

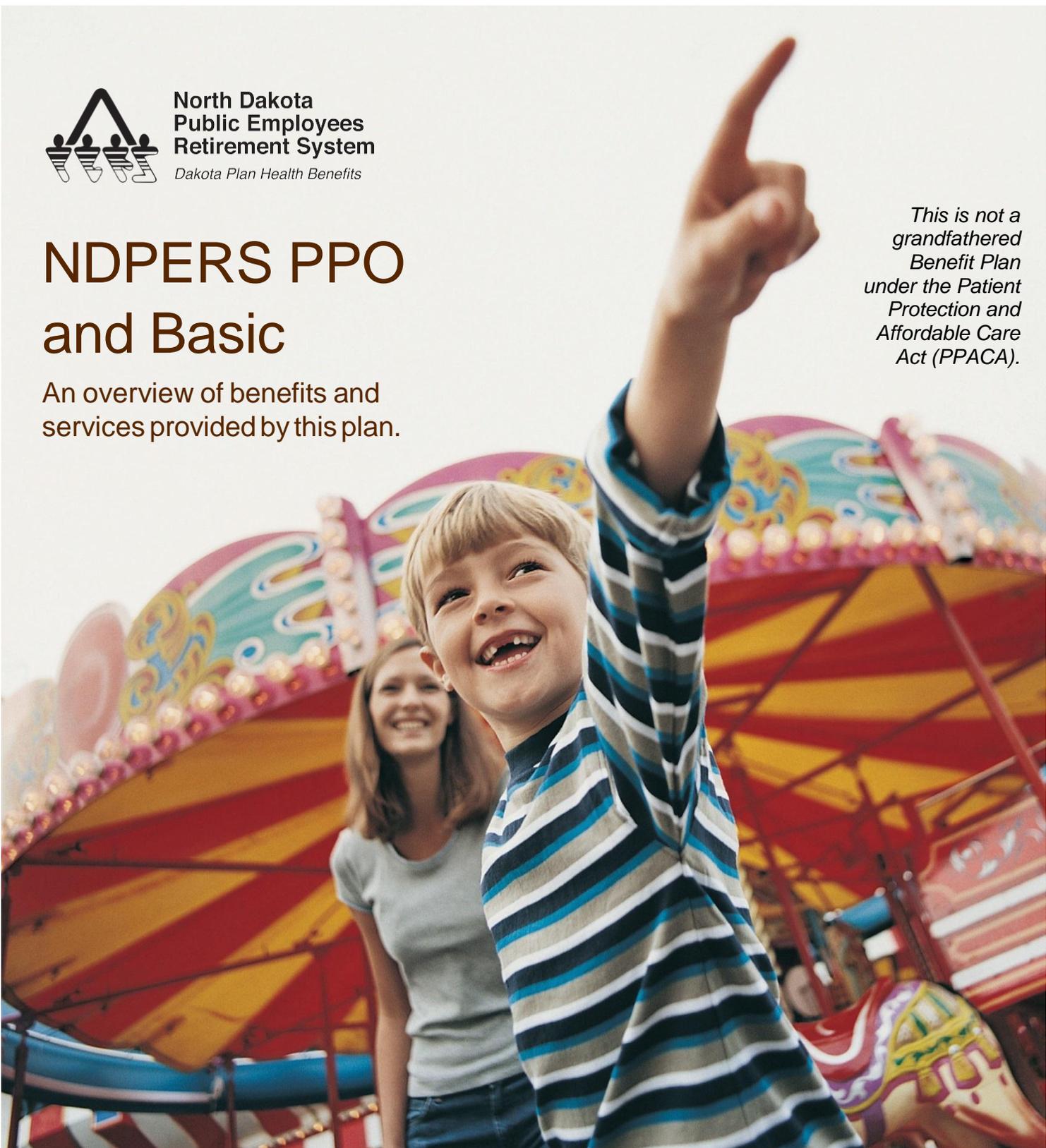


North Dakota
Public Employees
Retirement System
Dakota Plan Health Benefits

NDPERS PPO and Basic

An overview of benefits and
services provided by this plan.

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



SANFORD[®]
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 (877) 658-9194 | 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, copayment, 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:

- 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	Copayment	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.		Benefit Amount as a % of the allowed charge after the deductible is met.		See your certificate of insurance for details on participating and non-participating providers and how the PPO vs. Basic Plan determines benefit payment
	Amount you pay per visit (Basic/PPO)	Before medical out-of-pocket maximum is met	After medical out-of-pocket maximum is met	Before medical out-of-pocket maximum is met	After medical out-of-pocket maximum is met	
Inpatient Treatment Services		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.
Outpatient Treatment Services						Refer to the Certificate of Insurance for details on other covered outpatient therapy services. Benefits are based on the medical guidelines established by Sanford Health Plan. Deductible does not apply.
Physical Therapy	\$25/\$20	\$25, then 75%	100%	\$20, then 80%	100%	
Occupational & Speech Therapy	\$25 /\$20	\$25, then 75%	100%	\$20, then 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.
Professional Health Care Provider Charges						
Inpatient, Outpatient & Surgical charges		75%	100%	80%	100%	
Wellness Services						
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, copayment, 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 Certificate of Insurance for details.
Colonoscopy or Sigmoidoscopy		100%	100%	100%	100%	Deductible does not apply to these services. Refer to the benefit plan for details.
Mammography, Pap Smear & Fecal Occult Blood Testing		100%	100%	100%	100%	Deductible does not apply to these services. Refer to the benefit plan for details.
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.
Contraceptive Services		100%	100%	100%	100%	Deductible does not apply. Prescription contraception medications, obtainable with a Prescription Order, are paid under the Prescription Drug benefit.
Home & Office Visits	\$30 / \$25	100%	100%	100%	100%	Deductible does not apply.
Diagnostic Services						
Lab, X-ray, MRI		75%	100%	80%	100%	
Allergy Testing		75%	100%	80%	100%	
Radiation Therapy, Chemotherapy & Dialysis		75%	100%	80%	100%	
Maternity Services						Deductible does not apply to delivery services received from a PPO provider when the member is enrolled in the Healthy Pregnancy program. Pre & Postnatal care are covered at 100%.
Inpatient, Outpatient, Pre & Postnatal Care		75%	100%	80%	100%	
Mental Health and Substance Use Disorder Treatment Services						
Inpatient Includes acute inpatient admissions and residential treatment		75%	100%	80%	100%	Preauthorization/prior approval is required.
Outpatient						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%	
Emergency Services		80%	100%	80%	100%	Preauthorization/prior approval is not required.
Professional Health Care Provider Charge		80%	100%	80%	100%	
Emergency Room Visit	\$50 / \$50	80%	100%	80%	100%	Copayment is waived when admitted to hospital as an inpatient. Deductible does not apply.
Ambulance Services		80%	100%	80%	100%	
Skilled Nursing Facility Services		75%	100%	80%	100%	Preauthorization/prior approval is required.
Home Health Care Services		75%	100%	80%	100%	Preauthorization/prior approval is required.

Description of Benefits	Copayment	Basic Plan		PPO with a PPO-participating provider within or its contiguous counties		Special Conditions See your certificate of insurance for details on participating and non-participating providers North Dakota 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 medical out-of- pocket maximum is met	After medical out-of- pocket maximum is met	Before medical out-of- pocket maximum is met	After medical out-of- pocket maximum is met	
Hospice Services		75%	100%	80%	100%	Preauthorization/prior approval is required.
Chiropractic Services						
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%	
Medical Supplies & Equipment		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.

Prescription Drug and Diabetes Supplies Benefits	Copayment			Special Conditions
		Before prescription drug out-of-pocket maximum is met.	After prescription drug out-of-pocket maximum is met.	
				Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount. Deductible does not apply.
Prescription Medications or Drugs (Retail and Mail Order)				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. Copayment Amounts and any applicable Cost Sharing, including Deductibles, do not apply.
Formulary				Prescription Medication Coinsurance and Copay Amounts accumulate toward a Member's Prescription Drug Out-of-Pocket Maximum.
Generic	\$5	\$5, then 85%	100%	One copayment amount plus applicable coinsurance per prescription order or refill for a 1-34 day supply. Two copayment amounts plus applicable coinsurance per prescription order or refill for a 35-100 day supply. Two copayment amounts plus applicable coinsurance per prescription order or refill for a 2 month or 3 month supply of non-formulary contraceptives. Prescription medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.
Brand	\$20	\$20, then 75%	100%	Copayment amounts do not apply to the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions. Coinsurance still applies.
Nonformulary	\$25	\$25, then 50%	\$25, then 50%	Cost sharing amounts are waived for prenatal vitamins.
				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.
				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.
				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 does not apply.

Cost Sharing Amounts			
Prescription Drug Out-of-Pocket Maximum Amount	\$1,000 per member per benefit period		
When the Prescription Drug Out-of-Pocket maximum amount has been met for a member, formulary drugs will be covered at 100% of the allowed charge for the remainder of the benefit period for that member; this includes any prescription copayment amounts due. Prescription Medication Coinsurance and Copay Amounts accumulate toward a Member's Prescription Drug Out-of-Pocket Maximum.			
	PPO	Basic	
Single Coverage			
Medical Deductible amount	\$400	\$400	
Medical Coinsurance and Copay maximum	\$750	\$1,250	
Medical Out-of-pocket maximum	<u>\$1,150</u>	<u>\$1,650</u>	<i>You must meet the Medical Out-of-Pocket Maximum before this Benefit Plan begins to pay 100% of covered services. The Coinsurance and Copay Maximum listed is for illustrative purposes only.</i>
Family Coverage			
<i>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.</i>			
Medical Deductible amount	\$1,200	\$1,200	
Medical Coinsurance and Copay maximum	<u>\$1,500</u>	<u>\$2,500</u>	
Medical Out-of-pocket maximum	\$2,700	\$3,700	<i>You must meet the Medical Out-of-Pocket Maximum before this Benefit Plan begins to pay 100% of covered services. The Coinsurance and Copay 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. The Medical Out-of-Pocket Maximum Amounts accumulate separately from the Prescription Drug Out-of-Pocket Maximum Amount.

Definitions

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 a NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing at www.sanfordhealthplan.com/ndpers.

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