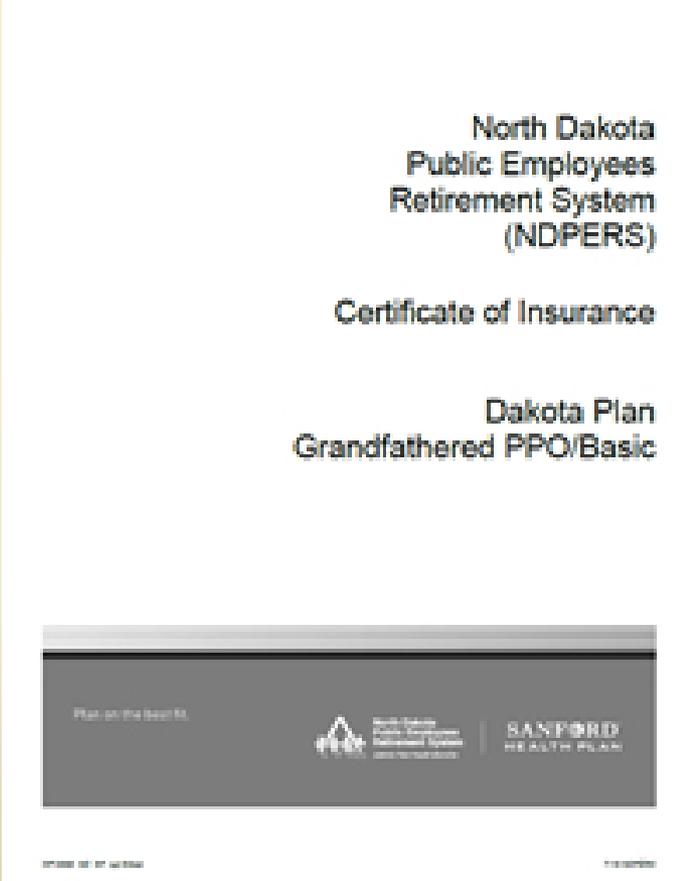


HEALTH PLAN

DAKOTA PLAN



Today's Presentation

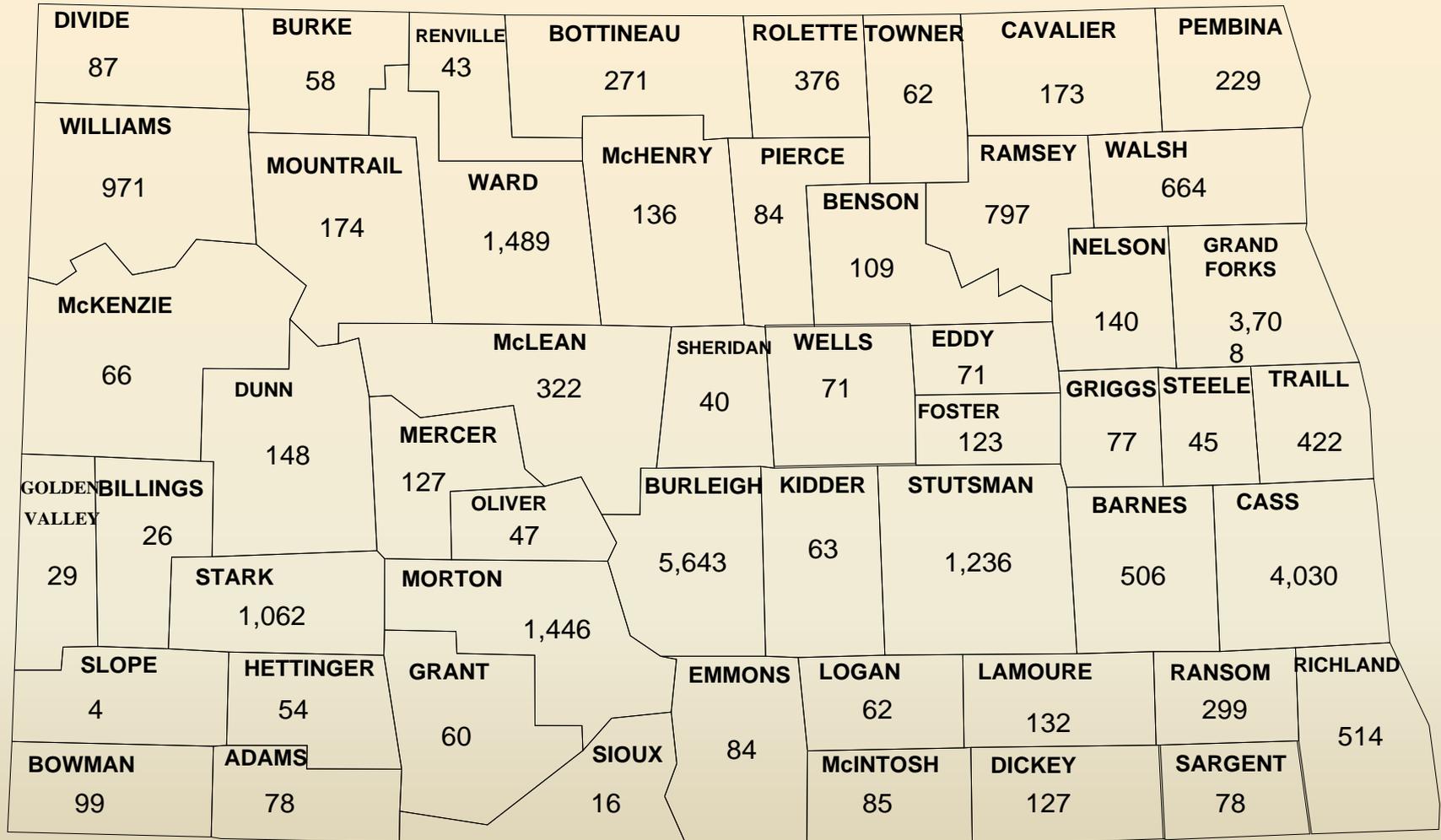
- Background on the Plan
 - Plan Demographics
 - Participation
 - History
- Plan Design
- ACA
- State Premiums

Today's Presentation

- Background on the Plan
 - Plan Demographics
 - Participation
 - History
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- ACA
- State Premiums

NDPERS Health Contracts

June 2015

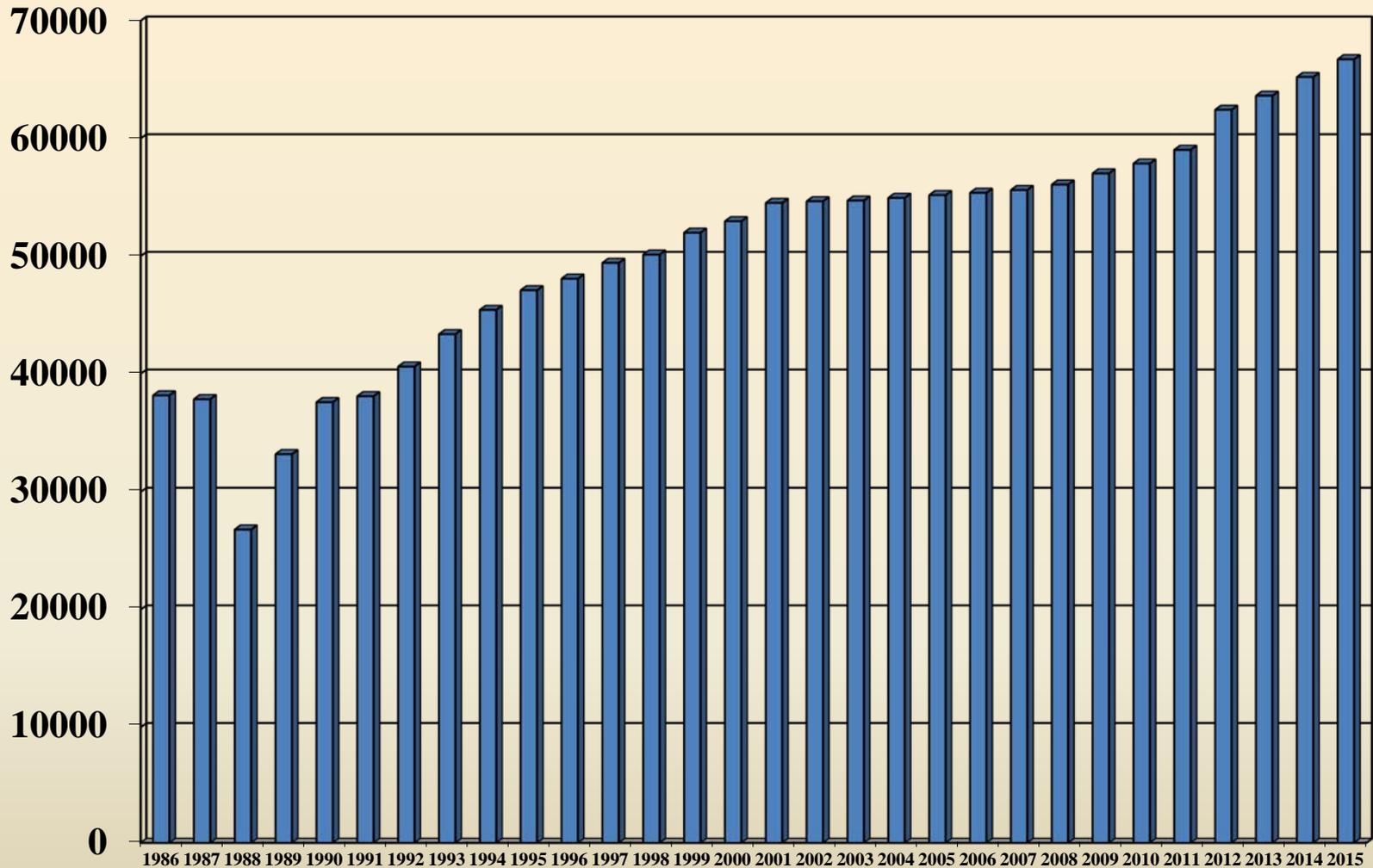


Out-of-State – 2,638

Total – 29,501

Average Contract Size = 2.26

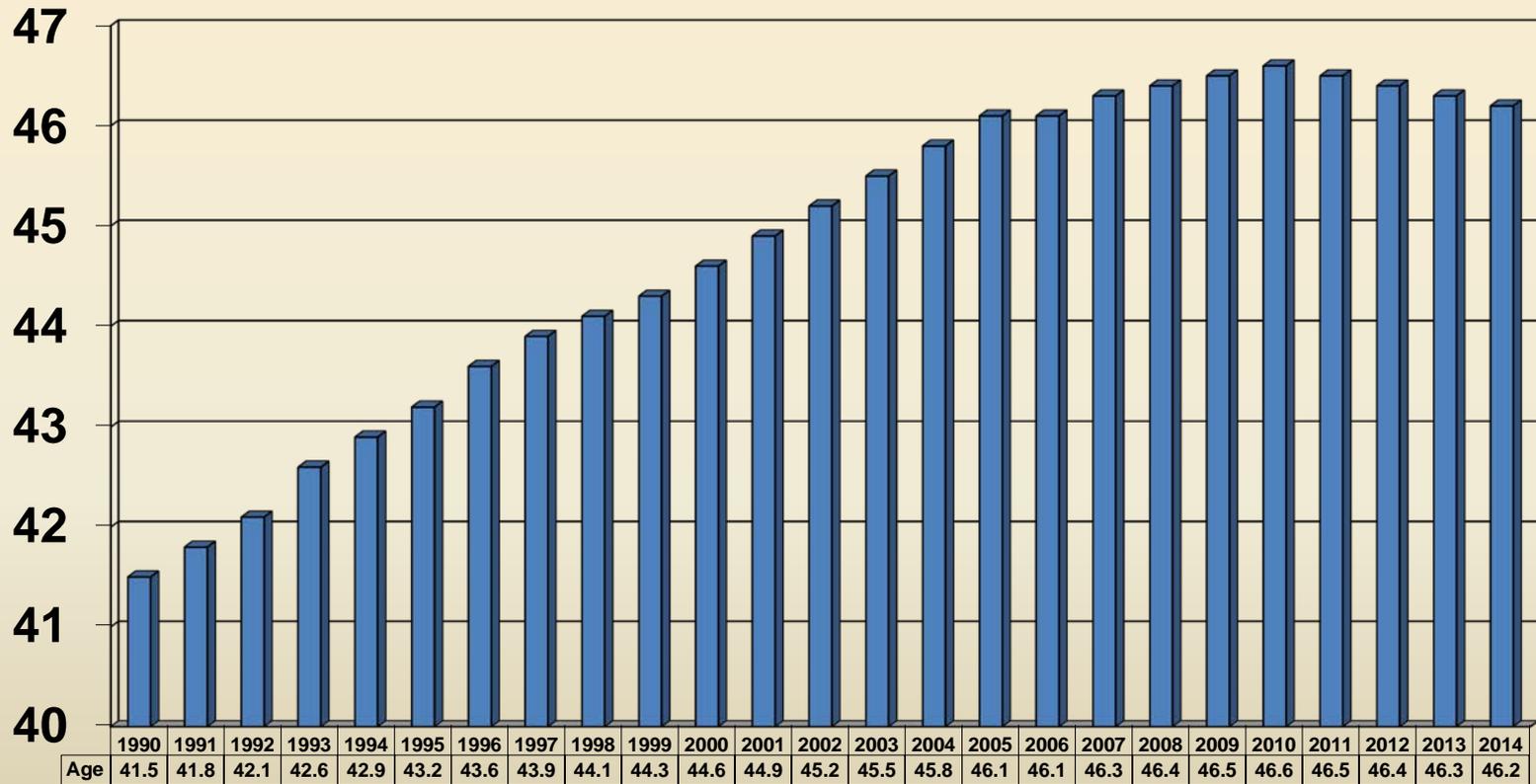
NDPERS Health Plan Membership



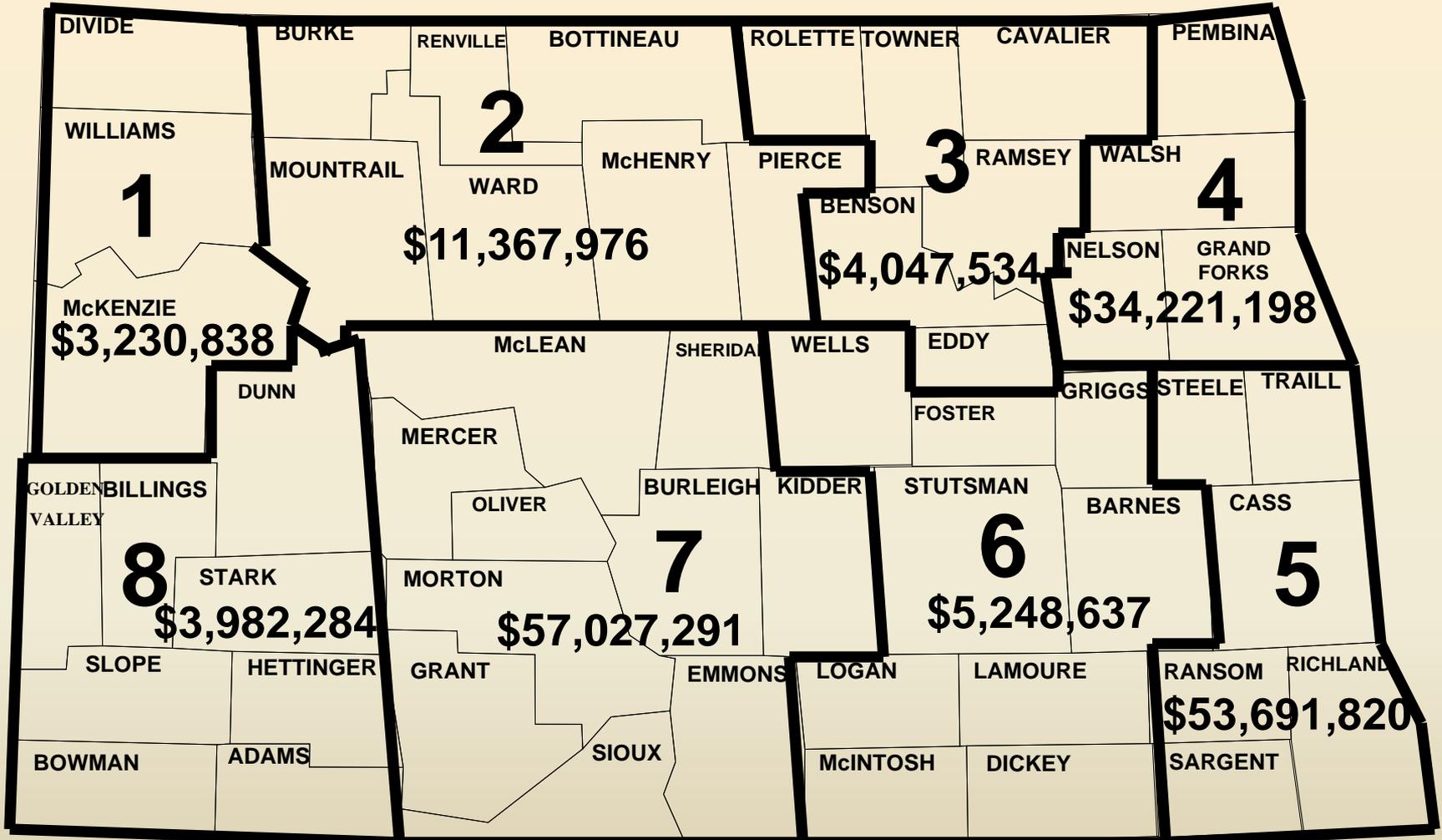
Covered Lives

NDPERS Active Employees

Average Age



NDPERS Health Plan Paid by Region 2014 Institutional & Professional



Out-of-State: \$40,703,582

Today's Presentation

- Background on the Plan
 - Plan Demographics
 - Participation (Political subs, active, retirees, pre-medicare retirees)
 - History
- Plan Design
- ACA
- State Premiums

Participation

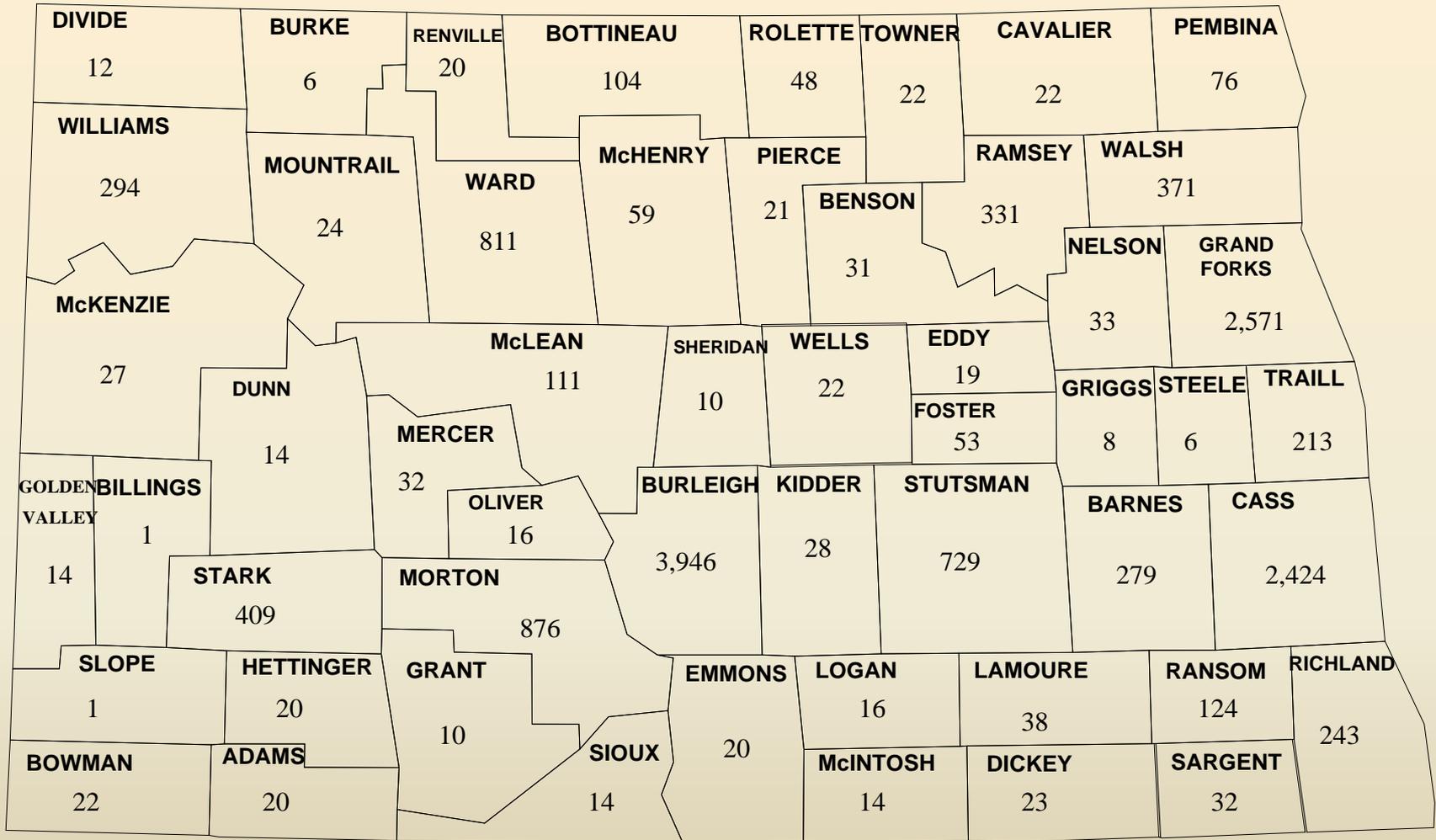
- State
- Political Subdivisions
- Pre- Medicare Retirees
- Retirees

State

- Participation is in Chapter 54-52.1
- Employee
 - At least 18 years of age
 - Work at least 20 hours a week
 - 20 or more weeks a year
 - Position is regularly funded & not of limited duration
- Spouse
- Children
 - Until the 1st of the month following 26th birthday

NDPERS State Active Employees

April 2015



Out-of-State – 1,142

Total – 15,832

NDPERS - September 2015

Active State Employees – 16,087

State Employee Health Contracts – 15,142

State Employees w/o NDPERS Health Plan – 945

(Dual Coverage & Waived Coverage)

POLITICAL SUBDIVISIONS

Political Sub Participation

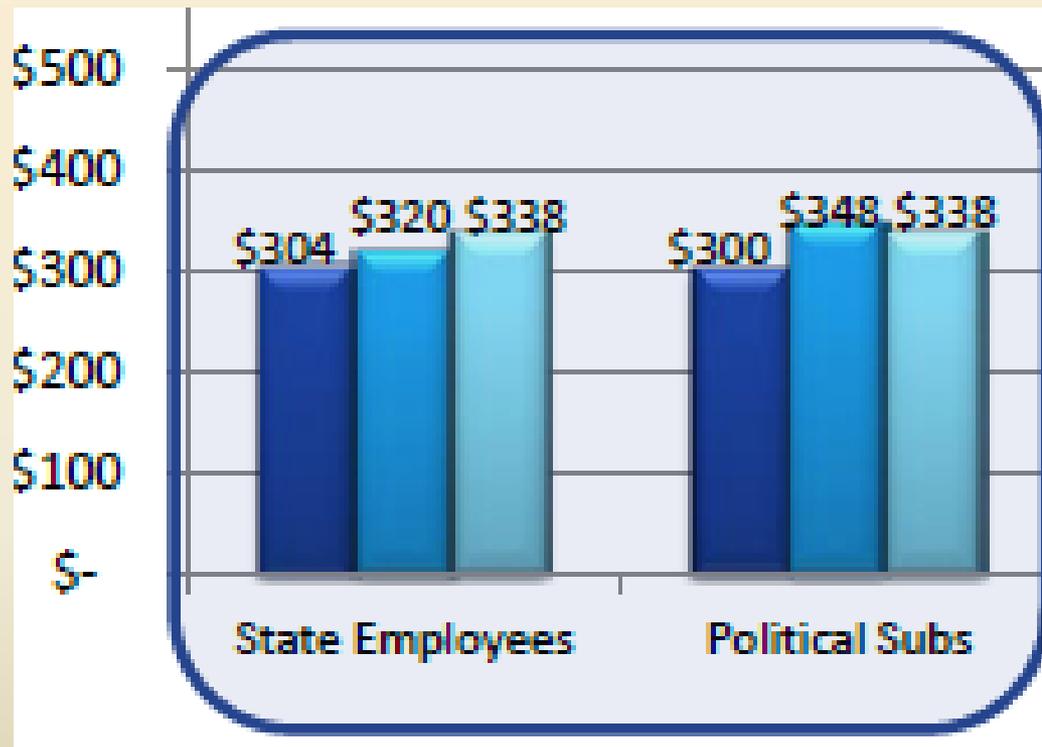
- According to North Dakota Century Code (NDCC) 54-52.1-03.1, political subdivisions may offer the benefits of the NDPERS group health plan to its permanent employees subject to the criteria provided in the Employer Participation Agreement. However, according to the Affordable Care Act (ACA), small employers, defined as 50 employees or less will not be eligible to participate in the NDPERS group health plan as of July 1, 2014 because the plan does not meet the ACA requirements.
- Sign a contract to participate
- May leave join or leave the plan at any time however if less than 5 years of participation NDCC54-52.1-03.1 requires the subdivision to pay the plan any losses associated with there participation before leaving. After 5 years not required.

Political Sub History

Participation

	2015	2012	2009	2006	2003
AGENCY	January	January	January	January	January
State	95	93	97	92	91
Counties	45	40	39	38	37
School Dist	38	23	27	25	25
Cities	50	57	57	56	51
Others	64	71	64	60	53
	292	284	284	271	257
EMPLOYEES					
State	15,203	15,196	14,325	13,779	13,470
Counties	2,244	1,868	1,811	1,757	1,707
School Dist	1,188	1,083	1,207	1,150	1,105
Cities	1,845	1,636	996	1,011	888
Others	592	483	519	427	401
Legislators	133	130	125	129	130
Retirees	6,973	5,843	5,627	5,208	5,061
COBRA	425	351	465	507	376
	28,603	26,590	25,075	23,968	23,138

PMPPM – 2012/2013/2014



PRE- MEDICARE RETIREE'S

PERS PreMedicare Coverage - HB 1058

- PreMedicare Retiree can stay on the PERS plan
 - COBRA @ 102% of premium
 - Thereafter at 150% for single, 2 to 2.5 times the single rate for family coverage

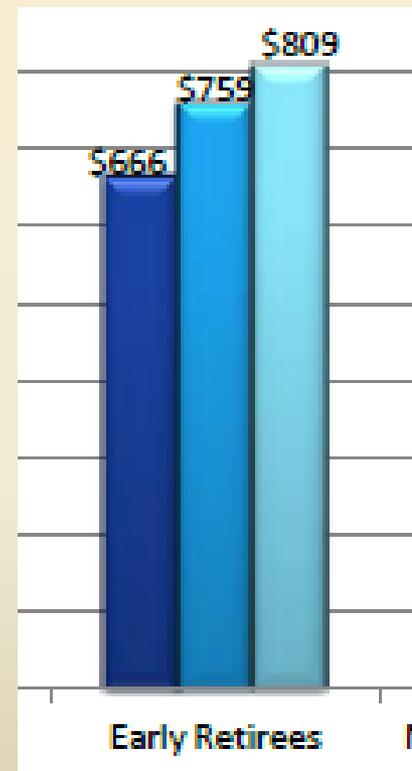
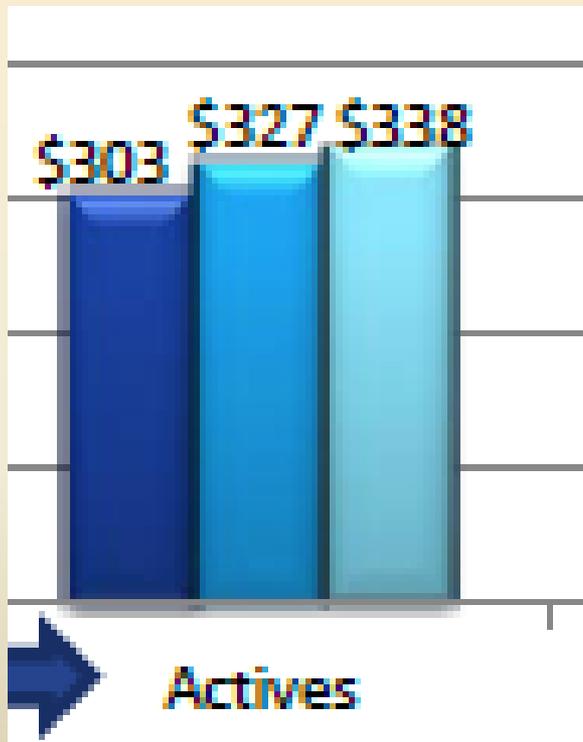
- Main reason is “guarantee issue” that is a PERS member will also be able to get health insurance
- An indirect subsidy for rates, shows on states financials

PERS PreMedicare Coverage - HB 1058

- Is not effective until July of 2015
- Only applies to new retirees after that date
- PreMedicare Retiree will still get COBRA @102%

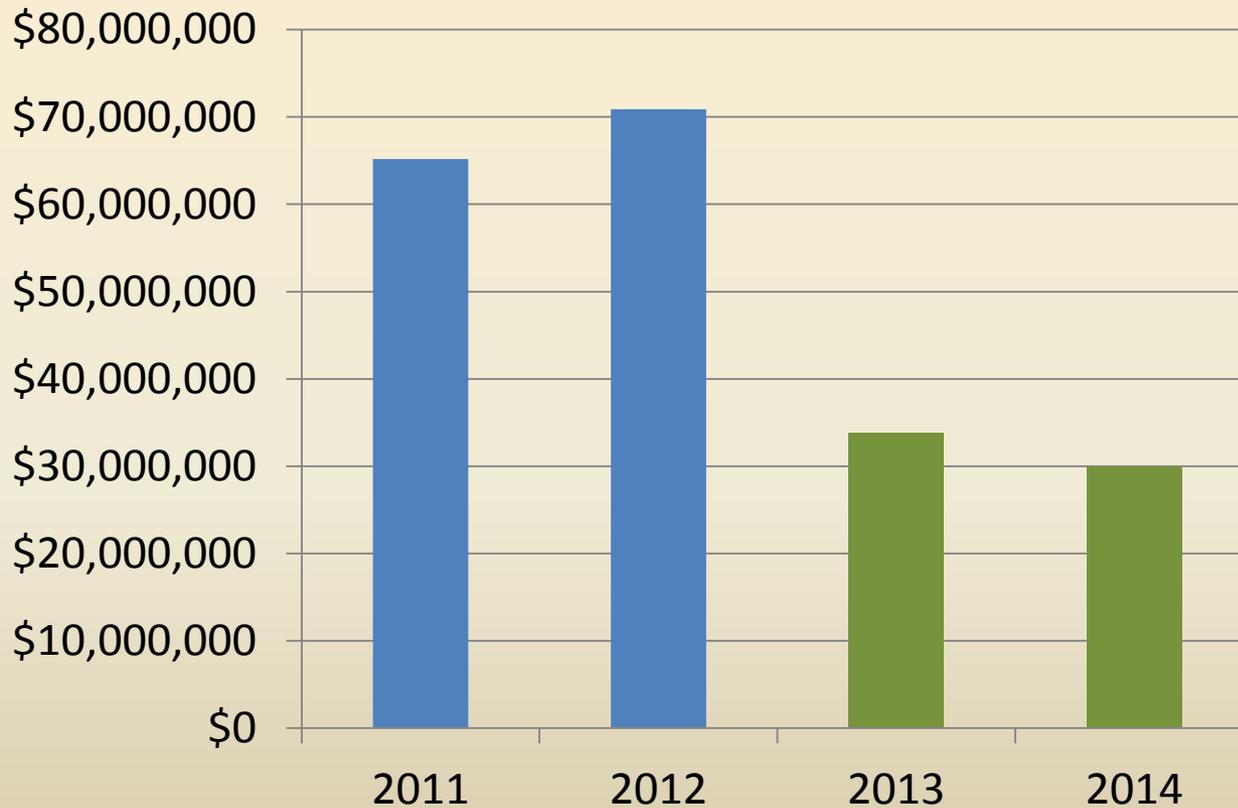
- With implementation of ACA PERS premedicare retirees will be able to access health care in the marketplace without having to be exposed to medical underwriting or pre-existing condition provisions
- Indirect subsidy for rates will state to be phased out in beginning in 2015.
- Implicit Subsidy on state financials will be reduced and eliminated in time for this coverage

Implicit Subsidy PMPM



NDPERS GASB45 OPEB Obligation

AAL – Actuarial Accrued Liability

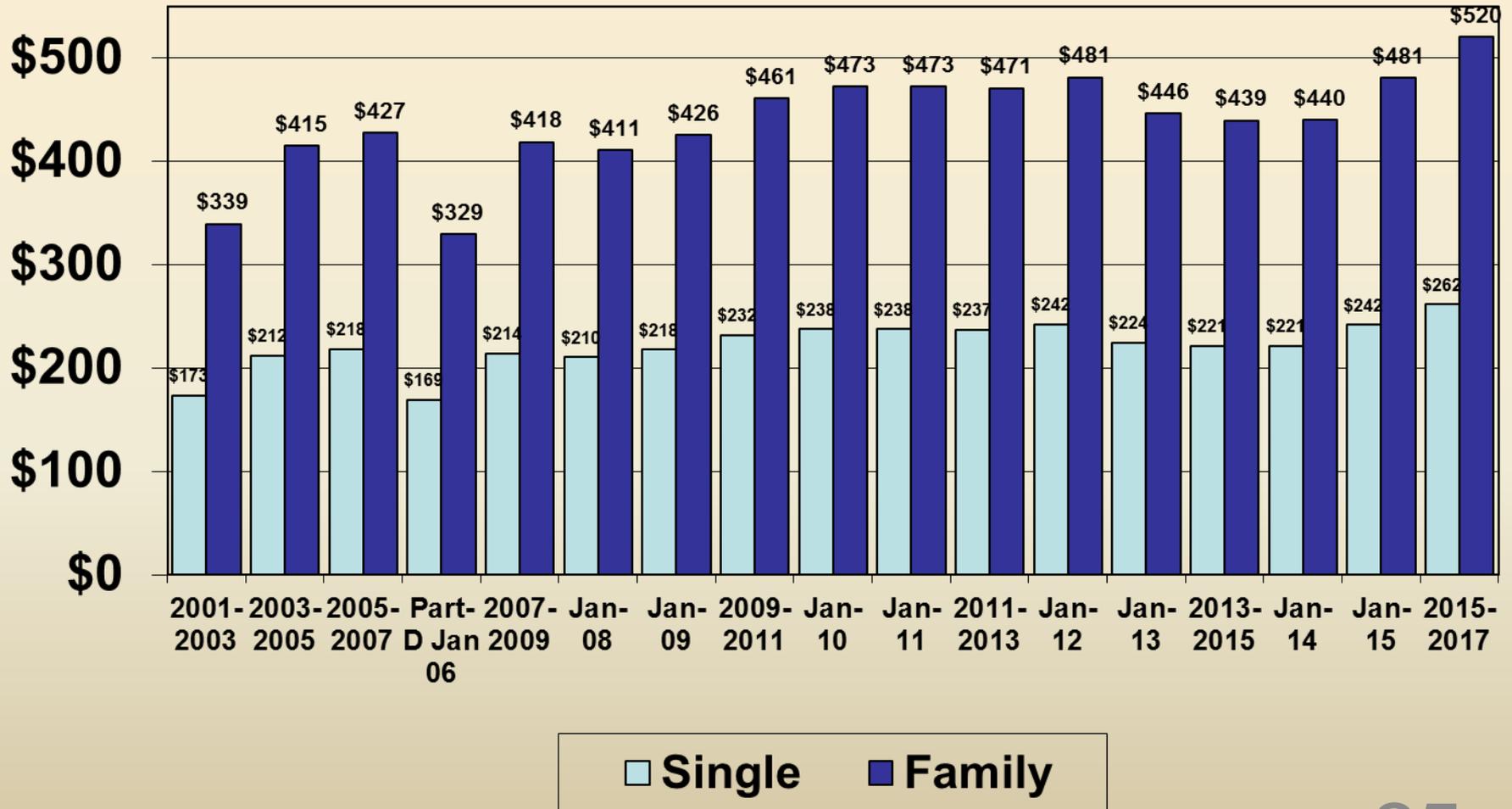


RETIREES

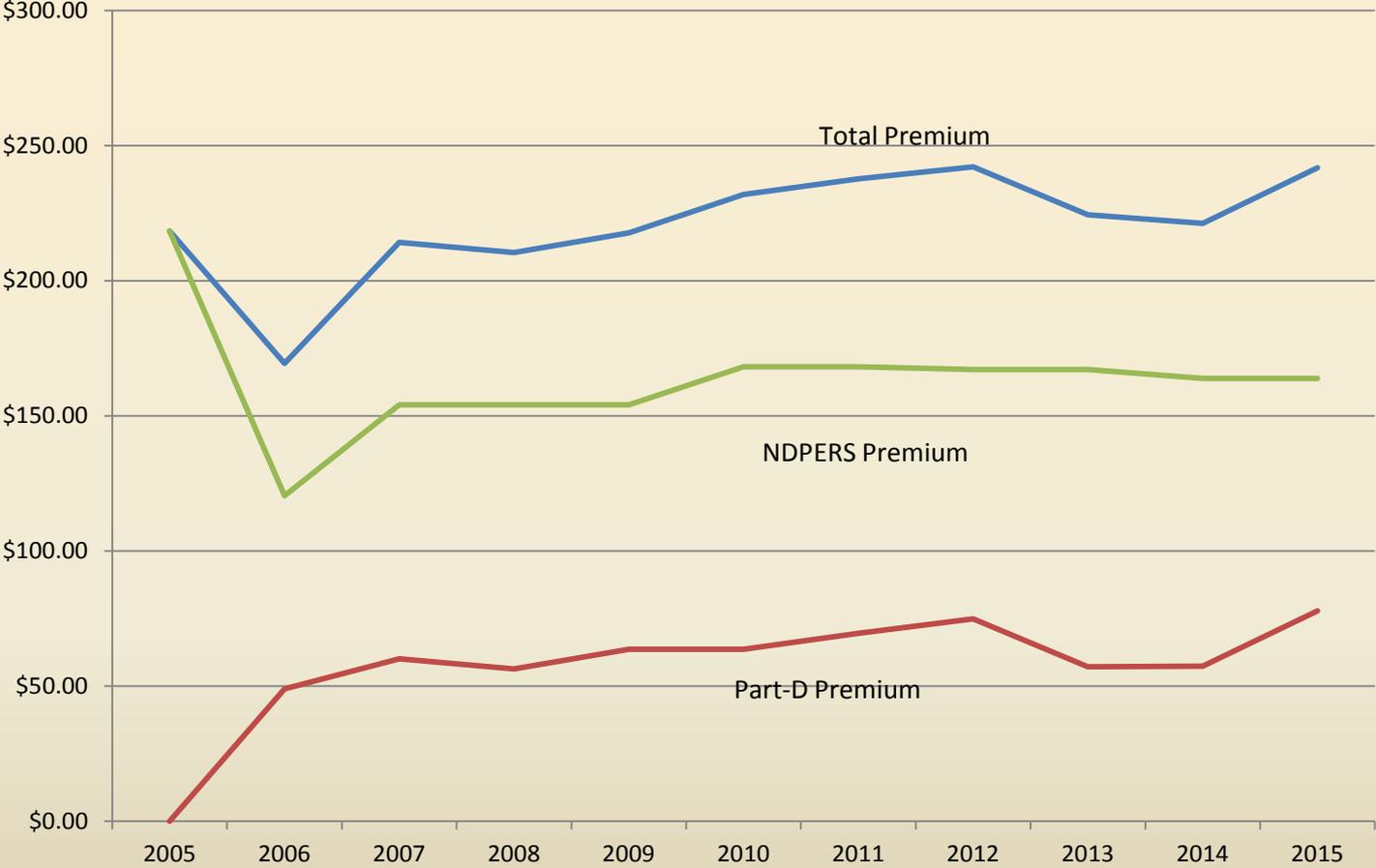
RETIRESS

- 6900 retiree contracts
- Coverage
 - Medical - Plan F
 - RX – Part D (EGWP)

NDPERS Medicare Premiums



Medicare Single Premium



Next Step In Transition

- Jan 1 will move to ESI
- Letter will be going out Oct
- Medicare Blue notice
- ESI Notice
- Rate Notice

Today's Presentation

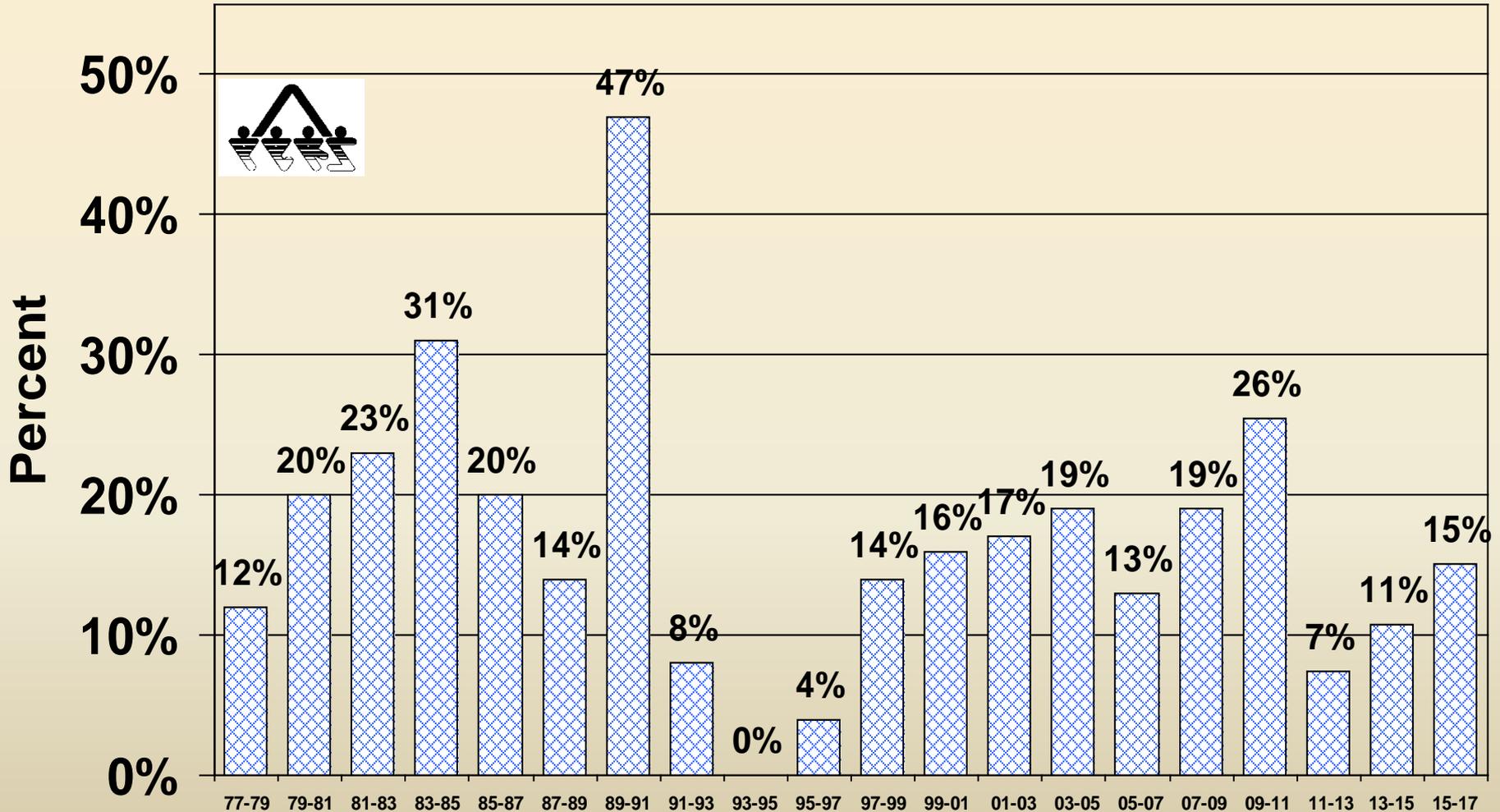
- Background on the Plan
 - Plan Demographics
 - Participation
 - **History**
- Plan Design
- ACA
- State Premiums

Self Insured In 80's

- Plan was self insured
- Plan ran out of funding in 1987-89 biennium
 - Premiums we advanced paid for cash flow
- In 1989 plan became fully insured
 - Actually a modified fully insured plan
 - PERS plan Design
 - Gain sharing and loss provision (50/50 in first 6 million of loss remainder to the carrier and 50/50 in first 3 million of gain remainder to PERS)

State Health Premium Percentage Increase From Previous Biennium

(Excludes Plan Design Changes)



Statutory Requirements self insured

- **Self insurance Decision Criteria (54-52.1-04.2 NDCC)**

Any self insurance plan under this sectionmay be established only if it is determined by the board that an administrative services only or third-party administrator plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits.

History of plan

DAKOTA PLAN - Grandfathered

PLAN FEATURES	1987	1989 – 1993		1993 – 1997				1997 – 1999			1999 – 2001			2001 – 2003		
		BASIC	PPO	BASIC	PPO	EPO ³ 01/01/94	SELF REFERRAL	BASIC / SELF REFERRAL	PPO	EPO	BASIC / SELF REFERRAL	PPO	EPO	BASIC / SELF REFERRAL	PPO	EPO
Deductible for Non-Physician Services																
Single (individual)	\$100	\$150	\$150	\$150	\$150	\$100	\$150	\$150	\$150	\$100	\$200	\$200	\$100	\$250	\$250	\$100
Family	\$200	\$450	\$450	\$450	\$450	\$300	\$450	\$450	\$450	\$300	\$600	\$600	\$300	\$750	\$750	\$300
Copayment Amounts																
Office Visits	-	\$20	\$10	\$20	\$10	\$5	\$20	\$20	\$10	\$5	\$20	\$15	\$10	\$25	\$20	\$15
Emergency Room Visits	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$50	\$50	\$50
Diagnostic Services (per service)	-	-	-	\$20	\$10	\$5	\$20	\$20	\$10	\$5	\$20	\$10	\$5	\$20	\$10	\$5
Diagnostic Copayment Maximum³																
Single (individual)	-			\$200	\$100	\$50	\$200	\$200	\$100	\$50	\$200	\$100	\$50	\$200	\$100	\$50
Family	-			\$400	\$200	\$100	\$400	\$400	\$200	\$100	\$400	\$200	\$100	\$400	\$200	\$100
Coinsurance	80/20	80/20	90/10	80/20	90/10	90/10	60/40	80/20	90/10	90/10	80/20	85/15	90/10	80/20	85/15	90/10
Coinsurance Maximum																
Single (individual)	\$400	\$1000	\$500	\$1000	\$500	\$500	Unlimited	\$1000	\$500	\$500	\$1250	\$750	\$500	\$1250	\$750	\$500
Family	\$1600	\$2000	\$1000	\$2000	\$1000	\$1000	Unlimited	\$2000	\$1000	\$1000	\$2500	\$1500	\$1000	\$2500	\$1500	\$1000
Total Out-of-Pocket per Benefit Period**																
Single (individual)	\$500	\$1150	\$650	\$1350	\$750	\$650	Unlimited	\$1350	\$750	\$650	\$1650	\$1050	\$650	\$1700	\$1100	\$650
Family	\$1800	\$2450	\$1450	\$2850	\$1650	\$1400	Unlimited	\$2850	\$1650	\$1400	\$3500	\$2300	\$1400	\$3650	\$2450	\$1400
Lifetime Maximum Per Insured	\$1,000,000	\$1,000,000		\$1,000,000				\$2,000,000			\$2,000,000			\$2,000,000		
Prescription Drugs																
Generic Prescription ¹	\$3 copay 20% coins	\$4 copay 10% coins		\$4 copay 10% coinsurance				\$3 copay 10% coins			\$5 copay 15% coins			\$5 copay, 15% coins		
Brand Name Prescription	\$5 copay 20% coins	\$7 copay 20% coins		\$7 copay 20% coinsurance				\$7 copay 20% coins			\$10 copay 25% coins			\$15 copay, 25% coins		
Nonformulary Prescription								\$10 copay 20% coins			\$10 copay 25% coins			\$25 copay, 25% coins		
Notes:		2		4, 5, 6				7, 8			9, 10			11		

** - Excludes copayments.

NOTES:

1. Pays difference between brand and generic if member doesn't accept generic.
2. In 1989 there was only one PPO. The number grew, but in 1993 the only major clinics on were in Fargo only.
3. Added diagnostic copayments in 1993.
4. EPO became effective in 01/01/94 in Fargo, Minot and Grand Forks. PPO was expanded into the same areas as a result of the EPO.
5. Added preventive screening benefits to Basic and PPO plans.
6. Formulary went into effect 07/01/95.
7. Changed the self-referral plan to have an out-of-pocket maximum, and from a 60/40 coinsurance to an 80/20 coinsurance when the EPO became a permanent option.
8. Increased lifetime maximum from \$1,000,000, to \$2,000,000.
9. Increased deductibles, copayments and coinsurance amounts to subscribers in basic/PPO. Increase office visit copay in EPO.
10. Increased RX copays and coinsurance.
11. Increased RX copays, ER Visit copay, Office Visit copay, and Basic/PPO Deductible.

History of plan

DAKOTA PLAN - Grandfathered

PLAN FEATURES	2003 – 2005			2005 – 2007			2007 – 2009			2009 – 2011		2011 – 2017		
	BASIC / SELF REFERRAL	PPO	EPO	BASIC / SELF REFERRAL	PPO	EPO	BASIC / SELF REFERRAL	PPO	EPO	BASIC / SELF REFERRAL	PPO	BASIC / SELF REFERRAL	PPO	
Deductible for Non-Physician Services														
Single (individual)	\$250	\$250	\$100	\$250	\$250	\$100	\$400	\$400	\$200	\$400	\$400	\$400	\$400	
Family	\$750	\$750	\$300	\$750	\$750	\$300	\$1200	\$1200	\$600	\$1200	\$1200	\$1200	\$1200	
Copayment Amounts														
Office Visits	\$25	\$20	\$15	\$25	\$20	\$15	\$30	\$25	\$20	\$30	\$25	\$30	\$25	
Emergency Room Visits	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	
Diagnostic Services (per service)														
Coinsurance	75/25	80/20	85/15	75/25	80/20	85/15	75/25	80/20	85/15	75/25	80/20	75/25	80/20	
Coinsurance Maximum														
Single (individual)	\$1250	\$750	\$500	\$1250	\$750	\$500	\$1250	\$750	\$500	\$1250	\$750	\$1250	\$750	
Family	\$2500	\$1500	\$1000	\$2500	\$1500	\$1000	\$2500	\$1500	\$1000	\$2500	\$1500	\$2500	\$1500	
Total Out-of-Pocket per Benefit Period**														
Single (individual)	\$1500	\$1000	\$600	\$1500	\$1000	\$600	\$1650	\$1150	\$700	\$1650	\$1150	\$1650	\$1150	
Family	\$3250	\$2250	\$1300	\$3250	\$2250	\$1300	\$3700	\$2700	\$1600	\$3700	\$2700	\$3700	\$2700	
Lifetime Maximum Per Insured	\$2,000,000			\$2,000,000			\$2,000,000			\$2,000,000		\$0		
Prescription Drugs														
Generic Prescription ¹	\$ 5 copay	15% coins		\$ 5 copay	15% coins		\$ 5 copay,	15% coins		\$ 5 copay,	15% coins		\$ 5 copay,	15% coins
Brand Name Prescription	\$ 15 copay	25% coins		\$ 15 copay	25% coins		\$ 20 copay,	25% coins		\$ 20 copay,	25% coins		\$ 20 copay,	25% coins
Nonformulary Prescription	\$ 25 copay	50% coins		\$ 25 copay	50% coins		\$ 25 copay,	50% coins		\$ 25 copay,	50% coins		\$ 25 copay,	50% coins
Prescription Drug Coinsurance Maximum				\$1,000			\$1,000			\$1,000			\$1,000	
Notes:	12,13,14			15			16			17		18		

** - Excludes copayments.

NOTES:

12. Deductible Applies to All Services.
13. Diagnostic Copayments Removed.
14. Nonformulary Prescription Drug Coinsurance Increased.
15. Formulary Prescription Drug Coinsurance Maximum of \$1,000 put in.
16. Increased Deductible, Office Visit Copayments, and Brand Drug Copayments.
17. Eliminated EPO Network and standardized benefits with BCBS.
18. Dependent Age 26 and Eliminated Lifetime Maximum ACA Provisions.

NDPERS Active Health Insurance Out-Of-Pocket						
Jan-Dec Calendar Year ending:						
	2009	2010	2011	2012	2013	2014
Active Contracts	19,317	19,728	20,016	20,940	21,203	21,530
Deductibles	\$9,290,919	\$9,816,469	\$10,073,095	\$10,967,963	\$11,328,815	\$11,374,638
Coinsurance	\$11,832,668	\$12,712,265	\$13,059,708	\$13,930,488	\$14,614,079	\$15,478,868
Sanctions	\$2,138,358	\$2,414,573	\$2,471,455	\$2,650,929	\$3,976,577	\$3,461,110
Copayments	\$10,295,041	\$11,464,880	\$11,696,304	\$12,214,972	\$12,396,682	\$12,336,376
Exclusions	\$5,604,131	\$4,497,621	\$5,851,646	\$9,056,696	\$10,857,602	\$20,948,164
TOTAL	\$39,161,117	\$40,905,808	\$43,152,208	\$48,821,048	\$53,173,755	\$63,599,156
Per Contract	\$2,027	\$2,073	\$2,156	\$2,331	\$2,508	\$2,954
State Classified Average Salary	\$42,382	\$44,698	\$46,057	\$48,554	\$50,942	\$53,297
Percent	4.8%	4.6%	4.7%	4.8%	4.9%	5.5%

Today's Presentation

- Background on the Plan
 - Plan Demographics
 - Participation
- **Plan Design**
- ACA
- State Premiums

Levels of Coverage

- PPO/Basic Plan
 - Basic
 - Coverage for services received in North Dakota not provided by a PPO provider
 - Out-of-state services
 - Preferred Provider Organization (PPO)
 - Freedom of choice to use any provider in North Dakota
- High Deductible Health Plan (HDHP)
 - with Health Savings Account (HSA)
 - Annual enrollment

Deductible - PPO/Basic

(Non-Physician Services ONLY)

	<u><i>Basic</i></u>	<u><i>PPO</i></u>
Individual	\$400	\$400
Family (3 or more)	\$1200	\$1200

Total Cost Impact if NDPERS loses Grandfathered Status* (incl. Rewrite) 3.2%

***Preventive @ 100%**

- Infants & Children •Adult/Adolescent (includes colorectal cancer screenings)
- Pregnant Women
- Men's Preventive Services
- Women's Preventive Services (includes contraception)

Co-payment Amounts - PPO/Basic



	<u>Basic</u>	<u>PPO</u>
Office Visit (No limit)	\$30	\$25
Emergency Room (No limit)	\$50	\$50

Coinsurance Amounts - PPO/Basic



	<u>Basic</u>	<u>PPO</u>
Coinsurance All Services except office visits	75/25	80/20
Coinsurance Maximum		
Individual	\$1,250	\$ 750
Family	\$2,500	\$1,500

Annual Out-of-Pocket Maximums – PPO/Basic

(Includes Deductible & Coinsurance)

	<u>Basic</u>	<u>PPO</u>
Individual	\$1,650	\$1,150
Family	\$3,700	\$2,700



PPO/Basic Prescription Drug

- Formulary Generic
 - \$5 Copayment + 15%
- Formulary Brand Name
 - \$20 Copayment + 25%
 - There is a \$1000 coinsurance Maximum for Formulary Generic and Brand Name prescriptions per member per CY
- Nonformulary Generic/Brand
 - \$25 Copayment + 50%
 - The \$1000 coinsurance Maximum does not apply to the Nonformulary Prescriptions.
 - Mail Order available to NDPERS members thru Express Scripts Pharmacy.

High Deductible Health Plan (HDHP)

HDHP Differences

- This will be a Comprehensive Deductible and Coinsurance plan.
- There are no Copayments under this plan.
- Deductible will apply first dollar since there is no copay structure on Prescriptions.
- Because this is a Comprehensive HDHP a Member can exceed the \$1500 Individual Deductible/Coinsurance.

HDHP Deductible

PLAN	INDIVIDUAL	FAMILY
PPO	\$1,500	\$3,000
BASIC	\$1,500	\$3,000

HDHP Coinsurance Maximums

PLAN	INDIVIDUAL	FAMILY
PPO 80/20 %	\$1,500	\$3,000
BASIC 75/25 %	\$2,000	\$4,000

HDHP Total Out-of-Pocket Maximum

PLAN	INDIVIDUAL	FAMILY
PPO	\$ 3,000	\$ 6,000
BASIC	\$ 3,500	\$ 7,000

Health Savings Account (HSA)

Benefits

- Enroll in High Deductible Health Plan
- Enroll in the HSA

Before Deductible Met

- Use HSA to pay for out-of-pocket/deductible expenses

After Deductible Met

- Now covered by HDHP
- Save your HSA funds

What is a Health Savings Account?

- A Health Savings Account allows you to set aside funds to pay for qualified medical expenses for you, your dependents or your spouse.
- *Think of it as a Medical IRA!*
- *Note- dependent status for an HSA is different than the health plan.*

Qualified Expenses

- Medical
- Dental
- Vision
- Chiropractor
- Prescriptions
- Some Over-the-Counter (OTC)*

May Require a Rx

- Not all eligible expenses go toward your HDHP deductible
- Save your receipts

HSA Contributions

- NDPERS Monthly Employer Contribution
 - Effective 7/1/15:
 - \$69.94 monthly for single policy
 - \$169.24 monthly for family policy
- 2015 Contribution limits:

Coverage	IRS 2015 Limits	NDPERS 2015 Contribution	
Single	\$3,350	\$784.08	(\$2,565.92)
Family	\$6,650	\$1,897.44	(\$4,752.56)
55+	\$1,000 Extra contribution		

Eligibility

- Must be covered by a HDHP to participate
- If you cease participation in HDHP, can no longer contribute to HSA, but can spend down balance
- You are not eligible if:
 - covered by any other insurance
 - If you have a supplemental insurance policy, check with your carrier to ensure the policy is HSA compatible
 - you/spouse participate in a traditional FSA
 - receiving Medicare/Tricare benefits

Prescription Drug Coverage for HDHP



- Formulary Drug
 - 80% of Allowed Charge after Deductible Amount

Nonformulary Drug

- 50% of Allowed Charge after Deductible Amount
- Prescription Medications or Drugs and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

Employee Wellness Initiatives

- The Plan offers two additional programs to covered employees and spouses
- Employees can qualify to receive up to a total of \$250 each year that can be earned for one or both of the following programs:
 - Fitness Center Reimbursement
 - bWell Online Tool

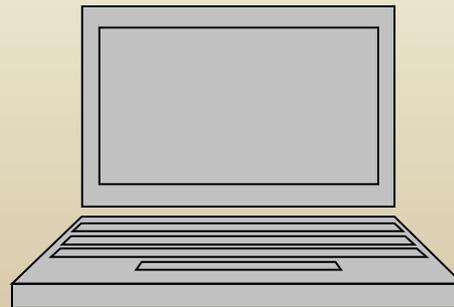
Fitness Center Reimbursement

- Covered employees and spouses can earn up to \$20 credit monthly for visiting a participating health club a minimum of 12 days a month.



bWell Online Tool

- Covered employees and spouses can earn points to apply toward incentive prizes
- Provides trackers for weight, blood pressure, cardio exercise and more



Tobacco Cessation Program

- Grant available through Dept of Health
- Enrollment: July 1, 2015 to April 30, 2016
- Eligible employees on health plan
- Dependents age 18 and over
- Includes smoke-free tobacco product cessation
- (800) 499-3416 or (701) 751-4125 – SHP member service unit
- Emails sent through agency wellness coordinator

Tobacco Cessation Program

Program Payment Responsibilities:

- Office Visit, RX & over the counter medications – 100% up to \$500
- Cessation Counseling: telephone - ND Quitline, online –ND Quitnet or pre-approved face-to-face counseling up to \$200
- Participants will receive a Debit Card to use for eligible expenses – must provide SHP receipts

How does our plan compare

- BCBS Comparison
- Sanford Comparison

Today's Presentation

- Background on the Plan
 - Plan Demographics
 - Participation
- Plan Design
- ACA
- State Premiums

ACA

- Grandfathered Plans
- Non-Grandfathered Plans

ACA - PERS

- Legislative Changes

House Bill 1059

Sixty-third Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 8, 2013

HOUSE BILL NO. 1059
(Government and Veterans Affairs Committee)
(At the request of the Public Employees Retirement System Board)

AN ACT to amend and reenact sections 54-52.1-03.1, 54-52.1-03.4, and 54-52.1-18 of the North Dakota Century Code, relating to withdrawal of a political subdivision from the uniform group insurance program, the definition of an eligible employee, payment of the cost of uniform group insurance premiums for temporary employees, and the health savings account option offered to political subdivisions as part of the high-deductible health plan alternative under the uniform group insurance program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52.1-03.1 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-03.1. Certain political subdivisions authorized to join uniform group insurance program - Employer contribution.

A political subdivision may extend the benefits of the uniform group insurance program under this chapter to its permanent employees, subject to minimum requirements established by the board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation in the uniform group insurance program, before completing sixty months of participation, unless federal or state laws or rules are modified or interpreted in a way that makes participation by the political subdivision in the uniform group insurance program no longer allowable or appropriate, the political subdivision shall make payment to the board in an amount equal to any expenses incurred in the uniform group insurance program that exceed income received on behalf of the political subdivision's employees as determined under rules adopted by the board. The Garrison Diversion Conservancy District, and district health units required to participate in the public employees retirement system under section 54-52-02, shall participate in the uniform group insurance program under the same terms and conditions as state agencies. A retiree who has accepted a retirement allowance from a participating political subdivision's retirement plan may elect to participate in the uniform group under this chapter without meeting minimum requirements at age sixty-five, when the employee's spouse reaches age sixty-five, upon the receipt of a benefit when the political subdivision joins the uniform group insurance plan if the retiree was a member of the former plan, or when the spouse terminates employment. If a retiree or surviving spouse does not elect to participate at the times specified in this section, the retiree or surviving spouse must meet the minimum requirements established by the board. Each retiree or surviving spouse shall pay directly to the board the premiums in effect for the coverage then being provided. The board may require documentation that the retiree has accepted a retirement allowance from an eligible retirement plan other than the public employees retirement system.

SECTION 2. AMENDMENT. Section 54-52.1-03.4 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-03.4. Temporary employees and employees on unpaid leave of absence.

A temporary employee employed before August 1, 2007, may elect to participate in the uniform group insurance program by completing the necessary enrollment forms and qualifying under the medical underwriting requirements of the program. A temporary employee employed on or after August 1, 2007, is only eligible to participate in the uniform group insurance program if the employee is employed at least twenty hours per week and at least twenty weeks each year of employment. A temporary employee first employed after December 31, 2013, is eligible to participate in the uniform group insurance program only if the employee meets the definition of a full-time employee under

- Section 1 allows political subs to leave plan if required by federal law
- Section 2 changes law to comply with shared responsibility rules
- Section 3 related to HDHP

House Bill 1059 - Eligibility

Federal Law	Full Time Employee	
State Law	Full time	Temp
Existing law	Services are not limited in duration, who is filling an approved and regularly funded position and who is employed at least 20 hours per week and at least 20 weeks per year	Not filling an approved and regularly funded position and is working at 20 hours per week for 20 weeks per year.
New law	Services are not limited in duration, who is filling an approved and regularly funded position and who is employed at least 20 hours per week and at least 20 weeks per year	Average of 30 hours per week during a month subject to the employers look back period

100% employer premium payment

Employee pays only 9.5% of household income¹

No employer premium payment

ACA - PERS

- Legislative Changes
- PERS has:
 - Grandfathered plan
 - Basic/PPO
 - Non-grandfathered plan
 - Basic/PPO
 - HDPHP

Plan Design Difference

- ***Preventive @ 100%***
 - •Infants & Children •Adult/Adolescent (includes colorectal cancer screenings)
 - •Pregnant Women
 - •Men's Preventive Services
 - •Women's Preventive Services (includes contraception)
- ***Out of Pocket Maximum Accumulation (Non-Grandfathered PPO plans only)***
 - •All cost shares have to accumulate to the out of pocket maximum.
 - •Deductible, Coinsurance, Copayments, Rx Copayments & Rx Coinsurance
 - •New out of pocket maximum amount - to account for the summed up cost shares

ACA Plan GF/NGF

- If grandfathered status is lost the cost of Grandfathered to Non Grandfather plan is:
 - \$8 on a single plan
 - \$28 on a family plan

ACA - PERS

- Legislative Changes
- PERS has:
 - Grandfathered plan
 - Basic/PPO
 - Non-grandfathered plan
 - Basic/PPO
 - HDPHP
- Limits
 - Premium
 - Plan Design

Deloitte

September 28, 2015

Sparb Collins
Executive Director
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Dear Sparb:

You asked Deloitte Consulting to prepare a letter explaining the changes that can be made with respect to a grandfathered health plan without causing the plan to lose its grandfathered status under the Affordable Care Act (ACA).

Following is a summary of the relevant rules relating to maintaining grandfathered status under the ACA. It is for general information purposes only, and is not intended as legal or tax advice.

What changes will cause plans to lose grandfathered status?

Before turning to a detailed overview of the changes that will cause a plan to lose grandfathered status, it is important to keep a few key points in mind.

1. All changes are measured against or compared with the terms of the plan in effect on March 23, 2010, the date the ACA was enacted.
2. All changes to the relevant plan terms occurring after March 23, 2010 must be aggregated for purposes of determining if a particular change will result in a loss of grandfathered status.

These are the changes will cause a plan to lose grandfathered status |

Eliminating benefits

A plan will lose its grandfathered status if eliminates all or substantially all benefits to diagnose or treat a particular condition. This includes eliminating benefits for any necessary element to diagnosing or treating a condition.

Example

A grandfathered group health plan stops paying for counseling, a necessary treatment for a covered mental health condition. The change causes the plan to lose its grandfathered status because counseling is an element necessary to treat the covered condition.

Increasing cost-sharing requirements

Sorry for the information and use of NDPERS and not to be relied upon by any other person or entity.

Member of
Deloitte Touche Tohmatsu Limited

ACA Plan Limits

- Premium Change
- Plan Design Change

Deloitte Memo

ACA - PERS

- Legislative Changes
- PERS has:
 - Grandfathered plan
 - Basic/PPO
 - Non-grandfathered plan
 - Basic/PPO
 - HDPHP
- Limits
 - Premium
 - Plan Design
- Cadillac Plan

Cadillac Plan

- The 2018 premium targets are \$10,200 individual and \$27,500 family for annual premiums. Excess coverage over these amounts are subject to a 40% employer tax.
- Our current converted flat rate premium to single/family premium through July 2017 are \$6,531.36 individual (\$544.28X12) and \$15,740.88 family (\$1,311.74X12).
- However if we are unable to convert the flat rate for measurement purposes and must use the flat rate to compare to the single rate threshold for Cadillac for plan measurement purposes we would exceed it for the single plan (\$1,130).

Other Federal Decisions

- ***U.S. Supreme Court ruling on same-gender marriage in Obergefell v.Hodges***
- ***Effective July 2015 for PERS***

Today's Presentation

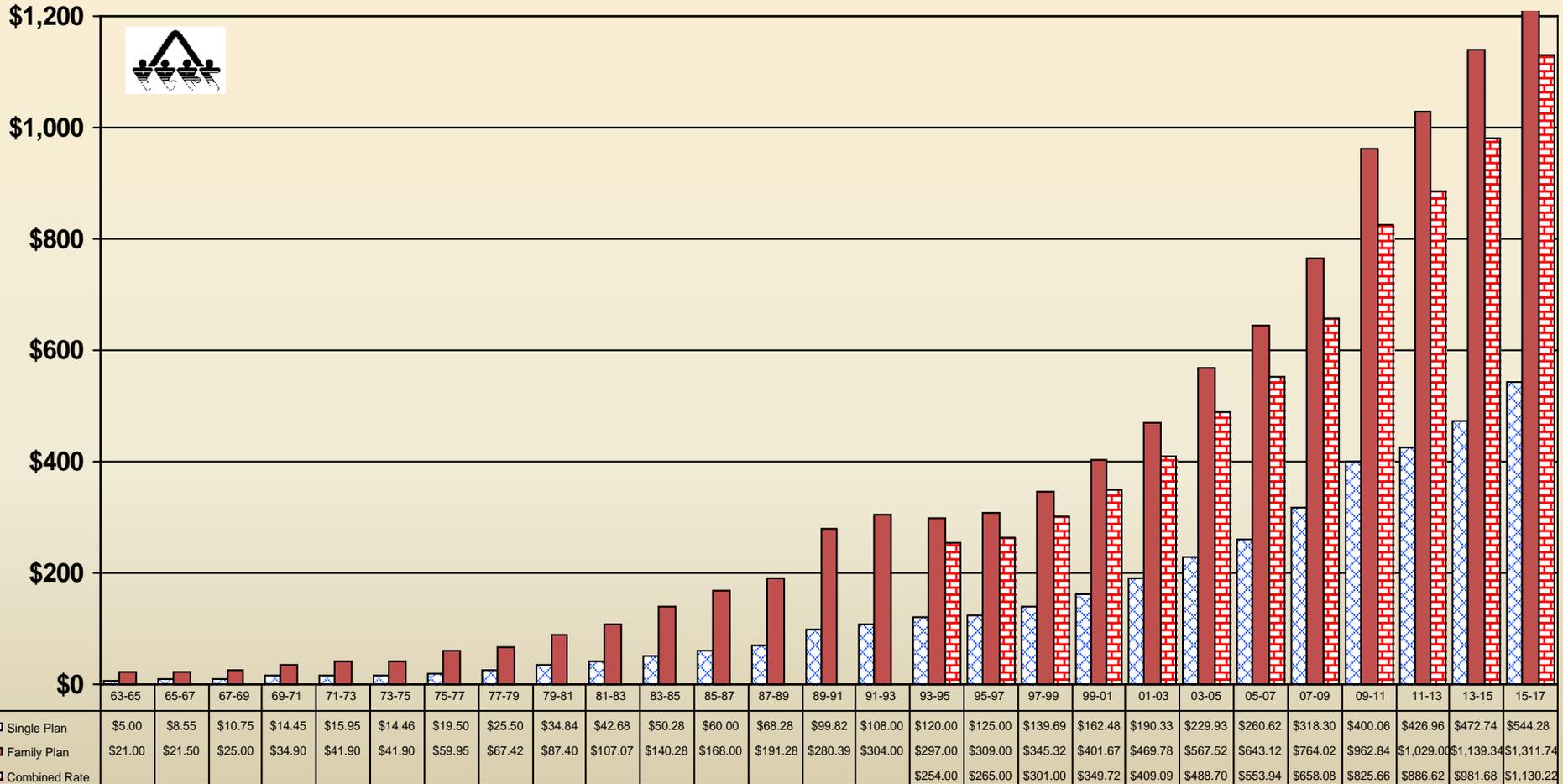
- Background on the Plan
 - Plan Demographics
 - Participation
- Plan Design
- ACA
- **State Premiums**

Active State Billed Health Insurance Premium

Single Plan

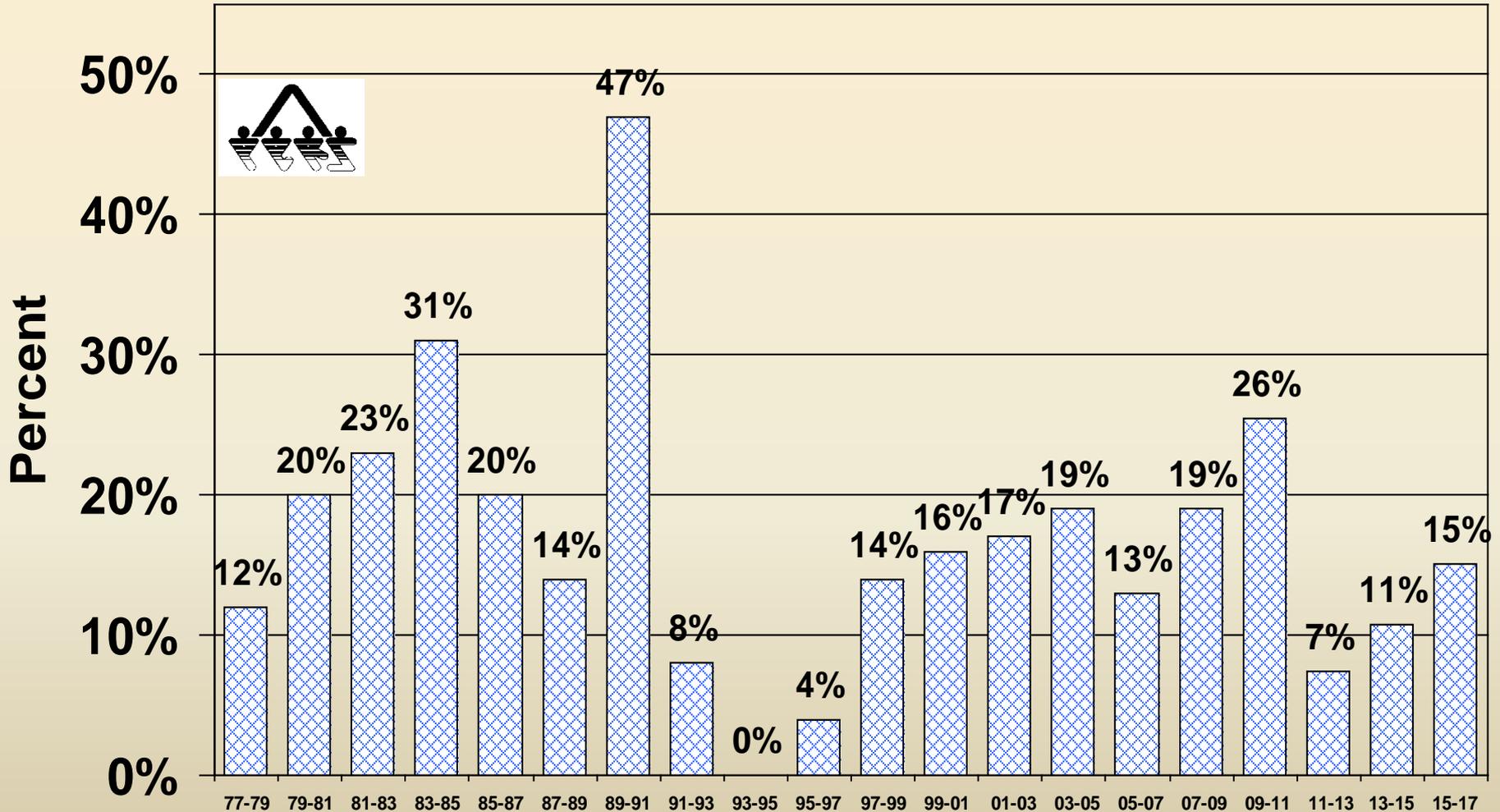
Family Plan

Combined Rate



State Health Premium Percentage Increase From Previous Biennium

(Excludes Plan Design Changes)



NDPERS STATE HEALTH PLAN

2009-11 Premium

\$825.66

2011-13 Premium

\$886.62

2013-15 PREMIUM

\$981.68

2015-17 PREMIUM

\$1130.22

- 2009-11 to 2011-13 Two year increase is 7.38% or about 3.7% per year.
- Includes extending coverage to dependents and eliminating the lifetime max.
- The cost assumes we maintain our grandfathered status.

- 2011-13 to 2013-15 Two year increase is 10.72% or about 5.5% per year.
- 2013-15 to 2015-17 Two year increase is 15.13% or about 7.7% per year.

State Premium Policy

54-52.1-06. State contribution.

Each department, board, or agency shall pay to the board each month from its funds appropriated for payroll and salary amounts a state contribution in the amount as determined by the primary carrier of the group contract for the full single rate monthly premium for each of its eligible employees enrolled in the uniform group insurance program and the full rate monthly premium, in an amount equal to that contributed under the alternate family contract, including major medical coverage, for hospital and medical benefits coverage for spouses and dependent children of its eligible employees enrolled in the uniform group insurance program pursuant to section 54-52.1-07.

State Premium Policy

- **54-52.1-07. Optional coverage for employee's family.**

Each eligible employee enrolled in the uniform group insurance program may elect to include that person's spouse and all qualified dependents, as provided for in the plan, within the hospital benefits coverage and medical benefits coverage, the state to pay the cost of such coverage as provided in section 54-52.1-06.

State of North Dakota Health Plan Appropriations (Excludes Higher Education)

	Total Budget Appropriation	FTE	Health Premium	Health Plan Appropriation	% of Total Appropriations
1991-93	2,771,064,605	8,179	\$254.00	\$49,859,184	1.80%
1993-95	2,935,767,081	8,216	\$254.00	\$50,084,736	1.71%
1995-97	3,107,356,520	8,024	\$265.00	\$51,032,640	1.64%
1997-99	3,347,823,922	8,118	\$301.00	\$58,644,432	1.75%
1999-01	3,767,007,536	8,400	\$349.72	\$70,503,552	1.87%
2001-03	4,325,559,659	8,538	\$409.09	\$83,827,450	1.94%
2003-05	4,587,351,203	8,392	\$488.70	\$98,428,090	2.15%
2005-07	5,186,963,789	8,438	\$553.94	\$112,179,497	2.16%
2007-09	5,843,419,715	8,808	\$658.08	\$139,111,900	2.38%
2009-11	8,052,214,358	8,960	\$825.66	\$177,549,926	2.20%
2011-13	8,556,123,763	9,011	\$886.62	\$191,743,988	2.24%
2013-15	12,666,651,460	9,179	\$981.68	\$216,260,177	1.71%
2015-17	13,238,812,510	9,392	\$1130.22	\$254,760,630	1.92%

NCASG 2014 Benefits Survey Report

Table 6:

Contribution for Employee Only Coverage						
Preferred Provider Org PPO/POS						
	# of Employees Enrolled	ER (state) share \$	EE share \$	Total	ER (state) share %	EE share %
Alaska	6,668	\$1,389.00	\$0.00	\$1,389.00	100.0%	0.0%
Colorado - United - Copay	4,949	\$434.10	\$72.04	\$506.14	85.8%	14.2%
Idaho	4,321	\$744.24	\$35.00	\$779.24	95.5%	4.5%
Iowa - contract	1,438	\$771.07	\$0.00	\$771.07	100.0%	0.0%
Minnesota	13,775	\$525.34	\$0.00	\$525.34	100.0%	0.0%
Montana*						
Nebraska - Reg	2,543	\$437.20	\$116.22	\$553.42	79.0%	21.0%
North Dakota *	3,505	\$472.74	\$0.00	\$472.74	100.0%	0.0%
South Dakota	6,807	\$718.50	\$0.00	\$718.50	100.0%	0.0%
Wisconsin	1,349	\$692.70	\$100.53	\$793.23	87.3%	12.7%
Wyoming	5,568	\$624.29	\$110.17	\$734.96	85%	15.0%

Montana

*Montana Employer contribution \$804 per month for all employees, with their choice of plans.

North Dakota

* The State of ND pays a 'composite premium' of \$981.68/mo for active employees from 7/1/2013

NCASG 2015 Benefits Survey Report

Table 6:

Contribution for Employee Only Coverage						
Preferred Provider Org PPO/POS						
	# of Employees Enrolled	ER (state) share \$	EE share \$	Total	ER (state) share %	EE share %
Alaska	6,731	\$1,346.00	\$0.00	\$1,346.00	100.0%	0.0%
Colorado United	3467	\$465.61	\$135.14	600.75	77.5%	22.5%
Idaho	4,773	\$859.98	\$47.00	\$906.98	94.8%	5.2%
IOWA	656	\$821.31	\$0.00	\$821.31	100.0%	0.0%
Kansas	18,589	\$522.80	\$17.10	\$539.90	96.8%	3.2%
Minnesota	13,340	\$499.08	\$26.26	\$525.34	95.0%	5.0%
Montana*						
North Dakota	3,668	\$544.28	\$0.00	\$544.28	100.0%	0.0%
Wisconsin	1,273	\$707.57	\$99.67	\$807.24	87.7%	12.3%
Wyoming	2,025	\$714.81	\$126.14	\$840.95	85.0%	15.0%

Montana

*Montana Employer contribution \$887 per month for all employees, with their choice of plans.

North Dakota

* The State of ND pays a 'composite premium' of \$1130/mo for active employees from 7/1/2015

NCASG 2014 Benefits Survey Report

Table 6:

Contribution for Family Coverage						
Preferred Provider Org PPO/POS/HMO						
	# of Employees Enrolled	ER (state) share \$	EE share \$	Total	ER (state) share %	EE share %
Alaska						
Colorado - United - Copay	1,480	\$1,080.90	\$435.74	\$1,516.64	71.3%	28.7%
Idaho	3,467	\$744.24	\$127.00	\$871.24	85.4%	14.6%
Iowa - contract	1,250	\$1,565.06	\$239.25	\$1,804.31	86.7%	13.3%
Minnesota	19,775	\$1,391.96	\$152.92	\$1,544.88	90.1%	9.9%
Montana*						
Nebraska - Reg	1,091	\$1,552.08	\$412.00	\$1,964.08	79.0%	21.0%
North Dakota *	12,349	\$1,139.34	\$0.00	\$1,139.34	100.0%	0.0%
Wisconsin	3,629	\$1,760.80	\$136.52	\$1,897.32	92.8%	7.2%
Wyoming	4,594	\$1,445.20	\$255.04	\$1,700.24	85.0%	15.0%

Montana

*Montana Employer contribution \$804 per month for all employees, with their choice of plans.

North Dakota

* The State of ND pays a 'composite premium' of \$981.68/mo for active employees from 7/1/2013 -

NCASG 2015 Benefits Survey Report

Table 6:

Contribution for Family Coverage						
Preferred Provider Org PPO						
	# of Employees Enrolled	ER (state) share \$	EE share \$	Total	ER (state) share %	EE share %
Colorado United	1101	\$1,230.06	\$553.10	\$1,783.16	69.0%	31.0%
Idaho	5,024	\$859.98	\$171.00	\$1,030.98	83.4%	16.6%
IOWA	730	\$1,634.36	\$288.42	\$1,922.78	85.0%	15.0%
Minnesota	19,927	\$1,365.70	\$179.18	\$1,544.88	88.4%	11.6%
Montana*						
North Dakota	11,887	\$1,311.74	\$0.00	\$1,311.74	100.0%	0.0%
Wisconsin	3,371	\$1,785.80	\$234.27	\$2,020.07	88.4%	11.6%
Wyoming	1,803	\$1,654.75	\$292.01	\$1,946.76	85.0%	15.0%

Montana

*Montana Employer contribution \$887 per month for all employees, with their choice of plans.

North Dakota

* The State of ND pays a 'composite premium' of \$1130/mo for active employees from 7/1/2015

Other Survey's

NCSL

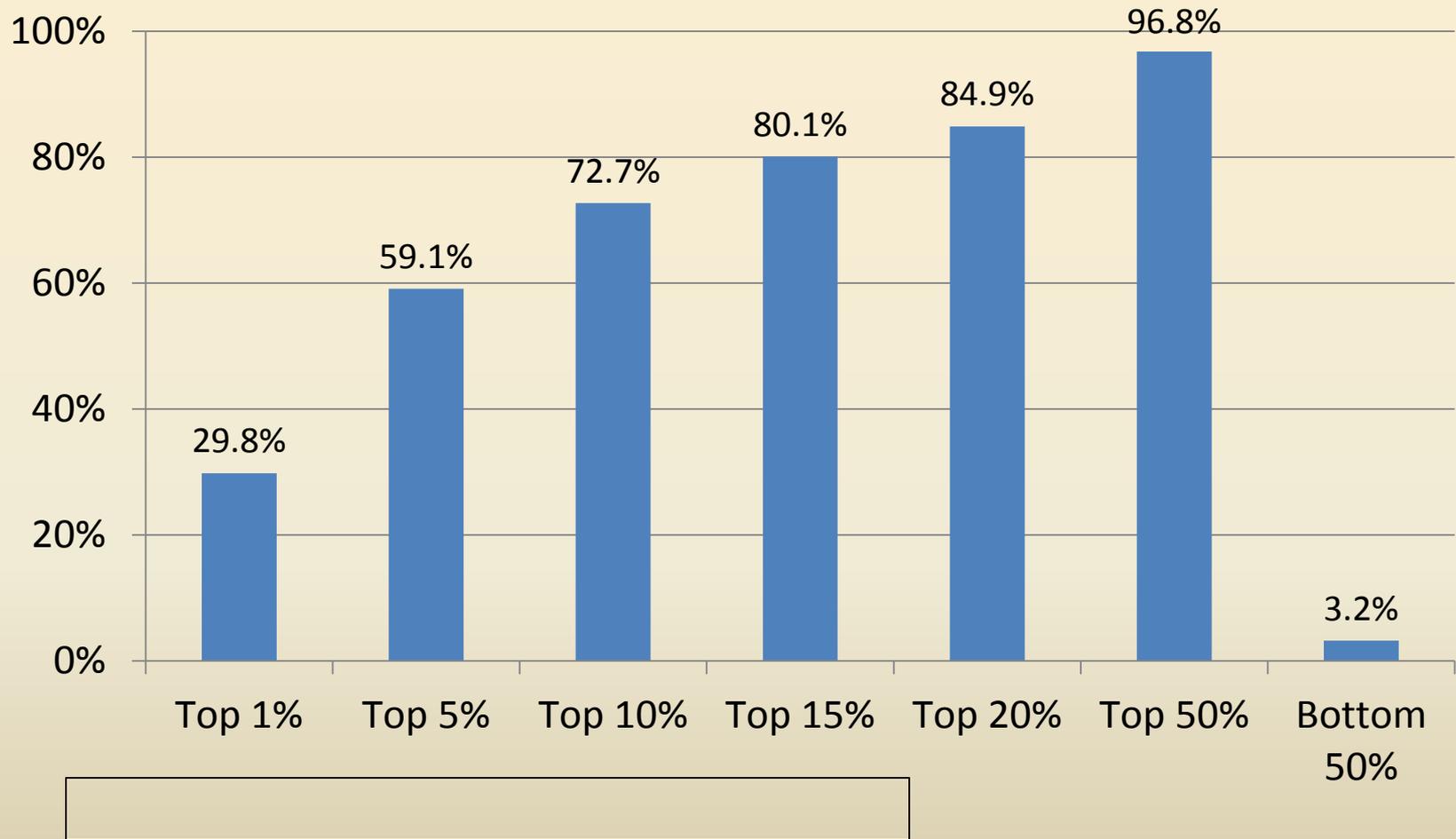
- <http://www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx>

PEW

- <http://www.pewtrusts.org/en/research-and-analysis/reports/2014/08/state-employee-health-plan-spending>

ADVERSE SELECTION

Concentration of Per Member NDPERS Health Care Spending in 2011



Includes Hospital, Physician/Clinic and Pharmacy Claims paid through April, 2012.

NDPERS - September 2015

Active State Employees – 16,087

State Employee Health Contracts – 15,142

State Employees w/o NDPERS Health Plan – 945

(Dual Coverage & Waived Coverage)

QUESTIONS

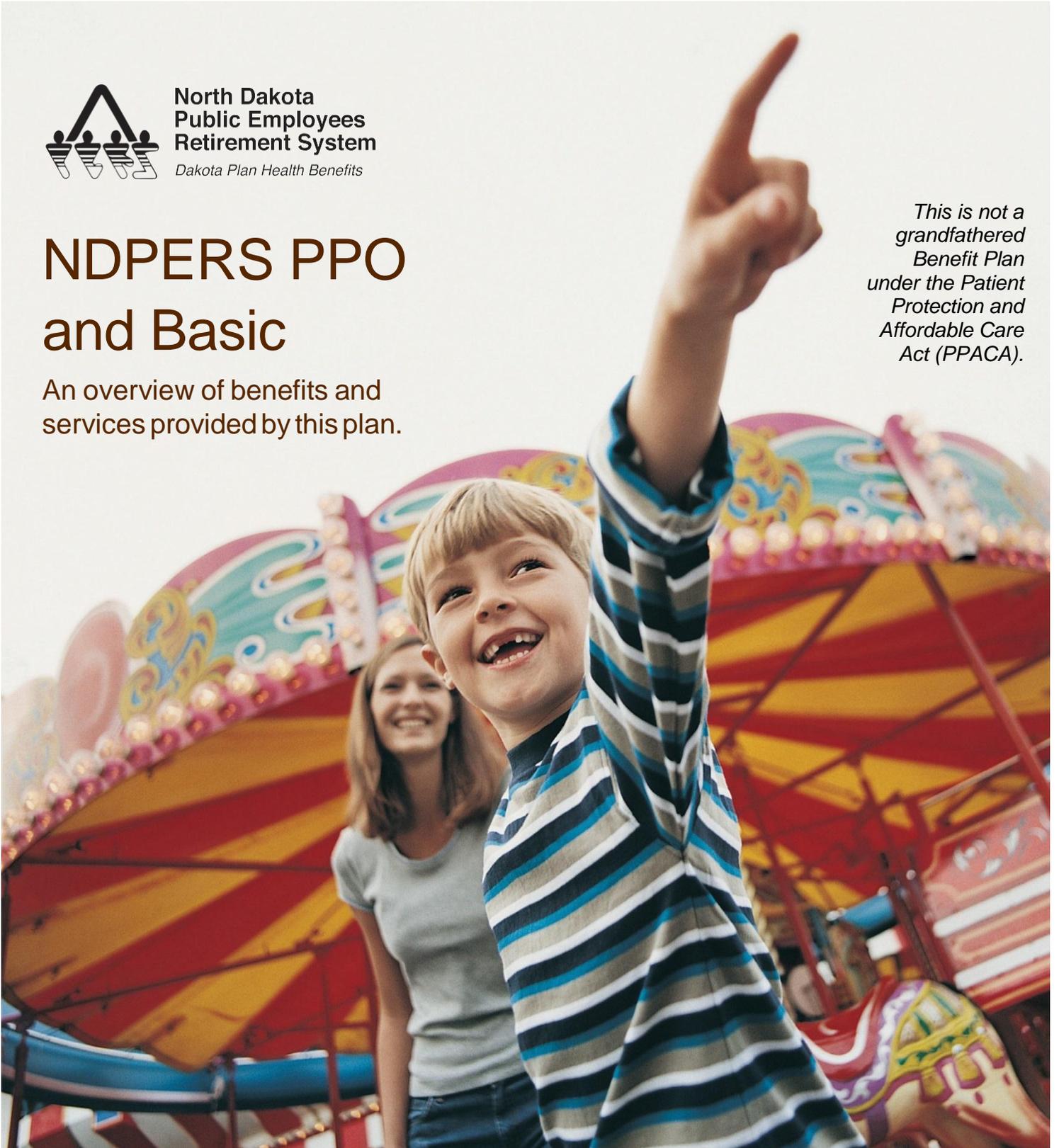


North Dakota
Public Employees
Retirement System
Dakota Plan Health Benefits

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 (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, 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.	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.

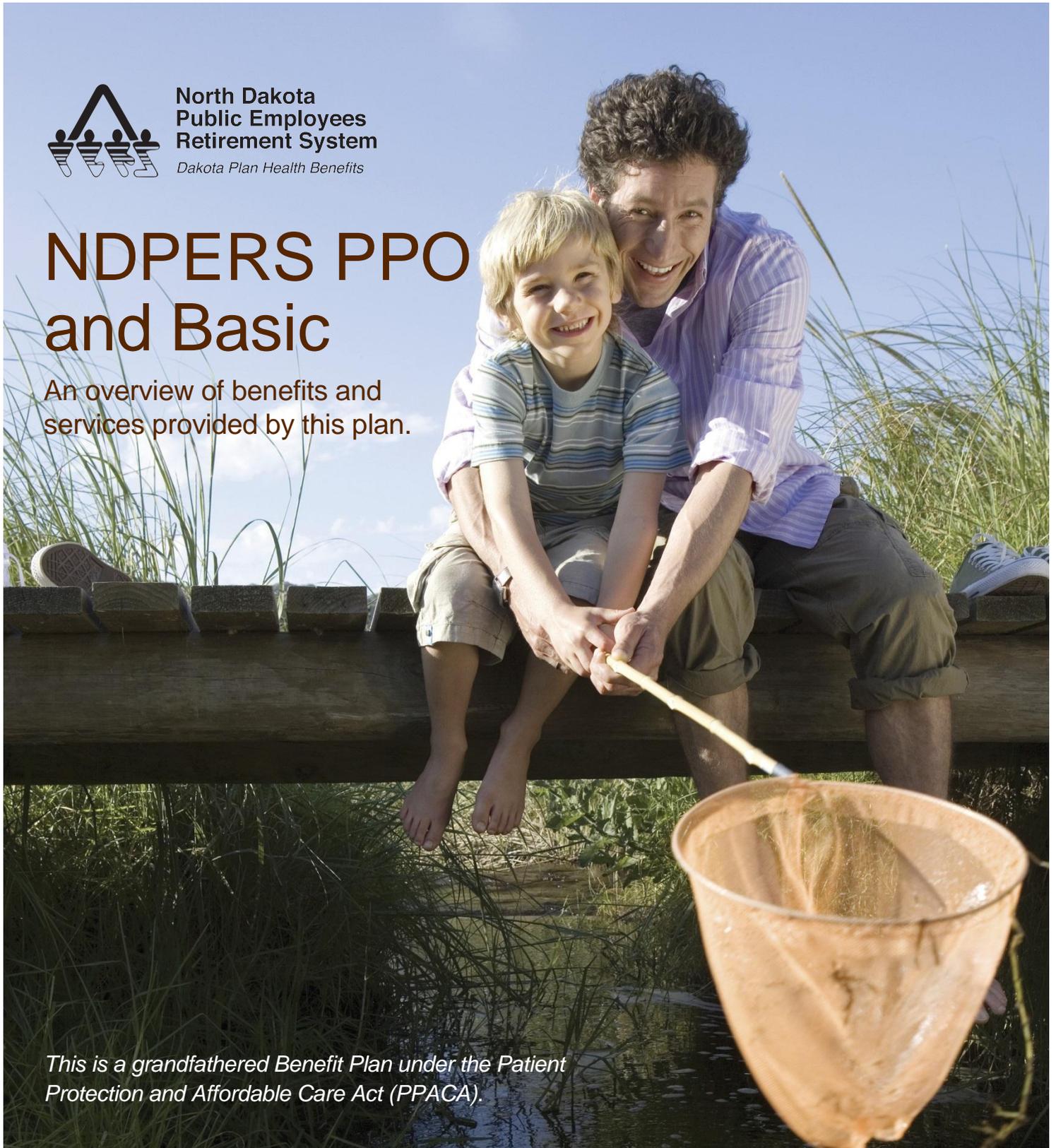
Call (800) 499-3416 to speak with Member Services.



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[®]
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	
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		\$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.
Physical Therapy	\$25 / \$20	\$25, then 75%	\$25, then 100%	\$20, then 80%	\$20, then 100%	Benefits are based on established medical guidelines. Deductible does not apply.
Occupational & Speech 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 st 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 Services		75%	100%	80%	100%	
Wellness Services						
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.
Home & Office Visits	\$30 / \$25	\$30, then 100%	\$30, then 100%	\$25, then 100%	\$25, then 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		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						
Mental Health and Substance Use Disorder Treatment Services						Preauthorization/prior approval is required for non-emergency inpatient treatment for mental health and/or substance use disorders.
Inpatient - Includes acute inpatient admissions and residential treatment		75%	100%	80%	100%	
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						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%	
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.
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.

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.
Outpatient Prescription Medications (Retail and Mail Order)				
Formulary				
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.
Brand	\$20	\$20, then 75% of allowed charge	\$20	
Nonformulary				
	\$25	\$25, then 50% of allowed charge	\$25, then 50% of allowed charge	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.

Cost Sharing Amounts		
	PPO	Basic
Single Coverage		
Deductible amount	\$400	\$400
Coinsurance maximum	\$750	\$1,250
Out-of-pocket maximum	\$1,150	\$1,650
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.		
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.

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. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or 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.



**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[®]
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
Inpatient Hospital 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 Therapy Services	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.
Professional Health Care Provider Services					
Inpatient, Outpatient & Surgical Services	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 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.
Home & Office Visits	75%	100%	80%	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	75%	100%	80%	100%	For prenatal and postnatal care, deductible is waived and coverage is at 100% (no charge).
Inpatient, Outpatient, Pre & Postnatal Care					
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 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%	
Emergency Services	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%	
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.
Hospice Services	75%	100%	80%	100%	Preauthorization/prior approval is required.
Chiropractic Services					
Home & Office Visits	75%	100%	80%	100%	
Therapy & Manipulations	75%	100%	80%	100%	
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.

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.	
Prescription Medications (Retail and Mail Order)			A Member must meet the Annual Deductible before Coinsurance Amounts will apply to prescription medications. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications.
Formulary and Diabetes Supplies	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.
Nonformulary	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.

Cost Sharing Amounts			
	PPO	Basic	
Single Coverage			
Deductible amount	\$1,500	\$1,500	
Coinsurance maximum	<u>\$1,500</u>	<u>\$2,000</u>	
Out-of-pocket maximum	\$3,000	\$3,500	<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>
Family Coverage			
Deductible amount	\$3,000	\$3,000	
Coinsurance maximum	<u>\$3,000</u>	<u>\$4,000</u>	
Out-of-pocket maximum	\$6,000	\$7,000	<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.

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

Comparison of PERS to Sanford Small Group Plan

		Small Group Plans		ND Employee Health Plans	
Major Benefit Category	Benefit Subcategories	Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
1). Ambulatory Patient Services	Primary Care Office Visits	X	X	X	X
	Specialist Office Visits	X	X	X	X
	Acupressure	NC	NC	NC	NC
	Acupuncture	NC	NC	NC	NC
	Allergy Services	X	X	X	X
	Biofeedback	NC	X	X	X
	Chemotherapy	X	X	X	X
	Chiropractor Services	X	X	X	X
	Preventive dental services (exams, cleaning)	NC	NC	NC	NC
	Basic dental services (fillings, periodontal disease, etc.)	NC	NC	NC	NC
	Dental Services Related to Accident	X	X	X	X
	Oral Surgery – removal of impacted teeth	NC	NC	NC	NC
	Oral Surgery for Cleft Lip/Palate	X	X	X	X
	Orthognathic Surgery (correcting deformities of the jaw)	X	X	X	X
	Diagnostic Services	X	X	X	X
	Hearing Exams	X	X	X	X
	Home Health Care	X	X	X	X
	Home Infusion Therapy	X	X	X	X
	Hospice	X	X	X	X
	Infertility	NC	X	X	X
	Artificial insemination	NC	X	X	X
	Donor eggs, sperm	NC	NC	NC	NC
	In vitro fertilization	NC	X	X	X
	Services to diagnose infertility	X	X	X	X
	Services to treat underlying cause of infertility	NC	X	X	X
	Preimplantation genetic diagnosis testing	NC	NC	NC	NC
	Surrogacy	NC	NC	NC	NC
	Nutritional Supplements (other than to sustain life)	NC	NC	NC	NC
	Outpatient Infusion Therapy	X	X	X	X
	Outpatient Surgery	X	X	X	X
	Radiation Therapy	X	X	X	X

Comparison of Plans to Standard Group Plan

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
	Reconstructive/Restorative Surgery (non-cosmetic)	X	X	X	X
	Renal Dialysis	X	X	X	X
	Second opinion (surgery)	X	X	X	X
	Sterilization - Voluntary				
	Men	X	X	X	X
	Women	X	X	X	X
	Reversal of Sterilization	NC	NC	NC	NC
	Treatment of Temporomandibular Joint (TMJ) & Craniomandibular Disorders - #6	X	X	X	X
	Urgent Care Services	X	X	X	X
	Vision Services (Adult)				
	Routine Eye Exams	NC	NC	NC	NC
	Eyeglasses or contact lenses	NC	NC	NC	NC
	Eyeglasses or contact lenses following a covered cataract surgery	NC	X	X	X
	Refractive Eye surgery (e.g. Lasik)	NC	NC	NC	NC
	Nutritional Counseling				
	Anorexia	X	X	X	X
	Bulimia	X	X	X	X
	Chronic Renal Failure	X	X	X	X
	Diabetes	X	X	X	X
	Gestational Diabetes	X	X	X	X
	Hyperlipidemia	X	X	X	X
	Hypertension	X	NC	X	X
	Obesity	X	X	X	X
	Phenylketonuria (PKU)	X	X	X	X

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
2). Emergency Services	Physician Charges	X	X	X	X
	Facility Charges (Room, Imaging, Testing and Supplies)	X	X	X	X
	Ambulance				
	Ground	X	X	X	X
	Air	X	X	X	X

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
3). Hospitalization	Inpatient Hospital (includes anesthesia, bed, board, general nursing, diagnostic services and surgery)	X	X	X	X
	Inpatient Medical	X	X	X	X
	Bariatric/Obesity Surgery	X	X	X	X
	Medical services related to suicide	X	X	X	X
	Medical services related to intoxication	X	X	X	X
	Reconstructive Breast Surgery - #11	X	X	X	X
	Private Duty Nursing	X	X	X	X
	Skilled Nursing	X	X	X	X
	Organ Transplants				
	Surgery	X	X	X	X
	Delivery of donor organ	X	X	X	X
	Removal of donor organ	X	X	X	X
	Transportation of recipient	X	X	X	X
	Lodging	X	NC	NC	NC

Major Benefit Category	Benefit Subcategories	Small Group Plans	Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
4). Maternity & Newborn Care	Medically necessary abortion	X	X	X	X
	Elective abortion	NC	NC	NC	NC
	Birthing centers	X*	X	X	X
	Delivery by Mid-wife in home	NC	NC	NC	NC
	Circumcision	X	X	X	X
	Complications of pregnancy - #5	X	X	X	X
	Delivery	X	X	X	X
	Post-delivery (mothers & newborn) - #9	X	X	X	X
	Neonatal Intensive Care	X	X	X	X
	Newborn Child Coverage -	X	X	X	X
	Normal pregnancy, newborn nursery & care	X	X	X	X
	Post Partum Care	X	X	X	X
	Prenatal Care	X	X	X	X
	Contraceptives				
	Implanted	X	NC	X	X
	Injectable	X	NC	X	X
Oral	X	NC	X	X	

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO	NDPERS NGF	NDPERS HDHP
5). Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Inpatient Mental Health - #3	X	X	X	X
	Outpatient Mental Health - #3	X	X	X	X
	Inpatient Substance Abuse - #2	X	X	X	X
	Outpatient Substance Abuse - #2	X	X	X	X
	Partial Day Hospitalization - #2,#3	X	X	X	X
	Residential Treatment - #3	X	X	X	X
	Supervised Living	NC	NC	NC	NC
	Applied Behavior Analysis	NC	NC	NC	NC
	Group therapy	X	X	X	X
	Learning Disorders/Behav.Issues	NC	NC	NC	NC
	Psychiatric services	X	X	X	X
	Psychological Testing	X	X	X	X
	Detoxification	X*	X	X	X
	Autism Services				
	Habilitative Therapies	X	X	X	X
	Rehabilitative Therapies	X	NC	NC	NC

* Covered if conducted in contracted facility

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
6). Prescription Drugs - #1	Generic Drugs	X	X	X	X
	Preferred Brand Drugs	X	X	X	X
	Non-Preferred Brand Drugs	X	X	X	X
	Specialty Drugs	X	X	X	X
	Off Label Drugs	X	X	X	X
	Growth Hormones	X	X	X	X
	Infertility Drugs	NC	X	X	X
	Medical Foods – PKU - #8	X	X	X	X
	Prenatal Vitamins	X	X	X	X
	Sexual Dysfunction Drugs	NC	X	X	X
	Smoking/Tobacco Cessation Drugs	X	NC	X	X

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
7). Laboratory Services	Diagnostic (Lab, X-ray, Imaging, etc.)	X	X	X	X
	Genetic Testing	X	X	X	X

Major Benefit Category	Benefit Subcategories	Small Group Plans	ND Employee Health Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
8). Rehabilitative & Habilitative Services & Devices	Cardiac Rehabilitation	X	X	X	X
	Habilitation for congenital or birth defect	X	X	X	X
	Rehab/Habilitation for disability from medical condition	X	X	X	X
	Occupational Therapy due to surgery, injury, or illness	X	X	X	X
	Outpatient Physical Therapy	X	X	X	X
	Pulmonary Rehabilitation	X	X	X	X
	Respiratory Therapy Services	X	X	X	X
	Speech Therapy due to surgery, injury, or illness	X	X	X	X
	Speech Therapy to correct speech impediments	NC	X	X	X
	Medical Equipment & Supplies				
	Breast Prosthesis	X	X	X	X
	Cochlear implants	X	X	X	X
	Diabetes (blood glucose monitors, testing, etc.)	X	X	X	X
	Hearing Aids (less than age 18)	X	X	X	X
	Hearing aids (18 +)	X	NC	NC	NC
	Orthotics & special footwear (medically approp. & necessary)	X	X	X	X
	Ostomy Supplies	X	X	X	X
	Oxygen	X	X	X	X
	Prosthetics	X	X	X	X
	Replacement or repair of DME (durable medical equipment)	X	X	X	X
Wigs & Scalp Prosthetics for hair loss due to chemotherapy	NC	NC	NC	NC	

Major Benefit Category	Benefit Subcategories	Small Gr	Plans		
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
9). Preventive & Wellness Services & Chronic Disease Mgmt	Colorectal Cancer Screening	X	X	X	X
	Diabetic Education	X	X	X	X
	Mammography - # 4	X	X	X	X
	Osteoporosis screening	X	NC	X	X
	Preventive Health Mandated by ACA (immunizations, well child and adult care)	X	X	X	X
	Prostate Specific Antigen (PSA) -#7	X	X	X	X
	Smoking/Tobacco Cessation Services	X	NC	X	X
	Preventive Care for Women (8/1/2012)				
	Minimum one well-woman preventive visit (gynecological exam) annually	X	NC	X	X
	Screening for gestational diabetes between 24 and 28 wks	X	NC	X	X
	Screening for gestational diabetes at 1st prenatal visit at high risk for diabetes	X	NC	X	X
	HPV testing > 29 y/o every 3 years if normal pap	X	NC	X	X
	Annual counseling on sexually transmitted infections for all sexually active women	X	NC	X	X
	Annual screening for HIV for sexually active women	X	NC	X	X
	Contraceptive methods and counseling	X	NC	X	X
	Lactation support and counseling by a trained provider	X	NC	X	X
Rental of Lactation Equipment	X	NC	X	X	
Screening & counseling for interpersonal and domestic violence	X	NC	X	X	

Major Benefit Category	Benefit Subcategories	Small Group Plans and Employee Health Plans			
		Sanford Health Plan	NDPERS PPO GF	NDPERS NGF	NDPERS HDHP NGF
10). Pediatric Services, including oral and vision care	Pediatric Oral Services				
	Preventive dental services (exams, cleaning)	X	NC	NC	NC
	Basic dental services (fillings, periodontal disease, etc.)	X	NC	NC	NC
	Dental Services Related to Accidental Injury	X	X	X	X
	Dental anesthesia and hospitalization for dental care to children under age 9, children who are severely disabled or children who have a medical condition that requires hospitalization or general anesthesia.- #10	X	X	X	X
	Pediatric Vision Care				
	Routine Eye Exams	X	NC	NC	NC
	Eyeglasses or contact lenses	X	NC	NC	NC
	Refraction and glaucoma screening	X	NC	NC	NC
	Dilated eye exam for diabetes related diagnosis	X	X	X	X
	Post-operative refractive examination	X	NC	NC	NC
	Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia	X	X	X	X

Explanation of ND state mandates

1. §26.1-36-06.1 - coverage for off-label uses of prescription drugs cannot be denied if the drug is recognized for the particular treatment in standard medical reference materials or literature
2. §26.1-36-08 - substance abuse coverage (Applies pursuant to Mental Health Parity Act)
3. §26.1-36-09 -mental disorder coverage (Applies pursuant to Mental Health Parity Act)
4. §26.1-36-09.1 - Mammogram examination coverage. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age.
5. §26.1-36-09.2 – coverage for involuntary complications of pregnancy
6. §26.1-36-09.3 – TMJ mandate. FEHBP does not have dollar limits.
7. §26.1-36-09.6 - Annual digital rectal examination and prostate-specific antigen test coverage. Male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer
8. §26.1-36-09.7 - coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease (e.g., maple syrup urine disease or phenylketonuria) (FEHBP does not have a dollar limit).
9. §26.1-36-09.8 - post-delivery coverage for mothers and newborns (e.g., 48 hours following normal vaginal delivery and 96 hours following caesarean section)
10. §26.1-36-09.9 - coverage for anesthesia and hospitalization for dental care for covered individual who is under age nine, is severely disabled or has a medical condition and requires dental anesthesia and hospitalization. FEHBP covers to age 22.
11. §26.1-36-09.11 - breast reconstruction surgery coverage

September 28, 2015

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Dear Sparb:

You asked Deloitte Consulting to prepare a letter explaining the changes that can be made with respect to a grandfathered health plan without causing the plan to lose its grandfathered status under the Affordable Care Act (ACA).

Following is a summary of the relevant rules relating to maintaining grandfathered status under the ACA. It is for general information purposes only, and is not intended as legal or tax advice.

What changes will cause plans to lose grandfathered status?

Before turning to a detailed overview of the changes that will cause a plan to lose grandfathered status, it is important to keep a few key points in mind.

1. All changes are measured against or compared with the terms of the plan in effect on March 23, 2010, the date the ACA was enacted.
2. All changes to the relevant plan terms occurring after March 23, 2010 must be aggregated for purposes of determining if a particular change will result in a loss of grandfathered status.

These are the changes will cause a plan to lose grandfathered status:

Eliminating benefits

A plan will lose its grandfathered status if eliminates all or substantially all benefits to diagnose or treat a particular condition. This includes eliminating benefits for any necessary element to diagnosing or treating a condition.

Example

A grandfathered group health plan stops paying for counseling, a necessary treatment for a covered mental health condition. The change causes the plan to lose its grandfathered status because counseling is an element necessary to treat the covered condition.

Increasing cost-sharing requirements

A plan will lose its grandfathered status if there is any increase to an individual’s coinsurance percentage requirement (or other percentage cost-sharing requirement) measured from March 23, 2010. For example, if the coinsurance percentage is increased from 10% to 20%, even if all other plan parameters remain unchanged (including out-of-pocket limits), the plan will lose its grandfathered status. Other cost-sharing increases may cause a plan to lose grandfathered status if the increase exceeds certain specific thresholds.

- In the case of *fixed-amount cost-sharing requirements other than copayments* – such as deductibles or out-of-pocket maximums – grandfathered status will be lost if the total percentage increase (measured from March 23, 2010) exceeds the “maximum percentage increase” (the increase in the overall medical care component of CPI-U since March 2010, plus 15 percentage points).
- In the case of *copayments*, grandfathered status will be lost if the total increase in the copayment (measured from March 23, 2010) exceeds the greater of \$5 (increased by medical inflation) or the “maximum percentage increase.”

The following table provides the maximum permitted increases to various cost-sharing requirements as of August 2015,¹ the most recent month for which the relevant CPI-U data are available.

<i>Maximum permitted increase to...</i>	<i>Is ...</i>
Coinsurance Percentage Requirements	0
Deductibles, Out-of-Pocket Maximum, and Other Fixed Amount Cost-Sharing Requirements (Other Than Copayments)	15.34% + 15% = 30.34%
Copayments	The greater of (15.34% + 15% =) 30.34% or \$5 x 1.1534 =) \$5.77

Example

Effective August 1, 2015, a grandfathered health plan increases its copayment for specialist office visits to \$45. The copayment on March 23, 2010 was \$30. Assuming the maximum percentage increase for copayments as of August 2015 is 30.34%, the 50% increase in the copayment requirement will cause the plan to lose its grandfathered status.

Decreasing employer premium contributions

A plan will lose its grandfathered status if –

¹ To the extent the thresholds are tied to medical inflation, the threshold in effect at a given time will depend on the most recent overall medical care component of CPI-U, which is updated monthly.

- The employer's contribution is based on the cost of coverage, and the employer decreases its contribution rate for any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period including March 23, 2010.
- The employer's contribution is based on a formula (e.g., hours worked) and the employer decreases its contribution rate for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period including March 23, 2010.

The contribution rate is the employer's contribution compared with the total cost of coverage, expressed as a percentage. (For self-insured plans the total cost of coverage is the plan's "applicable premium" pursuant to COBRA.) Note that the dollar amount of employer and employee contributions may increase as the total cost of coverage increases without changing the employer's contribution rate. However, freezing the dollar amount of employer contributions will lead to a reduction in the employer's contribution rate as the total cost of coverage increases.

Example

The sponsor of a grandfathered group health plan pays 100% of the total cost of self-only and family coverage. In 2014, the cost of self-only coverage is \$5,800 and the cost of family coverage is \$16,350. In 2015, the cost of family coverage increases to \$17,000, but the sponsor decides to make participants pay the additional \$650 per year. As a result, the sponsor's contribution rate drops from 100% in 2014 to $((16,350/17,000) \times 100 =) 96%$ in 2015. This does not result in a loss of grandfathered status because the reduction to the sponsor's contribution rate does not exceed 5 percentage points.

In 2016, the cost of family coverage increases to \$17,500, and the sponsor decides to increase its contribution to \$16,625. The sponsor's contribution rate drops again, this time from 96% in 2015 to $((\$16,625/17,500) \times 100 =) 95%$ in 2016. This does not result in a loss of grandfathered status because the total reduction to the sponsor's contribution rate (measured from March 23, 2010) does not exceed 5 percentage points.

Adding new annual limits or reducing existing ones

A plan will lose its grandfathered status if –

- It did not impose an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010, but subsequently imposes an overall annual limit on the dollar value of benefits.
- It imposed an overall lifetime limit, but no overall annual limit, on the dollar value of benefits on March 23, 2010, and subsequently imposes an overall annual limit at a dollar limit that is below the lifetime limit on March 23, 2010.
- It imposed an overall annual limit on the dollar value of benefits on March 23, 2010, and subsequently decreases the dollar value of the annual limit.

In addition to the potential consequences for grandfathered status, any changes with respect to overall lifetime or annual limits also must comply with the ACA's new restrictions on such limits. No overall

lifetime limits on essential health benefits are permitted for plan years beginning on or after September 23, 2010, and overall annual limits for essential health benefits are banned for plan years beginning on or after January 1, 2014. These restrictions apply to all group health plans, including grandfathered plans.

Anti-Abuse Rules

A plan also can lose grandfathered status pursuant to certain anti-abuse rules. Specifically, these anti-abuse rules provide a group health plan ceases to be a grandfathered health plan if –

- Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan under which the employees were covered on March 23, 2010 (the transferor plan);
- Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfathered status under the Interim Final Regulations; and
- There was no bona fide employment-based reason to transfer the employees into the transferee plan. (Note that, for this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason.)

Notice Requirements for Grandfathered Plans

Note also that, in order to maintain grandfathered status the Plan must disclose that it believes it is a grandfathered health plan and provide contact information for questions and complaints in any materials given to participants and beneficiaries that describe the plan's benefits. The Plan also must maintain sufficient records to verify its status as a grandfathered plan. These records must be available for examination by participants, beneficiaries, and government officials.

We hope this provides you the information you need. Please let me know if you have any questions or would like to discuss any of these issues in more detail.

Best,

Robert Davis
Director
Talent Performance and Rewards

cc: Pat Pechacek