

NDPERS BOARD MEETING

Agenda

Bismarck Location:
ND Association of Counties
1661 Capitol Way
Fargo Location:
BCBS, 4510 13th Ave SW

February 19, 2009

Time: 8:30 AM

I. MINUTES

A. January 22, 2008

II. RETIREMENT

A. Experience Study – Sparb (Board Action)

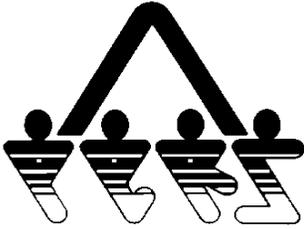
III. GROUP INSURANCE

- A. Diabetes Management Program Update – Jayme Steig (Information)
- B. Minimum Participation/Contribution Survey - Kathy (Information)
- C. PPO Participation – Kathy (Information)
- D. Go Red ND Initiative – Joan Enderle (Information)
- E. Health Plan Update – Sparb (Board Action)
- F. Pre-Medicare 3+ Rate – Sparb (Board Action)
- G. Retiree Plan Design – Sparb (Board Action)
- H. Employee Assistance Program Renewal – Sparb (Board Action)
- I. Surplus/Affordability Update – Bryan (Information)

IV. MISCELLANEOUS

- A. Board Election Committee – Kathy (Board Action)
- B. Legislative Update – Sparb (Information)
- C. PERSLink Quarterly Report – Bryan (Information)
- D. 2008 Business Plan – Sparb (Information)
- E. SIB Agenda

Any individual requiring an auxiliary aid or service must contact the NDPERS ADA Coordinator at 328-3900, at least 5 business days before the scheduled meeting.



North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 11, 2009
SUBJECT: Experience Study

NDCC section 54-52-04 states:

The board shall arrange for actuarial and medical advisers for the system. The board shall cause a qualified, competent actuary to be retained on a consulting basis. The actuary shall make an annual valuation of the liabilities and reserves of the system and a determination of the contributions required by the system to discharge its liabilities and pay the administrative costs under this chapter, and to recommend to the board rates of employer and employee contributions required, based upon the entry age normal cost method, to maintain the system on an actuarial reserve basis; **once every five years make a general investigation of the actuarial experience under the system including mortality, retirement, employment turnover, and other items required by the board, and recommend actuarial tables for use in valuations and in calculating actuarial equivalent values based on such investigation;** and perform other duties as may be assigned by the board. (Emphasis added)

The highlighted section requires us to have an experience study done at least every five years. Our last study was for the five years ending June 30, 2004. Consequently, we should conduct another study at the end of this next valuation in June of 2009. Options for us on this are:

1. Since Segal has one more year to go on their contract before it is bid (the existing contract is through June 30, 2010), we could have them submit an estimate and if it is reasonable, they could do the work. Please note they did the last experience study.
2. We could prepare an RFP, go to market and then select a firm

Please note we will be going to market later this year on the bid for the retirement consulting services for the 2010-2016 period.

Board Action Requested

Determine how to proceed with the experience study.



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Memorandum

TO: NDPERS Board

FROM: Kathy & Sparb

DATE: February 10, 2009

SUBJECT: Diabetes Management Program Update

Jayme Steig, Clinical Coordinator Provider with Frontier Pharmacy Services, will be at the meeting to present an overview on the clinical data obtained thusfar and its indications with regard to the Diabetes Management Program.

NDPERS Diabetes Program

Program Update & Data Overview As of January 28, 2009

Jayne Steig, PharmD, RPh
Frontier Pharmacy Services, Inc
Clinical Coordinator Provider
1-877-364-3932
jsteig@frontierpharmacyservices.com



Patient Profile

- 282 patients with documentation
 - 706 visits
- Average age = 53.5
 - Range – 10 to 65 years
 - 83% are over age 45
- 53.7% Female
- 5.5 Medical Conditions (range 1-16)
- 9 medications (range 2-31)
- 2.4 drug therapy problems

Drug Therapy Problems

- Needs additional therapy – 36%
- Dosage too low – 21%
- Non-compliance – 18%
- Adverse drug reaction – 11%
- Ineffective drug – 7%
- Dosage too high – 4%
- Unnecessary drug therapy – 3%

Drug Therapy Resolutions

- MD started new therapy – 29%
- Patient educated beyond OBRA – 28%
- MD changed dose – 23%
- MD changed product – 17%
- Patient self-monitoring initiated – 18%
- MD changed interval – 9%
- MD discontinued – 6%

- Note – there can be multiple resolutions per problem, resulting in % total greater than 100%

Drug Therapy Expenses

- Savings (295 encounters)
 - Office visit saved – 46%
 - \$100-200 rx net saved – 9%
 - \$51-100 rx net saved – 7%
 - \$11-25 rx net saved – 4%

- Note – rx net savings are per 90 days

Drug Therapy Expenses

- Expenses (263 total encounters)
 - \$11-25 Rx preventative cost – 21%
 - \$26-50 Rx preventative cost – 21%
 - \$10 or less Rx preventative cost – 18%
 - \$51-100 Rx preventative cost – 18%

- Note – rx net costs are per 90 days

Change in Health Status

- 40% of patients' conditions, which were not at recommended goals of therapy when the patient began the program, were recorded as improved on follow-up visits

Health Care Costs

- Costs avoided - as documented by providers
 - 165 clinic visits avoided
 - 22 lab services avoided
 - 12 specialty office visits avoided
 - 12 ER/Urgent Care visits avoided
- Costs Incurred – as documented by providers
 - 11 clinic visits
 - 43 laboratory service

Lab value changes

- A1C
 - 47% of patients initial A1C was above recommended value of 7.0
 - Average of 8.23
 - Average value for these patients is now 7.61
 - 34% of those out of range are now in range

Lab value changes

- Blood Pressure

- Systolic

- 41% initially not at recommended range
 - 20% of those are now at goal

- Diastolic

- 40% initially not at recommended range
 - 35% of those are now at goal

Lab value changes

○ Cholesterol

- Total - 13% initially not at goal
 - 53% of those are now at goal
- LDL - 27% initially not at goal
 - 30% of those are now at goal
- HDL – 38% initially not at goal
 - 16% of those are now at goal
- TG – 29% initially not at goal
 - 16% of those are now at goal



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Memorandum

TO: NDPERS Board

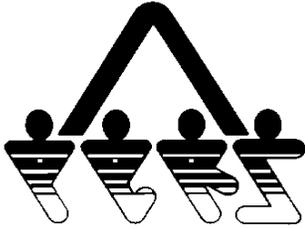
FROM: Kathy

DATE: February 10, 2009

SUBJECT: Minimum Participation & Contribution Requirements

BCBS completed its annual compliance review of our participating employers for the 2008 calendar year. Of the participating groups that responded, we have 100% compliance. One employer group, the City of Lamoure, has not responded to the questionnaire. BCBS has sent 2 requests and left 4 messages in an attempt to make contact. Efforts will continue in an attempt to make contact and we will report the outcome at such time as the issue is resolved.

Representatives of BCBS will be available to respond to any questions.



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Memorandum

TO: NDPERS Board

FROM: Kathy & Bryan

DATE: February 10, 2009

SUBJECT: PPO Participation/Discounts

Annually, PERS requests BCBS to provide us with an update regarding the activity relative to additions to our PPO network. In 2008, 454 professional pins were issued and 38 facilities and 11 institutional providers were added to our directory.

The total PPO discount for last year was \$2.64 million. The discount is only for the professional providers. Since the EPO is no longer capitated or targeted, the discount is applied. The following report from BCBS breaks down the discounts based on PPO and EPO membership.

\$62,038,376 (total PPO and EPO members)

\$27,523,942 (just PPO members)

~ \$ 8,912,560 (institutional)

~ \$14,206,189 (professional) of this PPO Discount = \$1,513,783

~ \$ 4,405,193 (Rx drugs)

\$34,514,434 (just EPO members)

~ \$10,938,107 (institutional)

~ \$17,225,237 (professional) of this EPO Discount = \$1,124,369

~ \$ 6,351,090 (Rx drugs)

Total PPO Discount \$2,637,152

Note: Institutional Discounts are built into the fee schedule so are not reported as discount.

We are available to answer any questions.



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Memorandum

TO: PERS Board
FROM: Rebecca
DATE: February 6, 2009
SUBJECT: Go Red ND Project

During the past two years, PERS has been pleased to have partnered with the American Heart Association and their Go Red Project in North Dakota. Through this partnership, we have been able to offer those employers participating in the wellness program the opportunity to relay to their employees information and programs offered through the American Heart Association.

We have also been able to offer special services funded through the Go Red ND project to three of our wellness employers. The three employers that are participating in these special services are:

- North Dakota State University
- Workforce Safety & Insurance
- Morton County

Here with us today is Joan Enderle, the director of the Go Red North Dakota project. Joan is going to share an overview of the project and services that are being provided to our PERS employers through this partnership.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 12, 2009
SUBJECT: Health Plan Update

BCBS is presently working on the reprojected 2009-2011 health insurance rates. We may have them for your review at the February meeting. At that time we will also review the funded status of the group insurance plan based upon legislative actions as of that date.



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Memorandum

TO: NDPERS Board

FROM: Kathy & Sparb

DATE: February 10, 2009

SUBJECT: Pre-Medicare 3+ Rate

We previously informed you that during an audit we had discovered a potential error with regard to the premiums being charged within the non-Medicare group. Further research indicated that there were 9 members that were potentially being charged the wrong premium based on the number of covered dependents on the contract. It appeared that at the conclusion of their COBRA continuation period, these members had been set up on a non-Medicare family contract of two instead of a non-Medicare contract of three or more family members.

In September, PERS sent letters to the 9 members outlining our findings and requesting their assistance in confirming their coverage. A copy of the letter is included for your information as attachment 1. Of the 9 members, 7 were verified as having been set up on a non-Medicare contract for two family members instead of for three family members and had, therefore, been undercharged for their premiums. Two of the members had been overcharged for their premiums as a result of each having a member on the contract that was eligible for Medicare. Attachment 2 is a spreadsheet that indicates the date ranges the non-Medicare coverage went into effect to the date coverage was confirmed and corrected. It also shows the total underpaid/overpaid premium amounts which are further broken down by biennium.

With regard to premium underpayments, Section 71-03-05-08 of the NDAC states the following:

An individual who underpays premiums is liable to pay those premiums upon receiving a request for repayment and an explanation of the amount due from the executive director. If not the result of any wrongdoing, negligence, misrepresentation, or omission by the individual, then the individual must make arrangements within sixty days of receiving written notification to either pay by lump sum or installments. The installment payment schedule is subject to approval by the executive director. If repayment arrangements are not in place within sixty days of the date of the written request for repayment, the executive director shall authorize payment to be made in three equal installments, using the same payment method the individual has authorized for paying current monthly premiums.

Based on the above, the next step is to notify each of the affected members in writing of the underpayment and to provide them with repayment options. In viewing previous actions regarding

similar situations that were addressed by the Board last year, we are informing you of this issue to provide you the opportunity to take any action prior to staff following through with the administrative procedures as set forth in Section 71-03-05-08.

With regard to the premium overpayments, Section 5.7(D) of the group health plan handbook states, "The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in family status within 31 days of the change." Section 71-03-05-07 of the Administrative Code states:

1. *An "overpayment" means a payment of money to the public employees retirement system for group insurance premiums that exceeds the premiums due for the level of coverage that should have been in effect.*
2. *If an overpayment occurs, the amount of the overpayment must be paid to the insured in a lump sum within thirty days of the discovery of the error.*

Based on the plan handbook, it was the responsibility of the two subscribers to notify us when the family members in question became eligible for Medicare. This action would have resulted in a change in their coverage level and a subsequent premium decrease to recognize Medicare as the primary payer for claims. The Administrative Code states we must refund an overpayment upon discovery; however, it does not provide any guidance as it relates to the negligence or omission by either party nor does it impose any limits on our liability for a retroactive refund of an overpayment. Therefore, staff is requesting the Board to determine whether a refund of premium is indicated for these two individuals.

A review of our administrative procedures identified why the premium underpayments occurred. They have since been modified to require that all members must complete a new health insurance application whenever there is a transition to a new rate structure in order to verify covered dependents on the member's contract and ensure they are set up with the correct premium.

Board Action Requested

1. Provide staff with direction regarding its next actions to address the underpayment of premiums for the seven members
2. Determine whether a refund is indicated for the two subscribers with a premium overpayment.

September 4, 2008

RE: NDPERS HEALTH INSURANCE COVERAGE

SSN:

During a recent audit, we discovered a discrepancy with regard to the premium you are being charged for your group health insurance coverage. At the time you retired, you elected COBRA continuation and were set up with the corresponding rate. This rate was effective for 18 months. After your 18 months ended, you were changed to a non-Medicare rate. It appears you may have been set up with the wrong premium for your coverage based on the number of covered dependents on your contract. Our records indicate that you are set up on a non-Medicare family contract of two instead of a non-Medicare contract of three or more family members. We show the following family members are currently covered on your contract:

In order to verify our records are correct, we are requesting that you please complete the enclosed health application form and return it to our office no later than Wednesday, September 17, 2008. If you do not return the form by this date, we will assume our records are correct as listed above and your monthly premium will be adjusted to the non-Medicare family (3+) rate. Your new rate effective October 1, 2008 will be \$1,181.98. Your premium adjusted for your retiree health credit will be \$. If you have your health premium deducted from your pension, and it is not large enough for the new premium amount, you will be set up to receive a monthly billing. If you have an automatic withdrawal set up from a checking or savings account, the new premium will be deducted on the 5th business day of the month.

After we have updated your record based on the information provided on the application or due to a premium adjustment as a result of no response to our request, we will contact you in a subsequent letter in the next several weeks notifying you of our determination regarding any premium or claims adjustments which may occur as result of a dependent update or premium change.

If you have any questions, please contact our office at 701-328-3900 or toll free at 1-800-803-7377.

Sincerely,

Accountant/Billing Department
Group Insurance Division

Enc.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 12, 2009
SUBJECT: NDPERS Dakota Retiree Plan

As we have previously discussed, the PERS Retiree Subcommittee has been reviewing the possibility of proposing a change to that retiree health plan from the existing “carve out” plan that provides secondary coverage after Medicare based upon the benefit provision of the existing active plan to one that would be based upon the Medicare supplement “ Plan F” design.

The committee is going to be meeting prior to the Board meeting to review this further and prepare a recommendation for your consideration at the February meeting. They will be reviewing the attached material. Attachment 1 is a draft explanation of the Plan F design for PERS. Attachment 2 is a PowerPoint presentation from BCBS discussing the implications and costs of such a change. We will review this material at the Board meeting and the Retiree Subcommittee’s recommendation.

2009-2011
NDPERS Proposed
Dakota Retiree Plan

A decorative graphic consisting of several horizontal lines of varying lengths and colors (teal, light blue, white) extending from the right side of the text area across the bottom of the slide.

General Items

- Proposed Plan - mirrors Plan F benefit design with no variations [not a Qualified Plan F product]
- Medicare Retirees must have BOTH Part A & B
- Benefit structure is very different than current plan
 - Follows Medicare and Plan F guidelines for benefits
 - **IF Medicare denies, this plan will deny**
 - Medicare makes changes to benefits at the beginning of each CY
 - 01/01/10 changes would be incorporated
 - Does not automatically coordinate benefits
 - Member responsible to re-file claims for coordination
 - In 2008, COB was only \$7,492
 - Overall benefit design is richer than current plan

Draft Summary Plan Description

**NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM**

DAKOTA RETIREE PLAN

DRAFT

Blue Cross Blue Shield of North Dakota
Medicare Supplement Benefit Plan

If, upon examination of this Benefit Plan you find you are not satisfied for any reason, you may return it to us within 31 days of its delivery to you and the premium you have paid will be refunded.

KEEP THIS DOCUMENT IN A SAFE PLACE

Blue Cross Blue Shield of North Dakota
A not-for-profit member of the
Blue Cross of North Dakota

23011966 Member Since 1914 10/15/09

Draft of Benefit Design Grid

Medicare and NDPERS Dakota Retiree Plan - 2009

PART A - HOSPITAL BENEFITS FOR MEDICARE APPROVED SERVICES

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Hospitalization <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i>			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st thru 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0*
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care <i>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital</i>			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First Three Pints	\$00	Three pints	\$0
Additional Amounts	100%	\$0	\$0
Hospice Care <i>Available as long as your doctor certifies you are terminally ill and you elect to receive these services</i>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

These Are Some Items Not Covered

- Services that are experimental or investigative in nature or that are not medically necessary as determined by Medicare.
- Services received prior to the effective date of your benefit plan.
- Services when benefits are provided by any governmental unit or social agency except Medicaid or when payment has been made under Medicare Part A or Part B.
- Outpatient prescription drugs, unless eligible under Medicare.
- Custodial care provided in a hospital or by a home health agency.
- Skilled nursing facility care costs beyond what is covered by Medicare and your benefit plan.
- Surgery to improve appearance.
- Services, treatments or supplies that are not a Medicare eligible expense.

PART B - HOSPITAL OUTPATIENT AND PHYSICIAN BENEFITS FOR MEDICARE APPROVED SERVICES

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Medical Expenses <i>In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment</i>			
First \$135 of Medicare Approved Amounts**	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
Blood			
First Three Pints	\$0	All costs	\$0
Next \$135 of Medicare Approved Amounts**	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services <i>Blood Tests For Diagnostic Services</i>			
	100%	\$0	\$0

PARTS A AND B - HOSPITAL AND PHYSICIAN BENEFITS FOR MEDICARE APPROVED SERVICES

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Home Health Care			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts**	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Foreign Travel <i>Not Covered by Medicare - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</i>			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

** Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

DRAFT

Draft of Benefit Design Grid

- Benefit Structure extremely different than current plan
- Areas with Richer Benefits

Deductible/Coinsurance

- Proposed plan eliminates current deductible & coinsurance (2008= \$1,492,571 & \$932,380)

Lifetime Maximum

- No Lifetime max
 - current plan = \$2 million

Cardiac Rehab

- 18 visits for Cardiac Rehab
 - current plan = 12

Areas with limited benefits

- Limited Services
 - Wound vac
 - Home infusion therapy
 - Long hour nursing
- Chiropractic

Chiropractic Services (limited)	Helps correct a subluxation (when one or more of the bones of your spine move out of position) using manipulation of the spine. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Current Plan	Office Visits/Manipulations – 80%/75%, deductible waived Therapy – 80%/75%, deductible applies.

Areas with limited benefits

- Skilled Nursing Facility

~Refer to Grid~

Proposed

- No benefits are available beyond the 100 days eligible under Medicare.

Current

- Allows after 100 days if medically appropriate, subject to deductible/coinsurance & lifetime max.

During 2008: \$52,084 in allowed charges

- Foreign Claims

~Refer to Grid~

Medicare Providers

- Providers not participating with Medicare may not be covered
- Provider may Accept Assignment
- During 2008
 - \$61,218 allowed charges of which \$29,360 @ VA (which is not balance billed to member)

96% of ND providers are PAR with Medicare

- 4,545 total providers in ND
- 4,353 providers PAR / 192 non-PAR

85% of ND chiropractors are PAR with Medicare

- 287 total Chiropractors in ND
- 245 Chiropractors PAR / 42 non-PAR

www.Medicare.gov

Address  http://www.medicare.gov/  Go 

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 **Medicare** The Official U.S. Government Site for People with Medicare

MyMedicare.gov 
Secure Sign In
This is an optional and free service
Sign In ID:
Password:

[learn more](#) | [sign up](#)

Prescription Drug Plan

NEW! Medicare & You 2009

Am I Eligible?

Medicare Billing ▶

Medicare Appeals ▶

Long-Term Care ▶

Plan Choices ▶

Medicare Spotlights **Site Updates**

[Medicare Premiums and Coinsurance Rates for 2009](#)
[View an online demonstration on how to use the Prescription Drug Plan Finder](#)

Medicare Prescription Drug Coverage

- ▶ [Medicare Prescription Drug Plans - 2009 Plan Data](#)
- ▶ [Medicare Health Plans - 2009 Plan Data](#)
- ▶ [Formulary Finder - 2009 Plan Data](#)
- ▶ [Lower Your Costs During the Coverage Gap](#)
- ▶ [Learn More About Plans in Your Area](#)

[Medicare & You 2009](#)

Prescription Drug Plan

- ▶ [Compare](#)
- ▶ [Check Current Enrollment](#)
- ▶ [Enroll](#)
- ▶ [Add/Update Drug & Pharmacy Information](#)

Medicare Stories

"We both find the coverage very beneficial. Judy was on Social Security disability so we have both..."

▶ [Read more](#)

7 **Index—A Quick Way to Find What You Need**

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11 What's New and Important in 2009?

12 What Is Medicare?

14 Where to Get Your Medicare Questions Answered

15 **Section 1—What's Covered? (Part A and Part B)**

19 Part A-Covered Services

25 Part B-Covered Services

38 What's NOT Covered by Part A and Part B?

41 **Section 2—Decide How to Get Your Medicare**

What's NOT Covered by Part A and Part B?

Items and services that Medicare doesn't cover include, **but aren't limited to**, the following:

- Acupuncture.
- Chiropractic services (except as listed on page 27).
- Cosmetic surgery.
- Custodial care, except when you also get skilled nursing care in a skilled nursing facility, at home, or as part of hospice care.
- Deductibles, coinsurance, or copayments when you get certain health care services. See pages 120–121 for these amounts. People with limited income and resources may get help paying these costs. See pages 82–84.
- Dental care and dentures (with a few exceptions).
- Eye exams (routine), eye refractions (exam that measures how well you see at specific distances), and eyeglasses (except as listed on page 30).
- Foot care (routine), like cutting corns or calluses (with few exceptions). See page 31.
- Hearing aids and exams for the purpose of fitting a hearing aid.
- Hearing tests that haven't been ordered by your doctor.
- Laboratory tests (screening), except those listed on pages 26–35.
- Long-term care. See pages 102–104.
- Orthopedic shoes (with few exceptions). See page 29 under Diabetes Supplies.
- Physical exams (routine or yearly). Medicare will cover a one-time physical exam. See page 33.
- Prescription drugs (with few exceptions). See page 34. See pages 63–71 for information about Medicare prescription drug coverage (Part D).
- Shots to prevent illness, except as listed on pages 30, 31, and 33. Part D must cover all commercially-available vaccines (like the shingles vaccine) except those covered by Part B.
- Surgical procedures given in ambulatory surgical centers that aren't included on Medicare's list of ambulatory surgical center covered procedures.
- Syringes or insulin. Insulin used with an insulin pump is covered by Part B. Syringes or insulin may be covered by Part D.
- Travel (health care while you're traveling outside the United States, except as listed on page 37).

Blue words in the text are defined on pages 115–118.



Preventive Services Checklist

Take this checklist to your doctor or other health care provider, and ask which preventive services are right for you. Look on pages 25–34 for more details about the costs, how often, and whether you meet the conditions to get these services. Write down any notes (like the date you get the service).

Medicare-covered Preventive Service	Details on Page	Notes
Abdominal Aortic Aneurysm Screening	26	
Bone Mass Measurement	27	
Cardiovascular Screenings	27	
Colorectal Cancer Screenings		
Fecal Occult Blood Test	28	
Flexible Sigmoidoscopy	28	
Colonoscopy	28	
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Diabetes Screenings	29	
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Flu Shots	30	
Glaucoma Tests	31	
Hepatitis B Shots	31	
Mammogram (screening)	32	
Medical Nutrition Therapy Services	32	
Pap Test and Pelvic Exam (includes breast exam)	33	
Physical Exam (one-time "Welcome to Medicare" physical exam)	33	
Pneumococcal Shot	33	
Prostate Cancer Screenings	34	
Smoking Cessation (counseling to stop smoking)	34	



**NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM**

DAKOTA RETIREE PLAN

DRAFT

Blue Cross Blue Shield of North Dakota Medicare Supplement Benefit Plan

If, upon examination of this Benefit Plan you find you are not satisfied for any reason, you may return it to us within 31 days of its delivery to you and the premium you have paid will be refunded.

KEEP THIS DOCUMENT IN A SAFE PLACE



**BlueCross
BlueShield
of North Dakota**

An Independent Member of the
Blue Cross & Blue Shield Association

PLAN F

**BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
MEDICARE SUPPLEMENT BENEFIT PLAN**

In consideration of payment of required premium and acceptance of the membership application, Blue Cross Blue Shield of North Dakota (BCBSND) enters into this legal agreement with You, the Subscriber. This legal agreement includes this Benefit Plan, Your membership application, Identification Card, benefit plan attachment and any endorsements, supplements, attachments, addenda or amendments.

NOTICE TO BUYER:

This Benefit Plan may not cover all of Your medical expenses. You should carefully review all limitations of coverage.

RENEWABILITY:

This Benefit Plan is guaranteed continuable and renewable for as long as the required premium is paid. BCBSND reserves the right to change premium to coincide with changes in Medicare benefits and to automatically adjust premium based on Your age.

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121-0001



**Michael B. Unhjem
Its President and CEO**

MEMBER SERVICES

- Questions?** Our Member Services staff is available to answer questions about Your Medicare Supplement coverage –
- Call Member Services:** Monday through Friday
7:30 a.m. – 5:30 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 or write to us at the following address –
Monday through Friday
8:00 a.m. – 4:30 p.m. CST
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121-0001
- Internet Address:** www.BCBSND.com
- 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 Northwest,
Suite 132
(701) 251-3180 |
| Bismarck District Office
Tuscany Square – 107 W. Main
(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
1600 South Broadway
(701) 858-5000 | Williston Office
1137 2nd Avenue West,
Suite 105
(701) 572-4535 |
- Call Medicare Customer Service:** 1-800-633-4227

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SECTION 1 INTRODUCTION

This Benefit Plan describes the benefits available to You as a person enrolled under Plan F – Blue Cross Blue Shield of North Dakota Medicare Supplement Benefit Plan.

This Benefit Plan, together with Your application for coverage, is a legal agreement between Blue Cross Blue Shield of North Dakota (BCBSND), and You, the Subscriber, as named on Your Identification Card.

The benefits described are available as long as the required premium is paid. Changes to provisions or premium amounts by BCBSND will be sent to the Subscriber's address as shown on BCBSND records by ordinary mail no less than 31 days prior to the effective date of change.

Please read this Benefit Plan very carefully. If You find You are not satisfied with this coverage for any reason, You may return it to us within 31 days of its delivery to You and the premium You have paid will be refunded.

Benefits described in this Benefit Plan are available to You for Your personal use only and cannot be transferred or assigned. Any attempt to transfer or assign the benefits of this Benefit Plan to ineligible persons will result in automatic termination of this Benefit Plan by BCBSND.

The Subscriber hereby expressly acknowledges and understands that BCBSND is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSND to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that BCBSND is not contracting as an agent of the Association. The Subscriber further acknowledges and agrees this Benefit Plan was not entered into based upon representations by any person or entity other than BCBSND and that no person, entity, or organization other than BCBSND shall be held accountable or liable to the Subscriber for any of BCBSND's obligations to the Subscriber created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this Benefit Plan.

SECTION 2 COVERED SERVICES

This Benefit Plan supplements Your Medicare Part A and Part B coverage by providing benefits for that portion of Medicare Cost Sharing Amounts applied to Medicare Eligible Expenses not paid by Medicare. Medicare Cost Sharing Amounts include Medicare Deductible, Coinsurance and Copayment Amounts. The benefits available under this Benefit Plan shall automatically change to coincide with any changes in the applicable Medicare Deductible, Coinsurance and Copayment Amounts. Premium may be modified to reflect such changes in the Cost Sharing Amounts.

You are entitled to the following covered services subject to the terms, conditions and limitations of this Benefit Plan.

2.1 INPATIENT HOSPITAL SERVICES

- A. The Medicare Part A Deductible Amount applied during the initial 60 days of an inpatient Hospital Admission in a Benefit Period.
- B. The Medicare Coinsurance Amounts applied to Medicare Eligible Expenses for days 61 through 90 of an Admission in any Benefit Period.

- C. The Medicare Coinsurance Amounts applied to Medicare Eligible Expenses for Lifetime Reserve Days utilized after the 90th day of an Admission in any Benefit Period.
- D. If an Admission continues beyond the 90th day and the Subscriber has utilized all of the Lifetime Reserve Days, benefits will be available for Medically Necessary care up to a lifetime maximum of an additional 365 days.

2.2 BLOOD SERVICES

- A. The first 3 pints of blood under Medicare Part A.
- B. The first 3 pints of blood and Medicare Coinsurance Amount applied under Medicare Part B.

2.3 SKILLED NURSING FACILITY SERVICES

Actual billed charges, up to the Medicare Coinsurance Amount, for days 21 through 100 of a Medicare Eligible Skilled Nursing Facility Admission. No benefits will be available if the Admission is not approved by Medicare.

2.4 MEDICARE PART B ELIGIBLE EXPENSES

The Medicare Deductible and Coinsurance Amounts, or in the case of Hospital outpatient department services paid under a prospective payment system, the Copayment Amounts, applied to Medicare Eligible Expenses, regardless of Hospital confinement.

2.5 MEDICARE PART B EXCESS CHARGES

In addition to the Medicare Deductible and Coinsurance Amounts, this Benefit Plan provides benefits for the difference between the actual Medicare Part B allowed charge and the actual charge for the service as billed, not to exceed any charge limitation established by the Medicare program.

2.6 BENEFITS FOR EMERGENCY CARE IN A FOREIGN COUNTRY

If You require care or treatment while You are outside of the United States, You will be entitled to benefits at 80% of the allowed charge for those Medically Necessary services that would have been Medicare Eligible Expenses, as well as the covered services provided by this Benefit Plan, if the care or treatment is received during the first 60 consecutive days of the trip. Benefits will be subject to a Calendar Year deductible amount of \$250 and a lifetime benefit maximum of \$50,000.

SECTION 3 PREEXISTING CONDITION LIMITATIONS

Services that are involved in the treatment of a Preexisting Condition will be covered only after this Benefit Plan has been in effect for a period of 6 months, beginning on the Effective Date of coverage. However, this period may be reduced by aggregate days of membership under Qualifying Previous Coverage, if continuous until at least 63 days prior to the Subscriber's Effective Date of coverage under this Benefit Plan.

When days of membership under Qualifying Previous Coverage are applied to this period, benefits for covered services will be available to the extent provided by the coverage in force at the time covered services are received by the Subscriber.

SECTION 4 EXCLUSIONS

4.1 EXCLUSIONS

No benefits are available for:

1. Services received prior to the Effective Date of this Benefit Plan.
2. 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 federal law.
3. Services that are experimental or investigative in nature or that are not Medically Necessary as determined by Medicare.
4. Outpatient prescription drugs, unless eligible under Medicare.
5. Services received from a Hospital or a distinct part of a Hospital located in the United States that is not certified by Medicare.
6. Custodial care provided in a Hospital or by a home health agency.
7. Skilled Nursing Facility care costs beyond what is covered by Medicare and this Benefit Plan.
8. Surgery and related services intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.
9. Services when benefits are provided or available under any workers' compensation, employers' liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
10. Services, treatments or supplies that are not a Medicare Eligible Expense.

SECTION 5 GENERAL PROVISIONS

5.1 PAYMENT OF PREMIUM

- A. This Benefit Plan continues and renews each month subject to the payment of premium and benefit plan provisions in effect on the date of renewal.
- B. All premium is due and payable before the first of the month. If premium is not received before the date due, a grace period of 31 days is allowed. The Subscriber remains responsible for payment of any premium due during the grace period.

This Benefit Plan will automatically terminate without notice if premium is not paid within the grace period. In the event of termination for nonpayment of premium, reinstatement of this Benefit Plan will be at the sole discretion of and subject to conditions established by BCBSND.

- C. If a Subscriber is enrolled under a Benefit Plan for which premium amounts are determined according to age and it is determined the age has been misstated or miscalculated, premium adjustments will be made as follows:

1. If premium amounts were paid in excess of the amount due, the excess premium will be refunded.
2. If the premium amount billed was less than required for the age, premium will be increased on the next billing date.

5.2 AUTOMATIC PAYMENT WITHDRAWAL

By completing the automatic payment withdrawal section on the membership application, the Subscriber authorizes their financial institution to periodically deduct the current premium from their checking account and to remit same to BCBSND. This authorization will continue in effect until revoked in writing by the Subscriber. A 31-day notice is needed when canceling an automatic withdrawal authorization. BCBSND is not responsible for overdrafts and fees due to insufficient funds in the Subscriber's checking account.

5.3 TIME LIMIT ON CERTAIN DEFENSES

The validity of this Benefit Plan may not be contested, except for nonpayment of premium, after it has been in force for 2 years, beginning on the individual Subscriber's Effective Date. Further, the validity of this Benefit Plan may not be contested on the basis of a statement made relating to insurability by any Subscriber after continuous coverage has been in force for 2 years during the Subscriber's lifetime, unless the statement is written and signed by such Subscriber. This time limit does not apply to fraudulent misstatements.

5.4 NOTICE AND PROOF OF CLAIM

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

5.5 PAYMENT OF CLAIMS

Payment of claims will be made upon receipt of written notice and proof of a claim as provided in Section 5.4.

5.6 PHYSICAL EXAMINATIONS

BCBSND at its own expense may require a physical examination of the Subscriber as often as necessary during the pendency of a claim and may require an autopsy in case of death if the autopsy is not prohibited by law.

5.7 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 BCBSND's receipt of a claim for covered services or later than 3 years after the expiration of the time within which notice and proof of claim is required by this Benefit Plan.

5.8 PREMIUM REFUND/DEATH OF THE SUBSCRIBER

In the event of the Subscriber's death, BCBSND will refund one-half month's premium if death occurred prior to the sixteenth of the month and all premiums paid beyond the month of the Subscriber's death, within 31 days after receiving notice of the death.

5.9 SUSPENSION OF COVERAGE

- A. If the Subscriber is eligible for Medicaid benefits, the premium and benefits under this Medicare Supplement Benefit Plan will be suspended at the request of the Subscriber for the period (not to exceed 24 months) in which the Subscriber has applied for and is determined to be entitled under Medicaid. The Subscriber must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of timely notice, BCBSND will return to the Subscriber that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.
- B. If the Subscriber is no longer entitled to Medicaid, this Benefit Plan shall be reinstated (effective the date of termination of Medicaid eligibility) if the Subscriber provides notice of loss of Medicaid eligibility to BCBSND within 90 days after the date of such loss and pays the premium due from that date.
- C. If the Subscriber is eligible for coverage under a group health plan, the premium and benefits under this Medicare Supplement Benefit Plan will be suspended at the request of the Subscriber for any period that may be provided by federal regulation. If the Subscriber loses coverage under the group health plan, this Benefit Plan will be reinstated effective the date of loss of group coverage, if the Subscriber provides notice of loss of group coverage to BCBSND within 90 days after the date of such loss and pays the premium due from that date.
- D. Reinstatement of coverage as described in paragraphs B and C:
 - 1. may not provide for any waiting period with respect to treatment of Preexisting Conditions;
 - 2. must provide for coverage that is substantially equivalent to the coverage in effect before suspension; and
 - 3. must provide for classification of premium on terms at least as favorable to the Subscriber as the terms that would have applied had the coverage not been suspended.

5.10 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

- A. The Subscriber may cancel this Benefit Plan at any time by giving written notice to BCBSND in advance of the requested cancellation date. Coverage will be cancelled the 1st or the 16th of the month following BCBSND's receipt of the request for cancellation. Premium paid beyond the date of cancellation will be refunded.
- B. This Benefit Plan supercedes all Benefit Plans previously issued by BCBSND.
- C. BCBSND may cancel this Benefit Plan for the following reasons:
 - 1. Nonpayment of required premium.
 - 2. Misrepresentation of a material fact by the Subscriber.

5.11 ASSIGNMENT OF RECORDS

The Subscriber agrees that any Health Care Provider or person(s) having information relating to an illness or injury for which benefits are claimed under this Benefit Plan may furnish such information to BCBSND upon request.

The Subscriber authorizes the Centers for Medicare and Medicaid Services to furnish information as to any payments under Medicare Part A or Part B to BCBSND for use in determining benefit payment under this Benefit Plan. BCBSND agrees to use this information only for the stated purpose.

5.12 CONFIDENTIALITY

All Protected Health Information (PHI) maintained by BCBSND under this Benefit Plan is confidential. Any PHI about You (the Subscriber) under this Benefit Plan obtained by BCBSND from You or from a Health Care Provider may not be disclosed to any person except:

- A. Upon a written, dated, and signed authorization by the Subscriber or prospective Subscriber 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, BCBSND may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. BCBSND 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 Subscriber or prospective Subscriber or the Health Care Provider, the data or information may 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 Subscriber or prospective Subscriber and BCBSND in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for BCBSND 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 Providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to PHI disclosed by BCBSND 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 BCBSND to the insurance commissioner for access to records of BCBSND for purposes of enforcement or other activities related to compliance with state or federal laws.

BCBSND has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Your PHI that BCBSND creates, receives, maintains, or transmits.

5.13 NOTICE OF PRIVACY PRACTICES

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

5.14 CONFORMITY WITH STATE STATUTES

Any provision of this Benefit Plan that, on its effective date, is in conflict with the statutes of the state of North Dakota on such date is hereby amended to conform to the minimum requirements of such statutes.

5.15 CERTIFICATE OF CREDITABLE COVERAGE

When coverage under this Benefit Plan is terminated, BCBSND will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the Subscriber. Certificates of Creditable Coverage may also be obtained from BCBSND upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through BCBSND.

SECTION 6 OTHER PARTY LIABILITY

6.1 MEDICAL PAYMENT BENEFIT COORDINATION

If a Subscriber 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.

6.2 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

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

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

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

- A. Right of Assignment and/or Subrogation: If a Subscriber 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), BCBSND has the right to bring said claim as the assignee and/or subrogee of the Subscriber and to recover any benefits paid under this Benefit Plan.
- B. Right of Reimbursement: If a Subscriber 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 Subscriber must notify BCBSND of said recovery and must reimburse BCBSND to the full extent of any benefits paid by BCBSND, 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 Subscriber has not received full compensation for the injury or condition. Any recovery the Subscriber may obtain is conclusively presumed to be for the reimbursement of benefits paid by BCBSND until BCBSND has been fully reimbursed.

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. BCBSND shall determine the interpretation and application of the definitions in each and every situation.

- 7.1 **ACCIDENT** - an accidental bodily injury or injuries for which Medicare benefits are provided as the direct result of an accident, independent of disease or bodily infirmity or any other cause, while this Benefit Plan is in force. Injuries do not include injuries for which benefits are provided or available under any workers' compensation, employers' liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
- 7.2 **ADMISSION** - entry into a facility as a registered inpatient for treatment and care when ordered by a Health Care Provider.
- 7.3 **BCBSND** - Blue Cross Blue Shield of North Dakota, a legal trade name of Noridian Mutual Insurance Company.
- 7.4 **BENEFIT PERIOD** - a Benefit Period begins the first day a Subscriber enters a Hospital or Skilled Nursing Facility as a Medicare patient and ends 60 consecutive days after a Subscriber is discharged from the Hospital or Skilled Nursing Facility. A new Benefit Period begins when 60 days without a Hospital or Skilled Nursing Facility stay have elapsed.
- 7.5 **BENEFIT PLAN** - the agreement with BCBSND, including the Subscriber's membership application, Identification Card, this Benefit Plan, the benefit plan attachment and any supplements, endorsements, attachments, addenda or amendments.
- 7.6 **CALENDAR YEAR** - the period starting with the Subscriber's Effective Date and ending on December 31 of that year. Each Calendar Year shall start on January 1 and end on December 31 of that year.

- 7.7 **COST SHARING AMOUNTS** - the portion of Medicare Eligible Expenses not covered by Medicare.
- A. **Medicare Coinsurance Amount** - a part of the charge for Your Hospital or medical care that Medicare does not pay, expressed as a percentage of the allowance for the Medicare Eligible Expense.
 - B. **Medicare Copayment Amount** - a predetermined dollar amount established by Medicare under a prospective payment system for some outpatient Hospital services.
 - C. **Medicare Deductible Amount** - a specified dollar amount of Medicare Eligible Expenses that You are responsible for before Medicare will begin making payments for covered services.
- 7.8 **EFFECTIVE DATE** - the date the Subscriber's coverage under this Benefit Plan begins.
- 7.9 **HEALTH CARE PROVIDER** - a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.) or a Board Eligible Oral Surgeon (D.D.S.), who is licensed and registered under the laws of the state in which the services are provided. To qualify under this Benefit Plan, the Health Care Provider must also be classified as eligible under Medicare.
- 7.10 **HOSPITAL** - an institution, licensed and operated in accordance with state law, that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Health Care Providers.
- 7.11 **IDENTIFICATION CARD** - a card issued in the Subscriber's name identifying the Benefit Plan number.
- 7.12 **LIFETIME RESERVE DAYS** - an additional 60 days of Medicare Eligible Expenses for Hospital care You may use once in a lifetime. These days are not renewable.
- 7.13 **MEDICALLY NECESSARY** - services, supplies or treatments provided by a Health Care Provider to treat an illness or injury that satisfy all the following criteria:
- A. The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the Subscriber's illness or injury;
 - B. The services, supplies or treatments are consistent with professionally recognized standards of health care; and
 - C. The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the Subscriber's illness or injury.
- 7.14 **MEDICARE** - the programs established by Title I, Part I of Public Laws 89-97 as enacted by the Congress of the United States of America and any later amendments of the laws (known as the Health Insurance for the Aged Act).
- 7.15 **MEDICARE ELIGIBLE EXPENSES** - those health care expenses that are covered services under Part A or Part B of Medicare that are recognized as reasonable and Medically Necessary by Medicare.

7.16 **MEDICARE PART A** - the part of Medicare insurance that includes Hospital inpatient, Skilled Nursing Facility and home health care benefits. It is sometimes referred to as Medicare Hospital insurance.

7.17 **MEDICARE PART B** - the part of Medicare insurance that includes Health Care Provider's services, outpatient Hospital care, home health care and many other health services and supplies not covered by Medicare Hospital insurance.

7.18 **PREEXISTING CONDITION** - any condition for which medical advice was given or treatment was recommended by or received from a Health Care Provider within a 6-month period prior to the Effective Date of this Benefit Plan.

7.19 **PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from You or on Your behalf 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 Your past, present or future physical or mental health or condition;
- C. relates to the provision of health care to You;
- D. relates to the past, present, or future payment for health care to You or on Your behalf; or
- E. identifies You or could reasonably be used to identify You.

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

7.20 **QUALIFYING PREVIOUS COVERAGE** - with respect to an individual, health benefits or coverage provided under any of the following:

- A. A group health benefit plan;
- B. A health benefit plan;
- C. Medicare Part A or Part B;
- D. Medicaid, other than coverage consisting solely of benefits under a program for distribution of pediatric vaccines;
- E. TRICARE (the health care program for military dependents and retirees);
- F. A medical care program of the Indian Health Service or of a tribal organization;
- G. A state health benefit risk pool, including coverage issued under N.D. Cent. Code §26.1-08;
- H. A Federal Employees Health Benefits Program;
- I. A public health plan as defined in federal regulations; and
- J. A health benefit plan under §5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)].

Qualifying Previous Coverage must be continuous until at least 63 days prior to the Subscriber's Effective Date under this Benefit Plan.

7.21 **SICKNESS** - an illness or disease of a Subscriber that first manifests itself after the Effective Date of this Benefit Plan while this Benefit Plan was in force. This does not include sickness or disease for which benefits are available under any workers' compensation, occupational disease, employers' liability or similar law.

- 7.22 **SKILLED NURSING FACILITY** - a nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
- 7.23 **SUBSCRIBER** - You, the individual whose application for coverage has been appropriately submitted to and approved by BCBSND.
- 7.24 **UNITED STATES** - all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and for purposes of services provided on board ship, the territorial waters adjoining the land areas of the United States.
- 7.25 **YOU AND YOUR** - also referred to as the Subscriber.



NDPERS DAKOTA RETIREE PLAN

DRAFT



**BlueCross
BlueShield**
of North Dakota

An independent licensee of the
Blue Cross & Blue Shield Association



**NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM**

PART A - HOSPITAL BENEFITS FOR MEDICARE APPROVED SERVICES

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Hospitalization			
<i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i>			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st thru 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0*
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care			
<i>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital</i>			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First Three Pints	\$00	Three pints	\$0
Additional Amounts	100%	\$0	\$0
Hospice Care			
<i>Available as long as your doctor certifies you are terminally ill and you elect to receive these services</i>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

These Are Some Items Not Covered

- Services that are experimental or investigative in nature or that are not medically necessary as determined by Medicare.
- Services received prior to the effective date of your benefit plan.
- Services when benefits are provided by any governmental unit or social agency except Medicaid or when payment has been made under Medicare Part A or Part B.
- Outpatient prescription drugs, unless eligible under Medicare.
- Custodial care provided in a hospital or by a home health agency.
- Skilled nursing facility care costs beyond what is covered by Medicare and your benefit plan.
- Surgery to improve appearance.
- Services, treatments or supplies that are not a Medicare eligible expense.

DRAFT

kota Retiree Plan - 2009

PART B - HOSPITAL OUTPATIENT AND PHYSICIAN BENEFITS FOR MEDICARE APPROVED SERVICES

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Medical Expenses <i>In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment</i>			
First \$135 of Medicare Approved Amounts**	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
Blood			
First Three Pints	\$0	All costs	\$0
Next \$135 of Medicare Approved Amounts**	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services <i>Blood Tests For Diagnostic Services</i>	100%	\$0	\$0

PARTS A AND B - HOSPITAL AND PHYSICIAN BENEFITS FOR MEDICARE APPROVED SERVICES

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Home Health Care			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$135 of Medicare Approved Amounts**	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

Services	Medicare Pays	NDPERS Dakota Retiree Pays	Member Pays
Foreign Travel <i>Not Covered by Medicare - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</i>			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

** Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.



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Memorandum

TO: PERS Board

FROM: Sparb & Bryan

DATE: February 19, 2009

SUBJECT: Employee Assistance Program (EAP) Renewal

Attached is a revised RFP for the EAP renewal for 2009-2011. We issue the EAP RFP every two years. There are currently four active EAP contracts:

St. Alexius Employee Assistance Program
Medcenter One Employee Assistance Program
The Village Business Institute EAP
Deer Oaks

The agency listing by EAP provider is on the following page.

We plan to issue the RFP next month and have the process completed before the start of the new contract period (July 1, 2009).

If you have any comments, suggestions, or changes to the RFP or the EAP in general, we will be available at the NDPERS Board meeting.

[Deer Oaks](#)

[Village Employee Assistance Program](#)

[St. Alexius/PrimeCare](#)

[St. Alexius/PrimeCare](#)

Cavalier County Health District Central Valley Health District

Adjutant General Army Natl. Grd.

Legislative Council

Lake Region District Health Unit Dickinson State University

Aeronautics Commission

Mcintosh District Health Unit

Nelson/Griggs District Health Unit Electrical Board

Attorney General's Office

Milk Marketing Board

Rolette County Public Health District Garrison Diversion Conserv. Dist.

Bank of North Dakota

Municipal Bond Bank

Lake Region State College
Mayville State University

Beef Commission
Board of Medical Examiners

ND Department of Health
ND Department of Labor

[Medcenter One Health Systems](#) Mill & Elevator Association

Board of Nursing

ND Div. of Emergency Management

Bismarck State College Minot State University

Board of Pharmacy

ND Oilseed Council

Game & Fish Department NDPERS

Central Duplicating

ND State Board of Cosmetology

Legal Counsel of Indigents ND Barley Commission

City-County Health District

ND State Board of Accountancy

ND Council on the Arts ND Corn Utilization Council

Commerce Department

ND State Library

ND Supreme Court ND Soybean Council

Custer District Health Unit

ND Youth Correctional Center

ND University System ND State College of Science

Department of Corrections

Office of Administrative Hearing

ND Wheat Commission ND State University

Department of Agriculture

Office of Management & Budget

Sargent County District Health ND Veterans Home

Dept. of Banking & Finance

Parks & Recreation Department

Southwestern District Health Unit School for the Deaf

Dept. of Career & Technical Education

Plumbing Board

State Board of Law Examiners State Fair Assoc.

Department of Human Services

Protection & Advocacy Project

Towner County Public Health District State Seed Department

Department of Transportation

Public Instruction

Veterans Affairs Trail District Health Unit

Developmental Center

Public Service Commission

Walsh County Health District Valley City State University

Dickey County Health District

Racing Commission

Wells County District Health Unit

Education Standards & Practice

Radio Communications

Emmons County Public Health
First District Health Unit

Real Estate Commission
Retirement & Investment Office

Governor's Office

Rough Rider Industries

Highway Patrol

School for the Blind

Historical Society

Secretary of State

Housing Finance Agency

Securities Commission

Indian Affairs Commission

State Auditor's Office

Industrial Commission

State Parole Board

Information Technology Department

State Penitentiary

Insurance Department

State Treasurer's Office

James River Correctional Center Tax Department

Jamestown State Hospital

UND Family Practice

Job Service North Dakota

University of North Dakota

Kidder County District Health Unit

Upper Missouri Dist. Health Unit

Land Department

Water Commission

Legislative Assembly

Williston State College

Workforce Safety & Insurance



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M E M O R A N D U M

TO: NDPERS BOARD
SPARB COLLINS, NDPERS
KATHY ALLEN, NDPERS

FROM: *BTR*
BRYAN T. REINHARDT

DATE: January 21, 2009

SUBJECT: GROUP MEDICAL PLAN - SURPLUS/AFFORDABILITY UPDATE

Here is the December surplus projection and affordability analysis for the NDPERS group medical plan. The plan made it through the 2005-2007 biennium and is over halfway through the 2007-2009 biennium.

Net premium sent to BCBS in July 2007 was \$13,406,858. In July 2005 it was \$10,853,370. There are now 24,933 contracts on the NDPERS Health Plan, covering 56,000 people. The NDPERS health plan ended up with 23,580 contracts in June, 2005. There were 22,947 contracts in June, 2003, and 21,792 in July 2001.

The 2003 - 2005 biennium settlement is on account at BCBS with a balance of over \$2,051,000. The remaining \$14.3 million was used to buy down premiums for the 05-07 biennium. This amount is at BCBS and receiving interest.

The first settlement for the 2005 - 2007 biennium transferred \$3,672,932 to the NDPERS account. In addition refunds came in greater than IBNR claims, so this biennium has a cash balance of \$323,126. The final settlement for this biennium is June 2009.

The projection for the 2007 - 2009 biennium shows total surplus at -\$3.7 million. If there is a surplus, we share 50/50 in the first \$3.0 million surplus with BCBS. This will make future growth in the gain for NDPERS difficult. The plan is fully insured by BCBS, so the June 30, 2009 NDPERS estimated gain is \$0.

If you have any questions or you should need anymore information, please contact me.

NDPERS - ESTIMATED SURPLUS PROJECTION: 2007-2009 BIENNIUM

December, 2008

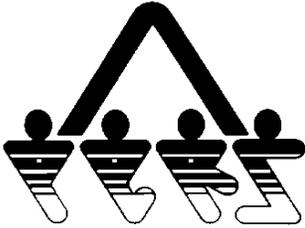
The following exhibit summarizes the estimated surplus for the NDPERS group medical plan at the end of the 2007-2009 biennium. The estimate has been updated to include account activity through December, 2008.

1) Preliminary Underwriting Gain/Loss for the 2007-2009 Biennium		(\$5,146,800)
2) Wellness Program Expenses		\$0
3) Estimated Underwriting Gain/Loss for the 2007-2009 Biennium		(\$5,146,800)
4) Projected Interest Accumulation (adjusted for usage as premium)		\$0
5) Refunds and Settlements		
11/30/07 Perform Rebate	(Included as claim rebates)	\$340,034
02/29/08 Perform Rebate	(Included as claim rebates)	\$385,151
05/31/08 Perform Rebate	(Included as claim rebates)	\$328,973
08/31/08 Perform Rebate	(Included as claim rebates)	\$354,915
11/31/08 Perform Rebate	(Included as claim rebates)	\$395,601
01/31/09 Perform Rebate		\$350,000
04/30/09 Perform Rebate		\$350,000
06/30/09 Perform Rebate		\$350,000
EPO Settlement Payments 7/07 - 6/08	(No target settlements)	\$0
6) Total Estimated Surplus Held by BCBS		(\$3,701,199)
7) BCBS Portion of Surplus (Half upto \$1,500,000)		\$0
8) PERS Portion of Surplus Held by BCBS		(\$3,701,199)
9) Cash Reserve Account Balance		\$0
Future Contributions:		\$0
Future Interest:		\$0
Total		\$0
10) NDPERS Wellness Accounts		
My Health Connection		\$216,228
Employer Based Wellness		\$2,163
Wellness Benefit Program		\$10,507
SubTotal		\$228,899
Total Adjusted for Usage		\$0
11) Total Estimated Funds Available to PERS on June 30, 2009		\$0

NDPERS - Projected Underwritten Experience for the 2007-2009 Biennium
December, 2008

MONTH	PREMIUM COLLECTED	PREMIUM ADJUSTMENT	TOTAL PREMIUM INCOME	ADMIN EXPENSE \$29.90/Con	NET PREMIUM	INTEREST ON CASH	CLAIMS INCURRED & PAID TO DATE	ESTIMATED IBNR CLAIMS	TOTAL CLAIMS(1)	ESTIMATED GAIN / LOSS
Jul-07	\$13,406,857	\$0	\$13,406,857	\$725,404	\$12,681,453	\$0	\$11,181,342	\$0	\$11,181,342	\$1,500,111
Aug-07	\$13,465,027	\$308	\$13,465,336	\$728,334	\$12,737,002	\$8,720	\$12,165,483	\$0	\$12,165,483	\$580,239
Sep-07	\$13,608,834	\$6,878	\$13,615,713	\$736,018	\$12,879,695	\$32,149	\$10,940,490	\$0	\$10,940,490	\$1,971,354
Oct-07	\$13,577,219	\$7,321	\$13,584,540	\$734,822	\$12,849,718	\$44,159	\$13,051,334	\$0	\$13,051,334	(\$157,457)
Nov-07	\$13,584,631	(\$6,547)	\$13,578,084	\$735,480	\$12,842,604	\$38,392	\$13,194,163	\$0	\$13,194,163	(\$313,167)
Dec-07	\$13,568,728	\$5,601	\$13,574,329	\$734,553	\$12,839,776	\$40,841	\$12,516,009	\$0	\$12,516,009	\$364,608
Jan-08	\$13,582,515	\$3,071	\$13,585,586	\$735,121	\$12,850,465	\$39,733	\$13,700,591	\$0	\$13,700,591	(\$810,393)
Feb-08	\$13,622,093	\$1,733	\$13,623,826	\$737,155	\$12,886,671	\$33,024	\$12,219,409	\$0	\$12,219,409	\$700,286
Mar-08	\$13,620,486	(\$2,685)	\$13,617,801	\$737,125	\$12,880,676	\$25,258	\$13,224,434	\$0	\$13,224,434	(\$318,500)
Apr-08	\$13,626,826	\$1,915	\$13,628,741	\$738,171	\$12,890,570	\$21,216	\$13,216,780	\$30,000	\$13,246,780	(\$334,994)
May-08	\$13,623,071	\$1,798	\$13,624,869	\$737,992	\$12,886,877	\$17,341	\$12,615,360	\$280,000	\$12,895,360	\$8,858
Jun-08	\$13,644,570	(\$2,237)	\$13,642,333	\$739,128	\$12,903,205	\$27,130	\$12,789,769	\$290,000	\$13,079,769	(\$149,434)
Jul-08	\$13,611,228	(\$4,554)	\$13,606,675	\$737,693	\$12,868,982	\$33,409	\$13,738,237	\$400,000	\$14,138,237	(\$1,235,847)
Aug-08	\$13,622,766	\$25,091	\$13,647,857	\$738,052	\$12,909,805	\$29,181	\$12,402,552	\$550,000	\$12,952,552	(\$13,566)
Sep-08	\$13,750,651	\$3,180	\$13,753,831	\$745,168	\$13,008,663	\$29,890	\$12,171,137	\$1,000,000	\$13,171,137	(\$132,584)
Oct-08	\$13,718,593	\$26,952	\$13,745,546	\$744,480	\$13,001,065	\$21,426	\$12,318,980	\$1,700,000	\$14,018,980	(\$996,488)
Nov-08	\$13,728,459	\$9,639	\$13,738,098	\$745,497	\$12,992,601	\$19,221	\$10,352,481	\$3,600,000	\$13,952,481	(\$940,658)
Dec-08	\$13,733,851	\$566	\$13,734,417	\$745,557	\$12,988,860	\$13,638	\$5,460,703	\$7,650,000	\$13,110,703	(\$108,204)
Jan-09	\$13,733,851	\$0	\$13,733,851	\$745,497	\$12,988,354	\$9,508	\$0	\$0	\$13,632,790	(\$634,927)
Feb-09	\$13,733,851	\$0	\$13,733,851	\$745,497	\$12,988,354	\$9,244	\$0	\$0	\$13,695,858	(\$698,259)
Mar-09	\$13,733,851	\$0	\$13,733,851	\$745,497	\$12,988,354	\$8,882	\$0	\$0	\$13,758,925	(\$761,689)
Apr-09	\$13,733,851	\$0	\$13,733,851	\$745,497	\$12,988,354	\$8,480	\$0	\$0	\$13,821,993	(\$825,159)
May-09	\$13,733,851	\$0	\$13,733,851	\$745,497	\$12,988,354	\$8,037	\$0	\$0	\$13,885,061	(\$888,669)
Jun-09	\$13,733,851	\$0	\$13,733,851	\$745,497	\$12,988,354	\$7,554	\$0	\$0	\$13,948,128	(\$952,220)
BIENNIAL										
TOTAL	\$327,499,511	\$78,031	\$327,577,541	\$17,748,728	\$309,828,813	\$526,433	\$217,259,254	\$15,500,000	\$315,502,008	(\$5,146,762)

(1) Future Months are Estimated based on Projection from NDPERS.



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Memorandum

TO: NDPERS Board

FROM: Kathy

DATE: January 30, 2009

SUBJECT: Board Election Committee

The terms of board members Joan Ehrhardt and Ron Leingang will expire on June 30, 2009. Pursuant to Section 71-01-02-01 of the election rules, the Retirement Board must appoint a committee of three from its membership, one of whom must be designated as chair, to oversee the election process.

The following is the 2009 election schedule developed in compliance with the rules:

May 1, 2009 – Deadline to file nomination petitions

May 26, 2009 – Ballots are sent out to membership

June 12, 2009 – Deadline to return ballots

June 15, 2009 – Ballot canvassing

June 18, 2009 – Presentation of results to Board membership

June 19, 2009 – Notification to candidate

BOARD ACTION REQUESTED:

Appoint a committee of three from the Board and designate one as chairman.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 11, 2009
SUBJECT: Legislative Update

Attached please find the update on those bills affecting the PERS plan. We will review this at the board meeting. Also at <http://www.nd.gov/ndpers/news/proposed-legislation.html> you can find a copy of our testimony on the PERS bills.

Current Legislative Status Report

[HB 1022](#) PERS Budget Bill

Title: (At the request of the Governor) A BILL for an Act to provide an appropriation for defraying the expenses of various state retirement and investment agencies; and to provide a transfer.

Sponsor(s): Appropriations Committee

File Date Chamber Comm ActionJournal Page
01/06HAPPRIntroduced, first reading, referred AppropriationsHJ0036
01/14HCOMMITTEE HEARING 01/14 09:00 AM
01/14HCOMMITTEE HEARING 01/14 10:00 AM

[HB 1120](#) Non-Medicare retiree insurance rates.

Title: Relating to non-medicare retiree insurance rates under the uniform group insurance program; and to provide an expiration date.

Sponsor(s): Government and Veterans Affairs Committee

File Date Chamber Comm ActionJournal Page
01/06HGVAIntroduced, first reading, referred Government and Veterans AffaiHJ0046
01/22HCOMMITTEE HEARING 01/22 09:00 AM
01/23HReported back, do not pass, placed on calendar y 011 n 001HJ0222
01/28HSecond reading, failed to pass, yeas 000 nays 092HJ0253

[HB 1121](#) Employer contributions, COLA.

Title: Relating to the old-age and survivor insurance trust fund.

Sponsor(s): Government and Veterans Affairs Committee

File Date Chamber Comm ActionJournal Page
01/06HGVAIntroduced, first reading, referred Government and Veterans AffaiHJ0046
01/22HCOMMITTEE HEARING 01/22 09:30 AM
01/30HReported back amended, do pass, amendment poc y 010 n 001HJ0290
02/02HAmendment adopted, placed on calendarHJ0303
02/05HSecond reading, passed, yeas 093 nays 000HJ0349
02/06SReceived from HouseSJ0314

[HB 1173](#) Relating to creating a trust health care savings for supreme and district court judges.

Title: Relating to the authority of the public employees retirement system board to create a trust health care savings plan for all supreme and district court judges participating in the public employees retirement system.

Sponsor(s): Rep. Klemin, Kretschmar, Griffin

Sen. Triplett, Hogue, Fiebiger
File Date Chamber Comm ActionJournal Page
01/06HGVAIntroduced, first reading, referred Government and Veterans
AffaiHJ0051
01/22HCOMMITTEE HEARING 01/22 10:00 AM
01/23HReported back, do pass, placed on calendar y 012 n 000HJ0223
01/28HSecond reading, passed, yeas 092 nays 000HJ0254
01/29SReceived from HouseSJ0214

[HB 1204](#) Bill to enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1, NDCC, relating to health insurance coverage for medical services related to intoxication.

Title: Relating to health insurance coverage for medical services related to intoxication; relating to health insurance coverage of injuries caused by intoxication or the use of narcotics or incurred in the commission of a crime; and to provide a statement of legislative intent.

Sponsor(s): Rep. Keiser, Klemin, Weisz

Sen. J. Lee

File Date Chamber Comm ActionJournal Page
01/08HHUMSERIntroduced, first reading, referred Human ServicesHJ0074
01/19HCOMMITTEE HEARING 01/19 09:00 AM
01/22HReported back amended, do pass, amendment poc y 013 n 000HJ0200
01/23HAmendment adopted, placed on calendarHJ0209
01/26HSecond reading, passed, yeas 092 nays 001HJ0233
01/27SReceived from HouseSJ0185

[HB 1340](#) Relating to metropolitan planning organizations

Title: Relating to metropolitan planning organizations; relating to master street plans developed by municipalities.

Sponsor(s): Rep. Glassheim

File Date Chamber Comm ActionJournal Page
01/12HPOLSUBIntroduced, first reading, referred Political
SubdivisionsHJ0099
02/06HReported back amended, do pass, amendment poc y 012 n 000HJ0401
02/06HCOMMITTEE HEARING 02/06 10:00 AM
02/09HAmendment adopted, placed on calendarHJ0417

[HB 1440](#) Relating to permits to operate pharmacies.

Title: Relating to permits to operate pharmacies.

Sponsor(s): Rep. Martinson, Nelson, Schneider

Sen. Krebsbach, J. Lee, Schneider

File Date Chamber Comm ActionJournal Page
01/16HIBLIntroduced, first reading, referred Industry, Business and
LaborHJ0145

02/03HCOMMITTEE HEARING 02/03 09:00 AM
02/09HReported back, do not pass, placed on calendar y 008 n 005HJ0435

HB 1575 Relating to a supplemental defined contribution retirement plan for BCI.

Title: Relating to public employee supplemental retiree benefit payments and a supplemental defined contribution retirement plan for certain employees of the bureau of criminal investigation; relating to use and investment of public employee retirement funds and confidentiality of records of the public employees retirement system; to provide a penalty; to provide an appropriation; and to provide a continuing appropriation.

Sponsor(s): Rep. Grande, Wald

Sen. Krebsbach, Lyson

File Date Chamber Comm ActionJournal Page

01/19HGVAIntroduced, first reading, referred Government and Veterans AffaiHJ0168

02/05HCOMMITTEE HEARING 02/05 09:30 AM

02/09HDivided committee report, amended, maj 009 min 004HJ0437

02/09HDivided committee report, do pass, maj 009 min 004HJ0437

02/09HAPPRRereferred to AppropriationsHJ0437

02/09HAPPRRereferred to AppropriationsHJ0439

02/12HMajority report adoptedHJ0496

SB 2153 Relating to membership on SIB, purchase of service credit, member benefit options.

Title: Relating to payment of employee contributions and retirement benefits under the highway patrolmen's retirement plan and the public employees retirement system; relating to membership of the state investment board, purchase of service credit, member refunds, Internal Revenue Code compliance, and board elections under the highway patrolmen's retirement plan and the public employees retirement system, and participation and employer payments under the uniform group insurance program; and to provide an effective date.

Sponsor(s): Government and Veterans Affairs Committee

File Date Chamber Comm ActionJournal Page

01/06SGVAIntroduced, first reading, referred Government and Veterans AffaiSJ0029

01/16SCOMMITTEE HEARING 01/16 09:30 AM

01/22SReported back, do pass, placed on calendar y 005 n 000SJ0147

01/23SSsecond reading, passed, yeas 043 nays 000SJ0157

01/26HReceived from SenateHJ0235

SB 2154 Retiree health benefits fund.

Title: Relating to participation in the public employees retirement system, purchase of sick leave credit, and the retiree health benefits fund.

Sponsor(s): Government and Veterans Affairs Committee
File Date Chamber Comm ActionJournal Page
01/06SGVAIntroduced, first reading, referred Government and Veterans
AffaiSJ0029
01/16SCOMMITTEE HEARING 01/16 10:00 AM
02/06SReported back amended, do pass, amendment poc y 005 n 000SJ0316
02/09SAmendment adoptedSJ0335
02/09SAPPRRreferred to AppropriationsSJ0335
02/12SReported back, do pass, placed on calendar y 013 n 000SJ0388
02/12SCOMMITTEE HEARING 02/12 08:00 AM

[SB 2272](#) Relating to parity for health insurance coverage of prosthetics.

Title: Relating to parity for public employees retirement system health insurance coverage of prosthetics; to provide an appropriation; and to provide an expiration date.

Sponsor(s): Sen. O'Connell, Fischer, Hogue
Rep. Kempenich, L. Meier, Onstad
File Date Chamber Comm ActionJournal Page
01/19SIBLIntroduced, first reading, referred Industry, Business and
LaborSJ0110
01/26SCOMMITTEE HEARING 01/26 02:00 PM
02/03SCOMMITTEE HEARING 02/03 02:15 PM
02/05SReported back amended, do pass, amendment poc y 007 n 000SJ0293
02/06SAmendment adoptedSJ0307
02/06SAPPRRreferred to AppropriationsSJ0307
02/09SCOMMITTEE HEARING 02/09 04:30 PM

[SB 2280](#) Relating to parity for mental health and substance abuse insurance coverage.

Title: Relating to federally required parity for mental health and substance abuse insurance coverage.

Sponsor(s): Sen. Mathern, Erbele
Rep. Metcalf, Nelson, Conrad, Kerzman
File Date Chamber Comm ActionJournal Page
01/19SHUMSERIntroduced, first reading, referred Human ServicesSJ0111
02/02SCOMMITTEE HEARING 02/02 09:00 AM
02/03SReported back, do not pass, placed on calendar y 004 n 002SJ0262
02/04SLaid over one legislative daySJ0272
02/05SSSecond reading, failed to pass, yeas 019 nays 027SJ0279

[SB 2294](#) Relating to health insurance coverage for telemedicine.

Title: Relating to health insurance policies for telemedicine.

Sponsor(s): Sen. Nelson, Mathern, Oehlke
Rep. Ekstrom

File Date Chamber Comm Action Journal Page
01/19SHUMSERIntroduced, first reading, referred Human ServicesSJ0112
02/02SCOMMITTEE HEARING 02/02 10:00 AM
02/04SReported back amended, do pass, amendment poc y 006 n 000SJ0275
02/05SAmendment adopted, placed on calendarSJ0279
02/10SSecond reading, passed, yeas 043 nays 000SJ0349
02/11HReceived from SenateHJ0485



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Memorandum

TO: PERS Board

FROM: Bryan and Sharon

DATE: February 19, 2008

SUBJECT: **PERSLink Project Quarterly Report**

Quarterly Report

Attached is the fourth quarter 2008 PERSLink status report. NDPERS is required to file this report with ITD throughout the duration of our system replacement project. This is the fourth progress report in the execution stage. Note that the planning phase went well and the project is on time and on budget.

Bryan or Sharon will be available at the Board meeting if you have any questions on the report.

Project Status Report

Project Name *PERSLink*

Project Phase *EXECUTION*

For period:	<i>September 1, 2008 – December 31, 2008</i>
Submitted by:	Sharon Schiermeister, NDPERS Project Manager
Green	Strong probability the project will be delivered on time, within budget, and with acceptable quality.
Yellow	Good probability the project will be delivered on time, within budget, and with acceptable quality. Schedule, budget, resource, or scope changes may be needed.
Red	Probable that the project will NOT be delivered with acceptable quality without changes to schedule, budget, resources, and/or scope.

EXECUTIVE SUMMARY

Status Item	Current Status	Prior Status	Summary
Overall Project Status	Green	Green	<i>Overall, the project remained within budget and scope, however, there is a schedule variance of 1 month, or 8%, that may extend the scheduled implementation date of October 1, 2010. The vendor is producing deliverables that conform to the acceptance criteria included in the Request for Proposal and that adhere to the ITD Enterprise Project Management criteria. The project team exhibits a dedicated, cooperative, and professional approach to the project – focused on producing and accepting deliverables while meeting the project timetables.</i>
Scope	Green	Green	<i>No variance on scope. New requirements and enhancements are being tracked using a Scope Management Register. Additions and removals from scope are recorded and a process to dispose of additions in excess of removals was agreed and is being executed by the Project Management Team with the approval from the Steering Committee as needed.</i>
Schedule	Yellow	Green	<i>The schedule variance of 2 months on the completion of UCS documentation creation and review tasks for Pilot 2.1 pointed out in the last period continues. Despite applying an action plan to correct this variance, the cumulative variances in the development of UCS documents has caused a variance on the Baseline Finish Date for Pilot 2.1 UAT beyond the schedule contingency buffer. This variance is expected to propagate to the other Pilots and to the final implementation, despite additional process improvement actions being taken. The scheduled implementation date of October 1 2010 could be extended by one month if the schedule variance cannot be recovered.</i>
Cost	Green	Green	<i>Actual costs are 5.44% less than expected costs. This variance is primarily due to actual NDPERS staff hours being less than projected. In addition, payment was not made during this quarter for 4 deliverables that were scheduled to be completed by September 30. These deliverables were completed by December 31; therefore, payment will be made in January.</i>

Project Risk	Green	Green	<i>The risk management log developed during the Planning Phase is maintained in SharePoint and is being reviewed periodically by the project management team. No new High Priority risks and no changes to risks have been identified during this period.</i>
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Accomplishments:

During this reporting period of the Execution phase the PERSLink Project Team deployed Pilot 1.1 into production on October 1. In addition, two releases to the production environment occurred, resolving about 50 PIRs (Problem Incident Reports).

In parallel, the project team also completed, reviewed and approved all UCS documentation packages for Pilot 2.1, completed technical design, construction and unit testing for all UCS, completed system test and completed 3 iterations of User Acceptance Testing. At the end of December 2008 the team identified 85 PIRs, classified as "Important" or "Critical", which need to be resolved and re-tested prior to closing Pilot 2.1. The team also captured 250 Business Rules classified as "Unable to test", which will be addressed as part of future Pilots. The Project team also continued to work on the data conversion, interfaces with PeopleSoft and vendors.

The project team completed planning for Pilots 2.2 and 2.3 and preparations are under way for the JAD sessions to be started in February 2009.

The backfile conversion task is in progress. A total of 6 of 7 batches have been converted by the vendor and NDPERS is in the process of completing the QA for batch 4.

The deliverables that were developed, reviewed and approved are listed in the Deliverable Acceptance Log Summary.

The following team building events occurred:

- 1. The PERSLink Team held several meetings to review the project plan and address challenges impacting the schedule. Specific action plans were developed and put into execution. Learning lessons and action plans are available on the SharePoint PERSLink Project Portal.*
- 2. The PERSLink project team held a lessons learned session with ITD related to the first production release. The resulting documentation is available on the SharePoint PERSLink Project Portal.*
- 3. Sagitec provided a demonstration of Pilot 2.1 iteration 3 to the NDPERS core project team and SMEs.*

The following project communications events occurred:

- 1. The October 2008 PERSLink Newsletter was published*
- 2. NDPERS Project Manager made periodic updates to the NDPERS Management Team and staff*
- 3. Additional staff training for common issues/questions that came up after going live*

Expected Accomplishments:

During the next reporting period the project team plans to accomplish the following:

- 1. Complete the following tasks and deliverables:

 - a. Bring closure to Pilot 2.1*
 - b. Start JAD sessions for Pilot 2.2**
- 2. Continue to conduct Lessons Learned Sessions to improve overall project performance:

 - a. User Acceptance Testing*
 - b. Data Conversion**
- 3. Work with PERS management team on change management strategy relating to Pilot 2.1*

RISK MANAGEMENT

	Current Status	Prior Status	Summary
Project Risk	Green	Green	<i>No new risks have been added. A detailed risk assessment session for the Project Team is scheduled for January 2009.</i>
Risk Management Log Summary			
Risk #	Description	Response Plan	Owner

Comments: A complete Risk Log is available on PERSLink Project Portal in SharePoint. A total of 17 risks have been identified, prioritized and are being monitored by the PERSLink Project Team.			
Issues Log Summary			
Issue #	Description	Required Action	Owner
Comments: An Issue Management process document was developed and approved during the project planning phase. As areas of risk eventuate an issue is created in the Issue Register (PERSLink Project Portal in SharePoint) and assigned an owner for resolution. At this time, there are no issues outstanding.			

SCOPE MANAGEMENT

Status Item	Current Status	Prior Status	Summary
Scope	Green	Green	<i>One change request was issued and approved for the implementation of enhancements for Release 1.0. This change request is within the project contingency.</i>
Change Control Log Summary			
Change #	Description	Action Accept / Reject	Action Date
1	Various Enhancements for Release 1.0	Accept	1/8/2009
Comments: A Change Management Process document was developed and approved by the PERSLink project team during the Planning Phase. CR01 – Enhancements to PERSLink Release 1.0 has been added in the Change Management Log on the PERSLink Project Portal in SharePoint. New requirements and enhancements are being tracked using a Scope Management Register in SharePoint. Additions and removals from scope are recorded and a process to dispose of additions in excess of removals was agreed and is being executed by the Project Management Team with approval from the Steering Committee as needed.			
Deliverable Acceptance Log Summary			
Deliverable #	Deliverable Name	Action Accept / Reject	Action Date
	Phase 4 Release 1.0 Certificate of Completion	Accept	12/18/2008
	Phase 5 Pilot 2.1 Data Model	Accept	12/23/2008
	Phase 5 Pilot 2.1 Object Model	Accept	12/23/2008
	Phase 5 Pilot 2.1 UI Navigation Maps	Accept	12/23/2008
	Phase 5 Pilot 2.1 Pilot	Accept	12/01/2008
	Phase 5 Pilot 2.2 Statement of Work	Accept	12/3/2008
	Phase 5 Pilot 2.2 Fine Grained Phase WBS	Accept	12/3/2008
	Phase 5 Pilot 2.2 Use Case Model	Accept	12/23/2008
	Phase 5 Pilot 2.2 Problem/Opportunity Analysis	Accept	12/23/2008
	Phase 5 Pilot 2.2 Updated RTM	Accept	12/23/2008
	Phase 5 Pilot 2.2 Current/Target Performance Analysis	Accept	12/23/2008
	Phase 5 Pilot 2.3 Use Case Model	Accept	12/23/2008
	Phase 5 Pilot 2.3 Problem/Opportunity Analysis	Accept	12/23/2008

	Phase 5 Pilot 2.3 Current/Target Performance Analysis	Accept	12/23/2008
Comments: All PERSLink deliverables are maintained on the PERSLink Project Portal in SharePoint. All accepted deliverables are maintained in the Acceptance Folder in word format and on the Archive folder in pdf format			

COST MANAGEMENT

Status Item	Current Status	Prior Status	Summary	
Budget	Green	Green	<i>At the end of the quarter, actual costs were lower than expected costs.</i>	
Project Budget	Revised Budget (if applicable)		Expenditures to Date	Estimated Cost at Completion
\$10,502,214	\$0.00		\$4,233,453	\$9,931,023

Budget Status

As of 12/31/08

	Original Budget	Actual Costs	Expected Costs	Actual vs Expected Variance	Remaining Budget
Sagitec	7,678,360	3,671,390	3,747,598	(76,208)	4,006,970
LRWL	1,000,000	313,444	349,997	(36,553)	686,556
Hardware/Software	185,000	12,430	12,430	0	172,570
Contingency	730,640	0	0	0	730,640
Total Appropriation	9,594,000	3,997,264	4,110,025	(112,761)	5,596,736
PERS Staffing hours	908,214	236,189	366,919	(130,730)	672,025
	24,000	6,241	9,696	(3,455)	17,759
Total Budget	10,502,214	4,233,453	4,476,944	(243,490)	6,268,761



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 11, 2009
SUBJECT: Business Plan

Attached, for your information, is the progress report on our agency business plan for 2008. The 2009 plan will be provided in March. The 2008 plan is provided to give you a perspective of the activities that happened in the last year. This document guides our many business activities for the year and is broken out by program agency drivers or guiding principles. You will note that many activities were completed during the last year and in terms of our internal monitoring of activities we met most of our performance objectives. You will also note that during the last year we received two national recognitions and an unqualified audit report:

- Certificate for Excellence in Financial reporting from GFOA
- Public Pension Coordinating Council Award for Administration from the PPCC

We started several new efforts during the last year including:

- Implemented Pilot 1.1 of the business system replacement project (PERSLink).
- Continued efforts on the P3 project.
- Worked with the PERS Benefits Committee's to prepare our legislative agenda.
- Provided a 13th check to PERS & HP retirees and COLA to Job Service retirees.
- Held our annual Wellness Conference.
- Implemented the Diabetes program with the NDPA.
- Completed the renewal on the dental and life plans. Life plan rates went down about 15% and dental went up.
- Completed our renewal with BCBS including expanded wellness benefits.
- Processed over 16,000 flex claims last year.
- Completed our rulemaking process.
- Three large groups joined PERS last year - the cities of Grand Forks, Fargo and Jamestown.
- Published newsletters for active and retiree members.
- Conducted 7 employer-sponsored PREP's, 2 PERS PREP's, 6 go-to-meetings and 10 agency site visits.

Please let me know if you have any questions.