- The past, present, or future payment for providing you with health care.

This Notice describes our privacy practices, which includes how we use, disclose (share), collect, manage, and protect your PHI and other non-public personal information. This Notice applies to all electronic and paper records we create, obtain, or maintain about you as a member, as well as all forms of communication (oral, written, and electronic) of this information. This Notice does not apply to Highmark in the context of being an employer.

### How we protect your privacy

We understand the importance of protecting the confidentiality of your information. We restrict access to your PHI and personal information to those employees, agents, consultants, and health care providers who need to know the information to provide products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to protect personal information against unauthorized use, access, and disclosure. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI or non-public personal information.

### How we use and share your information

We use and share PHI and other non-public personal information we collect only as necessary to deliver products and services to our members, to operate our business, or to comply with legal requirements. For example, we may use your PHI and non-public personal information internally to manage enrollment, process claims, or audit our operations. We share PHI and non-public personal information with our affiliated companies and non-affiliated third parties, as permitted

by law, who assist us in administering our programs, coordinating care, and delivering products and services to our members. We may also share PHI and non-public personal information with other third-party service providers that cooperate with us to jointly promote or administer health insurance products or services. Our contracts with all such service providers require them to protect the confidentiality of our members' information.

Please be advised that once information is shared with a third party other than a health care provider, health plan, or other person subject to federal privacy laws – for example, if you fill out an authorization form directing us to share your PHI with a life insurance carrier – the information may no longer be subject to privacy and security protections, and the recipient may use or share that information for other purposes.

### **Uses of PHI without your authorization.**

We have the right to collect, use, and share your PHI, if needed, without your written authorization while providing your health benefits. We have listed a few examples of how we use your information without authorization.

- **Help manage the health care you receive:** To manage the health care you receive, we can use your PHI and share it with health care professionals that are treating you. For example, a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services or assess the quality of your care.
- **Pay for your health services:** We may use and share your PHI as we pay for your health services. For example, we share information about you with your health care provider to coordinate payment for your particular treatment.
- **Run our business:** We may use and share your PHI to run our business and contact you when necessary. For example, we use information about you to develop and enhance products and services offered to our members, and we may share your information among our subsidiaries and affiliated entities for purposes permitted by applicable law.
- **Administer your benefits:** We may share your PHI with your group health plan administrator to perform administrative functions for the benefit plan in which you participate. For example, your employer contracts with us to administer health coverage, and we provide your employer's plan administrator with certain information to explain the premiums we charge, or to enroll or disenroll members in the benefit plan.

We may collect, use, and share your information in other ways without your authorization. We must meet certain conditions in the law before we can share your information for these purposes. The following are some of those examples.

- **As required by law:** We may share your PHI if federal or state law requires the use or disclosure. For example, we must share your PHI with the U.S. Department of Health and Human Services if they want to see that we are following federal privacy laws.
- **Help with public health and safety issues:** We can share your PHI for certain situations such as:
  - Preventing or controlling disease, injury, or disability;
  - Reporting abuse, neglect, or domestic violence;
  - Helping with product recalls;
  - Reporting adverse reactions to medications;
  - Preventing or reducing a serious threat to anyone's health or safety.
- **Respond to lawsuits and legal actions:** We may share your PHI in response to certain legal requests. For example, we may share your PHI in response to a court order, administrative order, or subpoena that complies with applicable law.
- **Respond to requests from coroners, medical examiners, funeral directors, and organ donation agencies:** We may share PHI with a coroner or medical examiner to identify deceased persons and the cause of death. If necessary, we will share PHI with funeral directors. Further, we may share PHI with organizations that handle organ, eye, or tissue donation and transplantation.
- **Do research:** We can use or share your information for health research purposes, subject to certain criteria.

- **Address workers' compensation, law enforcement, health oversight activities, and other government requests:** We can use or share your PHI when needed:
  - For workers' compensation claims;
  - For law enforcement purposes or with a law enforcement official;
  - With health oversight agencies for activities authorized by law;
  - For special government functions such as military, national security, and presidential protective services.
- **Cookies and Online Services:** We may collect information obtained when you visit and utilize Highmark websites (including the Highmark Member Portal or other online benefit sites) or mobile device applications. Through the use of cookies, pixels, and other digital tracking technologies, we may collect and share information about your use of these digital services, pursuant to applicable laws, to operate our business and improve our product and service offerings.
- **Underwriting Purposes:** We may use or disclose PHI for underwriting purposes, but we are prohibited from pricing your coverage or denying you coverage based on genetic information.
- **Business Associates:** We may contract with outside entities that perform business services for us that may require them to use or access your PHI. These entities are called business associates. We will have a written contract in place with the business associate requiring protection of the privacy and security of your health information. For example, we may share your PHI with a business associate to analyze your use of our websites and mobile device applications including, but not limited to, access times, pages viewed, etc. We may also use your PHI to develop, operate, and improve machine learning and other artificial intelligence solutions, for example, to support transcription of customer service calls or claims processing. You should review our Digital Privacy Policy (available on our website) and any applicable Terms of Use for supplemental details regarding our online services, the information we collect, and the terms associated with a particular website or application.
- **Health Information Exchange (HIE):** We may participate in certain Health Information Exchanges (HIEs), which may be an opt-in or opt-out model. An HIE is a secure electronic data sharing network which allows us to share health information electronically with other healthcare entities, such as insurers, health systems, hospitals, and physicians participating in your care for the purposes of treatment, payment, and healthcare operations. The health information we may share includes your claims, medical history, diagnosis, notes, test results, current medications, allergies, immunizations, and other vital information needed for your care. All providers who participate in an HIE have agreed to privacy and security rules to protect your health information from unauthorized access, use or disclosure.
 

You cannot choose to have only certain providers access your information. If you do not want your health information to be accessed through an HIE, you may choose not to participate or "opt-out" where applicable. Even if you opt-out, this will not prevent your health information from being shared in other ways as authorized or allowed by law for purposes such as managing your health care, paying claims for services you received, or administering your benefits.
- **Organized Health Care Arrangement (OHCA):** Highmark and its affiliated system of healthcare providers, Allegheny Health Network (AHN), participate in an OHCA to conduct analysis for quality assessment and improvement activities, utilization review and related activities to facilitate more effective and efficient health care services for our members and patients. Individual PHI may be accessed, used and/or disclosed as necessary to carry out treatment, payment, or health care operations relating to the OHCA.
- **Inmates.** If you are an inmate of a correctional institution, we may share your PHI with the correctional institution to provide you with health care, or to protect your health and safety or the health and safety of others.

**Uses of PHI that require your authorization.** Sometimes we are required to obtain your written authorization for the use and disclosure of your PHI. For example, we would need your authorization:

- To use your PHI for certain marketing purposes;
- To sell your information;

- To share your substance use disorder counseling notes; and
- To share your psychotherapy notes.

**Withdrawal.** We will not use or share your information other than as described in this Notice, or as permitted or required by applicable law, unless you tell us we can in writing. You may change your mind at any time by letting us know in writing. Any change or withdrawal of authorization will be effective for future uses and disclosures of PHI. It will not impact use of information or disclosures that we have already made while your previous authorization was in effect.

**Compliance with State and Federal laws.** We are required to comply with federal and state laws when they offer greater privacy protection for certain types of PHI. Where such laws apply, we will follow the stricter laws related to the use and sharing of sensitive PHI, such as:

- Genetic information;
- HIV/AIDS testing, diagnosis, or treatment;
- Venereal or communicable disease testing, diagnosis, or treatment;
- Alcohol or drug abuse prevention, treatment, and referral;
- Psychotherapy notes.

## Your personal information

We may also collect, use, and share other non-public personal information to administer our health and benefit programs. Personal information identifies you and may include such items as your name, address, telephone number, date of birth and Social Security number, or it may relate to health care services or premium payment history. We collect your personal information either directly from you or from others such as doctors, hospitals, or other insurers, as applicable. In some cases, we may also share your personal information with third parties and without your authorization as permitted or required by law. If sharing your personal information for a specific reason requires us to give you a chance to opt-out, we will give you that opportunity.

## Your choices

For certain health information, you can tell us your choices about what we share. We may use and share your information in the situations described below but you have the right to limit or object to sharing information for these reasons.

- Under certain circumstances, we may share your PHI with your family or close friends that you have identified as being involved in your health care or payment for your health care, unless you tell us not to do so. If you are unable to provide us permission, then we may provide the information we determine is in your best interest based on our professional judgement.
- We may share your information in a disaster relief situation.
- We may use or share your name, address, phone number, and the dates you received services to contact you to support our fundraising efforts, consistent with applicable laws.

## Your individual rights

When it comes to your health information, you have certain rights. The following is a description of those rights. Any request must be in writing and signed by you or your authorized representative. You can obtain more information about how to submit your request by calling the Customer Service phone number on the back of your identification card. You may also request more information or submit your request in writing to the contact listed at the end of this Notice.

- **Get a copy of your health and claims records:** You can ask to review or receive copies of your health and claims records that we have about you in a designated record set. We will provide a copy or summary of your health and claims records. We may charge a reasonable cost-based fee.

- **Get a list of those with whom we have shared information:** You can ask for a list (an “accounting”) of the times we have shared your PHI that are for reasons other than treatment, payment, health care operations, or those which you authorized. You may request the date range you want to review; however, this is limited to 6 years before the date of your request.
- **Ask us to limit what we use or share:** You can ask us not to use or share certain health information about you for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it is not consistent with the law, our policies, or our business operations.
- **Request confidential communications:** You can ask us to contact you in a specific way, or at a different address, if you believe that sharing your PHI could place you in danger. For example, you may ask that we contact you only at your work address or your work email.
- **Ask us to correct or amend health and claims records:** You can ask us to correct, or amend, your health and claims records if you believe they are incorrect or incomplete. Your request must explain why you believe the information needs to be corrected. We may say “no” to your request, but we will tell you why in writing.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian or other authorized representative, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **Get a paper copy of this Notice:** You can ask for a paper copy of this Notice, even if you have agreed to receive the Notice electronically.

## Changes to the terms of this Notice

On an ongoing basis, it may become necessary to revise the terms of this Notice. Any changes will apply to all information we have about you. If the Notice significantly changes, the new Notice will be available upon request, on our website, and we will mail a copy to you in our annual mailing.

## Complaints

If you want more information about our privacy practices or are concerned that we may have violated your privacy rights, you can complain to us using the following contact information:

Privacy Operations  
 120 Fifth Avenue Place, Suite 2114  
 Pittsburgh, PA 15222  
 Toll free: 1.800.985.2050  
[HighmarkHealthPrivacy@highmarkhealth.org](mailto:HighmarkHealthPrivacy@highmarkhealth.org)

You may also file a complaint with the U.S. Department of Health and Human Services by using the following contact information:

U.S. Department of Health and Human Services  
 Office for Civil Rights  
 200 Independence Avenue, S.W.  
 Washington D.C. 20201  
 Toll free: 1.877.696.6775  
[www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

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

## Effective date

We must follow the privacy practices described in this Notice while it is in effect. This Notice is revised and effective as of September 2025 and will remain in effect unless we replace it.

## ADDITIONAL PROVISIONS: PRIVACY PRACTICES RELATED TO SUBSTANCE USE DISORDER (SUD) RECORDS

These additional provisions to this Notice apply only to federally regulated SUD records. Your SUD records will be protected by federal and state privacy laws. Unless specifically indicated in these additional provisions, your SUD records will have the same protections and you will have the same rights as described elsewhere in this Notice. The following provisions identify added protections for SUD records, as required by law.

### When we can use and share your SUD records

For PHI collected by a SUD program governed by federal regulations, your consent will be obtained for all future uses or disclosures for treatment, payment, and healthcare operations before sharing such information consistent with applicable privacy laws. We may also obtain your consent to disclose SUD records to prevent multiple enrollments in withdrawal management or maintenance treatment programs, or to persons within the criminal justice system who have made participation in the substance use disorder program a condition of the disposition of any criminal proceedings against you or of your parole, or other release from custody, provided the disclosure is permitted by applicable privacy laws. In most cases, your consent is obtained for this when you begin treatment with a program covered under federal regulations. Except as described in these additional provisions, any other uses or disclosures of your SUD records will require your written consent.

Records that we share with your consent to a third party regulated by federal privacy laws may be further disclosed, without your written consent, by the third party, to the extent permitted by federal privacy laws.

We may use and share SUD records without your consent for the following reasons when all conditions required by federal law are met: medical emergencies, scientific research, management audits, financial audits, program evaluation, and disclosures to public health authorities when the health records are de-identified.

### Prohibition on sharing records in civil, criminal, administrative or legislative proceedings

We will not use or share your SUD records (or provide testimony based on such information) in any civil, criminal, administrative, or legislative proceedings against you, unless you have provided your written consent, or a special type of court order has been obtained and you have had the opportunity to object.

### Opt-out for fundraising

We will only use or share records to fundraise for the benefit of a SUD treatment program if you are first provided with an option to elect not to receive fundraising communications.

You can request to no longer receive fundraising communications following your participation in a SUD program, even if you initially permitted us to send such communications.

Disclosures:

\*Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

*Western and Northeastern PA:* Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Wholecare, or Highmark Senior Health Company.

*Central and Southeastern PA:* Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Wholecare, or Highmark Senior Health Company.

**PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.**

*Delaware:* Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark Health Options.

*West Virginia:* Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Health Options, or Highmark Senior Solutions Company. **Visit <https://www.highmarkbcbswv.com/networkaccessplan> to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.**

*Western NY:* Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

*Northeastern NY:* Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

