

- **HealthMedia® Overcoming™ Insomnia** is a six-week online program that uses proven techniques based on sound clinical evidence to help individuals recover from insomnia.
- **At "Choose Providers" you can:** access our provider directory which includes a wide range of information on doctors, hospitals and other providers; you can also take advantage of a Wellness Discount Program which offers discounts on complementary and alternative medicine, products and services such as fitness centers and spas, nutrition counseling, yoga and pilates, tai chi, massage and body work, health magazines, mind-body therapies, holistic practitioners, acupuncture, personal trainers, vitamins and chiropractic.
- **At "Health Topics" you can:** read articles, get information in the Health Encyclopedia, go "Inside the Human Body," and find the latest information on surgeries and procedures.

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach your healthiest potential. That's why, in addition to your Web site wellness tools, we keep you informed via your quarterly member newsletter, *Looking Healthward*. This newsletter contains new product updates, as well as a wide variety of health and preventive care articles and "stay healthy" tips. Watch for your copy in the mail!

## **Baby BluePrints**

### ***If You Are Pregnant, Now Is the Time to Enroll in Baby BluePrints***

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby BluePrints Maternity Education and Support Program.

By enrolling in this free program you will have access to printed and online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy. And you'll be sent valuable gifts for participating!

### ***Easy Enrollment***

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy.

Once you enroll, you will receive a Welcome Package that includes:

- a comprehensive Maternity Guide with important health information;
- a guide to educational resources found on your member Web site;
- flyers on available discount programs/services;
- a Childbirth Education Class Reimbursement form;
- a Child Immunization and Preventive Care pamphlet; and
- vouchers for the three free gifts:
  - gift at initial enrollment -- choice of book on pregnancy/childcare;

- gift at the end of the second trimester -- baby photo album; and
- gift after delivery -- child's dish set and book on child emergency and first aid care.

***For More Information***

If you have any questions about Baby BluePrints, please call Member Service at the number on your ID card. We encourage you to enroll early in your pregnancy to take full advantage of this exciting program.

# Member Rights and Responsibilities

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Your participation in the PPO program is vital to maintaining quality in your program and services. Your importance to this process is reflected in the following statement of principles.

***You have the right to:***

1. Receive information about Highmark, its products and its services, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or file an appeal about Highmark or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Highmark Members' Rights and Responsibilities policies.

***You have a responsibility to:***

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

## Terms You Should Know

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**Applied Behavioral Analysis** - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

**Assisted Fertilization** - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

**Autism Spectrum Disorders** - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

**BlueCard Program** - A program comprised of licensees of the Blue Cross and Blue Shield Association which allows you to receive covered services from participating professional, contracting supplier and participating facility providers located outside the plan service area. The local licensee of the Blue Cross and Blue Shield Association that services that geographic area where the covered services are provided is referred to as the "on-site" licensee of the Blue Cross and Blue Shield Association.

**Blues On Call** - A 24-hour health decision support program that gives you ready access to a specially-trained health coach.

**Board-Certified** - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

**Brand Drug** - A recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the pharmacy database used by Highmark Blue Cross Blue Shield.

**Claim** – A request for precertification 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 precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

**Covered Maintenance Prescription Drug** – A maintenance prescription drug, which Highmark is contractually obligated to pay or provide as a benefit to you under this program when dispensed by a participating maintenance pharmacy. Any prescription order for not more than a 90-day supply of a legend drug shall be considered a covered maintenance prescription drug, unless otherwise expressly excluded.

**Custodial Care** - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

**Designated Agent** - An entity that has contracted with Highmark to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

**Experimental/Investigative** - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by Highmark, Inc. to be medically effective for the condition being treated. Highmark will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical Researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Highmark believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Highmark recognizes that situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

**Generic Drug** - A drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by Highmark.

**Immediate Family** - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

**Infertility** - The medically documented inability to conceive with unprotected sexual intercourse between a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

**Maintenance Prescription Drug** - A prescription drug prescribed for the control of a chronic disease or illness, or to alleviate the pain and discomfort associated with a chronic disease or illness.

**Medically Necessary and Appropriate (Medical Necessity and Appropriateness)** - Services, supplies or covered medications 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: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) 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 definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

**Methadone Maintenance** - The treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

**Partial Hospitalization** - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

**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 to perform a function or service in the administration of this program.

**Plan Service Area** - The geographic area consisting of the following counties in Pennsylvania:

Allegheny	Centre (part)	Forest	Mercer
Armstrong	Clarion	Greene	Potter
Beaver	Clearfield	Huntingdon	Somerset
Bedford	Crawford	Indiana	Venango
Blair	Elk	Jefferson	Warren
Butler	Erie	Lawrence	Washington
Cambria	Fayette	McKean	Westmoreland
Cameron			

**Precertification (Preauthorization)** - The process through which selected covered services are pre-approved by Highmark.

**Preferred Provider Organization (PPO) Program** - A program that does not require the selection of a primary care physician, but is based on a provider network made up of physicians, hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

**Primary Care Physician (PCP)** - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

**Provider's Allowable Price** - The amount at which a participating pharmacy provider has agreed with Highmark to provide covered medications to you under this program.

**Provider's Reasonable Charge (also called "Allowable Charge")** - The allowance or payment that Highmark has determined is reasonable for covered services based on the provider who renders such services. The PRC is the portion of the provider's billed charge that is used by Highmark to calculate Highmark's payment to that provider and your liability.

**Specialist** - A physician, other than a primary care physician, who limits his or her practice to a particular branch of medicine or surgery.

**Totally Disabled (or Total Disability)** - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and

material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

**You or Your** - Refers to individuals who are covered under the program.

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Blues On Call is a service mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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# Introduction to Your Fashion Focus Program

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*The following benefits apply to those members who selected vision coverage. If you have any questions, contact your benefits administrator.*

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 Fashion Focus program.

# How Your Benefits Are Applied - Vision Program

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## 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 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 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 Focus

*The following benefits apply to those members who selected vision coverage. If you have any questions, contact your benefits administrator.*

Benefits	Network	Out-of-Network <sup>1</sup> Reimbursement
<b>FREQUENCY</b> <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)</li> </ul>	One visit every 12 months for members under age 19 and one visit every 24 months for members age 19 and over <sup>2</sup>  One pair every 12 months for members under age 19 and one pair every 24 months for members age 19 and over <sup>2</sup>  One frame every 24 months <sup>2</sup>  One pair of standard daily wear contact lenses or payment of program allowance every 12 months for members under age 19 and one pair of standard daily wear contact lenses or payment of program allowance every 24 months for members age 19 and over <sup>2</sup>	
<b>EYE EXAMINATION</b> (including dilation as professionally indicated)	Covered in full	Up to \$32 allowance
<b>FRAMES</b> <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 a provider's frame</li> </ul>	Covered in full \$20 copayment \$40 copayment Up to \$60 allowance	Up to \$30 allowance
<b>STANDARD EYEGLASS LENSES (per pair)</b> <sup>3</sup> <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>	Covered in full Covered in full Covered in full Covered in full	Up to \$25 allowance Up to \$36 allowance Up to \$46 allowance Up to \$72 allowance
<b>OPTIONAL EYEGLASS LENSES (per pair)</b> <ul style="list-style-type: none"> <li>Standard progressive lenses<sup>4</sup></li> <li>Premium 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> <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> </ul>	\$50 discounted price \$90 discounted price \$11 discounted price  \$30 discounted price  Covered in full  Covered in full  Covered in full  \$20 discounted price \$30 discounted price \$20 discounted price \$65 discounted price \$55 discounted price \$75 discounted price	Not Covered Not Covered Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered

Benefits	Network	Out-of-Network <sup>1</sup> Reimbursement
<b>OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS</b> <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> </ul>	\$11 discounted price \$12 discounted price \$20 discounted price \$35 discounted price \$48 discounted price \$60 discounted price	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
<b>CONTACT LENSES</b> (in lieu of eyeglass lenses - per pair or initial supply of disposable contact lenses) <sup>6</sup> <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</li> <li>• Medically necessary contact lenses (<i>prior approval required</i>)</li> </ul>	Covered in full Covered in full  Covered in full Up to \$75 allowance Up to \$75 allowance Covered in full	Up to \$20 allowance Up to \$30 allowance  Up to \$48 allowance Up to \$48 allowance Up to \$75 allowance Up to \$225 allowance
<b>LASER VISION CORRECTION SERVICES DISCOUNT PROGRAM</b>	Up to 25% off provider's charge or 5% off any advertised special price	Not Covered
<b>LOW VISION SERVICES<sup>7</sup></b> <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>		Up to \$300 allowance Up to \$100 allowance (per visit) Up to \$600 allowance (per aid) Up to \$1,200 lifetime maximum (for all aids)

- 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 from the date of the last similar service paid under this program or any other Highmark Blue Cross Blue Shield vision program for this group.
- 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 discounted price will not be refunded.
- 5 Discounted member price 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 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 - Vision Program

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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, (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
- 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
- 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 Davis Vision to provide such services.

## What Is Not Covered - Vision Program

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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 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;
- to the extent payment has been made under Medicare when Medicare is primary or would have been made if you had applied for Medicare and claimed Medicare

benefits; 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 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 - Vision Program

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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 Highmark Blue Cross Blue Shield member in a vision program administered by Davis Vision, and provide the office with your ID number (located on your Highmark 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.highmarkbcbs.com](http://www.highmarkbcbs.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 - Vision Program

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## Who is Eligible for Coverage

You may enroll your:

- Spouse
- Unmarried children under 19 years of age, including:
  - Newborn children
  - Stepchildren
  - Children legally placed for adoption
  - Legally adopted children or children for whom the employee or the employee's spouse is the child's legal guardian
  - Children awarded coverage pursuant to an order of court
- Unmarried children up to the age of 25, provided they are enrolled in and regularly attending a full-time accredited school, college or university or a licensed technical or specialized school and are dependent solely upon you for support. Except as otherwise indicated, coverage automatically terminates at the end of the month in which the student ceases to be eligible, whether or not notice to terminate is received by Highmark Blue Cross Blue Shield.

A student who takes a medically necessary leave of absence from school, or who changes his or her enrollment status (such as changing from full-time to part-time) due to a serious illness or injury may continue coverage for one year from the first day of the medically necessary leave of absence or other change in enrollment, or until the date coverage would otherwise terminate under the terms of this program, whichever is earlier. Highmark may require certification from the student's treating physician in order to continue such coverage.

- Unmarried children over age 19 who are not able to support themselves due to mental retardation, 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 unmarried 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.

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

## **Changes in Membership Status**

For Highmark to administer consistent coverage for you and your dependents, you must keep your Employee Benefit 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.

## **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 can be terminated in the following instances:

- When you cease to be an employee, your coverage will terminate at the end of the last month for which payment was made.
- 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 employer contract automatically terminates the coverage of all the members. It is the responsibility of the employer to notify you of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given to you by the employer.
- 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.

## How to File a Claim - Vision Program

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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.highmarkbcbs.com](http://www.highmarkbcbs.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 within 180 days from the date of your receipt of notification of the adverse decision.

Davis Vision handles all appeal decisions under the Highmark vision programs. The process involves one level of review. This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

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 Davis Vision 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. Davis Vision 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 your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Quality Assurance 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 which 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 Davis Vision. The Quality Assurance 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 Quality Assurance 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 Davis Vision 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 Davis Vision 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 legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

## **Member Service - Vision Program**

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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.highmarkbcbs.com](http://www.highmarkbcbs.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<sup>®</sup>, 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](http://www.Lens123.com).

#### ***Warranty Information***

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

## **Terms You Should Know - Vision Program**

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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.

**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 with Highmark 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.

**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 with Davis Vision pertaining to payment of covered services.

**Non-Network (Out-of-Network) Provider** - A provider who has not entered into a participation agreement with Davis Vision 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 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 with Davis Vision 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.