



**HIRE KIT**  
(Rev. 01-2017)

**NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM**  
**NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657**  
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This publication contains information, forms, and instructions necessary for enrolling an employee in the Defined Benefit Hybrid Retirement Plan and group insurance plans administered by NDPERS. This publication is to be completed by employee.

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

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





Did you know that you can complete your benefit plan enrollment(s) using PERSLink Member Self Service (MSS)!

PERSLink MSS provides you with on-line access to benefit information, the ability to complete benefit enrollments and changes, as well as updating personal profile instead of completing paper forms and submitting to NDPERS. This will also include Annual Enrollment elections.

The following tools and features are available through PERSLink MSS:

<b>Personal Profile</b>	View your personal information on record at NDPERS Update your Name/Marital Status Update your Address, Telephone numbers, and Email
<b>NDPERS Plans</b>	Displays all the NDPERS benefit plans you are enrolled in or are eligible to enroll in View Plan Details Document View Plan Highlights Video Provides link to the individual plans: Plans Enrolled In: View details of the plan Update Plan Enrollment Plans Eligible to Enroll In: On-line Enrollment Application
<b>Member Account Balance</b>	Provides a direct link to Retirement Plan member account balance details
<b>Benefits Estimates</b>	Request an official retirement benefit estimate from NDPERS Calculate a Benefit Estimate on-line View Benefit Estimate you performed
<b>Service Credit Purchase</b>	Request an official Service Purchase Cost from NDPERS Calculate a Service Purchase Cost Estimate on-line View any Service Purchase Contracts you have.

**Check it out now!!!**

- Step 1: Go to NDPERS website
- Step 2: Set up your ND Login ID
- Step 3: Log into MSS and see what you can do!

# NEW HIRE FORMS CHECKLIST



**EMPLOYER:**

Enter NDPERS Member Data information through Employer Self Service

**RETIREMENT PLAN:**

Yes  No

Retirement Membership Election [SFN 2561]

Designation of Beneficiary [SFN 2560]

Defined Contribution Retirement Program Election [SFN 52170] (for Permanent State Employees-Not included in New Hire Kit, mailed to member at later date)

Defined Benefit Participation Agreement/Waiver of Participation [SFN 17627] (*if member is a temporary/part-time employee*) or Defined Contribution Participation/Waiver of Participation [SFN 54366]

**HEALTH INSURANCE PLAN:**

Yes  No

Health Enrollment Change [SFN 60036]

Waiver of Insurance Coverage [SFN 58819]

Acknowledgement of or Decline Offer of Health Insurance Coverage [SFN 60711]

**LIFE INSURANCE PLAN:**

Yes  No

Group Life Insurance Enrollment/Change [SFN 53803]

Group Life Evidence of Insurability

Life Insurance Designation of Beneficiary [SFN 53855]

**VISION & DENTAL INSURANCE PLAN:**

(State, Higher Education & Health Units Only)

Yes  No

Vision/Dental Enrollment Change [SFN 58792]

**FLEX COMP PLAN:**

(State & Participating Health Units Only)

Yes  No

FlexComp Enrollment Form [SFN 53851]

**DEFERRED COMPENSATION PLAN:**

Yes  No

457 Deferred Compensation Plan Enrollment/Change Form [SFN 3803]

457 Deferred Compensation Plan Expedited Enrollment/Waiver [SFN 54362]

# NAVIGATING THE NEW HIRE KIT



The benefits described in this publication only pertain to members of NDPERS. Political subdivisions within the state of North Dakota are not eligible to participate in the NDPERS Dental, Vision, Employee Assistance, and Flexible Compensation Plans (with the exception of the health units).

## 1. GROUP RETIREMENT PLAN

### **EMPLOYER Responsibility:**

1. Determine eligibility of new hire to participate in NDPERS Defined Benefit Hybrid Retirement Plan. Do not complete the New Hire Kit if new hire is transferring from another participating employer. If transferring, complete a Notice of Transfer Kit.
2. Enter NDPERS member data information through Employer Self Service.
3. Ensure the employee completes a Designation of Beneficiary for the Group Retirement Plan, along with other appropriate forms.
4. If employee is a temporary/part-time employee, provide employee with an Agreement/Waiver of Participation for Optional Defined Benefit Retirement Plan SFN 17627 or Agreement/Waiver Participation for Optional Defined Contribution Plan SFN 54366. Make sure the employee makes an election regarding participation within first 180 days of employment as temporary/part-time.
5. Submit forms to NDPERS prior to reporting first month of contribution.

The North Dakota Administrative Code Chapter 71-02-06-01 states “Retirement Contributions must be returned if a membership enrollment application form has not been filed with the office. Contributions will be returned until proper membership enrollment forms have been filed.”

### **EMPLOYEE Responsibility:**

Before completing any forms, read all instructions, as well as, the terms and conditions on the back of each form. Read the “Group Retirement Plans” section carefully before proceeding.

1. Review eligibility requirements for NDPERS Group Retirement Plan.  
  
Complete Retirement Membership Application SFN 2561 or enroll through Member Self Service.
2. Complete Designation of Beneficiary for the Group Retirement Plan SFN 2560.
3. If you are a temporary/part-time employee and are electing to participate, complete an Agreement/Waiver of Participation for Optional Defined Benefit Retirement Plan

SFN 17627 or Agreement/Waiver of Participation for Optional Defined Contribution Plan SFN 54366.

4. Submit forms to employer/payroll office.

For specific plan detail, please visit the Defined Benefit Hybrid Retirement Plan information found under the Active Members or Temporary/Part-time Employee options on the NDPERS website.

## **2. DEFERRED COMPENSATION – 457 Deferred Compensation Plan**

### **EMPLOYER Responsibility:**

1. Provide new hire a copy of the Deferred Compensation Plan Handbook, Investment Summary Options, and Portability Enhancement Provision (PEP) Brochure.
2. Provide all newly hired employees who will be participating in the NDPERS Defined Benefit Retirement Plan with an 457 Deferred Compensation Plan Quick Enrollment/Waiver Form SFN 54362. All new hires must complete this form either electing to participate in the deferred compensation plan or to waive their rights to PEP in Section D. An exception to this would be if your employer does not participate in the NDPERS Deferred Compensation Plan.
3. If the employee chooses to make more than the minimum contribution or would like their minimum contribution to go to a provider other than the Companion Plan administered by TIAA, you will need to provide a 457 Deferred Compensation Plan Enrollment/Change Form SFN 3803.

### **EMPLOYEE Responsibility:**

Before completing any forms, read all instructions, as well as the terms and conditions on the back of each form. Read the “Deferred Compensation – 457 Supplemental Retirement” section carefully before proceeding.

1. All new hires must complete the 457 Deferred Compensation Plan Quick Enrollment/Waiver Form SFN 54362 either electing to participate in the deferred compensation plan or to waive their rights to PEP in Section D. An exception to this would be if your employer does not participate in the NDPERS Deferred Compensation Plan.
2. However, if you would like to choose a provider other than the Companion Plan administered by TIAA or you would like to make a contribution that exceeds the minimum contribution amount, you will need to complete a NDPERS 457 Deferred
3. the eligible providers for the plan. The provider representative you select will assist you in completing the required forms to open an account. Authorization for deductions must be made prior to the month in which the income is earned.

For specific plan detail, please visit the Deferred Compensation Plan information found under the Active Members options on the NDPERS website.

### **3. GROUP HEALTH INSURANCE PLAN**

#### **EMPLOYER Responsibility:**

1. To enroll a new employee in the PPO/Basic or HDHP option (for permanent state employees only).
2. Complete Health Enrollment Change SFN 60036.
3. Employees not electing health coverage need to fill out either the Waiver of Insurance Coverage SFN 58819 or the Acknowledgement of or Decline Offer of Health Insurance Coverage Decline Offer of Health Insurance Coverage SFN 60711 if they are eligible due to the affordable Care Act (ACA).

#### **EMPLOYEE Responsibility:**

Before completing any forms, read all instructions, as well as the terms and conditions on the back of each form. Read the “Group Health Plans” section carefully before proceeding. If you are a permanent State employee, view the information regarding the HDHP plan and determine if you want to participate in HDHP or PPO/Basic plan.

1. Complete appropriate form(s)
2. Ensure accuracy of form(s)
3. Return completed form(s) to your employer

For specific plan detail, please visit the Group Health Plan information found under the Active Members or Temporary/Part-Time Employee options on the NDPERS website.

### **4. GROUP LIFE INSURANCE PLAN**

#### **EMPLOYEE Responsibility:**

Before completing any forms, read all the instructions, as well as the terms and conditions on the back of each form. Read the “Group Life Plans” section carefully before proceeding.

1. Complete the Group Life Insurance Application and Life Insurance Designation of Beneficiary SFN 53855
2. Ensure accuracy of form(s)
3. Sign, date and return completed form(s) to employer within 31 days of your date of hire.

For specific plan detail, please visit the Group Life Plan information found under the Active Members or Temporary/Part-Time Employee options on the NDPERS website.

### **5. VOLUNTARY GROUP VISION & DENTAL INSURANCE PLAN**

Only State Agencies, Higher Education & District Health Units are eligible to participate in the group dental plan.

### **EMPLOYEE Responsibility:**

Before completing any forms, read all instructions, as well as the terms and conditions on the back of each form. Read the “Group Dental Plan” or “Group Vision Plans” section carefully before proceeding.

1. Complete Vision/Dental Enrollment Change SFN 58792
2. Ensure accuracy of form(s)
3. Sign, date and return completed form(s) to employer within 31 days of your date of hire.

For specific plan detail, please visit the Dental Plan or Vision Plan information found under the Active Members option on the NDPERS website.

## **6. EMPLOYEE ASSISTANCE PROGRAM**

Only State Agencies, Higher Education & District Health Units are eligible to participate in the EAP program. Eligible employees are automatically enrolled in the EAP program.

### **EMPLOYEE Responsibility:**

For specific plan detail, please visit the Employees Assistance Program (EAP) information found under the Active Members options on the NDPERS website.

## **7. NDPERS ADMINISTERED FLEXCOMP PLAN**

The NDPERS FlexComp Plan is available to eligible employees of the state of North Dakota, participating District Health units, and members of the Legislative Assembly. Employees of the University system and political subdivisions are excluded from participation in the plan.

### **EMPLOYER Responsibility:**

- Provide a new employee with the FlexComp Enrollment SFN 53851.

### **EMPLOYEE Responsibility:**

Before completing any forms, read all instructions, as well as the terms and conditions on the back of each form. Read the “State of North Dakota FlexComp Plans” section carefully before proceeding.

1. Complete appropriate form(s)
2. Ensure accuracy of form(s)
3. Sign, date, and return completed form(s) to your agency payroll/human resource department within 60 days of your date of hire.

For specific plan details and information, please visit the State of ND FlexComp Plan found under the Active Members option on the NDPERS website

## **8. LONG TERM CARE**

Please review information on importance of Long Term Care Insurance.

# **GROUP RETIREMENT PLANS DEFINED BENEFIT HYBRID PLAN**



In the Defined Benefit Hybrid Retirement plan, an account is established on your behalf and contributions are made to the account by you and your employer. If you are vested, you are guaranteed a benefit at retirement, which is generally based on your compensation, the benefit multiplier, and your years of service credit. The more years of service you have accumulated, the greater the benefit. You will receive the benefit determined under the plan regardless of the performance of the plan's investments.

## **Mandatory Participation Requirements:**

If you work for a participating employer in the Defined Benefit Plan, and work a minimum of 20 hours per week for 20 or more weeks of the year (32 hours for law enforcement retirement plan), are at least eighteen years of age, filling a permanent position that is regularly funded and not of limited duration, you must participate in the defined benefit plan unless you waived participation in writing when your employer joined NDPERS.

If you meet the above requirements and are a permanent state employee, you must elect to participate in either the defined benefit plan or the defined contribution plan. Upon receipt of your membership application NDPERS will verify eligibility to participate in the defined contribution plan and will mail you a packet of information comparing the two retirement plans. You will have six (6) months to elect to transfer to the defined contribution plan. A Defined Contribution Retirement Program Election Form SFN 52170 is required. This form is included in the comparison packet. If an election is not submitted to NDPERS within six (6) months of your hire date, you will automatically remain in the defined benefit retirement plan. The form must be signed by you and your spouse (if married).

You should be enrolled the first month of eligible employment, even when hired subject to a probationary period. There is no maximum age limit applicable for enrollment purposes.

## **Participation Requirements for State Elected and Appointed Officials:**

State elected or appointed officials taking office on or after December 31, 1999 who meet the mandatory participation requirements must be a participating member in the defined benefit plan. The elected or appointed official may make an election within the first six (6) months of taking office to join the defined contribution plan.

## **Participation Requirements for Other [Non-State] Elected Officials:**

If you are an elected official of a participating county, at your individual option, you may enroll or waive participation in the defined benefit plan within the first six (6) months of your term. All other elected officials who meet the above mandatory participation requirements must be enrolled in the defined benefit plan within the first six (6) months of their term.

## **Participation Requirements for Other [Non-State] Appointed Officials:**

If you are an official of any other participating employer appointed on or after August 1, 1999, and you meet the above mandatory participation requirements, you must be enrolled in the defined benefit plan effective with the first month of taking office.

**Optional Participation Requirements:**

If you are at least eighteen years old and do not meet the mandatory participation requirements, you may elect to participate in NDPERS within the first 180 days of employment or within 180 days of changing from permanent to temporary/part-time employment. Retirement participation is at your expense. You can not participate in NDPERS if you are actively contributing to another employer-sponsored plan. This applies to both private and public pension funds.

The law expressly prohibits the employer from paying any portion of an optional participant's contribution.

In order to participate as a temporary/part-time employee, an Agreement/Waiver of Participation for Optional Participant Defined Benefit Plan SFN 17627 is required.

**Enrollment:**

Eligible employees must enroll at the date of hire and retirement contributions must begin with the employee's first paycheck. Employees who do not meet the eligibility requirements can participate at their own cost, but must elect to enroll within the first six (6) months of beginning employment or experiencing an employment change in status.

**Contributions:**

Employee Contribution:	7.00% of salary
Employer Contribution:	7.12% of covered payroll

**Vesting:**

To be vested in the Defined Benefit Hybrid Plan means that you have become legally entitled to a monthly benefit when you terminate employment and reach retirement age or qualify for long-term disability.

Vesting in Disability Benefit:	6 months
Vesting in Retirement Benefit:	36 months

You will receive 1 month of service credit for each month a deposit is made to your member account.

## Portability Enhancement Provision (PEP)

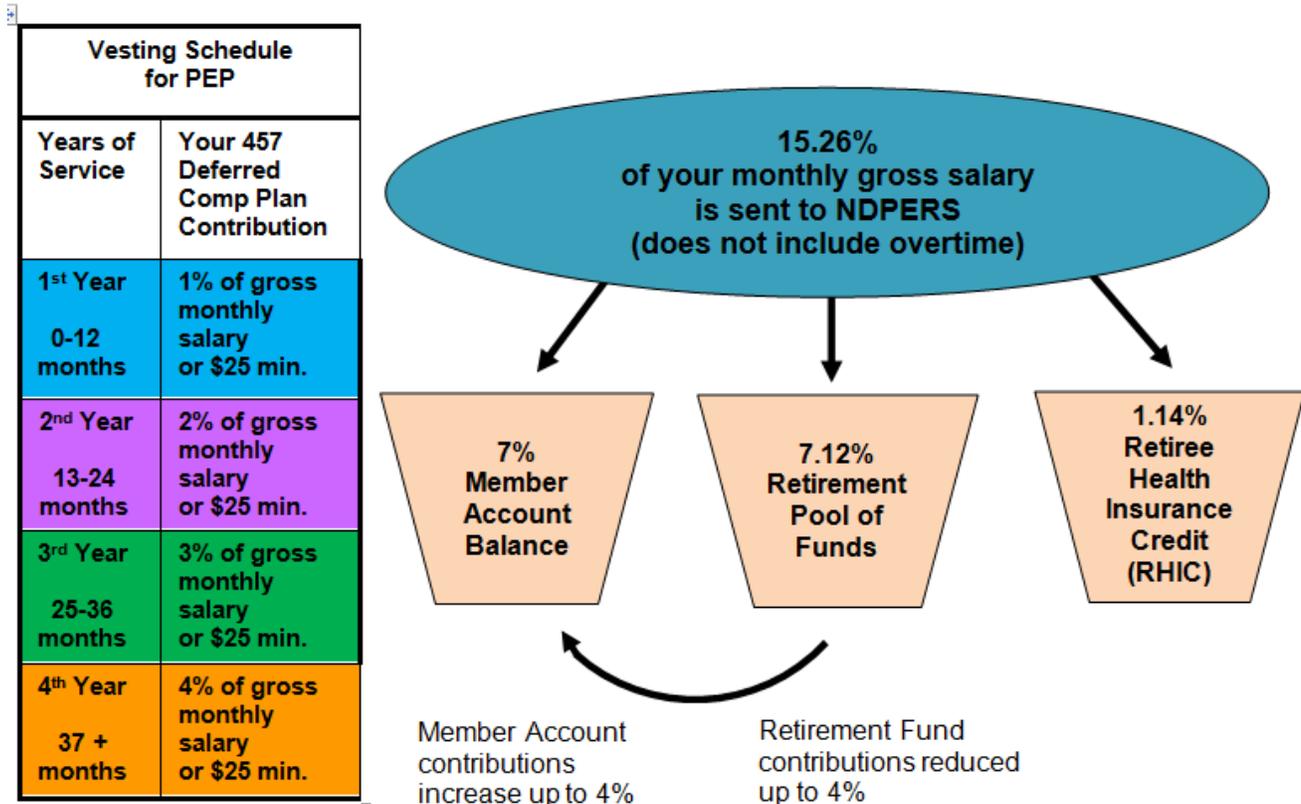
Vesting in the Employer Contribution:

As an active member in the Defined Benefit Hybrid Plan, you are able to vest in the employer contribution for cash distribution purposes by participating in a deferred compensation (457) program, 403(b) or other qualified retirement savings program approved by the NDPERS Board. The vesting schedule for the PEP contributions is based upon your existing service credit in the retirement program and the amount you defer into a qualified deferred compensation plan.

### How PEP works:

It allows you the option to vest in up to 4.00% of the 7.12% employer contribution paid into the retirement pool of funds and have this vesting percentage credited to your member account. For every dollar you put in a Deferred Compensation plan, NDPERS will add one dollar to your member account balance, subject to a vesting schedule. This can significantly increase the amount of money available to you, if you choose to “cash in” your retirement account or roll it over into another pension plan, if your North Dakota public service ends. PEP reallocates the employer contributions into your member account balance. As you can see, 4.00% of the 7.12% of the employer contribution may be paid into the member account rather than the retirement pool of funds as shown below.

### How PEP Works with your monthly Defined Benefit Hybrid Plan Retirement Contributions



## **BENEFITS AT TERMINATION OF EMPLOYMENT:**

### **Member Account Balance:**

Refund/Rollover of your member account balance, which consists of the monthly employee contributions, the vested portion of the employer contributions, and interest. This interest is compounded monthly up to the time you receive a refund/rollover of your account or begin receiving a monthly benefit. The interest paid on your account is based on a rate established by the NDPERS Board and builds on a tax deferred basis. You may also leave your money at NDPERS to receive a distribution at a later date.

### **Disability Retirement Benefits:**

If you are deemed eligible for disability benefits, you will receive 25% of your final average salary each month for as long as you are disabled under the basic disability payment option.

### **Surviving Spouse Benefits:**

If you die after completing 36 months of credited service, your spouse may elect to receive:

- (a) Refund/Rollover of your account; or
- (b) 50% of your unreduced retirement benefit for life; or
- (c) Equivalent of 100% joint & survivor option, if you had reached your normal retirement date.

## **BENEFITS AT RETIREMENT:**

**Early Retirement Age:** 55 (age 60 for members hired on or after 01-01-2016)

**Normal Retirement Age:** 65

### **“Rule”:**

Members hired before 01-01-2016 (Rule of 85)

Age + Years of Service = 85 or more

- No reduction in benefits for early retirement;
- No minimum age requirement.

Members hired on or after 01-01-2016 (Rule of 90)

Age + Years of Service = 90 or more

- No reduction in benefit for early retirement;
- Minimum age of 60

### **Retirement Formula:**

Final Average Salary X 2.00% X Years of Credited Service

Final Average Salary = Average of highest 36 salaries of the last 180 months you worked.

Benefit Multiplier = The rate established by the legislature at which you earn benefits.

**Retirement Options:**

Single Life  
Joint & Survivor 50% & 100%  
Term Certain 20 & 10 Year  
Partial Lump Sum Option  
Graduated Benefit Option

# DEFINED CONTRIBUTION PLAN



In the defined contribution plan, an account is established on your behalf and contributions are made to the account by you and your employer. Upon your retirement or termination, the total amount or value of your account is available for distribution. The amount of your benefit will be affected by the investments you select, the amount of time you have to invest, your vesting status, and the performance of your investments and may be limited in duration.

## **Eligibility:**

If you are a state employee filling a permanent position that is regularly funded and not of limited duration, work a minimum of 20 hours per week for 20 or more weeks of the year, and are at least 18 years of age, you may be eligible to participate in the Defined Contribution Retirement Plan. This is a special enrollment option for state employees hired on or after October 1, 2013 and through July 31, 2017. An employee who is eligible for the Highway Patrol Retirement System or the Teachers Fund For Retirement or the alternate retirement plan of the Board of Higher Education are not eligible to participate in the Plan.

If you are eligible for this plan, you must enroll in the defined benefit plan at your initial hire date. NDPERS will prepare a personal benefit comparison which will be sent to you after NDPERS receives your eligibility determination. The necessary form for you to make your election, as well other informational materials, will be enclosed with the comparison.

## **Enrollment:**

Every eligible State employee may participate in the Defined Contribution Plan. Such eligibility, however, shall terminate at any time employment with the employer is terminated. An eligible employee's participation in the Defined Contribution Plan shall be further governed by the following:

- An election made by an eligible employee is irrevocable, except that an employee who terminates employment with the State after making an election to participate in the Plan but before the amount held in the Defined Benefit Hybrid Plan is transferred to the Defined Contribution Plan shall not participate in the Defined Contribution Plan and shall remain under the Defined Benefit Hybrid Plan.
- An eligible employee who does not make a written election under the plan by the applicable deadline shall continue to be a member of the Defined Benefit Hybrid Plan.
- An employee who is married on the date he/she makes the election to participate in the Defined Contribution Plan must receive his/her spouse's signature on the election form in order for that election to be effective.
- If a member of the Defined Contribution retirement plan begins employment in a position covered under the highway patrol retirement plan, the teacher's fund for retirement plan or the alternate retirement plan of the board of higher education, the member's status as a member of the Defined Contribution Plan is suspended and the member becomes a new member of the retirement plan for which that member's new position is eligible. The member's account balance remains in the Defined Contribution Plan, but no new contributions may be made to that account. The member's service credit and salary history

that were forfeited as a result of the member's transfer to the Defined Contribution Plan remain forfeited, and service credit accumulation in the new retirement plan begins from the first day of employment in the new position. If the member later returns to employment that is eligible for the Defined Contribution Plan, the member's suspension is terminated, the member again becomes a member of the Defined Contribution Plan, and the member's account shall resume accepting contributions. The contributions to the alternate retirement plan shall remain with the plan unless, at the member's option, the member may transfer any available balance, as determined by the provisions of the alternate retirement plan, into the member's account in the Defined Contribution Plan.

**Contributions:**

Employee Contribution: 7.00% of salary  
Employer Contribution: 7.12% of covered payroll

**Vesting:**

The term "vesting" refers to your non-forfeitable right to the money in your account. You are always fully vested in the employee contributions, even if your employer has paid them. You will vest in the employer contributions in accordance with the following schedule:

<b><u>Years of Service</u></b>	<b><u>Percentage Vested</u></b>
Less than 2 years	0%
2 years	50%
3 years	75%
4 years	100%

For purposes of vesting, you will be credited for years of service earned as a participant in the Defined Benefit Hybrid Plan at the time of transfer. However, if you terminate employment with the State, are paid a distribution from the Defined Contribution Plan, and are later reemployed by the State, your years of service upon reemployment will be zero (i.e., your prior years of service will not count toward vesting).

# RETIREE HEALTH INSURANCE CREDIT



## Eligibility:

If you elect and receive a retirement allowance from one of the NDPERS Defined Benefit Plans or the Defined Contribution Plan, you are eligible to receive a credit towards eligible insurance premium expenses. RHIC is calculated as \$5.00 for each year of credited service, subject to early retirement reductions. For example, a member with 20 years of service at normal retirement age would receive a monthly credit of \$100.00, which is a tax-free benefit.

## Contributions:

**Employer Contribution:** 1.14% of covered payroll

**Benefit Formula:** \$5.00 x Years of Credited Service

## **BENEFITS AT RETIREMENT:**

**Retiree Health Credit Options:** Single Life  
Joint & Survivor 50% & 100%

Foot Note: Summary of Total Required Retirement Contributions discussed:

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EMPLOYEE CONTRIBUTION:	7.00%
EMPLOYER CONTRIBUTION RETIREMENT:	7.12%
EMPLOYER CONTRIBUTION (RHIC):	<u>1.14%</u>
<b>TOTAL RETIREMENT CONTRIBUTION:</b>	<b>15.26%</b>

# **457 DEFERRED COMPENSATION SUPPLEMENTAL RETIREMENT PLAN**



The Deferred Compensation Plan is a voluntary supplemental retirement plan for eligible employees of participating governmental agencies. The plan is set up under Section 457 of the Internal Revenue Code. This program permits you to make pretax deductions from your salary with the intent to receive the deferred amount at a later date, such as retirement. Neither the amount deferred to your investment account nor the income or gains on those investments are taxable until you begin to withdraw money from the account.

## **Eligibility:**

Eligible employees of a participating employer who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year, and whose positions are regularly funded and not of limited duration (i.e., permanent) are eligible to enroll.

## **Enrollment:**

In order to promote the ability for employees to supplement their retirement savings, we have designed our plan to make saving as convenient as possible by providing an quick enrollment option. The quick enrollment form does not require you to make a decision regarding the amount of the contribution, investment allocation, or selecting a provider company or agent. You need to login to your PERSLink Member Self Service (MSS) account online or complete the 457 Deferred Compensation Plan Quick Enrollment Form SFN 54362 to enroll. PEP is automatic upon your enrollment. All new hires must complete this form either electing to participate in the deferred compensation plan or to waive their rights to PEP. Your payroll deduction will be invested in the TIAA Life Cycle Mutual Funds allocated based upon your estimated retirement age. This is the NDPERS Companion Plan administered by TIAA. You can also choose to invest your money in other funds with TIAA.

Having a supplemental retirement savings plan is a vital key to a secure financial future when you retire. Saving even a little bit more each month – say \$50 a pay period – can add up to a lot more over time. Making voluntary contributions to your employer’s supplemental retirement plan is a great way to supplement your retirement savings.

The NDPERS 457 Deferred Compensation Plan features several benefits as motivation to enroll in a supplemental retirement savings such as the following:

- There are 9 approved provider companies comprising more than 300 investment fund options.
- Convenience of pretax payroll deductions.
- Automatic enrollment in the Portability Enhancement Provision (PEP),
- A Saver’s Credit,
- Convenience of a quick enrollment option into the NDPERS Companion Plan,
- The option to rollover/transfer funds to consolidate savings from other eligible retirement plans,
- The option to use funds to purchase service credit in the defined benefit plan, and

- Upon Termination, the option to defer on a pretax basis lump sum payments for accrued sick and annual leave.

Remember, it's never too late or too early to start saving more. Even a little can make a big difference, so take one small step toward financial security.

If you choose to defer more than the minimum contribution or would like your minimum contribution to go to a provider other than the Companion Plan, you will need to complete the NDPERS 457 Deferred Compensation Plan Enrollment/Change Form SFN 3803. You must select and contact an eligible investment provider first. The provider representative will assist you in completing the required forms to open an account. Eligible employees may enroll in the plan at any time. Providers of investment services for the Deferred Compensation Plan are as follows:

American Trust Center	Nationwide Life
AXA Equitable Life Ins. Co.	NDPERS Companion Plan [TIAA]
Bank of North Dakota	VALIC
Mass Mutual/Hartford Life Insurance Co.	Waddell & Reed Financial Services
Jackson National Life	

The Investment Options Summary booklet provides information on the Provider Companies and investment options they offer through the 457 Deferred Compensation Plan.

### **Contributions:**

- The annual minimum deferral is \$300 (\$25 a month).
- The annual maximum deferral is established by the IRS and is currently \$18,000.

The annual maximum you may defer is based upon the annual limits indicated on the maximum allowable deduction schedule provided on the back of 457 Deferred Compensation Enrollment/Change Form SFN 3808 or 100 percent of your includible compensation, whichever is less. The maximum you may defer is affected by your contributions to another Section 457 deferred compensation plan, or employee contributions to your regular retirement plan which are paid by your employer under an IRC Section 414(h) salary reduction arrangement.

An election to begin a deferral, make changes to your deferral amount, or to change your Provider Company or provider representative must be made in the month prior to the pay period in which the salary is earned. This can be done online through your Member Self Service Account or by completing form 457 Deferred Compensation Plan Enrollment/Change Form SFN 3803 .

### **Distributions:**

Your deferred compensation account is only available upon separation from employment which includes retirement, disability, death, resignation, or discharge. You must be off covered employment for 31 days before funds may be accessed. The funds are taxed when distributed to you. If you die before beginning distribution or receiving the total amount in the deferred compensation account, the account will be paid to your designated beneficiary.

You may withdraw your account prior to separation from service under two circumstances. In the event you have an unforeseeable emergency, you may apply for a financial hardship withdrawal subject to the approval of the NDPERS Board. A financial hardship is defined as an unforeseeable emergency resulting from a sudden and unexpected illness or accident occurring to you or one of your dependents, loss of your property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond your control.

A lump sum de minimus distribution is permissible if:

- 1) the total value of your account(s) is less than \$5,000,
- 2) you have not contributed to the plan in the preceding two years, and
- 3) you have not previously received a distribution of this nature from the plan.

# DAKOTA HEALTH PLAN FEATURES

## PPO/BASIC



For complete features of the Dakota Plan visit [www.nd.gov/ndpers](http://www.nd.gov/ndpers).

### **Eligibility:**

Eligible employees are those who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year, and whose positions are regularly funded and not of limited duration (i.e., permanent).

### **Part-Time /Temporary Employees:**

A Part-Time/Temporary Employee may be eligible to participate if the employee is employed at least 30 hours per week or 130 hours per month and meets the definition of a full-time employee as defined in the Affordable Care Act (ACA). Coverage will be effective the first of the month following date of employment. If application is not made within the first 31 days, the provisions of the Special Enrollment Periods will apply. The employer is responsible for determining eligibility and offering coverage when applicable.

### **Enrollment Period:**

You have an initial enrollment period of 31 days from your date of employment. Applications received within the enrollment period will be accepted with no restrictions or limitations for you and any eligible dependents. Coverage will be effective the first of the month following your hire date.

If you do not enroll during the initial 31 day eligibility period when hired or do not enroll within 31 days of a qualifying event, you may apply for coverage during the designated Annual Enrollment Season with coverage effective the following January 1.

### **Employment Change from Permanent to Temporary Status:**

If you change from Permanent to Part-Time/Temporary Status:

Your eligibility to continue on this plan will be determined based upon the Part-Time/ Temporary employee requirements.

Note: Your coverage provided by your employer for your permanent employment will stop at the end of the month of your change in status.

### **Preferred Provider Organization (PPO/BASIC):**

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

**DEDUCTIBLE AND COINSURANCE:**

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

<b><u>Plan Features:</u></b>	<b><u>Basic</u> <b>(Self Referral or Out-of-State)</b></b>	<b><u>PPO</u></b>
Deductible for All Services		
-Per Person	\$400	\$400
-Per Family	\$1200	\$1200
Copayment for Physician Office Visits (no limit)	\$ 30	\$ 25
Copayment for Emergency Room	\$ 50	\$ 50
Coinsurance on all covered services EXCEPT Physician Office Visits	75/25	80/20
Annual Coinsurance Maximum		
-Individual	\$1250	\$750
-Family	\$2500	\$1500
Out-of-Pocket Maximums (Deductible and Coinsurance)**		
-Individual	\$1650	\$1150
-Family	\$3700	\$2700

\* Out of Network coverage is at the basic level  
\*\*Office visit and emergency room copayments and prescription drug copayments and coinsurance are additional.

**DEDUCTIBLE AND COINSURANCE**

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

**DISEASE MANAGEMENT PROGRAM:**

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

**MEMBER REBATE ACCOUNTS:**

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

**PREVENTIVE SCREENING SERVICES- PPO/BASIC COVERAGE:**

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

**For a Complete list of benefits please refer to the Certificatie of Insurance**

**SUMMARY OF BENEFITS AND COVERAGE (SBC):**

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

**PRESCRIPTION DRUG COVERAGE:**

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

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

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

**MAIL ORDER PRESCRIPTION DRUGS:**

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

**MEMBER REBATE ACCOUNTS:**

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

## **REFERENCE MATERIALS AVAILABLE:**

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

### Provider Network

- Networks available.

### Member Handbook

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

### Special Notices

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

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

## **NON-GRANDFATHERED PPO/BASIC PLAN:**

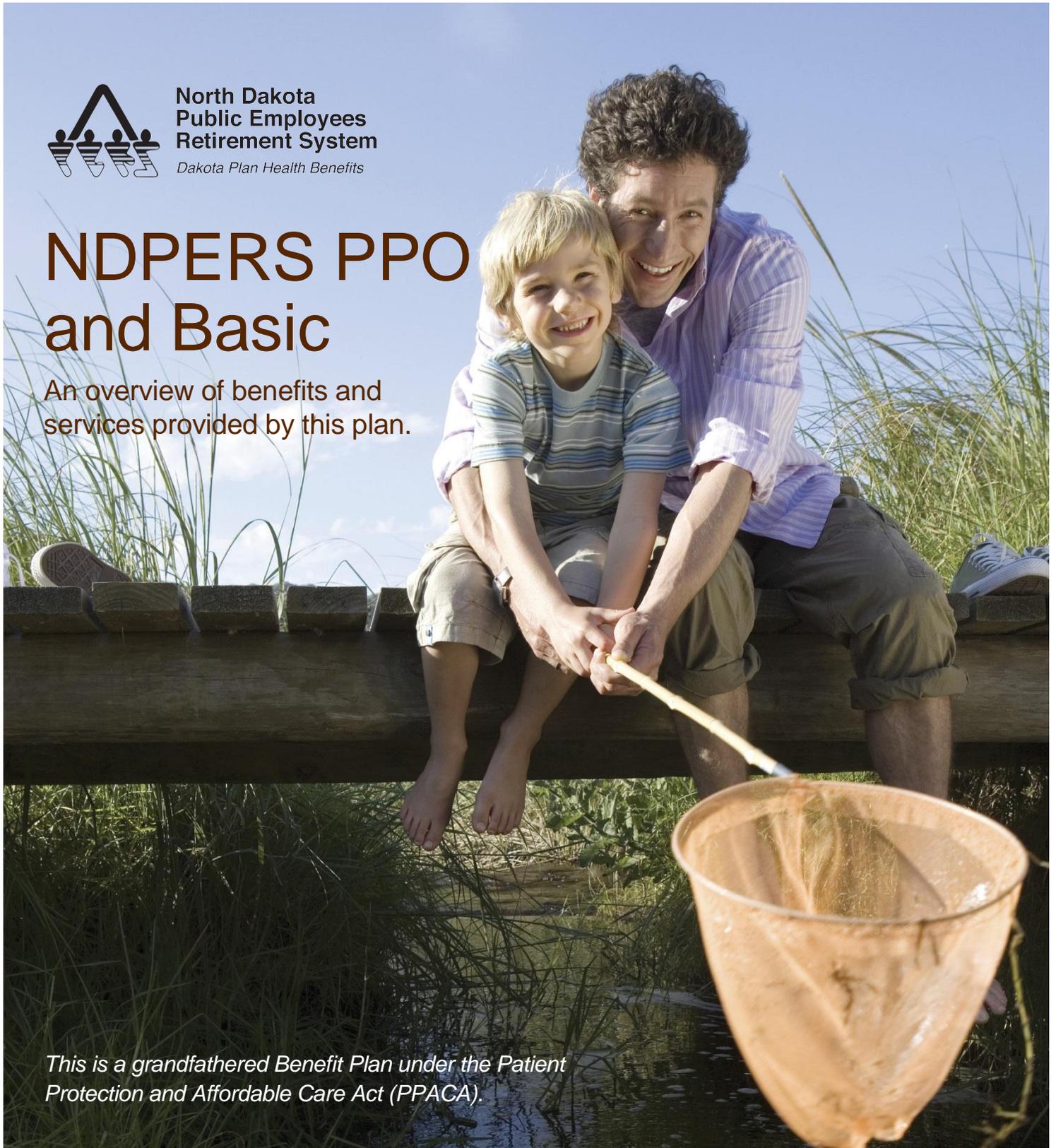
Some political subdivisions participate in the NDPERS Non-Grandfathered PPO/Basic Plan. Contact your employer to determine if this applies to you. If so, details on the plan are available on the NDPERS website.



North Dakota  
Public Employees  
Retirement System  
*Dakota Plan Health Benefits*

# NDPERS PPO and Basic

An overview of benefits and  
services provided by this plan.



*This is a grandfathered Benefit Plan under the Patient  
Protection and Affordable Care Act (PPACA).*

**SANFORD<sup>®</sup>**  
HEALTH PLAN



THIS BENEFIT PLAN COVERS  
THESE SERVICES AND MORE.

## WHO IS ELIGIBLE FOR BENEFITS?

If you have family coverage, benefits are available for you, your spouse and eligible children. Eligible children include:

- Children under age 26. Coverage will be continued until the end of the month in which the child becomes age 26.
- Children placed with you or your covered spouse for adoption, or whom you or your covered spouse has legally adopted.
- Children for whom you or your covered spouse have been appointed legal guardian by court order.
- Grandchildren of yours or your covered spouse if:
  - The parent of the grandchild is a covered eligible dependent under this Plan.
  - The parent and grandchild are primarily dependent on you or your covered spouse for their support.
- Children for whom you or your covered spouse are required by court order to provide health benefits.
- Children incapable of self-sustaining employment because of a disabling condition.

## PRESCRIPTION DRUG AND DIABETES SUPPLIES BENEFITS

This benefit plan includes a participating pharmacy network called Express Scripts, Inc. When you use this national network, your claims are filed for you.

Prescriptions are categorized as follows:

- Generic formulary medications
- Brand name formulary medications
- Non-formulary medications
- Specialty medications
- Excluded medications
- Other supplies

Certain medications may have a dispensing limit and/or require preauthorization/prior approval.

Benefits are available nationwide at any pharmacy participating in the Plan's pharmacy network. To locate a participating pharmacy, call the Pharmacy Management Team at (888) 315-0885 | TTY (877) 652-1844 (toll-free). Prescriptions filled at a non-participating pharmacy must be paid in full and submitted to Sanford Health Plan.

When a generic drug is available and you choose not to accept it, you are responsible for the difference between the cost of the generic and brand name medication, as well as the cost sharing amount.

All costs above the allowed charge are your responsibility.

This benefit grid presents a brief overview of covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written Certificate of Insurance governs the benefits available.

Description of Benefits	Copayment	Basic Plan		PPO with a PPO-participating provider within North Dakota or its contiguous counties		Special Conditions See your certificate of insurance for details on participating and non-participating providers and how the PPO vs. Basic Plan determines benefit payment
		Benefit Amount as a % of the allowed charge after the deductible is met.		Benefit Amount as a % of the allowed charge after the deductible is met.		
	Amount you pay per visit (Basic/PPO)	Before out-of-pocket maximum is met	After out-of-pocket maximum is met	Before out-of-pocket maximum is met	After out-of-pocket maximum is met	
<b>Inpatient Treatment Services</b>		75%	100%	80%	100%	Preauthorization/prior approval is required for all non-emergent medical and surgical overnight stays. This includes when you stay overnight for treatment of a mental health and/or substance use disorder but does not include maternity.
<b>Outpatient Treatment Services</b>		\$25, then 75%	\$25, then 100%	\$20, then 80%	\$20, then 100%	Refer to the Certificate of Insurance for details on other covered outpatient therapy services. Benefits are based on established medical guidelines. Deductible does not apply.
Physical Therapy	\$25 / \$20	\$25, then 75%	\$25, then 100%	\$20, then 80%	\$20, then 100%	Benefits are available for 90 consecutive calendar days per condition beginning on the date of the 1 <sup>st</sup> therapy treatment for the condition. Additional benefits may be allowed after the 90 days when medically appropriate and necessary. Deductible does not apply.
Occupational & Speech Therapy	\$25 / \$20	\$25, then 75%	\$25, then 100%	\$20, then 80%	\$20, then 100%	
<b>Professional Health Care Provider Charges</b>						
Inpatient, Outpatient & Surgical Services		75%	100%	80%	100%	
<b>Wellness Services</b>						
Well Child Care (to member's 6th birthday)	\$30 / \$25	\$30, then 100%	\$30, then 100%	\$25, then 100%	\$25, then 100%	Deductible does not apply.
Preventive Screening Services (members 6 and older)	\$30 / \$25	\$30, then 100%	\$30, then 100%	\$25, then 100%	\$25, then 100%	The Plan will pay up to a Maximum Benefit Allowance of \$200 per member per benefit period for any non-routine screening services not listed in the Certificate of Insurance or not recommended with a rating of "A" or "B" by the United States Preventive Services Task Force. Such non-routine screening services will be subject to copayment, deductible, and coinsurance amounts after the \$200 benefit allowance has been met.
Immunizations		100%	100%	100%	100%	Deductible does not apply.
Mammography		100%	100%	100%	100%	The number of mammography services varies by age group. Refer to the benefit plan for details. Deductible does not apply.
Pap Smear Screening Services	\$30 / \$25	\$30, then 100%	\$30, then 100%	\$25, then 100%	\$25, then 100%	Maximum benefit allowance of 1 Pap smear per benefit period. Refer to the benefit plan for details. Deductible does not apply.
Prostate Cancer Screening Services	\$30 / \$25 (per related office visit)	75%	100%	80%	100%	Deductible does not apply. Copayment amount applies to related office visit only; coinsurance applies to applicable diagnostic testing services performed. Refer to the Certificate of Insurance for details.
<b>Home &amp; Office Visits</b>	\$30 / \$25	\$30, then 100%	\$30, then 100%	\$25, then 100%	\$25, then 100%	Deductible does not apply.
<b>Diagnostic Services</b>						
Lab, X-ray, MRI		75%	100%	80%	100%	
Allergy Testing		75%	100%	80%	100%	
<b>Radiation Therapy, Chemotherapy &amp; Dialysis</b>		75%	100%	80%	100%	
<b>Maternity Services</b>		75%	100%	80%	100%	Deductible does not apply to delivery services received from a PPO provider when enrolled in the Healthy Pregnancy Program.
Inpatient, Outpatient, Pre & Postnatal Care						
<b>Mental Health and Substance Use Disorder Treatment Services</b>						Preauthorization/prior approval is required for non-emergency inpatient treatment for mental health and/or substance use disorders.
<b>Inpatient</b> - Includes acute inpatient admissions and residential treatment		75%	100%	80%	100%	
<b>Outpatient</b>						For all outpatient services, 100% of the allowed charge (includes copayment and deductible/coinsurance) is waived for the initial five (5) hours/visits, per member per benefit period.
Office visits	\$30 / \$25	100%	100%	100%	100%	
All other services, includes intensive outpatient and partial hospitalization		80%	100%	80%	100%	
<b>Emergency Services</b>						Preauthorization/prior approval is not required.
Professional Health Care Provider Charge		80%	100%	80%	100%	Deductible does not apply to the office or emergency room visit.
Emergency Room Visit	\$50 / \$50	80%	100%	80%	100%	Copayment is waived when member is admitted to inpatient hospital.
Ambulance Services		80%	100%	80%	100%	
<b>Skilled Nursing Facility Services</b>		75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Home Health Care Services</b>		75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Hospice Services</b>		75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Chiropractic Services</b>						
Home & Office Visits	\$30 / \$25	100%	100%	100%	100%	Deductible does not apply.
Therapy & Manipulations	\$25 / \$20	75%	100%	80%	100%	Deductible does not apply.
Diagnostic Services		75%	100%	80%	100%	
<b>Medical Supplies &amp; Equipment</b>		75%	100%	80%	100%	
Hearing Aids		75%	100%	80%	100%	Limited to one hearing aid, per ear, per Member every 3 years. For Members ages 18 and older, excludes hearing aids to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors.

Description of Prescription Drug Benefits	Copayment	Before prescription drug coinsurance maximum is met.	After prescription drug coinsurance maximum is met.	Special Conditions
				Benefits are subject to the Prescription Drug Coinsurance Maximum Amount. Deductible does not apply.
<b>Outpatient Prescription Medications (Retail and Mail Order)</b>				
<b>Formulary</b>				
Generic	\$5	\$5, then 85% of allowed charge	\$5	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. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 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. Cost Sharing Amounts are waived for prenatal vitamins. This benefit plan <u>does not</u> cover any contraceptive medications, devices, appliances, supplies, or related services when used for contraception, including contraceptive products that do not require a Prescription Order or dispensing by a Health Care Provider.
Brand	\$20	\$20, then 75% of allowed charge	\$20	
<b>Nonformulary</b>	\$25	\$25, then 50% of allowed charge	\$25, then 50% of allowed charge	

Cost Sharing Amounts		
	PPO	Basic
<b>Single Coverage</b>		
Deductible amount	\$400	\$400
Coinsurance maximum	\$750	\$1,250
Out-of-pocket maximum	\$1,150	\$1,650
<b>Family Coverage - All members in the family contribute to deductible and coinsurance amounts; however an individual family member's contribution cannot be more than the single coverage amount listed above.</b>		
Deductible amount	\$1,200	\$1,200
Coinsurance maximum	\$1,500	\$2,500
Out-of-pocket maximum	\$2,700	\$3,700

**Prescription Drug Coinsurance Maximum Amount** \$1,000 per member per benefit period

When the prescription drug coinsurance maximum amount has been met, copayment amounts will continue to apply, and formulary drugs will be covered at 100% of the allowed charge for the remainder of the benefit period. Prescription Medication Copayment Amounts do not apply toward the Prescription Drug Coinsurance Maximum Amount.

*This chart reflects the cost sharing amounts for each benefit period. PPO and Basic amounts accumulate jointly. Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amounts.*

#### Preferred Provider Organizations (PPO)

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 Sanford Health Plan 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 at [www.sanfordhealthplan.com/ndpers](http://www.sanfordhealthplan.com/ndpers).

*This grid describes an employer group health plan that is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits; and requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).*

*Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to Sanford Health Plan at [memberservices@sanfordhealth.org](mailto:memberservices@sanfordhealth.org). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). The Department of Labor website has a table summarizing which protections do and do not apply to grandfathered health plans.*

Call (800) 499-3416 to speak with Member Services.

# **GROUP HEALTH INSURANCE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**

Permanent state employees, university system employees and district health unit employees are eligible to participate in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). Participation in the HDHP/HSA is optional. Temporary employees and employees of political subdivisions are not eligible to participate in the HDHP/HSA at this time.

The HDHP/HSA option has higher annual deductibles and larger out-of-pocket costs for medical services. However, the higher initial out-of-pocket costs are partially offset by an employer contribution to an HSA created in the member's name. The NDPERS HDHP/HSA has a cap on how much you will pay out-of-pocket during a year, and covers preventive and other services (as designated by the Affordable Care Act (ACA) with no out-of-pocket costs to you.

The HSA helps cover medical expenses until your annual deductible and copayment are met. NDPERS will contribute to your HSA for each month you participate as follows:

	<b>Month</b>
Single	\$ 69.94
Family	\$169.24

The employer contributions are sent to the HSA vendor on a delayed schedule. For example the June coverage month contributions will be posted to your HSA account by the end of July.

In addition, you may contribute to your HSA on an after-tax basis, and claim those contributions when you file your annual tax return.

Please see the NDPERS High Deductible Health Plan summary for more details on benefits and services provided by this plan, the Health Savings Account (HSA) FAQ for Participants information sheet to learn more on how an HSA works. Additional information about the HDHP/HSA is also available on the NDPERS website.

NDPERS may require account verification in order to establish your HSA. However, if the HSA cannot be established, employer contributions will not be made on your behalf but you will remain in the HDHP Plan. HSAs cannot be established if you are a non-resident alien, covered under Tricare, Medicare or are enrolled in a medical spending account.

## **SUMMARY OF BENEFITS AND COVERAGE (SBC):**

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



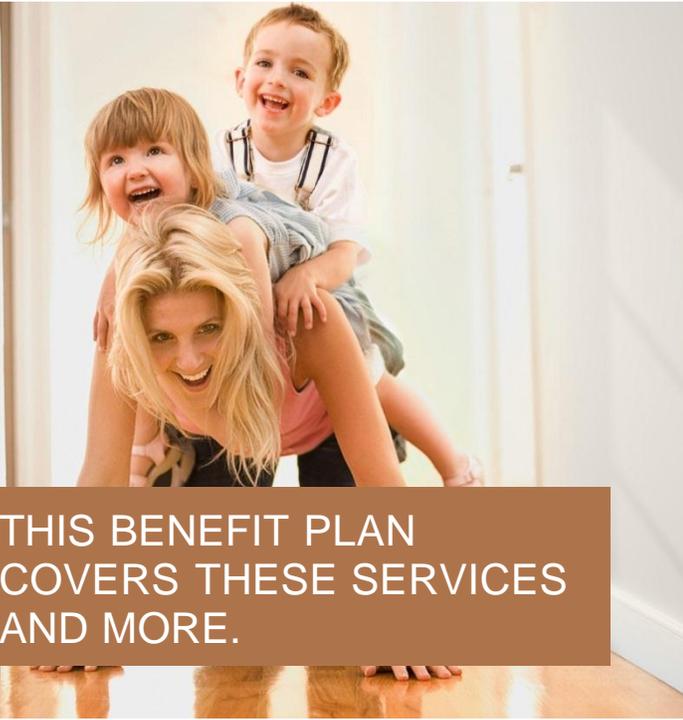
**North Dakota  
Public Employees  
Retirement System**  
*Dakota Plan Health Benefits*

# **NDPERS High Deductible Health Plan**

An overview of benefits  
and services provided  
by this plan.

*This is not a grandfathered Benefit  
Plan under the Patient Protection and  
Affordable Care Act (PPACA).*

**SANFORD<sup>®</sup>  
HEALTH PLAN**



**THIS BENEFIT PLAN  
COVERS THESE SERVICES  
AND MORE.**

## WHO IS ELIGIBLE FOR BENEFITS?

If you have family coverage, benefits are available for you, your spouse and eligible children. Eligible children include:

- Children under age 26. Coverage will be continued until the end of the month in which the child becomes age 26.
- Children placed with you or your covered spouse for adoption, or whom you or your covered spouse has legally adopted.
- Children for whom you or your covered spouse have been appointed legal guardian by court order.
- Grandchildren of yours or your covered spouse if:
  - The parent of the grandchild is a covered eligible dependent under this Plan.
  - The parent and grandchild are primarily dependent on you or your covered spouse for their support.
- Children for whom you or your covered spouse are required by court order to provide health benefits.
- Children incapable of self-sustaining employment because of a disabling condition.

## PRESCRIPTION DRUG AND DIABETES SUPPLIES BENEFITS

This benefit plan includes a participating pharmacy network called Express Scripts, Inc. When you use this national network, your claims are filed for you.

Prescriptions are categorized as follows:

- Generic formulary medications
- Brand name formulary medications
- Non-formulary medications
- Specialty medications
- Excluded medications
- Other supplies

Certain medications may have a dispensing limit and/or require preauthorization/prior approval.

Benefits are available nationwide at any pharmacy participating in the Plan's pharmacy network. To locate a participating pharmacy, call the Pharmacy Management Team at (888) 315-0885 | TTY (877) 652-1844 (toll-free). Prescriptions filled at a non-participating pharmacy must be paid in full and submitted to Sanford Health Plan.

When a generic drug is available and you choose not to accept it, you are responsible for the difference between the cost of the generic and brand name medication, as well as the cost sharing amount. All costs above the allowed charge are your responsibility.

## PREVENTIVE SCREENING SERVICES

Evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, when received from a Participating Provider, are covered without payment of any deductible or coinsurance requirement that would otherwise apply. As these recommendations change, your coverage may also change. Services performed outside of Plan Preventive Guidelines, and with a medical diagnosis, will be applied to your deductible and coinsurance.

Preventive screening services covered include:

- One routine physical examination
- Routine diagnostic screenings
- Mammography screening  
*(for members age 35 and older)*
- Cervical cancer screening
- Colorectal cancer screening  
*(for members age 50 through 75)*
  - Fecal occult blood testing and
  - Colonoscopy or
  - Sigmoidoscopy
- Certain nutritional counseling
- Tobacco cessation services

This benefit grid presents a brief overview of covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written Certificate of Insurance governs the benefits available.

Description of Benefits	Basic Plan		PPO with a PPO-participating provider within North Dakota or its contiguous counties		Special Conditions
	Benefit Amount as a % of the allowed charge after the deductible is met.	Before out-of-pocket maximum is met	After out-of-pocket maximum is met	Before out-of-pocket maximum is met	After out-of-pocket maximum is met
<b>Inpatient Hospital Services</b>	75%	100%	80%	100%	Preauthorization/prior approval is required for all non-emergent medical and surgical overnight stays. This includes when you stay overnight for treatment of a mental health and/or substance use disorder but does not include maternity.
<b>Outpatient Therapy Services</b>	75%	100%	80%	100%	Refer to the Certificate of Insurance for details on other covered outpatient therapy services.
Physical Therapy	75%	100%	80%	100%	Benefits are based on the medical guidelines established by Sanford Health Plan. Deductible does not apply.
Occupational & Speech Therapy	75%	100%	80%	100%	Benefits are available for 90 consecutive calendar days per condition beginning on the date of the 1st therapy treatment for the condition. Additional benefits may be allowed after the 90 days when medically appropriate and necessary. Deductible does not apply.
<b>Professional Health Care Provider Services</b>					
Inpatient, Outpatient & Surgical Services	75%	100%	80%	100%	
<b>Wellness Services</b>					
Immunizations	100%	100%	100%	100%	Deductible does not apply.
Well Child Care (to member's 18th birthday)	100%	100%	100%	100%	Deductible does not apply.
Preventive Screening Services (members 18 and older)	100%	100%	100%	100%	Evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, when received from a Participating Provider, are covered without payment of any deductible or coinsurance requirement that would otherwise apply. As these recommendations change, your coverage may also change. Services performed outside of Plan Preventive Guidelines, and with a medical diagnosis, will be applied to your deductible and coinsurance. Refer to the benefit plan for details.
Colonoscopy or Sigmoidoscopy	100%	100%	100%	100%	Deductible does not apply to these services.
Mammography, Pap Smear & Fecal Occult Blood Testing	100%	100%	100%	100%	Deductible does not apply to these services.
Tobacco Cessation Services including office visit	100%	100%	100%	100%	For Members who use tobacco products, at least two (2) tobacco cessation attempts per year, covering four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling); and all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider. Preauthorization/Prior Approval is not required for any tobacco cessation services. Deductible does not apply.
<b>Home &amp; Office Visits</b>	75%	100%	80%	100%	Deductible does not apply.
<b>Diagnostic Services</b>					
Lab, X-ray, MRI	75%	100%	80%	100%	
Allergy Testing	75%	100%	80%	100%	
<b>Radiation Therapy, Chemotherapy &amp; Dialysis</b>	75%	100%	80%	100%	
<b>Maternity Services</b>	75%	100%	80%	100%	For prenatal and postnatal care, deductible is waived and coverage is at 100% (no charge).
Inpatient, Outpatient, Pre & Postnatal Care					
<b>Mental Health and Substance Use Disorder Treatment Services</b>					
<b>Inpatient</b> - includes acute inpatient admissions and residential treatment	75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Outpatient</b>					For all outpatient services, 100% of the allowed charge (includes deductible/coinsurance) is waived for the initial five (5) hours/visits, per member per benefit period. Coverage of the first five (5) hours will not apply when you elect an HSA. For full details, please refer to your Certificate of Insurance.
Office visits	80%	100%	80%	100%	
All other services, includes intensive outpatient and partial hospitalization	80%	100%	80%	100%	
<b>Emergency Services</b>	80%	100%	80%	100%	Preauthorization/prior approval is not required.
Professional Health Care Provider Charges	80%	100%	80%	100%	
Emergency Room Visit	80%	100%	80%	100%	Deductible does not apply to the office or emergency room visit.
Ambulance Services	80%	100%	80%	100%	
<b>Skilled Nursing Facility Services</b>	75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Home Health Care Services</b>	75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Hospice Services</b>	75%	100%	80%	100%	Preauthorization/prior approval is required.
<b>Chiropractic Services</b>					
Home & Office Visits	75%	100%	80%	100%	
Therapy & Manipulations	75%	100%	80%	100%	
Diagnostic Services	75%	100%	80%	100%	
<b>Medical Supplies &amp; Equipment</b>	75%	100%	80%	100%	
Hearing Aids	75%	100%	80%	100%	Limited to one hearing aid, per ear, per Member every 3 years. For Members ages 18 and older, excludes hearing aids to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors.

This benefit grid presents a brief overview of covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written Certificate of Insurance governs the benefits available.

	Before out-of-pocket maximum is met.	After out-of-pocket maximum is met.	
<b>Prescription Medications (Retail and Mail Order)</b>			<b>A Member must meet the Annual Deductible before Coinsurance Amounts will apply to prescription medications.</b> When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications.
<b>Formulary and Diabetes Supplies</b>	80%	100%	Formulary contraceptive medications obtainable with a Prescription Order are paid at 100% of Allowed Charge; this includes over-the-counter Plan-B, if obtained with a Prescription Order. Deductible Amount is waived.
<b>Nonformulary</b>	50%	50%	Folic Acid Supplements are covered at 100% (no charge) for women planning to become pregnant, or in their childbearing years, if obtained with a Prescription Order. Deductible Amount is waived.
<i>Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.</i>			Vitamin D supplements are covered at 100% (no charge) for Members ages 65 and older at risk for falls, if obtained with a Prescription Order. Deductible Amount is waived.
			Formulary breast cancer preventive medications obtainable with a Prescription Order are covered at 100% (no charge) for women at increased risk for breast cancer. Deductible Amount is waived.

<b>Cost Sharing Amounts</b>			
	<b>PPO</b>	<b>Basic</b>	
<b>Single Coverage</b>			
<b>Deductible amount</b>	<b>\$1,500</b>	<b>\$1,500</b>	
Coinsurance maximum	<u>\$1,500</u>	<u>\$2,000</u>	
<b>Out-of-pocket maximum</b>	<b>\$3,000</b>	<b>\$3,500</b>	<i>You must meet the Out-of-Pocket Maximum before this Benefit Plan begins to pay 100% of covered services. The coinsurance maximum listed is for illustrative purposes only.</i>
<b>Family Coverage</b>			
<b>Deductible amount</b>	<b>\$3,000</b>	<b>\$3,000</b>	
Coinsurance maximum	<u>\$3,000</u>	<u>\$4,000</u>	
<b>Out-of-pocket maximum</b>	<b>\$6,000</b>	<b>\$7,000</b>	<i>You must meet the Out-of-Pocket Maximum before this Benefit Plan begins to pay 100% of covered services. The coinsurance maximum listed is for illustrative purposes only.</i>

This chart reflects the cost sharing amounts for each benefit period. PPO and Basic amounts accumulate jointly. Prescription Medication Coinsurance Amounts accumulate toward a Member's cumulative annual Out-of-Pocket Maximum.

**Preferred Provider Organizations (PPO)**

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 Sanford Health Plan 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 at [www.sanfordhealthplan.com/ndpers](http://www.sanfordhealthplan.com/ndpers).

Call (800) 499-3416 to speak with Member Services.

# HEALTH SAVINGS ACCOUNTS

Taking control of your health care dollars



**SANFORD**<sup>®</sup>  
HEALTH PLAN



**You will be enrolled in a Health Savings Account (HSA) to help you cover the costs of enrolling in a High Deductible Health Plan (HDHP).**

## **WHAT IS AN HSA?**

A Health Savings Account (HSA) is an individual account, like a personal bank account or an IRA. The money you deposit into your account can be used to pay for future medical expenses with tax benefits. You own the money. It's yours.

## **ELIGIBILITY**

You must be enrolled in a qualified High Deductible Health Plan (HDHP). You cannot be enrolled in a general FSA or HRA account, but you can have a limited FSA or HRA. It is your responsibility to check with your employer and ensure IRS compliance with your plans. **NOTE:** You can be enrolled in a dependent care FSA with an HSA.

You are not eligible if you are:

- Entitled to Medicare benefits
- Claimed as a dependent on anyone else's tax return
- Enrolled in a traditional HRA or FSA
- Non-resident alien

## **HOW DOES IT WORK?**

Check with your employer on how to enroll. Once you enroll in a qualified High Deductible Health Plan, you are eligible to set up an HSA the 1st of the next month. Then, simply deposit money into your account. You control your account. The money is yours – always – even if you switch jobs.

- High Deductible Health Plans generally have lower premiums, but higher deductibles. Use your HSA funds to pay for those out-of-pocket expenses until you reach your deductible.
- Deposit funds into your HSA account on a tax-deductible basis.
- Withdraw funds from your HSA account on a tax-free basis when using for eligible expenses.

## WHERE IS MY HSA ACCOUNT SET UP?

Once you are eligible and enroll, your account will be set up at HealthcareBank, a division of Bell State Bank & Trust (member FDIC).

## CAN I DEPOSIT AS MUCH AS I WANT?

No, there are rules regarding how much you can deposit into your HSA account each year. It is your responsibility to make sure you do not exceed the following annual dollar amounts:

HSA CONTRIBUTION LIMITS	2016	2017
Individual	\$3,350	\$3,400
Family	\$6,750	\$6,750
Additional contributions available to those age 55 or older	\$1,000	\$1,000

If your medical coverage changes single to family or family to single, you may adjust your contributions accordingly.

## ROLLING OVER FUNDS FROM OTHER ACCOUNTS

- You are allowed to rollover funds from another HSA or an Archer MSA, but only once per year.
- You are allowed to rollover your IRA, however, there are specific rules regarding an IRA rollover. Contact your IRA provider if interested.

## WAYS TO CONTRIBUTE TO YOUR ACCOUNT

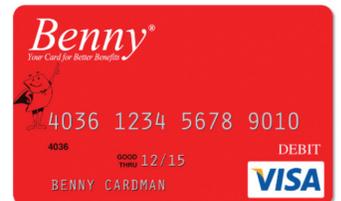
- Your employer will contribute to your HSA account.
- You can deposit funds directly on your own.

If you exceed the contribution limits, simply remove the excess contributions (and income you have earned) before you file your taxes the next year (April 15). If you forget, the extra contributions are taxed.

## ACCESSING YOUR HSA ACCOUNT

Your account can be conveniently accessed through your member account at [sanfordhealthplan.com/memberlogin](http://sanfordhealthplan.com/memberlogin). To access your money:

- Use your Benny Debit Card at your doctor's office or pharmacy. The dollar amount will be subtracted from your HSA account.
- Pay for your services up front, then request a distribution from your secure online account.
- We won't ask you for your receipts. It is your responsibility to use the account appropriately. The IRS could ask you for your receipts, so keep them for your tax records.
- If you are no longer covered by a HDHP, your HSA account remains your account and you will continue to be able to access your money. However, you will be responsible for paying the administrative fees.



Once contributions are posted, and there is money in your account, we will send you two debit cards – free of charge.

## WHAT TYPES OF EXPENSES ARE ELIGIBLE?

Use your account for eligible medical expenses, such as:

- Doctor visit copays
- Hospital expenses
- Prescription drugs
- Vision/dental care

You can use your HSA dollars to pay for medical expenses for yourself, your spouse, or your tax dependent children.

If you use your account for non-medical expenses, you will incur a tax/penalty on the withdrawal. However, once you turn 65, you can use your account for whatever you wish – not just medical expenses – without the tax penalty.



## WILL I EARN INTEREST?

Yes! If you have a:

- Balance of \$2,100 or less: Your account is held in an interest-bearing cash account.
- Balance exceeding \$2,100: Your money is automatically rolled into investment accounts at \$100 increments.

You choose the investments when you enroll in your account. Your investment earnings grow tax free!

## WHAT ARE THE TAX BENEFITS OF HAVING AN HSA? IS IT RIGHT FOR ME?

- Distributions (withdrawals) are tax free if used for eligible expenses.
- Interest (investment) earnings are not taxable.
- No “use-it-or-lose-it” rule.
- No receipts required to submit.
- Employer contributions are not taxable.

## OTHER IMPORTANT INFORMATION

- Unused money rolls over year to year. There is no “use it or lose it” provision.
- Since you own the account, you can change jobs and continue using the same account (you may lose your employer contributions if applicable).
- Once you become 55, you can make additional contributions to your account each year until you are 65.

**Call (605) 328-6810 or (877) 737-7730 for more information.**



# **NDPERS PPO/BASIC & HDHP Plan**

## **MAIL ORDER PRESCRIPTION DRUGS:**

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

## **DAKOTA WELLNESS PROGRAM**

### **Novu Online Portal:**

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

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

# NDPERS Member Handbook

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## Dear Sanford Health Plan NDPERS Member,

We are pleased to have you as a Member and welcome you to our care system! This booklet will help you get to know your benefits. It is made up of tips on how you can reach us, how to use your benefits and how to find Participating Providers [Doctors and hospitals that contract with Sanford Health Plan]. We look forward to serving you.

## Introduction

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

For details about your coverage, please see your COI, which gives all of the terms and conditions of enrollment.

**Note:** *This Plan may not cover all your health care costs. Read your COI with care to find out which costs are covered.*

## How to Contact Us

If you have more questions after reading the Handbook or your COI, or need any help, we are open between the hours of 8 a.m. to 5:30 p.m. Central Time, Monday through Friday.

<b>Physical Address</b> Sanford Health Plan ATTN: NDPERS 300 Cherapa Place, Suite 201 Sioux Falls, SD 57103	<b>Mailing Address</b> Sanford Health Plan ATTN: NDPERS PO Box 91110 Sioux Falls, SD 57109-1110
<b>Member Services</b> (800) 499-3416 ( <i>toll-free</i> ) or TTY/TDD: (877) 652-1844 ( <i>toll-free</i> )	<b>Preauthorization/Prior Approval</b> (888) 315-0885 ( <i>toll-free</i> ) or TTY/TDD: (877) 652-1844 ( <i>toll-free</i> )
<b>Sanford Health Plan Provider Locator</b> If you need to find a Provider in your area, call ( <i>toll-free</i> ): (800) 499-3416 or TTY/TDD: (877) 652-1844	<b>Utilization Management</b> The Hospital, your Provider, or you should call ( <i>toll-free</i> ): (888) 315-0885 or TTY/TDD: (877) 652-1844
<b>Website</b> <a href="http://www.sanfordhealthplan.com/ndpers">www.sanfordhealthplan.com/ndpers</a>	

## Privacy Practices

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

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

## Member Rights & Responsibilities

### Member Rights

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

1. You have the right to get access to health care and/or services that are ready or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.
2. You have the right to considerate, respectful treatment always, and under all circumstances, with recognition of your personal dignity.
3. You have the right to be questioned and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. You have the right, but are not required, to select a Primary Care Doctor of your choice. If you are not happy for any reason with the main doctor initially chosen, you have the right to choose another doctor.
5. You have the right to expect communications and other records about your care, along with the source of payment for treatment, to be treated as confidential, in line with the guidelines set up in applicable North Dakota law.
6. You have the right to know who someone is and professional status of people supplying services to you, and to know which Doctor and/or Provider is mainly responsible for your care. You also have the right to get information about our clinical guidelines and rules.

7. You have the right to a honest talk with the Doctors and/or Providers responsible for coordinating appropriate or medically necessary treatment choices for your conditions in a way that is clear, regardless of cost or benefit coverage for those treatment choices. You also have the right to join with Doctors and/or Providers in decision making about your treatment plan.
8. You have the right to give informed consent before the start of any procedure or treatment.
9. When you do not speak or understand the main language of the community, we will make reasonable efforts to access an interpreter. We have the duty to make reasonable efforts to access a treatment clinician that is able to communicate with you.
10. You have the right to get printed materials that describe important information about us in a format that is easy to understand and easy to read.
11. You have the right to a clear Grievance and Appeal process for complaints and comments and to have your issues resolved in a timely way.
12. You have the right to Appeal any decision on medical necessity made by us and our Doctors and/or Providers.
13. You have the right to end coverage, in line with NDPERS and/or Plan guidelines.
14. You have the right to make recommendations about the organization's Members' rights and responsibilities policies.
15. You have the right to get information about the organization, its services, its Doctors and Providers, and Members' rights and responsibilities.

## Member Responsibilities

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

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

## Member Services Department

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

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

We are open and can answer your questions from 8 a.m. to 5:30 p.m. Central Time, Monday through Friday.

## Eligibility of Dependents

The following Dependents are eligible for coverage ("Dependent coverage"):

**Spouse** - Your spouse, who is a person of the opposite sex, is always eligible for coverage, subject to the eligibility requirements of NDPERS.

**Dependent Child** - To be eligible for coverage, a dependent child must meet all of the following requirements:

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2. Be one of the following:
  - a. under age twenty-six (26); or
  - b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the you for support and maintenance. If we ask, you must give proof of your child's disability within *thirty-one (31)* days of our request; or
  - c. Your grandchild(ren) or those of the your living, covered Spouse, who legally live with you; given that (1) the parent of the grandchild(ren) is also covered as your Dependent; and (2) both the parent (Covered Dependent) and child of such Dependent (grandchild) are chiefly dependent upon you for support.

Coverage will continue to the end of the month in which the adult Dependent child reaches the limiting age. Coverage does not include the adult Dependent child's spouse or child of such Dependent (grandchild) unless that grandchild meets other coverage criteria established under state law. The adult Dependent's marital status, financial dependency, residency, student status or employment status will not be considered in deciding eligibility for initial or continued coverage.

**Limitations.** A Dependent shall not be covered under this Contract if he or she is eligible to be a Subscriber, already covered as a Dependent of another Subscriber, or already covered as a Subscriber.

### Newborn Coverage

If you have Family Coverage, you are encouraged to tell us when you are pregnant and know your due date. If you have a child through birth, your newborn child will become covered from the date of their birth. Newborn children will be added to a policy automatically if you are enrolled in Family Coverage and we are told of the pregnancy.

If you have Single Coverage, you must apply for Family Coverage with NDPERS within thirty-one (31) days from the newborn's date of birth.

### Special Communication Services

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

In compliance with the ADA, we have this document in other formats. If you need help, please contact the NDPERS ADA Coordinator at (701) 328-3900.

### Translation Services

We can arrange for translation services. Free written materials are available in many different languages and free oral translation services are available. Call Member Services toll-free (800) 499-3416 for help and to access translation services.

**Spanish (Español):** Para obtener asistencia en Español, llame al (800) 892-0675 (*toll-free*).

**Tagalog (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 892-0675 (*toll-free*).

**Chinese (中文):** 如果需要中文的帮助, 请拨打这个号码 (800) 892-0675 (*toll-free*).

**Navajo (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 892-0675 (*toll-free*).

### Services for the Deaf, Hearing Impaired, and/or Visually Impaired

If you are deaf or hearing impaired and need to speak to us, call TTY/TDD: (877) 652-1844 (*toll-free*). Please contact us toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

### Member Benefits

As a Plan Member, your benefits package is one of the most comprehensive available today. Basic primary care and preventive benefits are available through your Primary Care Doctor or other Participating Providers. Please see your Summary of Benefits & Coverage and your Certificate of Insurance for a description of covered services, as well as those that are not covered.

### Formulary

Sanford Health Plan covers prescribed medications according to our Formulary. A formulary is a list of Prescription Drug Products, which we prefer for dispensing to you when needed. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year. We will notify you of any Formulary changes. For a copy of our Formulary, contact Pharmacy Management at (888) 315-0885 | TTY/TDD: (877) 652-1844, or visit your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

## For More Detailed Pharmacy Information

Please see the following documents for specific drug coverage information. You may also contact Pharmacy Management for this information or find it on your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

1. **Summary of Benefits & Coverage (SBC)** – describes the payments for which you are responsible when purchasing prescription drugs and supplies.
2. **Summary of Pharmacy Benefits** – describes specific information on drug exclusions, drugs that require Preauthorization/Prior Approval, quantity level limits on drugs, our injectable drug program, and the formulary.
3. **Certificate of Insurance (COI)** – describes how and where to get your prescription drugs and supplies, dispensing limitations, and excluded drugs and supplies.

To see the pharmacy locator, health news, drug side effect and interaction information, generic substitution information, personal reminders, benefit information, and your current medications, go to your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin). You will find our Formulary and other pharmacy information as well. You may also click 'Find a Pharmacy' to access the Express Scripts web link.

For information on benefits when you need a prescription medication, and are outside the United States, see your COI.

## Emergency and Urgent Care Situations

### Emergency Medical Conditions

Emergency services from Basic Plan-level Doctors and Hospitals will be covered at the same benefit and cost sharing level as services supplied by PPO-level Doctors and Hospitals, both within and outside of the Sanford Health Plan Service Area, in cases where a Prudent Layperson reasonably believed that you had an Emergency Medical Condition.

**Note:** If we determine your condition did not meet Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, and you are responsible for charges above the Reasonable Cost.

If you have an Emergency Medical Condition, you are encouraged to get services at the nearest Emergency Facility that is a Participating Provider. If the Emergency Medical Condition is so bad that you cannot go safely to the nearest Participating Emergency Facility, then you should go to the nearest Emergency Facility. To find a list of Participating Doctors and Hospitals, visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or call us toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (*toll-free*). You, or a designated relative or friend must notify us, and your Primary Care Doctor, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition, but no later than *forty-eight (48)* hours after you are physically or mentally able to do so.

### What is an Emergency Medical Condition?

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

We cover worldwide Emergency services necessary to screen and stabilize you without Preauthorization/Prior Approval in cases where a Prudent Layperson would reasonably believe that an Emergency Medical Condition existed. Network restrictions do not apply to Emergency services from Doctors and Hospitals outside of the U.S.

### Participating Emergency Doctors and Hospitals

We cover Emergency services necessary to screen and stabilize you without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that you had an Emergency Medical Condition.

**Note:** If we determine your condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, depending on whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 1 of your COI.

### Non-Participating Emergency Doctors and Hospitals

We cover Emergency services necessary to screen and stabilize you and do not require Prospective (Pre-Service) Review if a Prudent Layperson would have reasonably believed that taking time to get to a Participating Doctor or Hospital would make your emergency worse, or if a provision of federal, state, or local law requires the use of a specific Doctor. Our coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Doctor or Hospital.

**Note:** If we determine your condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Doctors and Hospitals set forth in Section 1,

and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 1 in your COI for more information.

If you are admitted as an inpatient to a Non-Participating Hospital or other Facility, then we will contact the admitting Doctor to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, you may be transferred to a Participating Hospital and/or other appropriate Facility.

## Urgent Care Situations

Treatment supplied in Urgent Care Situations from Basic Plan-level Doctors and Hospitals will be covered at the same benefit and cost sharing level as services supplied by PPO-level Doctors and Hospitals, both within and outside of the Sanford Health Plan Service Area, in cases where a Prudent Layperson reasonably believed that you were in an Urgent Care Situation.

**Note:** If we determine your condition did not meet Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, and you are responsible for charges above the Reasonable Cost.

If an **Urgent Care Situation** occurs, you should contact your Primary Care Doctor immediately, if one has been selected, and follow his or her instructions. If a Primary Care Doctor has not been selected, you should contact us and follow our instructions. You may always go directly to any urgent care or after-hours clinic. If possible, you should go to participating provider (call us for a list of Participating Doctors and Hospitals or find it at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin)).

## What is an Urgent Care Situation?

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

An **Urgent Care Request** means that the time span for deciding a non-Urgent Care Request for a health care service or course of treatment:

1. Could seriously jeopardize your life or health, or your ability to regain maximum function, based on a Prudent Layperson's judgment; or
2. In the opinion of a Doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

## Participating Urgent Care Doctors and Hospitals

We cover services in an Urgent Care Situation without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that you had an Urgent Care Situation.

**Note:** If we determine your condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts may apply, depending on whether services were received from a PPO-level or Basic-level Participating Provider/Facility; see Section 1 of your COI for details.

## Non-Participating Urgent Care Doctors and Hospitals

We cover services in an Urgent Care Situation without Preauthorization/Prior Approval requirements if a Prudent Layperson would have reasonably believed that taking time to get to a Participating Doctor or clinic would make your situation worse, or if a provision of federal, state, or local law requires the use of a specific doctor. Your coverage will be at the same benefit level as if the service or treatment had been rendered by a Participating Doctor or clinic.

**Note:** If we determine your condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Doctors or Hospitals set forth in Section 1, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 1 in your COI for more information.

**Note:** For non-Emergency medical care or non-Urgent Care Situations when traveling outside our Service Area, benefits will be at the Basic level. See *Non-Participating Providers outside the Sanford Health Plan Service Area* in Section 1 of your COI.

## Ambulance and Transportation Services

Transportation by professional ground ambulance, air ambulance, or on a regularly scheduled flight on a commercial airline is covered when transportation is:

- a. Medically necessary; and
- b. To the nearest Participating Provider equipped to give you the necessary health care services; or as approved and arranged by us.

## Levels of Coverage

The benefit payment available under your Benefit Plan differs based on your choice of a Health Care Provider. We pay Doctors and Hospitals based on their relationship with us. Doctors or Hospitals that have signed contracts with us, and join our Network, will be paid at either the PPO Plan or Basic Plan level.

You should visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) for the Provider Directory, which lists both PPO and Basic level Participating (In-Network) Doctors and Hospitals. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Doctors and Hospitals. You may also call Member Services to request a Provider Directory.

## In-Network Coverage

In-Network coverage is supplied under two (2) plan levels: 1) Basic Plan; or 2) PPO Plan. For more information, see *Selecting a Health Care Provider* in Section 1 of your COI.

**Note:** If you travel out of our Service Area (as defined in your COI) to seek medical treatment, without Preauthorization/Prior Approval, for a service that requires authorization/approval, your claims will be paid at the Basic Plan benefits. Find more in Section 1 of your COI.

## How PPO vs. Basic Plan Determines Benefit Payment

PPO stands for “Preferred Provider Organization,” which is a health plan that contracts with independent providers at a discount for services. Covered services must be from an NDPERS PPO Doctor or Hospital to get PPO Plan level benefits. Please see the NDPERS PPO Health Care Provider Listing by visiting [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

If a PPO Doctor or Hospital is: 1) not available in your area; or 2) if you either choose or are referred to a Doctor or Hospital not participating in the PPO, you will get the Basic Plan level benefits. For more information on how benefits are paid, see your COI.

## Participating vs. Non-Participating Doctors and Hospitals

When you get health care services from a Participating Doctor or Hospital, they will send us needed information for you. You need to pay the Doctor or Hospital for any cost sharing amounts you owe (copays, deductible/coinsurance).

If you get health care services from a Non-Participating [has not signed a contract with Sanford Health Plan] Doctor or Hospital, you must tell us about the services you got and their cost. If we need copies of medical records to pay your claim, we will ask for your help in getting the records from the Non-Participating Doctor or Hospital.

## When You Need Preauthorization/Prior Approval

There may be times when your Participating Doctor or Hospital will need to send, or refer, you to a hospital or other facility for inpatient care. In these cases, you or your Doctor must contact Utilization Management to get Preauthorization/Prior Approval before you get care. Referrals to Doctors or Hospitals who are Non-Participating [have not signed a contract with Sanford Health Plan], and to special Doctors or Hospitals, must get Preauthorization/Prior Approval by us to get In-Network coverage.

**Note:** All inpatient admissions, other than emergency or maternity, to a hospital or other facility, must get Preauthorization/Prior Approval.

## Member Cost Sharing

A Cost Sharing Amount is the dollar amount you are responsible for paying when Covered Services are from a Doctor. **Note:** For more information on cost sharing amounts that apply to your specific Benefit Plan and Coverage Level, see Section 1 of your COI and your Summary of Benefits and Coverage (SBC).

## Wellness Principles

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

## Preventive Health Services

*For NDPERS Grandfathered Dakota Plan Members*

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**We will pay up to a Maximum Benefit Allowance of \$200 per Member per Benefit Period for any non-routine screening services not listed below or not recommended with a rating of “A” or “B” by the United States Preventive Services Task Force. Such non-routine screening services will be subject to any applicable Copayment, Deductible and Coinsurance amounts after the \$200 Benefit Allowance has been met.**

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A doctor will guide you as to how often preventive services are needed based on your age, gender and health status. Services include:

- **Well Child Care to the Member's 6<sup>th</sup> birthday**
  - Seven (7) visits for Members from birth through 12 months;
  - Three (3) visits for Members from 13 months through 24 months; and
  - One (1) visit per Benefit Period for Members 25 months through 72 months.
- **Well Child Care Immunizations to the Member's 6<sup>th</sup> Birthday**
  - 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, Influenza Virus.
- **Preventive Screening Services for Members age 6 and older**
  - One routine physical exam per Member per Benefit Period.
  - Routine diagnostic screenings.
  - Routine screening procedures for cancer.
- **Mammography Screening Services**
  - One (1) screening service for Members between the ages of 35 and 40.
  - One (1) screening service per year per Members ages 40 and older.
  - Additional benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Doctor.
- **Routine Pap Smear**
  - One (1) Pap smear per Member per Benefit Period. Office Visit Copay applies.
  - Added benefits will be available for Pap smears when Medically Necessary and ordered by a Doctor.
- **Prostate Cancer Screening for the following: Asymptomatic Males Ages 50 and Older; Males ages 40 and Older of African American descent; and Males Ages 40 with a Family History of Prostate Cancer**
  - One (1) digital rectal exam yearly per Member. Office Visit Copay applies.
  - One (1) prostate-specific antigen test yearly per Member. Office Visit Copay applies.
  - Added benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Doctor.
- **Fecal Occult Blood Testing for Colorectal Cancer Screening for Members age 50 and older**
  - One (1) test per Member per benefit period
- **Immunizations other than Well Child Care**
  - 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), Shingles (Zoster), Meningococcal Disease, and Human Papillomavirus (HPV). Certain age restrictions may apply.

#### *For NDPERS Dakota Non-Grandfathered Plan and HDHP Members*

The Preventive Health Guidelines published by us are based on the latest U.S. Preventive Health Task Force and Bright Futures guidelines as well as CDC guidelines for immunizations. Our Preventive Health Guidelines help you and your doctor make sure you get the tests and immunizations you and your family need to stay healthy at each stage in your life.

If you would like a copy of our Preventive Health Guidelines or an immunization schedule, please contact Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (*toll-free*) or visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

## Wellness Portal

Sanford Health Plan offers an online health assessment that is available to all members age 18 and older. Once the assessment is complete, the wellness portal becomes interactive and offers various programs and challenges to support your health and wellness goals. To access the wellness portal and online health assessment, create an account at [sanfordhealthplan.com/memberlogin](http://sanfordhealthplan.com/memberlogin).

## Case Management

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

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

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

Our case management process allows professional case managers to assist you with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans.

Working with case managers, we may authorize/approve coverage that extends beyond the limited time period and/or scope of treatment initially authorized/approved. This may include utilization management processes described below.

All decisions made through case management are based on the individual circumstances of your case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) for you. More information is available on your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or by calling our Care Management Department at (877) 652-1847.

## Care Coordinator Program

Sanford Health Plan recognizes the key to you and your family's overall wellness is made up of more than just physical health. That's why we created our *Care Coordinator Program*. We believe that by helping connect you to community support and resources, we empower you to achieve and maintain your optimal wellness.

For example, your Care Coordinator will collaborate with other professionals who are invested in your wellbeing, such as case managers or your doctor. Your Care Coordinator may also connect you to programs and services that will help you manage family, financial and social needs, such as housing, support groups, or child care.

## Healthy Pregnancy Program

The *Healthy Pregnancy Program* is designed to identify women at higher risk for premature birth and to prevent preterm births through assessment, intervention and education. Participation in the Healthy Pregnancy Program is voluntary and free to you.

To enroll, call our Care Management Department at (877) 652-1847 (*toll-free*) | TTY/TDD: (877) 652-1844 (*toll-free*) after the first prenatal visit, preferably before the 12<sup>th</sup> week and no later than the 34<sup>th</sup> week. You may also send a secure message from your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin), and a representative from the Care Management Department will contact you to complete your enrollment in the program.

Enrolling in the Healthy Pregnancy Program is easy and free to you. When you enroll, a Case Manager will review a brief preterm labor risk assessment questionnaire with you. To complete this questionnaire, you will need your Member ID number; Doctor's name, address and telephone number; and expected due date.

As a program participant, you will get information about pregnancy and prenatal care.

## Quality Improvement Program

We, and our Participating Doctors and Hospitals, have a duty to give you high quality care that is a good value, through ongoing monitoring, evaluation and improvement processes. The Quality Improvement (QI) program is how we monitor, evaluate, and improve the quality, safety and appropriateness of health care services, including behavioral health care. QI also addresses the quality of non-clinical aspects of service, including availability; accessibility; continuity and coordination of care; case management; discharge planning; Preauthorization/Prior Approval; Provider reimbursements; and Complaints and Appeals. A summary of QI and our annual HEDIS® reports (annual HEDIS® performance statistics and updates on quality improvement activities) are available at [www.sanfordhealthplan.com/ndpers](http://www.sanfordhealthplan.com/ndpers) or by calling our Care Management Department at (877) 652-1847.

## Our Quality Committees

The Board of Directors maintains the ultimate authority over our Quality Improvement Program. To implement our Quality Improvement Program, the Board has delegated its responsibility for monitoring the organization's Quality Improvement Process to the Chief Medical Officer, through a formal Board resolution. The Chief Medical Officer, along with the help of the Quality Improvement Committees, ensures that the Board meets its responsibility to monitor, evaluate and revise the clinical and service quality issues and care delivery system. The Health Plan Quality Improvement Committee is made up of Plan managers and staff and is charged with supporting our Board of Directors and Chief Medical Officer in meeting quality assurance goals on issues of service.

The Physician Quality Committee consists of Physician members. This Committee is charged with supporting our Board of Directors and Chief Medical Officer in meeting quality assurance goals on issues of care. They also have the responsibility of developing and continually evaluating the review criteria used in the evaluation of appropriate utilization. The Committee is also responsible for developing, overseeing, reviewing and updating our therapeutic drug Formulary based on clinical, quality and cost considerations.

## Health Management Programs

Our Health Management Programs are developed to identify populations proactively with, or at risk for, chronic medical conditions. These programs support the doctor-patient relationship and plan of care and continuously evaluate clinical and economic outcomes with the goal of improving your overall health condition.

Right now, Sanford Health Plan has health management programs for:

- Diabetes
- High Blood Pressure
- Heart Disease
- Heart Failure
- Asthma
- Attention Deficit/Hyperactivity Disorder (ADHD)

Eligible Members get an initial program packet which has information on how to use the program's services, the types of interventions that are involved and how to contact us regarding any questions related to the program or its services. To opt out of a program, you need only to contact us and you will be taken off the mailing list.

If you are interested in receiving information or in joining one of these health management programs and you have not yet been identified as eligible for the program, you may contact our Care Management Department toll free at (877) 652-1847 to get this information. Additional information is also available on these programs at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or email [quality@sanfordhealth.org](mailto:quality@sanfordhealth.org).

## mySanfordNurse

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

## Claim Payment Procedures

### When to File a Claim

The only time you will need to file a claim is if a Non-Participating Provider did not file one for you. If you, or the Non-Participating Practitioner and/or Provider, does not file the claim within one hundred eighty (180) days after the date that the cost was incurred, you may be responsible for payment of the claim.

Upon processing of the claim, you will get a statement explaining your benefits (Explanation of Benefits – EOB) within *thirty* (30) days of receipt of the claim. Remember, we will settle directly with the Practitioner and/or Provider for services you got. You will then be responsible for paying any applicable amounts (this includes, but is not limited to, copay/coinsurance and deductible amounts).

### How to File a Claim

A separate claim form must be completed for each member of your family who got health care services, and for each Provider who cared for you. To obtain a form, visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or call Sanford Health Plan Member Services and request a form be mailed to you.

You must complete all sections of the claim form and attach a copy of your Practitioner or Provider's itemized statement. This statement from Practitioners and/or Providers should show:

1. Covered Member's name and ID number;
2. Name and address of the Practitioner and/or Provider or Facility that delivered the service or supply;
3. Dates Member got the services or supplies;
4. Diagnosis;
5. Type of each service or supply;
6. The charge for each service or supply;
7. A copy of the explanation of benefits, payments, or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
8. Receipts/Member Costs, if you paid for your services.

Please make sure you sign the form and include a daytime phone number where you can be reached to answer any questions. Mail all information, including your claim form and itemized statement(s) to:

Sanford Health Plan  
ATTN: NDPERS  
PO Box 91110  
Sioux Falls, SD 57109-1110

### How a Medical Claim Gets Paid

1. You go to the doctor or facility to get medical services and present your Sanford Health Plan identification card.
2. After your services are completed, your provider's office prepares a claim to send to Sanford Health Plan for processing. You may also get a bill from the provider at this time. Participating providers may take up to 180 days to file a claim with Sanford Health Plan. You may contact the provider's office to determine how quickly your claim will be submitted to Sanford Health Plan. It may be helpful to wait to pay the provider bill until we have processed your claim.

3. Once Sanford Health Plan gets a claim from your provider, the claim is processed for payment, typically within 30 days or less. Claim payments are generally made directly to the provider. Once your claim is processed, an Explanation of Benefits (EOB) is generated and mailed to your home address.

## Pharmacy Claims

You must fill prescriptions at Participating pharmacies for Cost Sharing amounts to apply. A Participating Pharmacy has signed a contract with Sanford Health Plan; and agrees not to charge or collect any amount from you that exceeds your Cost Sharing Amounts. Participating Pharmacies must submit claims on your behalf. A listing of our Participating pharmacies is available upon request or can be viewed on your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

**You must present your ID card to the Plan Participating pharmacy; if you do not present your ID card to the Plan Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.**

**If you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.** If you get Prescription Medications from a Non-participating Pharmacy, you are responsible for submitting appropriate reimbursement information to Sanford Health Plan. Payment for covered Prescription Medications will be sent to you. Any charges in excess of the Allowed Charge are your responsibility.

If submitting pharmacy claims, you may attach receipts for more than one pharmacy to the claim form as long as all prescriptions are for the same person. To obtain a form, visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or call Member Services and request a form be mailed to you.

## Coordination of Benefits

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

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

## Member Bill Audit Program

Upon receiving notice of a claims payment, or Explanation of Benefits (EOB), from us, you are encouraged to audit your medical bills and notify us of any services which are improperly billed or of services that you did not get.

If, upon audit of a bill, an error of \$40 or more is found, you will get 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*, you must complete a *Member Bill Audit Refund Request Form*. To obtain a form, visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or call Member Services and request a form be mailed to you.

**Note:** This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim. For more information on claims with more than one payor, see Section 9, *Coordination of Benefits*, in your COI.

## Member Satisfaction Principles

We are committed to your satisfaction. One of the ways that we ensure that our services meet the needs of our Members is to ask you how we, and the Practitioners and Providers in our network, have been performing. We value what you say and we want to continue to improve our services. Therefore, as a Member of our Plan, you may get a survey from us at least once a year so that you can tell us how satisfied you are with the services you get. You may also be asked to fill out a survey after an appointment with a Doctor or you may periodically get a telephone call from one of our Member Services Representatives. Your satisfaction is important to us.

We encourage you to contact us with your comments and concerns. Member Services may be reached toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (*toll-free*) or by writing:

Sanford Health Plan  
ATTN: NDPERS  
PO Box 91110  
Sioux Falls, SD 57109-1110

You will also have an opportunity to express your opinions on matters of Plan policy and operations through Member representation on the Board of Directors.

# Understanding Your Explanation of Benefits (EOB)

The following describes important terms used in your Explanation of Benefits (EOB) and throughout the claims payment process. Please take the time to become familiar with these terms to understand your benefit plan better.

An EOB shows you, or your covered family member, the benefits coverage received for the services billed to us by your doctor. The Explanation of Benefits lets you know the dollar amount of services that were billed by your Doctor and how that amount is applied to deductible, coinsurance or copayments, or if any of the charges were for non-covered services. If you would like to sign up for electronic EOBs, visit [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

This area will contain important messages – take the time to read!

**SIMPLIFY YOUR LIFE.**  
Access your benefit information anytime, anywhere.

Online and with our mobile app, you can:

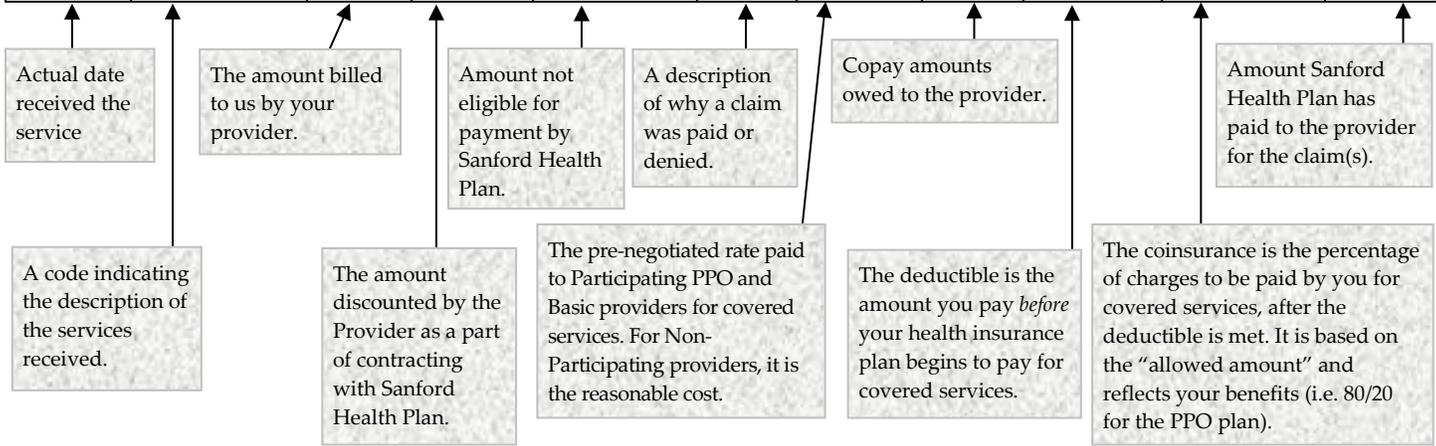
- View your deductible status/balance
- Find a provider or pharmacy
- View your ID card information
- View claims information

Create an online account today at:  
[www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin)

Mobile app keyword search: Sanford Health Plan

## Explanation of Benefits – This is NOT a Bill

<b>Member#:</b> 11122233301			<b>Member Name:</b> Jane Doe			<b>Provider:</b> 1234567892, Provider John				
<b>Claim#:</b> 123456						<b>Vendor:</b> Sanford Clinic				
Service Date	*Description	Amount Billed	Discount Amount	Non-Covered Amount	Reason Codes	Allowed Amount	Copay	Deductible	Co-insurance	Amount Paid



09/24/2013	73	117.00	70.49	0.00		46.51	0.00	46.51	0.00	0.00
09/24/2013	73	117.00	70.49	0.00		46.51	0.00	46.51	0.00	0.00
09/24/2013	98	226.00	70.31	0.00		155.69	20.00	0.00	0.00	135.69
<b>Totals</b>		460.00	211.29	0.00		248.71	20.00	93.02	0.00	135.69

**The total your responsibility for this claim is: \$113.02**

### \*Description/Messages

73 DIAGNOSIS MEDICAL

98 PROFESSIONAL (PHYSICIAN) VISIT - OFFICE

\*\*\* For additional information about benefits, please see to your COI. For questions about the determination of your benefits, please contact Member Services at (800) 499-3416. If your claim was denied in whole or in part, you have the right to appeal by writing to Sanford Health Plan. Please submit your written appeal to: Sanford Health Plan, ATTN: NDCERS, PO Box 91110, Sioux Falls, SD 57109-1110. Appeals must be submitted within 180 days.

## Utilization Management Department Functions

Utilization Management performs three primary functions: Utilization Review (which includes Prospective or Pre-service Review, Concurrent Review, Retrospective or Post-service Reviews and Focused Reviews), Case Management and Discharge Planning. Additional information on these Utilization Management functions can be found in your COI.

Utilization Management is available to Doctors, Providers and Members to discuss utilization review issues between the hours of 8 a.m. to 5:30 p.m. Central Time, Monday through Friday (excluding holidays). Utilization Management's toll-free number is (888) 315-0885 (a toll-free TTY/TDD line is also available at (877) 652-1844). After business hours, you may leave a confidential voicemail for Utilization Management and someone will return your call on the following business day. You can also fax us at (701) 234-4547. For information on how to obtain language assistance to discuss Utilization Management issues, please see the *Special Communication Services* section of this handbook.

Your COI has information on Preauthorization/Prior Approval; you may also find information on your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

## Provider Financial Incentives Policy

Sanford Health Plan does not specifically reward Practitioners and/or Providers or other individuals conducting Utilization Management and/or Utilization Review for issuing denials of coverage or benefits. Financial incentives for Utilization Management and/or Utilization Review decision makers do not encourage decisions that result in underutilization.

## New Technology

To ensure you have access to safe and effective care, we have adopted a formal mechanism to evaluate and address new developments in medical and behavioral procedures, pharmaceuticals and devices. The Physician Quality Committee is responsible for recognizing and evaluating new health care services, procedures and pharmacological treatments as well as their application for Plan Members. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a your of the Committee, will be invited to present the technological aspects of the service, procedure, or pharmacological treatment. Published scientific evidence and information from literature and the Internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies.

Once the new technology or new application of an existing technology has been reviewed by the Physician Quality Committee, this review can result in either of two types of decisions:

1. A policy determination to include a new technology as a covered benefit in the future.
2. A case-based decision on whether or not to cover a specifically requested service. There must be evidence that case-based decisions result in a review of medical necessity guidelines and procedures for possible revision.

Upon approval from the Board of Directors, we will notify you and Doctors by way of the newsletter, if appropriate.

## Member Complaint and Appeal Procedures & Independent External Reviews

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. You, your doctor, your Authorized Representative, or an attorney, have the right to file a complaint or an appeal of any Adverse Determination by Sanford Health Plan. You or your legal guardian may tell us that you want someone to speak for you. You should tell us in writing if you want someone to speak for you when you appeal. For Expedited Appeals, a Doctor with knowledge of your condition may act as your Authorized Representative.

You may contact the North Dakota Insurance Commissioner anytime at:

North Dakota Insurance Department  
600 E. Boulevard Ave.  
Bismarck, ND 58505-0320

Email: [insurance@nd.gov](mailto:insurance@nd.gov)  
Consumer hotline: (800) 247-0560 (toll-free)  
TTY: (800) 366-6888 (toll-free)

**Adverse Determination:** Means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on:

1. A determination of an individual's eligibility to participate in a plan;
2. A determination that a benefit is not a Covered Benefit;
3. The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, application of any utilization review, or other limitation on otherwise covered benefits;
4. A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or
5. A rescission of coverage. Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void application or COI, and deny claims.

**Appeal:** Request to change a previous Adverse Determination made by Sanford Health Plan

**Complaint:** An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Doctor Complaints.

**External Review:** An External Review is a request for an independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process. Information on how to initiate an External Review request is included in the Notice of Adverse Determination as well as your COI.

**Note:** For Members in the NDPERS Grandfathered Dakota Plan, you only have the right to an independent, third party, binding review after you have exhausted our internal Appeal process and our decision is unfavorable to you.

For more information how to submit a complaint or appeal, our procedure for timely handling of complaints and appeals, and your rights to an independent External Review, please see your COI for information. You may also find this information by visiting [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or by calling to request this information from Member Services at (800) 499-3416 (toll-free).

## Expedited Appeals and External Reviews

An **Expedited Appeal Procedure** is used when a condition presents as part of an **Urgent Care Situation**, as defined previously in this Handbook and in your COI.

**For Non-Grandfathered Benefit Plan Members only**, when submitting an Expedited Appeal, a request for an Expedited External Review may be submitted concurrently. This can be done orally or in writing, and we will accept all necessary information by telephone or electronically. In such situations, the Doctor who made the initial Adverse Determination may review the appeal and overturn the previous decision.

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**A complete description of your Appeal and/or External Review Rights and processes for each will be included in applicable written correspondence you get from us.**

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## Termination of Membership

If you are not able to continue coverage under an NDPERS benefit plan, please see your Certificate of Coverage for options after coverage has ended.

There may be other coverage options for you through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." The cost of these options may vary depending on your individual circumstances. To learn more, visit [www.healthcare.gov](http://www.healthcare.gov) or call the Marketplace Call Center toll-free at (800) 318-2596 | TTY/TDD: (855) 889-4325.

# Sanford Health Plan NDPERS Network

## Selecting a Health Care Provider

The benefit payment available under this Benefit Plan differs depending on your choice of Health Care Providers. Providers are paid based on the Health Care Provider's relationship with Sanford Health Plan. Providers that are contracted with Sanford Health Plan, and participate in the Plan's Network, will be paid at either the PPO Plan or Basic Plan level. To find out whether services from a particular Provider will be paid at the PPO Plan or Basic Plan level, search your Provider Directory on your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

## Finding Pharmacies in Our Network and Your Formulary

Sanford Health Plan has contracted with Express Scripts Inc. to deliver your prescription medication and diabetes supplies benefits.

## Plan Participating Pharmacies

You must fill the prescription, and show your Sanford Health Plan Member ID card, at a Plan Participating pharmacy for Cost Sharing amounts to apply. You may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication is dispensed. A Participating Pharmacy agrees not to charge or collect more from you than your Cost Sharing Amount. All claims from a Participating Pharmacy must be submitted by the Participating Pharmacy. You can request a Sanford Health Plan Participating Pharmacy Listing by calling (701) 751-4125 or (800) 499-3416 or view it online at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

## Non-Participating Pharmacies

If you choose to go to a Non-Participating pharmacy, you must pay the pharmacy directly for 100% of the costs of the medication at the time you receive it. You are then responsible for submitting a *Claim for Benefits Form* to the Plan for reimbursement. Payment for covered Prescription Medications will be sent to you. Any charges in excess of Allowed Charges are your responsibility. To obtain a form, call (800) 499-3416 | TTY/TDD: (877) 652-1844 or find it online at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

## Finding Participating Practitioners and Providers

Members should refer to the Sanford Health Plan website, [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin), for the Provider Directory, which lists Participating PPO and Basic Plan level Health Care Providers. As a member with Sanford Health Plan, you can simply enter the first 9 digits of your Member ID number and the directory will customize the results specific to your NDPERS network. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Health Care Providers. Members may also call Member Services at (800) 499-3416 (toll-free) or TTY/TDD: (877) 652-1844 (toll-free) to request a provider directory.

## How PPO vs. Basic Plan Determines Benefit Payment

### 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

Sanford Health Plan 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 at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

**NOTE:** Benefits for Covered Services received by Eligible Dependents who are residing out of the state of North Dakota will be paid at the Basic Plan 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 the Plan.

### **Basic Plan**

If a PPO Health Care Provider is: 1) not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO), the Member will receive the Basic Plan benefits.

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

Participating Health Care Providers have also agreed to perform managed benefits requirements on behalf of the Member. If the Health Care Provider is a Participating Health Care Provider, as defined in Section 10, the benefit payment will be as indicated in the Outline of Covered Services and the Member's Summary of Benefits and Coverage (SBC).

### **Non-participating Health Care Providers**

If a Member receives Covered Services from a Non-participating Health Care Provider (health care providers who are not contracted with Sanford Health Plan), the Member will be responsible for notifying Sanford Health Plan of the receipt of services. If Sanford Health Plan needs copies of medical records to process the Member's claim, the Member is responsible for obtaining such records from the Non-participating Health Care Provider.

### **Non-participating Health Care Providers within the State of North Dakota**

If a Member receives Covered Services from a Non-participating 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 Provider for Covered Services received from a Non-participating Health Care Provider. Sanford Health Plan may designate a Health Care Provider as Non-payable.

### **Non-participating Health Care Providers outside the State of North Dakota**

If a Member receives Covered Services from a Non-participating 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 Sanford Health Plan.

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 and SBC. If the Health Care Provider is not a Participating Health Care Provider, benefits will be available at the same level as Non-participating Health Care Providers within the state of North Dakota. Sanford Health Plan may designate a Health Care Provider as Non-payable.

### **Practitioner Qualifications**

If you would like additional information about your Practitioner's qualifications, please call Member Services at (800) 499-3416.

### **Special Communication Needs**

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

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.

### **After Hours Care**

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

### **Emergency**

If you have a condition requiring immediate surgical or medical attention, call 911 or go to the nearest emergency room for treatment. Sanford Health Plan covers any emergency services necessary to screen and stabilize you when a Prudent Layperson would reasonably believe that an Emergency Medical Condition exists. Preauthorization/Prior Approval is not needed to get Emergency services.

Emergency services from Basic Plan-level Providers will be covered at the same benefit and cost sharing level as services provided by PPO-level Providers, both within and outside of the Sanford Health Plan Service Area. If an Emergency Medical Condition arises, you are encouraged to seek services at the nearest Emergency Facility that is a Participating Provider. If the Emergency Medical Condition is such that you cannot go safely to the nearest Participating Emergency Facility, then

you should seek care at the nearest Emergency Facility. To find a listing of Participating Emergency Providers and Facilities, log into your account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) or call the Plan toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free).

You, or a designated relative or friend must notify the Plan, and your Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition, but no later than forty-eight (48) hours after you are physically or mentally able to do so.

If you are admitted as an inpatient to a Non-Participating Provider Facility, then the Plan will contact the admitting Practitioner and/or Provider to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, you may be transferred to a Participating Hospital and/or other appropriate Facility.

**Note:** If the Plan determines your condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, and if applicable, limitations on Non-Participating Providers as set forth in your Certificate of Insurance.

## **When you are outside of the Sanford Health Plan Service Area**

### **PHCS Healthy Directions and MultiPlan Networks\***

If you or any one of your family members live, travel or attend school outside of the Plans service area, log on to [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin) to locate a participating provider.



North Dakota  
Public Employees  
Retirement System  
*Dakota Plan Health Benefits*

**SANFORD**  
HEALTH PLAN

## Get Help Quitting Tobacco

We'll Help you Quit AND  
Help Cover the Costs

### **If you are a smoker or tobacco user and you want to quit, this program is for you!**

The North Dakota Public Employees Retirement System received a grant to help state employees and their dependents who are 18 and older quit smoking or chewing tobacco. The grant pays for approved tobacco cessation counseling, medications, health-care provider visits and co-pays. This program is administered by Sanford Health Plan.

### **Who is eligible?**

All current employees of the state of North Dakota, the North Dakota University system, district health units and Garrison Diversion Conservation District AND their dependents who are 18 and older, who have NDPERS health coverage, are eligible to participate. County, city and other members of the NDPERS group are not eligible through this program; however, smoking cessation funds may be available at the local level.

### **When can I enroll?**

You can enroll anytime between July 1, 2016 and April 30, 2017.

### **How do I enroll?**

1. Contact Sanford Health Plan at (877) 737-7730. Sanford Health Plan will verify your eligibility for this program and will send you a tobacco cessation program ID/debit card to use when you visit your health care provider and purchase medications. Be sure to show this ID card when you visit your health care provider.
2. Enroll in NDQuits (North Dakota's free tobacco cessation service). Visit [www.ndhealth.gov/ndquits](http://www.ndhealth.gov/ndquits) for more information and to enroll.

NDQuits counselors will provide an initial assessment to determine how ready you are to quit, your smoking or chewing triggers and what type of nicotine replacement therapy (patches, gum or lozenges) and/or prescription medication you may need. If prescription medication is recommended, you will need to visit your doctor. Members interested in face-to-face counseling must contact the North Dakota Department of Health at (866) 280-5512 for pre-approval.

### **What is paid for?**

For every six months, the program pays up to \$700 in expenses, including:

- Up to \$200 for your office visit and co-pays. (If face-to-face counseling is approved, this will be included in the \$200 maximum for office visits.)
- Up to \$500 for the following FDA-approved medications:
  - Over-the-counter: nicotine gum, nicotine patch, nicotine lozenge
  - Prescription: Bupropion, Chantix, nicotine nasal spray and nicotine inhaler

You will need to validate all purchases used with your ID/debit card by sending Sanford Health Plan your itemized receipts for office visit and pharmacy expenses.

**Who do I contact if I have questions?**

Contact Sanford Health Plan at (877) 737-7730.

# GROUP LIFE INSURANCE



Underwritten by: Voya

## **Eligibility:**

Eligible employees are those employees who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year, and whose positions are regularly funded and not of limited duration (i.e., permanent).

## **Part-Time /Temporary Employees:**

A Part-Time/Temporary Employee is eligible to participate at their own expense. To participate, the part-time/temporary employee must be employed at least 20 hours a week and at least 20 weeks each year of employment.

## **Enrollment:**

You have an initial enrollment period of 31 days from your date of employment. Applications received within the enrollment period will be accepted with no restrictions or limitations for you. Coverage will be effective the first of the month following your employment date.

## **Increase in Coverage:**

You may increase your supplemental, dependent or supplemental spouse life insurance coverage during the designated Annual Enrollment Season. Increases above \$5,000 will need evidence of insurability which must be approved by Voya. Contact your payroll department to obtain the proper application forms or visit our website at [www.nd.gov/ndpers](http://www.nd.gov/ndpers). NOTE: white out cannot be used on an Evidence of Insurability form.

## **Basic Life:**

If your employer is participating in the NDPERS Life Insurance Program, you will receive basic life insurance coverage in the amount of \$3,500. The premium is \$0.28 a month and is paid by the employer, if you are a permanent employee.

## **Employee Supplemental Life:**

You may elect to have supplemental coverage in addition to the basic life coverage of \$3,500. The first increment is \$1,500 (\$1,500 + basic of \$3,500 = \$5,000); thereafter, the supplemental increments are \$5,000 up to a maximum of \$200,000.

## **Dependent Life:**

If you elect supplemental coverage, you are eligible to purchase dependent life insurance. This coverage is available at either a \$2,000 or \$5,000 level for your spouse and each eligible dependent. The premium is based on the employee's age and is a flat rate regardless of the number of dependents covered.

### **Spouse Supplemental Life:**

If you elect dependent life insurance coverage, you are eligible to purchase supplemental spouse life insurance. This coverage is available in \$5,000 increments and may not exceed 50% of the total employee supplemental coverage or \$100,000, whichever is less. Evidence of Insurability is required on all spouse supplemental life over \$50,000. NOTE: white out cannot be used on an Evidence of Insurability form.

### **Accidental Death and Dismemberment (AD&D):**

The NDPERS Group Life Insurance contains an AD&D insurance benefit which will pay benefits if you lose your life, limb or sight due to accidental injury.

### **Living Benefit Option:**

The benefit is available only to active employees. It allows employees who have a terminal illness or condition to receive a portion of their life insurance benefit while they are living. A terminal condition is defined as having a life expectancy of six months or less with no reasonable expectation of recovery. The provision pays 50% of the total face amount of the life insurance with a minimum benefit of \$5,000 and a maximum benefit of \$50,000. At the present time, the living benefit option proceeds are taxable income. After the living benefit option is paid, the premium for the life coverage is reduced and based on the remaining amount of coverage which is payable to the beneficiary upon the employee's death.

Supplemental Life and Accidental Death and Dismemberment Insurance  
 Monthly Premium Amounts - Underwritten by ING  
 Rates Effective July 1, 2011

**Employee Total Coverage (Including Basic)**

<u>Employee's Age</u>	<u>\$5,000</u>	<u>\$10,000</u>	<u>\$15,000</u>	<u>\$20,000</u>	<u>\$25,000</u>	<u>\$30,000</u>	<u>\$35,000</u>	<u>\$40,000</u>	<u>\$45,000</u>	<u>\$50,000</u>
Under 25	\$0.05	\$0.20	\$0.35	\$0.50	\$0.65	\$0.80	\$0.95	\$1.10	\$1.25	\$1.40
25 to 29	\$0.05	\$0.20	\$0.35	\$0.50	\$0.65	\$0.80	\$0.95	\$1.10	\$1.25	\$1.40
30 to 34	\$0.06	\$0.26	\$0.46	\$0.66	\$0.86	\$1.06	\$1.26	\$1.46	\$1.66	\$1.86
35 to 39	\$0.09	\$0.39	\$0.69	\$0.99	\$1.29	\$1.59	\$1.89	\$2.19	\$2.49	\$2.79
40 to 44	\$0.14	\$0.59	\$1.04	\$1.49	\$1.94	\$2.39	\$2.84	\$3.29	\$3.74	\$4.19
45 to 49	\$0.17	\$0.72	\$1.27	\$1.82	\$2.37	\$2.92	\$3.47	\$4.02	\$4.57	\$5.12
50 to 54	\$0.26	\$1.11	\$1.96	\$2.81	\$3.66	\$4.51	\$5.36	\$6.21	\$7.06	\$7.91
55 to 59	\$0.51	\$2.21	\$3.91	\$5.61	\$7.31	\$9.01	\$10.71	\$12.41	\$14.11	\$15.81
60 to 64	\$0.78	\$3.38	\$5.98	\$8.58	\$11.18	\$13.78	\$16.38	\$18.98	\$21.58	\$24.18
65 to 69	\$1.49	\$6.44	\$11.39	\$16.34	\$21.29	\$26.24	\$31.19	\$36.14	\$41.09	\$46.04
70+	\$2.43	\$10.53	\$18.63	\$26.73	\$34.83	\$42.93	\$51.03	\$59.13	\$67.23	\$75.33

**Employee Total Coverage (Including Basic)**

<u>Employee's Age</u>	<u>\$55,000</u>	<u>\$60,000</u>	<u>\$65,000</u>	<u>\$70,000</u>	<u>\$75,000</u>	<u>\$80,000</u>	<u>\$85,000</u>	<u>\$90,000</u>	<u>\$95,000</u>	<u>\$100,000</u>
Under 25	\$1.55	\$1.70	\$1.85	\$2.00	\$2.15	\$2.30	\$2.45	\$2.60	\$2.75	\$2.90
25 to 29	\$1.55	\$1.70	\$1.85	\$2.00	\$2.15	\$2.30	\$2.45	\$2.60	\$2.75	\$2.90
30 to 34	\$2.06	\$2.26	\$2.46	\$2.66	\$2.86	\$3.06	\$3.26	\$3.46	\$3.66	\$3.86
35 to 39	\$3.09	\$3.39	\$3.69	\$3.99	\$4.29	\$4.59	\$4.89	\$5.19	\$5.49	\$5.79
40 to 44	\$4.64	\$5.09	\$5.54	\$5.99	\$6.44	\$6.89	\$7.34	\$7.79	\$8.24	\$8.69
45 to 49	\$5.67	\$6.22	\$6.77	\$7.32	\$7.87	\$8.42	\$8.97	\$9.52	\$10.07	\$10.62
50 to 54	\$8.76	\$9.61	\$10.46	\$11.31	\$12.16	\$13.01	\$13.86	\$14.71	\$15.56	\$16.41
55 to 59	\$17.51	\$19.21	\$20.91	\$22.61	\$24.31	\$26.01	\$27.71	\$29.41	\$31.11	\$32.81
60 to 64	\$26.78	\$29.38	\$31.98	\$34.58	\$37.18	\$39.78	\$42.38	\$44.98	\$47.58	\$50.18
65 to 69	\$50.99	\$55.94	\$60.89	\$65.84	\$70.79	\$75.74	\$80.69	\$85.64	\$90.59	\$95.54
70+	\$83.43	\$91.53	\$99.63	\$107.73	\$115.83	\$123.93	\$132.03	\$140.13	\$148.23	\$156.33

**Employee Total Coverage (Including Basic)**

<u>Employee's Age</u>	<u>\$105,000</u>	<u>\$110,000</u>	<u>\$115,000</u>	<u>\$120,000</u>	<u>\$125,000</u>	<u>\$130,000</u>	<u>\$135,000</u>	<u>\$140,000</u>	<u>\$145,000</u>	<u>\$150,000</u>
Under 25	\$3.05	\$3.20	\$3.35	\$3.50	\$3.65	\$3.80	\$3.95	\$4.10	\$4.25	\$4.40
25 to 29	\$3.05	\$3.20	\$3.35	\$3.50	\$3.65	\$3.80	\$3.95	\$4.10	\$4.25	\$4.40
30 to 34	\$4.06	\$4.26	\$4.46	\$4.66	\$4.86	\$5.06	\$5.26	\$5.46	\$5.66	\$5.86
35 to 39	\$6.09	\$6.39	\$6.69	\$6.99	\$7.29	\$7.59	\$7.89	\$8.19	\$8.49	\$8.79
40 to 44	\$9.14	\$9.59	\$10.04	\$10.49	\$10.94	\$11.39	\$11.84	\$12.29	\$12.74	\$13.19
45 to 49	\$11.17	\$11.72	\$12.27	\$12.82	\$13.37	\$13.92	\$14.47	\$15.02	\$15.57	\$16.12
50 to 54	\$17.26	\$18.11	\$18.96	\$19.81	\$20.66	\$21.51	\$22.36	\$23.21	\$24.06	\$24.91
55 to 59	\$34.51	\$36.21	\$37.91	\$39.61	\$41.31	\$43.01	\$44.71	\$46.41	\$48.11	\$49.81
60 to 64	\$52.78	\$55.38	\$57.98	\$60.58	\$63.18	\$65.78	\$68.38	\$70.98	\$73.58	\$76.18
65 to 69	\$100.49	\$105.44	\$110.39	\$115.34	\$120.29	\$125.24	\$130.19	\$135.14	\$140.09	\$145.04
70+	\$164.43	\$172.53	\$180.63	\$188.73	\$196.83	\$204.93	\$213.03	\$221.13	\$229.23	\$237.33

**Employee Total Coverage (Including Basic)**

<u>Employee's Age</u>	<u>\$155,000</u>	<u>\$160,000</u>	<u>\$165,000</u>	<u>\$170,000</u>	<u>\$175,000</u>	<u>\$180,000</u>	<u>\$185,000</u>	<u>\$190,000</u>	<u>\$195,000</u>	<u>\$200,000</u>
Under 25	\$4.55	\$4.70	\$4.85	\$5.00	\$5.15	\$5.30	\$5.45	\$5.60	\$5.75	\$5.90
25 to 29	\$4.55	\$4.70	\$4.85	\$5.00	\$5.15	\$5.30	\$5.45	\$5.60	\$5.75	\$5.90
30 to 34	\$6.06	\$6.26	\$6.46	\$6.66	\$6.86	\$7.06	\$7.26	\$7.46	\$7.66	\$7.86
35 to 39	\$9.09	\$9.39	\$9.69	\$9.99	\$10.29	\$10.59	\$10.89	\$11.19	\$11.49	\$11.79
40 to 44	\$13.64	\$14.09	\$14.54	\$14.99	\$15.44	\$15.89	\$16.34	\$16.79	\$17.24	\$17.69
45 to 49	\$16.67	\$17.22	\$17.77	\$18.32	\$18.87	\$19.42	\$19.97	\$20.52	\$21.07	\$21.62
50 to 54	\$25.76	\$26.61	\$27.46	\$28.31	\$29.16	\$30.01	\$30.86	\$31.71	\$32.56	\$33.41
55 to 59	\$51.51	\$53.21	\$54.91	\$56.61	\$58.31	\$60.01	\$61.71	\$63.41	\$65.11	\$66.81
60 to 64	\$78.78	\$81.38	\$83.98	\$86.58	\$89.18	\$91.78	\$94.38	\$96.98	\$99.58	\$102.18
65 to 69	\$149.99	\$154.94	\$159.89	\$164.84	\$169.79	\$174.74	\$179.69	\$184.64	\$189.59	\$194.54
70+	\$245.43	\$253.53	\$261.63	\$269.73	\$277.83	\$285.93	\$294.03	\$302.13	\$310.23	\$318.33

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

Employee Age	Total Coverage	
	\$2,000	\$5,000
Under 25	\$0.20	\$0.50
25 to 29	\$0.20	\$0.50
30 to 34	\$0.20	\$0.50
35 to 39	\$0.20	\$0.50
40 to 44	\$0.20	\$0.50
45 to 49	\$0.20	\$0.50
50 to 54	\$0.20	\$0.50
55 to 59	\$0.20	\$0.50
60 to 64	\$0.20	\$0.50
65 to 69	\$0.20	\$0.50
70 to 74	\$0.20	\$0.50
75 to 79	\$0.20	\$0.50
80 to 84	\$0.20	\$0.50
85 to 89	\$0.20	\$0.50
90+	\$0.20	\$0.50

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

Employee's Age	Spouse Total Coverage									
	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Under 25	\$0.15	\$0.30	\$0.45	\$0.60	\$0.75	\$0.90	\$1.05	\$1.20	\$1.35	\$1.50
25 to 29	\$0.15	\$0.30	\$0.45	\$0.60	\$0.75	\$0.90	\$1.05	\$1.20	\$1.35	\$1.50
30 to 34	\$0.20	\$0.40	\$0.60	\$0.80	\$1.00	\$1.20	\$1.40	\$1.60	\$1.80	\$2.00
35 to 39	\$0.30	\$0.60	\$0.90	\$1.20	\$1.50	\$1.80	\$2.10	\$2.40	\$2.70	\$3.00
40 to 44	\$0.45	\$0.90	\$1.35	\$1.80	\$2.25	\$2.70	\$3.15	\$3.60	\$4.05	\$4.50
45 to 49	\$0.55	\$1.10	\$1.65	\$2.20	\$2.75	\$3.30	\$3.85	\$4.40	\$4.95	\$5.50
50 to 54	\$0.85	\$1.70	\$2.55	\$3.40	\$4.25	\$5.10	\$5.95	\$6.80	\$7.65	\$8.50
55 to 59	\$1.70	\$3.40	\$5.10	\$6.80	\$8.50	\$10.20	\$11.90	\$13.60	\$15.30	\$17.00
60 to 64	\$2.60	\$5.20	\$7.80	\$10.40	\$13.00	\$15.60	\$18.20	\$20.80	\$23.40	\$26.00
65 to 69	\$4.95	\$9.90	\$14.85	\$19.80	\$24.75	\$29.70	\$34.65	\$39.60	\$44.55	\$49.50
70+	\$8.10	\$16.20	\$24.30	\$32.40	\$40.50	\$48.60	\$56.70	\$64.80	\$72.90	\$81.00

Employee's Age	Spouse Total Coverage									
	\$55,000	\$60,000	\$65,000	\$70,000	\$75,000	\$80,000	\$85,000	\$90,000	\$95,000	\$100,000
Under 25	\$1.65	\$1.80	\$1.95	\$2.10	\$2.25	\$2.40	\$2.55	\$2.70	\$2.85	\$3.00
25 to 29	\$1.65	\$1.80	\$1.95	\$2.10	\$2.25	\$2.40	\$2.55	\$2.70	\$2.85	\$3.00
30 to 34	\$2.20	\$2.40	\$2.60	\$2.80	\$3.00	\$3.20	\$3.40	\$3.60	\$3.80	\$4.00
35 to 39	\$3.30	\$3.60	\$3.90	\$4.20	\$4.50	\$4.80	\$5.10	\$5.40	\$5.70	\$6.00
40 to 44	\$4.95	\$5.40	\$5.85	\$6.30	\$6.75	\$7.20	\$7.65	\$8.10	\$8.55	\$9.00
45 to 49	\$6.05	\$6.60	\$7.15	\$7.70	\$8.25	\$8.80	\$9.35	\$9.90	\$10.45	\$11.00
50 to 54	\$9.35	\$10.20	\$11.05	\$11.90	\$12.75	\$13.60	\$14.45	\$15.30	\$16.15	\$17.00
55 to 59	\$18.70	\$20.40	\$22.10	\$23.80	\$25.50	\$27.20	\$28.90	\$30.60	\$32.30	\$34.00
60 to 64	\$28.60	\$31.20	\$33.80	\$36.40	\$39.00	\$41.60	\$44.20	\$46.80	\$49.40	\$52.00
65 to 69	\$54.45	\$59.40	\$64.35	\$69.30	\$74.25	\$79.20	\$84.15	\$89.10	\$94.05	\$99.00
70+	\$89.10	\$97.20	\$105.30	\$113.40	\$121.50	\$129.60	\$137.70	\$145.80	\$153.90	\$162.00

# GROUP DENTAL INSURANCE

Underwritten by: Delta Dental



## **Eligibility:**

Eligible employees are those employees who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year for a state agency, and whose positions are regularly funded and not of limited duration (i.e., permanent).

## **Enrollment:**

You have an initial enrollment period of 31 days from your date of employment. Coverage will be effective the first of the month following your employment date.

If you do not enroll during the initial 31 day eligibility period when hired you may apply for coverage during the designated Annual Enrollment Season with coverage effective January 1<sup>st</sup>.

## **Dental Rates:**

The following premiums are in effect through December 31, 2017:

Individual Only	\$ 38.64
Individual and Spouse	\$ 74.58
Individual and Child(ren)	\$ 86.58
Family	\$123.30

The premium is eligible for pre-tax treatment through the IRC Section 125 FlexComp program.

## **Coverage Questions:**

For additional information concerning coverage call 1- 800- 448-3815.



Delta Dental of Minnesota  
Serving North Dakota

## Delta Dental PPO<sup>SM</sup> & Delta Dental Premier<sup>®</sup>

**North Dakota Public Employees Retirement System**  
Group #537482

<u>2017 Monthly Premium Rates</u>	
Employee:	\$38.64
Employee + Spouse:	\$74.58
Employee + Child(ren):	\$86.58
Family:	\$123.30

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

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

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



Delta Dental of Minnesota  
Serving North Dakota

## Make the Most of Your Benefits

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



### Online Tools for Members: [www.DeltaDentalMN.org](http://www.DeltaDentalMN.org)



#### Save Money, Go In-Network:

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



#### Dental Insurance 101:

Robust member tools including commonly defined insurance terms, videos and frequently asked questions.



#### Oral Health Resources:

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



#### Cost Estimator:

Compare costs for top oral health procedures.



### Prefer to Speak to Someone Contact Customer Service

**Toll Free:** 1-800-448-3815

**Monday – Friday:** 7am-7pm C.S.T.



### Tools Available in the Secure Member Portal



#### Coverage Summary:

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



#### Claims Inquiry:

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



#### Request ID Cards:

Order duplicate or replacement ID cards.

#### Registration

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

Serving North Dakota  
Visit Our Website  
[DeltaDentalMN.org](http://DeltaDentalMN.org)

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



# GROUP VISION INSURANCE



Underwritten by: Superior Vision

## **Eligibility:**

Eligible employees are those employees who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year for a state agency, and whose positions are regularly funded and not of limited duration (i.e., permanent).

## **Enrollment:**

You have an initial enrollment period of 31 days from your date of employment. Applications received within the enrollment period will be accepted with no restrictions or limitations for you and any eligible dependents. Coverage will be effective the first of the month following your employment date.

If you do not enroll during the initial 31 day eligibility period when hired you may apply for coverage during the designated Annual Enrollment Season with coverage effective January 1<sup>st</sup>.

If you and/or your dependents do not elect to participate when initially eligible, you and/or dependents may elect to participate during an annual enrollment season. If you do not enroll when initially eligible you and/or dependents will be considered late entrants. As a late entrant, no benefits will be payable for expenses incurred in the first 12 months, except for the vision exam benefit.

## **VISION RATES:**

The following COBRA premiums are in effect through December 31, 2017:

Individual Only	\$ 6.64
Individual and Spouse	\$ 13.28
Individual and Child (ren)	\$ 12.10
Family	\$ 18.74

The premium is eligible for pre-tax treatment through the IRC Section 125 FlexComp program.

## **COVERAGE QUESTIONS**

For additional information concerning coverage call 1-(800) 507-3800.



## Vision Plan Benefits for North Dakota Public Employees Retirement System

Co-Pays	Monthly Premiums	Services/Frequency
Exam \$0	Emp. only \$6.64	Exam 1 per calendar year
Materials <sup>1</sup> \$35	Emp. + spouse \$13.28	Frame 1 per calendar year
Contact Lens Fitting (standard & specialty) \$35	Emp. + child(ren) \$12.10	Contact Lens Fitting 1 per calendar year
	Emp. + family \$18.74	Lenses 1 pair per calendar year
		Contact Lenses 1 allowance per calendar year

### Benefits

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

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

<sup>1</sup> Materials co-pay applies to lenses and frames only, not contact lenses

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

<sup>3</sup> Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

<sup>4</sup> Contact lenses are in lieu of eyeglass lenses and frames benefit

### Discount Features

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

#### Discounts on Covered Materials

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

The following options have out-of-pocket maximums<sup>5</sup> on standard (not premium, brand, or progressive) lenses.

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

#### Discounts on Non-Covered Exam and Materials

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

<sup>5</sup> Discounts and maximums may vary by lens type. Please check with your provider.

**SuperiorVision.com**  
**Customer Service**  
**800.507.3800**

### Refractive Surgery

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

*The Plan discount features are not insurance.*

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

*Discounts are subject to change without notice.*

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



# EMPLOYEE ASSISTANCE PROGRAM

(For State Agencies Only)



**Eligibility:**

Eligible employees are those employees who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year for a state agency, and whose positions are regularly funded and not of limited duration (i.e., permanent) and their covered dependents on the NDPERS health plan.

**Enrollment:**

You can enroll in the program through Member Self Service (MSS). The premium is paid by the employer.

**Program Description:**

The EAP is designed to provide special assistance in guidance and counseling and to determine appropriate diagnosis and/or course of treatment to employees and their eligible dependents in cases of alcoholism, drug abuse and personal problems. This assistance is rendered for a specified number of visits and the EAP is responsible for recommending further referrals to clinical or supportive organizations and medical professionals if necessary. They also conduct educational seminars and provide informational brochures.

Employees may be referred to an EAP by their supervisor in instances where an employee has deteriorating job performance and has not responded to established supervisory counseling or disciplinary procedures. Employees may also seek assistance on their own.

<b><u>Minimum Services:</u></b>	<b><u>Appointments Within:</u></b>
Provides 6 individual sessions per year	72 hours for non-emergency
Provides phone counseling	24 hours for emergency
Provides a toll-free number	Weekend/Holiday (Emergency)
Provides a 24-hour Crisis Hot Line	
<b><u>Range of Counseling Services:</u></b>	
Alcohol and Drug Dependence	Job Stress Concerns
Family or Marriage Problems	Financial Issues
Work-Related Problems	Physical or Sexual abuse
Emotional Problems	Gambling Issues
Behavioral Problems	Family Relationships

**Current EAP Providers:**

St. Alexius/Heartview	Village Family Services	Deer Oaks EAP Services	Live Well Solutions
900 E Broadway PO Box 5510	PO Box 9859	126 E Main Plaza, Ste 8	1100 19 <sup>th</sup> Ave N #155
Bismarck ND 58506-5510	Fargo ND 58106-9859	San Antonio TX 78240	Fargo ND 58102
(701) 530-7195	(701) 451-4900	1-866-327-2400	1-866-831-2181
1-800-327-7195	1-800-627-8220		

For more detailed information please visit the website and connect to the provider link.

**Client Confidentiality:**

The cornerstone of the EAP is the strict confidentiality that is adhered to regarding all program services. All clients can be assured that no information will be disclosed to anyone without the client's written authorization, or within the limits of the state and federal laws.

# STATE OF NORTH DAKOTA FLEXCOMP PLAN



**Third Party Administrator: ADP**

NDPERS is contracted with a Third Party Administrator (TPA) to process healthcare spending account and dependent care claims. The TPA is ADP Benefit Services. If you enroll in the FlexComp Plan you will be sent a debit card along with information on how to access you account. To learn more, log on to the ADP website at <http://www.spendingaccounts.info/> or contact ADP Customer Service Representatives available from 7 a.m. to 7 p.m. Central time Monday through Friday. The toll free number is 800-336-1881.

## **Eligibility:**

The NDPERS FlexComp Plan is available to eligible employees of the State of North Dakota, participating District Health Units, and members of the Legislative Assembly. Employees of the university system and political subdivisions are excluded from participation in the plan. To be eligible, an employee must be 18 years of age, work at least 20 hours per week for at least 20 weeks per year and be in a permanent position that is regularly funded and not of limited duration.

## **Enrollment:**

New employees will be eligible to participate the first day of the month following their permanent full-time employment if they make their election before the 15<sup>th</sup> of the month. An election made after the 15<sup>th</sup> of the month or during the extended 60-day enrollment period will not be effective until the first contribution is received. Participation is limited to expenses incurred for the remainder of the plan year on December 31.

ADP has provided a Flex Spending Account Calculator to assist you in determining estimated savings by participating. This tool is available on the NDPERS website at [www.nd.gov/ndpers](http://www.nd.gov/ndpers). Select the ADP icon on the home page.

Each year NDPERS designates an annual enrollment season during which employees may enroll or discontinue their participation in the plan beginning January 1 through December 31.

## **How the FlexComp Plan Works:**

The FlexComp Plan is a tax favored employee benefit program and is established and administered under Section 125 of the Internal Revenue Code. It allows you to save taxes on the amount you pay for eligible payroll deducted insurance premiums, medical expenses, and dependent care expenses. Since the dollars you contribute to the plan are deducted before income and social security tax are deducted you will pay less tax, which means you may have more money to spend or save. However, you should be aware you are reducing the social security taxes paid, which could slightly reduce your social security benefits.

*Employees may elect to participate in any combination of the three pre-tax accounts.*

**Premium Conversion:**

NDPERS Group Life Plan – If an employee elects to have supplemental life coverage in addition to the basic life coverage, the deduction up to the first \$50,000 of coverage will automatically default to a pre-tax deduction, unless the employee makes an election to decline this action and pay the premium with after tax dollars. The employee must decline this action when enrolling in the Plan.

NDPERS administered Delta Dental and Superior Vision plans are eligible for pre-tax payroll deduction.

If an employee elects to pretax an insurance premium, they may not change or drop coverage during the plan year unless they experience an IRS Qualified Change of Status.

Certain insurance products listed below may be paid with pretax dollars, by payroll deduction, through your employer.

AFLAC Product Name	Company Representative Cynthia Welken-Place 701-258-6040 Product Description	Pretax Eligibility
Cancer	Cancer indemnity policies providing benefits for diagnosis of skin cancer, internal cancer as well as annual screening benefits. Health Savings Account Compliant	Eligible
Hospital Confinement	Indemnity benefits whether hospitalized days or weeks.	Eligible
Hospital Intensive Care	Provides coverage in the event of a sickness or injury and is admitted to the ICU unit. Health Savings Account Compliant	Eligible
Accident	Accident indemnity policies providing benefits for accident/injury. Health Savings Account Compliant	Eligible
Lump Sum Critical Illness	Pays a lump sum benefit for code red major critical illness event. (Heart attack, stroke, coma, paralysis, major organ transplant, end stage renal failure. Riders available for cancer, sudden cardiac death.)	Eligible
Personal Sickness Indemnity	Indemnity policy for sickness related hospital confinement, major diagnostic exams, in & out-patient surgeries.	Not Eligible
Specified Health Event	Critical care, recovery indemnity policies for major critical illness.	Eligible
Disability	All disability policies that are specific replacement of income benefits. Health Savings Account Compliant	Not Eligible
Dental	Voluntary dental. No networks, no deductibles, no pre-certifications. Health Savings Account Compliant	Not Eligible

Vision Now	Vision indemnity policy providing vision insurance, vision correction benefits. Health Savings Account Compliant	Not Eligible
Life	All life policies. Health Savings Account Compliant	Not Eligible

Central United Product Name	Company Representative James M Kasper 701-232-6250 Product Description	Pretax Eligibility
Cancer Insurance	Provides cash benefits to covered persons for treatment of cancer. Health Savings Account Compliant	Eligible

Colonial Life & Accident Product Name	Company Representative David Ryden 651-633-7500 Product Description	Pretax Eligibility
Accident	Composite rated, guaranteed renewable accident product with choice of plan levels and optional riders. It provides indemnity benefits for on and off the job accidents. Health Savings Account Compliant	Eligible
Cancer	Composite rated, guaranteed renewable specified disease product with choice of plan levels and optional riders. Provides benefits for expenses related to cancer. Health Savings Account Compliant	Eligible
Disability	Age banded, guaranteed renewable short-term disability income product. (Disability insurance premium paid with pre-tax dollars – Please note: A benefit paid to an employee that becomes disabled will be subject to income taxes.)	Eligible
Medical Bridge	Age banded, guaranteed renewable hospital confinement indemnity product. Choice of plans, levels. Includes confinement, rehab unit, surgical and diagnostic procedures. Health Savings Account Compliant	Eligible
Critical Illness	Specified disease product with a lump sum benefit upon diagnosis of a covered specified disease with a choice of plan options for reoccurrence, cancer, face amounts, and optional riders. Health Savings Account Compliant	Not Eligible
Life	All life insurance policies. Health Savings Account Compliant	Not Eligible

Total Dental Administrators	Company Representative Logan Stucki 801-268-9740 Ext 306	Pretax Eligibility
Product Name	Product Description	
Elite Choice	Fully insured dental program. Health Savings Account Compliant	Eligible

USABLE	Company Representative Peg Dickelman 701-277-2319	Pretax Eligibility
Product Name	Product Description	
Accident Elite	Employees can get help prevent financial hardship due to medical/travel expenses caused from an accident. Payments direct to employee. Health Savings Account Compliant	Eligible
Cancer Care Elite	Payments direct to employee for new and experimental treatment, travel, lodging, out of pocket medical costs, deductibles, co-pay amounts. Health Savings Account Compliant	Eligible
Hospital Confinement Plan	Payment direct to employee for costs related to intensive care, hospitalization, birth of a child, accidents. Health Savings Account Compliant	Eligible

**Medical Spending Account:**

An employee may redirect a portion of their salary for eligible medical expenses up to a maximum of \$2,550 per plan year. The total annual medical spending election amount is available to you at any time during your participation within the Plan Year. Requests for reimbursement from a medical spending account are paid throughout the year according to a participant's annual medical spending election amount.

Employees who are enrolled in a High Deductible Health Plan with contributions made to a health savings account (HSA) cannot participate in the medical spending component of the FlexComp Plan.

Money set aside in a medical spending reimbursement account can be used to pay for qualified health care expenses for you, your spouse and dependent children. In addition, eligibility rules have been expanded to allow you to include your adult children that no longer meet the requirements of dependent. The extension of coverage applies to your son, daughter, stepson, stepdaughter, legally adopted and eligible foster children. It is not necessary that your child be a

student, be financially supported by you, or that he or she reside with you. Both married and unmarried children can now qualify as a dependent, but coverage does not extend to any spouse of your child or to grandchildren. You may now be reimbursed for qualified health care expenses for these individuals through age 26. Eligibility ceases January 1st of the calendar year in which the family member will turn age 27.

If an employee elects to participate in a medical spending reimbursement account, they may not change or drop coverage during the plan year unless they experience an IRS Qualified Change of Status.

### **Dependent Care Reimbursement Account:**

An employee may redirect a portion of their salary up to a maximum of \$5,000 per year for a single parent, \$5,000 per year for a married couple filing a joint tax return or

\$2,500 for a married person filing separately. Requests for reimbursement from a Dependent Care Reimbursement Account will be paid according to the dollars available in your account to date.

If an employee elects to participate in a dependent care reimbursement account, they may not change or drop coverage during the plan year unless they experience an IRS Qualified Change of Status.

Eligible Dependent Care expenses must:

- Be for the purpose of enabling you or you and your spouse to be employed.
- Be for a child under 13 years of age who is your dependent under Federal Tax Rules. The child must reside with you at least one-half of the taxable year.
- Be provided by someone other than your spouse or another dependent child.
- The dependent care account can also be used for the care of a spouse or dependent over the age of 13 who is incapable of self-care. The adult dependent who is incapable of self-care must live with you for more than one-half the taxable year and not have more than \$3,200 per year in gross income.

Eligible expenses may also include:

- Before and after school care.
- Registration fees if fee must be paid in order to obtain care.
- Day camp.
- Preschool/nursery school.
- Transportation expenses, if expenses are for transporting a child to or from the place where care is provided and transportation is furnished by the day care provider.
- Late "pick-up" fee.

You cannot obtain reimbursement for:

- Costs incurred before coverage is effective.
- Food if billed separately from the dependent care expenses.
- Late payment fees.
- Educational expenses, tuition for kindergarten or higher level education.

## **Dependent Care Reimbursement Account vs. Dependent Care Tax Credit:**

The dependent care reimbursement account is an alternative to taking a dependent care tax credit on your income tax return. You must choose whether to take the tax credit or enroll in the dependent care reimbursement account. The IRS will not allow you to receive two tax breaks on the same expenses.

The income level of you, or if married, you and your spouse, will determine whether the dependent care reimbursement account or the income tax credit is more favorable for you. Contact a qualified tax consultant for complete details.

Payments made to you from a dependent care account are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the FlexComp Plan. You are required to file IRS Form 2441 with your tax return.

Please note that this is for general information only and is not intended to provide specific advice or recommendations. We suggest you consult your accountant or tax advisor with regard to your individual situation.

## **Important IRS Rules .**

### **Grace Period:**

Amounts' remaining in a participant's medical spending and/or dependent care account at the end of the plan year can be used to reimburse expenses that are incurred between January 1 and March 15 of the new plan year under the following conditions:

Coverage must be in effect on the last day of the plan year on December 31.

There may be taxable income to an individual if reimbursements from a dependent care expense account exceed Internal Revenue Service permitted amounts in a calendar year. We suggest you consult your accountant or tax advisor with regard to your individual situation.

### **Use-or-Lose Rule:**

The deadline to file claims to your medical spending or dependant care account(s) is 4 months after the end of the plan year on December 31 or April 30. Any unused amount in a medical spending reimbursement account cannot be used for dependent care expenses or vice versa. Any amounts remaining in your accounts after April 30 is forfeited.

### **Change in Participation:**

The IRS requires that once you elect to participate, your payroll deductions may not be stopped or changed until the start of the next plan year. The only exception is if you experience an IRS Qualified Change of Status.

### **Separate Accounts:**

You may participate in either or both spending accounts. However, the Medical Spending Account and Dependent Care Account are separate accounts. You may not use money from one account to cover expenses in the other.

# LONG TERM CARE INSURANCE



## ENROLLMENT:

There are many reasons why you should consider obtaining Long Term Care Insurance. Here are just a few:

- 75% of the population will need long-term care services at some point in their lifetime.
- Protect your assets!
- Health insurance plans & Medicare typically do not cover long term care services.
- You can receive up to a **\$500 (married couple) or \$250 (single) tax credit** through the ND. Long-Term Care Partnership Program for having long-term care insurance.

North Dakota Partnership Plan Information:

<http://www.nd.gov/ndins/uploads/12/lcpartnershipalmcard.pdf>

North Dakota Insurance Department LTC Information:

<http://www.nd.gov/ndins/consumers/longtermcare/>

Federal Government LTC Information:

<http://longtermcare.gov/>

UNUM LTC – **NOT** a Partnership Plan:

<http://unuminfo.com/ndpers/index.aspx>

## TRANSFER OF COVERAGE:

Only employees of the State of North Dakota and the University System are eligible to participate in the plan as active employees. If you are enrolled in the UNUM Long -Term Care, no change in level of insurance coverage is allowed at the time of transfer. Increased coverage is based on UNUM's approval. Request to increase coverage may be filed with UNUM at anytime. You may decrease coverage at any time.

## **TERMINATION OF COVERAGE:**

If you and your spouse participate in the UNUM Long-Term Care plan, you both may elect portable coverage. This means that the same coverage you had under this plan can continue on a direct billing basis.

Any election for portable coverage must be made within 31 days of the date the group coverage would otherwise end by completing the UNUM's Election to Continue Your Long Term Care Insurance.

Any premium that applies must be paid directly to Unum by you and your spouse for any portable coverage to be continued.

Please refer to your "Certificate of Insurance" for details.

## **COVERAGE QUESTIONS?**

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