DISABILITY RETIREMENT KIT
(Rev. 01-2017)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920
www.nd.gov/ndpers

This publication contains information, forms, and instructions necessary for a terminating employee to apply for disability retirement benefits and insurance under the Defined Benefit Plan. This publication is to be completed by BOTH the Employer and Employee.

This publication is intended to provide general information and may not be considered to be a legal interpretation of law. Statements contained in this publication do not supersede the North Dakota Century Code or Administrative Code or restrict the authority granted to the Retirement Board.

The information in this publication is subject to changes made by the North Dakota legislature, by the Board of the North Dakota Public Employees Retirement System (NDPERS), and its agents.

USE THE DISABILITY KIT IF:

- the member or member's employer contributed to the NDPERS Defined Benefit Plan or Defined Contribution Plan for at least six (6) months, and

- the disability occurred during a period of eligible employment, and

- the member is unable to work due to a medically determinable physical or mental impairment that has or is expected to last at least for a continuous period of 12 months or result in death, and

- the member is currently on your payroll or the member is within twelve (12) months of their termination date.

DISABILITY RETIREMENT KIT

Defined Benefit and Defined Contribution Members Only

Use this kit if you want to apply for disability retirement benefits

Employer Responsibility

- Enter member termination information through Employer Self Service.
- Disability Retirement - Occupational Demands SFN 54398
- Employer Statement for Life Premium Waiver (If employee wishes to apply for waiver)

Retiree (Employee) Responsibility

- Read Disability Retirement Benefits. Application for Disability Benefits and appropriate legal documentation must be filed at least 31 days before distribution of the first payment.
- Insurance Coverage: Even if you did not have NDPERS insurance you will need to enroll or decline coverage
  - Health Insurance Dakota, HDHP and Dakota Retiree Plans
  - Long Term Care Insurance
  - Life Insurance
  - Dental Insurance
  - Vision Insurance
- What happens to your NDPERS FlexComp Plan?
- Did you participate in Deferred Compensation?

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

DISABILITY RETIREMENT CHECKLIST

	FORM NAME	SFN #
☐	ESTIMATED BENEFIT PAYMENT REQUEST	59058
☐	APPLICATION FOR DISABILITY RETIREMENT BENEFITS	18000
☐	DISABILITY RETIREMENT OCCUPATIONAL DEMANDS (EMPLOYER FILLED)	54398
☐	DISABILITY RETIREMENT ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY	54399
☐	LEGIBLE PHOTOCOPIES OF BIRTH CERTIFICATE, SPOUSE'S BIRTH CERTIFICATE & MARRIAGE CERTIFICATE	
☐	DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN	2560
☐	AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENT	18379
☐	WITHOLDING ALLOWANCE ELECTION FOR PENSION PAYMENTS	51506
☐	CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA) – To be used only for family members electing individual coverage if currently covered on NDPERS Dakota or HDHP Plan.	14120
☐	RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA) – To be used only if currently covered on NDPERS Dakota or HDHP Plan.	53799
☐	RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION	59562
☐	MEDICARE PRESCRIPTION DRUG PLAN (PDP) INDIVIDUAL ENROLLMENT FORM – One required for each member that will be on the Dakota Retiree Plan and **cannot** be signed or submitted more than 90 days prior to the requested effective date of coverage.	58860
☐	RETIREE LIFE INSURANCE APPLICATION	53622
☐	TERM LIFE CONVERSION INFORMATION REQUEST	
☐	AUTHORIZATION FOR RELEASE OF HEALTH	
☐	LONG TERM DISABILITY EMPLOYEE STATEMENT	
☐	LONG TERM DISABILITY- CLAIM NOTICE EMPLOYER STATEMENT	
☐	ATTENDING PHYSICIANS STATEMENT OF IMPAIRMENT AND FUNCTION	
☐	WAIVER OF PREMIUM DISABILITY CLAIM	
☐	ATTENDING PHYSICIAN STATEMENT OF DISABILITY- FOR WAIVER CLAIMS	
☐	RETIREE VISION-DENTAL INSURANCE ENROLLMENT/CHANGE	53504
☐	AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION	50134
☐	UNUM ELECTION FOR PORTABLE COVERAGE	
☐	CONTINUATION OF COVERAGE IN MEDICAL SPENDING ACCOUNT (COBRA)	53512

DISABILITY RETIREMENT BENEFITS

To be eligible for benefits listed on this sheet, you must terminate employment. The Administrative Code Chapter 71-02-01-01(24) states: “Termination of employment” means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

DISABILITY RETIREMENT BENEFIT – WHAT IS IT?

For the Defined Benefit plan members, the disability retirement benefit is funded by your employer’s contributions. The Plan provides a monthly benefit payment to eligible participants who are unable to engage in substantial gainful employment for an extended period of time. For Defined Contribution plan members, the disability benefit is funded by your member account balance.

WHO IS COVERED UNDER THE DISABILITY BENEFIT PLAN?

All participating members of the NDPERS Defined Benefit Plan or Defined Contribution Plan who have accumulated six (6) months of eligible service are covered under the disability retirement plan.

ELIGIBILITY REQUIREMENTS:

To be eligible for NDPERS disability retirement benefits the following must apply:

- Your disability must have occurred during a period of eligible employment.
- You must be unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment expected to result in death or which will or has lasted for a continuous period of not less than twelve months.
- You must submit a “Disability Retirement Kit” to the NDPERS office <u>within 12 (twelve) months of termination of employment.</u>
- You must be determined to be disabled by the NDPERS’ medical advisor, who is responsible for making disability eligibility determinations for the Board. In lieu of a review by the NDPERS’ medical advisor, a member who qualifies for Social Security Disability benefits and submits a “Disability Retirement Kit” with a copy of the Social Security Notice of Award, may be deemed eligible for NDPERS disability benefits without requiring a determination from the medical advisor. The Social Security Notice of Award must provide proof that the member’s disability was determined during his/her period of eligible employment.

HOW TO APPLY FOR DISABILITY BENEFITS:

You may submit a "NDPERS Disability Retirement Kit" up to four (4) months prior to your date of termination. However, you must submit an application to NDPERS within 12 months of your termination date along with a copy of your birth certificate and, if married, a copy of your spouse's birth certificate and marriage certificate. You may obtain a "NDPERS Disability Retirement Kit" from your payroll office, the NDPERS office, or the NDPERS Website.

Defined contribution members must contact the Defined Contribution plan program administrator to receive an application. Defined Benefit plan members, who are at least 55 years of age and have a minimum of thirty-six (36) months of service credit, may also apply for early retirement benefits. This will allow NDPERS to pay you under Early Retirement provisions while your disability application is being processed. To apply for early retirement benefits, you must complete a **"**Retirement Kit**".**

NDPERS must receive an application for disability retirement benefits and appropriate legal documentation at least 31 days before the distribution of the first disability retirement check. If documents are filed too late the payment may be DELAYED.

COORDINATION WITH OTHER DISABILITY PLANS:

Your NDPERS disability retirement benefit payment will not be reduced by any other benefits you may be receiving as a result of your disability.

DISABILITY BENEFIT PAYMENTS:

If the medical advisor determines that you are totally and permanently disabled according to the Plan, your benefit is payable retroactive to the first of the month following your date of termination. The benefit is payable as long as you are disabled.

DEFINED BENEFIT PLAN:

Your disability retirement benefit is computed as 25% of your final average salary. The minimum basic disability retirement benefit is $100.00 per month. Final average salary is the average of your highest 36 of the last 180 months you worked. You may obtain an estimate of your disability retirement benefit by completing a "Request for Benefit Information SFN 53603" or Estimate Benefit Payment Request SFN 59058.

BENEFIT PAYMENT OPTIONS:

There are several different benefit payment options available to choose from. These payment options differ in how they pay your beneficiary in the event of your death, and in the actuarial reduction necessary to provide these benefits to you and your beneficiary. Keep in mind that each payment option will pay you the member for as long as you meet the eligibility requirements to receive benefits. You cannot change your benefit option once you have cashed your first benefit payment.

SINGLE LIFE OPTION: Under this option there is no monthly income provision for your beneficiary. If you should die while receiving benefits, your beneficiary will get a lump sum payment of the balance of your member account, if any balance remains.

50% JOINT & SURVIVOR OPTION: This amount is actuarially reduced based upon your age and the age of your spouse. Upon your death, your spouse will receive 50% of your monthly benefit payment for his/her lifetime. If your spouse dies first, your benefit will be adjusted back to the single life benefit amount once a photocopy of your spouse's "Certificate of Death" has been received. If this benefit option is selected, it will be necessary for you to submit a copy of your spouse's birth certificate and your marriage certificate with your benefit application.

100% JOINT & SURVIVOR OPTION: This amount is actuarially reduced based upon your age and the age of your spouse. Upon your death, your spouse will receive 100% of your monthly benefit payment for his/her lifetime. If your spouse dies first, your benefit will be adjusted back to the single life benefit amount once a photocopy of your spouse's "Certificate of Death" has been received. If this benefit option is selected, it will be necessary for you to submit a copy of your spouse's birth certificate and your marriage certificate with your benefit.

TWENTY (20) YEAR TERM CERTAIN: This amount is reduced based upon actuarial factors. If you should die within the first twenty years of receiving your benefit, your beneficiary will continue to receive monthly payments of the same amount until the end of the twenty year term. If you die after receiving the benefit for twenty years, there will be no further benefit payments made to your beneficiary. This option is not available if you are age 79 or over.

If you are receiving a disability retirement benefit, a lump sum payment of the balance, if any, will also be paid to your beneficiary. If the payment to you has been longer than the term, your beneficiary will only receive the remaining account balance.

TEN (10) YEAR TERM CERTAIN: This amount is reduced based upon actuarial factors. If you should die within the first ten years of receiving your benefit, your beneficiary will continue to receive monthly payments of the same amount until the end of the ten year term. If you die after receiving the benefit for ten years, there will be no further benefit payments made to your beneficiary.

If you are receiving a disability retirement benefit, a lump sum payment of the balance, if any, will also be paid to your beneficiary. If the payment to you has been longer than the term, you beneficiary will only receive the remaining account balance.

CONVERTING SICK LEAVE:

At termination, you may purchase all or part of your sick leave for retirement service credit. One month of service credit may be purchased with NDPERS for each 173.3 hours of unused sick leave. Sick leave conversion with NDPERS is available to you, even if your employer pays out a portion of your sick leave at time of separation. Please confirm any rules that may apply to sick leave payout with your employer.

The cost to purchase sick leave is determined by taking the required contribution rate of your Final Average Salary times the number of months being converted. The final payment amount will be calculated by NDPERS, after your termination. Payment can be made either on an after-tax basis through personal check or pre-tax basis through direct rollover/transfer. To elect to convert your sick leave, the Conversion of Unused Sick Leave Application – Defined Benefit SFN 58358 must be completed. If using pre-tax dollars to do the purchase, please ask your

Employer to complete Part F on the form. Please review the terms on the conversion application carefully. The sick leave payment must be paid by the 15th of the month following the month of termination.

Required Contribution Rates:

Main System = 15.26%
Law Enforcement with Prior Service = 16.45%
Law Enforcement without Prior Service = 14.57%
Highway Patrol System = 34.14%
State Law Enforcement - BCI = 16.95%
State Law Enforcement – National Guard = 16.45%
Judges = 26.66%

FEDERAL LIMITATIONS:

Certain types of purchase payments may be subject to limitations established in the Internal Revenue Code Section 415(c). Current law may limit after-tax employee contributions into the retirement plan. NDPERS will notify you if federal limits apply to your purchase payment(s).

DEFINED CONTRIBUTION PLAN:

APPLICATION

To request an application for disability benefits for the Defined Contribution Plan, please contact the Defined Contribution Plan Program Administrator at the NDPERS office by calling (800) 803-7377. In addition, your agency's payroll office must send in your termination information through Employer Self Service. Your completed Disability Application and "Trustee Company Distribution Form" can be filed with NDPERS up to four (4) months prior to your date of termination. However, you must submit an application to NDPERS within 12 months of your termination date.

BENEFIT PAYMENT OPTIONS:

Deferred Member Account Balance
When you terminate employment, you can apply to defer your entire vested account balance. Under this option you leave your account balance with the Trustee Company until you either take it out as a lump sum or periodic distribution. If you choose this option, you and your employer must complete a NDPERS Deferred Retirement Kit to elect this option.

Lump Sum Distributions
If you elect this option, your entire vested account balance will be paid to you as a lump-sum distribution. You may elect to roll this lump-sum distribution into another eligible employer plan or a traditional IRA. If you choose this option you will need to complete the forms under NDPERS Refund/Rollover Forms and a "Trustee Company Distribution Form", which must be obtained from NDPERS**.**

Periodic Distributions
If you elect this option, your vested account balance will be paid to you in monthly, quarterly, semiannual or annual periodic payments until your account is exhausted. If you choose this

option you will need to complete the forms under NDPERS Retirement Forms and a “Trustee Company Distribution Form”, which must be obtained from NDPERS.

Distributions will be subject to the following rules:

1.) Refund Distribution
Any taxable distribution paid by the Trustee Company directly to you will be subject to mandatory Federal income tax withholding of 20% of the requested distribution. You cannot elect out of this tax withholding but you can avoid it by electing a direct rollover distribution. This withholding is not a penalty but rather a prepayment of your Federal income taxes, although there may also be an IRS penalty assessed in certain circumstances. If you are under age 59 1/2 at the time the distribution occurs, you will be subject to a 10% penalty at the time you file your income tax return for the year in which you took the distribution.

2.) Direct Rollover Distribution
As an alternative to a cash distribution, you may request that your entire distribution be rolled directly into an IRA or into another employer’s eligible plan (if it accepts rollover contributions); Federal income taxes will not be withheld on any direct rollover distribution.

> *a.) Rollover to an IRA* – You must complete a Qualified Plan Distribution Form and indicate the name and address of the custodian or trustee, and account number for your IRA. After authorizing your distribution, the Plan Administrator will forward the form to the Trustee Company. A check will be issued by the Trustee Company payable to the IRA custodian or trustee for your benefit. The check will contain the notation ‘Direct Rollover’ and it will be mailed directly to you. You will be responsible for forwarding it on to the custodian or trustee. You must provide NDPERS with complete information to facilitate your direct rollover distribution.
>
> *b.) Rollover to Another Eligible Employer Plan* – You should check with your new employer to determine if its plan will accept rollover contributions. If allowed, then you must complete a Qualified Plan Distribution Form and indicate the name, address and plan number of your new employer’s qualified plan. After authorizing your distribution, the Plan Administrator will forward the form to the Trustee. A check will be issued by the Trustee Company payable to the trustee of your new eligible employer plan. The check will contain the notation ‘Direct Rollover’ and it will be mailed directly to you. You will be responsible for forwarding it on to the new trustee. You must provide NDPERS with complete information to facilitate your direct rollover distribution.

3.) Combination Refund Distribution and Direct Rollover Distribution
You may request that part of your distribution be paid directly to you and the balance to be directly rolled into an IRA or your eligible employer Plan. Any cash distribution you receive will be subject to the Federal income tax withholding rules referred to in (1). Any direct rollover distribution will be made in accordance with (2).

You will pay income tax on the amount of any taxable distribution you receive from the Plan unless it is rolled into an IRA or your eligible employer plan. A 10% IRS premature distribution penalty tax may also apply to your taxable distribution unless it is rolled into an IRA or another eligible plan. The 20% Federal income tax withheld under this section may not cover your entire income tax liability.

If your vested account balance is less than $1,000, the entire amount will be automatically distributed to you unless you request in writing within 120 days after termination, that the vested account balance remain in the Plan.

DEFINED BENEFIT AND DEFINED CONTRIBUTION PLANS:

DENIAL OF BENEFITS – REVIEW PROCEDURE:

If you receive written notice that your application for disability retirement has been denied, you may request a review of the decision. A written request for review must be received in the NDPERS office within 60 days of receiving a denial notice. You will be notified of the time and date of the appeal hearing and may attend and/or be represented by legal counsel. The appeal discussion is confidential and closed to the general public.

If the Board's decision is to uphold the recommendation of the medical advisor, the applicant may file a request for a formal hearing to be conducted before an administrative law judge.

RECERTIFICATION OF DISABILITY STATUS:

Your eligibility to continue to receive disability benefits must be recertified 18 months after the date your first check is issued and thereafter as specified by the NDPERS medical consultant.

Prior to the 18 month payment anniversary date, you will receive an "Application for Recertification of Disability Benefits" and a "Recertification of Disability- Attending Physician's Statement". These two forms are to be completed and returned to NDPERS.

Also, as a part of the recertification process, you will be required to complete a "Statement of Annual Earnings for Disability Annuitants SFN 53157" to document all employment and gross earnings. (See Return to Work Provisions).

If it is determined that you were not eligible for benefits during any time period when benefits were provided, the executive director may do all things necessary to recover the erroneously paid benefits.

RETURN TO WORK PROVISIONS:

To be eligible for benefits, you must terminate employment or terminate membership. "Termination of employment" means a severance of employment by not being on the payroll of a covered employer for a minimum of one month (31 days). This period is determined by counting 31 days from your final regular payroll payment to the date you begin actual employment (first day of work) with a new NDPERS participating employer.

Approved leave of absence does not constitute termination of employment.

"Termination of participation" means termination of eligibility to participate in the retirement plan.

Disability

If you return to work in a permanent full-time position and are eligible to participate in NDPERS, your disability benefits must be suspended. You are not eligible to receive a disability retirement benefit while permanently employed with a NDPERS participating employer. (See "Overpayment of Benefits" section). If you are not able to continue employment for a consecutive period of time resulting in nine (9) months of service credit as a result of the

disability and continue to meet the eligibility requirements under the plan, you may resume disability.

If you return to employment not covered under NDPERS, your disability benefit may continue for up to nine (9) consecutive months. If you are not able to continue employment for at least nine (9) months as a result of the disability and continue to meet the eligibility requirements under the plan, you may continue disability status. You must notify the NDPERS office in writing of your intent to return to work.

OVERPAYMENT OF BENEFITS:

The laws governing NDPERS state that a person who receives an overpayment is liable to refund those payments upon receiving an explanation and a written request for the amount to be returned. Pursuant to that section, a member may be charged six (6) percent interest on the unpaid balance until the balance is paid in full. NDPERS executive director must approve any repayment proposal made.

TAXES AND YOUR BENEFIT PAYMENT:

The NDPERS disability benefit is provided by your employer's contributions to the retirement system and is therefore 100% taxable before age 65. At age 65, your benefit is considered a retirement benefit for income tax purposes. A portion of your monthly benefit may be non-taxable, based upon your contributions to your member account balance. An exclusion ratio will be computed to determine your non-taxable portion, if any.

According to IRS Regulation Section 1.72-15(c)(2), your member account balance will not be reduced before age 65. At age 65, your member account balance is reduced by the monthly benefit payments you receive.

You have the option of having federal and North Dakota state income taxes withheld from your monthly benefit payment. At the time of your retirement, NDPERS will have you complete the Withholding Allowance Election for Pension Payments SFN 51506. You may elect not to have income tax withheld from your pension payment by using this same form. You may change your tax withholding election at any time, and as often as you wish.

If you do not have federal income tax withheld from your benefit payment, you cannot have ND state income tax withheld.

Whether you should have taxes withheld depends upon your financial situation. Questions about the amount of taxes to withhold or the need for tax deduction should be directed to a professional tax consultant. Tax withholding tables can be found on the NDPERS website.

DIRECT DEPOSIT:

Your monthly payment is sent directly to your checking or savings account through Direct Deposit. You must complete an "Authorization for Direct Deposit for Annuity Payment SFN 18379". To change banks, simply complete a new direct deposit form with the new financial institution. NDPERS will not accept alternate Direct Deposit forms. Deposits are electronically sent for deposit the first working day of each month. If your forms are not completed in a timely manner or there is a delay in processing your retirement benefit calculation (i.e. unused sick leave purchase, employer reporting/wage verification), your 1st check may not be direct deposited. In these situations, a paper check will be mailed to you on the first business day of the payment date. Subsequent checks will be direct deposited in your account.

RETIREE INSURANCE COVERAGE:

The NDPERS Dakota Retiree Health, Dental, Vision, and Long-Term Care insurance plans are available to you even if your employer did not participate in these NDPERS Plans prior to your retirement or disability retirement.

You may be eligible to enroll in the above insurance if you do so within 31 days of retirement or disability retirement or during eligible qualifying events. Please refer to the NDPERS website for each plan's qualifying events, premium information, and plan design. Anyone age 65 or older must have both Part A and B of Medicare to be eligible to enroll in the Dakota Retiree Plan.

If you elect coverage and choose to have premiums deducted from your pension check, please note that your first month's premium must be paid by personal check. NDPERS will begin withholding premiums the month following your first retirement payment. Another option is to have your premium(s) withheld from your bank account by completing and submitting an Authorization for Premium Deduction SFN 50134 form.

RETIREE HEALTH INSURANCE CREDIT (RHIC):

The Retiree Health Insurance Credit Program offers you a credit to receive reimbursement of premiums you pay for upon retirement. This credit can only be used if you are drawing a monthly NDPERS or NDHPRS benefit payment. Your RHIC may be used for any health and/or prescription drug coverage, as well as for the NDPERS dental, vision, and long term care coverage.

Defined Contribution Plan members must be at least 55 years of age or meet the Rule of 85 and must also be receiving a periodic distribution from the trustee company at least annually to be eligible for the RHIC benefit. Your RHIC is only reimbursed for eligible insurance premiums as long as you are receiving a periodic distribution.

RHIC is calculated as $5.00 for every year of retirement service credit, subject to reduction for early retirement. Your retiree insurance credit will not be reduced if you are age 65, meet the Rule of 85 (Rule of 90 with minimum age 60 if you are hired on or after 01-01-2016) or are receiving NDPERS Disability retirement benefits.

If you are enrolled in NDPERS sponsored insurance coverage NDPERS will bill you for the full premium amount or deduct the full premium amount from your bank account or pension check each month. Then, NDPERS will substantiate your monthly premium amounts and the third party administrator will reimburse you up to your eligible monthly RHIC amount.

If you are enrolled in non-NDPERS sponsored health or prescription drug coverage, you will need to provide documentation of eligible insurance premiums and proof of payment to the third party administrator.

Under the Standard Option, upon your death, your RHIC will be transferred to your surviving spouse if your surviving spouse receives an ongoing monthly retirement payment from NDPERS. He or she can use the health insurance credit for as long as the benefit payments continue.

Under the Alternate Health Credit Option, if you are married and choose a Single Life, Ten or Twenty Year Term Certain, you have the opportunity to elect an alternate form of retiree health insurance credit. You may choose an actuarially reduced 50% or 100% Joint & Survivor retiree insurance credit option that applies only to the insurance credit portion of your retirement benefits. The alternate option is actuarially reduced based upon your age and the age of your spouse. With this option, upon your death, your surviving spouse will receive the RHIC amount for life. Refer to the RHIC overview and list of frequently asked questions for more information. Refer to the RHIC overview and list of frequently asked questions for more information.

NDPERS Retiree Health Insurance Credit (RHIC) Program

The NDPERS RHIC Program is a plan that was funded by your employer during your working years. You earn $5 for every year of service credit. Upon retirement, reimbursement up to your monthly RHIC amount may be issued to you for eligible insurance premium expenses. ASIFlex is the third party administrator for the RHIC program and will maintain RHIC account records, issue reimbursements, and provide customer service to answer any RHIC reimbursement related questions. Below are answers to frequently asked questions regarding your RHIC account.

1. Who is eligible for the RHIC benefit?	NDPERS, NDHPRS, and Job Service Defined Benefit Plan pensioners drawing a monthly payment; NDPERS Defined Contribution Plan pensioners drawing a periodic payment at least annually; and eligible surviving spouses of NDPERS members receiving a joint and survivor RHIC benefit. If you have questions regarding your eligibility or calculated RHIC benefit, please contact NDPERS or log in to your NDPERS Member Self Service (MSS) online account.
2. How is my RHIC calculated?	Your RHIC benefit amount is calculated based on your years of service and age at date of retirement. If you retired early or have selected a joint and survivor option, your RHIC may be reduced. To verify your available RHIC reimbursement amount, login to your NDPERS Member Self Service (MSS) account online.
3. What expenses are eligible?	You can use RHIC funds to reimburse insurance premiums paid for the following: Health Plans – NDPERS sponsored ***or*** non-NDPERS sponsored plans * Prescription Drug Plans – NDPERS sponsored ***or*** non-NDPERS sponsored plans * Dental – NDPERS sponsored plan only Vision – NDPERS sponsored plan only Long-Term Care – NDPERS sponsored plan only Life Insurance – not an eligible premium expense Supplemental Insurances – not an eligible premium expense *If you have an employer-sponsored health plan, premiums must be an after-tax deduction from your pay check. (Pre-tax premiums are ineligible.)
4. What documentation is required for NDPERS premium reimbursement?	For NDPERS sponsored health/prescription drug, dental and vision plans, **no action will be required on your part** for monthly reimbursement. NDPERS will report your monthly premium amounts to ASIFlex and a check will be sent to your address of record if direct deposit is not set up.
5. What documentation is required for non-NDPERS premium reimbursement?	For non-NDPERS health/prescription drug plans or NDPERS long term care insurance, you will need to provide the following: 1. *Documentation of eligible insurance premiums* – includes providing an itemized statement from your insurance carrier showing dates of your premium coverage period, type of insurance, and premium amount 2. *Proof of payment* – can be provided in the form of pay stub, bank statement, copy of cancelled check, credit card receipt, or electronic payments 3. *ASIFlex Claim Form* – Complete form and mail with required documentation to ASIFlex, PO Box 6044, Columbia, MO 65205-6044 or fax to 1-877-879-9038

ASIFlex Contact Customer Service Hours: 7:00 am - 7:00 pm CT Monday -Friday; 9:00 am - 1:00 pm CT Saturday

1.800.659.3035 www.asiflex.com asi@asiflex.com

NDPERS Retiree Health Insurance Credit (RHIC) Program (cont'd)

6. How can I be reimbursed for eligible premiums?	For NDPERS sponsored health/prescription drug, dental and vision plans, NDPERS will establish your account and report your monthly premium amount and RHIC to ASIFlex who will issue reimbursement to you. For all other plans, you can submit a claim form with proper documentation and proof of payment directly to ASIFlex. Claim forms will be available at asiflex.com. You will also be able to submit claims online at asiflex.com or through the ASIFlex Mobile app.
7. What are the payment method options?	You are encouraged to sign up to receive payments via direct deposit to a designated bank account. If you do not sign up for direct deposit, a check will be mailed to your address on file. Bank direct deposit forms are available on the ASIFlex website. *NOTE: NDPERS and ASIFlex are not responsible for lost or stolen checks or for delayed mail. For expedited payment, be sure to sign up for direct deposit.*
8. How often does ASIFlex process claims?	Claims are processed daily, with payments issued within one to three business days. You will also be able to sign up for electronic communication via email and/or text alerts. ASIFlex will send notice to you each time a payment is made.
9. How often can I submit claims for my non-NDPERS plans?	You may submit claims on any frequency that is convenient for you. You may submit monthly, quarterly, semi-annually, or even annually.
10. Can I receive premium reimbursement if I am a covered dependent?	You may submit claims for any eligible premium expense incurred as either the primary contract holder or as a covered dependent on a spouse's contract. Your policy may be employer-sponsored or an individual insurance plan.
11. Is there a deadline to file for reimbursement for non-NDPERS plans?	**The plan year is July 1 through June 30. The deadline to submit claims incurred during the plan year is September 30th following the close of the plan year.**
12. What if I miss the deadline for reimbursement?	RHIC not claimed by the September 30th deadline following the close of the plan year is forfeited.
13. Can I accumulate and carry over funds from month to month?	No. You can claim up to your monthly RHIC benefit amount each month, for any combination of eligible premiums paid for that month. If your premiums are less than your RHIC benefit amount, leftover funds do not carry forward to the next month. If your monthly premiums are more than your RHIC benefit, the plan will reimburse you up to your monthly RHIC amount.
14. Am I still eligible for a federal health plan subsidy?	If you are eligible for a federal subsidy through the healthcare exchange, you may not receive reimbursement of your RHIC benefit in addition to the lower amount paid for your health coverage.

Some things to remember

- **ASIFlex will mail a letter to you containing a personal identification number (PIN) that you can use to register online and view details of your account at asiflex.com.**
- You can submit claims for non-NDPERS sponsored medical plan premiums or NDPERS long term care insurance through your account at asiflex.com, the ASIFlex mobile app, or by faxing or mailing a completed claim form.
- RHIC eligibility requests should be directed to NDPERS. RHIC direct deposit authorization forms and claim form requests to receive reimbursement for premiums paid should be directed to ASIFlex.

NDPERS Retiree Health Insurance Credit Program

The NDPERS Retiree Health Insurance Credit (RHIC) program is administered by ASIFlex. All NDPERS, NDHPRS, and Job Service retirees receiving an ongoing retirement benefit at least annually from NDPERS are eligible for the RHIC benefit. RHIC funds may be used for **any health insurance and/or prescription drug plan** for which retirees incur an eligible premium expense. In addition, the RHIC credit can also be applied toward NDPERS administered dental, vision, and long term care plan premium expenses.

For members with NDPERS health, dental or vision coverage…

- NDPERS will bill you for the full premium amount or deduct the full premium amount from your bank account or pension check each month, as previously directed by you.
- NDPERS will report your RHIC amount to ASIFlex on a monthly basis.
- NDPERS will submit eligible premium amounts and proof of payment to ASIFlex.
- **No action will be required on your part** for monthly reimbursement. A check will be sent to your address of record if direct deposit is not set up.
- You will need to complete the ASIFlex Payment Authorization Form and return it to ASIFlex if you wish to have your RHIC reimbursement direct deposited.

For members with non-NDPERS eligible insurance coverage…

- NDPERS will report your RHIC amount to ASIFlex on a monthly basis.
- You complete a claim form and submit eligible premium amounts and proof of payment documentation to ASIFlex for reimbursement.
- A check will be sent to your address of record if direct deposit is not set up. You will need to complete the ASIFlex Payment Authorization Form and return it to ASIFlex if you wish to have your RHIC reimbursement direct deposited.

You are encouraged to sign up for direct deposit to receive your RHIC reimbursement. **To set up direct deposit, complete and return the enclosed authorization form to ASIFlex, PO Box 6044, Columbia, MO 65205-6044.** NDPERS and ASIFlex are not responsible for lost or stolen checks or for delayed mail.

WHO TO CONTACT	
Questions regarding: • Who is eligible • Amount of RHIC benefit • How RHIC benefit is calculated • Address changes (submit paper form or login to MSS account online)	NDPERS www.nd.gov/ndpers ndpers-info@nd.gov 1.800.803.7377
Questions regarding: • How to file claims • What premiums are eligible • How to access and view my account • Account balance • Claim payment status • How to get the mobile app • How to sign up for email/text alerts • How to sign up for direct deposit	ASIFlex www.asiflex.com asi@asiflex.com 1.800.659.3035

Information below outlines acceptable documentation to provide to ASIFlex for RHIC reimbursement if …

- **you have non-NDPERS sponsored health and/or prescription drug coverage OR**
- **you have NDPERS health, dental, or vision coverage under an "active" NDPERS employer-sponsored plan ***

  *As a reminder: If you have NDPERS insurance coverage as a "retiree", you DO NOT need to submit any documentation to ASIFlex for RHIC reimbursement. NDPERS will report your monthly premium amounts paid to ASIFlex.

All 3 forms of documentation must be provided to validate a claim: (1)Proof of Insurance, (2)Proof of Payment, and (3) Claim Form

(1) Proof of Insurance must be provided at least annually or when a change in health and/or prescription drug coverage cost occurs:

Letter from insurance carrier (individual policy)

- verify type of coverage (health or prescription drug only)
- verify retiree with RHIC is policy holder or covered dependent on health plan
- verify premium amount
- verify dates or month(s) of coverage (coverage start date)

Letter from employer (employer-sponsored policy)

- verify type of coverage (health or prescription drug only)
- verify retiree with RHIC is policy holder or covered dependent on health plan
- verify amount of premium paid by employee
- verify dates or month(s) of coverage
- confirm premium is paid after-tax

Annual Pension Statement Verifying Health Coverage Cost

- verify type of coverage (health or prescription drug only)
- verify retiree with RHIC is policy holder or covered dependent on health plan
- verify premium amount
- verify reoccurring monthly amount of coverage

Annual Social Security Statement (No proof of payment required)

- verify Part B and Part D premiums paid
- verify retiree with RHIC is policy holder
- verify premium amount
- verify reoccurring monthly amount of coverage

(2) Proof of Payment must be provided for each month your RHIC benefit is being claimed:

Bank Statement

- must show month and amount paid
- eliminate all other information except what is pertinent to prove expense (insurance company/coverage, amount, date, your name)

Cancelled Check

- must show month and amount paid

Electronic Payment Receipt

- must show month and amount paid

Pay stub

- must show after-tax deduction (pre-tax deductions are ineligible)
- must show month (beginning of pay period) and amount paid
- eliminate all other information except what is pertinent to prove expense (health deduction, amount, date, your name)

Itemized Statement from Insurance Company or Employer

- must verify month(s) and amount paid

(3) Claim Form must be submitted with each claim request

- Indicate dates, type, and amount of eligible premiums paid
- Indicate "reoccurring" if reoccurring claim (if applicable)
- Must be signed and dated
- POA (Power of Attorney) must be verified and on file with NDPERS (if applicable)
- Contact ASIFlex by Phone: 1.800-659.3035 or Online: www.asiflex.com and click "Forms"

DEFINITIONS: (Reference – N.D.A.C. Chapter 71-02-01-01)

Leave of absence means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years or indefinitely if the leave of absence is due to interruption of employment.

Medical consultant means a person or committee appointed by the board of the North Dakota Public Employees Retirement System to evaluate medical information submitted in relation to disability applications, recertification, and rehabilitation programs or other such duties as assigned by the board.

Permanent and total disability for members of the main retirement system and the national guard/law enforcement retirement plan means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months. For members of the judge's retirement plan, "permanent and total disability" is determined pursuant to subdivision e of subsection 3 of section 54-52-17 of the North Dakota Century Code.

Substantial gainful activity is to be based upon the totality of the circumstances including consideration of an individual's training, education, and experience; an individual's potential for earning at least seventy percent of the individual's pre-disability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.

Termination of employment is a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

Direct Deposit by Automated Clearing House (ACH)

ACH Direct Deposit service for the convenience of PERS benefit recipients

It is NDPERS Board's policy that all annuity payments are required to be direct deposited. This method of transferring funds is safe, secure and used nationwide. You do not have to change your current bank relationship to take advantage of this service. It is available through all banks, credit unions, savings and loans facilities and most other financial institutions.

Advantages of Direct Deposit:

- The money will be there on time each month.
- Your worries about mail delays or stolen checks are over.
- You'll avoid waiting in long bank lines to cash or deposit checks.
- Your money will be deposited quicker – the first business day of each month, which allows you to access money more quickly than before.

To begin Direct Deposit, simply complete an Authorization for Direct Deposit for Annuity Payments SFN 18379. (This form may be obtained on-line at www.nd.gov/ndpers).

You must complete and sign the "Annuitant/Payee" part of the form and attach a voided check.

Return the form to the NDPERS office by the 14th of any month. Your Direct Deposit of NDPERS benefit payments will begin the first of the following month, unless an alternate effective date is requested.

To change financial institutions or change any account information, just complete an Authorization for Direct Deposit for Annuity Payments SFN 18379.

Direct Deposit is safe, convenient and easy. Benefit payments are deposited electronically into your bank account.

There are no service fees charged by NDPERS for this service. It's free! However, you may have to check with your bank for any possible fees.

SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS

Revised 12/2014

YOUR ROLLOVER OPTIONS

You are receiving this notice because all or a portion of a payment you are receiving from the North Dakota Public Employee's Retirement Plan (the "Plan") is eligible to be rolled over to an IRA or an employer plan. This notice is intended to help you decide whether to do such a rollover.

Rules that apply to most payments from a plan are described in the "General Information About Rollovers" section. Special rules that only apply in certain circumstances are described in the "Special Rules and Options" section. **Please note that all references to spouse in this notice are references to the term spouse according to the federal law, which defines spouse as any lawfully married spouse, same or opposite sex.**

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes?
You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (unless an exception applies). However, if you do a rollover, you will not have to pay tax until you receive payments later and the 10% additional income tax will not apply if those payments are made after you are age 59½ (or if an exception applies).

Where may I roll over the payment?
You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity) or an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover?
There are two ways to do a rollover. You can do either a direct rollover or a 60-day rollover.

If you do a direct rollover, the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a rollover by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes. This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be

subject to the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

How much may I roll over?
If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Certain payments spread over a period of at least 10 years or over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Required minimum distributions after age 70½ (or after death)
- Corrective distributions of contributions that exceed tax law limitations

The Plan administrator or the payor can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions?
If you are under age 59½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments that start after you separate from service if paid at least annually in equal or close to equal amounts over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary)
- Payments from a governmental defined benefit pension plan made after you separate from service if you are a public safety employee and you are at least age 50 in the year of the separation
- Payments made due to disability
- Payments after your death
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Payments up to the amount of your deductible medical expenses
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA?
If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions from the IRA, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- There is no exception for payments after separation from service that are made after age 55.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- The exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe State income taxes?
This notice does not describe any State or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If your payment includes after-tax contributions
You can elect to rollover after-tax contributions to an IRA or another employer plan that will accept the contributions. If your rollover includes after-tax contributions, NDPERS will require a letter of acceptance from the financial institution that the rollover is to be sent to**. The letter of acceptance must indicate that they will accept the after-tax portion of the rollover**. You may also want to request information from the financial institution regarding how the record-keeping for the funds will be handled once the funds are deposited.

If NDPERS does not receive this letter of acceptance within 6 months from the date your rollover application is received, NDPERS will process the rollover by sending the taxable portion to the financial institution and the after-tax contributions to you at your mailing address.

After-tax contributions included in a payment are not taxed. If you have pre-1987 after-tax contributions maintained in a separate account, a special rule may apply to determine whether the after-tax contributions are included in a payment.

You may roll over to an IRA a payment that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRAs (in order to determine your taxable income for later payments from the IRAs). If you do a direct rollover or a 60- day rollover to an IRA of only a portion of the payment made to you, the after-tax contributions are treated as rolled over last. For example, assume you are receiving a complete distribution of your benefit which totals $12,000, of which $2,000 is after-tax contributions. In this case, if you roll over $10,000 to an IRA in a 60-day rollover, no amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions.

You may roll over to an employer plan all of a payment that includes after-tax contributions, but only through a direct rollover (and only if the receiving plan separately accounts for after-tax contributions and is not a governmental section 457(b) plan). You can do a 60-day rollover to an employer plan of part of a payment that includes after-tax contributions, but only up to the amount of the payment that would be taxable if not rolled over.

If you miss the 60-day rollover deadline
Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590, Individual Retirement Arrangements (IRAs).

If you were born on or before January 1, 1936
If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, Pension and Annuity Income.

If you are an eligible retired public safety officer and your pension payment is used to pay for health coverage or qualified long-term care insurance
If the Plan is a governmental plan, you retired as a public safety officer, and your retirement was by reason of disability or was after normal retirement age, you can exclude from your taxable income plan payments paid directly as premiums to an accident or health plan (or a qualified long-term care insurance contract) that your employer maintains for you, your spouse, or your dependents, up to a maximum of $3,000 annually. For this purpose, a public safety officer is a law enforcement officer, firefighter, chaplain, or member of a rescue squad or ambulance crew.

If you roll over your payment to a Roth IRA
You can roll over a payment from the Plan made before January 1, 2010 to a Roth IRA only if your modified adjusted gross income is not more than $100,000 for the year the payment is made to you and, if married, you file a joint return. These limitations do not apply to payments made to you from the Plan after 2009. If you wish to roll over the payment to a Roth IRA, but you are not eligible to do a rollover to a Roth IRA until after 2009, you can do a rollover to a traditional IRA and then, after 2009, elect to convert the traditional IRA into a Roth IRA.

If you roll over the payment to a Roth IRA, a special rule applies under which the amount of the payment rolled over (reduced by any after-tax amounts) will be taxed. However, the 10% additional income tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within 5 years, counting from January 1 of the year of the rollover). For payments from the Plan during 2010 that are rolled over to a Roth IRA, the taxable amount can be spread over a 2-year period starting in 2011.

If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age 59½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to $10,000) and after you have had a Roth IRA for at least 5 years. In applying this 5-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590, Individual Retirement Arrangements (IRAs).

You cannot roll over a payment from the Plan to a designated Roth account in an employer plan.

If you are not a plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you were born on or before January 1, 1936" applies only if the participant was born on or before January 1, 1936.

> **If you are a surviving spouse**. If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.
>
> An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70½.
>
> If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70½.
>
> **If you are a surviving beneficiary other than a spouse**. If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA. Payments from the inherited IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA.

Payments under a qualified domestic relations order. If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). Payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

If you are a nonresident alien

If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled

to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, U.S. Tax Guide for Aliens, and IRS Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Other special rules

If a payment is one in a series of payments for less than 10 years, your choice whether to make a direct rollover will apply to all later payments in the series (unless you make a different choice for later payments).

If your payments for the year are less than $200 (not including payments from a designated Roth account in the Plan), the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information, see IRS Publication 3, Armed Forces' Tax Guide.

FOR MORE INFORMATION

You may wish to consult with the Plan administrator or payor, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in:

IRS Publication 575, Pension and Annuity Income; IRS Publication 590, Individual Retirement Arrangements (IRAs); and IRS Publication 571, Tax-Sheltered Annuity Plans (403(b) Plans). These publications are available from a local IRS office, on the web at www.irs.gov, or by calling 1-800-TAX-FORM.

CONTINUATION OF INSURANCE COVERAGE (COBRA)
Retiring or Terminating Employees

Please read this information carefully. You should retain this notice for your records. Please disregard this notice if: 1. you transferred employment to another NDPERS covered employer, or 2. you are still employed with your current employer and just experienced a change in your employment status.

As a result of a recent "Qualifying Event", your insurance coverage has or will terminate on December 31, 1995. Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you and/or your covered dependents that are losing coverage are entitled to continue your group insurance coverage under the plan sponsored by your employer beyond the date coverage would normally end. You may have already made an election; however, we are required by federal law to provide you this notice for your records.

You and/or your covered dependents that are losing coverage are "Qualified Beneficiaries". A family member added to the covered employee's contract due to marriage or birth or placement for adoption during a period of continuation coverage will also be deemed a qualified beneficiary for COBRA purposes. The spouse or child must be added to COBRA coverage within 31 days from the date of the qualifying event.

As qualified beneficiaries, you and/or your eligible dependents losing coverage are entitled to continue the same group insurance coverage that you had on the day before the qualifying event (provided that the company has not eliminated the policy or changed insurance carriers since the qualifying event). Additionally, you are also entitled to COBRA continuation coverage if you have other insurance coverage *prior* to electing COBRA coverage (including entitlement to Medicare).

Under the law, you have a 60-day election period during which you must inform your employer in writing or by completing an application that you want continuation coverage. This election period begins on the later of (1) the date you lose coverage due to the qualifying event or (2) the date you are provided your COBRA notification. If you are or become mentally or physically incapacitated during this election period, an appointed guardian or responsible party may elect and/or pay for COBRA continuation coverage on your behalf. If you choose COBRA continuation coverage, your election is considered made on the date you send your payment to the Plan Administrator.

There may be other coverage options for you and your family through the Health Insurance Marketplace. Refer to the information below for additional details on the Marketplace.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

CONTINUATION PERIOD

Your Qualifying Event entitles you and/or your covered dependents to continue coverage for the period of 18 months if you are qualifying due to the member's termination of employment. This period begins on the date your coverage under the group insurance plan would normally cease. If you have signed an Early Retirement Agreement, whereby your employer will pay the premiums for a specified period of time, the first 18 months of employer paid premium is your COBRA continuation coverage.

EXTENDED COBRA CONTINUATION COVERAGE PERIOD

Any qualified beneficiary in connection with a qualifying event may be entitled to an extension of continuation coverage from 18 to 29 months if an individual is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. The disability extension applies only if any of the qualified beneficiaries provides notice to the plan administrator of the disability determination within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period. The affected individual must also notify NDPERS within 31 days of any final determination that the individual is no longer disabled. The disability extension applies separately to each qualified beneficiary including non-disabled family members who are qualified beneficiaries due to the termination or reduction in hours of employment.

In addition, if you are the spouse or dependent of an employee who has been terminated from employment or whose hours of employment have been reduced, you may receive an extension of continuation coverage if a second qualifying event occurs (such as employee death, divorce, legal separation, employee Medicare entitlement or losing dependent status under the Plan) during the original 18-month continuation coverage period. In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months. This extension applies only if the Plan Administrator is notified in writing within 60 days of the second qualifying event and within the original 18 or 29-month coverage period. This extension applies to individuals who are qualified beneficiaries as a result of the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. A reduction in hours followed by a termination of employment is not considered a second qualifying event for COBRA purposes.

PREMIUMS FOR COBRA CONTINUATION COVERAGE

You will be charged 102% of the applicable group premium rate for the level of coverage you select. Unless you expressly elect otherwise, the coverage to be continued will be that which you and/or your dependents (if any) had on the day before the qualifying event. However, be aware that each qualified beneficiary has independent COBRA election rights. Your monthly premium based on your current coverage level will be $981.68. The initial premium for continuation coverage must be made within 45 days of your COBRA election.

Your continuation coverage will not be effective until the initial premium payment is received. If the initial premium is not made within the indicated period, you will forfeit your right to continuation coverage. Subsequent monthly premium payments are due and payable on the 15th day of each month for that month's coverage. Pursuant to COBRA law, your continuation coverage will be terminated if your premium is not received by the last day of the month for which coverage was due.

HOW TO ELECT COBRA CONTINUATION OF INSURANCE COVERAGE

1. Obtain, complete and follow the instructions on the ‘CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA) SFN 14120 and return it to the NDPERS office before the Election Period Expiration Date. The form can be found on the NDPERS website at www.nd.gov/ndpers.
2. Pay the initial premium required for COBRA continuation coverage within forty-five (45) days of your COBRA election date. See the Premiums for COBRA Continuation Coverage section.

TERMINATION OF CONTINUATION COVERAGE

You may lose your continuation coverage before the end of your maximum coverage period for any of the following reasons:

1. If any required premium is not paid in a timely manner, coverage will cease for you and your qualified beneficiaries.
2. If you or any of your qualified beneficiaries become covered under another group insurance plan, after the date of COBRA election, that does not contain any applicable exclusion or limitation with respect to any pre-existing condition.
3. If all of our group insurance plans are terminated (including successor plans), coverage will cease for you and your qualified beneficiaries.
4. If coverage was extended to 29 months due to a disability, coverage will cease if there is a determination that the individual is no longer disabled. Please note: Federal law requires that you inform the plan administrator within 31 days of a final determination that the individual is no longer disabled.
5. If you or your qualified beneficiaries become entitled to coverage under Medicare, after the date of COBRA election, coverage will cease for each individual so eligible. If you are age 65 or over and receive or have applied for Social Security (or qualify for Social Security at an earlier age due to a disabling condition) you are considered to be entitled to Medicare.
6. If you request cancellation of COBRA continuation coverage in writing.
7. If the group insurance plan terminates the coverage for cause for similarly situated active employees, then the qualified beneficiary's coverage can be terminated on the same basis (such as for submission of fraudulent claims, etc.).

IMPORTANT: The plan is required to make a complete response to any inquiry from a insurance provider regarding your right to coverage under the plan during the election period. Similar requirements exist to provide the status of COBRA coverage inquiries made by insurance care providers during any applicable premium payment grace periods. If you elect the continuation coverage, the initial payment will cover the first period of continuation coverage beginning immediately after the date that your coverage under the group insurance plan ceased. Please see Premiums for COBRA Continuation Coverage section of this document.

PLAN OR BENEFIT CHANGES

If you elect continuation coverage, you will receive the same level of benefits under the plan as similarly situated active employees. Plan benefits may be modified or amended during the period of continuation coverage that may result in a change of premiums in accordance with federal COBRA regulation. As a qualified beneficiary, you are entitled to the same open enrollment rights as active employees. This includes special enrollment rights such as adding coverage for newly acquired family members.

Please be advised that notification to an individual, who is a qualified beneficiary as the spouse of a covered employee, shall be considered notification to all other qualified beneficiaries residing with such spouse at the time such notice is made.

HIGH DEDUCTIBLE PLAN MEMBERS

If you participate in the NDPERS High Deductible Health Plan with a Health Savings Account (HSA) and terminate employment, NDPERS is not responsible for any further employer contributions to your HSA. However, prior to depleting your funds or closing your account, please contact NDPERS to verify that all contributions have been deposited.

MARKETPLACE INSURANCE COVERAGE

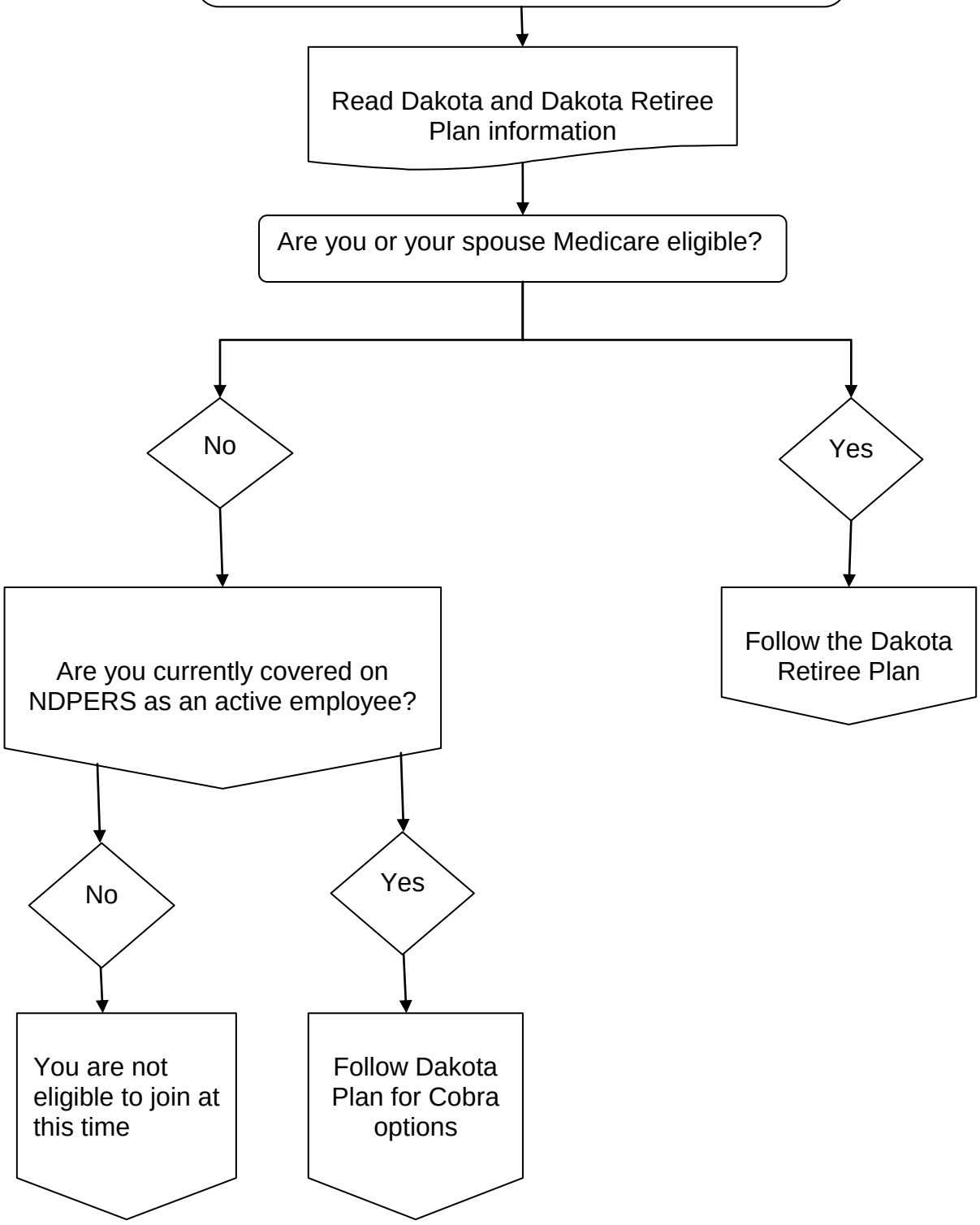
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered continuation coverage won't limit your eligibility for coverage or for a tax credit through the marketplace.

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace as a special enrollment event. After 60 days, your special enrollment period will end and you may not be able to enroll right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

Health Insurance

Even if you do are not participating you must make a decision to enroll or to waive coverage.



DAKOTA PLAN & DAKOTA RETIREE PLAN

This is information regarding the Dakota Plan and Dakota Retiree group health insurance Plans. Both plans are underwritten by Blue Cross Blue Shield of North Dakota (BCBSND). Please refer to the Certificate of Insurance for complete details.

ELIGIBILITY

To be eligible to continue the Dakota Plan if enrolled as an active employee or join the Dakota Retiree Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association (TIAA) (North Dakota University System only)

A member of certain Political Subdivisions, if enrolled in the Dakota Plan as an active employee, and:

- Receiving a "retirement allowance" from a NDPERS Board approved employer sponsored retirement plan, such as:

  - 401(a)
  - 401(k)
  - 403(b)
  - 457

A retiree continuing coverage from active employment in the Dakota Plan can continue coverage for 18 months of (COBRA). After COBRA ends, if the retiree or spouse is not eligible for Medicare, the retiree will need to find coverage outside of NDPERS until they or their spouse is Medicare eligible.

ENROLLMENT

A member who is receiving a qualified retirement allowance must apply within 31 days from any one of the following "qualifying events": Eligibility based upon if a member was receiving benefits prior to July 2015 will be verified at the time of enrollment.

1. Date of retirement, defined as either:

   - The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or
   - Date of first retirement check if member deferred his/her retirement benefit.

2. Member's 65th birthday or eligibility for Medicare;

3. Member's spouse or eligible dependent's 65th birthday or eligibility for Medicare;

4. The loss of coverage in a health plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.

5. Marriage

6. Birth, adoption, or appointment of children for legal guardianship.

A retiree may be determined eligible to enroll at the time of a qualifying event if he and/or his spouse is not Medicare eligible and the retiree was not receiving benefits prior to July 2015.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE

If a member is enrolled in the Dakota Plan as an active employee, coverage will become effective on the first of the month following the final date of coverage provided by his/her employer. If a member was not enrolled in the Dakota Plan at the time of application and is Medicare eligible, coverage in the Dakota Retiree Plan will become effective on the first day of the month following one of the "qualifying events" listed above.

PREMIUM PAYMENT POLICY:

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Benefit Check Bank Account
NDPERS Defined Contribution[3]	Bank Account
NDHPRS[1]	Benefit Check Bank Account
Job Service[1]	Benefit Check Bank Account
TFFR[2]	Benefit Check Bank Account
TIAA[3]	Bank Account
Approved Employer Sponsored[3]	Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. <u>However, the first month of premium will be billed to you and you will need to pay by personal check. NDPERS will begin withholding the premium(s) the month following the first benefit payment</u>. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134. It is the policy of NDPERS that a member's net annuity payment can not be less than $50.00.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete a Payroll Deduction Authorization (TFFR) SFN 19182. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134.

CANCELLATION POLICY:

To cancel NDPERS health coverage, a request to cancel Retiree Health Insurance Coverage SFN 58269 must be submitted. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy

Dakota Plan

Continue in this plan if covered as an active employee and if you and your spouse are not eligible for Medicare

Are you currently enrolled in NDPERS Dakota Plan as an active employee?

No

You are not eligible to join the NDPERS Dakota Plan. You may join the Dakota Retiree Plan when you or your spouse is eligible for Medicare

Yes

Read COBRA CONTINUATION and Dakota Plan Features

Do you want to continue your coverage in the Dakota Plan?

No

Yes

Complete Retiree Continuation of Group Health Insurance Coverage (COBRA) SFN 53799 to continue coverage or to waive coverage

DAKOTA PLAN
PPO/Basic and
High Deductible Health Plan (HDHP)

This is information regarding your eligibility for the NDPERS group health coverage under the Dakota Plan. The plan is underwritten by Sanford Health Plan (SHP).

COBRA CONTINUATION

Upon termination of employment, your NDPERS health coverage will continue to the end of month following the month of your separation from employment. You and your covered dependents may apply for COBRA coverage within 60 days of your separation of employment if:

- If you, and your covered dependents were enrolled in the NDPERS health plan, and
- Neither you nor your covered dependents are eligible for Medicare.

You will have the option to continue COBRA coverage for a maximum period of 18 months. COBRA coverage will be terminated if:

- You or your covered dependents become eligible for an employer sponsored health plan
- Your or your eligible dependents become eligible for Medicare.

The following COBRA premiums are in effect through June 30, 2017:

State Agencies	Single	Family
	$555.16	$1,337.96
Political Subdivisions, enrolled prior to July 1, 2015:	**Single**	**Family**
Grand Fathered	$593.10	$1,432.94
Non Grand Fathered	$602.12	$1,454.72
Political Subdivisions enrolled after July 1, 2015:		
Premiums through June 30, 2016:	**Single**	**Family**
Grandfathered	$577.78	$1,397.12
Non-Grandfathered	$586.56	$1,417.06
Premiums July 1, 2016 through June 30, 2017:		
Grandfathered	$608.46	$1,468.78
Non-Grandfathered	$617.72	$1,492.38

If you are a family of two on the health insurance, it may cost less for you to split your coverage into two separate contracts during the 18 month Cobra period. Please contact your NDPERS counselor for further details and to discuss if this option is best for you.

High Deductible Health Plan (HDHP):

If you are an active state employee covered on the High Deductible Health Plan (HDHP) at the time you terminate, your coverage in this plan will continue while you are on COBRA. You will have opportunity to discontinue your participation in the HDHP plan and switch to the PPO/Basic Plan during annual enrollment.

Once terminated, there is no longer an employer contribution to a Health Savings Account (HSA) on your behalf. However, the premium that you are required to pay reflects that the state does not pay an employer contribution and are lower than the PPO/Basic COBRA rates. The premiums for HDHP COBRA are:

Single: $ 483.82
Family: $1,165.34

NDPERS is not responsible for depositing employer contributions into your Health Savings Account once you close the account. Please contact NDPERS to verify that all contributions have been deposited into your account prior to closing it.

EXTENDED COBRA:

Disability

A member or their dependent determined to have been disabled by Social Security may extend the continuation of coverage to 29 months. If you or your dependent becomes disabled at any time during the first 60 days of COBRA continuation coverage the member must provide notice of such determination to NDPERS within 60 days after the date of any final determination of disability and before the end of the 18 month continuation period.

Death

Continuation of coverage may be extended for a period up to 36 months for an eligible dependent.

CANCELLATION OF COBRA:

If you wish to cancel your NDPERS health coverage you must submit a Request to Cancel Retiree Health Insurance Coverage SFN 58629. Cancellations will only be done at the end of the month. We cannot cancel your policy for a partial month or do a retroactive cancellation of a policy. NDPERS must receive your cancellation request by the end of the month prior to the effective cancellation date.

Additional Features of Dakota PPO/Basic and HDHP Plans:

DISEASE MANAGEMENT PROGRAM

A disease management program is offered through SHP. Please contact the SHP Care Management Department at 1-877-652-1847.

DAKOTA WELLNESS PROGRAM

Novu Online Portal:

Covered members and their eligible spouse can use the Novu online wellness portal. Novu provides exercise, blood pressure and calorie trackers.

After you receive your health insurance ID cards, you will receive a member packet that will explain the wellness program in detail.

DAKOTA HEALTH PLAN FEATURES
PPO/BASIC

For complete features of the Dakota Plan, visit www.nd.gov/ndpers.

Preferred Provider Organization (PPO/BASIC):

The Preferred Provider Organization (PPO) is a group of hospitals, clinics and physicians who have agreed to discount their services to members of NDPERS. You have "freedom of choice" in selecting which physician or medical facility to use for services. No referral is needed. If you choose a provider who participates in the PPO program, you will have lower out-of-pocket expenses. PPO benefits are only available in the State of North Dakota, unless the medical facility provides services at a satellite location in another State.

DEDUCTIBLE AND COINSURANCE:

Deductible, copayments, and coinsurance maximums accrue on a "Calendar-Year" basis, January 1 - December 31.

Plan Features:	Basic (Self Referral or Out-of-State)	PPO
Deductible for All Services		
-Per Person	$400	$400
-Per Family	$1200	$1200
Copayment for Physician Office Visits (no limit)	$ 30	$ 25
Copayment for Emergency Room	$ 50	$ 50
Coinsurance on all covered services except Physician Office Visits	75/25	80/20
Annual Coinsurance Maximum		
-Individual	$1250	$750
-Family	$2500	$1500
Annual Out-of-Pocket Maximums (Deductible and Coinsurance)**		
-Individual	$1650	$1150
-Family	$3700	$2700
*Out-of-network coverage is at the Basic level. **Office visit and emergency room copayments and prescription drug copayments and coinsurance are additional		

PREVENTIVE SCREENING SERVICES- PPO/BASIC COVERAGE:

Wellness Services				
	Copayment	PPO Plan	Basic Plan	Special Conditions
Well Child Care *(to member's 6th birthday)*	$25/$30	100%	100%	Deductible does not apply.
Preventive Screening Services *(members 6 and older)*	$25/$30	100%	100%	Maximum benefit allowance of $200 per member per benefit period for any non-routine screening services. Deductible does not apply. Benefits beyond the maximum benefit allowance will be subject to cost sharing amounts. Deductible does not apply.
Immunizations		100%	100%	Deductible does not apply.
Mammography & Pap Smear Screening Services		100%	100%	The number of visits for mammography varies by age group. Maximum benefit allowance of 1 Pap smear per benefit period. Refer to benefit plan for details.
Prostate Cancer Screening Services		80%	75%	Refer to the benefit plan for details. Deductible does not apply.

For a Complete list of benefits please refer to the Certificate of Insurance.

SUMMARY OF BENEFITS AND COVERAGE (SBC):

The Affordable Care Act (ACA) added a new requirement for the disclosure of a Summary of Benefits and Coverage (SBC). The Summary of Benefits & Coverage (SBC) for the various NDPERS group health insurance plans are located on the NDPERS website and can be found under the Publications listing for each plan (PPO/Basic - Grandfathered, PPO/Basic Non-Grandfathered and High Deductible Health Plan (HDHP)). These documents provide a comprehensive resource for the purposes of comparing coverage levels across all plans.

PRESCRIPTION DRUG COVERAGE:

Deductible, copayments, and coinsurance maximums accrue on a "Calendar-Year" basis, January 1 - December 31.

Plan Features:	**Basic (Self Referral or Out-of-State)**	**PPO**
Prescription Formulary Generic Drug		
-Copayment	$5	$5
- Coinsurance ($1,000 maximum per person per benefit period, covered at 100% after $1,000 maximum is met)	15%	15%
Prescription Formulary Brand-Name Drug***		
-Copayment	$20	$20
- Coinsurance ($1,000 maximum per person per benefit period, covered at 100% after $1,000 maximum is met)	25%	25%
Prescription Non-Formulary Drug		
-Copayment	$25	$25
-Coinsurance	50%	50%

***One copayment amount per prescription order or refill for a 1–34 day supply.
Two copayment amounts per prescription order or refill for a 35–100 day supply. Benefits are subject to the Outpatient Prescription Drug Coinsurance Maximum Amount. Deductible does not apply

MAIL ORDER PRESCRIPTION DRUGS:

Please contact Express Scripts Inc. (ESI) at 1-800-243-9800 regarding the mail order prescription plan

MEMBER REBATE ACCOUNTS:

Member rebate accounts for rebates on prescription drugs. Please contact the SHP Pharmacy Management Department at 1-888-315-0885.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Information regarding the High Deductible Health Plan (HDHP) including deductibles, coinsurance amounts, and preventive services is available on the NDPERS website at www.nd.gov/ndpers.

Dakota Retiree Plan

To enroll in this plan you and/or your spouse must be eligible for Medicare

Read the Dakota Retiree Plan, Dakota Retiree Plan Prescription Drug Coverage and Notice of Credible Coverage

Do you want to enroll in the Dakota Retiree Plan?

No

Complete the Retiree Group Health Insurance Application SFN 59562 to waive coverage

Yes

Complete the Retiree Health Insurance Application with Medicare SFN 59562 to enroll

Complete the Medicare Prescription Drug Plan (PDP) Individual Enrollment Form – SFN 58860 for each eligible member within 90 days of requested coverage effective date

Attach a photocopy of your Medicare card showing Part A and Part B effective dates for each eligible member.

Dakota Retiree Plan

The Dakota Retiree Plan provides health care coverage through Sanford Health Plan as a secondary payer to Medicare. You will not be assessed deductible or coinsurance amounts. Please refer to the schedule of benefits outlined below.

The following information is intended to provide a brief summary of your benefits. It should not be used to determine whether your health care expenses will be paid. The written Benefit Plan governs the benefits available. Covered Services are subject to your Benefit Plan Cost Sharing Amounts, unless otherwise indicated.

* The Dakota Retiree plan provides you with prescription drug coverage, see Express Scripts Inc. (ESI) Overview of Benefits. Express Scripts Inc. (ESI) is the prescription drug plan vendor.

A member or eligible dependent is eligible to enroll in this health coverage at the time of Medicare eligibility. If covered under the Dakota Plan at the time, a member will receive a notification approximately 60 days prior to the eligibility date regarding the enrollment procedures. To enroll, you must comply with the following requirements:

- The eligible member(s)/dependent(s) **must have both parts A and B of Medicare**. If the eligible member(s)/dependent(s) continue to be covered by an "active" employer group policy, Medicare Part B may be waived until the contract holder terminates employment.

- The eligible member(s) and dependent(s) must complete the Retiree Health Insurance with Medicare Application SFN 59562 as well as, Medicare Prescription Drug Plan (PDP) Individual Enrollment Form – SFN 58860 for each person who is Medicare eligible and also include a copy of the Medicare card showing both Part A and B. **Please note that the Medicare Prescription Drug Plan (PDP) Individual Enrollment Form – SFN 58860 cannot be signed or submitted more than 90 days prior to the requested effective date or coverage. You also must provide a letter of creditable coverage from your previous insurance carrier.**

If the above requirements are met and member enrolled prior to July 1, 2015, the following premiums are in effect through June 30, 2017:

***NOTE:** These rates are subject to Medicare Part D increase at the end of each calendar year

	Single *	Family *
One Medicare/One Non-Medicare		$711.76
Medicare Eligible (Must have both Medicare A & B)	$274.08	$545.06

If the above requirements are met and member enrolled in the plan on or after July 1, 2015, the following premiums are applicable:

Premiums through June 30, 2016 :	Single *	Family*
One Medicare/One Non-Medicare		$695.50
Medicare Eligible	$263.42	$523.76
(Must have both Medicare A & B)		

Premiums from July 1, 2016 to June 30, 2017:	Single *	Family*
One Medicare/One Non-Medicare		$719.70
Medicare Eligible	$276.42	$549.72
(Must have both Medicare A & B)		

If you have more than two people on your health insurance policy, please contact NDPERS for your rate. If member/dependent did not enroll in the plan at the time he/she is eligible, coverage will cease on the first day of the month in which the member or dependent(s) became eligible.

DAKOTA WELLNESS PROGRAM

Novu Online Portal:
Covered members and their eligible spouse can use the Novu online wellness portal. Novu provides exercise, blood pressure and calorie trackers.

After you receive your health insurance ID cards, you will receive a member packet that will explain the wellness program in detail.

REFERENCE MATERIALS AVAILABLE:

As a health plan accredited with the National Committee for Quality Assurance (NCQA), Sanford Health Plan is required to provide you with additional information as you make decisions regarding your medical benefit plan. This information, including accessing your provider network, pharmacy information and other important notices can be found - http://www.nd.gov/ndpers/insurance-plans/docs/sanford-health/reference-material/reference-material-medicare-retiree-new-hire-kit.pdf

Provider Network
- Networks available.

Member Handbook
- How to read an Explanation of Benefits (EOB).
- What to do in an emergency.
- Special communication services.
- How claims are paid.

Special Notices
- Learn about Sanford Health Plan's privacy policy.
- Find out more about the claims appeal process.

Feel free to contact Sanford Health Plan with any questions that you may have at (701) 751-4125 or toll-free at (800) 499-3416.

NDPERS Dakota Retiree Plan
Member Handbook

Table of Contents

Introduction **1**
How to Contact Us **1**
Privacy Practices **1**
Member Rights & Responsibilities **1**
Member Services Department **3**
Special Communication Services **3**
Services for the Deaf and Hearing Impaired 3
Services for Visually Impaired 3
Translation Services 3
Member Benefits **5**
Emergency and Urgent Care Situations **5**
Benefits for Emergency Care in a Foreign Country 5
Levels of Coverage **5**
Wellness Principles **6**
Case Management **6**
Care Coordinator Program 6
mySanfordNurse 6
Claim Payment Procedures **7**
When You May Need to File a Claim 7
Out-of-State Services and How to File a Claim 7
Coordination of Benefits 7
Important Information about the Complaint Process **7**
Get help & more information 8
Termination of Membership **8**

Dear Sanford Health Plan NDPERS Member,

We are pleased to have you as a Member and welcome you to our care system! This booklet will help you get to know your benefits. It is made up of tips on how you can reach us and how to use your benefits. We look forward to serving you.

Introduction

This Member Handbook is not a contract. This Handbook is designed to give you the basic facts needed as a Member. It will also serve as a guide when seeking health care services. Your Certificate of Insurance (COI) and the NDPERS Service Agreement are the formal benefit plan documents for this benefit plan as set up by NDPERS.

For details about your coverage, please see your COI, which gives all of the terms and conditions of enrollment. If you have more questions after reading this Handbook and your COI, or need any help, please call us toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free).

NOTE: This Plan may not cover all your health care costs. Read your Certificate of Insurance with care to find out which costs are covered.

How to Contact Us

If you have more questions after reading the Handbook or your Certificate of Insurance, or need any help, we are open between the hours of 8 a.m. to 5 p.m. Central Time, Monday through Friday.

Physical Address	Mailing Address
Sanford Health Plan ATTN: NDPERS 300 Cherapa Place, Suite 201 Sioux Falls, SD 57103	Sanford Health Plan ATTN: NDPERS PO Box 91110 Sioux Falls, SD 57109-1110
Member Services	**Website**
(800) 499-3416*(toll-free)* or TTY/TDD: 1-877-652-1844 *(toll-free)*	www.sanfordhealthplan.com/ndpers

Privacy Practices

Our Privacy policies may be found at www.sanfordhealthplan.com/ndpers in the Privacy of Health Information link at the bottom of the page:

- Notice of Privacy Practices
- Confidentiality and Disclosure of Personal Health Information
- Protection of Oral, Written and Electronic Information across Sanford Health Plan

Member Rights & Responsibilities

Member Rights

We are committed to treating you in a way that respects your rights. Each Member (or the Member's parent, legal guardian, or other responsible person, if the Member is a minor or not able to make choices on their own) has the right to the following:

1. You have the right to get access to health care and/or services that are ready or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.

2. You have the right to considerate, respectful treatment at all times and under all circumstances with recognition of your personal dignity.
3. You have the right to be questioned and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. You have the right, but are not required, to select a Primary Care Doctor of your choice. If you are not happy for any reason with the main doctor initially chosen, you have the right to choose another doctor.
5. You have the right to expect communications and other records about your care, along with the source of payment for treatment, to be treated as confidential, in line with the guidelines set up in applicable North Dakota law.
6. You have the right to know who someone is and professional status of people supplying services to you, and to know which Doctor and/or Provider is mainly responsible for your care.
7. You have the right to an honest talk with the Doctors and/or Providers responsible for coordinating appropriate or medically necessary treatment choices for your conditions in a way that is clear, regardless of cost or benefit coverage for those treatment choices. You also have the right to join with Doctors and/or Providers in decision making about your treatment plan.
8. You have the right to give informed consent before the start of any procedure or treatment.
9. When you do not speak or understand the main language of the community, we will make reasonable efforts to access an interpreter. We have the duty to make reasonable efforts to access a treatment clinician that is able to communicate with you.
10. You have the right to get printed materials that describe important information about us in a format that is easy to understand and easy to read.
11. You have the right to a clear Grievance and Appeal process for complaints and comments and to have your issues resolved in a timely way.
12. You have the right to end coverage, in line with NDPERS and/or Plan guidelines.
13. You have the right to make recommendations about the organization's Members' rights and responsibilities policies.
14. You have the right to get information about the organization, its services, its Doctors and Providers, and Members' rights and responsibilities.

Member Responsibilities

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or not able to make choices on their own) is responsible for cooperating with those supplying Health Care Services to you, and shall have the following responsibilities:

1. You have the responsibility to give, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, drugs, and other matters about your health. You have the responsibility to tell your Doctor about unexpected changes in your condition. You are responsible for speaking up if you do not understand a planned course of action and what your role is.
2. You are responsible for carrying your Plan ID cards with you and for having your identification numbers on hand when telephoning or talking with us.
3. You are responsible for following all access and availability procedures.
4. You are responsible for telling us of an Emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after being physically or mentally able to give notice.
5. You are responsible for keeping appointments and, when you are not able to do so for any reason, for telling the responsible Doctor or the Hospital.
6. You are responsible for following your treatment plan as told by the Doctor mainly responsible for your care. You are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding your health conditions, including mental health and/or substance use disorders.
7. You are responsible for your actions if you say no to treatment or do not follow the Doctor's orders.
8. You are responsible for telling NDPERS within *thirty-one (31)* days if you change your name, address, or phone number.

9. You are responsible for telling NDPERS of any changes of eligibility that may affect your membership or access to services.

Member Services Department

We believe that good service depends on good communication with you. We encourage you to contact Member Services for help when you need it by calling (800) 499-3416 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* or emailing memberservices@sanfordhealth.org. We are happy to help you with questions about:

- How claims are paid
- Where to find a doctor or facility in your area
- If you have a complaint
- Getting another ID card

We are open and can answer your questions from 8 a.m. to 5 p.m. Central Time, Monday through Friday.

Special Communication Services

In compliance with the Americans with Disabilities Act (ADA), this document can be provided in alternate formats. Anyone with any disability who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at 701-328-3900. The North Dakota Relay Service (TTY) toll-free number is (800) 366-6888.

Please call Sanford Health Plan Member Services if you need help understanding written Plan information at (800) 499-3416 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services.

Services for the Deaf and Hearing Impaired

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: (877) 652-1844 *(toll-free)*.

Services for Visually Impaired

Please contact Member Services toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this handbook, your COI, or other written materials.

Translation Services

The Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free 1-877-652-1844 for help and to access translation services.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-652-1844 (toll-free). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-652-1844 (toll-free). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-877-652-1844 (toll-free). 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-652-1844 (toll-free)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-652-1844 (toll-free). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-652-1844 (toll-free). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-652-1844 (toll-free) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-652-1844 (toll-free). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-652-1844 (toll-free) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-652-1844 (toll-free). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك بمساعدتك. هذه خدمة مجانية سوى الاتصال بنا على 1-877-652-1844. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-652-1844 (toll-free) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-652-1844 (toll-free). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-652-1844 (toll-free). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-652-1844 (toll-free). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-652-1844 (toll-free). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-652-1844 (toll-free) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Member Benefits

As a Plan Member, your benefits package is one of the most comprehensive available today. Basic primary care and preventive benefits are available through your Primary Care Doctor. Please see your Outline of Covered Services and your Certificate of Insurance (COI) for a description of covered services, as well as those that are not covered.

Emergency and Urgent Care Situations

An Emergency Medical Condition or Emergency Care is the sudden and unexpected onset of a health condition that would lead a Prudent Layperson acting reasonably and possessing the average knowledge of health and medicine to believe that the absence of that requires immediate medical attention , if failure to provide medical attention would could result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

A Prudent Layperson is a person who is without medical training and who possess an average knowledge of health and medicine and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.

An Urgent Care Situation is a degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger.

An Urgent Care Requests is a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination:

a) Could seriously jeopardize the life or health of the Certificate holder or the ability of the Certificate holder to regain maximum function, based on a prudent layperson's judgment; or
b) In the opinion of a Practitioner and/or Provider with knowledge of the Certificate holder's medical condition, would subject the Certificate holder to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Benefits for Emergency Care in a Foreign Country

Your policy covers 80% of certain medically necessary emergency care outside the U.S. during the first 60 days of each trip after you meet a $250 deductible for the year and if Medicare doesn't otherwise cover the care. This benefit has a lifetime maximum of $50,000.

Levels of Coverage

Your Medicare supplement health care coverage was developed to help you pay for some of your health care expenses not paid in full by Medicare. *This coverage only pays for those services accepted and approved by Medicare with the exception of benefits for Medically Necessary Emergency Care in a foreign country.*
To understand your supplemental benefits, you must first understand your Medicare benefits. Therefore, it is very important that you read your *Medicare Handbook* carefully. If you do not have a Medicare Handbook, you may order one by calling your Social Security office.

Medicare benefits are divided into two categories: Medicare Part A and Medicare Part B.

- Medicare Part A
  Medicare Part A helps pay for inpatient hospital care, care in a skilled nursing facility, home health care, and hospice services. We offer you supplemental benefits in all of these categories.

- Medicare Part B
  Medicare Part B helps pay for physician services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A. We offer you supplemental benefits in all these categories as stated in your Certificate of Insurance, *SECTION III: Schedule of Benefits,* with the addition of benefits for Medically Necessary Emergency Care in a foreign country.

Wellness Principles

It is better for you to be seen in your Primary Care Doctor's office when you are healthy, so that he or she can work with you to keep you in good health instead of trying to treat you when you are already sick. That is why we encourage you to select a Primary Care Doctor to arrange your care and to offer you such services as yearly physical exams, maternity care, yearly gynecological exams, and immunizations. We have a commitment not only to treating you when you are ill, but also to helping you stay well. We will give you educational and wellness materials to teach you how to stay fit and live a healthy life: physically and mentally.

Case Management

Case management is a collaborative process that: assesses; plans; carries out; arranges; checks-in; and evaluates the choices and services required to meet your health needs. We use available communication and supports to encourage quality, effective outcomes.

Cases are detected for possible case management, based on requests for review, or a combination of things like:

a. admissions that go beyond the recommended or approved length of stay;
b. utilization of health care services that causes constant and/or extremely high costs; and
c. conditions that are known to need broad and/or long-term treatment or continuous care.

Our case management process allows professional case managers to assist you with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans.
More information is available at www.sanfordhealthplan.com/ndpers or by calling our Care Management Department at (877) 652-1847.

Care Coordinator Program

Sanford Health Plan recognizes the key to you and your family's overall wellness is made up of more than just physical health. That's why we created our *Care Coordinator Program*. We believe that by helping connect you to community support and resources, we empower you to achieve and maintain your optimal wellness. For example, your Care Coordinator may collaborate with other professionals who are invested in your wellbeing, such as case managers or your doctor. Your Care Coordinator may also connect you to programs and services that will help you manage family, financial and social needs, such as housing, or support groups.

mySanfordNurse

mySanfordNurse is a 24-hour health information resource that provides answers to health-related questions that arise outside of your healthcare visits. You may call (888) 315-0886 to visit with a nurse, or register/login to your account at visit www.sanfordhealthplan.com/memberlogin and submit a question online.

Claim Payment Procedures

When You May Need to File a Claim

By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare, even if they do not accept assignment. We will accept notice from Medicare Carriers on claims submitted on your behalf by physicians and suppliers or you may submit the Medicare Summary Notice (MSN). Notice of claims should include your name and Certificate number.

You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in North Dakota, Medicare will automatically send your claim to us.

The only time you will need to file a claim is if you receive services outside of North Dakota and your Medicare Summary Notice (MSN) does not say your private insurer is receiving the information in the Notes section of the MSN.

Out-of-State Services and How to File a Claim

If you receive health services outside of North Dakota, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive a Medicare Summary Notice (MSN). If the *Notes* section of the MSN says that the information is being sent to your private insurer, we will automatically receive the MSN.

If the MSN does not say your private insurer is receiving the information, you need to send the MSN to us so we can process your Medicare supplement benefits. Be sure your identification number and mailing address are shown accurately on the MSN form. You do not need to complete a claim form, just send the MSN, and keep a copy for your own records.

Send your MSN to:

Sanford Health Plan
NDPERS/Medicare Supplement Claims
PO Box 91110
Sioux Falls, SD 57109-1110

Coordination of Benefits

In some cases, you may be covered by another insurance plan, in addition to your coverage with us. If so, we will work with the other insurer to be sure you get full benefits without paying for services twice. If you are covered by another insurance plan, please tell Member Services so that we can find out whether another insurer may be responsible for paying for some of your care.

If your eligibility shifts to another insurer, please notify us as soon as possible so that we may coordinate your benefits appropriately.

Important Information about the Complaint Process

Sanford Health Plan has a process to resolve complaints. You can call or write us with your complaint. We will send a complaint form to you upon request. If you need assistance, we will complete the written complaint form and mail it to you for your signature. We will work to resolve your complaint as soon as possible.
If your complaint involves a dispute relating to the payment of services covered by Medicare, you may file a Medicare appeal through Medicare. The steps to follow in filing a Medicare appeal are explained in the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) forms which can be obtained from the Medicare intermediary or carrier. You may contact your local Social Security office.

Get help & more information

- **Sanford Health Plan:** (800) 499-3416 | TTY/TDD users call toll-free: (877) 652-1844. We are open Monday through Friday, 8 am to 5 pm, Central Time.
- **Medicare:** 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY: 1-877-486-2048
- **Medicare Rights Center:** 1-888-HMO-9050
- **Elder Care Locator:** 1-800-677-1116
- **North Dakota Insurance Department:** (800) 247-0560
- **NDPERS:** (701) 328-3900

If you require accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at (701) 328-3900.

Termination of Membership

If you are not able to continue coverage under an NDPERS benefit plan, please see your Certificate of Insurance, "*Cancellation of this or Previous Benefit Plans*".

If you have any questions after reading your Medicare Handbook, your Certificate of Insurance, or this handbook, please call Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free).

When a physician or supplier agrees to accept the charge approved by Medicare as full payment for covered services, he or she is said to accept assignment. All physicians who participate in the Medicare program agree to accept assignment. If you are not sure if your physician participates in the Medicare program, ask, and he or she will tell you.

If a physician does not accept assignment, he or she may collect more than Medicare's approved amount; we will pay this difference for you when this happens. If your provider accepts assignment, we will send our payment directly to that provider. If your provider does not accept assignment, we send our payments to you, or, in the event of your death, to your estate.

Special Communication Needs

In compliance with the Americans with Disabilities Act (ADA), this document can be provided in alternate formats. Anyone with any disability who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at 701-328-3900. The North Dakota Relay Service (TTY) toll-free number is (800) 366-6888.

Please call Sanford Health Plan Member Services if you need help understanding Plan information at (800) 499-3416 (toll-free). We can read forms to you over the phone and we offer free oral translation in any language through our translation services.

Services for the Deaf and Hearing Impaired

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: (877) 652-1844 (toll-free).

Services for Visually Impaired

Please contact Member Services toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

Translation Services

The Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free 1-877-652-1844 for help and to access translation services.

After Hours Care

Your Primary Care Practitioner, if you choose to select one, has agreed to be available to , twenty four (24) hours a day, seven (7) days a week for emergency and urgent care. Be sure to call during normal office hours for routine situations and only call after hours in URGENT or EMERGENCY situations. Leave a message with the answering service and, in accordance with Plan standards, your Primary Care Practitioner's office should return your call within thirty (30) minutes, or as soon as possible thereafter.

Emergency

If you have a condition that requires immediate surgical or medical attention, call 911 or go to the nearest emergency room for treatment. Sanford Health Plan covers any emergency services necessary to screen and stabilize members when a prudent layperson, acting reasonably, would believe that an emergency medical condition exists.

NDPERS Dakota Retiree Plan

Outline of Medicare Supplement Coverage

Plan on the best fit.

SANFORD HEALTH PLAN

Medicare Supplement

Outline of Medicare Supplement Coverage

Disclosures

Use this outline to compare benefits and premiums among policies.

You do not need more than one Medicare Supplement Policy. You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-certified hospital.

Read Your Policy Very Carefully

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Sanford Health Plan.

Policy Replacement

If you are replacing another health insurance policy, do not cancel it until you have actually received your new Policy and are sure you want to keep it.

Notice

Items in brackets "[ ]" follow current Medicare amounts.

The service area includes all counties in North Dakota.

This Policy may not fully cover all of your medical costs.

Neither Sanford Health Plan nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your Social Security Office or consult "The Medicare and You Handbook" for more details.

NDPERS Dakota Retiree Plan Medicare (Part A) Hospital Services – Per Benefit Period			
Services	**Medicare Pays**	**Dakota Retiree Plan Pays**	**You Pay**
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,316]	$[1,316] (Part A deductible)	$0
• 61st thru 90th day	All but $[329] a day	$[329] a day	$0
• 91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses[2]	$0[2]
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[164.50] a day	Up to $[164.50] a day	$0
• 101st day and after	$0	$0	All costs
Blood			
• First 3 pints	$0	3 pints	$0
• Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	$0	Balance

[1] A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[2] 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.

NDPERS Dakota Retiree Plan Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**Dakota Retiree Plan Pays**	**You Pay**
Medical Expenses 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, durable medical equipment			
• First $[183] of Medicare approved amounts [3]	$0	$[183] (Part B deductible)	$0
• Remainder of Medicare approved amounts	Generally 80%	Generally 20%[4]	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
Blood			
• First 3 pints	$0	All costs	$0
• Next $[183] of Medicare approved amounts[3]	$0	$[183] (Part B deductible)	$0
• Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services Blood tests for diagnostic services	100%	$0	$0
Parts A & B			
Home Health Care Medicare approved services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $[183] of Medicare approved amounts [3]	$0	$[183] (Part B deductible)	$0
- Remainder of Medicare approved amounts	80%	20%	$0

[3] Once you have been billed $[183] of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

[4] Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

NDPERS Dakota Retiree Plan Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**Dakota Retiree Plan Pays**	**You Pay**
Other Benefits – Not Covered by Medicare			
Foreign Travel Not covered by Medicare, medically necessary emergency care services • Beginning during the first 60 days of each trip outside the USA - First $[250] each calendar year - Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $[50,000]	 $[250] 20% and amounts over the $[50,000] lifetime maximum

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.
- Surgery to improve appearance.
- Services, treatments or supplies that are not a Medicare eligible expense.

Non-discrimination notice

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions.
Sanford Health Plan:

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

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

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Director of Member Services, 300 Cherapa Place #201, Sioux Falls, SD 57109, (605) 328-6800, TTY Number: (877) 652-1844, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,*** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***.

Free help in other languages

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-892-0675 (TTY: 1-877-652-1844).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-892-0675 (TTY: 1-877-652-1844)。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-892-0675 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic: الخدمات اللغوية المساعدة، إذا كنت تتحدث اللغة، تتوفر لك مجانًا. اتصل بنا على رقم 1-800-892-0675 (رقم تليتايب: 1-877-652-1844)
الاتصال بنا على رقم هاتف 1-800-298-5760

Karen:
တက်ကွေးနိုင်အဝဲအံၤန္ဉာ်ဆိုင်ဒီးတက်ဂ့ၢ်တက်ကျိုၤလၢအရှဒိုဉ်တဖဉ်နှဉ်လီၤ.တက်ကွေးနိုင်အဝဲအံၤဆိုင်ဒီးတက်ဂ့ၢ်တက်ကျိုၤ
လၢအရှဒိုဉ်ဘဉ်ယးဒီးနလာ်ပတံထီဉ်မ့တမ့ၢ်တက်ကျၢ်ဘၢခီဖျိ Sanford Health Plan
နှဉ်လီၤ.ယုကွၢ်မ့ၢ်နံၤမ့ၢ်သီအခိုဉ်သ့ဉ်လၢတက်ကွေးနိုင်အံၤတက့ၢ်.ဘဉ်သ့ဉ်သ့ဉ်နကဘဉ်ဟံန့ၢ်မ့ဒၢ်လၢမ့ၢ်နံၤမ့
ၢ်သီလၢတက်ဆၢတဲာ်ယာ်လၢနကဟ်ယာ်နတက်ဆိုဉ်ဆ့ဉ်ဆိုဉ်ချတဉ်ကျၢ်ဉ်ဘၢမ့တမ့ၢ်တက်မၤစၢၤလၢနကဘဉ်ဟ့ဉ်အ
ပှၤန္ဉာ်လီၤ.နဆိုဉ်ဒီးတက်ခဲ့ၢ်တက်ယာ်လၢနကဒီးန့ၢ်ဘဉ်တက်မၤစၢၤဒီးတက်ဂ့ၢ်တက်ကျိုၤလၢနကျိ$ဒဉ်ခဲ့လၢတလိဉ်ဟ့ဉ်အ
ပှၤဘဉ်နှဉ်လီၤ.ကီး 1-800-892-0675 တက့ၢ်.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው: 1-877-652-1844).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-892-0675 (TTY: 1-877-652-1844).번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-892-0675 (ATS : 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:
បសមាតិដ៏ផ្ទៃណាមួយ: ម្ចងពាក្យ០ម្ចងយ០០ងសាន ។ បសមាតិដ៏ផ្ទៃណាមួយ: ម្ចងពាក្យ០ម្ចងយ០០ងសាន អ្ន០ពាក្យ០ម្ចងដ្ឋ០ងរ០ ឬ ការណ៍ផ្ទ ១ រ០ណ៍ផ្ទ ១ រ០ណ៍ផ្ទ
Sanford Health Plan ។ ស្ងមកាណ៍ការ០ណ០ណ០ណ

EXPRESS SCRIPTS®
Medicare (PDP)

Benefit Overview

Express Scripts Medicare® (PDP) for North Dakota Public Employees Retirement System (NDPERS)

YOUR 2017 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Plan Premium	Your group benefits administrator will tell you the amount that you pay for your plan. If you have any questions, please contact your group benefits administrator.
Initial Coverage stage	You will pay the following until your total yearly drug costs (what you and the plan pay) reach $3,700. Please note that you can get up to a 90-day supply either at a retail network pharmacy or through home delivery:

Tier	**Retail Three-Month (90-day) Supply**	**Home Delivery Three-Month (90-day) Supply**
Tier 1: **Generic Drugs**	$5 copayment plus 15% coinsurance	$5 copayment plus 15% coinsurance
Tier 2: **Preferred Brand Drugs**	$15 copayment plus 25% coinsurance	$15 copayment plus 25% coinsurance
Tier 3: **Non-Preferred Brand Drugs**	$25 copayment plus 50% coinsurance	$25 copayment plus 50% coinsurance

If you fill a prescription for a one-month (31-day) supply at a retail network pharmacy, you will pay the same copayment amount that you would for a three-month supply. If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy℠. There is no charge for standard shipping.

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more information.

Coverage Gap stage	Under your plan, you reach the Coverage Gap stage once your total yearly drug costs reach $3,700. During this stage, your cost-sharing amounts for generic and brand-name drugs will generally remain the same until your yearly out-of-pocket drug costs reach $4,950.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,950, you will pay **the greater of 5% coinsurance <u>or</u>:** • a $3.30 copayment for covered generic drugs (including brand drugs treated as generics) • an $8.25 copayment for all other covered drugs.

Long-Term Care (LTC) Pharmacy
If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage
You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more details.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- You are eligible for this plan if you are entitled to Medicare Part A and enrolled in Medicare Part B, are a U.S. citizen or are lawfully present in the United States, and are eligible for benefits from NDPERS. The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **www.Express-Scripts.com**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- To access your plan's list of covered drugs, visit our website at **www.Express-Scripts.com**.

- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the Non-Preferred Brand Drug cost-share for that drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

For a complete explanation of your plan benefits, contact Express Scripts Medicare Customer Service at the numbers on the back of this document or check your *Evidence of Coverage,* when you receive it. If you have not yet received an *Evidence of Coverage,* please contact Express Scripts Medicare Customer Service at the numbers on the back of this document to request one.

Does my plan cover Medicare Part B drugs?
Express Scripts Medicare does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare prescription drug benefit (Part D) and that are on our formulary.

Read the *Medicare & You* 2017 handbook.
The *Medicare & You* handbook has a summary of Original Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. You can get a copy at the Medicare website (http://www.medicare.gov) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Express Scripts Medicare Customer Service

1.855.315.4569

24 hours a day, 7 days a week

We have free language interpreter services available for non-English speakers.

TTY: **1.800.716.3231**

You can also visit us on the Web at **www.Express-Scripts.com**.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

For questions about premiums, enrollment and eligibility, please contact NDPERS at **1.800.803.7377.** Hours of operation are Monday through Friday (excluding holidays), 8:00 a.m. to 5:00 p.m., Central Time.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

© 2016 Express Scripts Holding Company. All Rights Reserved. Express Scripts and “E” Logo are trademarks of Express Scripts Holding Company and/or its subsidiaries. Other trademarks are the property of their respective owners.

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

10/1/2016

Important Notice from the North Dakota Public Employees Retirement System (NDPERS) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully before making a decision to change your Medicare D prescription drug coverage.

This notice may or may not apply to you. It has important information about your current prescription drug coverage with NDPERS and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join another Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the private plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current prescription drug coverage through the NDPERS Dakota Retiree Plan and other available Medicare D prescription drug coverage.

1. Medicare D prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan (PDP) or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. NDPERS has determined that the prescription drug coverage offered through the Dakota Retiree Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because the NDPERS coverage is Creditable Coverage, you will not pay a higher premium (a penalty) if you later decide to join another Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join another Medicare drug plan?

If you decide to join another Medicare drug plan, your current NDPERS Dakota Retiree Plan coverage will be affected. The Dakota Retiree Plan provides both medical and prescription drug coverage to eligible members and dependents entitled to Medicare. However, Medicare prescription drug coverage is also available through private companies. As you think about whether you want to enroll with one of these prescription plans or a Medicare Advantage plan, you need to consider the following:

- NDPERS has determined that the Medicare prescription drug plan provided by NDPERS is on average at least as good as the standard Medicare prescription drug coverage. Therefore, you can keep the NDPERS coverage and not pay extra if you later decide to enroll in other Medicare D coverage.

- According to the Centers for Medicare and Medicaid Services (CMS) regulations, you cannot be enrolled in two prescription drug plans. Therefore, if you choose to enroll in another Medicare D prescription drug plan or a Medicare Advantage plan, your prescription coverage through the Dakota Retiree Plan will be canceled. Because the NDPERS plan provides medical coverage in addition to prescription drug coverage, your NDPERS medical coverage will also be cancelled for you and all covered dependents. Be aware that you may not have an opportunity to get the NDPERS coverage back.

- To be eligible for coverage through the Dakota Retiree Plan, you must be enrolled for both Medicare A & B coverage. If you drop your Medicare A & B coverage to enroll in a Medicare Part C plan, you will no longer meet the NDPERS requirements and your medical and prescription drug coverage will be cancelled for you and all covered dependents. Be aware that you may not have an opportunity to get the NDPERS coverage back.

What happens if your NDPERS coverage is cancelled?

If your NDPERS coverage is cancelled because you enrolled in another Medicare prescription drug plan or Medicare Advantage plan you will only be allowed to re-enroll if you apply for coverage <u>within 31 days</u> from any one of the following "qualifying events":

1. Member's 65th birthday or eligibility for Medicare;
2. Member's spouse or eligible dependent's 65th birthday or eligibility for Medicare;
3. The loss of coverage in a health plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse.
4. Marriage, birth, adoption, or appointment of children for legal guardianship.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you drop or lose your current coverage with NDPERS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you exceed 63 continuous days without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without

creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll for coverage.

For more information about this notice or your current prescription drug coverage.

- Contact the NDPERS office at 701.328.3900 or 800.803.7377.
- This notice is available on the NDPERS web site home page at www.nd.gov/ndpers.
- You may request a copy of this notice at any time.

You will receive this notice each year before the next period you can join a Medicare drug plan and if this coverage through the NDPERS Dakota Retiree Plan changes.

For more information about your options under Medicare prescription drug coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

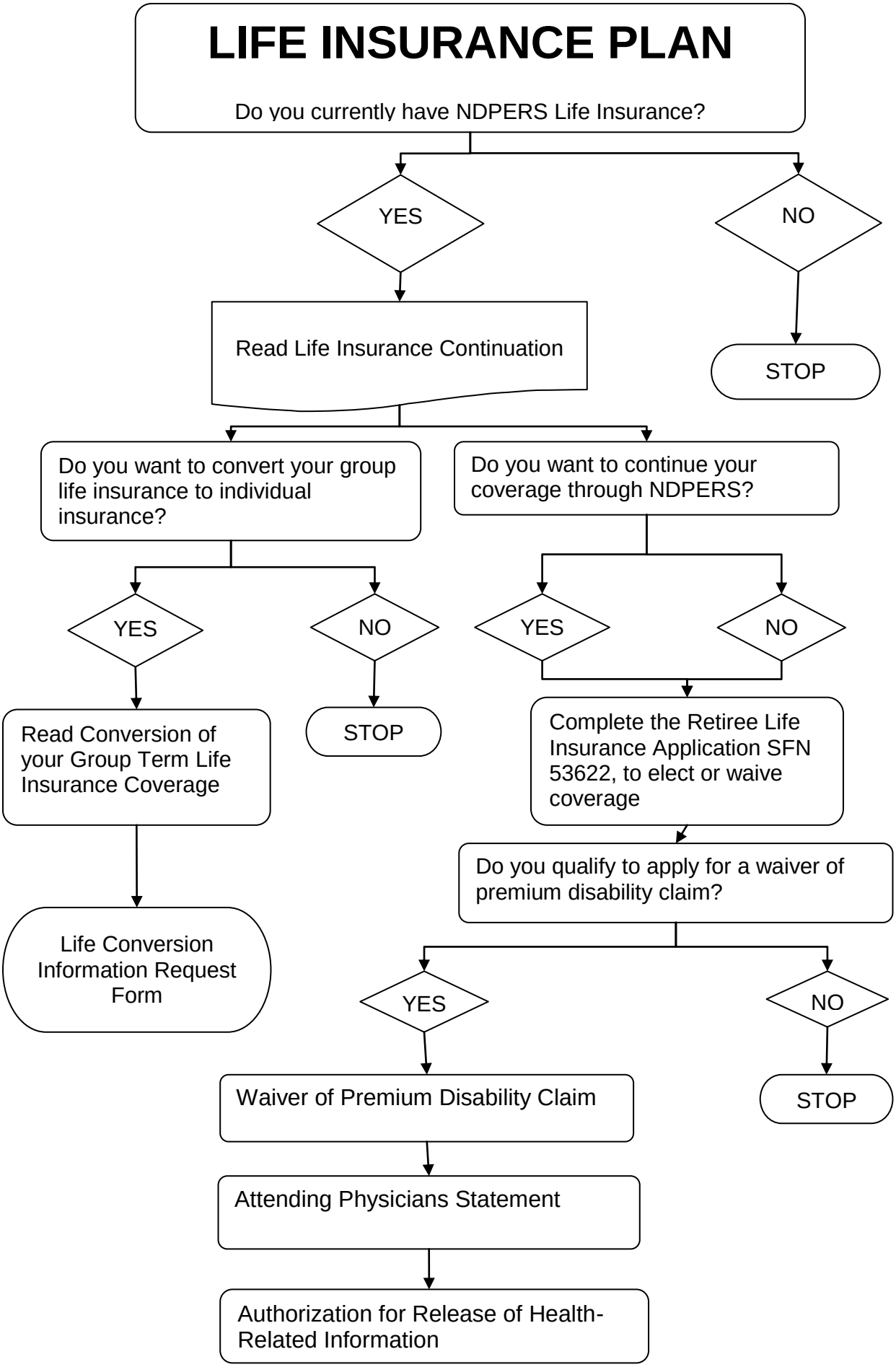
- Visit www.medicare.gov
- Call 800-MEDICARE (800.633.4227). TTY users call 877.486.2048.
- State Health Insurance Counseling program (SHIC) http://www.nd.gov/ndins/shic/ 701.328.2440 or 888.575.6611 or '211'. TTY users 800.366.6888

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this notice. If you decide to join another Medicare Part D plan, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). Also, it will serve as notice that joining another Medicare drug plan will affect the coverage you have with NDPERS.

Date: October 2016
Contact--Position/Office: Member Service Unit
Name of Entity/Sender: North Dakota Public Employees Retirement System
Address: 400 E Broadway Ave., Suite 505, Bismarck, ND 58502
Phone Number: 701.328.3900 or 800.803.7377

LIFE INSURANCE PLAN



LIFE INSURANCE CONTINUATION

If you are participating in the NDPERS group life insurance plan as an active employee, you will have the option to continue your employee supplemental, dependent supplemental, and spouse supplemental life insurance coverage to age 65. This election must be made within 31 days of date of retirement by completing a Retiree Life Insurance Application SFN 53622. If you do not apply to continue coverage during this time limit, you will have forfeited your right to enroll in the future.

You may either maintain the same level(s) of coverage you had as an active employee or elect to decrease or discontinue your level(s) of coverage. However, the basic level of coverage reduces from $3,500.00 as an active employee to $1,300.00 as a retiree. You cannot increase any coverage levels, apply for coverage you are not participating in at the time of retirement, nor are you eligible for the annual enrollment.

Life insurance premiums may be paid by deduction from the pension check, deduction from a bank account, or by individual billing. However, if you are also participating in the health plan, the life premium must be paid in the same manner as that selected for the health premium. Premiums can not be withheld from a retirement benefit as a pre-tax deduction.

The employee supplemental, dependent life, and spouse supplemental insurance will terminate at age 65. You are eligible to continue the basic $1300.00 coverage for life (cost = $4.32). However, to continue any other levels of coverage, you will be given the opportunity to convert to an individual life policy. You or your insured dependent may convert this insurance by applying and paying the first premium for an individual policy within 31 days after any part of your or your insured dependent's insurance stops. Voya or the Policyholder must be notified by completing a Term Life Conversion Information Request Form.

Refer to your Life Insurance Plan Handbook for further details on the Life Insurance benefits.

LIFE INSURANCE WAIVER OF PREMIUM-DISABILITY RETIREMENT ONLY:

To be eligible for the waiver of premium, you must:

1. be participating in NDPERS life insurance and
2. be under age 60, and
3. apply for a waiver of premium within one year from the date total disability begins.

To apply for a waiver, you and your employer must complete and file a Voya Group Life Claim for total Disability Form. Your physician must complete a Voya Group Life Benefit Form. The completed forms must be returned to NDPERS who will forward them to the Life Insurance Company. You will be notified in writing whether or not the waiver has been approved.

If approved, the premium is waived for the amount of life insurance you had on the day total disability began and your coverage will continue until age 65. Any premiums you paid will be reimbursed to you from to the effective date of the waiver.

If the waiver is denied you will be notified of your options:

1. If you are currently receiving a benefit you may continue the life insurance at your own expense.

2. If you are not receiving a benefit you will be given the opportunity to convert to an individual life policy.

CONVERTING GROUP TERM LIFE INSURANCE TO INDIVIDUAL INSURANCE:

You or your insured dependent may purchase any individual nonparticipating policy offered by the Voya, except term insurance. The new policy must provide for a level amount of insurance and have premiums at least equal to those of the Voya's whole life plan with the lowest premium.

Retiree Supplemental Life and Accidental Death and Dismemberment Insurance
Monthly Premium Amounts - Underwritten by ING
Rates Effective July 1, 2011
$1,300 Basic = $4.32

Employee Total Coverage (Including Basic)

Employee's Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
40 to 44	$4.65	$5.10	$5.55	$6.00	$6.45	$6.90	$7.35	$7.80	$8.25	$8.70
45 to 49	$4.73	$5.28	$5.83	$6.38	$6.93	$7.48	$8.03	$8.58	$9.13	$9.68
50 to 54	$4.95	$5.80	$6.65	$7.50	$8.35	$9.20	$10.05	$10.90	$11.75	$12.60
55 to 59	$5.58	$7.28	$8.98	$10.68	$12.38	$14.08	$15.78	$17.48	$19.18	$20.88
60 to 64	$6.24	$8.84	$11.44	$14.04	$16.64	$19.24	$21.84	$24.44	$27.04	$29.64

Employee Total Coverage (Including Basic)

Employee's Age	$55,000	$60,000	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000
40 to 44	$9.15	$9.60	$10.05	$10.50	$10.95	$11.40	$11.85	$12.30	$12.75	$13.20
45 to 49	$10.23	$10.78	$11.33	$11.88	$12.43	$12.98	$13.53	$14.08	$14.63	$15.18
50 to 54	$13.45	$14.30	$15.15	$16.00	$16.85	$17.70	$18.55	$19.40	$20.25	$21.10
55 to 59	$22.58	$24.28	$25.98	$27.68	$29.38	$31.08	$32.78	$34.48	$36.18	$37.88
60 to 64	$32.24	$34.84	$37.44	$40.04	$42.64	$45.24	$47.84	$50.44	$53.04	$55.64

Employee Total Coverage (Including Basic)

Employee's Age	$105,000	$110,000	$115,000	$120,000	$125,000	$130,000	$135,000	$140,000	$145,000	$150,000
40 to 44	$13.65	$14.10	$14.55	$15.00	$15.45	$15.90	$16.35	$16.80	$17.25	$17.70
45 to 49	$15.73	$16.28	$16.83	$17.38	$17.93	$18.48	$19.03	$19.58	$20.13	$20.68
50 to 54	$21.95	$22.80	$23.65	$24.50	$25.35	$26.20	$27.05	$27.90	$28.75	$29.60
55 to 59	$39.58	$41.28	$42.98	$44.68	$46.38	$48.08	$49.78	$51.48	$53.18	$54.88
60 to 64	$58.24	$60.84	$63.44	$66.04	$68.64	$71.24	$73.84	$76.44	$79.04	$81.64

Employee Total Coverage (Including Basic)

Employee's Age	$155,000	$160,000	$165,000	$170,000	$175,000	$180,000	$185,000	$190,000	$195,000	$200,000
40 to 44	$18.15	$18.60	$19.05	$19.50	$19.95	$20.40	$20.85	$21.30	$21.75	$22.20
45 to 49	$21.23	$21.78	$22.33	$22.88	$23.43	$23.98	$24.53	$25.08	$25.63	$26.18
50 to 54	$30.45	$31.30	$32.15	$33.00	$33.85	$34.70	$35.55	$36.40	$37.25	$38.10
55 to 59	$56.58	$58.28	$59.98	$61.68	$63.38	$65.08	$66.78	$68.48	$70.18	$71.88
60 to 64	$84.24	$86.84	$89.44	$92.04	$94.64	$97.24	$99.84	$102.44	$105.04	$107.64

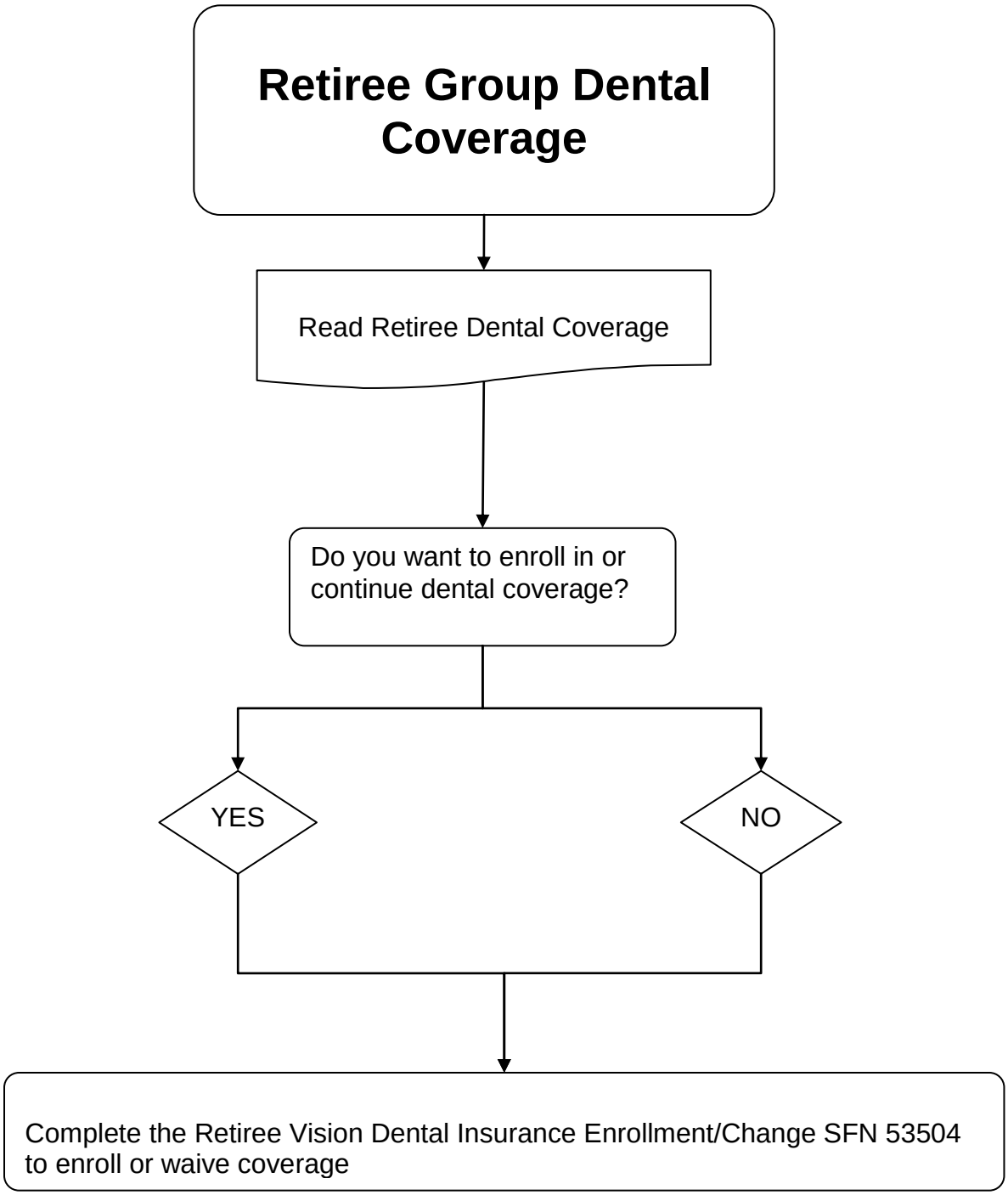
Dependent Supplemental Life Insurance Premiums
Monthly Premium Amounts
Rates Effective July 1, 2011

Employee Age	**Total Coverage** $2,000	$5,000
40 to 44	$0.20	$0.50
45 to 49	$0.20	$0.50
50 to 54	$0.20	$0.50
55 to 59	$0.20	$0.50
60 to 64	$0.20	$0.50

Spouse Supplemental Life Insurance
Monthly Premium Amounts
Rates Effective July 1, 2011

	Spouse Total Coverage									
Employee's Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
40 to 44	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
45 to 49	$0.55	$1.10	$1.65	$2.20	$2.75	$3.30	$3.85	$4.40	$4.95	$5.50
50 to 54	$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
55 to 59	$1.70	$3.40	$5.10	$6.80	$8.50	$10.20	$11.90	$13.60	$15.30	$17.00
60 to 64	$2.60	$5.20	$7.80	$10.40	$13.00	$15.60	$18.20	$20.80	$23.40	$26.00

	Spouse Total Coverage									
Employee's Age	$55,000	$60,000	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000
40 to 44	$4.95	$5.40	$5.85	$6.30	$6.75	$7.20	$7.65	$8.10	$8.55	$9.00
45 to 49	$6.05	$6.60	$7.15	$7.70	$8.25	$8.80	$9.35	$9.90	$10.45	$11.00
50 to 54	$9.35	$10.20	$11.05	$11.90	$12.75	$13.60	$14.45	$15.30	$16.15	$17.00
55 to 59	$18.70	$20.40	$22.10	$23.80	$25.50	$27.20	$28.90	$30.60	$32.30	$34.00
60 to 64	$28.60	$31.20	$33.80	$36.40	$39.00	$41.60	$44.20	$46.80	$49.40	$52.00


Retiree Group Dental Coverage
Read Retiree Dental Coverage
Do you want to enroll in or continue dental coverage?
YES
NO
Complete the Retiree Vision Dental Insurance Enrollment/Change SFN 53504 to enroll or waive coverage

RETIREE DENTAL COVERAGE

The group dental plan is available to retired employees and surviving spouses that are receiving a retirement benefit from North Dakota Public Employees Retirement System (NDPERS), TIAA, ND Teachers Fund For Retirement (TFFR), or Job Service Retirement plan.

Retirees or surviving spouse may elect to enroll in the dental plan within 31 days of a "qualifying event." The "qualifying events" are as follows:

ELIGIBILITY:

To be eligible to join the Dental Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association (TIAA) (North Dakota University System only)

A surviving spouse must be:

- Receiving a beneficiary benefit from the aforementioned retirement plans, or
- On the Dental Plan as a covered dependent at the time of member's death and there is no lapse in coverage.

A non-spouse beneficiary is not eligible to continue on the group dental plan.

ENROLLMENT:

A member or surviving spouse who is receiving a qualified retirement allowance must apply within 31 days from any one of the following "qualifying events":

1. Date of retirement, defined as either:

- The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or
- Date of first retirement check if member deferred his/her retirement benefit.

2. Members 65th birthday or eligibility for Medicare:

3. Members spouse 65th birthday or eligibility for Medicare:

4. The loss of coverage in a dental plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.

5. Marriage

6. Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE:

If a member is enrolled in the Dental Plan as an active employee, coverage will become effective on the first of the month following the last day of the month for which premiums were paid. If a member was not enrolled in the Dental Plan at the time of retirement, coverage will become effective on the first day of the month following one of the "qualifying events" listed above.

PREMIUM PAYMENT POLICY:

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Benefit Check Bank Account
NDPERS Defined Contribution[3]	Bank Account
NDHPRS[1]	Benefit Check Bank Account
Job Service[1]	Benefit Check Bank Account
TFFR[2]	Benefit Check Bank Account
TIAA[3]	Bank Account
Approved Employer Sponsored[3]	Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. <u>However, the first month of premium will be billed to you and you will need to pay by personal check. NDPERS will begin withholding the premium(s) the month following the first benefit payment</u>. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134. It is the policy of NDPERS that a member's net annuity payment can not be less than $50.00.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete a Payroll Deduction Authorization (TFFR) SFN 19182. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134.

CANCELLATION POLICY:

To cancel NDPERS dental coverage, a written request must be submitted. The request must provide the contract holder's name, social security number and effective date. NDPERS must receive a cancellation request by the **end** of the month prior to the effective date.

Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PREMIUM INFORMATION:

You can purchase dental coverage for yourself and your eligible dependents by choosing from any one of the following coverage categories. Premium rates are effective until December 31, 2017.

	Monthly Premium
Retiree only	$ 38.64
Retiree & spouse	$ 74.58
Retiree & child(ren)	$ 86.58
Family (retiree, spouse & children)	$123.30

COVERAGE QUESTIONS?

For additional information concerning coverage call **1-800-448-3815**. Reference Group #537482.

DELTA DENTAL

Delta Dental of Minnesota
Serving North Dakota

Delta Dental PPO℠ & Delta Dental Premier®

2017 Monthly Premium Rates	
Employee:	$38.64
Employee + Spouse:	$74.58
Employee + Child(ren):	$86.58
Family:	$123.30

North Dakota Public Employees Retirement System

Group #537482

Plan Benefit Highlights			
Network(s)	**Delta Dental PPO℠**	**Delta Dental Premier®**	**Non-Participating***
Calendar Year Plan Maximum Per person	**$1,000**		
Lifetime Ortho Maximum Per eligible covered person	**$1,500**		
Deductible Per person per calendar year No deductible for diagnostic and preventive services or orthodontics	**$50 per person**		
Eligible Dependents	**Spouse** **Dependent children up to age 26**		
Covered Services	**Dental Benefit Plan Coverage**		
	Delta Dental PPO℠	**Delta Dental Premier®**	**Non-Participating***
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Space maintainers Sealants	**100%**	**100%**	**100%**
Basic Services Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) and posterior (back) teeth	**80%**	**80%**	**80%**
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	**80%**	**80%**	**80%**
Periodontics Surgical/Nonsurgical periodontics	**80%**	**80%**	**80%**
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	**80%**	**80%**	**80%**
Major Restorative Crowns	**50%**	**50%**	**50%**
Prosthetic Repairs and Adjustments Denture adjustments and repairs Bridge repair	**80%**	**80%**	**80%**
Prosthetics Dentures (full and partial) Bridges	**50%**	**50%**	**50%**
Orthodontics Treatment for the prevention/ correction of malocclusion Available for eligible covered persons ages 8 and up	**50%**	**50%**	**50%**

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

***Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.**

Delta Dental of Minnesota
Serving North Dakota

Make the Most of Your Benefits

Thank you for choosing Delta Dental as your partner in oral health. Dental insurance is designed to pay a portion of the costs associated with your dental care. Having dental insurance is essential to keeping your mouth healthy by providing access to preventive care, such as cleanings and x-rays, and helps cover extensive dental procedures such as crowns and fillings.

Online Tools for Members:
www.DeltaDentalMN.org

Save Money, Go In-Network:
Search for a participating dentist or specialist, clinic or location. By seeking care from a Delta Dental network dentist, you will save the most money because the dentist is not allowed to bill you more than our allowable charge.

Dental Insurance 101:
Robust member tools including commonly defined insurance terms, videos and frequently asked questions.

Oral Health Resources:
Preventive care is critical. Access dental and health information, through the ages including a section dedicated to Kids' Oral Health.

Cost Estimator:
Compare costs for top oral health procedures.

Tools Available in the Secure Member Portal

Coverage Summary:
Review your dental plan information including eligibility, waiting periods, plan maximums and frequency limitations.

Claims Inquiry:
View claim status, procedure details, dates of service and applied deductibles.

Request ID Cards:
Order duplicate or replacement ID cards.

Registration

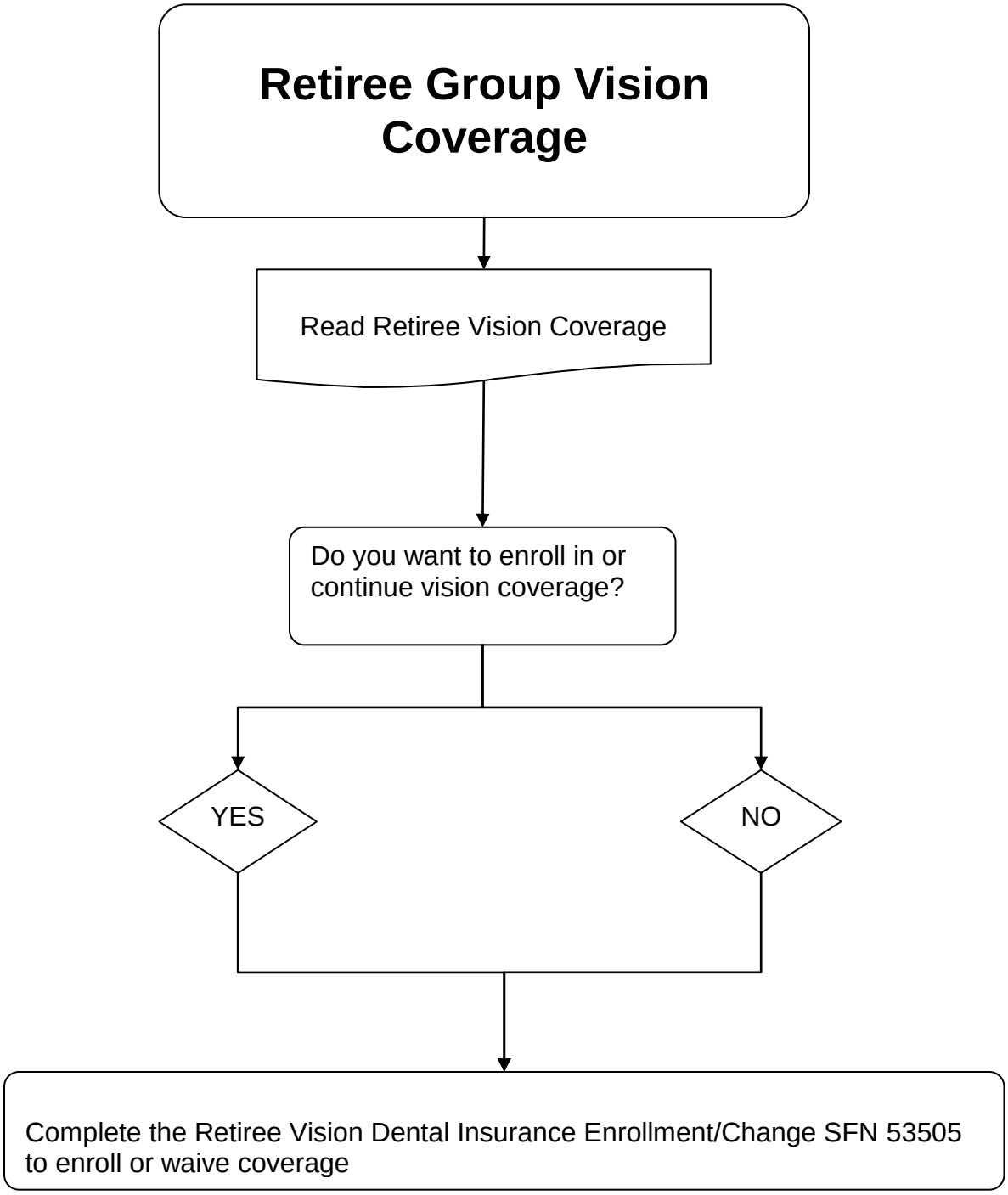
1. On www.DeltaDentalMN.org, go to the member page and click "Create Account."
2. Read the Privacy Notice, click Continue and follow the steps to register.
3. Remember your user name and password because you will need them each time you log in.

Prefer to Speak to Someone
Contact Customer Service

Toll Free: 1-800-448-3815
Monday – Friday: 7am-7pm C.S.T.

Serving North Dakota
Visit Our Website
DeltaDentalMN.org

Serving North Dakota
Administered by Delta Dental of Minnesota
P.O. Box 59238
Minneapolis, MN 55459


Retiree Group Vision Coverage
Read Retiree Vision Coverage
Do you want to enroll in or continue vision coverage?
YES
NO
Complete the Retiree Vision Dental Insurance Enrollment/Change SFN 53505 to enroll or waive coverage

RETIREE VISION COVERAGE

The group vision plan is available to retired employees that are receiving a retirement benefit from North Dakota Public Employees Retirement System (NDPERS), TIAA, ND Teachers Fund for Retirement (TFFR), or the Job Service Retirement Plan.

Retirees may elect to enroll in the vision plan within 31 days of a "qualifying event." The "qualifying events" are as follows:

ELIGIBILITY:

To be eligible to join the Vision Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association (TIAA) (North Dakota University System only)

A surviving spouse must be:

- Receiving a beneficiary benefit from the aforementioned retirement plans, or
- On the Vision Plan as a covered dependent at the time of member's death and there is no lapse in coverage.

A non-spouse beneficiary is not eligible to continue on the group vision plan.

ENROLLMENT:

A member or surviving spouse who is receiving a qualified retirement allowance must apply <u>within 31 days</u> from any one of the following "qualifying events":

1. Date of retirement, defined as either:
   - The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or

- Date of first retirement check if member deferred his/her retirement benefit.

2. Members 65th birthday or eligibility for Medicare:

3. Members spouse 65th birthday or eligibility for Medicare:

4. The loss of coverage in a vision plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.

5. Marriage

6. Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE:

If a member is enrolled in the Vision Plan as an active employee, coverage will become effective on the first of the month following the last day of the month for which premiums were paid. If a member was not enrolled in the Vision Plan at the time of retirement, coverage will become effective on the first day of the month following one of the "qualifying events" listed above.

PREMIUM PAYMENT POLICY:

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Benefit Check Bank Account
NDPERS Defined Contribution[3]	Bank Account
NDHPRS[1]	Benefit Check Bank Account
Job Service[1]	Benefit Check Bank Account
TFFR[2]	Benefit Check Bank Account
TIAA[3]	Bank Account
Approved Employer Sponsored[3]	Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. <u>However, the first month of premium will be billed to you and you will need to pay by personal check. NDPERS will begin withholding the premium(s) the month following the first benefit payment.</u> If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134. It is the policy of NDPERS that a member's net annuity payment can not be less than $50.00.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete a Payroll Deduction Authorization (313) SFN 19182. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50134.

CANCELLATION POLICY:

To cancel NDPERS vision coverage, a written request must be submitted. The request must provide the contract holder's name, social security number and effective date. NDPERS must receive a cancellation request by the **end** of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PREMIUM INFORMATION:

You can purchase vision coverage for yourself and your eligible dependents by choosing from any one of the following coverage categories. Premium rates are effective until December 31, 2017.

	Monthly Premium
Retiree only	$ 6.64
Retiree & spouse	$ 13.28
Retiree & child(ren)	$ 12.10
Family (retiree, spouse & children)	$ 18.74

COVERAGE QUESTIONS?

For additional information concerning coverage call 1-800-507-3800. Reference Group #29854.

SUPERIOR VISION
See yourself healthy.

Vision Plan Benefits for North Dakota Public Employees Retirement System

Co-Pays	
Exam	$0
Materials[1]	$35
Contact Lens Fitting (standard & specialty)	$35

Monthly Premiums	
Emp. only	$6.64
Emp. + spouse	$13.28
Emp. + child(ren)	$12.10
Emp. + family	$18.74

Services/Frequency	
Exam	1 per calendar year
Frame	1 per calendar year
Contact Lens Fitting	1 per calendar year
Lenses	1 pair per calendar year
Contact Lenses	1 allowance per calendar year

Benefits

	In-Network	Out-of-Network
Exam (Ophthalmologist)	Covered in full	Up to $45 retail
Exam (Optometrist)	Covered in full	Up to $45 retail
Frames	$75 retail allowance	Up to $40 retail
Contact Lens Fitting (standard)	Covered in full	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance	Not covered
Lenses (standard) per pair		
Single Vision	Covered in full	Up to $35 retail
Bifocal	Covered in full	Up to $50 retail
Trifocal	Covered in full	Up to $70 retail
Progressive lens upgrade	See description[3]	Up to $70 retail
Contact Lenses[4]	$100 retail allowance	Up to $100 retail

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses*

[2] *The specialty contact lens fitting is for new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit*

Discount Features

Look for providers in the Provider Directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums[5] on standard (not premium, brand, or progressive) lenses.

	Maximum Member Out-of-Pocket	
	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High index 1.6	$55	20% off retail
Photochromics	$80	20% off retail

Discounts on Non-Covered Exam and Materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

[5] *Discounts and maximums may vary by lens type. Please check with your provider.*

SuperiorVision.com
Customer Service
800.507.3800

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%, and are the best possible discounts available to Superior Vision.

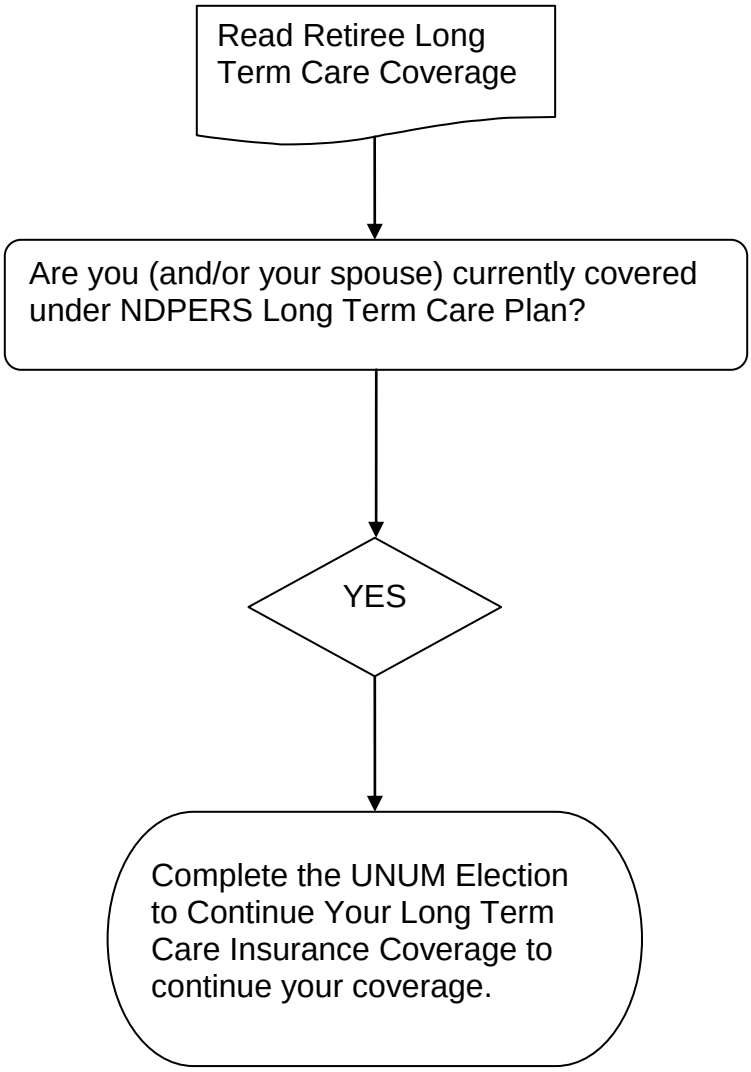
The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

LONG TERM CARE COVERAGE



RETIREE LONG TERM CARE COVERAGE

TERMINATION OF COVERAGE:

Upon termination of employment your NDPERS long term care coverage will end on the last day of the month for which premiums were paid you or your spouse may elect portable coverage. This means that the coverage you have under this plan can continue on a direct billed basis, by paying the premiums directly to UNUM.

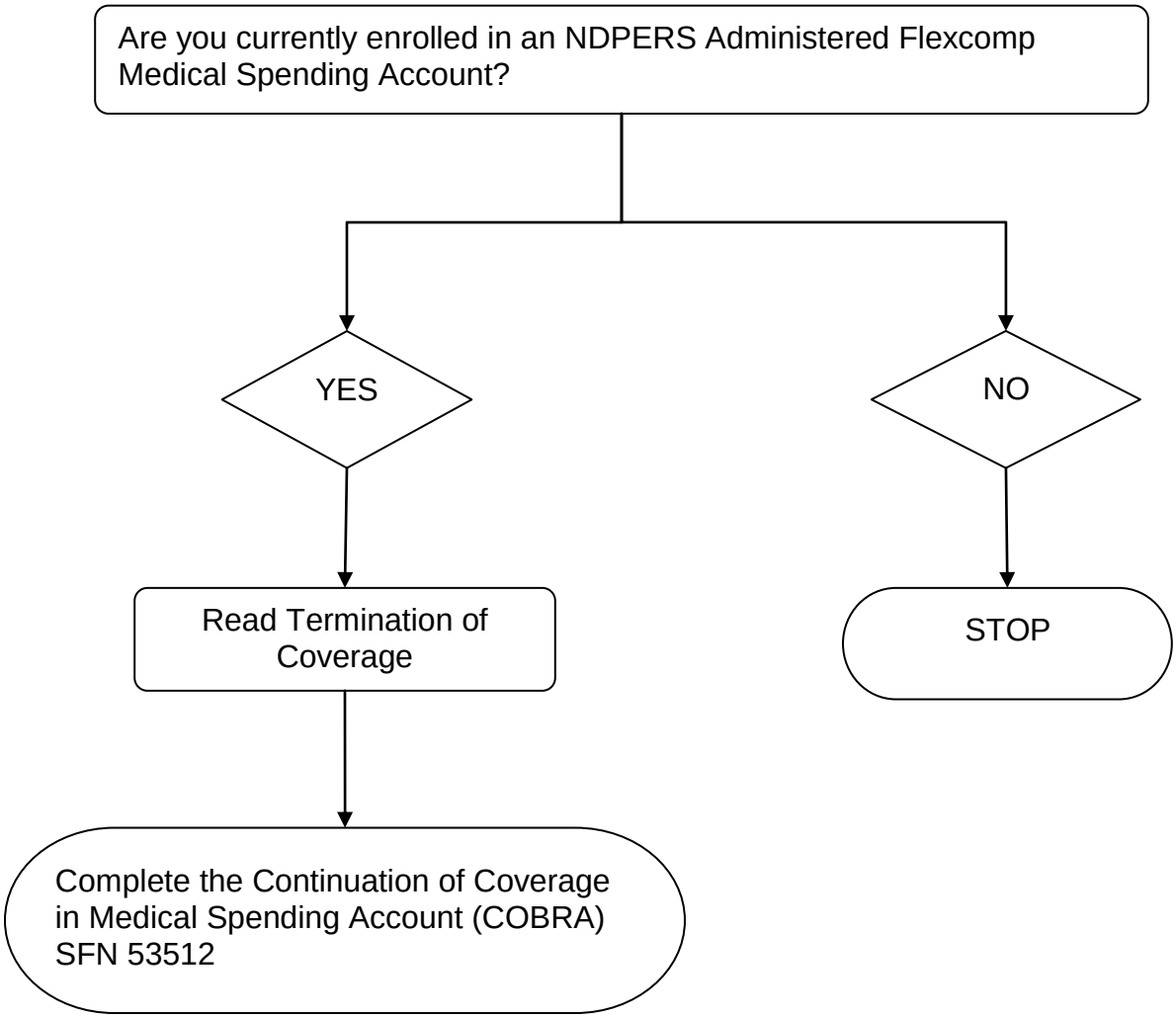
To apply for portable coverage you must complete and submit to UNUM the Election to Continue Your Long Term Care Insurance Coverage within 31 days of the date your coverage will end.

Please refer to your “Certificate of Insurance” for details.

COVERAGE QUESTIONS?

Please contact UNUM, plan administrator, at 1-800-227-4165

NDPERS ADMINISTERED FLEXCOMP PLAN



NDPERS FLEXCOMP PLAN

Third Party Administrator: ADP

The NDPERS Flex Comp Plan is available to eligible employees of the State of North Dakota, participating District Health Units and members of the Legislative Assembly. Employees of the university system and political subdivisions are excluded from participation in the plan.

TERMINATION OF COVERAGE - MEDICAL SPENDING ACCOUNT:

If you retire or terminate employment during the plan year, you will be offered continuation coverage through the end of the plan year on December 31. You will have 60 days from your separation of service in which to elect continuation coverage and complete the Continuation of Coverage in Medical Spending Account (COBRA) SFN 53512. Unless you elect Continuation of Coverage, your participation will end on the last day of the month of your separation from service.

Employees, who elect continuation coverage, are permitted to pre-tax their premiums and pre-pay the premium through the end of the current plan year from their final salary paycheck.

Payments may also be paid with after-tax dollars by personal check or money order throughout the plan year. If you elect to pay for continuation coverage with after-tax dollars throughout the plan year, your premium will be the amount currently being payroll deducted plus a 2% administrative charge. Coverage will be extended to the end of the current plan year but may terminate sooner if the premiums are not paid within 30 days of their due date which is the 1st of every month.

If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the “grace period” from January 1 through March 15 of the new plan year, reimbursed from the balance.

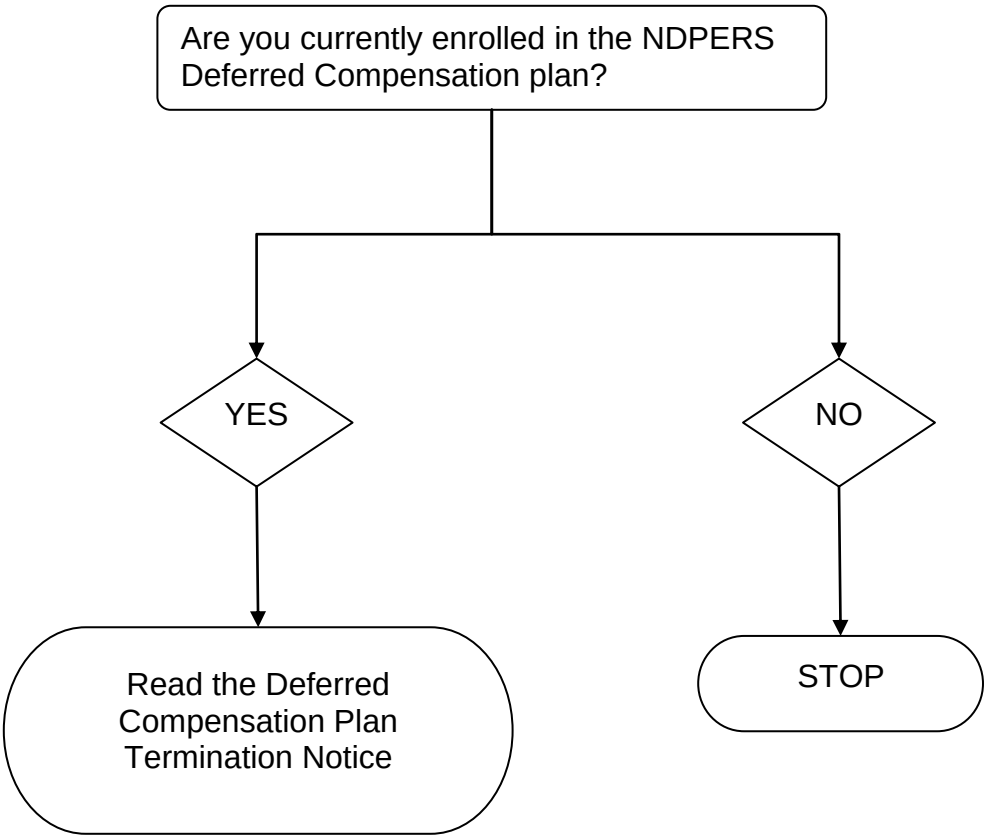
If participation terminated due to a separation of service and you return to state employment within 30 days in the same plan year, your election will be reinstated as it was immediately prior to the separation of service. If you return to state employment after 30 days in the same plan year, you can not participate for the remainder of the plan year.

DEPENDENT CARE ACCOUNT:

Your contributions will cease and payroll deductions will stop the end of the month of your separation from service. You may continue to file claims for qualifying expenses through the last day of the month of your separation of service up to the remaining balance in your account.

The final day for accepting claims for the plan year from either your Medical Spending or Dependent Care Reimbursement account for services received while you were a participant is four months after the plan year ends on December 31 or April 30.

DEFERRED COMPENSATION PLAN TERMINATION NOTICE



457 DEFERRED COMPENSATION PLAN

Lump sum payments for accumulated annual leave, sick leave, or back pay may be deferred on a pre-tax basis to your deferred compensation plan account. These deferrals are treated as part of your annual deferrals, and are subject to the IRS 457 Plan limits in effect for the year in which the deferrals are made. Lump sum deferrals are subject to FICA taxes before deferral.

You must elect to defer sick leave, annual leave and back pay payments while actively employed and in the month prior to the month of termination by completing the 457 Deferred Compensation Plan Enrollment/Change Form SFN 3803. The regulations do not allow deferrals for severance or buyout pay or bonuses.

You may not begin to receive distributions from a deferred compensation account until you have been off the payroll of a covered employer for one month. You may elect to begin distribution immediately after you have satisfied the 30 day period of separation from service, regardless of your age, or you may defer payments to a future date.

If you elect a lump sum distribution of your plan account, you will be subject to a 20% Federal income tax withholding requirement. The Provider Company will send you a 1099R statement the year in which you receive a distribution from your account. There is no IRS 10% penalty or requirement for age 59 ½.

You also have the option to do a direct rollover to an eligible 401(a), 401(k), 457(b), 403(b), IRA or another qualified plan that accepts eligible rollover distributions. If you do a direct rollover, taxes are not due until you begin receiving a distribution from your account.

Once you have begun distribution, you have the option to suspend or change the amount of the distribution; so long as the minimum required distribution at age 70 ½ is distributed.

Please consult with your investment Provider representative for assistance in selecting a payment option or if you have any questions regarding your tax liability or withdrawal penalties.