VISION CARE BENEFITS

VISION PROGRAM

The Pennsylvania State University
Groups 25263-50, 51
Effective January 1, 2015
Produced February, 2015

HIGHMARK®

HIGHMARKBLUESHIELD.COM

Highmark 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.

Disclosure

Your health benefits are entirely funded by your employer. Highmark Blue Shield provides administrative and claims payment services only.

Table of Contents

How Your Benefits Are Applied

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. 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 12 consecutive months beginning on January 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 provider's reasonable charge.

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 Summary 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 provider's reasonable charge, 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 provider's reasonable charge 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 Summary 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 Summary 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 Summary of Benefits, you are responsible for paying the entire discounted price to the 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 Summary 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.

Summary of Vision Benefits - Fashion Flex

Benefits	Network	Out-of-Network[1]
FREQUENCY		
• Eye Examination (including dilation as professionally indicated)	One visit every 12 months[2]	
• Eyeglass lenses	One pair every 12 months for members under age 19 and one pair every 24 months for members age 19 and over[2]	
• Frames	One frame every 24 months[2]	
• Contact lenses (in lieu of eyeglass lenses)		
• Formulary	One pair of standard daily wear or an initial supply of disposable (4 multi-packs) or planned replacement (2 multi-packs) contact lenses every 12 months for members under age 19 and one pair of standard daily wear or an initial supply of disposable or planned replacement contact lenses every 24 months for members age 19 and over[2]	
• Non-Formulary	Payment of the program allowance[2]	
EYE EXAMINATION (including dilation as professionally indicated)	Member pays $20	Plan pays up to $40
FRAMES		
• Fashion level frames from "The Collection"	Covered in full	
• Designer level frames from "The Collection"	Member pays $20	
• Premier level frames from "The Collection"	Member pays $40	
• Retail allowance toward an independent provider's frame	Plan pays up to $100	Plan pays up to $30
• Retail allowance toward a Visionworks frame	Plan pays up to $150	Plan pays up to $30
STANDARD EYEGLASS LENSES (per pair) [3]		
• Single vision lenses	Covered in full	Plan pays up to $35
• Bifocal vision lenses	Covered in full	Plan pays up to $40
• Trifocal vision lenses	Covered in full	Plan pays up to $50
• Lenticular vision lenses	Covered in full	Plan pays up to $72
OPTIONAL EYEGLASS LENSES (per pair)		
• Standard progressive lenses [4]	Member pays $50	Not Covered
• Premium progressive lenses [4]	Member pays $90	Not Covered
• Ultra progressive lenses [4]	Member pays $140	Not Covered
• Glass-Grey #3 prescription sunglasses	Member pays $11	Not Covered
• Polycarbonate lenses		
• Adult[5]	Member pays $30	Not Covered
• Dependent children		
• Single vision Polycarbonate lenses (in lieu of single vision eyeglass lenses)	Covered in full	Not Covered
• Bifocal Polycarbonate lenses (in lieu of bifocal eyeglass lenses)	Covered in full	Not Covered
• Trifocal Polycarbonate lenses (in lieu of trifocal eyeglass lenses)	Covered in full	Not Covered
• Blended segment lenses	Member pays $20	Not Covered
• Intermediate vision lenses	Member pays $30	Not Covered
• Glass photochromic lenses	Member pays $20	Not Covered
• Plastic photosensitive lenses	Member pays $65	Not Covered
• High-index (thinner and lighter) lenses	Member pays $55	Not Covered
• Polarized lenses	Member pays $75	Not Covered

Benefits	Network	Out-of-Network[1]
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS		
• Fashion, sun or gradient tinted plastic lenses	Member pays $11	Not Covered
• Ultraviolet coating	Member pays $12	Not Covered
• Scratch-resistant coating	Covered in full	Not Covered
• Standard ARC (anti-reflective coating)	Member pays $35	Not Covered
• Premium ARC (anti-reflective coating)	Member pays $48	Not Covered
• Ultra ARC (anti-reflective coating)	Member pays $60	Not Covered
• Scratch protection plan	Member pays $20 for single vision Member pays $40 for multifocal	Not Covered
CONTACT LENSES (in lieu of eyeglass lenses - per pair or initial supply of disposable contact lenses) [6]		
• Contact lens evaluation and fitting		
• Daily wear	Covered in full when the performing provider dispenses formulary contact lenses	Not Covered
• Extended wear	Covered in full when the performing provider dispenses formulary contact lenses	Not Covered
	Formulary[7]/Non-Formulary	
• Standard daily wear contact lenses	Covered in full / Plan pays up to $90 [8]	Plan pays up to $90
• Specialty contact lenses	Covered in full / Plan pays up to $90 [8]	Plan pays up to $90
• Disposable contact lenses	Covered in full / Plan pays up to $90 [8]	Plan pays up to $90
• Medically necessary contact lenses ***(prior approval required)***	Covered in full	Plan pays up to $225
LASER VISION CORRECTION SERVICES DISCOUNT PROGRAM	Member can receive discount up to 25% off provider's charge or 5% off any advertised special price	Not Covered
LOW VISION SERVICES [9]		
• Initial evaluation ***(prior approval required)***	Plan pays up to $300 per visit	
• Follow-up visits	Plan pays up to $100 per visit	
• Low vision aids	Plan pays up to $600 per aid Plan pays up to $1,200 lifetime maximum	

1 If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.

2 Eligibility will be determined by the benefit period applicable to your program.

3 Includes glass, plastic or oversized lenses.

4 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.

5 Member payment is waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

6 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.

7 Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

8 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.

9 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.

Covered Services

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, (ie, 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
- 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

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

- Tinted plastic lenses
- Ultraviolet coating
- Scratch-resistant coating
- Standard anti-reflective coating (ARC)
- Premium anti-reflective coating (ARC)
- Ultra 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 - Soft contact lenses that are worn for a prescribed length of time and then are discarded. Compared to conventional soft 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 are 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 are 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

Except as specifically provided in this booklet, covered services will not include charges:

- 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 legislation of any governmental unit. 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 in the absence of this or any similar coverage;
- 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;
- performed 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;
- unless the group is otherwise obligated by federal law to offer you all of the benefits of this program, to the extent payment has or would have been made by Medicare (both Parts A and B) regardless of whether you applied for such

Medicare benefits. Accordingly, unless otherwise required by federal law, this program will provide you with supplemental benefits only (i.e., Medicare benefits will be taken into account when calculating the payment of your benefits.)

- 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 self-insured plan, or 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; and
- for sales tax and shipping charges that may be associated with purchases of post-refractive products covered herein.

How Your Program Works

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 service are maintained. To find a network provider, go to www.highmarkblueshield.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

Who is Eligible for Coverage

Refer to your Penn State Summary Plan Document.

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep your plan administrator/employer 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.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (private sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Employers that are subject to COBRA must temporarily extend their vision coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

Contact your employer for more information about COBRA and the events that may allow you or your dependents to temporarily extend vision coverage.

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 Employer Contract

Your coverage will be terminated when you cease to be eligible to participate under your group health plan in accordance with its terms and conditions for eligibility.

How to File a Claim

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:

Vision Care
P.O. Box 1525
Latham, NY 12110-1525

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 Highmark Web site at www.highmarkblueshield.com or call 1-800-223-4795.

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. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parent(s) 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 Service 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 the claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from the Quality Assurance Department will review your appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Quality Assurance Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Quality Assurance Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on appeal that is based, in whole or in part, on medical judgment, the Quality Assurance Department will consult with a vision care professional who has appropriate training and experience. The vision care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with 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; or

- 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 benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review

You have four months from the date you receive notice of a final Highmark adverse benefit determination (except a determination that you failed to meet the eligibility requirements of your benefit program) to file a request for an external review with Highmark. Note that for pre-service claims, the four month period begins to run from the date you received Highmark's first-level adverse benefit determination.

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final

adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Highmark. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Expedited External Review

You are entitled to the same procedural rights to an external review as described above on an expedited basis if:

- The final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or

- A final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.)

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Highmark, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Member Service

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.highmarkblueshield.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 Highmark program, you are also eligible for free membership and access to a mail order replacement contact lens service, Lens 1-2-3®, which allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 1-2-3 Web site at www.Lens123.com.

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

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

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.

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 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.

Network Provider - A provider who has entered into a participation 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.

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, ie, sunlight, and which lighten in color when illumination is reduced.

Plan - Refers to Highmark, which is an independent licensee of the Blue Cross and 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.

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.

Provider's Reasonable Charge - The negotiated fee or contracted fee schedule amount that a network provider has agreed, either directly or indirectly, to accept as payment for a covered service.

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.

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.

Highmark is a registered mark of Highmark Inc.

You are hereby notified that Highmark Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark 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 Shield to use the familiar Blue Shield words and symbol. Highmark Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark al número al réves de su tarjeta de identificación de Highmark. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00, y los sábados de 8:00 a 17:00.

HIGHMARK
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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

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

Our Legal Duties

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

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

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

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

members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

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

I. Uses and Disclosures of Protected Health Information

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

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

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

Payment

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

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

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

For example:
We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care

providers, to engage in care coordination or case management, and/or to manage our business.

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

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

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

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

II. Other Possible Uses and Disclosures of Protected Health Information

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

A. To Plan Sponsors

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

bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

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

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

D. **Health Oversight Activities**
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

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

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

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

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

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

I. **Research**

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

J. **To Prevent a Serious Threat to Health or Safety**

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

K. **Military Activity and National Security, Protective Services**

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

L. **Inmates**

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

M. **Workers' Compensation**

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

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

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

P. **Health Information Exchange**
We all participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

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

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

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

use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

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

In order to opt-out, you must complete an opt-out Form, which is available at highmark.com or by calling the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but provider will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

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

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

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

B. Disclosures to You

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

IV. Other Uses and Disclosures of Your Protected Health Information

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

1. For marketing purposes
2. If we intend to see your PHI

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

    a. Used by the person who created the psychotherapy note for treatment purposes, or
    b. Used or disclosed for the following purposes:
        (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
        (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
        (iii) if required for enforcement purposes;
        (iv) if mandated by law;
        (v) if permitted for oversight of the provider that created the note;
        (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
        (vii) if needed to avert a serious and imminent threat to health or safety.

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

V. Your Individual Rights

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

A. Right to Access

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

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

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

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

B. Right to an Accounting

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

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

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

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

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

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

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

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

E. Right to Request Amendment

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

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

F. Right to a Paper Copy of this Notice

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

VI. Questions and Complaints

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

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

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

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

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

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

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

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

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

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

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

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only

as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.
- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

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

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222


HIGHMARK.