Healthy Steps

North Dakota's Children's Health Insurance Plan

VISION BENEFIT PLAN

North Dakota Vision Services Incorporated

North Dakota Vision Services, Incorporated

Healthy Steps

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The Healthy Steps Children's Health Insurance Program was created by the 1999 Legislature (N.D. Cent. Code §50-29) to provide health assistance to low-income children of the state. North Dakota Vision Services, Incorporated (VSI) has entered into an agreement with Blue Cross Blue Shield of North Dakota (BCBSND) to provide benefits and administer the Healthy Steps program.

In consideration of payment of required premium and acceptance of the membership application by the Department, North Dakota Vision Services, Incorporated (VSI), through an agreement with BCBSND, provides this Benefit Plan, including the membership application, Identification Card, Benefit Plan Attachment and any endorsements, supplements, attachments, addenda or amendments. These documents describe the vision benefits available to the Member Child. No change in this Benefit Plan is valid unless approved by the President of VSI. Changes to provisions will be sent to the address of the Member Child or the Member Child's Parent as shown on VSI records by mail no less that 31 days prior to the effective date of change.

NORTH DAKOA VISION SERVICES, INCORPORATED

Its President

MEMBER SERVICES

Questions?

Our Member Services staff is available to answer questions about your coverage –

Call Member Services:

Monday through Friday
7:30 a.m. - 5:00 p.m. CST

(701) 277-2227

or

1-800-342-4718

Office Address and Hours:

You may visit our Home Office during normal business hours –

Monday through Friday
8:00 a.m. – 4:30 p.m. CST

North Dakota Vision Services, Incorporated
4510 13th Avenue South
Fargo, North Dakota 58121-0001

Mailing Address:

You may write to us at the following address –

North Dakota Vision Services, Incorporated
4510 13th Avenue South
Fargo, North Dakota 58121-0001

Internet Address:

www.nd.gov/humanservices/services/medicalserv/chip

District Offices:

We invite you to contact our District Office closest to you –

Fargo District Office
4510 13th Avenue South
(701) 282-1149

Jamestown Office
300 2nd Avenue Northeast
Suite 132
(701) 251-3180

Bismarck District Office
1411 Mapleton Avenue
(701) 223-6348

Dickinson Office
150 West Villard, Suite 2
(701) 225-8092

Grand Forks District Office
American Office Park
2810 19th Avenue South
(701) 795-5340

Devils Lake Office
425 College Drive South, Suite 13
(701) 662-8613

Minot District Office
1308 20th Avenue Southwest
(701) 858-5000

Williston Office
1137 2nd Avenue West, Suite 105
(701) 572-4535

Provider Directories:

Members can obtain a Provider Directory by calling the telephone number on the back of the Identification Card.

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INTRODUCTION

Benefits described in this Benefit Plan are available to Member Children and cannot be transferred or assigned.

The Member Child will receive an Identification Card displaying the Benefit Plan Number and other information about this Benefit Plan. Carry the Identification Card at all times. If the Identification Card is lost, contact VSI to request a replacement.

Allowing another individual to use your Identification Card is prohibited. If you do so, you will be investigated by the fraud and abuse unit of the North Dakota Department of Human Services which could lead to civil or criminal sanctions and termination of coverage by the Department.

Present your Identification Card to your Provider to identify yourself as a Member Child. Participating Providers will submit claims on your behalf. You will be notified in writing by VSI of benefit payments made for Covered Services. Please review your Explanation of Benefits and advise VSI if you were billed for services you did not receive.

SECTION 1
SELECTING A VISION PROVIDER

SELECTING A VISION PROVIDER

At the time of enrollment, VSI will provide the Member Child or Member Child's Parent with a list of Participating Providers. All care and services must be sought from a Participating Provider to be eligible for payment as a Covered Service.

A. **Participating Providers**

Participating Providers must provide or arrange for Covered Services in order for a Member Child to receive benefits under this Benefit Plan. At the time of enrollment the Member Child or the Member Child's Parent will be provided with a list of all Participating Providers.

Participating Providers agree to submit claims to VSI on behalf of the Member Child. Reimbursement for Covered Services will be made directly to the Participating Provider according to the terms of this Benefit Plan and the participation agreement between the Provider and VSI.

When Covered Services are received from a Participating Provider a provider contract is in effect. This means the Allowance paid by VSI will be considered by the Participating Provider as payment in full, except for Maximum Benefit Allowances.

B. **Nonparticipating Providers or Out-of-State Providers**

No benefits will be provided for services received directly from a Nonparticipating or out-of-state Provider. Charges for such services will be the Member Child's or Member Child's Parent's responsibility.

The Member Child's vision care is between the Member Child or the Member Child's Parent and the Member Child's Provider. The ultimate decision on the Member Child's vision care must be made by the Member Child or the Member Child's Parent and the Member Child's Provider. VSI only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.

SECTION 2
COVERED SERVICES

The benefit amounts specified below only apply to Covered Services received from a Participating Provider.

This section describes the services for which benefits are available under this Benefit Plan subject to the definitions, exclusions, conditions and limitations of this Benefit Plan and the Maximum Benefit Allowance as described below, **Covered Services are paid at 100% of Allowed Charge**.

VSI shall determine the interpretation and application of the Covered Services in each and every situation.

2.1 VISION EXAMINATION

Benefits are available for routine vision examinations, Including refraction and glaucoma screening (tonometry test) subject to the conditions set forth below:

One examination is allowed once per Benefit Period;

2.2 PRESCRIBED LENSES AND FRAMES

Benefits are available for prescribed single vision, bifocal or trifocal lenses and frames, Including directly related professional services, subject to the conditions set forth below:

A. Prescribed lenses are allowed once per Benefit Period;

B. Benefits for frames (or contact lenses) are allowed once every other Benefit Period, limited to a Maximum Benefit Allowance of $80. Charges above the $80 Maximum Benefit Allowance for frames (or contact lenses) are the Member Child's or the Member Child's Parent's responsibility.

Benefits are available for contact lenses in lieu of the prescribed frames and/or lenses benefit. The benefit for contact lenses is limited to the Maximum Benefit Allowance for frames and/or prescribed single vision or bifocal lenses as determined Optometrically Appropriate and Necessary, not to exceed billed charges. If the Member Child purchases contact lenses in an amount below the Maximum Benefit Allowance for frames and/or prescribed lenses, no further benefits are available within the Benefit Period.

2.3 POST-OPERATIVE REFRACTIVE EXAMINATION(S)

Benefits are available for a post-operative refractive examination(s) when used instead of the benefits listed above. The full Allowance for the vision examination, refraction, single vision lenses and frames must be available in order for a post-operative refractive examination(s) benefit to be available. If the Member Child uses the vision benefit Allowance for a post-operative refractive examination(s), additional benefits for vision examinations and refractions, lenses and frames, or contact lenses will not be allowed until the next Benefit Period.

SECTION 3
EXCLUSIONS

No benefits are available for services listed in this section. The following list is not a complete list. In addition to these general exclusions, limitations and conditions there may be others that apply to specific Covered Services that can be found in the Covered Services section and elsewhere in this Benefit Plan. If a benefit or service is not covered, then all services, treatments, devices or supplies provided in conjunction with the benefit or services are not covered. If the Member Child receives services listed in this section, the Member Child or the Member Child's Parent will be responsible for the payment of those services. Please read this section carefully before seeking services and submitting claims. Please contact Member Services at the telephone number listed on the back of the Identification Card if you have any questions. VSI shall determine the interpretation and application of the exclusions in each and every situation.

3.1 EXCLUSIONS

No benefits are available for:

1. Services not prescribed or performed by or under the direct supervision of a Participating Provider. If services are received from a Nonparticipating Provider, the charges will be the Member Child's or the Member Child's Parent's responsibility.

2. Costs above the Maximum Benefit Allowance.

3. Medical or surgical treatment or diagnostic services, other than those provided as a component of a routine vision examination.

4 Services that are not Optometrically Appropriate and Necessary.

5. Prescription drugs or medications. (Benefits for prescription drugs or medications are available under the Healthy Steps health plan when Medically Appropriate and Necessary.)

6. The replacement of lost or broken lenses or frames unless at the time of replacement the Member Child is eligible for prescribed lenses or frames.

7. Costs incurred above the Allowance for cosmetic attachments to lenses or frames such as :

   A. monograms or facets,
   B. roll or polish edges for rimless lenses,
   C. tinting of lenses; i.e. photogray for glass lenses and transition for plastic lenses,
   D. slimlite or hi-index lenses,
   E. polythin or polycarbonate lenses,
   F. oversized lenses; i.e. large or oversize goggle blanks,
   G. highpower,
   H. specialty lenses; i.e. Smart Seq., executive, bifocal or trifocal extra wide.

8. Visual field exams.

9. Sunglasses.

10. Safety lenses.

11. Protective or scratch coating for plastic lenses.

12. Slab-off lenses.

13. Services for which a Member Child incurs no charge.

14. Services not prescribed by or performed by or under the direct supervision of a Provider and services that are beyond the Provider's scope of licensure.

15. Services when benefits are provided by a vision or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, similar person or group.

16. Charges for failure to keep a scheduled appointment or charges for completion of any forms required by VSI.

17. Services or supplies determined by VSI to be special or unusual, Including orthoptics, vision training and vision aids.

18. Claims for services that exceed the amount that would have been paid by the Member Child if no coverage existed under this Benefit Plan.

19. Services when benefits are provided by any governmental unit or social agency, except for Medicaid or when payment has been made under Medicare Part A or Part B. Medicare Part A and Part B will be considered the primary payor with respect to benefit payments unless otherwise required by law.

20. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.

21. Illness or bodily injury that arises out of and in the course of the Member Child's employment if benefits or compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.

22. Loss caused or contributed by a Member Child's commission or attempted commission of a felony (except losses caused or contributed by an act of domestic violence or any health condition) or the Member Child's involvement in an illegal occupation following the Member Child's enrollment in this Benefit Plan.

23. Services considered inconsistent with accepted vision practices as determined by VSI.

24. Services that a Member Child or the Member Child's Parent has no legal obligation to pay in the absence of this or any similar coverage.

25. Services provided to a Member Child prior to the effective date of this Benefit Plan. This includes services in process before and concluded after the effective date of coverage.

26. Vision screening assessment programs or vision education services, Including all forms of communication media whether audio, visual, or written.

27. Sales or health care tax.

28. Contact lens cleaning supplies and contact lens fitting fee.

29. Pre- and post-operative refractive services except as specified in the Covered Services Section of this Benefit Plan. Benefits are not available for complications resulting from refractive surgery.

30. Services, treatments or supplies that are not specified as a Covered Service under this Benefit Plan.

SECTION 4
GENERAL PROVISIONS

4.1 MEMBER CHILD ELIGIBILITY

The Department determines eligibility for Healthy Steps and furnishes the required information to VSI. Any questions regarding eligibility for Healthy Steps must be directed to the Department. The Department can be reached at 1-800-755-2604.

4.2 NOTICE AND PROOF OF CLAIM

The Member Child or the Member Child's Parent is responsible for providing VSI with written notice and proof of a claim for benefits within 18 months after the occurrence of commencement of a loss for which benefits are available under this Benefit Plan. The written notice and proof of a claim must include the information necessary for VSI to determine benefits.

4.3 PAYMENT OF CLAIMS

Payment of claims will be made upon receipt of written notice of a claim as provided in Section 4.3.

4.4 VISION EVALUATIONS

VSI at its own expense may require a vision examination of the Member Child as often as necessary during the pendency of a claim.

4.5 LIMITATION OF ACTIONS

No legal action may be brought for payment of benefits under this Benefit Plan prior to the expiration of 60 days following VSI's receipt of a claim for Covered Services or later than 3 years after the expiration of the time within which notice of claim is required by this Benefit Plan.

4.6 NOTIFICATION REQUIREMENTS

The Member Child or the Member Child's Parent is responsible for notifying VSI and the Department of any mailing address change within 31 days of the change.

The Member Child or the Member Child's Parent is responsible for notifying the Department if they move out of the State of North Dakota.

The Member Child's Parent is responsible for notifying the Department, within 31 days, of the birth of a new eligible Member Child.

4.7 CANCELLATION OF THIS BENEFIT PLAN

The Department will determine when this Benefit Plan will be cancelled due to income guidelines currently in effect or eligibility requirements. Coverage will be terminated the end of the month when the Member Child reaches age 19 or when VSI receives notification of termination from the Department.

4.8 MEMBER CHILD - PROVIDER RELATIONSHIP

Benefits are available only upon the recommendation and while under the care and treatment of a Provider. Nothing herein contained shall interfere with the professional relationship between the Member Child or the Member Child's Parent and his or her Provider.

Each Member Child or the Member Child's Parent is free to select a Provider and discharge such Provider. Providers are free to provide medical care according to his or her own judgment. Nothing contained in this Benefit Plan will interfere with the ordinary relationship that exists between a Provider and patient or obligate VSI in any circumstances to supply a Provider for any Member Child. The provision of vision care and/or the decision not to provide vision care may have a financial impact on the Provider. The Member Child or the Member Child's Parent should consult with his/her Provider regarding the nature and extent of such a financial impact, if any, as well as how it might affect vision care decisions.

The Member Child's care is between the Member Child or the Member Child's Parent and the Member Child's Provider, and this Benefit Plan only explains what is or is not covered, not what care the Member Child or the Member Child's Parent should seek.

4.9 CONFIDENTIALITY AND SECURITY

All Protected Health Information (PHI) maintained by VSI under this Benefit Plan is confidential. Any PHI about a Member Child under this Benefit Plan obtained by VSI from that Member Child, the Member Child's Parent or from a Health Care Provider may not be disclosed to any person except:

A. Upon a written, dated, and signed authorization by the Member Child or prospective Member Child or by a person authorized to provide consent for a minor or an incapacitated person;

B. If PHI identifies the Health Care Provider, upon a written, dated, and signed approval by the Health Care Provider. However, VSI may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. VSI may also disclose to a Health Care Provider, as part of a contract or agreement in which the Health Care Provider is a party, data or information that identifies a Health Care Provider as part of mutually agreed upon terms and conditions of the contract or agreement;

C. If the data or information does not identify either the Member Child or prospective Member Child or the Health Care Provider, the data or information my be disclosed upon request for use for statistical purposes or research;

D. Pursuant to statute or court order for the production or discovery of evidence; or

E. In the event of a claim or litigation between the Member Child, prospective Member Child or the Member Child's Parent and VSI in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for VSI to conduct health care operations, Including utilization review or management consistent with state law, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with Health Care Provider, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to PHI disclosed by VSI as part of a research project approved by an institutional review board established under federal law. This section does not apply to PHI disclosed by VSI to the insurance commissioner for access to records of VSI for purposes of enforcement or other activities related to compliance with state or federal laws.

VSI has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Member Children's PHI that VSI creates, receives, maintains, or transmits.

4.10 NOTICE OF PRIVACY PRACTICES

VSI maintains a Notice of Privacy Practices. This Notice of Privacy Practices outlines VSI's uses and disclosures of PHI, sets forth VSI's legal duties with respect to PHI and describes a Member Child's rights with respect to PHI. Member Children can obtain a Notice of Privacy Practices by contacting Member Services at the telephone number and address on the back of the Identification Card.

SECTION 5
APPEALS

If VSI makes a determination that results in a reduction or denial of benefits, the Member Child, the Member Child's Parent and/or the Member Child's Health Care Provider may appeal the determination. The following appeals process applies:

If the Member Child or the Member Child's Parent is not satisfied with a decision on an appeal, the Member Child or the Member Child's Parent has 20 days from the date in which the final adverse decision was made by VSI to appeal that decision to the North Dakota Department of Human Services. The appeal must be in writing and can be sent to the following address:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

To inquire on the appeals process, please contact Member Services at the telephone number and address on the back of the Identification Card.

SECTION 6
OTHER PARTY LIABILITY

This section describes VSI's Other Party Liability programs and coordinating benefits and services when a Member Child has other vision care coverage available, and outlines the Member Child's responsibilities under these programs. VSI shall determine the interpretation and application of the following Other Party Liability provisions in each and every situation.

6.1 COORDINATION OF BENEFITS

This provision applies when a Member Child is enrolled under another limited group or individual contract, certificate or plan (plan), whether insured or self-funded, that also provides benefits for services covered under this Benefit Plan. If the sum of benefits payable under this Benefit Plan and the other plan exceed the total charge for Covered Services, the benefits payable under this Benefit Plan will be reduced so the sum of benefits payable under all plans does not exceed 100% of the total charge for Covered Services.

For the purposes of this coordination of benefits provision, the following definitions apply:

“Allowable expense” means a vision care expense, including deductibles, coinsurance and copayments (if required as part of a plan), that is covered at least in part by any plan covering a Member Child. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense not covered by any plan covering a Member Child is not an allowable expense. In addition, any expense that a vision care provider by law or in accordance with a contractual agreement is prohibited from charging a Member Child is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) If a Member Child is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(2) If a Member Child is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(3) If a Member Child is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(4) The amount of any benefit reduction by the primary plan because a Member Child has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second opinions, precertifications, and preferred provider arrangements.

“Closed panel plan” means a plan that provides vision care benefits to Member Children primarily in the form of services through a panel of vision care providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other vision care providers, except in cases of emergency or referral by a panel member.

“Custodial parent” means the parent awarded physical custody by a court order or, in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

A. Order of Benefits Determination Rules. The order of benefits determination rules govern the order in which this Benefit Plan and another plan will pay benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The secondary plan may reduce the benefits it pays so that the benefits payable under all plans does not total more than 100% of the total allowable expense for Covered Services.

A plan that does not contain a coordination of benefits provision that is consistent with this Benefit Plan's provision is always primary unless the rules of both plans state that this Benefit Plan is primary. An exception exists for coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder.

If a claim or any other request for reimbursement is submitted under this Benefit Plan the order of payment will be the first of the following rules that apply:

1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

   However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

   a. Secondary to the plan covering the person as a dependent; and

   b. Primary to the plan covering the person as other than a dependent (e.g., a retired employee).

   Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

   b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph shall not apply with respect to any plan year during which Covered Services are paid or provided before the entity has actual knowledge of the court order provision. A copy of the court order must be provided to VSI upon request;

      (2) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 6.1(A.)(2.)(a.) shall determine the order of benefits;

(3) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Section 6.1(A.)(2.)(a.) shall determine the order of benefits; or

(4) If there is no court order allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The plan covering the custodial parent;

(b) The plan covering the custodial parent's spouse;

(c) The plan covering the non-custodial parent; and then

(d) The plan covering the non-custodial parent's spouse.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Section 6.1(A.)(2.)(a.) or Section 6.1(A.)(2.)(b.) as if those individuals were parents of the child.

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

   If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 6.1(A.)(1.) can determine the order of benefits.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber, policyholder or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

   If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 6.1(A.)(1.) can determine the order of benefits.

5. Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

   To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

   The start of a new plan does not include:

   a. A change in the amount or scope of a plan's benefits;

   b. A change in the entity that pays, provides or administers the plan's benefits; or

   c. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

      The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

B. If it is determined this Benefit Plan is secondary, the benefits of this Benefit Plan will be reduced so that the total benefits paid or provided by all plans during a Benefit Period are not more than the total allowable expenses. In determining the amount to be paid for any claim, this Benefit Plan will calculate the benefits it would have paid in the absence of coverage under another plan and apply that calculated amount to the allowable expense under this Benefit Plan that is unpaid by the primary plan. The benefits of this Benefit Plan will then be reduced so that they and the benefits payable under the other plans for the claim do not total more than 100% of the total allowable expense for that claim. When the benefits of this Benefit Plan are reduced as described in this subsection, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Plan. In addition, if this Benefit Plan has a deductible and/or coinsurance, the deductible and/or coinsurance will be credited with any amounts that would have been credited in the absence of the other plan.

The ultimate responsibility of VSI for payment of Covered Services will never exceed the amount payable in the absence of other coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about vision care coverage and services are needed to administer this coordination of benefits provision and to determine benefits payable under this Benefit Plan and other plans. VSI may obtain the facts it needs from or give them to other organizations or persons for the purpose of administering this provision. VSI need not tell, or obtain the consent of, any person to do this. Each Member Child claiming benefits under this Benefit Plan must provide VSI with any facts it needs to administer this provision and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Benefit Plan. If it does, VSI may pay that amount to the organization that made the payment. The amount will then be treated as though it were a benefit paid under this Benefit Plan. VSI will not have to pay that amount again.

RIGHT OF RECOVERY

If payments have been made by VSI for Covered Services in excess of the amount payable under this Benefit Plan, VSI may recover the excess from any persons to or for whom such payments were made, including any Member Child, provider or other organization. The Member Child agrees to execute and deliver any documentation requested by VSI to recover excess payments.

This provision is administered in accordance with the Coordination of Benefits Regulation adopted by the North Dakota Insurance Commissioner.

6.2 AUTOMOBILE NO-FAULT OR VISION PAYMENT BENEFIT COORDINATION

If a Member Child is eligible for basic automobile no-fault benefits or other automobile vision payment benefits as the result of accidental bodily injury arising out of the operation, maintenance or use of a motor vehicle, the benefits available under this Benefit Plan will be reduced by and coordinated with the basic automobile no-fault benefits or other automobile vision payment benefits.

6.3 VISION PAYMENT BENEFIT COORDINATION

If a Member Child is eligible for medical payment benefits provided by any other collectible insurance as a result of an injury, the benefits available under this Benefit Plan will be reduced by and coordinated with the medical payment benefits provided by any other collectible insurance not prohibited from coordination of benefits.

6.4 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

If VSI pays benefits for Covered Services to or for a Member Child for any injury or condition caused or contributed to by the act or omission of any third party, VSI shall have certain rights of assignment, subrogation and/or reimbursement as set forth below. VSI has full discretionary authority to determine whether to exercise any or all of said rights.

The Member Child or the Member Child's Parent must notify VSI of the circumstances of the injury or condition, cooperate with VSI in doing whatever is necessary to enable VSI to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. VSI has no obligation to notify the Member Child or the Member Child's Parent of VSI's intent to exercise one or more of these rights and VSI's failure to provide such a notice shall not constitute a waiver of these rights.

If a Member Child or the Member Child's Parent does not comply with these provisions or otherwise prejudices the rights of VSI to assignment, subrogation or reimbursement, VSI shall have full discretion to withhold payment of any future benefits to or for the Member Child and to set off the benefits already paid to or for the Member Child or the Member Child's Parent against the payment of any future benefits to or for the Member Child regardless of whether or not said future benefits are related to the injury or condition.

A. Right of Assignment and/or Subrogation: If a Member Child or the Member Child's Parent fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), VSI has the right to bring said claim as the assignee and/or subrogee of the Member Child and to recover any benefits paid under this Benefit Plan even if the Member Child has not received full compensation for the injury or condition.

B. Right of Reimbursement: If a Member Child or the Member Child's Parent makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member Child or the Member Child's Parent must notify VSI of said recovery and must reimburse VSI to the full extent of any benefits paid by VSI, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member Child or the Member Child's Parent has not received full compensation for the injury or condition. Any recovery the Member Child or the Member Child's Parent may obtain is conclusively presumed to be for the reimbursement of benefits paid by VSI until VSI has been fully reimbursed.

The Member Child and the Member Child's Parent agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid VSI's rights under this Benefit Plan. The Member Child and the Member Child's Parent agrees that any recovery shall be held in trust for VSI until VSI has been fully reimbursed and/or that VSI shall have a lien on any recovery to the full extent of any benefits paid under this Benefit Plan. The Member Child and the Member Child's Parent agrees that to enforce its rights under this section, VSI may pursue any and all remedies, legal or equitable, available under state or federal law, Including subrogation, breach of contract, constructive trust, equitable lien, injunction, restitution and any other remedies.

6.5 WORKERS' COMPENSATION

If benefits or compensation are available, in whole or in part, under provisions of a state workers' compensation act, laws of the United States or any state or political subdivision thereof, the benefits under this Benefit Plan will be reduced by and coordinated with such other benefits or compensation available to the Member Child.

If a Member Child is injured or suffers any condition caused or contributed to by the Member Child's employment, the Member Child must notify VSI of the circumstances of the injury and condition, cooperate with VSI and the United States or any state or political subdivision thereof in doing whatever is necessary to determine the availability of such benefits or compensation, and do nothing to prejudice them.

In the event of the failure of a Member Child to comply with this provision or if a Member Child prejudices that Member Child's right or entitlement to benefits or compensation available under such a program, VSI shall have full discretion to withhold payment of any future benefits to or for the Member Child and to off set the benefits already paid to or for the Member Child against the payment of any future benefits to or for the Member Child regardless of whether or not said future benefits are related to the injury or condition.

SECTION 7
DEFINITIONS

This section defines the terms used in this Benefit Plan. These terms will be capitalized throughout this Benefit Plan when referred to in the context defined. VSI shall determine the interpretation and application of the definitions in each and every situation.

7.1 **ALLOWANCE OR ALLOWED CHARGE** - the maximum dollar amount that payment for a procedure or service is based on as determined by VSI.

7.2 **BENEFIT PERIOD** - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A claim for benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a calendar year (January 1 through December 31) Benefit Period.

7.3 **BENEFIT PLAN** - includes the Member Child's membership application, Identification Card, this "Healthy Steps Vision Benefit Plan", the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments. If there is more than one Member Child in a family, the family will receive one "Healthy Steps Vision Benefit Plan". Each Member Child will receive an Identification Card and Attachment.

7.4 **BENEFIT PLAN ATTACHMENT** - the statement accompanying the Identification Card that identifies current Benefit Plan information.

7.5 **BENEFIT PLAN NUMBER** - the number assigned by VSI and listed on the Identification Card identifying the Member Child for administrative purposes.

7.6 **CLASS OF COVERAGE** - the type of coverage the Member Child is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Class of Coverage is as follows:

Single Coverage - Member Child only.

7.7 **COVERED SERVICES** - services and supplies that are Optometrically Appropriate and Necessary for the care of a Member Child's eyes.

7.8 **DEPARTMENT** - the North Dakota Department of Human Services, which will pay premiums and determine eligibility and enrollment for the Healthy Steps program.

7.9 **EXPLANATION OF BENEFITS** - a document sent to the Member Child by VSI after a claim for reimbursement has been processed. It includes the patient's name, claim number, type of service, Provider, date of service, charges submitted for the services, amounts covered by this Benefit Plan, noncovered services and the amount of the charges that are the Member Child's or the Member Child's Parent's responsibility. This form should be carefully reviewed and kept with other important records.

7.10 **IDENTIFICATION CARD** - a card issued in the Member Child's name identifying the Benefit Plan Number.

7.11 **INCLUDING** - means including but not limited to.

7.12 **MAXIMUM BENEFIT ALLOWANCE** - the maximum amount of benefits expressed in dollars, days or visits, available under this Benefit Plan for a specified Covered Service.

7.13 **MEMBER CHILD(ren)** - a child who meets the eligibility requirements of the Healthy Steps Program as determined by the Department and in whose name the Identification Card and Benefit Plan Attachment are issued.

7.14 **MEMBER CHILD'S PARENT** - the person responsible for the care and custody of the Member Child Including a natural parent, stepparent, adoptive parent, guardian or custodian of a Member Child as identified by the Department.

7.15 **OPHTHALMOLOGIST** - a Doctor of Medicine (M.D.) specializing in ophthalmology and licensed to practice medicine in the state where Covered Services are provided.

7.16 **OPTICIAN/OPTICAL SUPPLIER** - one who is a specialist in filling prescriptions for corrective lenses for eyeglasses and contact lenses, and is licensed in the state where Covered Services are provided.

7.17 **OPTOMETRICALLY APPROPRIATE AND NECESSARY** - the appropriateness and necessity of the care, treatment or the prescribing visual aids to a Member Child by a Provider.

7.18 **OPTOMETRIST** - a Doctor of Optometry (O.D.) licensed to provide vision care in the state where Covered Services are provided.

7.19 **PROTECTED HEALTH INSORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member Child that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:

A. is created by or received from a health care provider, health care employer, or health care clearinghouse;
B. relates to a Member Child's past, present or future physical or mental health or condition;
C. relates to the provision of health care to a Member Child;
D. relates to the past present, or future payment for health care to or on behalf of a Member Child; or
E. identifies a Member Child or could reasonably be used to identify a Member Child.

Educational records and employment records are not considered PHI under federal law.

7.20 **PROVIDER** - any Ophthalmologist, Optometrist, Optician or Optical Supplier as defined herein:

A. **Participating Provider** - a Provider who has entered into a participation agreement with VSI to provide Covered Services to a Member Child.

B. **Nonparticipating Provider** - a Provider who does not have a participation agreement with VSI.

7.21 **VSI** - North Dakota Vision Services, Incorporated.