

NDPERS BOARD MEETING

Agenda

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

June 18, 2009

Time: 8:30 AM

I. MINUTES

A. May 21, 2008

II. RETIREMENT

- A. Retiree Health Insurance Credit Update – Sparb (Information)
- B. Job Service Update – Sparb (Information)

III. GROUP INSURANCE

- A. ND Pharmacy Services Corporation Contract and Program Update – Sparb (Board Action)
- B. BCBS Response – Sparb (Information)
- C. BCBS Update – Sparb (Information)
- D. Group Insurance Renewal Contract – Sparb
- E. Member Services Survey – BCBS (Information)
- F. Vision Plan – Kathy (Board Action)
- G. Smoking Cessation Program – Kathy (Information)

IV. DEFERRED COMPENSATION

- A. First Quarter Investment Report – Bryan (Information)

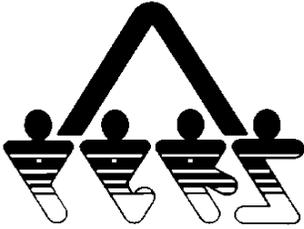
V. FLEX COMP

- A. Flex Payments – Kathy (Information)

VI. MISCELLANEOUS

- A. PERSLink Quarterly Update – Bryan (Information)
- B. PERSLink Data Conversion – Sharon (Board Action)
- C. Request for Proposal – Sparb (Board Action)
- D. Board Election – Kathy (Board Action)
- E. Audit Committee Minutes – (Information)
- F. Executive Director Review – Mr. Leingang (Board Action)
- G. Payroll Conference – Sparb (Information)
- H. SIB Agenda

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



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

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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 11, 2009
SUBJECT: Retiree Health Credit Program

At the March PERS Board meeting the asset allocation study for the retiree health credit program was reviewed. The board decided to transition to the enhanced asset allocation in that study. Steve Cochrane had several questions concerning implementation that the board referred to the PERS Investment Committee. That committee met on May 13th to discuss the questions. Steve Cochrane and Connie Flanagan were also at the meeting. They were asking for PERS thoughts relating to implementation of the new asset allocation in the following areas:

1. Should the plan remain with State Street?
2. In withdrawing funds from the existing State Street account there are two options
 - a. Withdraw 59% immediately and 41% over 3 years
 - b. 4% each month over two years
3. When withdrawing the funds and before the new asset allocation is implemented where should the funds be held?

After discussion, the Investment Committee offered the following advice to RIO:

1. The Investment Board should consider other managers in implementing the asset allocation.
2. The funds should be withdrawn from State Street as quickly as possible so they can be invested in the new asset allocation and the committee felt method 2.a above would best achieve that objective.
3. Funds in transition should be held in the Northern Trust STIF account until they can be invested pursuant to the new allocation.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 10, 2009
SUBJECT: Job Service Retirement Plan

Last year when the board reviewed the COLA for the Job Service retirement plan it was suggested that a working group be set up with Job Service retirees to share information and solicit comments on their plan. This committee has been set up and consists of the following members:

Don Bitz
Tom Pederson
Jerry Balzer
Joe Novak
Mike Deisz
Jim Kuntz
Tim Heisler
Mike Wilma

We had our first meeting with the group on May 19th at the Job Service Office. Attached for your information is a copy of the material we discussed.

We also talked about the potential need to access the federal funds that have been set aside pursuant to the agreement reached in the late 90's. It was suggested that we should send a letter to the Department of Labor to advise them of this possibility. It was suggested that the letter should come from Job Service and PERS. Pursuant to this suggestion we are in the process of drafting such a letter.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 10, 2009
SUBJECT: Diabetes Renewal

At the last meeting we discussed the proposed renewal for the diabetes program set up pursuant to HB 1433. Attachment #1 is the board meeting material from the last meeting for your reference.

During our discussion of the renewal questions were asked relating to the administrative fees. Attachment #2 is the response to this question. Also included for your reference is the project performance report from the April board meeting as Attachment #3.

Board Action Requested

To approve or disapprove the renewal.

ND Disease State Management of Diabetes Cost Proposal – 2009-2010

To: Sparb Collins, NDPERS Executive Director

From: Jayme Steig, Clinical Coordinator

Re: Justification for administrative fee added to 2009-2010 cost proposal

Mr. Collins,

At the last NDPERS board meeting, questions were raised regarding the addition of an administrative fee to the cost proposal for 2009-2010. The section that was added is below:

Administrative Fee:

Due to lower than anticipated enrollments and additional administrative costs, a flat annual administrative fee of \$7,000 is being added for this contract renewal. \$3,500 will be due in July and January of each year (July 2009, January 2010, July 2010, and January 2011). There are higher than anticipated administrative costs associated with IRB approval and renewals, licensing fees due to broad utilization of pharmacy providers, and travel expenses to provide visits to members in very rural areas. The fee will be used to help offset travel expenses and additional administrative costs.

Additional clarification regarding the check writing fee and justification of the administrative fee was requested. After discussion, the costs for the check writing service for the member copay incentive is now included in this administrative fee.

The initial cost proposal for the program, started in 2008, anticipated around 800 NDPERS members participating in the program. Administrative costs, such as data management software licensing, clinical coordinator, postage, travel expenses, document production, etc. were incorporated into the reimbursements for the patient visits based on the estimate of 800 participants. Currently there are approximately 300 NDPERS members enrolled in the program, much lower than the initial projections. Therefore, the initial projections involving distributing the administrative costs through the provider reimbursements were inadequate due to the lower member enrollment. The NDPSC has, and continues to make a significant contribution to this effort. This fee was added to the cost proposal to help share these costs. Even with this fee, the overall costs to NDPERS for this program are well below projections.

Even with the lower than anticipated enrollment, there has been broad utilization of pharmacy provider locations. Approximately 70 pharmacies are being utilized for

services across the state. This has made it difficult to manage costs such as computer licensing fees.

Thus far, the program is showing positive health outcomes to participating members. I have attached the presentation I made in April to the NDPERS board regarding the status of the program. In addition to the health outcomes, there is a high level of patient satisfaction being conveyed through patient surveys. The program is producing outcomes and they do look promising.

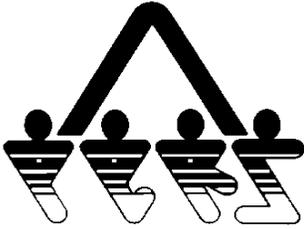
In summary, the administrative fee will include the check writing fees. There will no additional billing of NDPERS for those check writing fees for the 2009-2010 term. The fee was added to the cost proposal due to lower than anticipated member enrollment. The program is still on pace to cost NDPERS less than projected. The fee will help to maintain the current system that is producing positive health outcomes with high patient satisfaction.

Please contact me with any additional questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Jayme Steig". The signature is fluid and cursive, with a large initial "J" and "S".

Jayme Steig, PharmD, RPh
Clinical Coordinator



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Executive Director
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Memorandum

TO: PERS Board

FROM: Sparb

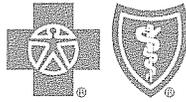
DATE: June 11, 2009

SUBJECT: BCBS Response

Attached is a letter from Mr. Tim Huckle, interim BCBS CEO, in response to our letter sent April 21, 2009.

BlueCross BlueShield of North Dakota

An independent licensee of the
Blue Cross & Blue Shield Association



4510 13th Avenue South
Fargo, North Dakota 58121

TIM HUCKLE
Interim President and CEO

(701) 282-1539
FAX (701) 282-1866
tim.huckle@bcbsnd.com

RECEIVED

JUN 01 2009

ND PERS

May 29, 2009

Mr. Sparb Collins, Executive Director & NDPERS Board of Directors
North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, ND 58502-1657

Dear Mr. Collins,

Please convey our appreciation to your board members for taking time to share their views and perceptions regarding our performance. Blue Cross Blue Shield of North Dakota (BCBSND) values the business relationship with the North Dakota Public Employee Retirement System and remains committed to doing what is possible to maintain and strengthen it. It is important we hear what our customers expect from us and we take your comments and feedback very seriously.

The expectations outlined in your letter provided us the opportunity to examine and refocus the company's efforts in working with NDPERS. I think we can agree these topics involve complex issues which deserve closer examination. To this end I think it important for each organization to commit to more frequent communication. This would provide the time needed to work through difficult issues and better understand what is expected of each other.

Since receiving your letter, members of the Marketing department have worked with other key staff throughout the organization to develop a plan to accomplish this objective. I understand a meeting is scheduled for June 16 when Chad Niles, Jim Sorensen and Kevin Schoenborn will present BCBSND's plan recommendations and review some performance indicators. Your commitment of time, your input and feedback will be essential to this effort. Thank you in advance for your willingness to work together on these important issues.

RECEIVED

JUN 01 2009

ND PERS

While BCBSND is confident its performance ranks among the best in the industry, public perception of its performance is currently low. As member satisfaction is a key performance measurement for the company we want to ensure the NDPERS staff, board and employees that we will work hard to keep them informed as to our commitment, activities and results in delivering the best possible service, products and rates.

In short, you can expect increased access to key staff and a renewed emphasis on understanding each organization's roles and responsibilities in meeting the expectations identified in this letter.

We look forward to a long and mutually beneficial relationship.

Sincerely,



Tim Huckle
Interim President & CEO

cc: Dennis Elbert
Chairman of the Board



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 10, 2009
SUBJECT: BCBS Update

Representative of BCBS will be at the next board meeting to give you an update on the plan's performance. As we go forward this biennium we will be requesting more frequent presentations on the plan's status for your information. In addition, I asked them to give us an update on the information we reviewed this last Fall. Specifically at that time we were expecting an 11% trend for the remaining months of this biennium and a 10% for the next biennium.



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1-800-803-7377

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Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 11, 2009
SUBJECT: Group Insurance Renewal

Attached are the proposed 2009-2011 BCBS renewal documents. Staff has started their review of the attached and we are also forwarding it to Aaron for his review as well.

This first draft is being shared with you at this time for your review and comments. Based upon this review, final documents will be prepared for your approval at the July Board meeting.

Certificate of Insurance & Summary Plan Description



**NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM
DAKOTA PLAN**

July 1, 2009

Health Care Coverage



**BlueCross BlueShield
of North Dakota**

An independent licensee of the Blue Cross & Blue Shield Association

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
NDPERS SERVICE CENTER

- Questions?** Our Member Services staff is available to answer questions about your coverage –
- Call Member Services:** Monday through Friday
8:00 a.m. - 5:00 p.m. CST
- (701) 282-1400
- or
- 1-800-223-1704
- North Dakota Relay Service:** 1-800-366-6888
- Office Address and Hours:** You may visit our Home Office during normal business hours –
- Monday through Friday
8:00 a.m. - 4:30 p.m. CST
- Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121
- Mailing Address:** You may write to us at the following address –
- Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121
- BCBSND Internet Address:** www.BCBSND.com
NDPERS Address: www.nd.gov/ndpers
- Provider Directories:** Members can obtain a Provider Directory by calling the telephone number listed above or by visiting the BCBSND or NDPERS website.

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Certificate of Insurance and Summary Plan Description is provided to you in accordance with the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information. This Certificate of Insurance and Summary Plan Description and the NDPERS Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance and Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

BCBSND shall construe and interpret the provisions of the Service Agreement, the Certificate of Insurance and Summary Plan Description and related documents, including doubtful or disputed terms and to determine all questions of eligibility; and to conduct any and all reviews of claims denied in whole or in part.

PLAN NAME

North Dakota Public Employees Retirement System Dakota Plan

NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)

NDPERS
400 East Broadway, Suite 505
PO Box 1657
Bismarck, North Dakota 58502

PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER

45-0282090

PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR

N/A

TYPE OF WELFARE PLAN

Health

TYPE OF ADMINISTRATION

This employee welfare benefit plan is fully insured by BCBSND and issued by BCBSND.

NAME AND ADDRESS OF BCBSND

Blue Cross Blue Shield of North Dakota (BCBSND)
4510 13th Avenue South
Fargo, North Dakota 58121

PLAN ADMINISTRATOR'S NAME, BUSINESS ADDRESS AND BUSINESS TELEPHONE NUMBER

NDPERS
400 East Broadway, Suite 505
PO Box 1657
Bismarck, North Dakota 58502
701-328-3900

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator:

Sparb Collins
NDPERS
400 East Broadway, Suite 505
PO Box 1657
Bismarck, North Dakota 58502

BCBSND:

Daniel E. Schwandt
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Service of legal process may be made upon a Plan trustee or the Plan Administrator.

TITLE OF EMPLOYEES AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION

Benefit Programs Division
Research & Benefit Program Development Division
Accounting & IT Division

Administrative Services Division
Internal Audit Division
Executive Director

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

STATEMENT OF ELIGIBILITY TO RECEIVE BENEFITS

State employees or employees of participating Political Subdivisions who are eighteen (18) years of age whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employed at least 17 and one-half hours per week and at least five months each year or those first employed after August 1, 2003, is employed at least twenty (20) hours per week and at least twenty weeks each year of employment are eligible to receive benefits. Temporary employees who work a minimum of 20 hours per week and at least 20 weeks each year are eligible to receive benefits. An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment. As an eligible employee, you will be provided with an application when you become eligible for coverage. Each eligible employee may elect to enroll his/her Eligible Dependents. Eligible employees also include non-Medicare eligible retired and terminated employees and their Eligible Dependents who remain eligible to participate in the uniform group insurance program pursuant to applicable state law as provided in NDCC section 54-52.1-03(3) and federal COBRA continuation regulations. For a comprehensive description of eligibility refer to the NDPERS web site.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. BCBSND has the ultimate decision making authority regarding eligibility to receive benefits.

DESCRIPTION OF BENEFITS

See the Schedule of Benefits and the Covered Services Sections. Refer to the Table of Contents for page numbers.

SOURCES OF PREMIUM CONTRIBUTIONS TO THE PLAN AND THE METHOD BY WHICH THE AMOUNT OF CONTRIBUTION IS CALCULATED

The contributions for single or family for state employees is paid at 100% by the state. The contributions for employees of participating political subdivisions is at the discretion of the subdivision and subject to the minimum contribution requirements of BCBSND. The contributions for temporary employees is either at their own expense or their employer may pay the premium subject to its budget authority.

END OF THE YEAR DATE FOR PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS

June 30

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INTRODUCTION

This Certificate of Insurance describes the health care benefits you have under the NDPERS Benefit Plan. The various Covered Services you receive are called your "benefits". All the benefits described are subject to all the terms, conditions, limitations and definitions included in the NDPERS Benefit Plan, as well as all provisions required by state law.

Participants in this employee health benefit plan are not vested. The benefit plan may be modified, amended or terminated by NDPERS and BCBSND at any time.

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.

In compliance with the Americans with Disabilities Act this document can be provided in alternate formats. If you require accommodation or assistance concerning the services or information provided please contact the NDPERS ADA Coordinator at 701-328-3900.

If you have questions, please consult your employer for more specific information on your benefits. You may also call the Blue Cross Blue Shield of North Dakota's NDPERS Service Center at 1-800-223-1704 and 282-1400 for Fargo area Members. The North Dakota Relay Service toll-free number is 1-800-366-6888.

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

Please review this Benefit Plan and retain it with your other important papers. If you are not satisfied with this Benefit Plan for any reason, you may return it to BCBSND within 10 days of its delivery to you and the premium paid will be refunded.

The Subscriber will receive an Identification Card displaying the Benefit Plan Number and other information about this Benefit Plan. All Members share this Benefit Plan Number. Carry the Identification Card at all times. If the Identification Card is lost, contact BCBSND to request a replacement. The Subscriber must not let anyone other than an Eligible Dependent, see definition 8.21, use the Identification Card. If another person is allowed to utilize the Identification Card, the Member's coverage will be terminated.

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

If you receive services from a Health Care Provider that will not submit claims on your behalf, you are responsible for the submission of a written notice of a claim for benefits of the services you received within 18 months after services were provided. The written notice must include information necessary for BCBSND to determine benefits.

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

**SECTION 1
SCHEDULE OF BENEFITS**

This section outlines the payment provisions for Covered Services described in Section 2, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

1.1 COST SHARING AMOUNTS

Cost Sharing Amounts include Coinsurance, Copayment, Deductible, Prescription Medication or Drug Coinsurance Maximum, Infertility Services Deductible and Out-of-Pocket Maximum Amounts. A Member is responsible for the Cost Sharing Amounts. Please see Section 1.5, Outline of Covered Services, and the Benefit Plan Attachment for the specific Cost Sharing Amounts that apply to this Benefit Plan. All Members contribute to the Deductible and Coinsurance Amounts. However, a Member's contribution cannot be more than the Single Coverage amount. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided.

	Basic Plan	PPO Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	\$400 per Benefit Period	\$400 per Benefit Period
Family Coverage	\$1,200 per Benefit Period	\$1,200 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	\$1,250 per Benefit Period	\$750 per Benefit Period
Family Coverage	\$2,500 per Benefit Period	\$1,500 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	\$1,650 per Benefit Period	\$1,150 per Benefit Period
Family Coverage	\$3,700 per Benefit Period	\$2,700 per Benefit Period
Under this Benefit Plan the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount is:		
<p>\$1,000 per Member per Benefit Period</p>		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
<p>\$500 per Member</p>		

1.2 LIFETIME MAXIMUM

The Lifetime Maximum is \$2,000,000 per Member. This Lifetime Maximum includes all specific Lifetime Maximums listed in the Outline of Covered Services.

1.3 SELECTING A HEALTH CARE PROVIDER

The benefit payment available under this Benefit Plan differs depending on the Subscriber's choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with BCBSND:

Members should refer to the BCBSND website for a list of Health Care Providers or call Member Services at the telephone number on the back of the Identification Card for a provider directory. The website is continuously updated and is the most up-to-date listing of Health Care Providers.

PPO Plan

PPO stands for "Preferred Provider Organization" and is a group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge BCBSND less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts.

To receive a higher payment level Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing.

Basic Plan

If a PPO Health Care Provider is not available in the Member's area, or if the Member chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization, the Member will receive the Basic Plan benefits.

Other Health Care Providers

Participating Health Care Providers

When Covered Services are received from a Participating Health Care Provider, the Participating Health Care Provider agrees to submit claims to BCBSND on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider according to the terms of this Benefit Plan and the participation agreement between the Health Care Provider and BCBSND.

When Covered Services are received from a Participating Health Care Provider, a provider discount provision is in effect. This means the Allowance paid by BCBSND will be considered by the Participating Health Care Provider as payment in full, except for Cost Sharing Amounts, Maximum Benefit Allowances or Lifetime Maximums.

Participating Health Care Providers have also agreed to perform managed benefits requirements on behalf of the Member.

Nonparticipating Health Care Providers

If a Member receives Covered Services from a Nonparticipating Health Care Provider, the Member will be responsible for notifying BCBSND of the receipt of services. If BCBSND needs copies of medical records to process the Member's claim, the Member is responsible for obtaining such records from the Nonparticipating Health Care Provider. In addition, the Member will be responsible for compliance with all required managed benefits provisions. See Section 3, Managed Benefits.

1. Nonparticipating Health Care Providers Within the State of North Dakota

If a Member receives Covered Services from a Nonparticipating Health Care Provider within the state of North Dakota, benefit payments will be based on the Allowance and reduced by an additional 20%. The 20% payment reduction does not apply toward the Out-of-Pocket Maximum Amount. The Allowance will not exceed 80% of the billed charge.

The Member is responsible for the 20% payment reduction and any charges in excess of the Allowance for Covered Services.

Benefit payments will be made directly to the Subscriber for Covered Services received from a Nonparticipating Health Care Provider. BCBSND will not honor an assignment of benefit payments to any other person or Health Care Provider.

2. Nonparticipating Health Care Providers Outside the State of North Dakota

If a Member receives Covered Services from a Nonparticipating Health Care Provider outside the state of North Dakota, the Allowance for Covered Services will be an amount within a general range of payments made and judged to be reasonable by BCBSND.

The Member is responsible for any charges in excess of the Allowance for Covered Services.

If a Member receives Covered Services from a Health Care Provider in a county contiguous to North Dakota, the benefit payment will be provided on the same basis as a Health Care Provider located in the state of North Dakota. If the Health Care Provider is a Participating Health Care Provider, the benefit payment will be as indicated in the Outline of Covered Services. If the Health Care Provider is not a Participating Health Care Provider, benefits will be available at the same level as Nonparticipating Health Care Providers within the state of North Dakota.

Payment for Covered Services received from out-of-state Health Care Providers will be made directly to the Subscriber unless a special arrangement exists between BCBSND and the Health Care Provider. BCBSND may designate an out-of-state Health Care Provider as Nonpayable.

An assignment of payment to an out-of-state Health Care Provider must be in writing, filed with each claim and approved by BCBSND.

Nonpayable Health Care Providers

If BCBSND designates a Health Care Provider as Nonpayable, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the Nonpayable Health Care Provider. Notice of designation as a Nonpayable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Nonpayable Health Care Provider. As of the date of termination, all charges incurred by a Member for services received from the Nonpayable Health Care Provider will be the Subscriber's responsibility.

Participating Providers with the BlueCard® Program

When a Member obtains health care services through BlueCard outside the geographic area BCBSND serves, the amount the Member pays for Covered Services is calculated on the **lower** of:

- The billed charges for Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to BCBSND.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a Health Care Provider or with a specified group of Health Care Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with the Health Care Provider or with a specified group of Health Care Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount the Member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, BCBSND would then calculate the Member's liability for any Covered Service in accordance with the applicable state statute in effect at the time the Member received care.

Health Care Providers Outside the United States

The benefits available under this Benefit Plan are also available to Members traveling or living outside of the United States. The Preauthorization and Prior Approval requirements will apply. If the Health Care Provider is a Participating Provider with the BlueCard Program, the Participating Health Care Provider will submit claims for reimbursement on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider. If the Health Care Provider does not participate with the BlueCard Program the Member will be responsible for payment of services and submitting a claim for reimbursement to BCBSND. BCBSND will provide translation and currency conversion services for the Member's claims outside of the United States.

BCBSND will reimburse Prescription Medications or Drugs purchased outside the United States by Members who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Members are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

Medicare Private Contracts

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services and indicate that neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider and that the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge. Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and BCBSND will limit its payment to the amount BCBSND would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by BCBSND.

1.4 WAITING PERIODS FOR PREEXISTING CONDITIONS FOR LATE ENROLLEES

Members accepted as Late Enrollees will not be eligible for benefits for any services, supplies or charges for the care or treatment the Member receives for a Preexisting Condition during a period of 12 months following the individual Member's effective date of this Benefit Plan. However, this waiting period may be reduced by aggregate days of membership under Qualifying Previous Coverage, if continuous until at least 63 days prior to the individual Member's Enrollment Date under this Benefit Plan.

1.5 OUTLINE OF COVERAGE

This outline of covered services describes the Covered Services and the level of payment for the Covered Services. **For a description of the Covered Services, see page 15.**

PPO Plan: Benefits for Covered Services received by Eligible Dependents, see definition 8.21, who are residing out-of-area will be paid at the Basic level if the Subscriber or the Subscriber's spouse is required by court order to provide health coverage for that Eligible Dependent. You may be asked to provide a copy of the court order to BCBSND.

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Inpatient Hospital and Medical Services		
• Inpatient Hospital Services	75% of Allowed Charge.	80% of Allowed Charge.
• Inpatient Medical Care Visits	75% of Allowed Charge.	80% of Allowed Charge.
• Ancillary Services	75% of Allowed Charge.	80% of Allowed Charge.
• Inpatient Consultations	75% of Allowed Charge.	80% of Allowed Charge.
• Concurrent Services	75% of Allowed Charge.	80% of Allowed Charge.
• Initial Newborn Care	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
Inpatient and Outpatient Surgical Services		
• Professional Health Care Provider Services	75% of Allowed Charge.	80% of Allowed Charge.
• Assistant Surgeon Services when Medically Appropriate and Necessary	75% of Allowed Charge.	80% of Allowed Charge.
• Ambulatory Surgical Facility Services	75% of Allowed Charge.	80% of Allowed Charge.
• Hospital Ancillary Services	75% of Allowed Charge.	80% of Allowed Charge.
• Anesthesia Services	75% of Allowed Charge.	80% of Allowed Charge.
Transplant Services	Benefits are subject to a Lifetime Maximum of 2 transplant procedures for the same condition.	
• Inpatient and Outpatient Hospital and Medical Services	75% of Allowed Charge when Prior Approval is received from BCBSND.	80% of Allowed Charge when Prior Approval is received from BCBSND.
• Transportation Services	75% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of \$1,000 per transplant procedure.	80% of Allowed Charge.
Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment		
• Surgical Services	75% of Allowed Charge. Benefits are subject to a Lifetime Maximum of \$10,000 per Member.	80% of Allowed Charge.
• Nonsurgical Services	75% of Allowed Charge. Benefits are subject to a Lifetime Maximum of \$2,500 per Member.	80% of Allowed Charge.

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Outpatient Hospital and Medical Services		
• Home and Office Visits	\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.	\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.
• Diagnostic Services	75% of Allowed Charge.	80% of Allowed Charge.
• Emergency Services	\$50 Copayment Amount, then 75% of Allowed Charge for emergency room facility fee billed by a Hospital.	\$50 Copayment Amount, then 80% of Allowed Charge for emergency room facility fee billed by a Hospital.
	The Copayment Amount for the emergency room facility fee is waived when a Member is admitted directly as an Inpatient to a Hospital.	
	75% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. Deductible Amount is waived.	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. Deductible Amount is waived.
	75% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.
• Dental Services Related to Accidental Injury	75% of Allowed Charge.	80% of Allowed Charge.
• Radiation Therapy and Chemotherapy	75% of Allowed Charge.	80% of Allowed Charge.
• Dialysis Treatment	75% of Allowed Charge.	80% of Allowed Charge.
• Home Infusion Therapy Services	75% of Allowed Charge.	80% of Allowed Charge.
• Visual Training for Members under age 10	75% of Allowed Charge. Benefits are subject to a Lifetime Maximum of 16 visits per Member.	80% of Allowed Charge.
• Allergy Services	75% of Allowed Charge.	80% of Allowed Charge.
• Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)	75% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of \$3,000 per Member per Benefit Period.	80% of Allowed Charge.
• Dental Anesthesia and Hospitalization	75% of Allowed Charge. Prior Approval is required for all Members age 9 and older.	80% of Allowed Charge. Prior Approval is required for all Members age 9 and older.

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount

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|--|---|---|
| <ul style="list-style-type: none"> Outpatient Nutrition Care Services | \$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | \$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. |
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Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions:

- Hyperlipidemia – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period.
- Gestational Diabetes – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period.
- Chronic Renal Failure – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- Diabetes Mellitus – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- Anorexia Nervosa – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- Bulimia – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- PKU – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- Obesity – Maximum Benefit Allowance of 1 Office Visit per Member per Benefit Period.

Wellness Services

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| <ul style="list-style-type: none"> Well Child Care to the Member's 6th birthday | \$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. | \$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. |
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Benefits are available as follows:

- 7 visits for Members from birth through 12 months;
- 3 visits for Members from 13 months through 24 months;
- 1 visit per Benefit Period for Members 25 months through 72 months.

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| <ul style="list-style-type: none"> Well Child Care Immunizations to the Member's 6th birthday | 100% of Allowed Charge. Deductible Amount is waived. | 100% of Allowed Charge. Deductible Amount is waived. |
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Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease and Influenza Virus.

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
<ul style="list-style-type: none"> Preventive Screening Services for Members age 6 and older 	<p>\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge subject to a Maximum Benefit Allowance of \$200 per Member per Benefit Period. Deductible Amount is waived.</p> <p>Benefits include:</p> <ul style="list-style-type: none"> One routine physical examination per Member per Benefit Period. Routine diagnostic screenings. Routine screening procedures for cancer. <p>A Health Care Provider will counsel Members as to how often preventive services are needed based on the age, gender and medical status of the Member.</p> <p>Benefits beyond the Maximum Benefit Allowance will be subject to Cost Sharing Amounts. See Outpatient Hospital and Medical Services.</p>	<p>\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge subject to a Maximum Benefit Allowance of \$200 per Member per Benefit Period. Deductible Amount is waived.</p>
<ul style="list-style-type: none"> Mammography Screening Services 	<p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>Benefits are available as follows:</p> <ul style="list-style-type: none"> One service for Members between the ages of 35 and 40; One service per year for Members age 40 and older. <p>Additional benefits will be available for mammography services when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Outpatient Hospital and Medical Services.</p>	<p>100% of Allowed Charge. Deductible Amount is waived.</p>
<ul style="list-style-type: none"> Routine Pap Smear 	<p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>Benefits are subject to a Maximum Benefit Allowance of 1 pap smear per Benefit Period.</p>	<p>100% of Allowed Charge. Deductible Amount is waived.</p>
<p>Related Office Visit</p>	<p>\$30 Copayment Amount for the Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> <p>Additional benefits will be available for pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Outpatient Hospital and Medical Services.</p>	<p>\$25 Copayment Amount for the Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p>

Covered Services	Provider of Service:	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
<ul style="list-style-type: none"> Prostate Cancer Screening 	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
<p>Related Office Visit</p>	\$30 Copayment Amount for the Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.	\$25 Copayment Amount for the Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.
	Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for an asymptomatic male age 50 and older, a black male age 40 and older, and a male age 40 and older with a family history of prostate cancer.	
	Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Outpatient Hospital and Medical Services.	
<ul style="list-style-type: none"> Fecal Occult Blood Testing for Colorectal Cancer Screening 	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	Benefits are available for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period.	
<ul style="list-style-type: none"> Immunizations other than Well Child Care 	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.	
<ul style="list-style-type: none"> Diabetes Education Services 	75% of Allowed Charge Deductible Amount is waived.	80% of Allowed Charge Deductible Amount is waived.
	Benefits are subject to a Lifetime Maximum of \$1,000 per Member for programs approved by BCBSND.	
<ul style="list-style-type: none"> Dilated Eye Examination (for diabetes related diagnosis) 	\$30 Copayment Amount, then 75% of Allowed Charge. Deductible Amount is waived.	\$25 Copayment Amount, then 80% of Allowed Charge. Deductible Amount is waived.
	Benefits are subject to a Maximum Benefit Allowance of one examination per Member per Benefit Period.	
Outpatient Therapy Services		
Physical Therapy	\$25 Copayment Amount per visit, then 75% of Allowed Charge. Deductible Amount is waived.	\$20 Copayment Amount per visit, then 80% of Allowed Charge. Deductible Amount is waived.
	Benefits are subject to the medical guidelines established by BCBSND.	

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Occupational Therapy	\$25 Copayment Amount per visit, then 75% of Allowed Charge. Deductible Amount is waived.	\$20 Copayment Amount per visit, then 80% of Allowed Charge. Deductible Amount is waived.
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
Speech Therapy	\$25 Copayment Amount per visit, then 75% of Allowed Charge. Deductible Amount is waived.	\$20 Copayment Amount per visit, then 80% of Allowed Charge. Deductible Amount is waived.
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
Respiratory Therapy Services	75% of Allowed Charge.	80% of Allowed Charge.
Cardiac Rehabilitation Services	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
	Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions:	
	<ul style="list-style-type: none"> • Myocardial Infarction • Coronary Artery Bypass Surgery • Coronary Angioplasty and Stenting • Heart Valve Surgery • Heart Transplant Surgery 	
	Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.	
Pulmonary Rehabilitation Services	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
	Benefits are subject to a Lifetime Maximum of 3 visits per Member.	

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Chiropractic Services	Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.	
• Home and Office Visits	\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.	\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.
• Therapy and Manipulations	\$25 Copayment Amount per visit, then 75% of Allowed Charge. Deductible Amount is waived.	\$20 Copayment Amount per visit, then 80% of Allowed Charge. Deductible Amount is waived.
• Diagnostic Services	75% of Allowed Charge.	80% of Allowed Charge.
Maternity Services	The Deductible Amount is waived for delivery services received from a PPO Health Care Provider when the Member is enrolled in the Prenatal Plus Program.	
• Inpatient Hospital and Medical Services	75% of Allowed Charge.	80% of Allowed Charge.
• Prenatal and Postnatal Care	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
• 1 Prenatal Nutritional Counseling visit per pregnancy	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
Infertility Services	80% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a \$500 Lifetime Infertility Services Deductible Amount and a \$20,000 Lifetime Maximum per Member. This Coinsurance Amount and the Infertility Services Deductible Amount do not apply toward the Out-of-Pocket Maximum Amount. Prior Approval is required.	
Psychiatric and Substance Abuse Services		
• Inpatient Services	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to an aggregate Maximum Benefit Allowance of 45 days per Member per Benefit Period. Preauthorization is required.	
• Detoxification Services	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Maximum Benefit Allowance of 5 days per Admission. Days of detoxification care will reduce available inpatient benefits.	

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
<ul style="list-style-type: none"> Ambulatory Behavioral Health Care (Partial Hospitalization) Services 	<p>75% of Allowed Charge.</p> <p>Benefits are subject to an aggregate Maximum Benefit Allowance of 120 days per Member per Benefit Period. Preauthorization is required.</p>	<p>80% of Allowed Charge.</p>
<ul style="list-style-type: none"> Psychiatric Residential Treatment Services for Members under age 21 	<p>75% of Allowed Charge.</p> <p>Benefits are subject to a Maximum Benefit Allowance of 120 days per Member per Benefit Period. Available inpatient days may be traded for additional days of Residential Treatment services. Each day of available inpatient service is equivalent to 2 days of Residential Treatment services. However, no more than 23 days of available inpatient services may be traded for additional Residential Treatment services. Preauthorization is required.</p>	<p>80% of Allowed Charge.</p>
<ul style="list-style-type: none"> Substance Abuse Residential Treatment Services 	<p>75% of Allowed Charge.</p> <p>Benefits are subject to a Maximum Benefit Allowance of 60 days per Member per Benefit Period. Available inpatient days may be traded for additional days of Residential Treatment services. Each day of available inpatient service is equivalent to 2 days of Residential Treatment services. However, no more than 23 days of available inpatient services may be traded for additional Residential Treatment services. Preauthorization is required.</p>	<p>80% of Allowed Charge.</p>
<ul style="list-style-type: none"> Outpatient Services <ul style="list-style-type: none"> Psychiatric Services 	<p>Benefits are available up to 30 hours per Member per Benefit Period. Deductible Amount is waived and benefits are payable at 100% of Allowed Charge for the first 5 hours.</p> <p>Benefits for the remaining 25 hours are subject to the Deductible Amount and are payable at 80% of Allowed Charge.</p>	<p>Benefits for the remaining 25 hours are subject to the Deductible Amount and are payable at 80% of Allowed Charge.</p>
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Group Psychotherapy Services 	<p>Two hours of group psychotherapy reduce available outpatient psychiatric benefits by 1 hour.</p>	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Substance Abuse Services 	<p>Benefits are available up to 20 visits per Member per Benefit Period. Deductible Amount is waived and benefits are payable at 100% of Allowed Charge for the first 5 visits.</p> <p>Benefits for the remaining 15 visits are subject to the Deductible Amount and are payable at 80% of Allowed Charge.</p>	<p>Benefits for the remaining 15 visits are subject to the Deductible Amount and are payable at 80% of Allowed Charge.</p>
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Group Psychotherapy Services 	<p>Two group psychotherapy visits reduce available outpatient substance abuse benefits by 1 visit.</p>	
Ambulance Services	<p>75% of Allowed Charge.</p>	<p>80% of Allowed Charge.</p>

Covered Services	<u>Provider of Service:</u>	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Skilled Nursing Facility Services	75% of Allowed Charge.	80% of Allowed Charge.
Home Health Care Services	75% of Allowed Charge.	80% of Allowed Charge.
Hospice Services	75% of Allowed Charge.	80% of Allowed Charge.
Private Duty Nursing Services	75% of Allowed Charge.	80% of Allowed Charge.
Medical Supplies and Equipment	75% of Allowed Charge.	80% of Allowed Charge.
<ul style="list-style-type: none"> • Home Medical Equipment • Prosthetic Appliances • Orthotic Devices • Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Outpatient Prescription Medications or Drugs • Oxygen Equipment and Supplies • Ostomy Supplies • Hearing aids for Members under age 18 	<p>Benefits are subject to a Maximum Benefit Allowance of \$6,000 per Member per Benefit Period.</p> <p>Subject to a \$3,000 Maximum Benefit Allowance per Member every 3 years. Prior Approval is required. This benefit is also subject to the Medical Supplies and Equipment Maximum Benefit Allowance.</p>	
<ul style="list-style-type: none"> • Prosthetic Limbs 	<p>Subject to a Maximum Benefit Allowance every 5 years of \$6,000 per limb above or below the elbow and \$16,000 per limb above or below the knee. This benefit is not subject to the Medical Supplies and Equipment Maximum Benefit Allowance.</p>	
Eyeglasses or Contact Lenses (following a covered cataract surgery)	75% of Allowed Charge.	80% of Allowed Charge.
	<p>Benefits are subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.</p>	

Covered Services	Provider of Service:	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount

**Outpatient Prescription Medications
or Drugs and Diabetes Supplies**

Retail and Mail Order

- Formulary Drug
 - Generic \$5 Copayment Amount, then 85% of Allowed Charge. Benefits are subject to the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. Deductible Amount is waived.
 - Brand Name \$20 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. Deductible Amount is waived.
- Nonformulary Drug \$25 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived.

Copayment Amount Application:

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.

Copayment Amounts do not apply to the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions.

If a Generic Prescription Medication or Drug is the therapeutic equivalent for a Brand Name Prescription Medication or Drug, and is authorized by a Member's Professional Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication or Drug and applicable Cost Sharing Amounts.

Prescription Medication or Drug Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

Prescription Medications or Drugs and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

The Copayment Amounts are waived for prenatal vitamins when the Member is enrolled under the Prenatal Plus Program.

SECTION 2 COVERED SERVICES

This section describes the services for which benefits are available for Medically Appropriate and Necessary services under this Benefit Plan, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan, Cost Sharing Amounts, Maximum Benefit Allowances and Lifetime Maximums described in the Schedule of Benefits and Benefit Plan Attachment.

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

2.1 INPATIENT HOSPITAL AND MEDICAL SERVICES

Preauthorization may be required for Inpatient Hospital Admissions. See Section 3, Managed Benefits.

A. Inpatient Hospital Services include:

1. Bed, board and general nursing services.
2. Special Care Units when Medically Appropriate and Necessary.
3. Long Term Acute Care Facility, Rehabilitation Facility or Transitional Care Unit when Medically Appropriate and Necessary.
4. Ancillary Services when Medically Appropriate and Necessary, Including:
 - a. use of operating, delivery and treatment rooms;
 - b. prescribed drugs;
 - c. blood, blood substitutes and the administration of blood and blood processing;
 - d. anesthesia and related supplies and services provided by an employee of or a person under contractual agreement with a Hospital;
 - e. medical and surgical dressings, supplies, casts and splints;
 - f. Diagnostic Services; and
 - g. Therapy Services.
5. Dental anesthesia and hospitalization for dental care to Members under age 9, Members who are severely disabled or Members who have a medical condition that requires hospitalization or general anesthesia. Prior Approval is required for all Members age 9 and older.

B. Inpatient Medical Services include:

1. Inpatient medical care visits by a Professional Health Care Provider, except inpatient stays related to surgery or maternity care. See Section 2.2, Inpatient and Outpatient Surgical Services and Section 2.9, Maternity Services. Benefits are available for inpatient medical care visits for the treatment of mental illness or substance abuse only when provided in conjunction with a covered inpatient psychiatric or substance abuse Admission.
2. Consultation services by another Professional Health Care Provider at the request of the attending Professional Health Care Provider for the purpose of advice, diagnosis or instigation of treatment requiring special skill or knowledge. Benefits are available only if a written report from a consultant is a part of the Member's medical records. Consultation benefits do not include staff consultations required by hospital rules and regulations.
3. Concurrent services Including medical, surgical, maternity, Chemotherapy or Radiation Therapy provided during one inpatient stay by one Professional Health Care Provider. Benefits for concurrent services will be based on the Covered Service with the highest Allowance.

When two or more Professional Health Care Providers have attended the Member during one inpatient stay because the nature or severity of the Member's condition requires the skills of separate Professional Health Care Providers, benefits will be available for the Covered Service that carries the highest Allowance for the type of service provided by each Professional Health Care Provider, provided the service is Medically Appropriate and Necessary and would otherwise be a Covered Service under this Benefit Plan.

4. Routine nursery care and the initial inpatient examination of the newborn child by a Professional Health Care Provider, if the newborn child is a Member. The newborn child is also entitled to benefits from the moment of birth for any illness, accident, deformity or congenital conditions.

2.2 **INPATIENT AND OUTPATIENT SURGICAL SERVICES**

A. Inpatient Surgical Services include:

1. Surgical Services provided by a Professional Health Care Provider. Separate benefit payments will not be made for preoperative and postoperative services. Payment for these services is included in the surgical fee.
2. Assistant surgeon services by a Professional Health Care Provider who actively assists the operating surgeon in the performance of covered surgery if the type of surgery performed requires an assistant, as determined by BCBSND, and no Hospital or Ambulatory Surgical Facility staff is available to provide such assistance.
3. Administration of Medically Appropriate and Necessary anesthesia for a covered surgical procedure when ordered by the attending Professional Health Care Provider and provided by or under the direct supervision of an Anesthesiologist or Professional Health Care Provider other than the operating surgeon or the assistant surgeon.

B. The benefits described above are also available for Outpatient Surgical Services in addition to:

1. Supplies used for a covered surgical procedure when performed in a Professional Health Care Provider's office, clinic or Ambulatory Surgical Facility.
2. Facility charges for covered outpatient Surgical Services performed in an Ambulatory Surgical Facility.
3. Hospital Ancillary Services and supplies used for a covered outpatient surgery, including removal of sutures, anesthesia and related supplies and services when provided by an employee of or under contractual agreement with the Hospital, other than the surgeon or assistant at surgery.

C. Benefits are available for the following special surgeries:

1. Reconstructive surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

Benefits include reconstructive breast surgery performed as a result of a partial or total mastectomy subject to Benefit Plan Cost Sharing Amounts. Benefits also include reconstructive breast surgery on the nondiseased breast to establish symmetry with the reconstructed diseased breast. Benefits for prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, are allowed under Section 2.17, Medical Supplies and Equipment. Benefits will be allowed in a manner determined in consultation with the attending Professional Health Care Provider and the Member.

Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition.

2. Sterilization procedures. Procedures to evaluate and reverse sterilization are not covered under this Benefit Plan.
3. Surgery for morbid obesity when Prior Approval is received from BCBSND. Benefits are subject to a Lifetime Maximum of 1 operative procedure for morbid obesity per Member. Guidelines and criteria are available upon request.

No benefits are available for the repair or modification of any or all types of surgical morbid obesity procedures, except a Lifetime Maximum of 1 revision will be allowed per Member due to technical staple line failure. Benefits for all proposed surgical procedures for the treatment of complications resulting from any or all types of surgical morbid obesity procedures are available only when Prior Approval is received from BCBSND.

2.3 TRANSPLANT SERVICES

A. Subject to the exclusions of this Benefit Plan, benefits are available for the following transplant procedures based on medical criteria if the recipient is a Member under this Benefit Plan. Benefits are not available under this Benefit Plan if the Member is the donor for transplant services. Benefits are subject to a Lifetime Maximum of 2 transplant procedures for the same condition. Prior Approval is required.

1. Heart
2. Heart-lung
3. Lung (single or double)
4. Liver
5. Pancreas
6. Small bowel
7. Kidney - Prior Approval is not required. Preauthorization may be required, see Section 3.2.
8. Cornea - Prior Approval is not required. Preauthorization may be required, see Section 3.2.
9. Bone marrow transplants or other forms of stem cell rescue with related services and supplies are covered only in the following cases and in no others:
 - a. Autologous Bone Marrow Transplants and Autologous peripheral stem cell transplants are only allowed for the following diagnoses: Non-Hodgkin's lymphoma, Stage III or IV; Hodgkin's Disease (lymphoma) Stage III or IV; Neuroblastoma, Stage III or IV; Acute lymphocytic or non-lymphocytic leukemia in first or subsequent remission; Multiple myeloma; Metastatic (Stage IV) breast cancer; and Germ Cell tumors.
 - b. Allogeneic Bone Marrow Transplants are only allowed for the following diagnoses: Non-Hodgkin's lymphoma, Stage III or IV; Hodgkin's Disease (lymphoma) Stage III or IV; Neuroblastoma, Stage III or IV; Chronic myelogenous leukemia in blast crisis or chronic phase; and Acute lymphocytic or non-lymphocytic leukemia (acute myelocytic leukemia) in first or subsequent remission, but at high risk for relapse.
 - c. Allogeneic Bone Marrow Transplants for Non-Malignancies are only allowed for the following diagnoses: Severe aplastic anemia; Homozygous Beta-Thalassemia; Wiskott-Aldrich Syndrome; Severe combined immunodeficiencies; Infantile malignant osteopetrosis; Mucopolysaccharidoses; Mucopolysaccharidoses; Myelodysplastic Syndromes; Kostmann's Syndrome; Leukocyte adhesion deficiencies; X-linked lymphoproliferative syndrome; and Myeloproliferative disorders.

Please contact BCBSND to ensure benefits are available for specific transplant procedures. In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

If a Member chooses to receive Covered Services from a program not approved by BCBSND, the Member will be responsible for any charges over the Allowance.

B. Covered Services include:

1. One evaluation is allowed per transplant procedure. Services must be performed at a qualified transplant center.
2. Inpatient and outpatient Hospital and Medical Services for the recipient and the donor, if the living donor is not eligible for any other medical coverage.
3. Surgical Services Including the evaluation and removal of the donor organ as well as transplantation of the organ or tissue into the recipient. Separate payment will not be made for the removal of an organ for transplantation at a later date.
4. Compatibility testing services provided to the donor.
5. Supportive medical procedures and clinical management services, Including postoperative procedures to control rejection and infection.
6. Transportation costs by air ambulance, commercial carrier or charter when a Member must be transported within a restricted time frame to obtain a covered transplant procedure. Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

C. Benefits are not available for artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

2.4 **TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT TREATMENT**

Temporomandibular (TMJ) or craniomandibular (CMJ) joint treatment, Including surgical and nonsurgical services, when such care and treatment is Medically Appropriate and Necessary as determined by BCBSND. Benefits are subject to the Lifetime Maximum listed in the Schedule of Benefits, Section 1.

2.5 **OUTPATIENT HOSPITAL AND MEDICAL SERVICES**

Outpatient Hospital and Medical Services include:

- A. Home and Office Visits and consultations for the examination, diagnosis and treatment of an illness or injury, Including administered Prescription Medications or Drugs.
- B. Diagnostic Services when ordered by a Professional Health Care Provider.
- C. Emergency Services.
- D. Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by BCBSND is in place. An accidental injury is defined as an injury that is the result of an external force causing a specific impairment to the jaw, sound natural teeth, dentures, mouth or face. Injury as a result of chewing or biting is not considered an accidental injury.
- E. Surgical preadmission testing for Medically Appropriate and Necessary preoperative tests and studies provided on an outpatient basis prior to a Member's scheduled Admission to the Hospital as an Inpatient for surgery.

Benefits are available only under the following conditions:

1. The tests or studies would have been provided on an inpatient basis for the same condition; and
2. The tests or studies are not repeated upon the Member's Admission to the Hospital.

- F. Second surgical opinion consultations on covered elective surgery recommended by a Health Care Provider and those directly related Diagnostic Services required for a valid second surgical opinion. A second surgical opinion must be provided by a Professional Health Care Provider qualified to perform the suggested surgery and whose practice is unrelated to the Member's original Health Care Provider.
- G. Radiation and Chemotherapy Services, except as limited by this Benefit Plan.
- H. Dialysis Treatment.
- I. Home Infusion Therapy services. Covered Services include the provision of nutrients, antibiotics, and other drugs and fluids intravenously, through a feeding tube, or by inhalation; all Medically Appropriate and Necessary supplies; and therapeutic drugs or other substances. Covered Services also include Medically Appropriate and Necessary enteral feedings when such feedings are the sole source of nutrition for a Member.
- J. Visual training services, Including orthoptics and pleoptic training, provided to Members under age 10 for the treatment of amblyopia. Benefits are subject to the Lifetime Maximum listed in the Schedule of Benefits, Section 1.
- K. Allergy Services, Including serum, direct skin testing and patch testing when ordered by a Professional Health Care Provider and performed in accordance with medical guidelines and criteria established by BCBSND. Guidelines and criteria for Medically Appropriate and Necessary services are available from a Participating Health Care Provider or BCBSND.
- L. Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU) subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. The following foods and food products are available:
 - 1. Low protein modified food product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.
 - 2. Medical food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a Physician.
- M. Dental anesthesia and hospitalization for dental care to Members under age 9, Members who are severely disabled or Members who have a medical condition that requires hospitalization or general anesthesia. Prior Approval is required for all Members age 9 and older.
- N. Outpatient nutrition care services provided by a Licensed Registered Dietitian when ordered by a Professional Health Care Provider. Covered Services include assessment of food practices and dietary/nutritional status and diet counseling for preventive and therapeutic needs for the diagnosed medical conditions listed in the Schedule of Benefits, Section 1.

2.6 **WELLNESS SERVICES**

- A. Well child care and immunizations for Members to their 6th birthday in accordance with the schedule listed in the Schedule of Benefits, Section 1.
- B. Preventive screening services for Members age 6 and older as listed in the Schedule of Benefits, Section 1. A Health Care Provider will counsel Members as to how often preventive services are needed based on the age, gender and medical status of the Member.
- C. Mammography screening services in accordance with the schedule listed in the Schedule of Benefits, Section 1.

- D. One routine pap smear per Member per Benefit Period. Benefits include the related Office Visit.
- E. Prostate cancer screening services subject to the guidelines listed in the Schedule of Benefits, Section 1. Benefits include the related Office Visit.
- F. Fecal occult blood testing for colorectal cancer screening subject to the guidelines listed in the Schedule of Benefits, Section 1.
- G. Immunizations other than well child care as listed in the Schedule of Benefits, Section 1.
- H. Diabetes care services include Outpatient Home and Office Visits, Diagnostic Services, Outpatient Nutrition Care Services, Diabetes Education Services, Dilated Eye Examinations and Outpatient Prescription Medications or Drugs and Diabetes Supplies. Benefits are subject to the Maximum Benefit Allowances as listed in the Schedule of Benefits, Section 1.

2.7 **OUTPATIENT THERAPY SERVICES**

- A. Physical Therapy: Benefits will be based on a predetermined number of visits (also referred to as "window periods") according to the condition. Additional visits beyond the window period require Preauthorization from BCBSND. See Section 3, Managed Benefits. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.
- B. Occupational Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.
- C. Speech Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.
- D. Respiratory Therapy services performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of patients with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.
- E. Cardiac rehabilitation services subject to the criteria listed in the Schedule of Benefits, Section 1.
- F. Pulmonary rehabilitation services subject to the Lifetime Maximum listed in the Schedule of Benefits, Section 1.

2.8 **CHIROPRACTIC SERVICES**

Chiropractic services provided on an inpatient or outpatient basis when Medically Appropriate and Necessary as determined by BCBSND and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician. Benefits are not available for maintenance care.

2.9 **MATERNITY SERVICES**

Benefits are available for Covered Services for pregnancy and complications of pregnancy. Benefits are limited to 1 ultrasound per pregnancy unless, based on the Member's condition and history, additional services are determined to be Medically Appropriate and Necessary.

Benefits for inpatient maternity services allow a minimum stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The Health Care Provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Benefits for Outpatient Nutrition Care Services for Gestational Diabetes are available. See Outpatient Nutrition Care Services in the Schedule of Benefits, Section 1.

If the newborn child is a Member, benefits are available from the moment of birth for routine nursery care and the treatment of any illness, accident, deformity or congenital condition.

Prenatal nutritional counseling is limited to one prenatal visit per pregnancy.

Prenatal Plus Program

The prenatal plus program is designed to identify women at higher risk for premature birth and to prevent the incidence of preterm birth through assessment, intervention and education. Participation in the prenatal plus program is voluntary.

To participate, the Member must notify a Member Services representative after the first prenatal visit; preferably before the 12th week, and no later than the 34th week. The number to call regarding prenatal plus is on the back of the Identification Card. A Member Services representative will obtain the Member's name, Benefit Plan Number and telephone number and request a medical management representative contact the Member.

A medical management representative will review the preterm labor risk assessment questionnaire with the Member. The questionnaire will take approximately ten minutes to complete. The information needed to complete this form is the Member's Benefit Plan Number, Professional Health Care Provider's name, address and telephone number and the Member's expected due date.

As a program participant, the Member will receive a packet containing information concerning pregnancy and prenatal care.

When a Member is enrolled under the prenatal plus program, the Deductible Amount is waived for delivery services received from a PPO Health Care Provider.

The Copayment Amount for prenatal vitamins is waived when the Member is enrolled under the prenatal plus program.

2.10 INFERTILITY SERVICES

Benefits are available for services, supplies and drugs related to artificial insemination (AI) and assisted reproductive technology (ART), including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) or in vitro fertilization (IVF), subject to the Cost Sharing Amounts and Lifetime Maximum listed in the Schedule of Benefits, Section 1. Guidelines and criteria for Medically Appropriate and Necessary services are available from BCBSND. In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

Prior Approval is required for assisted reproductive technology for GIFT, ZIFT, ICSI and IVF.

2.11 PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

A. Inpatient Services

Benefits are available for the inpatient treatment of mental illness and substance abuse when provided by a Hospital, Psychiatric Care Facility or Substance Abuse Facility subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Preauthorization is required.

All out-of-state Admissions require Prior Approval from BCBSND.

B. Detoxification Services

In the case of an Admission for detoxification only, benefits will be limited to 5 days per Admission unless further acute care is Medically Appropriate and Necessary. Days of detoxification care will reduce the benefit for inpatient services whether services are provided in an acute Hospital setting or a Substance Abuse Facility.

C. Ambulatory Behavioral Health Care (Partial Hospitalization) Services

Benefits are available for Ambulatory Behavioral Health Care Services received through a Partial Hospitalization or intensive outpatient program for mental illness and substance abuse subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Preauthorization is required.

D. Psychiatric Residential Treatment Services

Benefits are available for Residential Treatment services received through a Residential Treatment program subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Preauthorization is required.

E. Substance Abuse Residential Treatment Services

Benefits are available for Residential Treatment services received through a Residential Treatment program subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Preauthorization is required.

F. Outpatient Psychiatric Services

Benefits are available subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Benefits include diagnostic, evaluation and treatment services when provided by a Physician, Licensed Clinical Psychologist, Licensed Independent Clinical Social Worker and treatment services provided by a Psychiatric Nurse.

Group psychotherapy services received by a Member through a program approved by BCBSND. Two hours of group psychotherapy reduce available outpatient psychiatric benefits by 1 hour.

G. Outpatient Substance Abuse Services

Benefits are available subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Benefits include diagnostic, evaluation and treatment services provided by a Physician, Licensed Clinical Psychologist or Licensed Addiction Counselor.

Group psychotherapy services received by a Member through a program approved by BCBSND. Two group psychotherapy visits reduce available outpatient substance abuse benefits by 1 visit.

H. BCBSND may designate an out-of-state Health Care Provider as Nonpayable.

I. Depending upon the type and extent of psychiatric or substance abuse services, BCBSND may invite the parents or guardians of a Member under age 18 to participate in a voluntary program involving an evaluation of the Member by a care coordinator. Based on the outcome of the evaluation, the care coordinator may recommend modifications in the treatment plan, which may include an expansion of reimbursable services. This program has been developed as part of a pilot program by the North Dakota Department of Health, the Mental Health Association of North Dakota and BCBSND.

2.12 **AMBULANCE SERVICES**

Medically Appropriate and Necessary Ambulance Services to the nearest facility equipped to provide the required level of care, including transportation:

- from the home or site of an Emergency Medical Condition.
- between Hospitals.
- between a Hospital and Skilled Nursing Facility.

Benefits for air transportation are available only when ground transportation is not Medically Appropriate and Necessary as determined by BCBSND.

2.13 **SKILLED NURSING FACILITY SERVICES**

The benefits available under this Benefit Plan for Inpatient Hospital and Medical Services are also available for Skilled Nursing Services and supplies customarily provided to an Inpatient of a Skilled Nursing Facility when the condition requires daily Skilled Nursing Services that are Medically Appropriate and Necessary and such services can only be provided in a Skilled Nursing Facility. Preauthorization is required. Benefits are not available for Maintenance Care or Custodial Care.

2.14 **HOME HEALTH CARE SERVICES**

Home Health Care when provided to an essentially homebound Member in the Member's place of residence. The services must be provided on a part-time visiting basis according to a Professional Health Care Provider's prescribed plan of treatment approved by BCBSND prior to Admission to Home Health Care. Benefits are available only if, in the absence of Home Health Care, the Member would require Inpatient Hospital or Skilled Nursing Facility Services. Preauthorization is required.

A. Covered Services include:

1. The professional services of an R.N., Licensed Vocational Nurse or L.P.N.;
2. Physical, Occupational or Speech Therapy;
3. Medical and surgical supplies;
4. Administration of prescribed drugs;
5. Oxygen and the administration of oxygen; and
6. Health aide services for a Member who is receiving covered Skilled Nursing Services or Therapy Services.

B. No Home Health Care benefits will be provided for:

1. Dietitian services;
2. Homemaker services;
3. Social worker services;
4. Maintenance Care;
5. Custodial Care;
6. Food or home delivered meals;
7. Respite care; or
8. Home Health Care or supplies for Members who are ventilator dependent unless a skilled nursing facility bed is not available. In the event a skilled nursing facility bed is not available, the Maximum Benefit Allowance for Home Health Care Services will be the average daily room rate for a skilled nursing bed.

2.15 HOSPICE SERVICES

The benefits available under this Benefit Plan for Inpatient Hospital and Medical Services, Outpatient Hospital and Medical Services, Therapy Services, Skilled Nursing Facility Services, Home Health Care Services and Private Duty Nursing Services are also available when coordinated or provided through an organized and approved hospice program. Hospice benefits are provided only for the treatment of Members diagnosed with a condition where there is a life expectancy of 6 months or less. Preauthorization is required.

2.16 PRIVATE DUTY NURSING SERVICES

Private Duty Nursing Services provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when ordered by a Professional Health Care Provider. The nurse must not ordinarily reside in the Member's home or be a member of the Member's Immediate Family. Benefits are not available for Maintenance Care.

2.17 MEDICAL SUPPLIES AND EQUIPMENT

Benefits are available for Medically Appropriate and Necessary medical supplies and equipment subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

A. Home Medical Equipment

The rental or purchase, at the option of BCBSND of new, used or refurbished Home Medical Equipment, including wheelchairs, hospital-type beds, infusion pumps and related supplies, crutches and canes when prescribed by a Professional Health Care Provider and Medically Appropriate and Necessary. The rental cost shall not exceed the Allowance of such equipment. No benefits are available for motorized equipment, except wheelchairs when Prior Approval is received from BCBSND. No benefits are available for batteries required for Home Medical Equipment, except for wheelchair batteries. Covered Services include replacement and repairs when Medically Appropriate and Necessary.

Benefits will not be provided for any Home Medical Equipment required for leisure or recreational activity or to allow a Member to participate in a sport activity.

B. Prosthetic Appliances

The purchase, fitting and necessary adjustments of Prosthetic Appliances and supplies that replace all or part of an absent body part. Benefits are available for standard Prosthetic Appliances only. Covered Services include replacement and repairs when Medically Appropriate and Necessary.

Benefits are not available for dental appliances, artificial organs or Prosthetic Appliances intended only for cosmetic purposes.

C. Orthotic Devices

Medically Appropriate and Necessary Orthotic Devices when ordered by a Professional Health Care Provider. Guidelines and criteria for Medically Appropriate and Necessary custom molded foot orthotics are available from BCBSND.

Benefits will not be provided for any Orthotic Devices required for leisure or recreational activity or to allow a Member to participate in a sport activity.

D. Supplies for Administration of Prescription Medications or Drugs

Therapeutic devices or appliances related to the administration of Prescription Medications or Drugs in the home, such as hypodermic needles and syringes. See Outpatient Prescription Medications or Drugs for diabetes supplies.

E. Oxygen

Administration of oxygen, including the rental of equipment.

F. Ostomy Supplies

G. Hearing aids for Members under age 18 subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Prior Approval is required.

H. Prosthetic Limbs

The purchase, fitting and necessary adjustments of Prosthetic Limbs and supplies that replace all or part of an absent limb subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Benefits are available for standard Prosthetic Limbs only. When 2 Prosthetic Limbs are received for the same body part, payment will be based on the Prosthetic Limb with the highest Allowance. No additional payment will be made for an alignment procedure, as the charges are included in the Allowance for the Prosthetic Limb. Covered Services include replacement and repairs when Medically Appropriate and Necessary. Prior Approval is required if replacement of a Prosthetic Limb is necessary before 5 years.

Benefits are not available for Prosthetic Limbs or components intended only for cosmetic purposes, deluxe prosthetic knees controlled by microprocessors or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Member to participate in sport activities.

2.18 EYEGASSES OR CONTACT LENSES

One pair of eyeglasses or contact lenses if received within 6 months of a covered cataract surgery.

2.19 OUTPATIENT PRESCRIPTION MEDICATIONS OR DRUGS

Benefits are available for Prescription Medications or Drugs approved by BCBSND and that are Medically Appropriate and Necessary for the treatment of a Member and dispensed on or after the effective date of coverage. Benefits include the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions.

All FDA approved Prescription Medications or Drugs and diabetes supplies will be categorized by BCBSND as a Formulary Drug, Nonformulary Drug, Nonpayable Drug, Restricted Use Drug or Payable Over-the-Counter (OTC) Drug. Prior Approval may be required for Restricted Use Drugs. Benefits may vary based on the various categories. A list of the various categories of Prescription Medications or Drugs may be obtained by visiting our website at www.BCBSND.com or by calling Member Services. See the telephone number on the back of the Identification Card.

BCBSND utilizes a formulary listing. This listing contains both Brand Name and Generic Prescription Medications or Drugs. If a Member receives a Nonformulary Drug the Nonformulary Drug sanction will apply.

A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication or Drug is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims must be submitted by the Participating Pharmacy. If the Member submits a Claim for Benefits when services are received at a Participating Pharmacy, charges in excess of the Allowed Charge are the Subscriber's responsibility.

If a Member receives Prescription Medications or Drugs from a Nonparticipating Pharmacy, the Member is responsible for payment of the Prescription Order or refill in full at the time it is dispensed and to submit appropriate reimbursement information to BCBSND. Payment for covered Prescription Medications or Drugs will be sent to the Subscriber. Any charges in excess of the Allowed Charge are the Subscriber's responsibility.

A Member may call the toll-free number on the Identification Card to obtain information on Pharmacies participating in the BCBSND Preferred Pharmacy Network.

SECTION 3 MANAGED BENEFITS

This section describes BCBSND's managed benefits programs and the Member's responsibilities under these programs. The Member's medical care is between the Member and the Member's Health Care Provider. **The ultimate decision on the Member's medical care must be made by the Member and the Member's Health Care Provider. BCBSND only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.**

In an effort to control rising health care costs, BCBSND reserves the option to implement cost management and/or disease management programs. If a cost management and/or disease management program is implemented, BCBSND will establish policies and procedures governing the program.

A Member seeking Covered Services from a Health Care Provider requiring either Prior Approval or Preauthorization grants to that Health Care Provider authority to act on behalf of the Member as the Member's Authorized Representative. As an Authorized Representative, the Health Care Provider assumes responsibility to act on behalf of the Member in pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. See Section 6, Claims for Benefits and Appeals.

The designation of a Health Care Provider as an Authorized Representative is limited in scope and not an assignment of benefits, nor does it grant the Health Care Provider any of the Member's rights and privileges under the terms of this Benefit Plan.

The managed benefits provisions of this Benefit Plan provide that care must be provided or authorized by the Network chosen by the Subscriber. The Network assumes responsibility for the coordination of a Member's health care needs and that the health care system is properly accessed and utilized. However, if a Member seeks care on a Self-Referral basis without an Authorized Referral from the Network, compliance with the following Managed Benefits Provisions becomes the responsibility of the Member.

3.1 PRIOR APPROVAL PROCESS

This Benefit Plan requires Members to obtain Prior Approval before benefits are available for specified services, including:

- A. assisted reproductive technology for GIFT, ZIFT, ICSI and IVF;
- B. chronic pain management program;
- C. cosmetic surgeries;
- D. dental anesthesia and hospitalization for all Members age 9 and older;
- E. electric wheelchairs;
- F. growth hormone therapy/treatment;
- G. hearing aids for Members under age 18;
- H. human organ and tissue transplants, except kidney and cornea transplants;
- I. insulin infusion pump;
- J. intradiscal electrothermal therapy (IDET);
- K. lung volume reduction surgery;
- L. morbid obesity surgery;
- M. obstructive sleep apnea treatment;
- N. orthodontic services for the treatment of temporomandibular or craniomandibular joint disorders;
- O. osseointegrated implants;
- P. out-of-country services - all elective admissions and services received outside the United States;
- Q. Prosthetic Limbs replacement within 5 years;
- R. psychiatric or substance abuse Admissions out-of-state;
- S. Restricted Use Drugs;
- T. rhinoplasty;
- U. sleep studies; and
- V. weight loss Prescription Medications or Drugs.

To request Prior Approval, the Member or the Member's Health Care Provider, on the Member's behalf, must notify BCBSND of the Member's intent to receive services requiring Prior Approval. The Member's Health Care Provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary. This information must be submitted in writing from the Member's Health Care Provider.

A Member seeking Covered Services requiring Prior Approval designates the Authorized Representative to act and receive notices and information related to a Claim for Benefits on behalf of the Member pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. The Member agrees that all information and notifications related to the Claim for Benefits requiring Prior Approval is to be directed solely to the Authorized Representative unless the Member specifically requests that any notices or information also be delivered to the Member.

Receipt of Prior Approval does not guarantee payment of benefits. All services provided are subject to further review by BCBSND to ensure the services are Medically Appropriate and Necessary. Benefits will be denied if the Member is not eligible for coverage under this Benefit Plan on the date services are provided or if services received are not Medically Appropriate and Necessary as determined by BCBSND. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan.

Prior Approval is required prior to obtaining services.

Information on the guidelines and criteria for Prior Approval are available from Participating Health Care Providers and BCBSND upon written request.

3.2 **PREAUTHORIZATION**

Preauthorization to BCBSND is required by each Member or the Member's representative prior to services being provided for the following services:

- Inpatient Admissions to a Health Care Provider not participating with BCBSND;
- Skilled Nursing Facility;
- Long Term Acute Care Facility;
- Transitional Care Unit;
- Inpatient Admission to a Rehabilitation Facility;
- Hospice;
- Home Health Care; and
- Psychiatric and Substance Abuse Admissions, including Ambulatory Behavioral Health Care (Partial Hospitalization) or Residential Treatment. All out-of-state Admissions require Prior Approval from BCBSND. See Section 3.1.

Admissions for maternity services do not require Preauthorization.

If the Member's medical condition does not allow the Member to obtain Preauthorization due to an emergency Admission, the Member or the Member's representative is requested to notify BCBSND of the Admission during the next BCBSND business day or as soon thereafter as reasonably possible to obtain authorization.

Notification Responsibility

If a Member seeks Covered Services from a Health Care Provider that participates with BCBSND, the Participating Health Care Provider assumes responsibility for all Preauthorization requirements.

If a Member seeks Covered Services from a Health Care Provider that does not participate with BCBSND, compliance with Preauthorization requirements is the Member's responsibility.

BCBSND will issue a notice of authorization, partial authorization or denial of authorization following review of the Preauthorization request.

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

A Member seeking Covered Services requiring Preauthorization designates the Authorized Representative to act and receive notices and information related to a Claim for Benefits on behalf of the Member pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. The Member agrees that all information and notifications related to the Claim for Benefits requiring Preauthorization is to be directed solely to the Authorized Representative unless the Member specifically requests that any notices or information also be delivered to the Member.

Receipt of Preauthorization does not guarantee payment of benefits. All services provided are subject to further review by BCBSND to ensure the services are Medically Appropriate and Necessary. Benefits will be denied if the Member is not eligible for coverage under this Benefit Plan on the date services are provided or if services received are not Medically Appropriate and Necessary as determined by BCBSND. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan.

3.3 CONCURRENT REVIEW

Concurrent review is the ongoing review of the Medical Appropriateness and Necessity of the required Admissions outlined in Section 3.2 to an Institutional Health Care Provider. BCBSND will monitor the inpatient Admission to determine whether benefits will be available for continued inpatient care.

If BCBSND determines benefits are not available because the continued stay is not Medically Appropriate and Necessary, BCBSND will provide notice to the Member, the Member's attending Professional Health Care Provider or the Institutional Health Care Provider. No benefits will be available for services received after the date provided in BCBSND's notice of the termination of benefits.

3.4 DISCHARGE PLANNING

Discharge planning is the process of assessing the availability of benefits after a hospitalization. BCBSND supports discharge planning by providing information on benefits available for those services determined to be Medically Appropriate and Necessary for the Member's continued care and treatment.

3.5 CASE MANAGEMENT

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes.

Cases are identified for possible case management involvement based on a request for review or the presence of a number of parameters, such as:

- admissions that exceed the recommended or approved length of stay;
- utilization of health care services that generates ongoing and/or excessively high costs;
- conditions that are known to require extensive and/or long term follow up care and/or treatment.

Benefits under case management may be provided if BCBSND determines that the services are Medically Appropriate and Necessary, cost effective and feasible and that the total benefits for services do not exceed the Lifetime Maximum that the Member would otherwise be entitled to under this Benefit Plan.

All decisions made by case management are based on the individual circumstances of that Member's case. Each case is reviewed on its own merits and any benefits provided are under individual consideration.

SECTION 4 EXCLUSIONS

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

4.1 EXCLUSIONS

No benefits are available for:

1. Services not prescribed or performed by or under the direct supervision of a Professional Health Care Provider consistent with the Professional Health Care Provider's licensure and scope of practice.
2. Services provided and billed by a registered nurse (other than an Advanced Practice Registered Nurse), intern (professionals in training), licensed athletic trainer or other paramedical personnel.
3. Inpatient Admission services received prior to the effective date of the Member's eligibility under this Benefit Plan.
4. Special education, counseling, therapy or care for learning disorders or behavioral problems whether or not associated with a manifest mental disorder, mental retardation or other disturbance.
5. Sex therapy services or therapy for marital or family dysfunction.
6. Bereavement, codependency, marital dysfunction, family dysfunction, sex or interpersonal relationship counseling services.
7. Counseling services for the treatment of a gambling addiction or nicotine addiction.
8. Any drug, device, medical service, treatment or procedure that is Experimental or Investigative.
9. Services, treatments or supplies that BCBSND determines are not Medically Appropriate and Necessary.
10. Human organ and tissue transplants, except as specified in this Benefit Plan. Benefits are not available for donor organs or tissue other than human donor organs or tissue. Benefits are not available for autologous, allogeneic and syngeneic bone marrow transplants or other forms of stem cell rescue, together with all related services and supplies except as specifically allowed in the Covered Services Section of this Benefit Plan. In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

Related services and supplies include all services and supplies that BCBSND determines are not Medically Appropriate and Necessary for the patient's receipt of Chemotherapy or Radiation Therapy requiring stem cell support, and includes specifically and without limitation, Chemotherapy and Radiation Therapy when supported by transplant or other stem cell rescue procedures.

11. Chemotherapy or Radiation Therapy together with all related services and supplies when the dose or manner of administration is expected to result in damage to or suppression of the bone marrow, the blood or blood forming systems, warranting or requiring receipt by the patient of autologous, allogeneic, or syngeneic stem cells, or that are derived from the bone marrow or the peripheral blood, unless the procedure is specifically allowed in the Covered Services Section of this Benefit Plan.

Related services and supplies include all services and supplies that BCBSND determines are not Medically Appropriate and Necessary for the patient's receipt of Chemotherapy or Radiation Therapy requiring stem cell rescue and includes specifically and without limitation, all forms of bone marrow transplant or peripheral stem cell transplant.

12. Services that are related to annual, periodic or routine examinations, except as specifically allowed in the Covered Services Section of this Benefit Plan.
13. Immunizations, testing or other services required for foreign travel.
14. Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitarium care.
15. Services by a vocational residential rehabilitation center, a community reentry program, Halfway House or Group Home.

For the purpose of this exclusion, the following definitions apply:

Halfway House - a facility for the housing or rehabilitation of persons on probation, parole, or early release from correctional institutions, or other persons found guilty of criminal offenses or a facility for the housing or rehabilitation of alcoholics or drug dependent persons.

Group Home - a facility for the housing or rehabilitation of developmentally, mentally or severely disabled persons that does not provide skilled or intermediate nursing care.

16. The surgical or nonsurgical treatment of temporomandibular (TMJ) or craniomandibular (CMJ) joint disorder(s) when charges exceed the limits covered by this Benefit Plan. No benefits will be provided for orthodontic services (except as determined Medically Appropriate and Necessary and when Prior Approval is received from BCBSND) or osseointegrated implant surgery or related services performed for the treatment of temporomandibular or craniomandibular joint disorder(s).
17. Treatment leading to or in connection with sex change or transformation surgery and related complications.
18. All contraceptive medications, devices, appliances, supplies and related services when used for contraception, including contraceptive products that do not require a Prescription Order or dispensing by a Health Care Provider.
19. Evaluations and related procedures to evaluate sterilization reversal procedures and the sterilization reversal procedure.
20. Abortions, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation.

21. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of unfertilized sperm or eggs, Surrogate pregnancy and delivery, Gestational Carrier pregnancy and delivery, and preimplantation genetic diagnosis testing.

For the purpose of this exclusion, the following definitions apply:

Gestational Carrier - an adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.

Surrogate - an adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.

22. Medications obtained without a Prescription Order or for any charges for the administration of legend drugs or insulin that may be self-administered unless such administration is Medically Appropriate and Necessary.
23. Medical treatment and dietary management programs for obesity, except as specifically allowed in the Covered Services Section of this Benefit Plan. Benefits for surgical services performed for the treatment of morbid obesity are available only when Prior Approval is obtained from BCBSND. Benefits are subject to a Lifetime Maximum of 1 operative procedure per Member. A Lifetime Maximum of 1 revision will be allowed per Member due to technical staple line failure. Benefits are not provided for repair or modification of a gastric bypass/banding procedure.
24. Surgery and related services primarily intended to improve appearance and not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.
25. Standby services provided or billed by a Health Care Provider.
26. Biofeedback services.
27. Acupuncture services.
28. All forms of thermography for all uses and indications.
29. Testicular prostheses regardless of the cause of the absence of the testicle.
30. Orthotic Devices, Including orthopedic shoes and Home Medical Equipment required for leisure or recreational activities or to allow a Member to participate in sport activities unless Medically Appropriate and Necessary and approved by BCBSND.
31. Palliative or cosmetic foot care, foot support devices (except custom made support devices) or subluxations of the foot, care of corns, bunions (except for capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. Benefits are available for the care of corns, calluses and toenails when Medically Appropriate and Necessary for Members with diabetes or circulatory disorders of the legs or feet.
32. Dentistry or dental processes and related charges, Including extraction of teeth, dental appliances Including orthodontia placed in relation to a covered oral surgical procedure, removal of impacted teeth, root canal therapy or procedures relating to the structures supporting the teeth, gingival tissues or alveolar processes.
33. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits are available for routine vision examinations. No benefits are available for refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses.

34. Hearing aids or examinations for the prescription or fitting of hearing aids. Benefits are available for hearing aids for Members under age 18 when Prior Approval is received from BCBSND. No benefits are available for routine hearing examinations. No benefits are available for a tinnitus masker.
35. Services when benefits are provided by any governmental unit or social agency, except for Medicaid or when payment has been made under Medicare Part A or Part B. Medicare Part A and Part B will be considered the primary payor with respect to benefit payments unless otherwise required by federal law.
36. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.
37. Illness or bodily injury that arises out of and in the course of a Member's employment if benefits or compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.
38. Loss caused or contributed by a Member's commission or attempted commission of a felony (except losses caused or contributed by an act of domestic violence or any health condition) or a Member's involvement in an illegal occupation following the Member's enrollment in this Benefit Plan.
39. Any services when benefits are provided by a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, similar person or group.
40. Services provided by a Health Care Provider who is a member of the Member's Immediate Family.
41. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebeck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.

The following methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.

This exclusion also includes clinical ecology, orthomolecular therapy, vitamins or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.
42. Telephone consultations or charges for failure to keep a scheduled visit or charges for completion of any forms required by BCBSND.
43. Personal hygiene and convenience items, including air conditioners, humidifiers or physical fitness equipment.
44. Health screening assessment programs or health education services, including all forms of communication media whether audio, visual or written.
45. Health and athletic club membership or facility use, and all services provided by the facility, including Physical Therapy, sports medicine therapy and physical exercise.
46. Electronic speech aids, artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

47. Prosthetic Limbs or components intended only for cosmetic purposes, deluxe prosthetic knees controlled by microprocessors or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Member to participate in sport activities.
48. Physical Therapy Maintenance Care, Occupational Therapy Maintenance Care or Speech Therapy Maintenance Care, work hardening programs, prevocational evaluation, functional capacity evaluations or group speech therapy services.
49. Chiropractic maintenance care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent further problems.
50. Complications resulting from noncovered services received by the Member.
51. Services prescribed by, performed by or under the direct supervision of a Nonpayable Health Care Provider.
52. Services that a Member has no legal obligation to pay in the absence of this or any similar coverage.
53. Cost Sharing Amounts.
54. Services when Prior Approval was required but not obtained.
55. Smoking deterrents.
56. Massage therapy provided by a masseuse or masseur.
57. Low protein modified food products or medical food for maple syrup urine disease or phenylketonuria (PKU), to the extent those benefits are available under a department of health program or other state agency.
58. Collection and storage of umbilical cord blood.
59. Services, treatments or supplies not specified as a Covered Service under this Benefit Plan.

SECTION 5 GENERAL PROVISIONS

5.1 TIME LIMIT ON CERTAIN DEFENSES

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

5.2 MEMBER BILL AUDIT

Upon receiving notice of a claims payment from BCBSND, the Member is encouraged to audit their medical bills and notify BCBSND of any services which are improperly billed or services that the Member did not receive. If, upon audit of a bill an error of \$40 or more is found, the Member will receive a minimum payment of \$20 or 50% of the resulting savings for paid Covered Services up to a maximum payment of \$500.

To obtain payment through the Member Bill Audit Program, the Subscriber must complete a Member Bill Audit Refund Request Form. Forms are available from Blue Cross Blue Shield of North Dakota's NDPERS Service Unit.

This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim.

5.3 STATUS OF MEMBER ELIGIBILITY

The Plan Administrator agrees to furnish BCBSND with any information required by BCBSND for the purpose of enrollment. Any changes affecting a Member's eligibility for coverage must be provided to BCBSND by the Plan Administrator and/or the Member immediately, but in any event the Plan Administrator and/or the Member shall notify BCBSND within 31 days of the change.

Statements made on membership applications are deemed representations and not warranties. No statements made on the membership application may be used in any contest unless a copy has been furnished to that person, or in the event of the death or incapacity of that person, to the individual's beneficiary or personal representative. The Subscriber is provided a copy of the membership application at the time of completion.

5.4 PHYSICAL EXAMINATIONS

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

5.5 LIMITATION OF ACTIONS

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

5.6 PREMIUM REFUND/DEATH OF THE SUBSCRIBER

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

5.7 NOTIFICATION REQUIREMENTS AND SPECIAL ENROLLMENT PROVISIONS

- A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within 31 days of the change.
- B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within 31 days of the change.

- 1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period and the Eligible Dependent is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

If the membership application is submitted within 31 days of the date of marriage, the effective date of coverage for the Eligible Dependent will be the first of the month immediately following the date of marriage. If the membership application is not submitted within 31 days of the date of marriage and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

- 2. If, because of legal separation, divorce, annulment or death, the Subscriber's spouse is no longer eligible for coverage under this Benefit Plan, the Subscriber's spouse must apply within 31 days of legal separation, divorce, annulment or death to be eligible for continued health coverage. See Section 5.8.

Coverage for the Subscriber's spouse under Family Coverage will cease effective the first of the month immediately following legal separation, divorce, annulment or death.

The Subscriber's spouse must apply within 31 days of legal separation, divorce, annulment or death to be eligible for continuous health coverage under a separate benefit plan. If the Subscriber's spouse does not submit a membership application within 31 days, continuous health coverage under a separate benefit plan will not be available.

- C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and BCBSND of any change in family status within 31 days of the change.

The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date. The following provisions will apply:

- 1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within 31 days of the date of birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.
- 2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to BCBSND within 31 days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.
- 3. Children for whom the Subscriber or the Subscriber's living, covered spouse have been appointed legal guardian may be added to this Benefit Plan by submitting a membership application within 31 days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting a membership application within 31 days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.
5. If any of the Subscriber's children beyond the age of 23 are medically certified as mentally retarded or physically disabled, the Subscriber may continue their coverage under Family Coverage. Coverage will remain in effect as long as the child remains disabled, unmarried and financially dependent on the Subscriber or the Subscriber's living, covered spouse. BCBSND may request annual verification of a child's disability after coverage for a disabled child has been in effect for 2 years.

The Subscriber must provide proof of incapacity and dependency of a child's disability within 31 days after the end of the calendar year in which a child turns 23 or, if a child is beyond age 23, at the time of initial enrollment. If proof of incapacity and dependency for the dependent's disability is not made within 31 days and a lapse in coverage occurs, the child will be required to apply for coverage under a separate benefit plan. Medical qualification will be required.

6. If a child is no longer an Eligible Dependent under this Benefit Plan, the child must apply within 31 days of the loss of eligibility to be eligible for continuous health coverage under a separate benefit plan. See Section 5.8.
 7. At the time of birth or adoption, Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to BCBSND within 31 days of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision and the Eligible Dependent is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.
- D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:
1. During the initial enrollment period the employee or dependent states in writing that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
 2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
 - a. was either terminated as a result of loss of eligibility (including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special enrollment under the Benefit Plan but again choosing not to enroll, loss of other coverage triggered by a claim that meets or exceeds a lifetime benefit limitation or the Lifetime Maximum) or employer contributions toward such coverage were terminated; or
 - b. was under COBRA and the coverage was exhausted.
 3. The employee requests such enrollment within 31 days after the exhaustion or termination of coverage.

The effective date of coverage for an employee and/or dependent who previously declined coverage under this Benefit Plan and is enrolling pursuant to this provision will be the first of the month following the exhaustion or termination of the employee's and/or dependent's previous coverage. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

If the membership application is not received in accordance with this provision and the employee or dependent is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied and the effective date of coverage will be the Group's anniversary date.

5.8 CONTINUATION AND CONVERSION

A. Blue Cross Blue Shield Transfers

1. Inside the BCBSND Service Area

If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet BCBSND's requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:

- a. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion the Plan Administrator through which the Subscriber is eligible has terminated coverage with BCBSND and the Plan Administrator has enrolled with another insurance carrier.
- b. The Plan Administrator no longer meets BCBSND's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.
- c. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.
- d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under group membership as provided in Section 5.9 (A.)(1.)(c.). The Subscriber may elect conversion coverage on a nongroup basis, subject to premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for nongroup coverage within 31 days after the termination date of the previous group health plan coverage.

2. Outside the BCBSND Service Area

If a Member moves to the service area of another Blue Cross Blue Shield Plan and BCBSND premiums are billed to the new address, membership must be transferred to the Blue Cross Blue Shield Plan serving that new address. The new Blue Cross Blue Shield Plan must at least offer the Subscriber its conversion benefit plan. Conversion benefit plans provide coverage without medical qualification. If the Member accepts the conversion benefit plan, the new Blue Cross Blue Shield Plan will credit the Member for days of continuous membership with BCBSND toward the Waiting Periods of the conversion benefit plan. Any physical or mental conditions covered by this Benefit Plan will be covered by the conversion benefit plan without a new Waiting Period if the Blue Cross Blue Shield Plan offers that feature to other members carrying the same type of coverage. The premium rate and benefits available through the conversion benefit plan of the Blue Cross Blue Shield Plan may vary significantly from those offered by BCBSND.

B. Federal Continuation (COBRA)

This provision applies under amendments to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq. and the Public Health Service Act, 42 U.S.C. §300bb-1, et seq. These amendments are collectively referred to as "COBRA". COBRA provides for optional continuation coverage for certain Subscribers and/or Eligible Dependents under certain circumstances if the employer maintaining the group health plan normally employed 20 or more employees on a typical business day during the preceding calendar year. This provision is intended to comply with the law and any pertinent regulations and its interpretation is governed by them. This provision is not intended to provide any options or coverage beyond what is required by federal law. Subscribers should consult their Plan Administrator to find out if and how this provision applies to them and/or their Eligible Dependents.

A Subscriber covered by this Benefit Plan may have the right to choose continuation coverage if the Subscriber's group coverage is terminated because of a reduction in hours of employment or the termination of employment for reasons other than gross misconduct.

The spouse of the Subscriber covered by this Benefit Plan may have the right to choose continuation coverage if group coverage is terminated for any of the following reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment for reasons other than gross misconduct or a reduction in hours of employment;
3. Divorce or legal separation; or
4. The Subscriber becomes entitled to Medicare benefits.

A dependent child of the Subscriber covered by this Benefit Plan may have the right to continuation coverage if group coverage is terminated for any of the following reasons:

1. The death of the Subscriber;
2. The termination of the Subscriber's employment for reasons other than gross misconduct or reduction in a parent's hours of employment;
3. Parent's divorce or legal separation;
4. The Subscriber becomes entitled to Medicare; or
5. The dependent ceases to be an Eligible Dependent under this Benefit Plan.

A child who is born to a Subscriber or is placed for adoption with the Subscriber during the period of continuation coverage is eligible for COBRA coverage.

Continuation may apply in the event of a bankruptcy of the Group for certain retired Subscribers and their Eligible Dependents under certain conditions. If there is a bankruptcy of the Group, retired Subscribers and their Eligible Dependents should contact their Plan Administrator for more information.

The Subscriber or the Subscriber's Eligible Dependents have the responsibility to inform the Plan Administrator within 60 days of a divorce, legal separation or a child losing dependent status under this Benefit Plan. Where the Subscriber or an Eligible Dependent have been determined to be disabled under the Social Security Act, they must inform the Plan Administrator of such determination within 60 days after the date of the determination. The Subscriber or the Subscriber's Eligible Dependents are responsible for notifying the Plan Administrator within 30 days after the date of any final determination under the Social Security Act that the Subscriber or Eligible Dependent is no longer disabled.

When the Plan Administrator is notified that one of these events has occurred or has knowledge of the Subscriber's death, termination of employment, reduction in hours or Medicare entitlement, the Plan Administrator will notify the Subscriber or Eligible Dependents, as required by law of the right to choose continuation coverage. The Subscriber or Eligible Dependents has 60 days from the date coverage is lost, because of one of the events described above or 60 days from the date the Subscriber or Eligible Dependent is sent notice of his or her right to choose continuation coverage, whichever is later, to inform the Plan Administrator of the decision to continue coverage. If the Subscriber or Eligible Dependent does not choose continuation coverage, group coverage will terminate.

If the Subscriber chooses continuation coverage, the Plan Administrator is required to provide coverage identical to the coverage provided under the plan to similarly situated employees or family members. If group coverage is lost because of a termination of employment or reduction in hours, the Subscriber and Eligible Dependents may maintain continuation of coverage for 18 months. The law requires Eligible Dependents be given the opportunity to maintain continuation of coverage for 36 months in the event of the Subscriber's death, divorce, legal separation, or Medicare entitlement, or a child's loss of dependent status.

An 18-month extension of coverage is available to Eligible Dependents who elect continuation coverage if a second event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second event occurs is 36 months. A second event includes loss of dependency status. A second event occurs only if it causes an Eligible Dependent to lose coverage under the Plan as if the first event had not occurred. Eligible Dependents must notify the Plan Administrator within 60 days after the second event occurs. If group coverage is lost because of a termination of employment or reduction in hours and the Subscriber becomes entitled to Medicare benefits less than 18 months before the termination or reduction in hours, Eligible Dependents may maintain continuation coverage for up to 36 months after the date of Medicare entitlement.

A Subscriber or Eligible Dependent determined to have been disabled for Social Security purposes at the time of termination of employment or reduction in hours or who becomes disabled at any time during the first 60 days of COBRA continuation coverage and who provides notice of such determination to the Plan Administrator, may be entitled to receive up to an additional 11 months of continuation coverage, for a total maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage. If the individual entitled to the disability extension has nondisabled family members who are entitled to continuation coverage, those nondisabled family members also may be entitled to extend the continuation coverage to 29 months.

There is a second 60-day election period for certain individuals who lose group health coverage and are eligible for federal trade adjustment assistance. The second election period applies only to those individuals who did not elect continuation coverage under the initial 60-day election period and who meet federal trade adjustment assistance eligibility guidelines. The second 60-day election period begins on the first day of the month in which the individual is determined to be eligible for trade adjustment assistance, but in no event may elections be made later than 6 months after the loss of group coverage. If elected, continuation coverage will be measured from the date of loss of group coverage.

Notwithstanding the availability of continuation coverage, the law also provides that continuation coverage may be terminated for any of the following reasons:

1. The Group no longer provides group coverage to any of its employees;
2. Failure to make the premium payment;
3. The person receiving continuation coverage becomes covered under another benefit plan providing the same or similar coverage (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition of such person; (for plan years beginning on or after July 1, 1997, or later for certain plans maintained pursuant to one or more collective bargaining agreements, if the other benefit plan limits or excludes benefits for preexisting conditions but because of new rules applicable under the Health Insurance Portability and Accountability Act of 1996 those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage under this benefit plan, then this benefit plan can stop making the COBRA continuation coverage available to the individual); or
4. Entitlement to Medicare benefits.

Medical qualification is not required for a Subscriber to choose continuation of coverage. However, under the law a Subscriber may have to pay all or part of the premium for continuation coverage. The law also says that during the 180-day period ending on the expiration of the 18, 29 or 36-month continuation period, a Subscriber or Eligible Dependent who has chosen continuation coverage may be provided with the option of enrollment under a conversion health plan otherwise generally available under this Benefit Plan. A membership application must be submitted within 31 days to be eligible for conversion coverage. If a membership application is not submitted within the 31-day period, medical qualification will be required.

Conversion Privileges

When the 18 or 36-month continuation period has ended, the Subscriber will be given the opportunity of enrolling under a conversion health plan.

If ineligibility occurs because of a failure to make timely payment for health care coverage, the Subscriber will be given the opportunity of enrolling under a conversion health plan if application is made within 60 days of ineligibility.

Contact BCBSND's NDPERS Service Unit at 1-800-223-1704 with any questions or for further information on conversion privileges.

5.9 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

If the Benefit Plan is terminated, modified or amended, coverage is automatically terminated, modified or amended for all enrolled Members of the group health plan. It is the Plan Administrator's responsibility to notify Members of the termination of coverage.

5.10 NOTICE TO MOTHERS AND NEWBORNS

BCBSND generally may not, under state law (Section 26.1-36-09.8, N.D.C.C.), restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, state law generally does not prohibit the mother's or newborn's attending Health Care Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, BCBSND may not, under state law, require that a Health Care Provider obtain authorization from BCBSND for prescribing a length of stay not in excess of 48 hours (or 96 hours).

5.11 MEMBER - PROVIDER RELATIONSHIP

Benefits are available only for Medically Appropriate and Necessary services while under the care and treatment of a Health Care Provider. Nothing herein contained shall interfere with the professional relationship between the Member and his or her Health Care Provider.

If the Member remains in an institution after advice is received from the attending Physician that further hospitalization is unnecessary, the Subscriber shall be solely responsible to the institution for all charges incurred after he or she has been so advised. Further, BCBSND may at any time request the attending Physician to certify the necessity of further confinement. If the attending Physician does not certify that further confinement is necessary, the Member is not entitled to further benefits during the confinement.

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

A Member's medical care is between the Member and the Member's Health Care Provider, and this Benefit Plan only explains what is or is not covered, not what medical care the Member should seek.

Costs relating to any services subject to the managed benefits provisions that are not approved by BCBSND will not be covered. **The ultimate decision on the Member's medical care must be made by the Member and the Member's Health Care Provider. BCBSND only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.**

The Member agrees to conform to the rules and regulations of the Hospital in which he or she is a patient, including those rules governing Admissions and types and scope of services furnished by said Hospital.

5.12 BCBSND'S RIGHT TO RECOVERY OF PAYMENT

All Members expressly consent and agree to reimburse BCBSND for benefits provided or paid for which a Member was not eligible under the terms of this Benefit Plan. Such reimbursement shall be due and payable immediately upon notification and demand by BCBSND. Further, at the option of BCBSND, benefits or the Allowance therefore may be diminished or reduced as an off set toward such reimbursement. Acceptance of membership fees, or providing or paying benefits by BCBSND, shall not constitute a waiver of their rights to enforce these provisions in the future.

5.13 CONFIDENTIALITY

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

- A. Upon a written, dated, and signed authorization by the Member or prospective Member or by a person authorized to provide consent for a minor or an incapacitated person;
- B. If PHI identifies the Health Care Provider, upon a written, dated, and signed approval by the Health Care Provider. However, BCBSND may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. BCBSND may also disclose to a Health Care Provider, as part of a contract or agreement in which the Health Care Provider is a party, data or information that identifies a Health Care Provider as part of mutually agreed upon terms and conditions of the contract or agreement;
- C. If the data or information does not identify either the Member or prospective Member or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;

- D. Pursuant to statute or court order for the production or discovery of evidence; or
- E. In the event of a claim or litigation between the Member or prospective Member and BCBSND in which the PHI is pertinent.

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

5.14 **PRIVACY OF PROTECTED HEALTH INFORMATION**

BCBSND will not disclose the Member's Protected Health Information (PHI) to the Group unless the Group certifies that the Benefit Plan has been amended to incorporate the privacy restrictions required under federal and state law, and agrees to abide by them.

BCBSND will disclose the Member's PHI to the Group to carry out administrative functions under the terms of the Benefit Plan, but only in accordance with applicable federal and state law. Any disclosure to and use by the Group of the Member's PHI will be subject to and consistent with this section. BCBSND will not disclose the Member's PHI to the Group unless such disclosures are included in a notice of privacy practices distributed to the Member. BCBSND will not disclose the Member's PHI to the Group for actions or decisions related to the Member's employment or in connection with any other benefits made available to the Member.

The following restricts the Group's use and disclosure of the Member's PHI:

- A. The Group will neither use nor further disclose the Member's PHI except as permitted by the Benefit Plan or required by law.
- B. The Group will ensure that anyone who receives the Member's PHI agrees to the restrictions and conditions of the Benefit Plan with respect to the Member's PHI.
- C. The Group will not use or disclose the Member's PHI for actions or decisions related to the Member's employment or in connection with any other benefit made available to the Member.
- D. The Group will promptly report to the Plan Administrator any use or disclosure of the Member's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
- E. In accordance with federal law, the Group will make PHI available to the Member who is the subject of the information. Such information is subject to amendment and, upon proper notice, the Group will amend the Member's PHI where appropriate.
- F. The Group will document disclosures it makes of the Member's PHI so the Plan Administrator is able to provide an accounting of disclosures as required under applicable state and federal law.
- G. The Group will make its internal practices, books, and records relating to its use and disclosure of the Member's PHI available to the Plan Administrator and to the U.S. Department of Health and Human Services as necessary to determine compliance with federal law.

- H. The Group will, where feasible, return or destroy all Members PHI in whatever form or medium received from the Plan Administrator, including all copies of and any data or compilations derived from and allowing identification of any Member when the Member's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Group will limit the use or disclosure of any Member PHI to those purposes that make the return or destruction of the information infeasible.

5.15 **NOTICE OF PRIVACY PRACTICES**

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

5.16 **SECURITY MEASURES FOR ELECTRONIC PROTECTED HEALTH INFORMATION**

- A. The Group will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Members' electronic PHI that the Group creates, receives, maintains, or transmits on the Plan Administrator's behalf.
- B. The Group will report to the Plan Administrator any attempted or successful (1) unauthorized access, use, disclosure, modification, or destruction of Members' electronic PHI or (2) interference with the Group's system operations in the Group's information systems, of which the Group becomes aware, except any such security incident that results in disclosure of Members' PHI not permitted by the Benefit Plan must be reported to the Plan Administrator as required by 5.17 (D).
- C. The Group will support the adequate separation between the Group and the Plan Administrator, as specified in the Benefit Plan, with reasonable and appropriate security measures.

5.17 **RETROSPECTIVE DISCOUNT PAYMENT DISCLOSURE**

A Member may be required to pay Cost Sharing Amounts for each Prescription Medication or Drug provided under the terms of this Benefit Plan. A Member will pay these Cost Sharing Amounts directly to the Health Care Provider at the time the Prescription Medication or Drug is dispensed or administered.

In some cases, drug manufacturers may offer retrospective discount payments on certain specific Prescription Medications and Drugs dispensed or administered to Members under the terms of this Benefit Plan. Such retrospective discount payments from the manufacturer are not determined or paid by the manufacturer until at least one year following the date a Prescription Medication or Drug was provided to a Member under the terms of this Benefit Plan. A portion of these retrospective discount payments, if offered, is retained by an entity that performs pharmaceutical manufacturer discount program services through a contract with BCBSND on behalf of this Benefit Plan. Another portion of these retrospective discount payments, if offered, is paid to BCBSND. In its sole discretion, and only in the case where a Member is required to pay Coinsurance as part of the Cost Sharing Amounts for each Prescription Medication and Drug provided under the terms of this Benefit Plan, BCBSND may periodically refund to Members a proportional amount of any retrospective discount payments received. The calculation and payment of any such proportional refund rests in the sole discretion of BCBSND. The manner in which such retrospective discount program payment refund, if any, is distributed to a Member rests in the sole discretion of BCBSND. The Member waives any right, title, or interest in and to such proportional retrospective discount payment once the Member is no longer eligible for benefits under the terms of this Benefit Plan, and BCBSND may use its discretion and disburse any such retrospective discount payments as it deems appropriate and necessary in its administration of this Benefit Plan. The Member shall pay all Cost Sharing Amounts at the time the Prescription Medication or Drug is provided, without regard to any potential retrospective discount.

Pharmaceutical manufacturer discount program services Include the following: processing and handling of pharmaceutical manufacturer retrospective discounts for applicable claims; billing and collecting appropriate retrospective discounts on those claims from manufacturers; distributing payments in accordance with the terms of manufacturer discount program service agreements; formulary development, use and communication; benefit design analysis and consultation; annual analysis of claims data and recommendations; monthly utilization reporting; formulary appeals; and clinical services including physician and disease-state education programs.

5.18 **CERTIFICATE OF CREDITABLE COVERAGE**

A Member covered under this Benefit Plan may obtain a Certificate of Creditable Coverage by contacting BCBSND at the telephone number and address on the back of the Identification Card. A Certificate of Creditable Coverage will be provided to the Member within 31 days of this request.

When coverage under this Benefit Plan is terminated, BCBSND will, within 31 days, issue a Certificate of Creditable Coverage to the Subscriber. Upon notification by the Subscriber of the ineligibility of a dependent, a Certificate of Creditable Coverage will be issued to the affected Member within 31 days.

**SECTION 6
CLAIMS FOR BENEFITS AND APPEALS**

A Member may submit a Claim for Benefits by contacting BCBSND at the telephone number or address listed on the back of the Identification Card. The Member is responsible for providing BCBSND with a Claim for Benefits within 18 months after the date the benefits or services offered under this Benefit Plan were incurred. A Claim for Benefits must include the information necessary for BCBSND to determine benefits or services.

The Member may designate an Authorized Representative to pursue a Claim for Benefits or appeal an adverse determination from a Claim for Benefits. The designation of an Authorized Representative is limited in scope and not an assignment of benefits. It does not grant the Authorized Representative any of the Member's rights and privileges under the terms of this Benefit Plan. See Section 3, Managed Benefits.

Upon receipt of a Claim for Benefits under this Benefit Plan from a Member and/or the Member's Authorized Representative, the following claims review and appeals process applies:

Maximum Time Limits for Claims Processing

Type of Notice	Emergency Claim for Benefits	Pre-Service Claim for Benefits	Post-Service Claim for Benefits	Ongoing Course of Treatment Claim for Benefits
Initial Determinations (Plan) Extensions	72 Hours NONE	15 Days 15 Days	30 Days 15 Days	Notification "sufficiently in advance" of reduction or termination of benefits.*
Improperly Filed Claims (Plan)	24 Hours	5 Days	NONE	N/A
Additional Information Request (Plan)	24 Hours	15 Days	30 Days	N/A
Request for Appeal (Claimant)	180 Days	180 Days	180 Days	N/A
Appeal Determinations (Plan) Extensions	72 Hours NONE	30 Days NONE	60 Days NONE	As appropriate to the type of claim.

*If claim is made at least 24 hours before expiration of treatment and the claim involves an urgent care claim, BCBSND's decision must be made within 24 hours of receipt of the claim.

6.1 CLAIMS FOR BENEFITS INVOLVING PREAUTHORIZATION AND PRIOR APPROVAL (PRESERVICE CLAIMS FOR BENEFITS)

A. Claims for Benefits Requiring Preauthorization or Prior Approval.

1. Claims for Benefits Requiring Preauthorization or Prior Approval. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative that is conditioned on a Member obtaining approval in advance of obtaining the benefit or service, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days from receiving the claim. BCBSND may extend this initial time period an additional 15 days if BCBSND is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 15-day time period.

If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits, BCBSND will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 5 days after receipt of the Claim for Benefits and provide the Member and/or the Member's Authorized Representative with the proper procedures to be followed when filing a Claim for Benefits. BCBSND may also request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 15-day time period after receiving the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to properly file the Claim for Benefits and submit the requested information. After receiving the properly filed Claim for Benefits or additional or specified information, BCBSND shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days after receipt of the properly filed Claim for Benefits and additional information.

2. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, BCBSND will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.
3. Appeals of Claims for Benefits Requiring Preauthorization and Prior Approval. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits requiring Preauthorization or Prior Approval benefits or services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

B. Claims for Benefits Involving Emergency Care or Treatment

1. Claims for Benefits for Emergency Services. Upon receipt of a Claim for Benefits for Emergency Services from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 72 hours after receiving the Claim for Benefits.

If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits or the Claim for Benefits is incomplete and BCBSND requests additional or specified information, BCBSND will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 24 hours after receipt of the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or the request from BCBSND for additional or specified information, the Member and/or the Member's Authorized Representative has 48 hours to properly file the Claim for Benefits or to provide the requested information. After receiving the properly filed Claim for Benefits or requested information, BCBSND shall notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 48 hours after receipt of the additional or specified information requested by BCBSND or within 48 hours after expiration of the Member's time period to respond.

2. Appeals of Claims for Benefits for Emergency Services. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits for Emergency Services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination, whether adverse or not, as soon as possible but no later than 72 hours after receiving the Member's and/or the Member's Authorized Representative's request for review. A Member and/or a Member's Authorized Representative may request an appeal from a determination involving a Claim for Benefits for Emergency Services orally or in writing, and BCBSND will accept needed materials by telephone or facsimile.

6.2 ALL OTHER CLAIMS FOR BENEFITS (POST SERVICE CLAIM FOR BENEFITS)

- A. Claims for Benefits for All Other Services or Benefits. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days from receiving the Claim for Benefits and only if the determination is adverse to the Member. BCBSND may extend this initial time period in reviewing a Claim for Benefits an additional 15 days if BCBSND is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 30-day time period.

BCBSND may request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 30-day time period after receiving the Claim for Benefits. Upon receiving a request for additional or specified information, the Member and/or the Member's Authorized Representative has 14 days in which to submit the requested information. After receiving the additional or specified information, BCBSND shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receipt of the additional information.

- B. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For a Claim for Benefits involving services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, BCBSND will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.
- C. Appeals from Initial Claims for Benefits Determinations for All Other Claims for Services or Benefits. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 60 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

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

SECTION 7 OTHER PARTY LIABILITY

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

7.1 COORDINATION OF BENEFITS

This provision applies when a Member is enrolled under another plan (defined below), whether insured or self-funded, with a similar coordination of benefits provision. If the sum of benefits payable under this Benefit Plan and the other plan exceed the total allowable expense for Covered Services, the benefits payable under this Benefit Plan will be reduced so the sum of benefits payable under all plans does not exceed 100% of the total allowable expense for Covered Services.

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

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

- (1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- (2) If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- (3) If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- (4) If a Member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- (5) The amount of any benefit reduction by the primary plan because a Member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

"Plan" includes any of the following that provides benefits or services for medical or dental care or treatment: group and nongroup insurance contracts, health maintenance organization contracts, closed panel plans or other forms of group or group-type coverage; medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal government plan, as permitted by law. A "plan" does not include any of the following: hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

A plan that does not contain a coordination of benefits provision that is consistent with this Benefit Plan's provision is always primary unless the rules of both plans state that this Benefit Plan is primary. An exception exists for coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

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

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

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

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

2. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
 - b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph shall not apply with respect to any plan year during which Covered Services are paid or provided before the entity has actual knowledge of the court order provision. A copy of the court order must be provided to BCBSND upon request;
 - (2) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 7.1(A.)(2.)(a.) shall determine the order of benefits;
 - (3) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Section 7.1(A.)(2.)(a.) shall determine the order of benefits; or
 - (4) If there is no court order allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - a. The plan covering the custodial parent;
 - b. The plan covering the custodial parent's spouse;
 - c. The plan covering the non-custodial parent; and then
 - d. The plan covering the non-custodial parent's spouse.
 - c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Section 7.1(A.)(2.)(a.) or Section 7.1(A.)(2.)(b.) as if those individuals were parents of the child.
3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired, or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 7.1(A.)(1.) can determine the order of benefits.

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

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 7.1(A).(1.) can determine the order of benefits.

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

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

The start of a new plan does not include:

- a. A change in the amount or scope of a plan's benefits;
- b. A change in the entity that pays, provides or administers the plan's benefits; or
- c. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

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

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.
- B. If it is determined this Benefit Plan is secondary, the benefits of this Benefit Plan will be reduced so that the total benefits paid or provided by all plans during a Benefit Period are not more than the total allowable expenses. In determining the amount to be paid for any claim, this Benefit Plan will calculate the benefits it would have paid in the absence of coverage under another plan and apply that calculated amount to the allowable expense under this Benefit Plan that is unpaid by the primary plan. The benefits of this Benefit Plan will then be reduced so that they and the benefits payable under the other plans for the claim do not total more than 100% of the total allowable expense for that claim. When the benefits of this Benefit Plan are reduced as described in this subsection, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Plan. In addition, if this Benefit Plan has a deductible and/or coinsurance, the deductible and/or coinsurance will be credited with any amounts that would have been credited in the absence of the other plan.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

7.2 **AUTOMOBILE NO-FAULT OR MEDICAL PAYMENT BENEFIT COORDINATION**

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

7.3 **MEDICAL PAYMENT BENEFIT COORDINATION**

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

7.4 **RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT**

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

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

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

- A. Right of Assignment and/or Subrogation: If a Member fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), BCBSND has the right to bring said claim as the assignee and/or subrogee of the Member and to recover any benefits paid under this Benefit Plan.
- B. Right of Reimbursement: If a Member makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member must notify BCBSND of said recovery and must reimburse BCBSND to the full extent of any benefits paid by BCBSND, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member has not received full compensation for the injury or condition. Any recovery the Member may obtain is conclusively presumed to be for the reimbursement of benefits paid by BCBSND until BCBSND has been fully reimbursed.

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

7.5 **WORKERS' COMPENSATION**

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

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

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

SECTION 8 DEFINITIONS

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

- 8.1 **ADMISSION** - entry into a facility as an Inpatient or Outpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Member is discharged or released from the facility and is no longer registered as a patient.
- 8.2 **ALLOWANCE OR ALLOWED CHARGE** - the maximum dollar amount that payment for a procedure or service is based on as determined by BCBSND.
- 8.3 **AMBULATORY BEHAVIORAL HEALTH CARE** - the continuum of services provided for substance abuse and psychiatric illness less intensive than inpatient and more intensive than outpatient treatment. This continuum includes those services referred to as Partial Hospitalization or intensive outpatient treatment as long as the treatment meets or exceeds the minimum required for Partial Hospitalization.
- 8.4 **AMBULATORY (OUTPATIENT) SURGERY** - surgery performed in the outpatient department of a Hospital, Ambulatory Surgical Facility or Professional Health Care Provider's office.
- 8.5 **ANCILLARY SERVICES** - services required for the treatment of a Member in a Hospital, other than room, board and professional services.
- 8.6 **ANNUAL ENROLLMENT PERIOD** - a period of time an eligible employee or Eligible Dependent may apply for coverage under this Benefit Plan as a Late Enrollee. The Annual Enrollment Period will be a period of 31 days prior to the Group's anniversary date.
- 8.7 **AUTHORIZED REPRESENTATIVE** - a Health Care Provider or other individual authorized by the Member to inquire or request information on a Member.
- 8.8 **BASIC PLAN** - the Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level.
- 8.9 **BCBSND** - Blue Cross Blue Shield of North Dakota, a legal trade name of Noridian Mutual Insurance Company.
- 8.10 **BENEFIT PERIOD** - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a calendar year (January 1 through December 31) Benefit Period.
- 8.11 **BENEFIT PLAN** - the agreement with BCBSND, including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments.
- 8.12 **BENEFIT PLAN ATTACHMENT** - the statement accompanying the Identification Card that identifies current Benefit Plan information.
- 8.13 **BENEFIT PLAN NUMBER** - a number assigned by BCBSND and listed on the Identification Card that identifies the Subscriber for administrative purposes.
- 8.14 **BLUECARD PROGRAM** - The Blue Cross and Blue Shield Association, of which BCBSND is an independent licensee, has implemented the BlueCard Program. This allows Members seeking medical services outside BCBSND's (Home Plan) service area, access to the Health Care Provider discounts of the local Blue Cross and/or Blue Shield entity (Host Plan) participating in the BlueCard Program.

8.15 **CLAIM FOR BENEFITS** - a request for a benefit or benefits under the terms of this Benefit Plan made by a Member in accordance with BCBSND's reasonable procedures for filing a Claim for Benefits as outlined in Section 6, Claims for Benefits and Appeals. A Claim for Benefits includes both Claims for Benefits requiring Preauthorization and Prior Approval (Preservice Claim for Benefits) and all other Claims for Benefits (Post Service Claim for Benefits). A Claim for Benefits involving payment of a claim shall be made promptly and in accordance with state law.

8.16 **CLASS OF COVERAGE** - the type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage are as follows:

- A. **Single Coverage** - Subscriber only.
- B. **Family Coverage** - Subscriber and Eligible Dependents.

8.17 **COST SHARING AMOUNTS** - the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Applicable Cost Sharing Amounts are identified on the Benefit Plan Attachment. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. See Section 1, Schedule of Benefits for the specific Cost Sharing Amounts that apply to this Benefit Plan.

- A. **Coinsurance Amount** - a percentage of the Allowed Charge for Covered Services that is a Member's responsibility.

BCBSND shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the BCBSND service area on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

If Covered Services are obtained by a Member out of the BCBSND service area, the local Blue Cross Blue Shield Plan's (Host Plan) provider contract may require coinsurance calculation that is not based on the discounted price the Health Care Provider has agreed to accept from the Host Plan. Rather, it may be based on the Health Care Provider's billed charges. This may result in a significantly higher Coinsurance Amount for certain services a Member incurs out of the BCBSND service area. It is not possible to provide specific information for each out-of-area Health Care Provider because of the many different arrangements between Host Plans and Health Care Providers. However, if a Member contacts BCBSND prior to incurring out-of-area services, BCBSND may be able to provide information regarding specific Health Care Providers.

- B. **Coinsurance Maximum Amount** - the total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period.
- C. **Copayment Amount** - a specified dollar amount payable by the Member for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service. Copayment Amounts do not apply toward the Out-of-Pocket Maximum Amount or the Prescription Medication or Drug Coinsurance Maximum Amount.
- D. **Deductible Amount** - a specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period. The Deductible Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward the Deductible Amount.

The Deductible Amounts for Covered Services received from a PPO Health Care Provider or on a Basic Plan basis accumulate jointly up to the PPO Deductible Amount.

- E. **Out-of-Pocket Maximum Amount** - the total Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility during a Benefit Period. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts and the Outpatient Prescription Medication or Drug Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider or on a Basic Plan basis accumulate jointly up to the PPO Out-of-Pocket Maximum Amount. When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. Covered Services sought on a Basic Plan basis will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.

- F. **Prescription Medication or Drug Coinsurance Maximum Amount** - the total Formulary Coinsurance Amount for Outpatient Prescription Medications or Drugs that is a Member's responsibility during a Benefit Period. When this Coinsurance Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Outpatient Prescription Medications or Drugs, less Copayment Amounts incurred during the remainder of the Benefit Period. This Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward this Coinsurance Maximum Amount.

- G. **Infertility Services Deductible Amount** - a specified dollar amount payable by the Member during their lifetime for infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.

8.18 **COVERED SERVICE** - Medically Appropriate and Necessary services and supplies for which benefits are available when provided by a Health Care Provider.

8.19 **CUSTODIAL CARE** - care that BCBSND determines is designed essentially to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.

8.20 **DIAGNOSTIC SERVICE** - a test or procedure provided because of specific symptoms and directed toward the determination of a definite condition. A Diagnostic Service must be ordered by a Professional Health Care Provider. Diagnostic Services include, but are not limited to X-ray and other imaging services, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

8.21 **ELIGIBLE DEPENDENT** - a dependent of the Subscriber who qualifies for membership under this Benefit Plan in accordance with the requirements specified below:

- A. The Subscriber's spouse under a legally existing marriage between persons of the opposite sex.
- B. The Subscriber's or the Subscriber's living, covered spouse's unmarried children under the age of 23 years who are financially dependent on the Subscriber or the Subscriber's spouse. Children are considered under age 23 until the end of the month in which the child becomes 23 years of age. The term child or children includes:
 1. Children physically placed with the Subscriber for adoption or whom the Subscriber or the Subscriber's living, covered spouse has legally adopted.
 2. Children living with the Subscriber for whom the Subscriber or the Subscriber's living, covered spouse has been appointed legal guardian by court order.

3. The Subscriber's grandchildren or those of the Subscriber's living, covered spouse if: (a) the parent of the grandchild is a covered Eligible Dependent under this Benefit Plan and (b) both the parent and the grandchild are primarily dependent on the Subscriber for support. If a lapse in coverage occurs due to ineligibility of the parent under this Benefit Plan, the grandchild cannot be reenrolled unless the Subscriber has been appointed legal guardian.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits.
5. Children beyond the age of 23 who are full-time students at accredited institutions who are financially dependent on the Subscriber or the Subscriber's spouse. Coverage in such cases will be continued only until the end of the month in which the child becomes 26 years of age. An accredited institution is defined as an institution of higher education offering a degree or certificate in a specific field or trade for which the recipient may gain employment after completing course work. The institution must be licensed, certified or accredited.
6. Children beyond the age of 23 who are incapable of self support because of mental retardation or physical handicap that began before the child attained age 23 and who are primarily dependent on the Subscriber or the Subscriber's spouse for support. Coverage for such a disabled child will continue for as long as the child remains unmarried, disabled and the Subscriber's dependent for federal income tax purposes. The Subscriber may be asked periodically to provide evidence satisfactory to BCBSND of these disabilities.

8.22 **EMERGENCY MEDICAL CONDITION** - a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any 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.

8.23 **EMERGENCY SERVICES** - health care services, supplies or treatments furnished or required to screen, evaluate and treat an Emergency Medical Condition.

8.24 **ENROLLMENT DATE** - the first day of coverage or, if there is a Probation Period, the first day of the Probation Period.

8.25 **EXPERIMENTAL OR INVESTIGATIVE** - a drug, device, medical service, treatment or procedure is Experimental or Investigative if:

- A. the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- B. the drug, device, medical service, treatment or procedure, or the patient informed consent document utilized with the drug, device, medical service, treatment or procedure was reviewed and approved by the treating facility's institutional review board as required by federal law; or
- C. BCBSND determines that there exists reliable evidence that the drug, device, medical service, treatment or procedure
 1. is the subject of ongoing phase 1 or phase 2 clinical trials,
 2. is the research, experimental, study or investigational arm of an ongoing phase 3 clinical trial, or
 3. is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

- D. BCBSND determines that there exists reliable evidence with respect to the drug, device, medical service, treatment or procedure and that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of reliable treatment or diagnosis; or
- E. BCBSND determines that based on prevailing medical evidence the drug, device, medical service, treatment or procedure is Experimental or Investigative.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical service, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical service, treatment or procedure.

- 8.26 **EXPLANATION OF BENEFITS** - a document sent to the Member by BCBSND after a claim for reimbursement has been processed. It includes the patient's name, claim number, type of service, Health Care Provider, date of service, charges submitted for the services, amounts covered by this Benefit Plan, noncovered services, Cost Sharing Amounts and the amount of the charges that are the Subscriber's responsibility. This form should be carefully reviewed and kept with other important records.
- 8.27 **GROUP** - NDPERS has signed an agreement with BCBSND to provide health care benefits for its eligible employees and Eligible Dependents, [see definition 8.21](#).
- 8.28 **HEALTH CARE PROVIDER** - Institutional or Professional Health Care Providers providing Covered Services to Members as listed below. The Health Care Provider must be licensed, registered or certified by the appropriate state agency where the Covered Services are performed and provided in accordance with the Health Care Provider's scope of licensure as provided by law. Where there is no appropriate state agency, the Health Care Provider must be registered or certified by the appropriate professional body. A Health Care Provider includes but is not limited to:
 - A. **Advanced Practice Registered Nurse** - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner or Psychiatric Nurse.
 - B. **Ambulance** - a specially designed or equipped vehicle used only for transporting the critically ill or injured to a health care facility. The ambulance service must meet state and local requirements for providing transportation for the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.
 - C. **Ambulatory Surgical Facility** - a facility with an organized staff of Professional Health Care Providers that:
 1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
 2. provides treatment by or under the direct supervision of a Professional Health Care Provider;
 3. does not provide inpatient accommodations; and
 4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Health Care Provider.
 - D. **Audiologist**.
 - E. **Certified Diabetes Educator (C.D.E.)**.
 - F. **Chiropractor** - a Doctor of Chiropractic (D.C.).
 - G. **Dentist** - a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.).

- H. **Home Health Agency** - an agency providing, under the direction of a Professional Health Care Provider, skilled nursing and related services to persons in their place of residence.
- I. **Home Infusion Therapy Provider.**
- J. **Home Medical Equipment Supplier.**
- K. **Hospice** - an organization that provides medical, social and psychological services in the home or inpatient facility as palliative treatment for patients with a terminal illness and life expectancy of less than 6 months.
- L. **Hospital** - an institution that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Professional Health Care Providers.
- M. **Independent Clinical Laboratory** - a medical laboratory providing Diagnostic Services that is approved for reimbursement by BCBSND and is not affiliated or associated with a Hospital or Professional Health Care Provider otherwise providing patient services.
- N. **Licensed Addiction Counselor.**
- O. **Licensed Clinical Psychologist** - a licensed psychologist with a doctorate degree in psychology who is eligible for listing in the National Register of Health Service Providers in Psychology.
- P. **Licensed Independent Clinical Social Worker** - an individual who has a doctorate or master's degree in social work from a college or university and who has fulfilled the requirements for licensure or has been registered by the North Dakota Board of Social Work Examiners for third party reimbursement before August 1, 1997.
- Q. **Licensed Professional Clinical Counselor.**
- R. **Licensed Registered Dietitian.**
- S. **Long Term Acute Care Facility** - a facility that provides long-term acute hospital care for medically complex conditions or specialized treatment programs.
- T. **Mobile Radiology Supplier.**
- U. **Occupational Therapist.** [see 8.74](#)
- V. **Optometrist** - a Doctor of Optometry (O.D.).
- W. **Oral Pathologist** - a Doctor of Dental Surgery (D.D.S.) meeting all formal requirements for certification by the American Board of Oral Pathologists.
- X. **Oral Surgeon** - a Doctor of Dental Surgery (D.D.S.) meeting all formal requirements for certification by the American Board of Oral Surgery.
- Y. **Pain Treatment Facility** - a facility that has satisfied the CARF accreditation requirements of a chronic pain management program.
- Z. **Pharmacist.**
- AA. **Pharmacy** - an establishment where the profession of pharmacy is practiced by a Pharmacist.
- BB. **Physical Therapist.** [see](#)
- CC. **Physician** - a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

- DD. **Physician Assistant.**
- EE. **Podiatrist** - a Doctor of Podiatry (D.P.), a Doctor of Surgical Chiropractic (D.S.C.), a Doctor of Podiatric Medicine (D.P.M.) or a Doctor of Surgical Podiatry (D.S.P.).
- FF. **Psychiatric Care Facility** - an institution or a distinct part of an institution providing diagnostic and therapeutic services for the inpatient treatment of mental illness under the direct supervision of a Professional Health Care Provider.
- GG. **Rehabilitation Facility** - an institution or a distinct part of an institution providing Rehabilitative Therapy.
- HH. **Residential Treatment Center.**
- II. **Respiratory Therapist.**
- JJ. **Skilled Nursing Facility** - an institution or a distinct part of an institution providing skilled nursing and related services to persons on an inpatient basis under the direct supervision of a Professional Health Care Provider.
- KK. **Sleep Lab.**
- LL. **Speech Therapist.** [see](#)
- MM. **Substance Abuse Facility** - an institution or a distinct part of an institution providing detoxification or rehabilitation treatment for alcohol or other drug abuse.
- NN. **Transitional Care Unit** - a sub-acute unit of a Hospital that provides skilled services necessary for the transition between Hospital and home or to a lower level of care.
- 8.29 **HOME HEALTH CARE** - Skilled Nursing Services provided under active Physician and nursing management through a central administrative unit coordinated by a registered nurse. Benefit eligibility requires that the Member's medical condition must be such that, without the availability of Skilled Nursing Services, the Member would require inpatient care.
- 8.30 **HOME HEALTH VISIT** - the provision of skilled nursing and other therapeutic services up to a maximum of 8 hours per day to a Member confined to their home.
- 8.31 **HOME MEDICAL EQUIPMENT** - items that can withstand repeated use and are primarily used to serve a medical purpose outside of a health care facility. Such items would not be of use to a person in the absence of illness, injury or disease.
- 8.32 **IDENTIFICATION CARD** - a card issued in the Subscriber's name identifying the Benefit Plan Number and the Network of the Member. If a Member is also enrolled in a primary Medicare Part D Plan, a card for this Benefit Plan may be issued in the Member's name.
- 8.33 **IMMEDIATE FAMILY** - a person who ordinarily resides in a Member's household or is related to the Member, including a Member's parent, sibling, child or spouse, whether the relationship is by blood or exists in law.
- 8.34 **INCLUDING** - means including, but not limited to.
- 8.35 **INPATIENT** - a person confined as a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.
- 8.36 **INSTITUTIONAL HEALTH CARE PROVIDER** - an Ambulance, Home Health Agency, Home Medical Equipment Supplier, Hospital, Long Term Acute Care Facility, Mobile Radiology Supplier, Pain Treatment Facility, Pharmacy, Psychiatric Care Facility, Rehabilitation Facility, Residential Treatment Center, Skilled Nursing Facility, Sleep Lab, Substance Abuse Facility or Transitional Care Unit.

- 8.37 **LATE ENROLLEE** - an eligible employee or Eligible Dependent who requests enrollment under this Benefit Plan after the initial enrollment period when the individual was entitled to enroll under the terms of this Benefit Plan and applies for coverage during the Annual Enrollment Period. However, an eligible employee or Eligible Dependent may not be considered a Late Enrollee if:
- A. The individual:
 - 1. was covered under Qualifying Previous Coverage at the time of the initial enrollment;
 - 2. lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage, death of a spouse or divorce; and
 - 3. requests enrollment within 31 days after termination of the Qualifying Previous Coverage.
 - B. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.
 - C. A court has ordered coverage be provided for a spouse or minor or dependent child under the eligible employee's Benefit Plan and the request for enrollment is made within 30 days after issuance of the court order.
 - D. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.
- 8.38 **LIFETIME MAXIMUM** - the total dollar amount of Covered Services an eligible Member may receive during a lifetime while enrolled under a Benefit Plan sponsored by the Group. The benefit amounts paid under all previous Benefit Plans sponsored by the Group will be applied toward the Lifetime Maximum of this Benefit Plan.
- 8.39 **MAINTENANCE CARE** - treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. Exception: periodic reassessments are not considered Maintenance Care.
- 8.40 **MAXIMUM BENEFIT ALLOWANCE** - the maximum amount of benefits expressed in dollars, days or visits, available under this Benefit Plan for a specified Covered Service.
- 8.41 **MEDICAL DIRECTOR** - the Physician designated by BCBSND and the Network to oversee and direct all matters pertaining to the management of the benefits for medical care and treatment.
- 8.42 **MEDICALLY APPROPRIATE AND NECESSARY** - services, supplies or treatments provided by a Health Care Provider to treat an illness or injury that satisfy all the following criteria as determined by BCBSND:
- A. The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the Member's illness or injury;
 - B. The services, supplies or treatments are consistent with professionally recognized standards of health care; and
 - C. The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the Member's illness or injury.
- 8.43 **MEMBER** - the Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents.
- 8.44 **NONPARTICIPATING HEALTH CARE PROVIDER** - a Health Care Provider that does not have a participation agreement with BCBSND.

- 8.45 **NONPAYABLE HEALTH CARE PROVIDER** - a Health Care Provider that is not reimbursable by BCBSND. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Nonpayable Health Care Provider.
- 8.46 **OFFICE VISIT** - a professional service, including an examination for the purpose of diagnosing or treating an illness or injury or the determination, initiation or monitoring of a treatment plan provided in an outpatient setting by a Professional Health Care Provider.
- 8.47 **ORTHOTIC DEVICES** - any rigid or semi-rigid supportive device that restricts or eliminates the motion of a weak or diseased body part.
- 8.48 **OUTPATIENT** - a person treated as a registered Outpatient at a Hospital, clinic or in a Professional Health Care Provider's office, who is not, at the time of treatment, a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.
- 8.49 **PARTIAL HOSPITALIZATION** - continuous treatment of mental illness or substance abuse by a Health Care Provider for at least 3 hours, but not more than 12 hours in any 24-hour period. Preauthorization is required.
- 8.50 **PARTICIPATING HEALTH CARE PROVIDER** - a Health Care Provider that has entered into a participation agreement with BCBSND to provide Covered Services to a Member for an agreed upon payment.
- 8.51 **PARTICIPATING PHARMACY** - a Pharmacy that has entered into an agreement with BCBSND's Preferred Pharmacy Network.
- 8.52 **PLAN ADMINISTRATOR** - the administrator of the Plan as defined by Section 3(16) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").
- 8.53 **PREAUTHORIZATION** - the process of the Member or the Member's representative notifying BCBSND to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions of Section 3.2. Preauthorization does not guarantee payment of benefits.
- 8.54 **PREEXISTING CONDITION** - a condition, disease, illness or injury for which the Member received medical advice or treatment within the 6-month period immediately preceding the Member's Enrollment Date under this Benefit Plan. Pregnancy is not considered a Preexisting Condition.
- 8.55 **PRESCRIPTION MEDICATION OR DRUG** - any legend drug, Payable Over-the-Counter Drug, biologic or insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of the disease or illness for which the Member is receiving care.
- A. **Brand Name** - the registered trademark name of a Prescription Medication or Drug by its manufacturer, labeler or distributor.
 - B. **Formulary Drug** - a Brand Name or Generic Prescription Medication, Drug, or diabetes supply that is a safe, therapeutically effective, high quality and cost effective drug as determined by a committee of Physicians and Pharmacists.
 - C. **Generic** - the established name or official chemical name of the drug, drug product or medicine.
 - D. **Nonformulary Drug** - a Prescription Medication, Drug, or diabetes supply that is not a Formulary Drug.
 - E. **Nonpayable Drug** - a Prescription Medication or Drug that is not reimbursed by BCBSND or is included in Section 4, Exclusions.

F. **Payable Over-the-Counter (OTC) Drug** - a medication or drug approved by the U.S. Food and Drug Administration for marketing without a Prescription Order and approved by BCBSND when dispensed by a Pharmacist upon the receipt of a Prescription Order.

G. **Restricted Use Drug** - a Prescription Medication or Drug that may require Prior Approval and/or be subject to a limited dispensing amount.

8.56 **PRESCRIPTION ORDER** - the order for a Prescription Medication or Drug issued by a Professional Health Care Provider licensed to make such order in the ordinary course of professional practice.

8.57 **PRIOR APPROVAL** - the process of the Member or Member's representative providing information to BCBSND substantiating the medical appropriateness of specified services to BCBSND in order to receive benefits for such service. This information must be submitted in writing from the Member's Health Care Provider. BCBSND reserves the right to deny benefits if Prior Approval is not obtained.

8.58 **PROBATION PERIOD** - the period that must pass before an employee or dependent is eligible for coverage in a group health plan.

8.59 **PROFESSIONAL HEALTH CARE PROVIDER** - an Advanced Practice Registered Nurse, Ambulatory Surgical Facility, Audiologist, Certified Diabetes Educator, Chiropractor, Dentist, Home Infusion Therapy Provider, Independent Clinical Laboratory, Licensed Addiction Counselor, Licensed Clinical Psychologist, Licensed Independent Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Registered Dietitian, Occupational Therapist, Optometrist, Oral Pathologist, Oral Surgeon, Pharmacist, Physical Therapist, Physician, Physician Assistant, Podiatrist, Respiratory Therapist or Speech Therapist as defined.

8.60 **PROSTHETIC APPLIANCE** - a fixed or removable artificial body part that replaces an absent natural part, excluding Prosthetic Limbs.

8.61 **PROSTHETIC LIMB** - a fixed or removable artificial body part that replaces all or part of an absent arm or leg.

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

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

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

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

- A. A group health benefit plan;
- B. A health benefit plan;
- C. Medicare;
- D. Medicaid;
- E. TRICARE (the health care program for military dependents and retirees);
- F. A medical care program of the Indian health service or of a tribal organization;
- G. A state health benefit risk pool, including coverage issued under N.D. Cent. Code §26.1-08;
- H. A health plan offered under §5 U.S.C. 89;
- I. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government or a foreign government;
- J. A health benefit plan under §5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and
- K. A state children's health insurance program (SCHIP).

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

8.64 **RESIDENTIAL TREATMENT** - a 24 hour a day program under the clinical supervision of a Health Care Provider, in a residential treatment center other than an acute care hospital, for the active treatment of chemically dependent or mentally ill persons. The residential treatment center must be licensed by the state of North Dakota. If the residential treatment center is located outside the state of North Dakota, it must meet the North Dakota licensure requirements. Preauthorization is required.

8.65 **SKILLED NURSING SERVICES** - services that can be safely and effectively performed only by or under the direct supervision of licensed nursing personnel and under the direct supervision of a Professional Health Care Provider.

8.66 **SPECIAL CARE UNIT** - a section, ward or wing within a Hospital operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered nurses or other highly trained personnel, excluding any section, ward or wing within a Hospital maintained for the purpose of providing normal postoperative recovery treatment services.

8.67 **SUBSCRIBER** - an employee whose application for membership has been accepted, whose coverage is in force with BCBSND and in whose name the Identification Card and Benefit Plan Attachment are issued. A Subscriber is an eligible employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled and actually covered under this Benefit Plan.

8.68 **SURGICAL SERVICES** - the performance of generally accepted operative and cutting procedures by a Professional Health Care Provider.

8.69 **THERAPY SERVICES** - the following services when provided according to a prescribed plan of treatment ordered by a Professional Health Care Provider and used for the treatment of an illness or injury to promote recovery of the Member:

- A. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents approved and administered in accordance with the approval granted by the U.S. Food and Drug Administration and/or listed as an accepted unlabeled use by the current edition of the USPDI Drug Information for the Health Care Professional and is determined by BCBSND to have been administered in accordance with standard medical practice.
- B. **Dialysis Treatment** - the process of diffusing blood across a semipermeable membrane to remove toxic materials and to maintain fluid, electrolyte and acid-base balance in cases of impaired kidney function or absence of the kidneys.

- C. **Occupational Therapy** - the treatment of physical or psychological dysfunction by or under the direct supervision of a licensed Occupational Therapist designed to improve and maximize independence in perceptual-motor skills, sensory integrative functioning, strength, flexibility, coordination, endurance, essential activities of daily life and preventing the progression of a physical or mental disability.
- D. **Physical Therapy** - the treatment of disease, injury or medical condition by the use of therapeutic exercise and other interventions by or under the direct supervision of a licensed Physical Therapist that focuses on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, age appropriate motor skills, alleviating pain and preventing the progression of a physical or mental disability.
- E. **Radiation Therapy** - the treatment of disease by the flow of a radiation beam of therapeutically useful radiant energy, through a defined area; Including emission of X-rays, gamma rays, electrons or other radiations from a treatment machine.
- F. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs when performed by or under the direct supervision of a registered or certified Respiratory Therapist.
- G. **Speech Therapy** - the treatment of speech and language disorders that result in communication disabilities and swallowing disorders when provided by or under the direct supervision of a certified and licensed Speech Therapist. Speech Therapy services facilitate the development of human communications and swallowing through assessment, diagnosis and treatment when disorders occur due to disease, surgery, trauma, congenital anomaly or prior therapeutic process.

ADMINISTRATIVE SERVICE AGREEMENT

This Administrative Service Agreement ("Agreement") is entered into between North Dakota Public Employees Retirement System (NDPERS) ("the Plan Sponsor"), North Dakota Public Employees Retirement System (NDPERS) ("the Plan Administrator") and Blue Cross Blue Shield of North Dakota ("BCBSND"), the terms of which are as follows:

The Plan Sponsor has established and maintains a fully insured group health plan (the Plan) which provides, among other things, various benefits to Members in the Plan, as set forth in the Certificate of Insurance provided to plan Members. The Plan Administrator is the administrator of the Plan established through this Agreement.

In consideration of payment of required premium and acceptance of membership applications, BCBSND enters into this Agreement with the Plan Sponsor and the Plan Administrator. BCBSND agrees to provide plan Members the benefits set forth in the Certificate of Insurance, in accordance with its terms and conditions. This Agreement also includes the Certificate of Insurance, membership applications, Identification Cards, Benefit Plan Attachments and any endorsements, supplements, attachments, addenda or amendments.

1. **EFFECTIVE DATE:**

This agreement is effective July 1, 2009 through June 30, 2011, unless terminated as provided.

2. **DEFINITIONS**

This section defines the terms used in this Agreement. These terms will be capitalized throughout this Agreement when referred to in the context defined.

- A. **BENEFIT PAYMENTS** - payments of benefits under the Plan.
- B. **CERTIFICATE OF CREDITABLE COVERAGE** - a certificate disclosing information relating to an individual's creditable coverage under a health care benefit program for purposes of reducing any preexisting condition waiting period imposed by any group health plan coverage.
- C. **CLAIM** - notification in a form acceptable to BCBSND that service has been provided or furnished to a Member.
- D. **DRG** - shall mean diagnostic related groups.
- E. **DATA AGGREGATION** - the combining of Protected Health Information that BCBSND creates or receives for or from the Plan and for or from other health plans or health care providers for which BCBSND is acting as a business associate to permit data analyses that relate to the Health Care Operations of the Plan and those other health plans or providers.
- F. **FEES AND CHARGES** - the amounts the Plan Administrator must pay BCBSND for the administrative services described in Section 6. FEES AND CHARGES.
- G. **HEALTH CARE OPERATIONS** - any of the activities of a health plan to the extent the activities relate to functions that make it a health plan.
- H. **HEALTH CARE PROVIDER** - any eligible provider that has provided care, diagnosis, or treatment to or for a Member for which benefits are sought under the Plan.
- I. **INELIGIBLE PERSON** - any person, firm, or corporation that has received benefits or on whose behalf benefits have been paid but for whom benefits are not payable under the terms of the Plan.

- J. **MEMBER** - the Subscriber and any dependent of a Subscriber or any other person designated by a Subscriber or by the terms of the Plan who is or may become entitled to a benefit under the Plan. The term shall also include any proprietor, partner, or owner of the Plan Sponsor, if any, who is designated by the terms of the Plan who is or may become entitled to a benefit under the Plan. In no case shall the term Member include any person not otherwise entitled to coverage under the terms of the Plan.

For the purposes of determining the various benefits and restrictions or other limitations thereto made available to a Member under the terms of this Agreement, all benefits under any Plan option or tier (and any restrictions or other limitations thereto) made available to or received by a Member shall accumulate toward that Member's benefits and any restrictions and other limitations thereto.

- K. **PAYMENT** - activities undertaken to obtain premiums, determine or fulfill coverage and benefits, or obtain or provide reimbursement for health care services.

- L. **PLAN ADMINISTRATOR - NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM.** North Dakota Public Employees Retirement System (NDPERS) is the administrator of the Plan, with all of the duties and responsibilities applicable to plan administrators, including but not necessarily limited to compliance with any and all administrative, reporting, and disclosure requirements. BCBSND is not the Plan Sponsor or the Plan Administrator of the Plan and is not responsible for any of the duties assigned to the Plan Sponsor or the Plan Administrator by the terms of the Plan, or by this Agreement.

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

1. is created by or received from a Health Care Provider, health care employer, or health care clearinghouse;
2. relates to a Member's past, present or future physical or mental health or condition;
3. relates to the provision of health care to a Member;
4. relates to the past, present, or future payment for health care to or on behalf of a member; or
5. identifies a Member or could reasonably be used to identify a Member.

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

- N. **SECURITY INCIDENT** - any attempted or successful unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with BCBSND's system operations in BCBSND's information systems.

- O. **STANDARD TRANSACTIONS** - health care financial or administrative transactions conducted electronically for which standard data elements, code sets and formats have been adopted in accordance with federal or state law.

- P. **SUBSCRIBER** - any employee of the Plan Sponsor who is or may become eligible to receive a benefit under the Plan. The term includes all common law employees and possibly proprietors, partners, or other owners who work for the Plan Sponsor and are otherwise entitled to coverage under the Plan. Notwithstanding the above, in no case shall the term Subscriber include any person not otherwise entitled to coverage under the terms of the Plan.

- Q. **SUCCESSFUL SECURITY INCIDENTS** - Security Incidents that result in unauthorized access, use, disclosure, modification or destruction of information or interference with system operations.
- R. **UNSUCCESSFUL SECURITY INCIDENTS** - Security Incidents that do not result in unauthorized access, use, disclosure, modification or destruction of information or interference with system operations.

3. **BCBSND SHALL:**

- 3.1 Establish a membership record for existing Members containing information as provided by NDPERS.
- 3.2 Provide Identification Cards, Certificates of Insurance/Summary Plan Descriptions and applications for enrollment for each Subscriber.
- 3.3 Upon enrollment under the NDPERS Benefit Plan, BCBSND will provide written notice to covered employees and their covered spouses of their continuation rights pursuant to the Consolidated Omnibus Budget Reconciliation Act. ("COBRA").
- 3.4 Receive applications for enrollment for late entrants.
- 3.5 Provide Managed Benefits services in accordance with appropriate licensure and certification requirements including a dedicated staff person.
- 3.6 Provide a dedicated service unit to adjudicate all claims and respond to Member's inquiries. Provide toll-free Member and Health Care Provider service lines between the hours of 8 AM and 5:00 PM CST or CDT at the home office in Fargo, ND, as appropriate. A toll-free managed benefits line for Health Care Providers will also be available between the hours of 7:30 AM and 5:30 PM CST or CDT. During nonbusiness hours, answering machine services will be available for managed benefits calls.
- 3.7 Process claims and inquiries per MTM (Member Touchpoint Measures) for Non-BlueCard claims.
- 3.8 Correspond with the Members and Health Care Providers if additional information is deemed necessary by BCBSND to complete the administrative process.
- 3.9 Administer other party liability programs.
- 3.10 Provide to Members an Explanation of Benefits Statement.
- 3.11 Provide a procedure for detection of fraud and unlawful activity.
- 3.12 Provide to Members a conversion policy when application is made within 31 days of the termination of enrollment under NDPERS.
- 3.13 Provide assistance to NDPERS for the conduct of enrollment, servicing and education.
- 3.14 Provide to NDPERS formal Policy and Procedure guidelines for the conduct of external audits or reviews commissioned by NDPERS.

NDPERS shall provide BCBSND with the scope and requirements of any audit or review prior to the commencement of activities. If a sample of claims is required, BCBSND will provide or NDPERS will select a statistically valid computerized sample of claims, if not prohibited by law, regulation or rule.

NDPERS will provide a copy of the report of all audit or review findings and shall discuss the findings with BCBSND upon discovery to allow further investigation or implementation of corrective action.

- 3.15 Provide NDPERS with reporting to include but not limited to:
 - a. Annual group reporting of membership and utilization by group segments and product.
 - b. Estimates of future claim reserves and premium to claim ratio.
 - c. Such other special claims reports as requested from time-to-time by NDPERS, subject to the availability of data and appropriate cost considerations.
 - d. Interest calculation monthly report.
 - e. Semi-annual performance objectives as outlined in section 2 of the BCBSND response to question 15 of the RFP.
- 3.16 Provide NDPERS with claims specific data on a monthly basis on compact disc or other agreed upon medium. This information shall be in a format acceptable to NDPERS and subject to all federal and state laws on confidentiality and open records.
- 3.17 Provide support to NDPERS for the establishment of a Preferred Provider Network consistent with objectives established by NDPERS.
 - a. BCBSND will provide technical and administrative advice to NDPERS relative to the appropriateness of PPO arrangements compared to existing Blue Cross Blue Shield participation and reimbursement arrangements, to verify that PPO arrangements provide for payments which are no greater than the existing arrangements. BCBSND will provide current information regarding Blue Cross Blue Shield participation and reimbursement arrangements in place on a provider-specific basis for comparative purposes.
 - b. BCBSND will develop jointly with NDPERS a written instrument to be used as the basis for providers participating in the PPO Program.
 - c. BCBSND will secure provider agreements upon completion of negotiations with providers. Such negotiations will be conducted jointly by BCBSND and NDPERS.
 - d. BCBSND will enforce strict managed benefits, utilization review and quality assurance criteria to assure attainment of Preferred Provider program objectives.
 - e. BCBSND will, upon NDPERS direction, terminate a Provider's NDPERS PPO participation agreement in accordance with terms of the agreement, when a PPO Provider is noncompliant with NDPERS policies and procedures. Said policies and procedures shall be documented and communicated to the participating provider prior to implementation.
- 3.18 Carry over any Deductible and/or Coinsurance Amounts incurred from January 1 to June 30, of the prior contract period.

4. **NDPERS SHALL:**

- 4.1 Prepare and distribute monthly billings to participating employers and retirees participating in the Plan. NDPERS shall respond to the participating employers inquiries concerning eligibility rules, billing, etc.
- 4.2 Prepare monthly eligibility tape by participating employer and premium classification for both active and retired employees and provide the tape to BCBSND to be used for eligibility certification purposes. Along with the eligibility tape, NDPERS will furnish a monthly listing of participants added or terminated during the month. Such listing will reflect the name of the employee, dependents, Social Security Number, the effective date of coverage for a new employee or the termination date of a terminated employee and the coverage classification.

- 4.3 Provide enrollment forms, obtain completed classifications or addresses, etc. from participants and furnish BCBSND with a copy of the enrollment forms or request for coverage or address changes and retain the original copy. Enrollment forms will include the NDPERS and Blue Cross Blue Shield Service Marks.
- 4.4 Be responsible for the administration of and compliance with COBRA. BCBSND will forward requests for COBRA participation by membership to NDPERS upon notification.
- 4.5 Comply with BCBSND's established administrative policies which are reasonable and consistent with the NDPERS Health Plan and the bid specifications agreed to by the parties, including but not limited to: underwriting policies, standard adjudication and Medical Policy Guidelines, Payable Provider Guidelines, Managed Benefits Program Guidelines and claim payment procedures.
- 4.6 Develop and provide BCBSND the objectives established for the Preferred Provider programs.
- 4.7 Assume joint responsibility for the determination of provider eligibility and performance criteria in the Preferred Provider programs.
- 4.8 Be responsible for any systems redesign costs to BCBSND which result from the implementation of any new reimbursement mechanisms not presently in place within BCBSND automated claims payment systems. Those reimbursement mechanisms currently in place include:

Institutional

- Percent of Billed Charges
- Percent of DRGs
- Percent of Per Diems
- Targeted Cost per Member

Professional

- Percent of Physician Payment Schedule
- Percent of Billed Charges
- Capitation
- Targeted Cost per Member

- 4.9 Pay premiums to BCBSND according to the schedule in Section 6.

5. PRIVACY USE AND DISCLOSURE RESPONSIBILITIES

5.1 RESPONSIBILITIES OF BCBSND

A. Privacy of Protected Health Information (PHI)

- 1. BCBSND will keep confidential all Claim records and all other PHI that BCBSND creates or receives in the performance of its duties under this Agreement. Except as permitted or required by this Agreement for BCBSND to perform its duties under this Agreement, BCBSND will not use or disclose such Claim information or other PHI without the authorization of the Member who is the subject of such information or as required by law.
- 2. BCBSND will neither use nor disclose Members' PHI (including any Members' PHI received from a business associate of the Plan) except (1) as permitted or required by this Agreement, (2) as permitted in writing by the Plan Administrator, (3) as authorized by Members, or (4) as required by law.
- 3. BCBSND will be permitted to use or disclose Members' PHI only as follows:
 - a. BCBSND will be permitted to use and disclose Members' PHI (a) for the management, operation and administration of the Plan the Plan Administrator offers Members, and (b) for the services set forth in the Plan, which include Payment activities, Health Care Operations, and Data Aggregation as these terms are defined under federal law.

1. BCBSND will be permitted to use Members' PHI as necessary for BCBSND proper management and administration or to carry out BCBSND's legal responsibilities.
2. BCBSND will be permitted to disclose Members' PHI as necessary for BCBSND's proper management and administration or to carry out BCBSND's legal responsibilities only if (i) the disclosure is required by law, or (ii) before the disclosure, BCBSND obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by a written contract, that the entity will hold Members' PHI in confidence, use or further disclose Members' PHI only for the purposes for which BCBSND disclosed it to the entity or as required by law, and notify BCBSND of any instance the entity becomes aware of where the confidentiality of any Members' PHI was breached.
 - b. BCBSND will make reasonable efforts to use, disclose, or request only the minimum necessary amount of Members' PHI to accomplish the intended purpose.
4. Other than disclosures permitted by Section 5.1(A)3, BCBSND will not disclose Members' PHI to the Plan Administrator or to the Plan's business associate except as directed by the Plan Administrator in writing.
5. BCBSND will require each subcontractor and agent to which BCBSND is permitted by this Agreement or in writing by the Plan Administrator to disclose Members' PHI to provide reasonable assurance, evidenced by written contract, that such other entity will comply with the same privacy and security obligations with respect to Members' PHI as this Agreement applies to BCBSND.
6. BCBSND will not disclose any Members' PHI to the Plan Sponsor, except as permitted by and in accordance with Section 5.1(A)3.
7. BCBSND will report to the Plan Administrator any use or disclosure of Members' PHI not permitted by this Agreement. BCBSND will make any such report to the Plan Administrator after BCBSND learns of such non-permitted use or disclosure.
8. BCBSND will report to the Plan Administrator attempted or successful unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with BCBSND's system operations in BCBSND's information systems ("Security Incident"), of which BCBSND becomes aware. With regard to attempted unauthorized access, use, etc., BCBSND and the Plan Administrator recognize and agree that the significant number of meaningless attempts to, without authorization, access, use, disclose, modify or destroy electronic PHI will make real-time reporting formidable. Therefore, BCBSND and the Plan Administrator agree to the following reporting procedures for Security Incidents that result in unauthorized access, use, disclosure, modification or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

For Unsuccessful Security Incidents, BCBSND and the Plan Administrator agree that this Agreement constitutes notice from BCBSND of any such Unsuccessful Security Incidents. In other words, the Plan Administrator waives any separate notice of Unsuccessful Security Incidents. By way of example, BCBSND and the Plan Administrator consider the following to be illustrative of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with an information system:

1. Pings on BCBSND's firewall,
2. Port scans,
3. Attempts to log on to a system or enter a database with an invalid password or username,
4. Denial-of-service attacks that do not result in a server being taken off-line, and
5. Malware (e.g., worms, viruses).

For Successful Security Incidents, BCBSND shall give notice promptly to the Plan Administrator in the event a Member's electronic PHI was compromised.

9. Disposition of Protected Health Information

The parties agree that upon termination, cancellation, expiration or other conclusion of this Agreement, BCBSND will return or destroy all PHI received or created by BCBSND on the Plan Administrator's behalf as soon as feasible. Due to various regulatory and legal requirements, the Plan Administrator acknowledges that immediate return or destruction of all such information is not feasible. BCBSND agrees that upon conclusion of this Agreement for any reason, it will use or disclose the PHI it received or created on the Plan's behalf only as necessary to meet BCBSND's regulatory and legal requirements and for no other purposes unless permitted in writing by the Plan Administrator. BCBSND will destroy PHI received or created by BCBSND on the Plan Administrator's behalf that is in BCBSND's possession under such circumstances and upon such schedule as BCBSND deems consistent with its regulatory and other legal obligations.

These responsibilities agreed to by BCBSND and related to protecting the privacy and safeguarding the security of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and, where applicable, shall govern BCBSND's receipt, use or disclosure of PHI pursuant to the terms of this Agreement.

B. Access, Amendment and Disclosure Accounting for Protected Health Information

1. Upon the Plan Administrator's written request, BCBSND will make available for inspection and obtaining copies by the Plan Administrator, or at the Plan Administrator's direction by the Member (or the Members' representative), any PHI about the Member created or received for or from the Plan Administrator in BCBSND's custody or control so the Plan Administrator may meet its access obligations under federal law.
2. Upon receipt of a written request from the Plan Administrator, or at the Plan Administrator's direction by the Member (or the Members' representative), BCBSND will amend or permit the Plan Administrator access to amend any portion of the PHI created or received for or from the Plan Administrator in BCBSND's custody or control, so the Plan Administrator may meet its amendment obligations under federal law.

3. So the Plan Administrator may meet its disclosure accounting obligations under federal law, BCBSND will do the following:

a. BCBSND will record each disclosure of Members' PHI which is not excepted from disclosure accounting under Section 5.1(B)3.b that BCBSND makes to the Plan Administrator or to a third party.

The information about each disclosure that BCBSND must record ("Disclosure Information") is (i) the disclosure date, (ii) the name and (if known) address of the person or entity to whom BCBSND made the disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the disclosure.

For repetitive disclosures of Members' PHI that BCBSND makes for a single purpose to the same person or entity (including the Plan Administrator), BCBSND may record (i) the disclosure information for the first of these repetitive disclosures, (ii) the frequency, periodicity or number of these repetitive disclosures, and (iii) the date of the last of these repetitive disclosures.

b. BCBSND will not be required to record disclosure information or otherwise account for disclosures of Members' PHI that this Agreement or the Plan Administrator in writing permits or requires:

- (1) for Payment activities or Health Care Operations,
- (2) to the Member who is the subject of the PHI or to that Members' personal representative,
- (3) to persons involved in that Members' health care or payment for health care, as provided under federal law,
- (4) for notification for disaster relief purposes or national security or intelligence purposes as provided under federal law,
- (5) to law enforcement officials or correctional institutions regarding inmates,
- (6) for incidental uses or disclosures,
- (7) as part of a limited data set in accordance with federal law,
- (8) that occurred prior to the HIPAA Privacy Compliance Date,
- (9) pursuant to a valid authorization.

c. BCBSND will have available for the Plan Administrator the disclosure information required by Section 5.1(B)3.a. for the six (6) years immediately preceding the date of the Plan Administrator's request for the disclosure information.

d. Upon the Plan Administrator's written request, BCBSND will make available to the Plan Administrator, or at the Plan Administrator's direction to the Member (or the Member's representative), disclosure information regarding the Member, so the Plan Administrator may meet its disclosure accounting obligations under federal law.

C. Information Safeguards

1. BCBSND will maintain reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of Member PHI. The safeguards must reasonably protect Member PHI from any intentional or unintentional use or disclosure in violation of federal law and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.

2. BCBSND will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI BCBSND creates, receives, maintains, or transmits on behalf of the Plan Administrator as required by federal law.

D. Inspection of Books and Records

BCBSND will make its internal practices, books, and records relating to its use and disclosure of PHI created or received for or from the Plan Administrator available to the Plan Administrator and to the U.S. Department of Health and Human Services to determine compliance with federal law or this Agreement.

E. BCBSND will prepare and distribute a notice of privacy practices appropriate for the Plan to meet its notice obligations under federal law. The Plan Administrator authorizes BCBSND to disclose the minimum necessary PHI to the Plan Sponsor for plan administration functions specified in the Plan documents as amended.

F. Information Privacy and Safeguard Provisions Survive Termination of Agreement

These responsibilities agreed to by BCBSND and related to protecting the privacy of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and where applicable, shall govern BCBSND's receipt and use of PHI obtained pursuant to the terms of this Agreement.

5.2 RESPONSIBILITIES OF THE PLAN SPONSOR

A. The Plan Sponsor retains full and final authority and responsibility for the Plan and its operation. BCBSND is empowered to act on behalf of the Plan only as stated in this Agreement or as mutually agreed in writing by the Plan Sponsor and BCBSND.

B. Except with respect to services provided by BCBSND set forth in this agreement, the Plan Sponsor will have the sole responsibility for and will bear the entire cost of compliance with all federal, state and local laws, rules, and regulations concerning the privacy of PHI, including any licensing, filing, reporting, and disclosure requirements, that may apply to the Plan. BCBSND will have no responsibility for or liability with respect to the Plan's compliance or noncompliance with any applicable federal, state, or local law, rule, or regulation.

C. By executing this Agreement, the Plan Sponsor certifies to BCBSND it has amended the Plan documents to incorporate the provisions required by and under federal law, and agrees to comply with the Plan Administrator's plan documents as amended.

BCBSND may rely on Plan Sponsor's certification and Plan Administrator's written authorization, and will have no obligation to verify (1) that the Plan Administrator's plan documents have been amended to comply with the requirements of Federal law or this Agreement or (2) that the Plan Sponsor is complying with the Plan Administrator's plan document as amended.

6. FEES AND CHARGES

6.1 In consideration of the fully insured contract under this Agreement, BCBSND agrees to accept the following provisions and premium rates for the Effective Date of this Agreement.

**NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
PREMIUM RATE STRUCTURE FOR THE 2009-2011 BIENNIUM**

Rate Structure A		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
July 1, 2009 - December 31, 2009							(3)-(4)+(5)		
		Total	Less	(1)-(2) Total	Premium	Medicare	Total	Plus	(6)+(7) NDPERS
Code	Description	BCBSND	NDPERS	Premium to	Buydown	Part D	Monthly	NDPERS	Billing
		Bid	Retention	BCBSND		Premium	Paid to	Retention	Rate
							BCBSND		

Political Subdivision Rates with Wellness Program

Active

1	4	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$2.80	\$424.96
2	4	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$2.80	\$1,026.62

COBRA

4	4	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$11.30	\$433.46
5	4	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$23.32	\$1,047.14

Political Subdivision Rates w/o Wellness Program

Active

1	3	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$7.04	\$429.20
2	3	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$13.06	\$1,036.88

COBRA

4	3	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$11.30	\$433.46
5	3	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$23.32	\$1,047.14

State Contracts with Wellness Program

Active

1-3	2	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14	\$822.86	\$2.80	\$825.66
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COBRA

4	2	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$10.80	\$408.06
5	2	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$22.06	\$982.10

Part-Time/Temporary/LOA

6	2	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$2.80	\$400.06
7	2	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$2.80	\$962.84

State Contracts w/o Wellness Program

Active

1-3	1	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14	\$822.86	\$11.06	\$833.92
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COBRA

4	1	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$10.80	\$408.06
5	1	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$22.06	\$982.10

Part-Time/Temporary/LOA

6	1	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$6.80	\$404.06
7	1	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$12.42	\$972.46

Non-Medicare Retiree

21	11	Single	\$600.22	\$2.80	\$597.42	\$0.14	\$597.28	\$2.80	\$600.08
22	11	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14	\$1,197.36	\$2.80	\$1,200.16
23	11	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14	\$1,497.40	\$2.80	\$1,500.20

COBRA

24	11	Single	\$600.22	\$2.80	\$597.42	\$0.14	\$597.28	\$14.80	\$612.08
25	11	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14	\$1,197.36	\$26.80	\$1,224.16
26	11	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14	\$1,497.40	\$32.80	\$1,530.20

Medicare Retiree

41	11	1 Medicare only	\$168.16	\$2.80	\$165.36		\$63.70	\$229.06	\$2.80	\$231.86
42	11	2 Medicare only	\$333.52	\$2.80	\$330.72		\$127.40	\$458.12	\$2.80	\$460.92
50	11	3 Medicare only	\$498.88	\$2.80	\$496.08		\$191.10	\$687.18	\$2.80	\$689.98
51	11	4 Medicare only	\$664.24	\$2.80	\$661.44		\$254.80	\$916.24	\$2.80	\$919.04
43	11	1 Medicare+Others	\$496.42	\$2.80	\$493.62	\$0.14	\$63.70	\$557.18	\$2.80	\$559.98
49	11	2 Medicare+Others	\$661.78	\$2.80	\$658.98	\$0.14	\$127.40	\$786.24	\$2.80	\$789.04
55	11	3 Medicare+Others	\$827.14	\$2.80	\$824.34	\$0.14	\$191.10	\$1,015.30	\$2.80	\$1,018.10
44	11	Part A Single	\$346.20	\$2.80	\$343.40	\$0.14	\$63.70	\$406.96	\$2.80	\$409.76

Rate Structure A (cont'd)

July 1, 2009 - December 31, 2009

Code	Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
		Total BCBSND Bid	Less NDPERS Retention	(1)-(2) Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	(3)-(4)+(5) Total Monthly Paid to BCBSND	Plus NDPERS Retention	(6)+(7) NDPERS Billing Rate	
COBRA										
46	11	1 Medicare only	\$168.16	\$2.80	\$165.36		\$63.70	\$229.06	\$7.44	\$236.50
47	11	2 Medicare only	\$333.52	\$2.80	\$330.72		\$127.40	\$458.12	\$12.02	\$470.14
53	11	3 Medicare only	\$498.88	\$2.80	\$496.08		\$191.10	\$687.18	\$16.60	\$703.78
54	11	4 Medicare only	\$664.24	\$2.80	\$661.44		\$254.80	\$916.24	\$21.18	\$937.42
48	11	1 Medicare+Others	\$496.42	\$2.80	\$493.62	\$0.14	\$63.70	\$557.18	\$14.00	\$571.18
52	11	2 Medicare+Others	\$661.78	\$2.80	\$658.98	\$0.14	\$127.40	\$786.24	\$18.58	\$804.82
56	11	3 Medicare+Others	\$827.14	\$2.80	\$824.34	\$0.14	\$191.10	\$1,015.30	\$23.16	\$1,038.46
Medicare Low Income Subsidy										
41	13	1 Medicare only (1cr)	\$168.16	\$2.80	\$165.36		\$33.30	\$198.66	\$2.80	\$201.46
42	13	2 Medicare only (2cr)	\$333.52	\$2.80	\$330.72		\$66.60	\$397.32	\$2.80	\$400.12
50	13	3 Medicare only (1cr)	\$498.88	\$2.80	\$496.08		\$160.70	\$656.78	\$2.80	\$659.58
51	13	4 Medicare only (1cr)	\$664.24	\$2.80	\$661.44		\$224.40	\$885.84	\$2.80	\$888.64
43	13	1 Medicare+Others(1cr)	\$496.42	\$2.80	\$493.62	\$0.14	\$33.30	\$526.78	\$2.80	\$529.58
49	13	2 Medicare+Others (1cr)	\$661.78	\$2.80	\$658.98	\$0.14	\$97.00	\$755.84	\$2.80	\$758.64
55	13	3 Medicare+Others (2cr)	\$827.14	\$2.80	\$824.34	\$0.14	\$130.30	\$954.50	\$2.80	\$957.30
61	13	1 Medicare only (.75cr)	\$168.16	\$2.80	\$165.36		\$40.90	\$206.26	\$2.80	\$209.06
71	13	1 Medicare only (.5cr)	\$168.16	\$2.80	\$165.36		\$48.50	\$213.86	\$2.80	\$216.66
81	13	1 Medicare only (.25cr)	\$168.16	\$2.80	\$165.36		\$56.10	\$221.46	\$2.80	\$224.26
57	13	4 Medicare only (2cr)	\$664.24	\$2.80	\$661.44		\$194.00	\$855.44	\$2.80	\$858.24
72	13	2 Medicare only (1cr)	\$333.52	\$2.80	\$330.72		\$97.00	\$427.72	\$2.80	\$430.52
Grandfathered Rates										
50	14	3 Medicare only	\$354.62	\$2.80	\$351.82		\$191.10	\$542.92	\$2.80	\$545.72
51	14	4 Medicare only	\$217.64	\$2.80	\$214.84		\$254.80	\$469.64	\$2.80	\$472.44
49	14	2 Medicare+Others	\$491.78	\$2.80	\$488.98	\$0.14	\$127.40	\$616.24	\$2.80	\$619.04
55	14	3 Medicare+Others	\$354.80	\$2.80	\$352.00	\$0.14	\$191.10	\$542.96	\$2.80	\$545.76
Grandfathered Rates COBRA										
53	14	3 Medicare only	\$354.62	\$2.80	\$351.82		\$191.10	\$542.92	\$13.70	\$556.62
54	14	4 Medicare only	\$217.64	\$2.80	\$214.84		\$254.80	\$469.64	\$12.24	\$481.88
52	14	2 Medicare+Others	\$491.78	\$2.80	\$488.98	\$0.14	\$127.40	\$616.24	\$15.18	\$631.42
56	14	3 Medicare+Others	\$354.80	\$2.80	\$352.00	\$0.14	\$191.10	\$542.96	\$13.72	\$556.68
Grandfathered Rates with Medicare Low Income Subsidy										
50	15	3 Medicare only (1cr)	\$354.62	\$2.80	\$351.82		\$160.70	\$512.52	\$2.80	\$515.32
57	15	4 Medicare only (2cr)	\$217.64	\$2.80	\$214.84		\$194.00	\$408.84	\$2.80	\$411.64

(1) - BCBSND premium rates, per bid.

(2) - Per contract charge retained by NDPERS

(3) - Total premium paid to BCBSND.

(4) - Amount of premium paid from surplus funds.

(5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))

(6) - Amount of premium NDPERS will send to BCBSND.

(7) - Per contract charge retained by NDPERS.

(8) - Premium amount NDPERS will bill its contract holders.

Rate Structure A			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
January 1, 2010 - December 31, 2010					(1)-(2)			(3)-(4)+(5)		(6)+(7)
			Total	Less	Total	Premium	Medicare	Total	Plus	NDPERS
			BCBSN	NDPERS	Premium to	Buydown	Part D	Monthly	NDPERS	Billing
Code	Description		D	Retention	BCBSND		Premium	BCBSND	Retention	Rate
			Bid							
<u>Political Subdivision Rates with Wellness Program</u>										
Active										
1	4	Single	\$425.10	\$2.80	\$422.30	\$0.14		\$422.16	\$2.80	\$424.96
2	4	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14		\$1,023.82	\$2.80	\$1,026.62
COBRA										
4	4	Single	\$425.10	\$2.80	\$422.30	\$0.14		\$422.16	\$11.30	\$433.46
5	4	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14		\$1,023.82	\$23.32	\$1,047.14
<u>Political Subdivision Rates w/o Wellness Program</u>										
Active										
1	3	Single	\$425.10	\$2.80	\$422.30	\$0.14		\$422.16	\$7.04	\$429.20
2	3	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14		\$1,023.82	\$13.06	\$1,036.88
COBRA										
4	3	Single	\$425.10	\$2.80	\$422.30	\$0.14		\$422.16	\$11.30	\$433.46
5	3	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14		\$1,023.82	\$23.32	\$1,047.14
<u>State Contracts with Wellness Program</u>										
Active										
1-3	2	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$2.80	\$825.66
COBRA										
4	2	Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	2	Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA										
6	2	Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$2.80	\$400.06
7	2	Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$2.80	\$962.84
<u>State Contracts w/o Wellness Program</u>										
Active										
1-3	1	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$11.06	\$833.92
COBRA										
4	1	Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	1	Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA										
6	1	Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$6.80	\$404.06
7	1	Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$12.42	\$972.46
<u>Non-Medicare Retiree</u>										
21	11	Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$2.80	\$600.08
22	11	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$2.80	\$1,200.16
23	11	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$2.80	\$1,500.20
COBRA										
24	11	Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$14.80	\$612.08
25	11	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$26.80	\$1,224.16
26	11	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$32.80	\$1,530.20
<u>Medicare Retiree</u>										
41	11	1 Medicare only	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80	TBD
42	11	2 Medicare only	\$333.52	\$2.80	\$330.72		TBD	TBD	\$2.80	TBD
50	11	3 Medicare only	\$498.88	\$2.80	\$496.08		TBD	TBD	\$2.80	TBD
51	11	4 Medicare only	\$664.24	\$2.80	\$661.44		TBD	TBD	\$2.80	TBD
43	11	1 Medicare+Others	\$496.42	\$2.80	\$493.62	\$0.14	TBD	TBD	\$2.80	TBD
49	11	2 Medicare+Others	\$661.78	\$2.80	\$658.98	\$0.14	TBD	TBD	\$2.80	TBD
55	11	3 Medicare+Others	\$827.14	\$2.80	\$824.34	\$0.14	TBD	TBD	\$2.80	TBD
44	11	Part A Single	\$346.20	\$2.80	\$343.40	\$0.14	TBD	TBD	\$2.80	TBD

Rate Structure A (cont'd)

January 1, 2010 - December 31, 2010

			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
			(3)-(4)+(5)							
Code	Description		Total BCBSND Bid	Less NDPERS Retention	(1)-(2) Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	Total Monthly Paid to BCBSND	Plus NDPERS Retention	(6)+(7) NDPERS Billing Rate
COBRA										
46	11	1 Medicare only	\$168.16	\$2.80	\$165.36		TBD	TBD	TBD	TBD
47	11	2 Medicare only	\$333.52	\$2.80	\$330.72		TBD	TBD	TBD	TBD
53	11	3 Medicare only	\$498.88	\$2.80	\$496.08		TBD	TBD	TBD	TBD
54	11	4 Medicare only	\$664.24	\$2.80	\$661.44		TBD	TBD	TBD	TBD
48	11	1 Medicare+Others	\$496.42	\$2.80	\$493.62	\$0.14	TBD	TBD	TBD	TBD
52	11	2 Medicare+Others	\$661.78	\$2.80	\$658.98	\$0.14	TBD	TBD	TBD	TBD
56	11	3 Medicare+Others	\$827.14	\$2.80	\$824.34	\$0.14	TBD	TBD	TBD	TBD
Medicare Low Income Subsidy										
41	13	1 Medicare only (1cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80	TBD
42	13	2 Medicare only (2cr)	\$333.52	\$2.80	\$330.72		TBD	TBD	\$2.80	TBD
50	13	3 Medicare only (1cr)	\$498.88	\$2.80	\$496.08		TBD	TBD	\$2.80	TBD
51	13	4 Medicare only (1cr)	\$664.24	\$2.80	\$661.44		TBD	TBD	\$2.80	TBD
43	13	1 Medicare+Others (1cr)	\$496.42	\$2.80	\$493.62	\$0.14	TBD	TBD	\$2.80	TBD
49	13	2 Medicare+Others (1cr)	\$661.78	\$2.80	\$658.98	\$0.14	TBD	TBD	\$2.80	TBD
55	13	3 Medicare+Others (2cr)	\$827.14	\$2.80	\$824.34	\$0.14	TBD	TBD	\$2.80	TBD
61	13	1 Medicare only (.75cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80	TBD
71	13	1 Medicare only (.5cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80	TBD
81	13	1 Medicare only (.25cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80	TBD
57	13	4 Medicare only (2cr)	\$664.24	\$2.80	\$661.44		TBD	TBD	\$2.80	TBD
72	13	2 Medicare only (1cr)	\$333.52	\$2.80	\$330.72		TBD	TBD	\$2.80	TBD
Grandfathered Rates										
50	14	3 Medicare only	\$354.62	\$2.80	\$351.82		TBD	TBD	\$2.80	TBD
51	14	4 Medicare only	\$217.64	\$2.80	\$214.84		TBD	TBD	\$2.80	TBD
49	14	2 Medicare+Others	\$491.78	\$2.80	\$488.98	\$0.14	TBD	TBD	\$2.80	TBD
55	14	3 Medicare+Others	\$354.80	\$2.80	\$352.00	\$0.14	TBD	TBD	\$2.80	TBD
Grandfathered Rates COBRA										
53	14	3 Medicare only	\$354.62	\$2.80	\$351.82		TBD	TBD	TBD	TBD
54	14	4 Medicare only	\$217.64	\$2.80	\$214.84		TBD	TBD	TBD	TBD
52	14	2 Medicare+Others	\$491.78	\$2.80	\$488.98	\$0.14	TBD	TBD	TBD	TBD
56	14	3 Medicare+Others	\$354.80	\$2.80	\$352.00	\$0.14	TBD	TBD	TBD	TBD
Grandfathered Rates with Medicare Low Income Subsidy										
50	15	3 Medicare only (1cr)	\$354.62	\$2.80	\$351.82		TBD	TBD	\$2.80	TBD
57	15	4 Medicare only (2cr)	\$217.64	\$2.80	\$214.84		TBD	TBD	\$2.80	TBD

(1) - BCBSND premium rates, per bid.

(2) - Per contract charge retained by NDPERS

(3) - Total premium paid to BCBSND.

(4) - Amount of premium paid from surplus funds.

(5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))

(6) - Amount of premium NDPERS will send to BCBSND.

(7) - Per contract charge retained by NDPERS.

(8) - Premium amount NDPERS will bill its contract holders.

Rate Structure A

January 1, 2011 - June 30, 2011

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Total	Less	(1)-(2)		Medicare	(3)-(4)+(5)	Plus	(6)+(7)
Code	Description	BCBSND	NDPERS	Total	Premium	Part D	Monthly	NDPERS	NDPERS
		Bid	Retention	Premium to	Buydown	Premium	Paid to	Retention	Billing
				BCBSND			BCBSND		Rate
<u>Political Subdivision Rates with Wellness Program</u>									
Active									
1	4	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$2.80	\$424.96
2	4	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$2.80	\$1,026.62
COBRA									
4	4	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$11.30	\$433.46
5	4	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$23.32	\$1,047.14
<u>Political Subdivision Rates w/o Wellness Program</u>									
Active									
1	3	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$7.04	\$429.20
2	3	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$13.06	\$1,036.88
COBRA									
4	3	Single	\$425.10	\$2.80	\$422.30	\$0.14	\$422.16	\$11.30	\$433.46
5	3	Family	\$1,026.76	\$2.80	\$1,023.96	\$0.14	\$1,023.82	\$23.32	\$1,047.14
<u>State Contracts with Wellness Program</u>									
Active									
1-3	2	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14	\$822.86	\$2.80	\$825.66
COBRA									
4	2	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$10.80	\$408.06
5	2	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	2	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$2.80	\$400.06
7	2	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$2.80	\$962.84
<u>State Contracts w/o Wellness Program</u>									
Active									
1-3	1	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14	\$822.86	\$11.06	\$833.92
COBRA									
4	1	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$10.80	\$408.06
5	1	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	1	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$6.80	\$404.06
7	1	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$12.42	\$972.46
<u>Non-Medicare Retiree</u>									
21	11	Single	\$600.22	\$2.80	\$597.42	\$0.14	\$597.28	\$2.80	\$600.08
22	11	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14	\$1,197.36	\$2.80	\$1,200.16
23	11	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14	\$1,497.40	\$2.80	\$1,500.20
COBRA									
24	11	Single	\$600.22	\$2.80	\$597.42	\$0.14	\$597.28	\$14.80	\$612.08
25	11	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14	\$1,197.36	\$26.80	\$1,224.16
26	11	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14	\$1,497.40	\$32.80	\$1,530.20
<u>Medicare Retiree</u>									
41	11	1 Medicare only	\$168.16	\$2.80	\$165.36		TBD	\$2.80	TBD
42	11	2 Medicare only	\$333.52	\$2.80	\$330.72		TBD	\$2.80	TBD
50	11	3 Medicare only	\$498.88	\$2.80	\$496.08		TBD	\$2.80	TBD
51	11	4 Medicare only	\$664.24	\$2.80	\$661.44		TBD	\$2.80	TBD
43	11	1 Medicare+Others	\$496.42	\$2.80	\$493.62	\$0.14	TBD	\$2.80	TBD
49	11	2 Medicare+Others	\$661.78	\$2.80	\$658.98	\$0.14	TBD	\$2.80	TBD
55	11	3 Medicare+Others	\$827.14	\$2.80	\$824.34	\$0.14	TBD	\$2.80	TBD
44	11	Part A Single	\$346.20	\$2.80	\$343.40	\$0.14	TBD	\$2.80	TBD

Rate Structure A (cont'd)

January 1, 2011 - June 30, 2011

Code	Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Total BCBSND Bid	Less NDPERS Retention	(1)-(2) Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	(3)-(4)+(5) Total Monthly Paid to BCBSND	Plus NDPERS Retention	(6)+(7) NDPERS Billing Rate
COBRA									
46	11	1 Medicare only	\$168.16	\$2.80	\$165.36		TBD	TBD	TBD
47	11	2 Medicare only	\$333.52	\$2.80	\$330.72		TBD	TBD	TBD
53	11	3 Medicare only	\$498.88	\$2.80	\$496.08		TBD	TBD	TBD
54	11	4 Medicare only	\$664.24	\$2.80	\$661.44		TBD	TBD	TBD
48	11	1 Medicare+Others	\$496.42	\$2.80	\$493.62	\$0.14	TBD	TBD	TBD
52	11	2 Medicare+Others	\$661.78	\$2.80	\$658.98	\$0.14	TBD	TBD	TBD
56	11	3 Medicare+Others	\$827.14	\$2.80	\$824.34	\$0.14	TBD	TBD	TBD
Medicare Low Income Subsidy									
41	13	1 Medicare only (1cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80
42	13	2 Medicare only (2cr)	\$333.52	\$2.80	\$330.72		TBD	TBD	\$2.80
50	13	3 Medicare only (1cr)	\$498.88	\$2.80	\$496.08		TBD	TBD	\$2.80
51	13	4 Medicare only (1cr)	\$664.24	\$2.80	\$661.44		TBD	TBD	\$2.80
43	13	1 Medicare+Others (1cr)	\$496.42	\$2.80	\$493.62	\$0.14	TBD	TBD	\$2.80
49	13	2 Medicare+Others (1cr)	\$661.78	\$2.80	\$658.98	\$0.14	TBD	TBD	\$2.80
55	13	3 Medicare+Others (2cr)	\$827.14	\$2.80	\$824.34	\$0.14	TBD	TBD	\$2.80
61	13	1 Medicare only (.75cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80
71	13	1 Medicare only (.5cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80
81	13	1 Medicare only (.25cr)	\$168.16	\$2.80	\$165.36		TBD	TBD	\$2.80
57	13	4 Medicare only (2cr)	\$664.24	\$2.80	\$661.44		TBD	TBD	\$2.80
72	13	2 Medicare only (1cr)	\$333.52	\$2.80	\$330.72		TBD	TBD	\$2.80
Grandfathered Rates									
50	14	3 Medicare only	\$354.62	\$2.80	\$351.82		TBD	TBD	\$2.80
51	14	4 Medicare only	\$217.64	\$2.80	\$214.84		TBD	TBD	\$2.80
49	14	2 Medicare+Others	\$491.78	\$2.80	\$488.98	\$0.14	TBD	TBD	\$2.80
55	14	3 Medicare+Others	\$354.80	\$2.80	\$352.00	\$0.14	TBD	TBD	\$2.80
Grandfathered Rates COBRA									
53	14	3 Medicare only	\$354.62	\$2.80	\$351.82		TBD	TBD	TBD
54	14	4 Medicare only	\$217.64	\$2.80	\$214.84		TBD	TBD	TBD
52	14	2 Medicare+Others	\$491.78	\$2.80	\$488.98	\$0.14	TBD	TBD	TBD
56	14	3 Medicare+Others	\$354.80	\$2.80	\$352.00	\$0.14	TBD	TBD	TBD
Grandfathered Rates with Medicare Low Income Subsidy									
50	15	3 Medicare only (1cr)	\$354.62	\$2.80	\$351.82		TBD	TBD	\$2.80
57	15	4 Medicare only (2cr)	\$217.64	\$2.80	\$214.84		TBD	TBD	\$2.80

(1) - BCBSND premium rates, per bid.

(2) - Per contract charge retained by NDPERS

(3) - Total premium paid to BCBSND.

(4) - Amount of premium paid from surplus funds.

(5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))

(6) - Amount of premium NDPERS will send to BCBSND.

(7) - Per contract charge retained by NDPERS.

(8) - Premium amount NDPERS will bill its contract holders.

Rate Structure B		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
First Year							(3)-(4)+(5)			
July 1, 2009 - December 31, 2009				(1)-(2)			Total	Plus	(6)+(7)	
Code	Description	Total BCBSND Bid	Less NDPERS Retention	Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	Monthly Paid to BCBSND	NDPERS Retention	NDPERS Billing Rate	
Political Subdivision Rates with Wellness Program										
Active										
1	8	Single	\$405.00	\$2.80	\$402.20	\$0.14	\$402.06	\$2.80	\$404.86	
2	8	Family	\$978.02	\$2.80	\$975.22	\$0.14	\$975.08	\$2.80	\$977.88	
COBRA										
4	8	Single	\$405.00	\$2.80	\$402.20	\$0.14	\$402.06	\$10.90	\$412.96	
5	8	Family	\$978.02	\$2.80	\$975.22	\$0.14	\$975.08	\$22.36	\$997.44	
Political Subdivision Rates w/o Wellness Program										
Active										
1	7	Single	\$405.00	\$2.80	\$402.20	\$0.14	\$402.06	\$6.84	\$408.90	
2	7	Family	\$978.02	\$2.80	\$975.22	\$0.14	\$975.08	\$12.58	\$987.66	
COBRA										
4	7	Single	\$405.00	\$2.80	\$402.20	\$0.14	\$402.06	\$10.90	\$412.96	
5	7	Family	\$978.02	\$2.80	\$975.22	\$0.14	\$975.08	\$22.36	\$997.44	
State Contracts with Wellness Program (see Rate Structure 'A')										
Active										
1-3	2	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14	\$822.86	\$2.80	\$825.66	
COBRA										
4	2	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$10.80	\$408.06	
5	2	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$22.06	\$982.10	
Part-Time/Temporary/LOA										
6	2	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$2.80	\$400.06	
7	2	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$2.80	\$962.84	
State Contracts w/o Wellness Program (see Rate Structure 'A')										
Active										
1-3	1	S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14	\$822.86	\$11.06	\$833.92	
COBRA										
4	1	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$10.80	\$408.06	
5	1	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$22.06	\$982.10	
Part-Time/Temporary/LOA										
6	1	Single	\$400.20	\$2.80	\$397.40	\$0.14	\$397.26	\$6.80	\$404.06	
7	1	Family	\$962.98	\$2.80	\$960.18	\$0.14	\$960.04	\$12.42	\$972.46	
Non-Medicare Retiree (see Rate Structure 'A')										
21	12	Single	\$600.22	\$2.80	\$597.42	\$0.14	\$597.28	\$2.80	\$600.08	
22	12	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14	\$1,197.36	\$2.80	\$1,200.16	
23	12	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14	\$1,497.40	\$2.80	\$1,500.20	
COBRA										
24	12	Single	\$600.22	\$2.80	\$597.42	\$0.14	\$597.28	\$14.80	\$612.08	
25	12	Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14	\$1,197.36	\$26.80	\$1,224.16	
26	12	Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14	\$1,497.40	\$32.80	\$1,530.20	
Medicare Retiree										
41	12	1 Medicare only	\$165.72	\$2.80	\$162.92		\$63.70	\$226.62	\$2.80	\$229.42
42	12	2 Medicare only	\$328.64	\$2.80	\$325.84		\$127.40	\$453.24	\$2.80	\$456.04
50	12	3 Medicare only	\$491.56	\$2.80	\$488.76		\$191.10	\$679.86	\$2.80	\$682.66
51	12	4 Medicare only	\$654.48	\$2.80	\$651.68		\$254.80	\$906.48	\$2.80	\$909.28
43	12	1 Medicare+Others	\$489.10	\$2.80	\$486.30	\$0.14	\$63.70	\$549.86	\$2.80	\$552.66
49	12	2 Medicare+Others	\$652.02	\$2.80	\$649.22	\$0.14	\$127.40	\$776.48	\$2.80	\$779.28
55	12	3 Medicare+Others	\$814.94	\$2.80	\$812.14	\$0.14	\$191.10	\$1,003.10	\$2.80	\$1,005.90

Rate Structure B

First Year (cont'd)
July 1, 2009 - December 31, 2009

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
				(1)-(2)			(3)-(4)+(5)		(6)+(7)
Code	Description	Total BCBSND Bid	Less NDPERS Retention	Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	Monthly Paid to BCBSND	Plus NDPERS Retention	NDPERS Billing Rate
COBRA									
46	12 1 Medicare only	\$165.72	\$2.80	\$162.92		\$63.70	\$226.62	\$7.38	\$234.00
47	12 2 Medicare only	\$328.64	\$2.80	\$325.84		\$127.40	\$453.24	\$11.92	\$465.16
53	12 3 Medicare only	\$491.56	\$2.80	\$488.76		\$191.10	\$679.86	\$16.44	\$696.30
54	12 4 Medicare only	\$654.48	\$2.80	\$651.68		\$254.80	\$906.48	\$20.98	\$927.46
48	12 1 Medicare+Others	\$489.10	\$2.80	\$486.30	\$0.14	\$63.70	\$549.86	\$13.84	\$563.70
52	12 2 Medicare+Others	\$652.02	\$2.80	\$649.22	\$0.14	\$127.40	\$776.48	\$18.38	\$794.86
56	12 3 Medicare+Others	\$814.94	\$2.80	\$812.14	\$0.14	\$191.10	\$1,003.10	\$22.92	\$1,026.02

- (1) - BCBSND premium rates, per bid.
- (2) - Per contract charge retained by NDPERS
- (3) - Total premium paid to BCBSND.
- (4) - Amount of premium paid from surplus funds.
- (5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))
- (6) - Amount of premium NDPERS will send to BCBSND.
- (7) - Per contract charge retained by NDPERS.
- (8) - Premium amount NDPERS will bill its contract holders.

Rate Structure B		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
First Year							(3)-(4)+(5)		
January 1, 2010 - June 30, 2010				(1)-(2)			Total		(6)+(7)
Code	Description	Total BCBSND Bid	Less NDPERS Retention	Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	Total Monthly Paid to BCBSND	Plus NDPERS Retention	NDPERS Billing Rate
Political Subdivision Rates with Wellness Program									
Active									
1	8 Single	\$405.00	\$2.80	\$402.20	\$0.14		\$402.06	\$2.80	\$404.86
2	8 Family	\$978.02	\$2.80	\$975.22	\$0.14		\$975.08	\$2.80	\$977.88
COBRA									
4	8 Single	\$405.00	\$2.80	\$402.20	\$0.14		\$402.06	\$10.90	\$412.96
5	8 Family	\$978.02	\$2.80	\$975.22	\$0.14		\$975.08	\$22.36	\$997.44
Political Subdivision Rates w/o Wellness Program									
Active									
1	7 Single	\$405.00	\$2.80	\$402.20	\$0.14		\$402.06	\$6.84	\$408.90
2	7 Family	\$978.02	\$2.80	\$975.22	\$0.14		\$975.08	\$12.58	\$987.66
COBRA									
4	7 Single	\$405.00	\$2.80	\$402.20	\$0.14		\$402.06	\$10.90	\$412.96
5	7 Family	\$978.02	\$2.80	\$975.22	\$0.14		\$975.08	\$22.36	\$997.44
State Contracts with Wellness Program (see Rate Structure 'A')									
Active									
1-3	2 S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$2.80	\$825.66
COBRA									
4	2 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	2 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	2 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$2.80	\$400.06
7	2 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$2.80	\$962.84
State Contracts w/o Wellness Program (see Rate Structure 'A')									
Active									
1-3	1 S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$11.06	\$833.92
COBRA									
4	1 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	1 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	1 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$6.80	\$404.06
7	1 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$12.42	\$972.46
Non-Medicare Retiree (see Rate Structure 'A')									
21	12 Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$2.80	\$600.08
22	12 Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$2.80	\$1,200.16
23	12 Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$2.80	\$1,500.20
COBRA									
24	12 Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$14.80	\$612.08
25	12 Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$26.80	\$1,224.16
26	12 Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$32.80	\$1,530.20
Medicare Retiree									
41	12 1 Medicare only	\$165.72	\$2.80	\$162.92		TBD	TBD	\$2.80	TBD
42	12 2 Medicare only	\$328.64	\$2.80	\$325.84		TBD	TBD	\$2.80	TBD
50	12 3 Medicare only	\$491.56	\$2.80	\$488.76		TBD	TBD	\$2.80	TBD
51	12 4 Medicare only	\$654.48	\$2.80	\$651.68		TBD	TBD	\$2.80	TBD
43	12 1 Medicare+Others	\$489.10	\$2.80	\$486.30	\$0.14	TBD	TBD	\$2.80	TBD
49	12 2 Medicare+Others	\$652.02	\$2.80	\$649.22	\$0.14	TBD	TBD	\$2.80	TBD
55	12 3 Medicare+Others	\$814.94	\$2.80	\$812.14	\$0.14	TBD	TBD	\$2.80	TBD

Rate Structure B

First Year (cont'd)
 January 1, 2010 - June 30, 2010

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
				(1)-(2)			(3)-(4)+(5)		(6)+(7)
		Total	Less	Total	Premium	Medicare	Total	Plus	NDPERS
		BCBSND	NDPERS	Premium to	Buydown	Part D	Monthly	NDPERS	NDPERS
Code	Description	Bid	Retention	BCBSND		Premium	Paid to	Retention	Billing
							BCBSND		Rate
COBRA									
46	12 1 Medicare only	\$165.72	\$2.80	\$162.92		TBD	TBD	TBD	TBD
47	12 2 Medicare only	\$328.64	\$2.80	\$325.84		TBD	TBD	TBD	TBD
53	12 3 Medicare only	\$491.56	\$2.80	\$488.76		TBD	TBD	TBD	TBD
54	12 4 Medicare only	\$654.48	\$2.80	\$651.68		TBD	TBD	TBD	TBD
48	12 1 Medicare+Others	\$489.10	\$2.80	\$486.30	\$0.14	TBD	TBD	TBD	TBD
52	12 2 Medicare+Others	\$652.02	\$2.80	\$649.22	\$0.14	TBD	TBD	TBD	TBD
56	12 3 Medicare+Others	\$814.94	\$2.80	\$812.14	\$0.14	TBD	TBD	TBD	TBD

(1) - BCBSND premium rates, per bid.

(2) - Per contract charge retained by NDPERS

(3) - Total premium paid to BCBSND.

(4) - Amount of premium paid from surplus funds.

(5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))

(6) - Amount of premium NDPERS will send to BCBSND.

(7) - Per contract charge retained by NDPERS.

(8) - Premium amount NDPERS will bill its contract holders.

Rate Structure B		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Second Year							(3)-(4)+(5)		
July 1, 2010 - December 31, 2010				(1)-(2)			Total		(6)+(7)
Code	Description	Total BCBSND Bid	Less NDPERS Retention	Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	Monthly Paid to BCBSND	Plus NDPERS Retention	NDPERS Billing Rate
Political Subdivision Rates with Wellness Program									
Active									
1	8 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$2.80	\$445.06
2	8 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$2.80	\$1,075.36
COBRA									
4	8 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$11.70	\$453.96
5	8 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$24.30	\$1,096.86
Political Subdivision Rates w/o Wellness Program									
Active									
1	7 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$7.24	\$449.50
2	7 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$13.54	\$1,086.10
COBRA									
4	7 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$11.70	\$453.96
5	7 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$24.30	\$1,096.86
State Contracts with Wellness Program (see Rate Structure 'A')									
Active									
1-3	2 S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$2.80	\$825.66
COBRA									
4	2 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	2 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	2 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$2.80	\$400.06
7	2 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$2.80	\$962.84
State Contracts w/o Wellness Program (see Rate Structure 'A')									
Active									
1-3	1 S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$11.06	\$833.92
COBRA									
4	1 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	1 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	1 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$6.80	\$404.06
7	1 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$12.42	\$972.46
Non-Medicare Retiree (see Rate Structure 'A')									
21	12 Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$2.80	\$600.08
22	12 Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$2.80	\$1,200.16
23	12 Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$2.80	\$1,500.20
COBRA									
24	12 Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$14.80	\$612.08
25	12 Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$26.80	\$1,224.16
26	12 Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$32.80	\$1,530.20
Medicare Retiree									
41	12 1 Medicare only	\$170.60	\$2.80	\$167.80		TBD	TBD	\$2.80	TBD
42	12 2 Medicare only	\$338.40	\$2.80	\$335.60		TBD	TBD	\$2.80	TBD
50	12 3 Medicare only	\$506.20	\$2.80	\$503.40		TBD	TBD	\$2.80	TBD
51	12 4 Medicare only	\$674.00	\$2.80	\$671.20		TBD	TBD	\$2.80	TBD
43	12 1 Medicare+Others	\$503.74	\$2.80	\$500.94	\$0.14	TBD	TBD	\$2.80	TBD
49	12 2 Medicare+Others	\$671.54	\$2.80	\$668.74	\$0.14	TBD	TBD	\$2.80	TBD
55	12 3 Medicare+Others	\$839.34	\$2.80	\$836.54	\$0.14	TBD	TBD	\$2.80	TBD

Rate Structure B

Second Year (cont'd)

July 1, 2010 - December 31, 2010

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
				(1)-(2)			(3)-(4)+(5)		(6)+(7)
		Total	Less	Total	Premium	Medicare	Total	Plus	NDPERS
		BCBSND	NDPERS	Premium to	Buydown	Part D	Monthly	NDPERS	Billing
Code	Description	Bid	Retention	BCBSND		Premium	Paid to	Retention	Rate
							BCBSND		
COBRA									
46	12 1 Medicare only	\$170.60	\$2.80	\$167.80		TBD	TBD	TBD	TBD
47	12 2 Medicare only	\$338.40	\$2.80	\$335.60		TBD	TBD	TBD	TBD
53	12 3 Medicare only	\$506.20	\$2.80	\$503.40		TBD	TBD	TBD	TBD
54	12 4 Medicare only	\$674.00	\$2.80	\$671.20		TBD	TBD	TBD	TBD
48	12 1 Medicare+Others	\$503.74	\$2.80	\$500.94	\$0.14	TBD	TBD	TBD	TBD
52	12 2 Medicare+Others	\$671.54	\$2.80	\$668.74	\$0.14	TBD	TBD	TBD	TBD
56	12 3 Medicare+Others	\$839.34	\$2.80	\$836.54	\$0.14	TBD	TBD	TBD	TBD

(1) - BCBSND premium rates, per bid.

(2) - Per contract charge retained by NDPERS

(3) - Total premium paid to BCBSND.

(4) - Amount of premium paid from surplus funds.

(5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))

(6) - Amount of premium NDPERS will send to BCBSND.

(7) - Per contract charge retained by NDPERS.

(8) - Premium amount NDPERS will bill its contract holders.

Rate Structure B		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Second Year							(3)-(4)+(5)		
January 1, 2011 - June 30, 2011				(1)-(2)			Total		(6)+(7)
Code	Description	Total BCBSND Bid	Less NDPERS Retention	Total Premium to BCBSND	Premium Buydown	Medicare Part D Premium	Monthly Paid to BCBSND	Plus NDPERS Retention	NDPERS Billing Rate
Political Subdivision Rates with Wellness Program									
Active									
1	8 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$2.80	\$445.06
2	8 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$2.80	\$1,075.36
COBRA									
4	8 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$11.70	\$453.96
5	8 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$24.30	\$1,096.86
Political Subdivision Rates w/o Wellness Program									
Active									
1	7 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$7.24	\$449.50
2	7 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$13.54	\$1,086.10
COBRA									
4	7 Single	\$445.20	\$2.80	\$442.40	\$0.14		\$442.26	\$11.70	\$453.96
5	7 Family	\$1,075.50	\$2.80	\$1,072.70	\$0.14		\$1,072.56	\$24.30	\$1,096.86
State Contracts with Wellness Program (see Rate Structure 'A')									
Active									
1-3	2 S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$2.80	\$825.66
COBRA									
4	2 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	2 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	2 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$2.80	\$400.06
7	2 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$2.80	\$962.84
State Contracts w/o Wellness Program (see Rate Structure 'A')									
Active									
1-3	1 S/F/Dual	\$825.80	\$2.80	\$823.00	\$0.14		\$822.86	\$11.06	\$833.92
COBRA									
4	1 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$10.80	\$408.06
5	1 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$22.06	\$982.10
Part-Time/Temporary/LOA									
6	1 Single	\$400.20	\$2.80	\$397.40	\$0.14		\$397.26	\$6.80	\$404.06
7	1 Family	\$962.98	\$2.80	\$960.18	\$0.14		\$960.04	\$12.42	\$972.46
Non-Medicare Retiree (see Rate Structure 'A')									
21	12 Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$2.80	\$600.08
22	12 Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$2.80	\$1,200.16
23	12 Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$2.80	\$1,500.20
COBRA									
24	12 Single	\$600.22	\$2.80	\$597.42	\$0.14		\$597.28	\$14.80	\$612.08
25	12 Family	\$1,200.30	\$2.80	\$1,197.50	\$0.14		\$1,197.36	\$26.80	\$1,224.16
26	12 Family (3+)	\$1,500.34	\$2.80	\$1,497.54	\$0.14		\$1,497.40	\$32.80	\$1,530.20
Medicare Retiree									
41	12 1 Medicare only	\$170.60	\$2.80	\$167.80		TBD	TBD	\$2.80	TBD
42	12 2 Medicare only	\$338.40	\$2.80	\$335.60		TBD	TBD	\$2.80	TBD
50	12 3 Medicare only	\$506.20	\$2.80	\$503.40		TBD	TBD	\$2.80	TBD
51	12 4 Medicare only	\$674.00	\$2.80	\$671.20		TBD	TBD	\$2.80	TBD
43	12 1 Medicare+Others	\$503.74	\$2.80	\$500.94	\$0.14	TBD	TBD	\$2.80	TBD
49	12 2 Medicare+Others	\$671.54	\$2.80	\$668.74	\$0.14	TBD	TBD	\$2.80	TBD
55	12 3 Medicare+Others	\$839.34	\$2.80	\$836.54	\$0.14	TBD	TBD	\$2.80	TBD

Rate Structure B

Second Year (cont'd)
 January 1, 2011 - June 30, 2011

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
				(1)-(2)			(3)-(4)+(5)		(6)+(7)
		Total	Less	Total	Premium	Medicare	Total	Plus	NDPERS
		BCBSND	NDPERS	BCBSND	Buydown	Part D	Monthly	NDPERS	NDPERS
Code	Description	Bid	Retention	Premium to		Premium	Paid to	Retention	Billing
				BCBSND			BCBSND		Rate
COBRA									
46	12 1 Medicare only	\$170.60	\$2.80	\$167.80		TBD	TBD	TBD	TBD
47	12 2 Medicare only	\$338.40	\$2.80	\$335.60		TBD	TBD	TBD	TBD
53	12 3 Medicare only	\$506.20	\$2.80	\$503.40		TBD	TBD	TBD	TBD
54	12 4 Medicare only	\$674.00	\$2.80	\$671.20		TBD	TBD	TBD	TBD
48	12 1 Medicare+Others	\$503.74	\$2.80	\$500.94	\$0.14	TBD	TBD	TBD	TBD
52	12 2 Medicare+Others	\$671.54	\$2.80	\$668.74	\$0.14	TBD	TBD	TBD	TBD
56	12 3 Medicare+Others	\$839.34	\$2.80	\$836.54	\$0.14	TBD	TBD	TBD	TBD

- (1) - BCBSND premium rates, per bid.
- (2) - Per contract charge retained by NDPERS
- (3) - Total premium paid to BCBSND.
- (4) - Amount of premium paid from surplus funds.
- (5) - Medicare Part D Premium submitted to BCBSND. (rates for January 1, 2010 and after are to be determined (TBD))
- (6) - Amount of premium NDPERS will send to BCBSND.
- (7) - Per contract charge retained by NDPERS.
- (8) - Premium amount NDPERS will bill its contract holders.

- 6.2 NDPERS will pay BCBSND, on or before the last day of each month, premium income based on the amount identified in Column 6 of the above Table for type of contract for that month.
- 6.3 NDPERS will maintain a deposit of \$3,000,000 in a Cash Reserve Account held by BCBSND until the settlement of the biennium. This Cash Reserve Account shall earn interest at a rate to be determined monthly, based on US Treasury Notes quoted by the Wall Street Journal. The monthly rate will be established at the close of the first trading day each month based on the closing yield to maturity of US Treasury Notes maturing 24 months hence. If there are multiple notes for that maturity, the rate will be based on an average. If there are no notes with that maturity, the next subsequent maturity will be used.
- 6.4 To fund the amounts identified in Column 4, NDPERS will maintain surplus sufficient to fund transfers of \$2,900.00 per month to BCBSND and these Premium Buydown funds will be considered premium income. Final Premium Buydown will be based on actual Non-Medicare contract month exposure times the premiums listed in Column 4 and will be subject to settlement.
- 6.5 BCBSND will retain any surplus funds from the amounts identified in Column 3 of the above tables. Surplus funds retained by BCBSND shall earn interest at a rate to be determined monthly, based on US Treasury Notes quoted by the Wall Street Journal. The monthly rate will be established at the close of the first trading day each month based on the closing yield to maturity of US Treasury Notes maturing 24 months hence. If there are multiple notes for that maturity, the rate will be based on an average. If there are no notes with that maturity, the next subsequent maturity will be used.

Surplus funds described in the above section 6.5 not used by BCBSND to pay NDPERS Health Plan incurred claims plus retention will be subject to the Final Accounting as described in Section 7 of this Agreement.

- 6.6 Payments made pursuant to Section 6.2 and pursuant to column 5 of the above Table will be handled as follows:

BCBSND will dispense to Regional Advantage Services LLC, Medicare Part D premiums identified in Column 5 of the above Table for type of contract for that month. Interest will not be paid on this account.

Funds described in section 6.6 are not subject to final accounting as described in section 7 of this Agreement.

7. FINAL ACCOUNTING

- 7.1 A continual accounting of NDPERS Health Plan experience will take place during the 2009-2011 biennium. Monthly reports of earned income less incurred claims and retention will be produced during the biennium and the twelve months following the biennium.
- 7.2 Within 31 days of 12 months after the end of the biennium (by July 31, 2012) BCBSND will provide an accounting which will result in an initial settlement of the biennium agreement as follows:
1. Earned Premium Income during the Biennium
 2. Plus Premium Buydown Deposits
 3. Plus interest on Surplus Funds
 4. Less Claims Incurred during the Biennium and Paid July 1, 2009 through June 30, 2012
 5. Less Estimated Claims Incurred and Unpaid at June 30, 2012
 6. Less Administrative Expense during the Biennium (\$27.64 per contract per month)
 7. Less Conversion Cost during the Biennium (\$1.38 per contract per month)
 8. Less Service Charge during the Biennium (\$6.92 per contract per month)
 9. If 1+2+3-4-5-6-7-8 of 7.2 is positive, the lesser of 50% of this amount or \$1.5 million is retained by BCBSND. The remainder equals Refund paid to NDPERS.
 10. If 1+2+3-4-5-6-7-8 of 7.2 is negative, the lesser of 50% of this amount or \$3.0 million will be refunded by NDPERS to BCBSND.

Claims incurred and unpaid will be estimated by the mean of the latest three actual IBNR claims (Incurred But Not Reported) amounts for equivalent periods in the NDPERS history.

7.3 Within 31 days of 24 months after the end of the biennium (by July 31, 2013), BCBSND will provide an accounting, which will result in a final settlement of the biennium agreement as follows:

1. Earned Premium Income during the Biennium
2. Plus Premium Buydown Deposits
3. Plus interest on Surplus Funds
4. Less Claims Incurred during the Biennium and Paid July 1, 2009 through June 30, 2013
5. Less Administrative Expenses during the Biennium (\$27.64 per contract per month)
6. Less Conversion Cost during the Biennium (\$1.38 per contract per month)
7. Less Service Charge during the Biennium (\$6.92 per contract per month)
8. Less any refund paid to NDPERS at initial settlement on July 31, 2012
9. If 1+2+3-4-5-6-7-8 of 7.3 is positive, the lesser of 50% of this amount or \$1.5 million is retained by BCBSND for the July 1, 2009 through June 30, 2011 biennium. The remainder equals Refund paid to NDPERS. The maximum retained by BCBSND for the biennium is 50% of \$3.0 million of gain.
10. If 1+2+3-4-5-6-7-8 of 7.3 is negative, the lesser of 50% of this amount or \$3.0 million will be refunded by NDPERS to BCBSND. BCBSND retains all losses beyond \$6.0 million and any estimated gains previously distributed to NDPERS are subject to refund back to BCBSND based on this final settlement. The maximum loss NDPERS is subject to is 50% of \$6.0 million of loss.

8. **TERM AND TERMINATION OF AGREEMENT**

8.1 The term of this Agreement shall be for a two year period from July 1, 2009 through June 30, 2011.

8.2 This Agreement may be terminated by mutual agreement of both parties, upon 60 days notice, in writing.

Either party may terminate this Agreement effective 90 days following delivery of written notice to the other party, or at such later date as may be stated in the notice, under any of the following conditions:

- a. If funding from federal, state or other sources is not obtained and continued at levels sufficient to allow for purchase of the services or supplies in the indicated quantities or term. The Agreement may be modified by agreement of the parties in writing to accommodate a reduction of funds.
- b. If federal or state laws, rules or regulations are modified, changed or interpreted in such a way that the services are no longer allowable or appropriate for purchase under this Agreement or are no longer eligible for the funding proposed for payments authorized by this Agreement.
- c. If any license, permit or certificate required by law, rule or regulation, or by the terms of this Agreement, is for any reason denied, revoked, suspended or not renewed.

Any such termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination.

- d. In the event of a breach by either party, other than for nonpayment of premium, the other party may terminate this Agreement by written notice to the breaching party. The breaching party has 31 days to fully cure the breach. If the breach is not cured within 31 days after written notice, this Agreement will immediately terminate.

9. **BLUECARD PROGRAM®**

Like all Blue Cross and Blue Shield Licensees, BCBSND participates in a program called "BlueCard." Whenever Members access health care services outside the geographic area BCBSND serves, the claim for those services may be processed through BlueCard and presented to BCBSND for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Members receive Covered Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), BCBSND will remain responsible to the Group for fulfilling BCBSND's contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim - The calculation of Member liability on claims for Covered Services incurred outside the geographic area BCBSND serves and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price BCBSND pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by BCBSND on a claim for health care services processed through BlueCard may represent:

1. the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"), or
2. an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"), or
3. an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Member and the Group from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate Member liability for any Covered Services in accordance with the applicable state statute in effect at the time the Member received those services.

Return of Overpayments - Under BlueCard, recoveries from a Host Blue or from participating providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

10. **RETROSPECTIVE DISCOUNT PAYMENT**

Regarding prescription medications or drugs purchased by Members under the terms of the Plan, the Plan Administrator agrees to pay to BCBSND the amount due to the pharmacy (or other prescription drug retailer) under the terms of the pharmacy provider participating agreement. The amount due to the pharmacy under the terms of the pharmacy provider participating agreement is that which is due at the time the prescription medication or drug is purchased by the Member. The amount due to the pharmacy under the pharmacy provider participating agreement is calculated without regard to any subsequent, retrospective manufacturer discount that may apply to the cost of the prescription medication or drug. The Plan Administrator acknowledges and agrees that, in some cases but not all, drug manufacturers may offer retrospective discounts to BCBSND on prescription medications and drugs purchased under the terms of the Plan. If a drug manufacturer makes a retrospective discount payment available, the Plan Administrator acknowledges and agrees that a portion of any such rebate may be retained by an entity that performs manufacturer discount program services on behalf of BCBSND under the terms of this Agreement. The Plan Administrator further acknowledges and agrees that, when made available by the drug manufacturer, another portion of the retrospective discount payment is retained by BCBSND. In its sole discretion, BCBSND may periodically refund to the Plan all or part of any rebate payments received. The calculation of any refund rests in the sole discretion of BCBSND.

In its sole discretion, and only in the case where a Member is required to pay Coinsurance as part of the Cost Sharing Amounts for each Prescription Medication and Drug provided under the terms of this Benefit Plan, BCBSND may periodically refund to Members a proportional amount of any retrospective discount payments received. The calculation and payment of any such proportional refund rests in the sole discretion of BCBSND. The manner in which such retrospective discount program payment refund, if any, is distributed to a Member rests in the sole discretion of BCBSND. The Member waives any right, title, or interest in and to such proportional retrospective discount payment once the Member is no longer eligible for benefits under the terms of this Benefit Plan, and BCBSND may use its discretion and disburse any such retrospective discount payments as it deems appropriate and necessary in its administration of this Benefit Plan. The Member shall pay all Cost Sharing Amounts at the time the Prescription Medication or Drug is purchased, without regard to any potential retrospective discount.

11. **GENERAL PROVISIONS:**

- 11.1 This Agreement is between NDPERS and BCBSND and does not create any rights or legal relationships between BCBSND and any Member(s).
- 11.2 This Agreement, together with the Response to the Request for Proposal and any exhibits, attachments and amendments constitutes the entire Agreement between the parties. No promises, terms, conditions or obligations other than those contained in this Agreement are valid or binding. Any prior agreements, statements, promises, negotiations, inducements or representations, either oral or written, made by either party or agent of either party that are not contained in this Agreement are of no effect. No modification of the terms or provisions of this Agreement shall be effective unless evidenced by a written amendment, signed by an authorized officer or employee of NDPERS and BCBSND.
- 11.3 This Agreement shall be governed by and construed according to the laws of the state of North Dakota.
- 11.4 Failure of either party at any time to require performance by the other party of any provision of this Agreement shall not be deemed to be a continuing waiver of that provision or a waiver of any other provision of this Agreement.
- 11.5 No assignment of this Agreement in whole or in part may be made by either party without written agreement approved by both parties.

- 11.6 All notices and correspondence required or permitted to be given under this Agreement shall be given by personal delivery to the other party or may be sent by mail, postage prepaid to the other party at the following addresses:

**NORTH DAKOTA PUBLIC EMPLOYEES
RETIREMENT SYSTEM**

PO Box 1657
Bismarck, North Dakota 58502

**BLUE CROSS BLUE SHIELD
OF NORTH DAKOTA**

4510 13th Avenue South
Fargo, North Dakota 58121

- 11.7 Neither party shall be liable for any delay in or failure to perform under this Agreement due to an act of God or due to war mobilization, insurrection, rebellion, civil commotion, riot, act of an extremist or public enemy, sabotage, labor dispute, explosion, fire, flood, storm, accident, drought, equipment failure, power failure, fuel or energy shortages, unavoidable delay of carriers, embargo, law, ordinance, act, rule or regulation of any government, whether valid or invalid.
- 11.8 NDPERS hereby expressly acknowledges and understands that BCBSND is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSND to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that BCBSND is not contracting as an agent of the Association. NDPERS further acknowledges and agrees this Agreement was not entered into based upon representations by any person or entity other than BCBSND and that no person, entity, or organization other than BCBSND shall be held accountable or liable to NDPERS for any of BCBSND's obligations to NDPERS created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this Agreement.
- 11.9 If NDPERS or BCBSND creates benefit communications for Members, relating to the Certificate of Insurance attached as Exhibit A, such communications will be sent to BCBSND or NDPERS for comment prior to distribution. Either party will have 5 business days to comment on the communication. If one party fails to advise the other within that 5-day period, it will be presumed there are no comments on the communication. If NDPERS has a digital or online version of the Certificate of Insurance available to its Members, NDPERS agrees that it will not alter, modify or change the language of the Certificate of Insurance, and further agrees the Certificate of Insurance, attached as Exhibit A, will be the controlling document in the event of any conflict or liability that might arise as the result of any alterations, modifications or changes made by NDPERS. In the event a claim is paid based on NDPERS's modified or altered digital or online Certificate of Insurance, NDPERS is liable for all such claims. NDPERS further agrees that no waiver of this agreement is valid unless in writing and approved by BCBSND.
- 11.10 When coverage under this Agreement is terminated, BCBSND will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the Subscriber. Upon notification by the Subscriber of the ineligibility of a dependent, a Certificate of Creditable Coverage will be issued to the affected Member within a reasonable period of time. Certificates of Creditable Coverage may also be obtained from BCBSND upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through BCBSND.
- 11.11 Upon the effective date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan Sponsor, the Plan Administrator and BCBSND remain in compliance with such regulations, unless BCBSND elects to terminate this Agreement by providing the Plan Sponsor and the Plan Administrator notice of termination in accordance with this Agreement at least thirty-one (31) days before the effective date of such final regulation or amendment to final regulations.

12. **DISPUTES AND INDEMNIFICATION**

If litigation is filed regarding denial of benefits or otherwise, and BCBSND is named as the sole defendant, BCBSND will have the right to manage and have full control of litigation and to determine whether to pay, compromise, litigate or appeal the litigation.

NDPERS agrees that all Retrospective Discount Payments will be made to Members of the Plan. BCBSND agrees to indemnify NDPERS for any judgments against NDPERS solely arising out of NDPERS' decision to participate in the Retrospective Discount Payment program.

**NORTH DAKOTA PUBLIC EMPLOYEES
RETIREMENT SYSTEM (PLAN SPONSOR)**
PO Box 1657
Bismarck, North Dakota 58502

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA*
4510 13th Avenue South
Fargo, North Dakota 58121



By: _____

Its Interim President and CEO

Title: _____

Date: _____

Date: June 9, 2009

**NORTH DAKOTA PUBLIC EMPLOYEES
RETIREMENT SYSTEM
GROUP HEALTH PLAN (PLAN ADMINISTRATOR)**
PO Box 1657
Bismarck, North Dakota 58502

By: _____

Title: _____

Date: _____

Effective Date: 07/01/2009-06/30/2011

*An Independent Licensee of the Blue Cross and Blue Shield Association.

Certificate of Insurance & Summary Plan Description



**NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM
DAKOTA PLAN**

Dakota Retiree Plan

July 1, 2009

Health Care Coverage



Blue Cross Blue Shield of North Dakota
NDPERS Service Center

Questions? Our Service Center staff is available to answer questions about your coverage

Call the Service Center: Monday through Friday
8:00 a.m. - 5:00 p.m. – CST
(701) 282-1400
or
1-800-223-1704

North Dakota Relay Service: 1-800-366-6888

Office Address and Hours: You may visit our Home Office during normal business hours

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

Blue Cross Blue Shield of North Dakota
4510 13th Ave. South
Fargo, North Dakota 58121

Mailing Address: You may write to us at the following address:

Blue Cross Blue Shield of North Dakota
4510 13th Ave. South
Fargo, North Dakota 58121

BCBSND Internet Address: www.BCBSND.com

NDPERS Internet Address: www.nd.gov/ndpers

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Certificate of Insurance is provided to you in the same manner as required under the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information. This Certificate of Insurance and the NDPERS Service Agreement is the official benefit plan document for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

BCBSND shall construe and interpret the provisions of the Service Agreement, the Certificate of Insurance and related documents, including doubtful or disputed terms and to determine all questions of eligibility; and to conduct any and all reviews of claims denied in whole or in part.

PLAN NAME

North Dakota Public Employees Retirement System – Dakota Retiree Plan

NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)

NDPERS
400 East Broadway, Suite 505
Box 1657
Bismarck, North Dakota 58502

PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER

45-0282090

TYPE OF WELFARE PLAN

Health

TYPE OF ADMINISTRATION

This employee welfare benefit plan is fully insured through BCBSND and issued by BCBSND.

NAME AND ADDRESS OF BCBSND

Blue Cross Blue Shield of North Dakota (BCBSND)
4510 13th Avenue South
Fargo, North Dakota 58121

PLAN ADMINISTRATOR'S NAME, BUSINESS ADDRESS AND BUSINESS TELEPHONE NUMBER

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
Box 1657
Bismarck, North Dakota 58502
1-800-803-7377
701-328-3900

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator:

Sparb Collins
North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
Bismarck, North Dakota 58502

BCBSND:

Daniel E. Schwandt
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Service of legal process may be made upon a Plan trustee or the Plan Administrator.

TITLE OF EMPLOYEES AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION

Benefit Programs Division
Research & Benefit Program Development Division
Accounting & IT Division
Administrative Services Division
Internal Audit Division
Executive Director

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

STATEMENT OF ELIGIBILITY TO RECEIVE BENEFITS

Retirees or surviving spouses who are age 65 or entitled to Medicare and are receiving a retirement benefit from the Public Employees Retirement System, the Highway Patrolmen's Retirement System, the Teachers' Insurance and Annuity Association of America-College Retirement Equities Fund (TIAA-CREF), the Job Service Retirement System, Judges' Retirement System, the Teachers' Fund for Retirement (TFFR), or an eligible public retirement system are eligible to receive benefits.

An eligible retiree or surviving spouse is entitled to coverage if an application is submitted within 31 days of Medicare entitlement. Each eligible retiree may elect to enroll his/her Eligible Dependents. Eligible employees includes Medicare eligible retired and terminated employees and their Eligible Dependents who remain eligible to participated in the uniform group insurance program pursuant to applicable state law as provided in NDCC section 54-52.1-03(3). Medicare eligible and non-Medicare eligible members will receive separate Benefit Plans. For a comprehensive description of eligibility refer to the NDPERS web site. To obtain an application you must contact the NDPERS office by writing: NDPERS, Box 1657, Bismarck, ND 58502 or by calling 701-328-3900 or 1-800-803-7377.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. BCBSND has the ultimate decision making authority regarding eligibility to receive benefits.

DESCRIPTION OF BENEFITS

Refer to page 1 Covered Services Section.

SOURCES OF PREMIUM CONTRIBUTIONS TO THE PLAN AND THE METHOD BY WHICH THE AMOUNT OF CONTRIBUTION IS CALCULATED

The contributions for single and family coverage are paid by the retiree or surviving spouse. For retirees or surviving spouses that are eligible for the Retiree Health Insurance Credit Program, contributions are calculated using the accrued health credit as an offset to the gross premium.

END OF THE YEAR DATE FOR PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS

June 30

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SECTION 1 INTRODUCTION

This Benefit Plan describes the benefits available to You as a person enrolled under the Dakota Retiree - Blue Cross Blue Shield of North Dakota Medicare supplement Benefit Plan.

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

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

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

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

SECTION 2 COVERED SERVICES

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

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

2.1 INPATIENT HOSPITAL SERVICES

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

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

2.2 BLOOD SERVICES

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

2.3 SKILLED NURSING FACILITY SERVICES

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

2.4 MEDICARE PART B ELIGIBLE EXPENSES

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

2.5 MEDICARE PART B EXCESS CHARGES

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

2.6 BENEFITS FOR EMERGENCY CARE IN A FOREIGN COUNTRY

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

SECTION 3 EXCLUSIONS

3.1 EXCLUSIONS

No benefits are available for:

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

SECTION 4 GENERAL PROVISIONS

4.1 PAYMENT OF PREMIUM

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

In the event of termination for nonpayment of premium, reinstatement of this Benefit Plan will be at the sole discretion of and subject to conditions established by BCBSND.

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

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

4.2 AUTOMATIC PAYMENT WITHDRAWAL

By completing the automatic payment withdrawal authorization, the Subscriber authorizes their financial institution to periodically deduct the current premium from their bank account and to remit same to NDPERS. This authorization will continue in effect until revoked in writing by the Subscriber. To cancel an automatic withdrawal authorization, notification must be received in writing by the NDPERS office by the 15th of the month prior to the month the change is effective.

4.3 TIME LIMIT ON CERTAIN DEFENSES

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

4.4 NOTICE AND PROOF OF CLAIM

The Subscriber is responsible for providing BCBSND with written notice and proof of a claim for benefits within 24 months after the occurrence or commencement of a loss for which benefits are available under this Benefit Plan. The written notice and proof of claim must include the information necessary for BCBSND to determine benefits.

4.5 PAYMENT OF CLAIMS

Payment of claims will be made upon receipt of written notice and proof of a claim as provided in Section 4.4.

4.6 PHYSICAL EXAMINATIONS

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

4.7 LIMITATION OF ACTIONS

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

4.8 PREMIUM REFUND/DEATH OF THE SUBSCRIBER

In the event of the Subscriber's death, BCBSND will refund to the Plan Administrator (NDPERS) all premiums paid beyond the month of the Subscriber's death, within 31 days after receiving notice of the death.

4.9 **SUSPENSION OF COVERAGE**

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

4.10 **CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS**

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

4.11 **ASSIGNMENT OF RECORDS**

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

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

4.12 **CONFIDENTIALITY**

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

- A. Upon a written, dated, and signed authorization by the Subscriber or prospective Subscriber or by a person authorized to provide consent for a minor or an incapacitated person;
- B. If PHI identifies the Health Care Provider, upon a written, dated, and signed approval by the Health Care Provider. However, BCBSND may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. BCBSND may also disclose to a Health Care Provider, as part of a contract or agreement in which the Health Care Provider is a party, data or information that identifies a Health Care Provider as part of mutually agreed upon terms and conditions of the contract or agreement;
- C. If the data or information does not identify either the Subscriber or prospective Subscriber or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;
- D. Pursuant to statute or court order for the production or discovery of evidence; or
- E. In the event of a claim or litigation between the Subscriber or prospective Subscriber and BCBSND in which the PHI is pertinent.

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

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

4.13 PRIVACY OF PROTECTED HEALTH INFORMATION

BCBSND will not disclose the Subscriber's Protected Health Information (PHI) to the Group unless the Group certifies that the Benefit Plan has been amended to incorporate the privacy restrictions required under federal and state law, and agrees to abide by them.

BCBSND will disclose the Subscriber's PHI to the Group to carry out administrative functions under the terms of the Benefit Plan, but only in accordance with applicable federal and state law. Any disclosure to and use by the Group of the Subscriber's PHI will be subject to and consistent with this section. BCBSND will not disclose the Subscriber's PHI to the Group unless such disclosures are included in a notice of privacy practices distributed to the Subscriber. BCBSND will not disclose the Subscriber's PHI to the Group for actions or decisions related to the Subscriber's employment or in connection with any other benefits made available to the Subscriber.

The following restricts the Group's use and disclosure of the Subscriber's PHI:

- A. The Group will neither use nor further disclose the Subscriber's PHI except as permitted by the Benefit Plan or required by law.
- B. The Group will ensure that anyone who receives the Subscriber's PHI agrees to the restrictions and conditions of the Benefit Plan with respect to the Subscriber's PHI.
- C. The Group will not use or disclose the Subscriber's PHI for actions or decisions related to the Subscriber's employment or in connection with any other benefit made available to the Subscriber.
- D. The Group will promptly report to the Plan Administrator any use or disclosure of the Subscriber's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
- E. In accordance with federal law, the Group will make PHI available to the Subscriber who is the subject of the information. Such information is subject to amendment and, upon proper notice, the Group will amend the Subscriber's PHI where appropriate.
- F. The Group will document disclosures it makes of the Subscriber's PHI so the Plan Administrator is able to provide an accounting of disclosures as required under applicable state and federal law.
- G. The Group will make its internal practices, books, and records relating to its use and disclosure of the Subscriber's PHI available to the Plan Administrator and to the U.S. Department of Health and Human Services as necessary to determine compliance with federal law.
- H. The Group will, where feasible, return or destroy all Subscribers PHI in whatever form or medium received from the Plan Administrator, including all copies of and any data or compilations derived from and allowing identification of any Subscriber when the Subscriber's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Subscriber PHI, the Group will limit the use or disclosure of any Subscriber PHI to those purposes that make the return or destruction of the information infeasible.

4.14 NOTICE OF PRIVACY PRACTICES

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

4.15 SECURITY MEASURES FOR ELECTRONIC PROTECTED HEALTH INFORMATION

- A. The Group will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Subscribers' electronic PHI that the Group creates, receives, maintains, or transmits on the Plan Administrator's behalf.
- B. The Group will report to the Plan Administrator any attempted or successful (1) unauthorized access, use, disclosure, modification, or destruction of Subscribers' electronic PHI or (2) interference with the Group's system operations in the Group's information systems, of which the Group becomes aware, except any such security incident that results in disclosure of Subscribers' PHI not permitted by the Benefit Plan must be reported to the Plan Administrator as required by 4.13 (D).
- C. The Group will support the adequate separation between the Group and the Plan Administrator, as specified in the Benefit Plan, with reasonable and appropriate security measures.

4.16 CONFORMITY WITH STATE STATUTES

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

4.17 CERTIFICATE OF CREDITABLE COVERAGE

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

SECTION 5 OTHER PARTY LIABILITY

5.1 MEDICAL PAYMENT BENEFIT COORDINATION

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

5.2 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

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

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

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

- A. Right of Assignment and/or Subrogation: If a Subscriber fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), BCBSND has the right to bring said claim as the assignee and/or subrogee of the Subscriber and to recover any benefits paid under this Benefit Plan.
- B. Right of Reimbursement: If a Subscriber makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Subscriber must notify BCBSND of said recovery and must reimburse BCBSND to the full extent of any benefits paid by BCBSND, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Subscriber has not received full compensation for the injury or condition. Any recovery the Subscriber may obtain is conclusively presumed to be for the reimbursement of benefits paid by BCBSND until BCBSND has been fully reimbursed.

SECTION 6 DEFINITIONS

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

- 6.1 **ACCIDENT** - an accidental bodily injury or injuries for which Medicare benefits are provided as the direct result of an accident, independent of disease or bodily infirmity or any other cause, while this Benefit Plan is in force. Injuries do not include injuries for which benefits are provided or available under any workers' compensation, employers' liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
- 6.2 **ADMISSION** - entry into a facility as a registered inpatient for treatment and care when ordered by a Health Care Provider.

- 6.3 **BCBSND** - Blue Cross Blue Shield of North Dakota, a legal trade name of Noridian Mutual Insurance Company.
- 6.4 **BENEFIT PERIOD** - a Benefit Period begins the first day a Subscriber enters a Hospital or Skilled Nursing Facility as a Medicare patient and ends 60 consecutive days after a Subscriber is discharged from the Hospital or Skilled Nursing Facility. A new Benefit Period begins when 60 days without a Hospital or Skilled Nursing Facility stay have elapsed.
- 6.5 **BENEFIT PLAN** - the agreement with BCBSND, including the Subscriber's membership application, Identification Card, this Benefit Plan, the benefit plan attachment and any supplements, endorsements, attachments, addenda or amendments.
- 6.6 **CALENDAR YEAR** - the period starting with the Subscriber's Effective Date and ending on December 31 of that year. Each Calendar Year shall start on January 1 and end on December 31 of that year.
- 6.7 **COST SHARING AMOUNTS** - the portion of Medicare Eligible Expenses not covered by Medicare.
- A. **Medicare Coinsurance Amount** - a part of the charge for Your Hospital or medical care that Medicare does not pay, expressed as a percentage of the allowance for the Medicare Eligible Expense.
- B. **Medicare Copayment Amount** - a predetermined dollar amount established by Medicare under a prospective payment system for some outpatient Hospital services.
- C. **Medicare Deductible Amount** - a specified dollar amount of Medicare Eligible Expenses that You are responsible for before Medicare will begin making payments for covered services.
- 6.8 **EFFECTIVE DATE** - the date the Subscriber's coverage under this Benefit Plan begins.
- 6.9 **GROUP** - the Plan Sponsor that has signed an agreement with BCBSND to provide health care benefits for Subscribers.
- 6.10 **HEALTH CARE PROVIDER** - a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.) or a Board Eligible Oral Surgeon (D.D.S.), who is licensed and registered under the laws of the state in which the services are provided. To qualify under this Benefit Plan, the Health Care Provider must also be classified as eligible under Medicare.
- 6.11 **HOSPITAL** - an institution, licensed and operated in accordance with state law, that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Health Care Providers.
- 6.12 **IDENTIFICATION CARD** - a card issued in the Subscriber's name identifying the Benefit Plan number.
- 6.13 **LIFETIME RESERVE DAYS** - an additional 60 days of Medicare Eligible Expenses for Hospital care You may use once in a lifetime. These days are not renewable.
- 6.14 **MEDICALLY NECESSARY** - services, supplies or treatments provided by a Health Care Provider to treat an illness or injury that satisfy all the following criteria:

- A. The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the Subscriber's illness or injury;
 - B. The services, supplies or treatments are consistent with professionally recognized standards of health care; and
 - C. The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the Subscriber's illness or injury.
- 6.15 **MEDICARE** - the programs established by Title I, Part I of Public Laws 89-97 as enacted by the Congress of the United States of America and any later amendments of the laws (known as the Health Insurance for the Aged Act).
- 6.16 **MEDICARE ELIGIBLE EXPENSES** - those health care expenses that are covered services under Part A or Part B of Medicare that are recognized as reasonable and Medically Necessary by Medicare.
- 6.17 **MEDICARE PART A** - the part of Medicare insurance that includes Hospital inpatient, Skilled Nursing Facility and home health care benefits. It is sometimes referred to as Medicare Hospital insurance.
- 6.18 **MEDICARE PART B** - the part of Medicare insurance that includes Health Care Provider's services, outpatient Hospital care, home health care and many other health services and supplies not covered by Medicare Hospital insurance.
- 6.19 **PLAN ADMINISTRATOR** - North Dakota Public Employees Retirement System (NDPERS).
- 6.20 **PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from You or on Your behalf that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:
- A. is created by or received from a Health Care Provider, health care employer, or health care clearinghouse;
 - B. relates to Your past, present or future physical or mental health or condition;
 - C. relates to the provision of health care to You;
 - D. relates to the past, present, or future payment for health care to You or on Your behalf; or
 - E. identifies You or could reasonably be used to identify You.

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

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

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

- 6.22 **SICKNESS** - an illness or disease of a Subscriber that first manifests itself after the Effective Date of this Benefit Plan while this Benefit Plan was in force. This does not include sickness or disease for which benefits are available under any workers' compensation, occupational disease, employers' liability or similar law.
- 6.23 **SKILLED NURSING FACILITY** - a nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
- 6.24 **SUBSCRIBER** - You, the individual whose application for coverage has been appropriately submitted.
- 6.25 **UNITED STATES** - all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and for purposes of services provided on board ship, the territorial waters adjoining the land areas of the United States.
- 6.26 **YOU AND YOUR** - also referred to as the Subscriber.



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

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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 10, 2009
SUBJECT: Member Services Survey

Representatives from BCBS will be at the next board meeting to review with you the attached Member Services Survey.



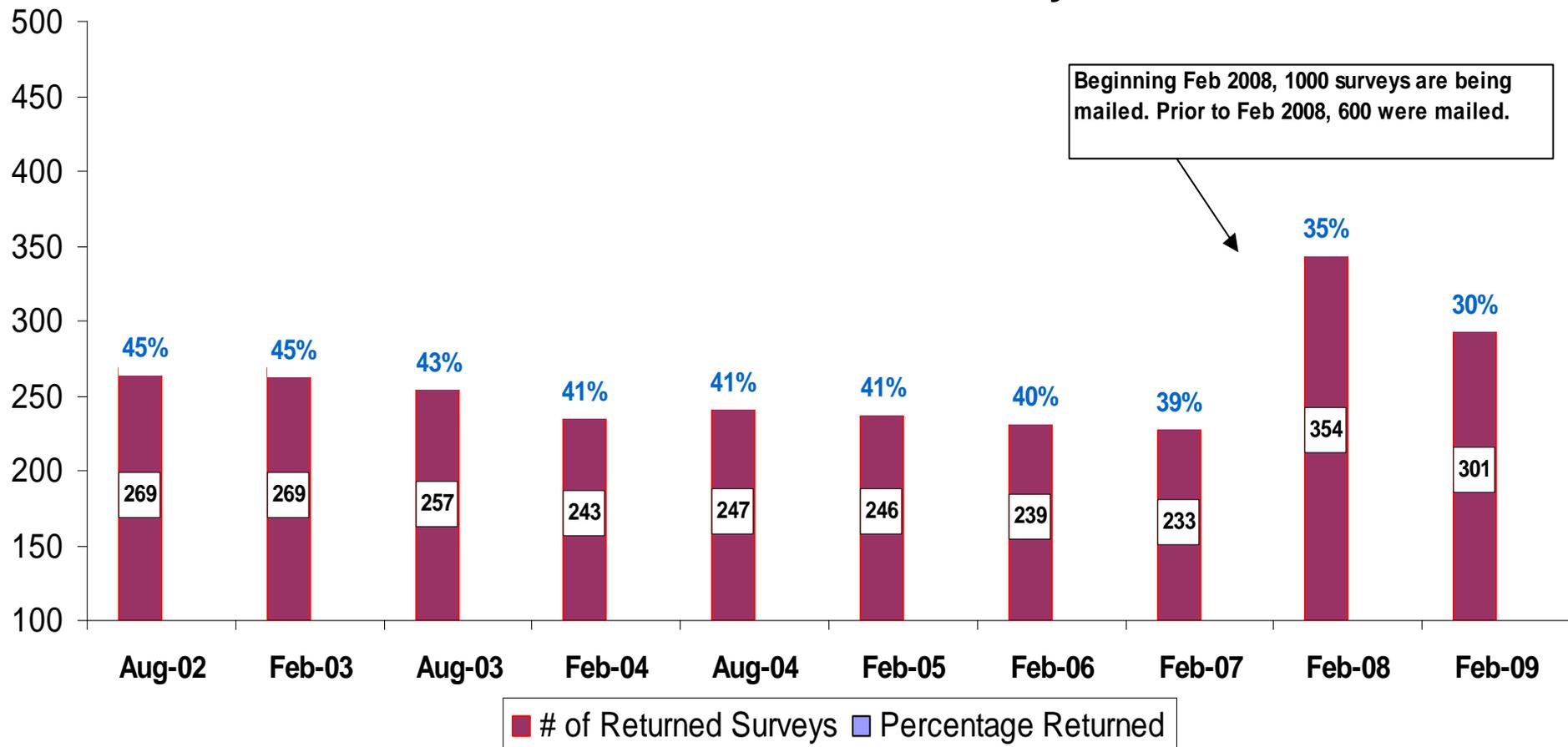
NDPERS

Member Services Survey

February 2009

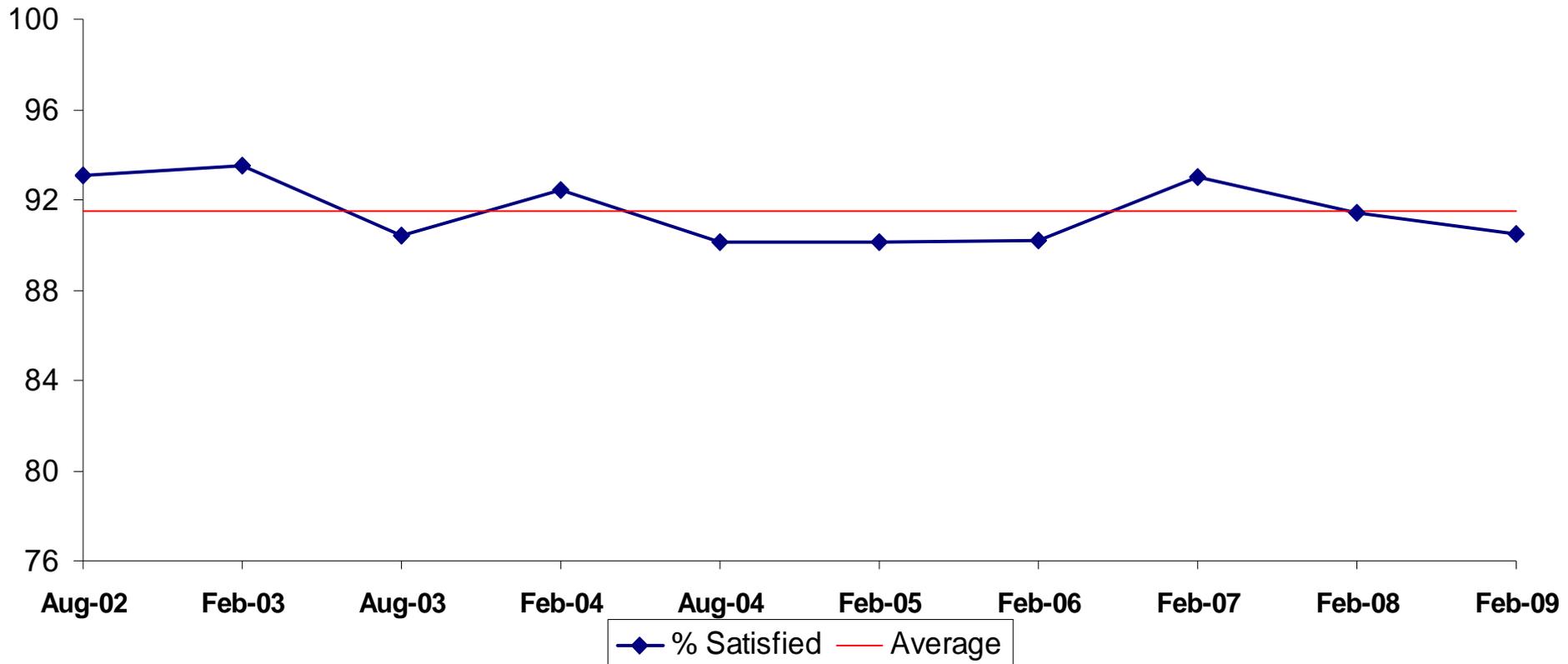


Volume of Returned Surveys



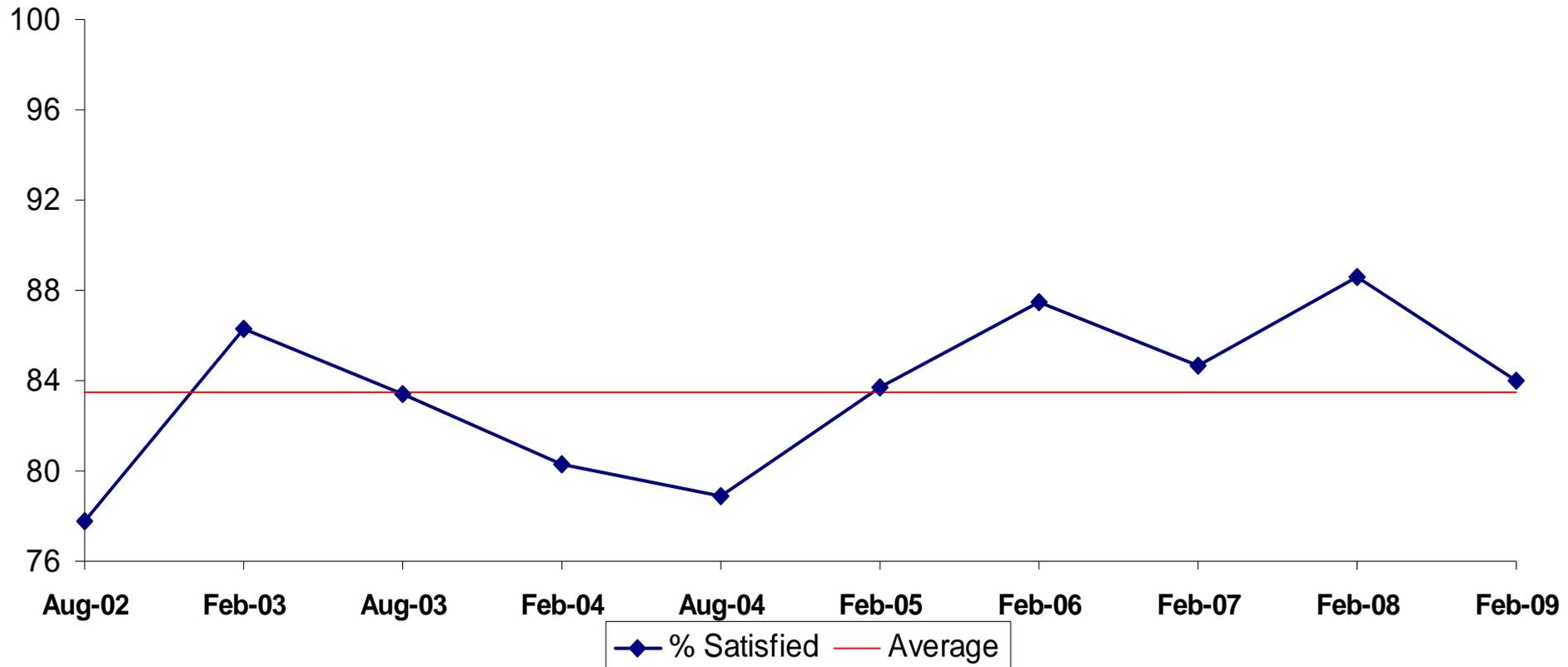


Q2 - Overall Satisfaction Rating



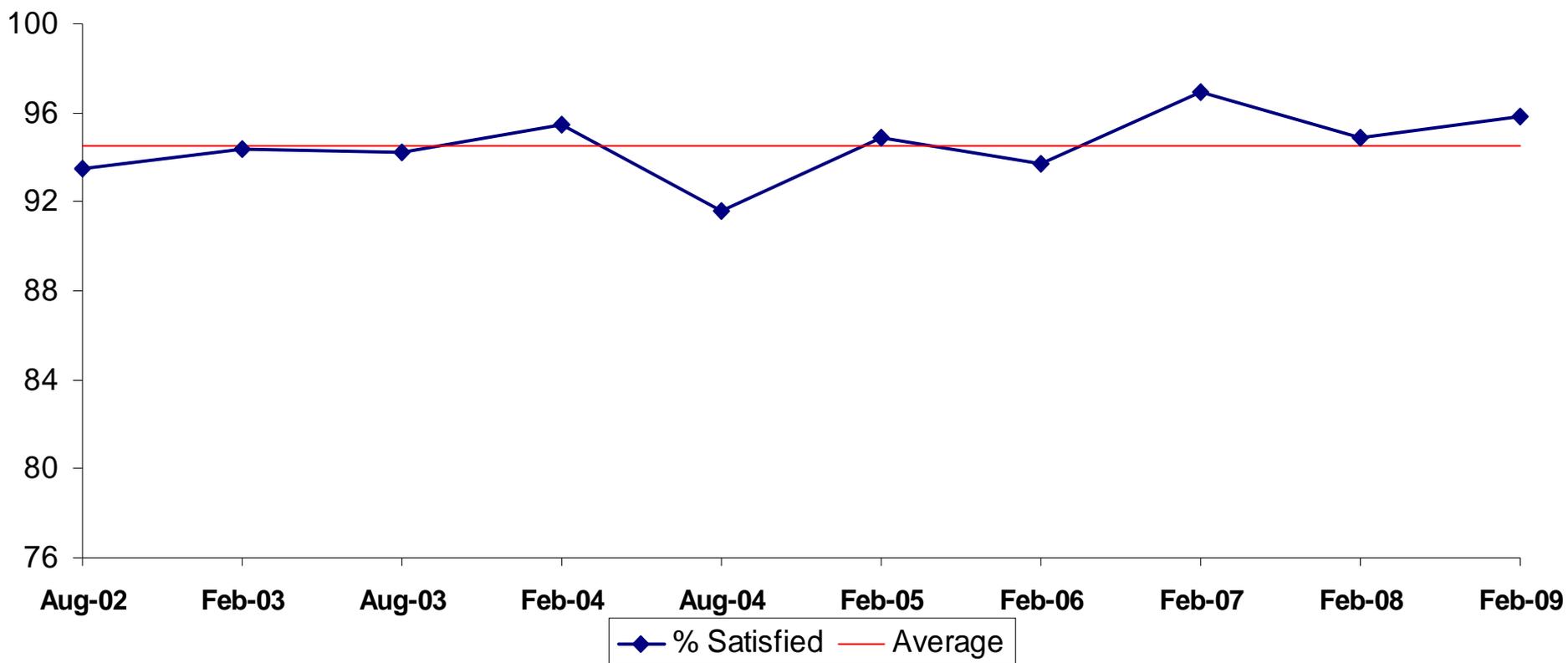


Q3 - Question Answered/Problem Solved



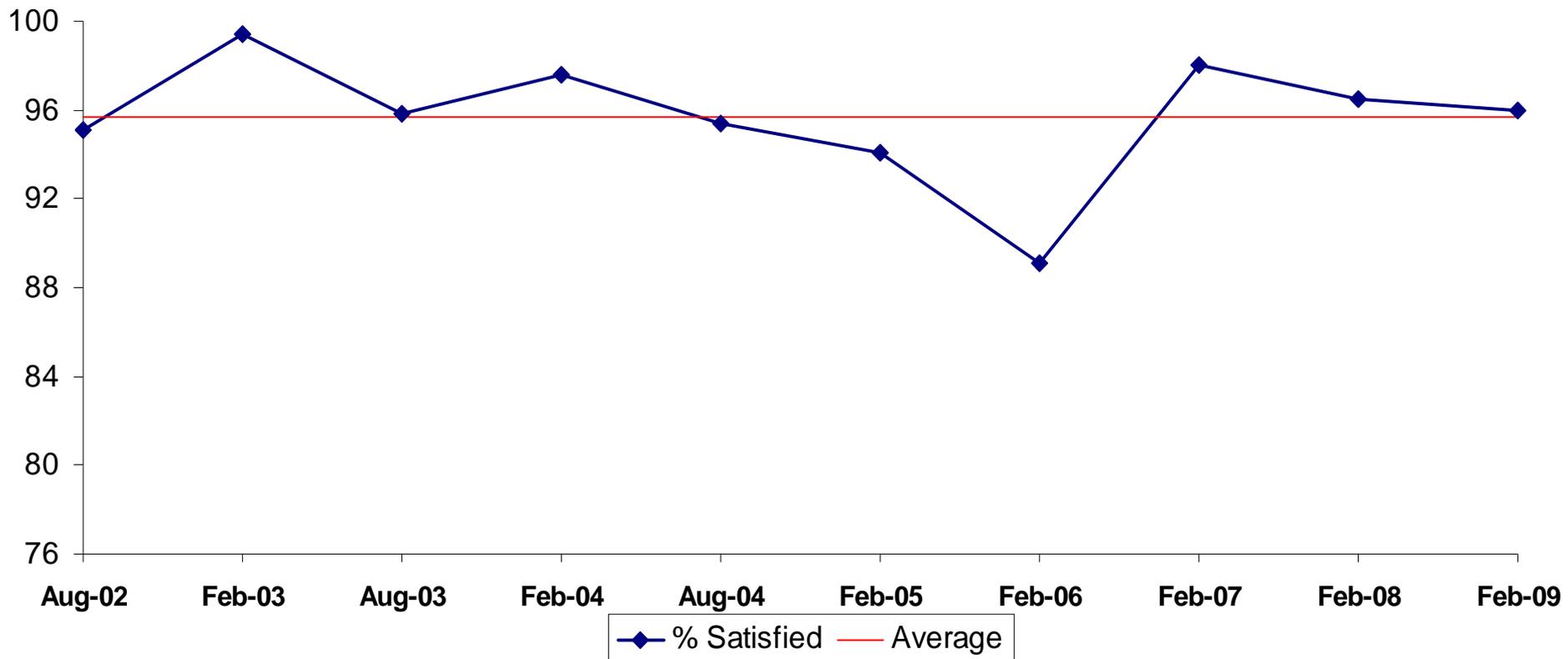


Q5a - Time Reasonable to Resolve Inquiry



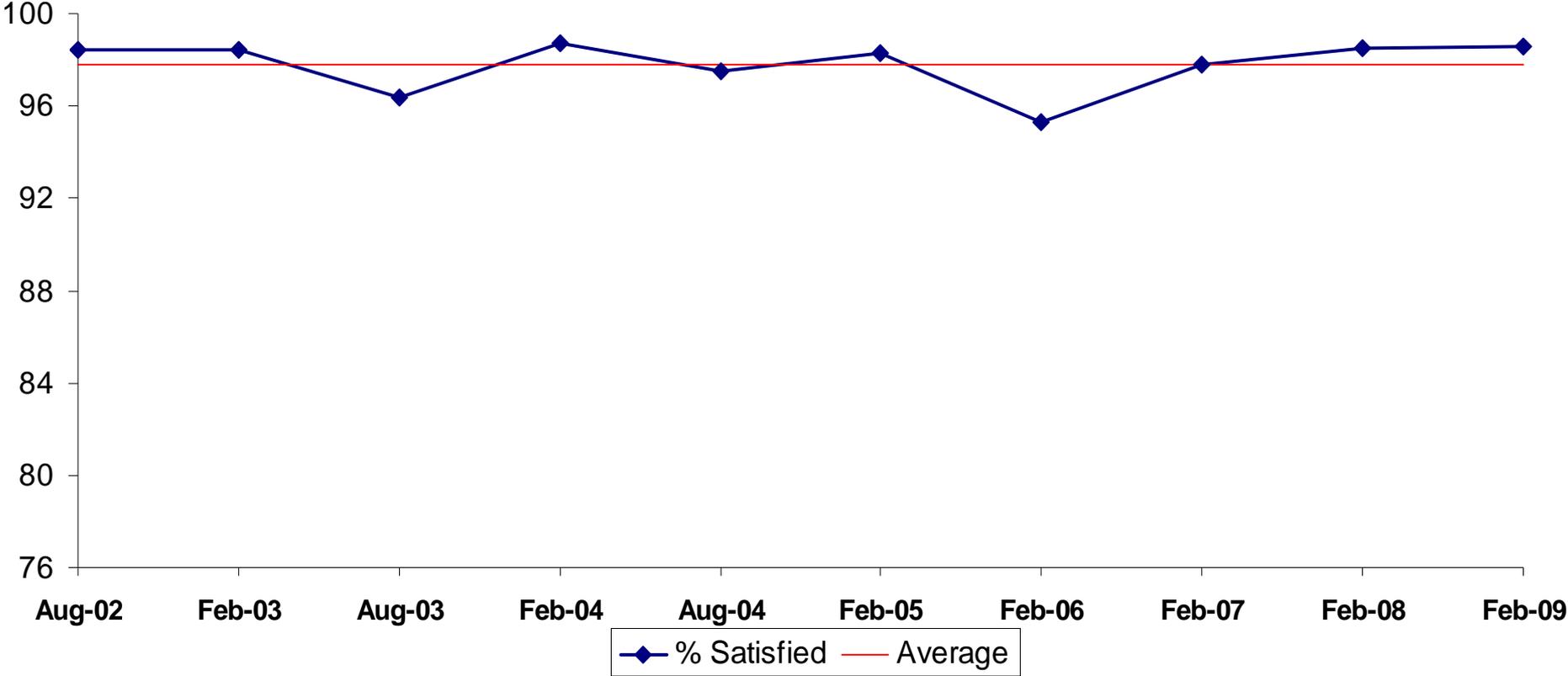


Q7 - Wait Time Reasonable



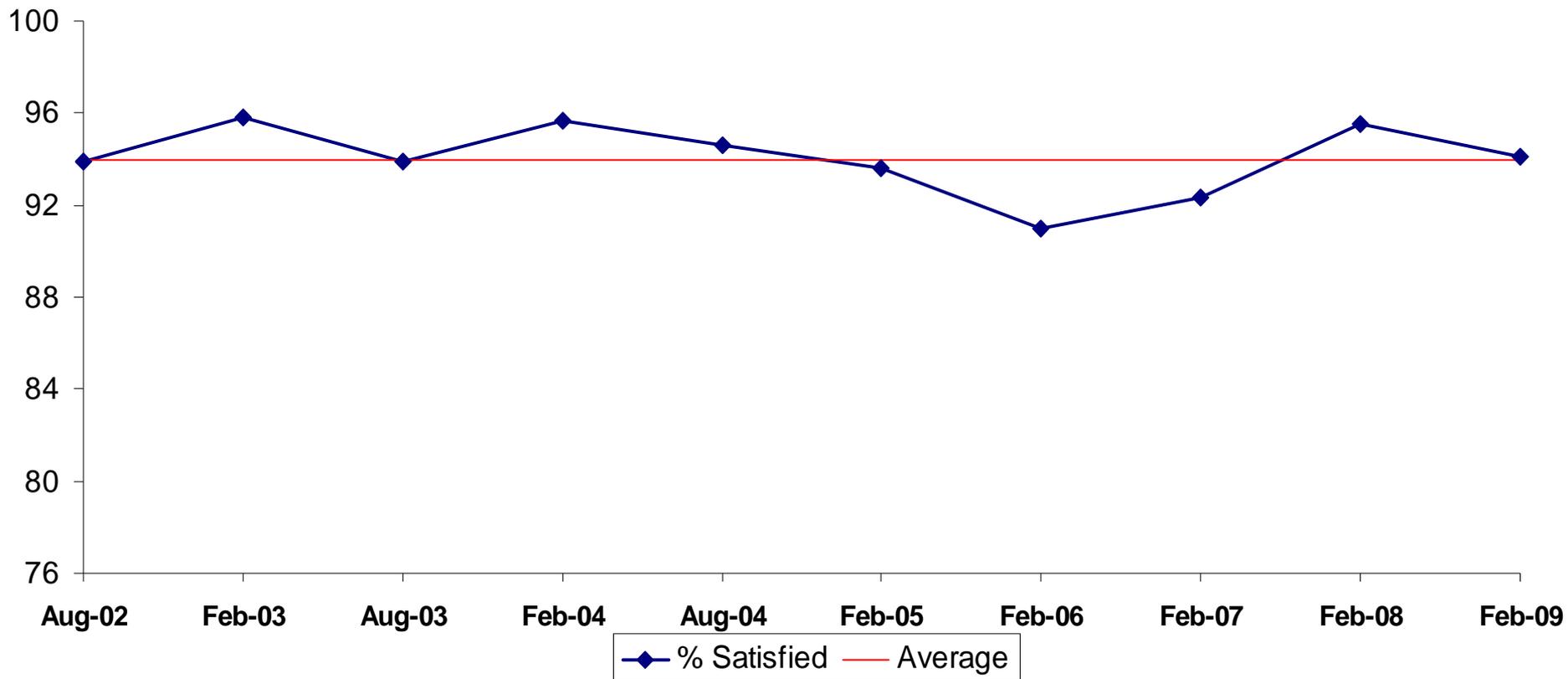


Q9b - Caller Treated with Courtesy



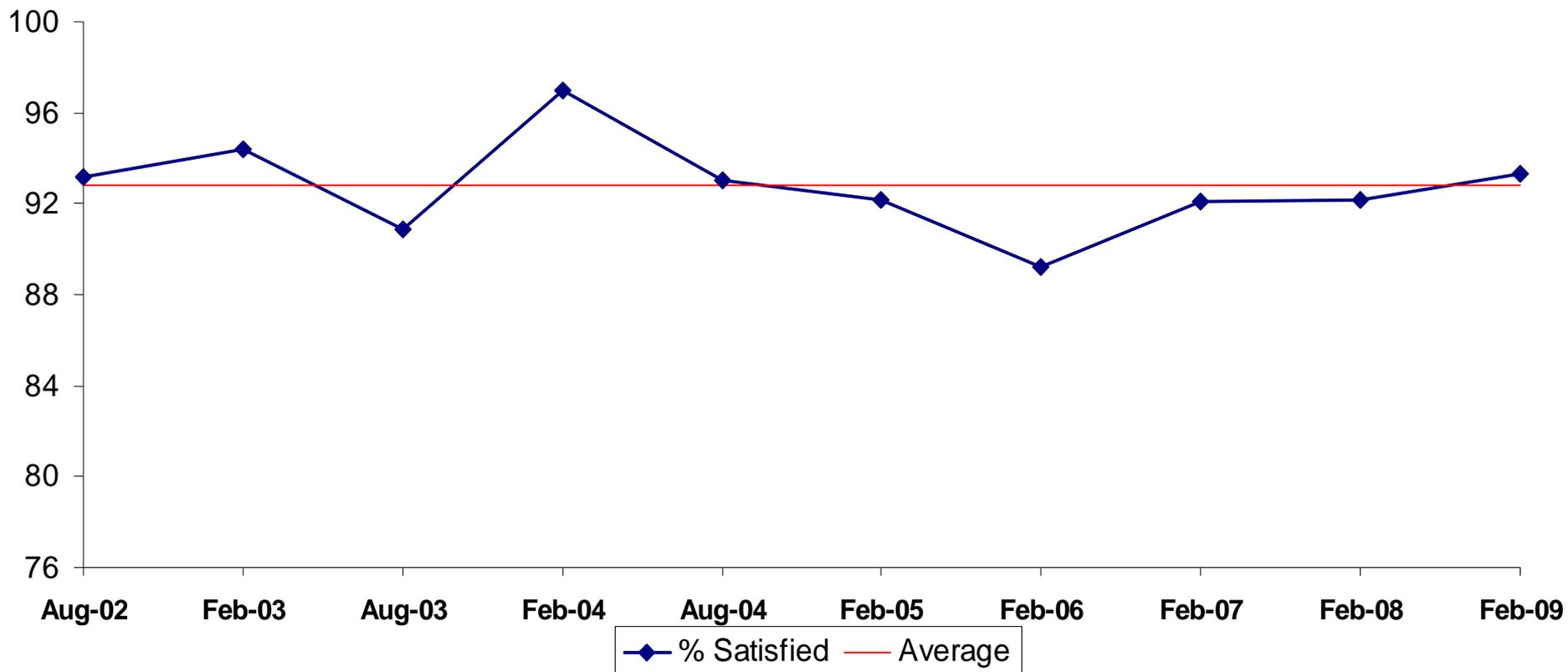


Q9c - Representative was Knowledgeable



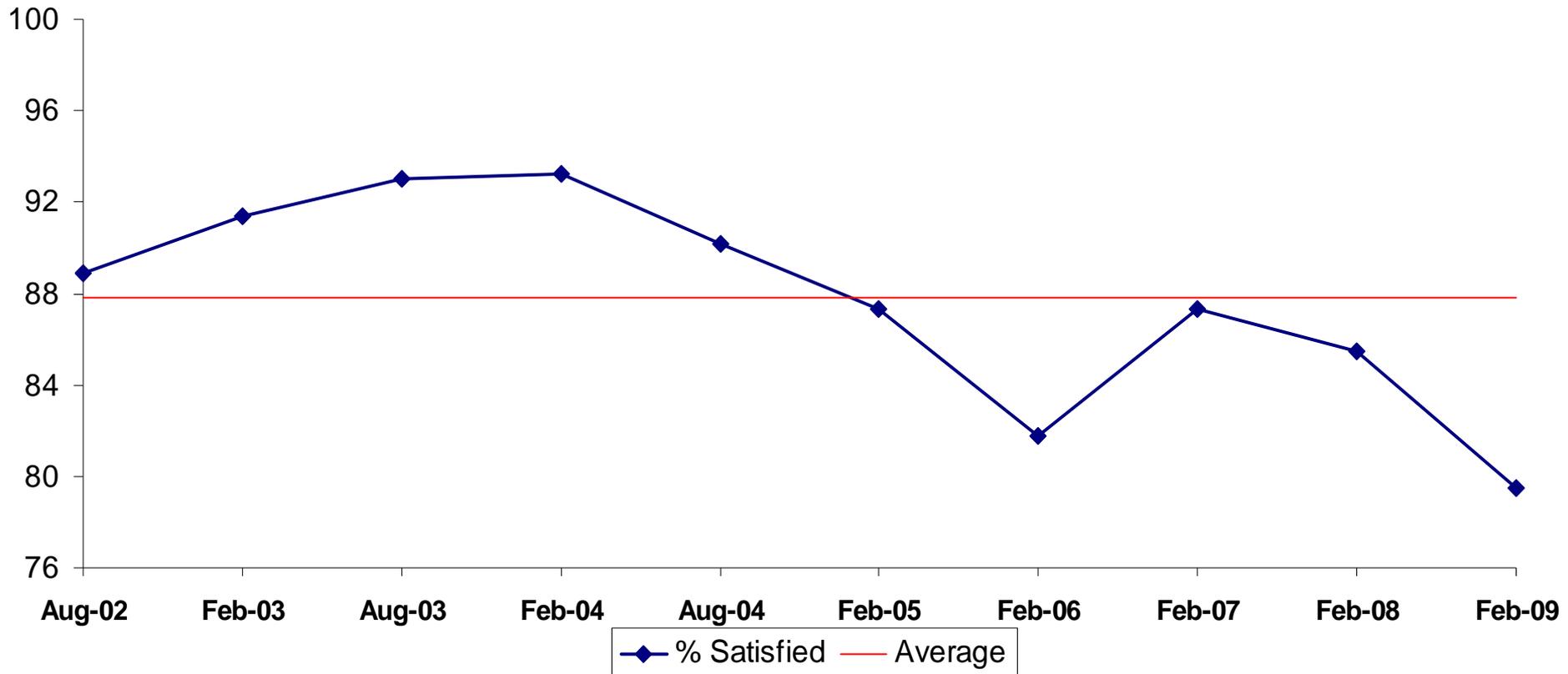


Q9e - Representative Completed Follow-up



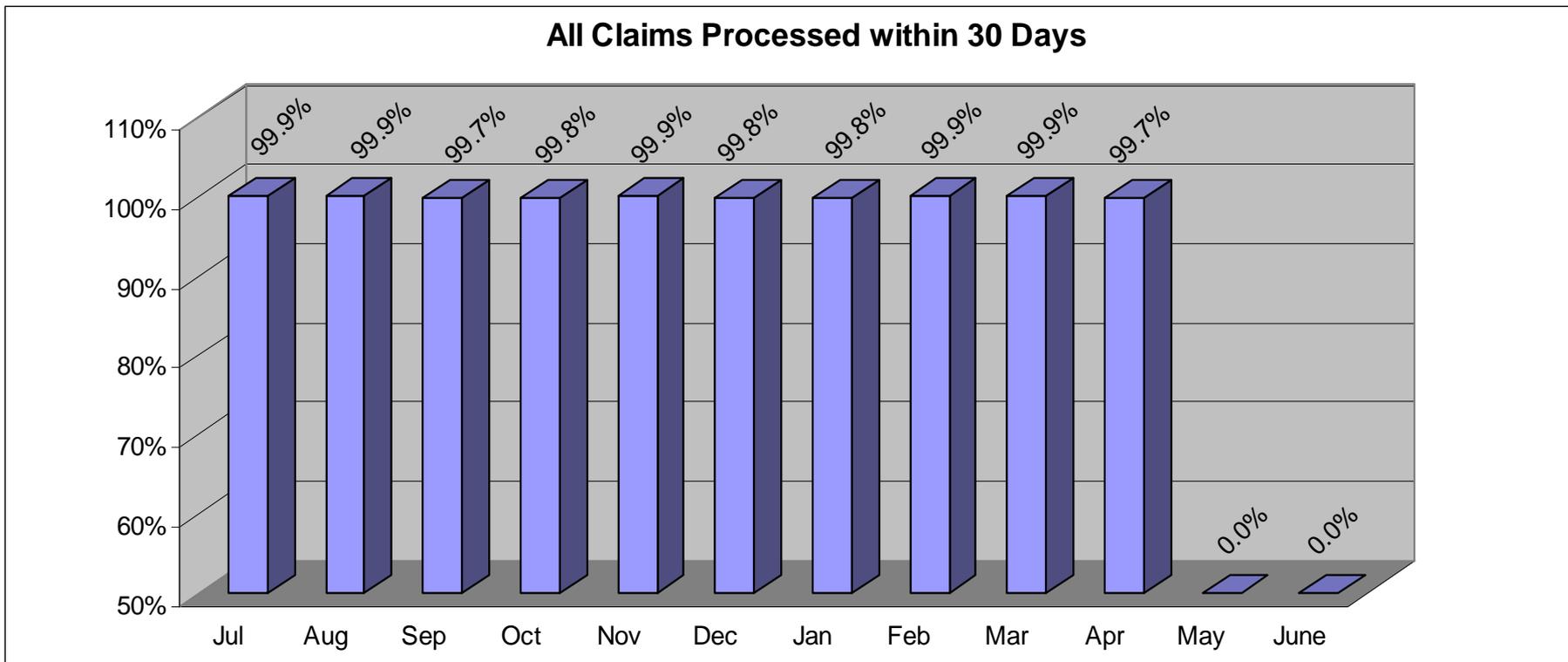


Q10 - Claim Processed Timely





NDPERS Group July 2008 through June 2009 Claims Processing Turnaround Time





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Public Employees Retirement System**
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Bismarck, North Dakota 58502-1657

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

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

Memorandum

TO: NDPERS Board

FROM: Kathy

DATE: June 9, 2009

SUBJECT: Vision Plan Renewal

The original effective date of our vision plan contract with Ameritas was January 1, 2003. This contract has been subject to two year renewals since that time. In 2008 we would have concluded the sixth year of the contract and typically, we would have issued an RFP to rebid the plan. However, due to the anticipated involvement of staff in the PERSLink project, we requested from Ameritas a proposal for a one year extension. Ameritas responded with a one-year proposal with no premium increase and the Board approved the extension to our vision contract through December of 2009.

At this time, due to staff's continued involvement in the PERSLink project and to align the bidding of this contract with our other products, we contacted Ameritas regarding the extension of the contract for an additional year. They proposed to extend the contract and will guarantee the current rates for a two-year period or through December 31, 2011. In addition, due to the favorable experience of the plan, they have also proposed an increase to the annual eye exam benefit from \$40 to \$45 effective January 1, 2010. Included is the Ameritas response for your information.

We referred the Ameritas proposal to Gallagher Benefit Services (GBS) for analysis. Using its normative vision trend of 5% along with normative retention charges, they calculated the renewal at a 6% decrease. The GBS underwriting department has indicated that the exam benefit increase from the \$40 to the \$45 is worth 6%, so the renewal at 0% is exactly where it should be based on the benefit change that is proposed. As a result the Board has two options; take the benefit change with no rate increase, or push back for a 3-6% rate decrease keeping the exam benefit at \$40.

Board Action Requested

- Accept the Ameritas proposal to extend the vision contract for one year guaranteeing the current rates through December 31, 2009 and accept the change to the annual eye exam benefit from \$40 to \$45.
- Accept the Ameritas proposal for a one-year extension without the benefit change and request the associated rate decrease.

Kathy Allen
North Dakota Public Employees Retirement System
P.O. Box 1657
Bismarck, Nd 58502

Dear Kathy:

The renewal analysis of your voluntary vision plan has been completed.

As shown on the renewal data page, claims for the most recent 12 month period ran somewhat below the target or expected level. Combining current and past experience results in no rate change at this renewal and the offer to continue the current rates through December 31, 2011.

The favorable experience also allows us to increase the annual eye exam benefit from \$40 to \$45 effective January 1, 2010.

Kathy, please let us know if there are any questions or if we can be of any service.

We look forward to working with you in the future.

Sincerely,

Daniel J. Snyder CLU,FLMI
Regional Group Manager

DJS:me

Encl.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

RENEWAL DATA

	<u>CURRENT RATES</u>	<u>RENEWAL RATES*</u> Effective 1-1-2010 to 1-1-2012
EE	\$ 5.16	\$ 5.16
EE & SPOUSE	\$10.32	\$10.32
EE & CHILD(REN)	\$ 9.40	\$ 9.40
EE, SP & CH	\$14.56	\$14.56

*Includes increasing the exam benefit from \$40 to \$45.

EXPERIENCE

3/08 TO 3/09

<u>MONTH</u>	<u>PREMIUM</u>	<u>CLAIMS</u>	<u>EMP</u>	<u>DEP</u>
MARCH	\$38,105	\$28,649	4,080	2,392
APRIL	\$37,455	\$24,764	4,087	2,388
MAY	\$37,815	\$26,100	4,097	2,395
JUNE	\$37,880	\$26,173	4,117	2,404
JULY	\$38,381	\$22,063	4,144	2,420
AUGUST	\$38,438	\$22,624	4,160	2,434
SEPTEMBER	\$38,924	\$25,403	4,211	2,461
OCTOBER	\$39,519	\$28,740	4,250	2,487
NOVEMBER	\$39,447	\$19,157	4,268	2,501
DECEMBER	\$39,559	\$26,953	4,280	2,516
JANUARY	\$41,318	\$32,479	4,314	2,545
FEBRUARY	\$40,167	\$24,984	4,305	2,539
TOTAL	\$467,008	\$308,089		

Incurred Loss Ratio 3-1-08 to 3-1-09:	66%
Target Loss Ratio 3-1-08 to 3-1-09:	72%
Actual Loss Ratio as % of Target:	92%

CLAIMS ACTIVITY

3-1-08 through 3-1-09

Claims Processed	5356
------------------	------

CURRENT PARTICIPATION

4305 Employees of which 1047 have Spouse coverage, 357 have Children coverage and 1135 have Spouse & Children coverage.

June 11, 2009

GALLAGHER BENEFIT SERVICES, INC. ≈ ≈ Memo

To: Kathy Allen, NDPERS

From: Bill Robinson, Denver Office

DRAFT

Date: June 10, 2009

Re: Ameritas Group Voluntary Vision Renewal

As requested, we have reviewed the Ameritas Group Voluntary Vision Plan renewal proposal for 2010. As part of our review, we requested and received claims and utilization data from the carrier.

Ameritas has proposed to maintain the current premiums with a benefit improvement for two years. The benefit enhancement is increasing the annual eye exam benefit from \$40 to \$45 effective January 1, 2010.

Our analysis indicates that with no change in benefits, the rate should be reduced by approximately 6% for 2010. With the two year rate guarantee being offered, this would equate to a 3% reduction over the two year period 2010-11. Further, our analysis validates that with the benefit improvement, holding the premiums at their current levels for two years is justified.

In summary, it appears that NDPERS has two choices regarding the renewal. First, it can accept the proposed benefit improvement and maintain the current rates for two more years. Alternatively, if NDPERS wants to maintain the current benefit design with no improvement, we would contact Ameritas and attempt to negotiate a reduction in the 3% of premium range.

If after reviewing this memo, you want us to contact Ameritas about a renewal with no plan design change, please let me know. Also, if we can provide any additional assistance or information, please call or email me.

Regards,

cc: Betty Woodruff, GBS



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Memorandum

TO: NDPERS Board

FROM: Kathy & Sparb

DATE: June 9, 2009

SUBJECT: Smoking Cessation Program

The Department of Health (DoH) has notified us that the Smoking Cessation Program funding will be continued for the upcoming biennium. Funding will remain at \$150,000; however, there will be some administrative changes which are being recommended by the DoH as follows:

1. The promotion pieces (posters, e-mail flyers, postcard reminder, brochures) would now be developed by DoH and NDPERS/BCBS will distribute them.
2. BCBS would continue to maintain the website, provide the New Member enrollment materials, supply ID cards to new members, process claims, do provider contracting, and program reporting.
3. Remove the \$200 reimbursement for classes. They are recommending that the language be changed so that there would be reimbursement if the program charges a fee, but not just reimburse \$200 to each state employee participant. This is because most of the local public health units don't charge a fee for classes so individuals using these providers are receiving \$200 for a service that is already provided for free. However, if a provider does charge a fee, it will be reimbursed.

Neither BCBS nor NDPERS have any objections to these recommendations. The DoH and BCBS will be working out the details of these changes and incorporating them into the final contract for the Board's review and approval at its next meeting.



Memo

To: NDPERS Board
From: Bryan T. Reinhardt
Date: 6/4/2009
Re: 457 Companion Plan & 401(a) plan 1st Quarter 2009 Reports

Here is the 1st quarter 2009 investment report for the 401(a) & 457 Companion Plan. The reports are available separately on the NDPERS web site. The NDPERS Investment Sub-committee reviewed the 1st quarter report and has no Board action.

Assets in the 401(a) plan decreased to \$12.1 million as of March 31, 2009. This is down about 30% from the same period in 2008. The number of participants is at 296, about the same as when the plan started. The largest fund is the Fidelity Managed Income Portfolio with 20% of the assets.

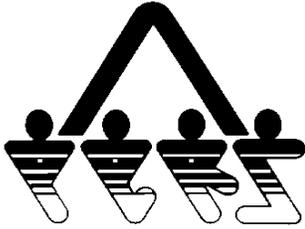
Assets in the 457 Companion Plan decreased to \$17.9 million as of March 31, 2008. The number of participants is increasing and is now at 2,590. The largest funds are the Fidelity Freedom 2020 Fund (12% of assets), the Fidelity Managed Income Portfolio (11% of assets), Allianz Small Cap Fund and Fidelity Diversified International (each 10% of assets).

Benchmarks:

Fund returns for the quarter were negative except for the stable value fund and the PIMCO Total Return Bond Fund (PTRAX). **Fidelity Equity-Income, Fidelity US Equity Index, and Fidelity Mid Cap Stock** were the funds that performed lower than their benchmarks for all periods (QTR, Y-T-D, 1-year, 3-year, and 5-year). Note that index funds are expected to slightly underperform their benchmarks because of fund administration fees.

Fund / Investment News:

The Investment Sub-Committee reviewed the NDPERS Investment Policies and had no changes. Representatives from Fidelity attended the Investment Sub-Committee meeting and presented the 1st quarter report. The committee will review international options again next quarter. The Investment Sub-Committee marked **Dividend Growth (FDGFX), Fidelity Equity-Income (FEQIX), and the Fidelity Freedom Funds** as underperforming for the quarter.



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Memorandum

TO: NDPERS Board
FROM: Kathy & Sparb
DATE: June 9, 2009
SUBJECT: FlexComp Plan

We discovered an error with regard to a process that was run by Oracle and ITD on May 15 and 16, 2009 to upgrade the software program for the PeopleSoft FlexComp claim processing system. As a result of this update, when Higher Education ran its account closure process for its flexcomp plan on May 21, 2009, it paid flexible spending account balances for pending claims in the State's flexcomp system. The overall effect was that checks were generated to these individuals from 2008 account balances that were not authorized for payment.

Staff has discussed this issue with our consultant, The Segal Company, and are in the process of developing a plan of action to correct these unauthorized payments. Based on our review thus far, 107 participants received checks totaling nearly \$10,000. Of the 107, approximately 55 checks were cashed before we issued stop payment orders.

Staff will be monitoring this issue and will provide the Board with an update at its next meeting in July.



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

Memorandum

TO: PERS Board

FROM: Bryan and Sharon

DATE: June 10, 2009

SUBJECT: **PERSLink Project Quarterly Report**

Quarterly Report

Attached is the first quarter 2009 PERSLink status report. NDPERS is required to file this report with ITD throughout the duration of our system replacement project. This is the fifth progress report in the execution stage. Note that the planning phase went well and the project is on time and on budget.

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

Project Status Report

Project Name *PERSLink* **Project Phase** *EXECUTION*

For period:	<i>January 1, 2009-March 31, 2009</i>
Submitted by:	Sharon Schiermeister, NDPERS Project Manager
Green	Strong probability the project will be delivered on time, within budget, and with acceptable quality.
Yellow	Good probability the project will be delivered on time, within budget, and with acceptable quality. Schedule, budget, resource, or scope changes may be needed.
Red	Probable that the project will NOT be delivered with acceptable quality without changes to schedule, budget, resources, and/or scope.

EXECUTIVE SUMMARY

Status Item	Current Status	Prior Status	Summary
Overall Project Status	Green	Green	<i>Overall, the project is on time, on budget and within scope. The vendor is producing deliverables that conform to the acceptance criteria included in the Request for Proposal and that adhere to the ITD Enterprise Project Management criteria. The project team exhibits a dedicated, cooperative, and professional approach to the project – focused on producing and accepting deliverables while meeting the project timetables.</i>
Scope	Green	Green	<i>No variance on scope. New requirements and enhancements are being tracked using a Scope Management Register. Additions and removals from scope are recorded and a process to dispose of additions in excess of removals was agreed and is being executed by the Project Management Team with the approval from the Steering Committee as needed.</i>
Schedule	Green	Green	<i>Pilot 2.1 was closed and incomplete construction and data conversions tasks were carried over into Pilot 2.2. The revised schedule for Pilot 2.2 incorporated a one month delay resulting from Pilot 2.1. The revised plan being followed is on track. The scheduled implementation date of October 1 2010 could be extended by one month if the current schedule variance cannot be recovered.</i>
Cost	Green	Green	<i>Actual costs are 3.2% less than expected costs primarily due to actual NDPERS staff hours being less than projected</i>
Project Risk	Green	Green	<i>The risk management log developed during the Planning Phase is maintained in SharePoint and is being reviewed periodically by the project management team. One new high priority risk and three medium priority risks were added during this period and other risks were updated.</i>
Accomplishments:			
<p><i>During this reporting period of the Execution phase the PERSLink Project Team deployed one release into the PERSLink Release 1.0 production environment, resolving 18 PIRs.</i></p> <p><i>In parallel, the project team also completed, reviewed and approved all UCS documentation for Pilot 2.1. At the end of December 2008 the team identified 85 PIRs, classified as "Important" or "Critical", which needed to be resolved and re-tested prior to closing Pilot 2.1. During the month of January 2009 these PIRs were resolved and retested, satisfying the criteria for bringing closure to Pilot 2.1. The team also logged approximately 290 Business Rules and classified them as "Unable to test".</i></p>			

These Business Rules and the remaining PIR's will be addressed as part of future Pilots. The Project team also continued to work on data conversion and interfaces with PeopleSoft and vendors. The project team started the execution of Pilot 2.2, completing JAD sessions for two thirds of the 12 UCS, and developing and reviewing documentation for six UCS. In parallel the project team is completing construction and unit testing for one completed UCS and initiated system testing. The backfile conversion task was completed for close to 1 million images uploaded into FileNet, including member data and organization data. The deliverables that were developed, reviewed and approved are listed in the Deliverable Acceptance Log Summary. The following team building events occurred:

- 1. Sagitec conducted two Lessons Learned Sessions on User Acceptance Testing and Data Conversion for Pilot 2.1 including both Sagitec and NDPERS team members*
- 2. NDPERS and Sagitec held a session to discuss UAT for future Pilots based on the lessons learned.*
- 3. The project team conducted 3 'best practices' sessions with NDPERS staff seeking feedback on what is working in Production, what is not working in Production and what could work better.*

The following project communications events occurred:

- 1. The January 2009 PERSLink Newsletter was published*
- 2. NDPERS Project Manager made periodic updates to the NDPERS Management Team and staff*

Expected Accomplishments:

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

- 1. Complete the following tasks and deliverables:*
 - a. Bring closure to Pilot 2.2*
 - b. Start JAD sessions for Pilot 2.3*
 - c. Conduct testing of provider interfaces from Pilot 2.1*

RISK MANAGEMENT

Status Item	Current Status	Prior Status	Summary
Project Risk	Green	Green	<i>One new high priority risk and 3 medium priority risks were added. A risk assessment session was conducted in January 2009 to update and review all the items in the Risk Register.</i>
Risk Management Log Summary			
Risk #	Description	Response Plan	Owner
22	Having UAT for Pilot 2.2 and 2.3 together at the end may cause a schedule delay if major defects or missed functionality is discovered	Two weeks were added for Pilot Execution to allow Core Team hands on experience and opportunity to identify major issues	Sagitec Project Manager
23	Designing during JADs can increase schedule	From lessons learned, more focus on monitoring the milestones for each UCS. Pre-JAD meetings will help focus on business requirements. JAD participants need to follow the JAD protocol	Sagitec Business Analysts
24	Splitting the Core team during pre-JAD may result in missed functionality	Core team will be split for Pre-JADS but entire team will participate in all JADs. Conduct early review of the new process and make adjustments if necessary	NDPERS Project Manager
25	Not able to finish data conversion with quality and on schedule could impact schedule for System Test and UAT	Assign dedicated resources; conduct weekly meetings – more frequently when necessary; create action plans	Sagitec Delivery Manager
Comments:			

Comments: All PERSLink deliverables are maintained on the PERSLink Project Portal in SharePoint. All accepted deliverables are maintained in the Acceptance Folder in word format and on the Archive folder in pdf format			

COST MANAGEMENT

Status Item	Current Status	Prior Status	Summary
Budget	Green	Green	<i>At the end of the quarter, actual costs were lower than expected costs. Actual payments made to Sagitec were greater than expected payments as a result of the backfile conversion being completed ahead of schedule.</i>
Project Budget	Revised Budget (if applicable)		Expenditures to Date
\$10,502,214	\$0.00		\$4,981,427
			Estimated Cost at Completion
			\$10,161,734

Budget Status
As of 3/31/09

	Original Budget	Actual Costs	Expected Costs	Actual vs Expected Variance	Remaining Budget	C In
Sagitec	7,678,360	4,244,901	4,217,445	27,456	3,433,459	
LRWL	1,000,000	414,668	429,163	(14,496)	585,332	
Hardware/Software	185,000	12,430	12,430	0	172,570	
Contingency	730,640	17,820	17,820	0	712,820	
Total Appropriation	9,594,000	4,689,818	4,676,858	12,960	4,904,182	
PERS Staffing hours	908,214 24,000	291,609 7,706	471,477 12,459	(179,868) (4,753)	616,605 16,294	
Total Budget	10,502,214	4,981,427	5,148,335	(166,908)	5,520,787	



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

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Memorandum

TO: PERS Board

FROM: Sharon Schiermeister

DATE: June 10, 2009

SUBJECT: PERSLink Data Conversion

One of the major activities within the PERSLink project is data conversion. Data is the foundation for any system; therefore it is critical that our legacy data be converted accurately and thoroughly into PERSLink. The PERSLink project team does not have one person that can be dedicated to this activity and be assigned primary responsibility. Therefore, we have been splitting the duties and working on this effort as time allows. Unfortunately, this is not allowing us to give data conversion the level of attention that is required.

Not being able to finish data conversion with quality and on schedule has been identified as a project risk by the project team. To prevent this risk from becoming a reality, we feel it is necessary to add additional resources to assist the project team. The following options were identified:

- Option 1:** Add another PERS staff member to the PERSLink project team to work on data conversion
- Option 2:** Increase ITD's involvement with data conversion
- Option 3:** Contract with a vendor for assistance with data conversion

Option 1 was determined not to be feasible as we do not have any one PERS staff member with the knowledge of the data and the technical skills to assist with data conversion as needed. Our internal IT staff members are stretched very thin keeping our day to day operations running in addition to their involvement with the PERSLink project.

Option 2 was also determined not to be feasible. We are currently experiencing a shortage of experienced programming staff at ITD to work on requests to our mainframe system. We did not feel comfortable adding additional work responsibilities on a programming team that is already struggling to meet our day to day needs.

This leaves Option 3. We asked LR Wechsler, the consultant we are using for oversight project management, if they could provide us with an additional resource to assist with data conversion. They indicated they do have a 'data expert' who could provide assistance to us. This person previously assisted us with our user acceptance testing back in December 2008. The hourly rate for this person is \$155/hour plus travel expenses.

In April, while attending the annual conference for Public Retirement Information Systems Managers, I was introduced to a vendor, ICON Integration and Design, Inc., who specializes in data conversion. I learned that this vendor has experience working on data conversion projects for public pension funds and is currently working with 3 clients who are also working with Sagitec. I was able to talk with 2 of ICON's current clients who were both very pleased with the quality of work being provided. Sagitec's experience with ICON has also been very positive and they feel ICON would be able to provide us with the assistance we need. The hourly rate for the person who would assist us is \$145 when working on-site and \$105 when working off-site. The on-site rate includes travel expenses.

We estimate the bulk of the work effort would be completed within a 6 month period and the fees would not exceed \$120,000. We would be able to absorb this cost within our original project budget as a result of our backfile conversion project coming in under budget. Therefore, an increase in our project budget will not be required.

The scope of work that would be performed by ICON includes:

- A reconciliation to ensure data is migrated completely and successfully from the legacy system to PERSLink
- A data migration reconciliation report that would include a reconciliation of control totals from the legacy system to the migrated data in PERSLink
- Assist NDPERS staff with recommendations as to resolving any discovered data issues
- Assist with reconciling the final converted data at time of deployment

Attached is a brief biography of ICON.

Staff Recommendation: Retain ICON to assist the PERSLink project team with data conversion activities. They have proven experience with other pension plans and with our software vendor; their hourly rate is less than LRWL's proposed rate; and they would be available to begin work in July. This will allow us to improve the progress on data conversion activities in order to provide for accurate converted data within the project timelines.

Board Action Requested: Approve reallocation of project budget to contract with ICON for data conversion assistance up to \$120,000

Attachment

ICON Integration & Design, Inc

Icon Integration and Design, Inc. a company focused on data - data profiling, cleansing, conversion, and integration. ICON provides certified professionals in Oracle, Microsoft, DB2, AS/400, Project Management Institute, IT Infrastructure Library, PeopleSoft, and others. ICON consultants provide the data expertise an organization requires for avoiding obstacles and failures resulting in months of delays, runaway costs, and issues that negatively impact day-to-day business.

Data quality impacts every level and department within an organization. Whether you are in a call center responding to a member or making critical financial decisions for the organization - data is the foundation. *What happens if the data is inaccurate, incomplete, or not current...membership confidence suffers and the organization may face financial risk?* PricewaterhouseCoopers produced a survey in which 75% of the respondents reported significant problems as a result of defective data when implementing a CRM strategy. ICON has the experience to successfully map and cleanse an organizations data to meet business and application requirements.

Whether you are converting your organization's file structure from an AS/400 flat file to an RDBMS (Relational Data Base Management System), MS SQL Server to Oracle, DB2 to MS SQL Server, or implementing a new Pension Administration system - ICON has certified experienced professionals to make the

conversion successful. Converting millions of records containing historical information is a daunting task that cannot be taken lightly - using ICON can reduce the risk due to our copyrighted process containing numerous quality and integrity checkpoints ensuring a successful conversion.

One of the major challenges facing organizations today is the need to create a single, accurate, consistent, and timely view of their members, a view which spans across all applications, systems, business units, and member touch points. While a vast majority of organizations acknowledge the value of a single member view, few organizations have implemented such a view and many organizations still want the ability to provide a single accurate, complete, and timely view of their members. ICON provides the expertise in data integration required to meet these challenges. It is important to realize an organization cannot begin to fully leverage member information without integrating information obtained throughout the organization concerning the member. ICON assists in integrating the various sources of data: pension administration systems, accounting systems, member services systems, employer services systems and other "siloes" data sources. Data integration allows the organization a 360 degree view of its membership.

ICON is currently working with five (5) pension administration organizations to provide cleansed and converted data for their new pension administration application systems.

ICON Highlights

The Data Warehouse Institute is reporting an increase in the number of IT departments investing in data quality.

Organizations and companies alike are becoming aware of the millions spent on application software systems with minimal

investment in their data severely limiting their applications usefulness. The best application system will fail if the data it relies on is invalid or incomplete. With more companies realizing the return on investment for data integrity, individuals/companies with data profiling, cleansing, conversion and integration are in demand.

ICON's business is centered on the foundation of every business that utilizes information technology data. ICON does not attempt to be "*everything to everyone*", ICON consultants are experts in data - profiling, cleansing, conversion, integration, stewardship, administration, and mining. Software application vendors focus on developing software which access, present, and manipulate the data, their product expects quality data. ICON's line of business is data and working directly with clients or software application vendors. The information technology industry is beginning to recognize data as being a prominent and critical piece of the IT puzzle. ICON is poised to help its clients achieve success by securing the foundation of IT infrastructure..... data.

ICON, through continued client satisfaction and consultant expertise, is going to be the preeminent data management consulting firm. The primary line of business for ICON encompasses the data of the IT infrastructure. Supported by the industries best practices and using a proven methodology that has been refined through numerous projects, ICON provides a superior product through project management, thorough documentation, and sound data knowledge. The change management process, critical in managing data and structure of the target staging database, is based on the best practices outlined within ITIL (Information Technology Information Library) concepts. All projects undertaken by ICON follow PMI (Project Management Institute) project management protocol. ICON can use either Microsoft Project or Rational Rose as the tool for project planning and tracking.

ICON works directly with clients and application software vendors to improve data quality. For clients, ICON provides an independent knowledgeable voice in working with application vendors concerning data. Clients may not have a dedicated data management staff to address critical and difficult data issues, ICON provides this and augments the client's existing staff. ICON partners with our clients to identify, quantify, document, and resolve data issues such as data

** Company focused on data management activities*

** Average consultant has 10+ years in data management experience*

** Experts in data: profiling, cleansing, conversion, administration, integration and mining*

** Experts in utilizing high-productivity data tools: DataFlux, Pervasive, Oracle OWB,...*

validity, standardization, normalization, orphaned records, detail-summary deltas, historical business requirements, etc.



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

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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 10, 2009
SUBJECT: Request for Proposal

The deadline for the proposals for the experience study and the OPEB valuation were due June 5th at 5:00 p.m. (CST). We received four written proposals in the office from:

1. Segal
2. Aon
3. Vanlwaarden
4. GRS

We also received via email a proposal from Gallagher Benefit Services (GBS). They had forwarded their proposal for delivery with UPS. They found out on Friday afternoon (June 5) that UPS had misdirected their proposal to the wrong location (attached is a letter from Bill Robinson and UPS tacking slip). They called me that afternoon and asked if anything could be done. I suggested that they email me the proposal by 5:00 p.m. (CST) that day and I would review it with the board.

The RFP states the following concerning submission of proposals.

Twenty five copies of the technical and price proposals must be received at the listed location by 5:00 p.m. Central Standard Time on June 5, 2009. The package proposal is delivered in must be plainly marked "Proposal to provide Consulting and Actuarial Services". A proposal shall be considered late and will be rejected if received at any time after the exact time specified for return of proposals.

The RFP also states the following:

The failure to meet all procurement policy requirements shall not automatically invalidate a proposal of procurement. The final decision rests with the Board

In recognition of the above staff is seeking your direction concerning the GBS proposal and if it should be rejected or reviewed.

Board Action Requested

Determine if the GBS proposal should be rejected or not.

GALLAGHER BENEFIT SERVICES, INC. ≈≈ Memo

To: Sparb Collins, NDPERS
From: Bill Robinson, Denver Office
Date: June 7, 2009
Re: Actuarial Services Proposal

Sparb,

As requested, I am submitting this request to NDPERS to consider our proposal to provide GASB 45 and DB Plan Experience Study actuarial services. Although our electronic technical and cost proposals were submitted to NDPERS prior to the June 5, 2009 afternoon deadline, our 25 hardcopy proposals will not be delivered by UPS until Monday June 8th.

I personally dropped off the 25 proposals at our local UPS office at about 9 AM Thursday June 4th and was assured that they would arrive in Bismarck by 10 AM the following morning, well in advance of your afternoon deadline.

As we routinely do with proposals with deadlines, we checked on June 5th with UPS to confirm the box containing our proposals had been delivered. At that time we were advised by UPS that the box had been incorrectly misrouted and would not arrive in Bismarck by the RFP deadline. Once we learned this, we immediately contacted you to alert you of the delayed delivery. We then submitted the electronic technical and cost proposals to verify that we had completed our proposal within the RFP deadline period.

We are requesting the NDPERS accept our proposal. Our technical and cost proposals were mailed within UPS' timeframes for delivery by the submission deadline. However, due to UPS' admitted errors, the proposals were not send to Bismarck but some other location. Under separate cover, we will email a copy of the UPS documentation that confirms their routing error. As noted, our electronic technical and cost proposals were submitted prior to your deadline.

We would appreciate NPDERS' favorable consideration of our request. Please let me know if I can provide any additional information to support our request.

Regards,

Bill Robinson

cc: Les Kohn, GBS

Tracking Detail

Tracking Number: 1Z 492 V5R 13 9461 638 5
 Type: Package
 Status: **In Transit**
 Rescheduled Delivery: 06/08/2009
 Shipped To: NORTH DAKOTA PERS
 CHERYL STOCKERT
 400 E. BROADWAY SUITE 505
 BISMARCK, ND, US 58502
 Shipped/Billed On: 06/03/2009
 Reference Number(s): 601411
 Service: NEXT DAY AIR SAVER
 Weight: 36.00 Lbs

*5 parcels
 701-328-3901*

Package Progress

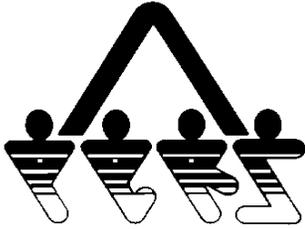
Location	Date	Local Time	Description
ROCKFORD, IL, US	06/05/2009	2:07 A.M.	INCORRECT ROUTING AT UPS FACILITY
	06/05/2009	12:30 A.M.	ARRIVAL SCAN
COMMERCE CITY, CO, US	06/04/2009	9:30 P.M.	DEPARTURE SCAN
	06/04/2009	8:20 P.M.	ARRIVAL SCAN
ENGLEWOOD, CO, US	06/04/2009	7:35 P.M.	DEPARTURE SCAN
	06/04/2009	6:37 P.M.	ORIGIN SCAN
US	06/03/2009	8:38 P.M.	BILLING INFORMATION RECEIVED

Tracking results provided by UPS: 06/05/2009 3:01 P.M. ET

NOTICE: UPS authorizes you to use UPS tracking systems solely to track shipments tendered by or for you to UPS for delivery and for no other purpose. Any other use of UPS tracking systems and information is strictly prohibited.

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400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

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

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

Memorandum

TO: NDPERS Board

FROM: Election Committee:
Jon Strinden
Levi Erdmann
Mike Sandal

DATE: June 9, 2009

SUBJECT: Election Results

The deadline to return ballots is Friday, June 12, 2009. Canvassing will be conducted on Monday, June 15, 2009 at the NDPERS Office. A complete accounting of the election results will be provided by the Committee prior to the meeting.



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Public Employees Retirement System
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Bismarck, North Dakota 58502-1657

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

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

MEMORANDUM

TO: NDPERS Board

FROM: Jamie Kinsella *Jamie*

DATE: May 20, 2009

SUBJECT: February 18, 2009 PERS Audit Committee Minutes

Attached are the approved minutes from the February 18, 2009 meeting. Those who attended the meeting are available to answer any questions you may have.

These minutes may also be viewed on the NDPERS web site at www.nd.gov/ndpers.

The next audit committee meeting is scheduled for August 19, 2009, 10:00 a.m., in the NDPERS Conference Room.

Attachment



MEMORANDUM

TO: Audit Committee
Jon Strinden
Ron Leingang

FROM: Jamie Kinsella, Internal Auditor

DATE: February 19, 2009

SUBJECT: February 18, 2009 Audit Committee Meeting

In Attendance:

Jon Strinden, via conference call
Ron Leingang
Rebecca Dorwart
Jamie Kinsella
Sparb Collins
Leon Heick

The meeting was called to order at 10:00 a.m.

I. November 19, 2008 Audit Committee Minutes

The audit committee minutes were examined and approved by the Audit Committee.

II. Internal Audit Quarterly Report

- A. Internal Audit Quarterly Report – The Internal Audit quarterly report listed all of the projects that are in active status as of January 31, 2009. There were several items added to the report. These were items that were found on the audit plan for 2007-2009 and never added to the quarterly audit plan status report. There was 1 audit project and 2 other projects that were completed this quarter.

Quarterly Audit Recommendation Status Report – As stated in the Audit Policy #103, the Internal Audit Division is to report quarterly to management and the audit committee the status of the audit recommendations of the external auditors, as well as any found by the internal auditor.

During the past year efforts have been made to ensure that management continues to work on these recommendations. As part of this process, staff reviews these recommendations and their progress at the quarterly Loss Control Committee meetings. Ms. Kinsella reported that three internal audit recommendations should show significant progress by the May meeting. The last recommendation was questioned, which was regarding the IT anti-virus software. It was noted that it was to be completed by December 2008, but there has been no change in the last quarter. This should be done by the next external audit.

III. Administrative

- A. Internal Audit Annual Report for 2008 - Included with the audit committee materials was a copy of the Annual Audit Report for January 1, 2008 through December 31, 2008. The audit committee approved the 2008 Internal Audit Report.
- B. Audit Committee Charter Activity Review – The Audit Committee Charter stated that it will “17. Confirm annually that all responsibilities outlined in this charter have been carried out. Report annually to the Board, members, retirees and beneficiaries, describing the committee’s composition, responsibilities and how they were discharged, and any other information required by rule, including approval of non-audit services.” To meet this requirement a matrix was developed to review against current practices to ensure that the audit committee is meeting its responsibilities. Included with the audit committee materials was a copy of the matrix for the audit committee’s review. A copy of the matrix will also be provided to the NDPERS Board for their information.
- C. Performance Evaluation – It is time for Ms. Kinsella’s performance evaluation. The due date for having these completed is February 28. Mr. Collins discussed the format for Ms. Kinsella’s evaluation with the audit committee.
- D. Audit Committee Meeting Date & Time – The May audit committee meeting is scheduled for May 20, 2009 at 10:00am..

IV. Miscellaneous

- A. Pharmacy Benefits Manager (PBM) Project – Ms. Kinsella conveyed staff had received information from BCBS but due to the BCBS renewal process and legislative bills, staff had not been able to review the material. Ms. Kinsella indicated it was staff’s goal to have this fully initiated during the second quarter of 2009.
- B. Risk Management Report – At the May audit committee meeting, it was determined that a Risk Management Policy for PERS would not be necessary since a Loss Control Committee is in place to manage risk for the agency. At that time It was suggested that the Loss Control Committee provide a copy of the last meeting agenda and the approved minutes. Deb Knudsen, who oversees the Loss Control Committee, will come to the August meeting each year to update the audit committee on the Loss Control Committee, its purpose, and to answer any questions the audit committee may have. Included with the audit committee materials was a copy of the approved meeting minutes for September 2008 and the agenda for the December 2008 meeting.
- C. PERSLink Quarterly Report – Included with the audit committee minutes was the PERSLink quarterly status report. NDPERS is required to file this report with ITD throughout the duration of the system replacement project. This was for information only.

- D. Report on Consultant Fees - According to the Audit Committee Charter, the audit committee should "Periodically review a report of all costs of and payments to the external financial statement auditor. The listing should separately disclose the costs of the financial statement audit, other attest projects, agreed-upon-procedures and any non-audit services provided." Included with the audit committee materials was a copy of the report showing the consulting, investment and administrative fees paid during the quarter ended December 31, 2008. Mr. Collins indicated that the investment fees are being reviewed and compared to other public pension funds.
- E. Continuing Professional Education – Ms. Kinsella indicated she and Leon attended the IIA Central NoDak's seminar in December 2008. This seminar provided 16 continuing professional education credits and the topic was Communication and Interpersonal Issues for Auditors and High Impact Auditing.
- F. Publications – Included with the audit committee materials were publications and/or articles from the Institute of Internal Auditors.

The meeting adjourned at 10:40 a.m.



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Memorandum

TO: PERS Board

FROM: Performance Review and Compensation Committee

DATE: June 10, 2009

SUBJECT: ANNUAL EVALUATION OF EXECUTIVE DIRECTOR

The Performance Review and Compensation Committee was appointed by the PERS Board at the April meeting and charged with coordinating the performance review and preparing a salary recommendation for the Board's consideration. The Committee members are Ron Leingang, Mike Sandal and Levi Erdmann.

The committee reviewed the Public Funds Compensation and Salary Survey for 2008 prepared by McLagen Partners. This organization completes an annual survey of public pension fund positions including the Executive Directors/CEO. The survey is dated November 21, 2008. The Committee also reviewed the results of the performance evaluation.

Highlights from the salary survey for the CEO are:

1. There were 54 Public Funds participating in the survey. There are approximately 83 such funds.
2. The median salary by all funds participating in the survey was \$167,100.
3. The median salary for the Midwest survey participants was \$170,300.

Median salary in 2007 was \$165,500 and increased 1% to \$167,100 in 2008 (there were 52 participating in the survey in 2007).

Highlights of the performance evaluation are:

1. All six PERS Board members returned performance evaluations.
2. The average rating of all Board members was 3.67 on a scale of 4, with 4 being the highest rating.

Other information:

1. The state legislative salary budget for state employees for the second year of the biennium is 5%.
2. Unlike many of the other systems in the survey, NDPERS also manages non-retirement programs including the health plan, flex plan, EAP, and other group insurance products.
3. The Committee reviewed salaries of other ND public employees.

Recommendation:

The Committee recommends that the PERS Board accommodate Mr. Collins request and grant a 4.5% for the first year and limit the second year to no more than 4.5% with that actual amount to be determined next year by the review committee and subject to continued good performance.

**Critical Job Elements
NDPERS Executive Director
2009**

CJE – Critical Job Element	Expectation	Average Rating
Category 1 Board Meetings	<ol style="list-style-type: none"> 1. Agenda items are prepared with supporting information. 2. Board materials are distributed at least 3 days before the meeting. 3. Appropriate information is provided to Board either orally/verbally to aid the Board in arriving at a decision. 4. Board material identifies items, which need “Board Action”, and makes a staff recommendation where appropriate. 5. Education is provided at Board meetings in order that Board may adequately perform their policy setting role. 	3.86
Category 2 Board Relations	<ol style="list-style-type: none"> 1. The Director is responsive to Board requests. 2. The Director is adaptable to Board direction on PERS policy and able to work with the board as a team member. 3. The Director keeps Board members aware of current issues and when appropriate provides information to Board members between board meetings. 4. The Director provides timely and accurate problem identification to the Board as well as providing solutions and options for the Boards consideration. 	3.82
Category 3 Operations	<ol style="list-style-type: none"> 1. Accurate Records <ol style="list-style-type: none"> 1.1 Maintain appropriate, accurate and accessible data for individual members and benefit recipients. 1.2 Accurate accounting records and a system of internal controls is maintained to result in an annual, unqualified opinion by the System’s auditor. 1.3 An application to GFOA for the Certificate of Achievement for Excellence in Financial Reporting is submitted annually. 1.4 The Public Pension Coordinating Council’s Award of Excellence is submitted biennially. 2. Biennial Budget <ol style="list-style-type: none"> 2.1 Biennial budget is prepared pursuant to OMB guidelines and submitted pursuant to guidelines established by the Governor. 2.2 Board is provided opportunity to review the budget before it is submitted. 2.3 Expenditures for budget items do not exceed appropriation without approval of the Board. 3. Timely and Understandable Service <ol style="list-style-type: none"> 3.1 Member inquiries are responded to in a timely manner. (Survey information shall be reported to the board relating to this from the “How are we doing” cards and the biennial survey). 3.2 Participating employers shall be provided the necessary support to administer the PERS programs in which they participate. (Biennial surveys shall be done relating To this and reported to the Board). 4. Staffing <ol style="list-style-type: none"> 4.1 All applicable personnel rules of the State of North Dakota shall be followed. 4.2 Staff performance evaluations are completed at least annually. 4.3 Employee’s receiver recognition, direction or discipline as appropriate. 	3.11

CJE – Critical Job Element	Expectation	Average Rating
Category 4 Investment Programs	<ol style="list-style-type: none"> 1. Maintain board approved Investment Objectives and Policies for: <ol style="list-style-type: none"> 1.1 The defined benefit plan 1.2 The defined contribution plan 1.3 The deferred compensation plan 2. Performance <ol style="list-style-type: none"> 2.1 Produce and report investment return information for the defined contribution plan and the PERS Companion Plan. 2.2 Accurate yearly reports are given to the Board concerning the defined benefit plan and its progress and compliance with the investment policies. 2.3 Advice and recommendations are given to the board on investment matters to support Board decision making. 2.4 Recommend corrective actions including termination of funds in the deferred comp plan and the defined contribution plan. 3. Provider Monitoring <ol style="list-style-type: none"> 3.1 Monitor the various providers in the defined contribution plan and deferred compensation to insure that all contract provisions are being followed. 3.2 Identify and report to the board all infractions of the contract provisions. 4. Fiduciary Standards Discharge investment duties solely in the interest of the members and benefit recipients With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. 	3.82
Category 5 Benefit Program Operations	<ol style="list-style-type: none"> 1. Actuarial Management <ol style="list-style-type: none"> 1.1 Provide accurate member, retiree and asset data necessary for the Actuary to perform the annual actuarial valuation for the four PERS defined benefit plans. 1.2 Provide accurate member and retiree data for the actuary to perform biennial premiums estimates for the group insurance plans. 1.3 Maintain knowledge of actuarial methods, the current status of the actuarial makeup of the various retirement and group insurance plans and the impact of benefit enhancements to the contribution rates. 1.4 Provide actuarial information to the Board, Legislature, employers, members and retirees so they have sufficient background to make 	3.96

CJE – Critical Job Element	Expectation	Average Rating
	knowledgeable decisions. 2. Contract Management 2.1 Distribute and analyze bids for services for the various retirement, group insurance, EAP and Flex Programs to facilitate Board decision making. 2.2 Monitor contractor performance and advise the Board of any issues, including options for responding and recommended action plan. 2.3 Provide direction to all contractors to insure that board objectives are achieved. 2.4 Insure that all contractors comply with contract provisions, state law and administrative rules.	
Category 6 Public Relations	1. Publish a newsletter at least semiannually. 2. Provide informational programs to employers, members, retirees, and public groups. 3. Represent the System with appropriate affiliate organizations and functions. 4. Maintain availability to the news media.	3.43
Category 7 Legislative Relations	1. Develop Legislative proposals in concert with the Board and its advisory committee. 2. Present requests for legislative changes to the Legislature. 3. Make the Boards position known to members, employers and the legislature. 4. Keep the Legislature, through the Interim Committee informed regarding the financial, legislative and administrative status of the system. 5. Develop adequate rapport with Legislators so that the legislative body as a whole has a sense of credibility with the positions taken by the Board on behalf of the System.	3.74
Category 8 Professional and Personal Development	1. Maintain membership and involvement in professional organizations. 2. Maintain professional certifications. 3. Be dependable. 4. Exhibit stability/reaction to pressure. 5. Have strong leadership skills.	3.71
Category 9 General	1. Follow safety procedures. 2. Adhere to all laws, rules, policies, procedures and professional ethics. 3. Work as part of a team. 4. Use courtesy and respect in all interactions. 5. Maintain a well-organized work area and a business like appearance. 6. Foster good working relations by being responsive to requests. 7. Maintain confidentiality policy.	3.54
	Average overall rating	3.67

Comments:

My thanks and gratitude to Sparb and his fine staff. They do a great job for PERS' members.

Board relations are very good.

Sparb is well respected and a great spokesperson.

Materials always timely, clearly organized and understandable.

Keeps the Board well informed on state and national issues.

Generally well done (accurate records), a few errors, ended up with appeals to Board.

Keeps the Board well informed during these difficult investment times.

Timely information, helpful in Board decision making process.

I've personally attended legislative hearings where Sparb and staff presented, very well accepted by legislators.

Sparb has done an excellent job this past year, during very difficult challenges.

MINUTES

North Dakota Public Employees Retirement System Executive Director Performance Review and Compensation Committee

**Friday, May 1, 2009, 3:00 p.m.
ND Department of Transportation
Human Resources Division**

Attendance: Mr. Mike Sandal, Mr. Levi Erdmann, and Mr. Ron Leingang.

The meeting was called to order at 3:00 p.m. at the ND Department of Transportation, Human Resources Division. The agenda was approved with no additions.

Ron reported that the performance evaluations had been mailed to all Board members and several had been returned. The deadline for returning evaluations was May 11. Mr. Erdmann asked if the evaluation were retained in compliance with the public records requirements. This is likely the case but will ask Mr. Collins.

The Mclagen Partners salary survey for 2008 was reviewed. There was only a small change in the median salary for Mr. Collins benchmark position. The difference is 1%. This may be attributable to a larger number of participants or because of economic conditions.

The survey indicated that Mr. Collins salary was somewhat lower than the national average but still competitive within the market survey. The committee also reviewed salary data for appointed and exempted positions within the ND state classified service and determined the salary was competitive; however, there are no good benchmarks positions within that group. This data does not include Higher Education.

The salary plan for state employees has not been finally approved by the ND State Legislature; however, it is anticipated that the Legislature will approve a 5% increase for each year of the 2009 –2011 biennium to include a \$16 million equity pool for state agencies. The bill including the increases for state employees is HB 1015.

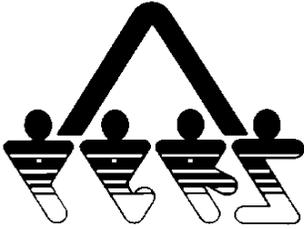
The committee initially discussed a 5% increase for July 2009; however, Mr. Collins requested that the increase be no more than 4.5% for each year of the next two years. It was his intent to pool the remaining .5% to make equity adjustments within the PERS office.

Mr. Sandal moved that since Mr. Collins salary was competitive in relation to other state employees, the committee accommodate Mr. Collins request and grant a 4.5% for first year and limit the second year to no more than 4.5% with that actual amount to be determined next year by the review committee and subject to continued good performance. It was noted by Mr. Sandal that state employee salaries are also somewhat lower than market. Mr. Erdmann seconded the motion with all voting in favor. This action is subject to the remaining evaluations indicating very good performance.

The committee requested that Mr. Leingang complete the report to the Board in the same format as last year. This will be in addition to these meeting minutes.

The meeting was adjourned at 3:45.

Submitted by Mr. Leingang, Committee Chair



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

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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: June 10, 2009
SUBJECT: Payroll Conference

Biennially PERS provides a one day conference for our participating employers. The purpose of this meeting is to discuss changes that may be occurring in each of our programs and to highlight administrative/process changes. This year the meeting was held on Tuesday, June 9, at the ND Heritage Center.

Thanks to the Health Department, we were able to broadcast this over the internet (webcast) and record it so we can put it on our website for later viewing by those who could not attend. We had 170 attend at the Heritage Center and 90 viewed via webcast.

Attached, for your information, is the agenda and handout materials. If you wish to view the webcast, please go to our website at <http://www.nd.gov/ndpers/>.