NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Board Meeting Agenda

Location: WSI Board Room, 1600 East Century Avenue, Bismarck ND
By phone: 701.328.0950 Conference ID: 528 414 373#
Date: **Tuesday, June 10, 2025**
Time: 8:30 A.M. **Join the meeting now**

I. MINUTES
A. May 13, 2025

II. CONFLICT OF INTEREST DISCLOSURE CONSIDERATION

III. PRESENTATION
A. Asset Liability Study – RVK (Board Action)

IV. DEFERRED COMPENSATION / DEFINED CONTRIBUTION
A. 457(b) Deferred Compensation Plan IRS Private Letter Ruling – Rebecca (Information)
B. 457(b) Companion Plan and 401(a) DC Plan 1st Quarter 2025 Report – Derrick (Information)
C. 457(b) Deferred Compensation and Companion Plan Documents – Marcy (Board Action)
D. SECURE 2.0 and 457(b) Deferred Compensation Plan Options – Marcy (Board Action)
    1. Roth Catch-up Contributions for High Earners
    2. Super Catch-up Contributions
    3. Self-Certification of Unforeseeable Financial Hardship
    4. Empower List for Roth Programming

V. DEFINED BENEFIT / RETIREE HEALTH INSURANCE CREDIT
A. RHIC & Job Service Asset Allocation – Derrick (Board Action)

VI. GROUP INSURANCE / FLEXCOMP
A. Health Insurance Administrative Services Agreement Exhibits – Katheryne (Board Action)
B. Vision Insurance Plan Contract Amendment – Katheryne (Board Action)
C. Employee Assistance Program (EAP) Update – Katheryne (Information)
D. 2024 Health Insurance Plan Claims Review – Rebecca (Information)

VII. LEGISLATION / ADMINISTRATIVE RULES
A. Legislation Implementation
    1. HB 1113 457 Deferred Compensation Plan Administrative Fees – Derrick (Board Action)
    2. HB 1146 & HB 1419 Retirement Employer Participation Agreements – Marcy & MaryJo (Board Action)
B. Proposed Administrative Rules – Rebecca (Board Action)

VIII. OPERATIONS / ADMINISTRATIVE
A. Audit Committee Minutes – Shawna (Information)

B. Sagitec Maintenance Contract – Derrick (Board Action)
C. Presort Contract – Derrick (Board Action)
D. Office Lease – Derrick (Board Action)
E. UHY External Audit Contract – Derrick (Board Action)
F. Contracts Under $10,000 – Rebecca (Information)
G. Next Meeting Date: July 8, 2025

North Dakota
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Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: Asset Liability Study

Representatives from RVK, Inc. will present the results of the Asset Liability Study for the PERS and RHIC Plans.

BOARD ACTION:

Approve the Asset Liability Study.

Attachment

RVK

Memorandum

To	North Dakota Public Employees Retirement System
From	RVK, Inc.
Subject	Asset/Liability Study – Executive Summary
Date	May 2025

Introduction

The purpose of this memorandum is to summarize the key inferences we draw from the Asset/Liability ("A/L") study of the North Dakota Public Employees Retirement System ("NDPERS" or "System"). While this memorandum refers directly to points raised within the study, we emphasize that a full understanding of the A/L study and its implications requires a close review of the study in its entirety. This study aggregates the following Plans:

- North Dakota Public Employees Retirement System
- North Dakota Highway Patrolmen's Retirement System

Background and Key Conclusions

As of the July 1, 2024, the date of the most recent actuarial valuation and the start date of the projections in this study, the System was approximately 70% funded (on a market value basis). In short, this means that assets were available to cover 70% of the System's liabilities as currently estimated by the System's actuary. This equates to a shortfall of approximately $1.85 billion. This funding ratio falls generally within the range we frequently observe in public pension plans in the U.S., though there are certainly outliers with funded status well below and above this range.

These studies show that the Systems remain firmly solvent throughout the entire study period. By solvent, we mean that the Systems' assets intended to pre-fund accrued and accruing benefit obligations remain fully capable of doing so. While the Systems' funding ratio will certainly fluctuate during this period, our study suggests the potential for reducing the funding gap over the next 20 years, with further reductions beyond our study horizon, likely. Critical to this conclusion is our assumption that the current contribution policy remains in place and long-term investment returns reach levels near those currently assumed.

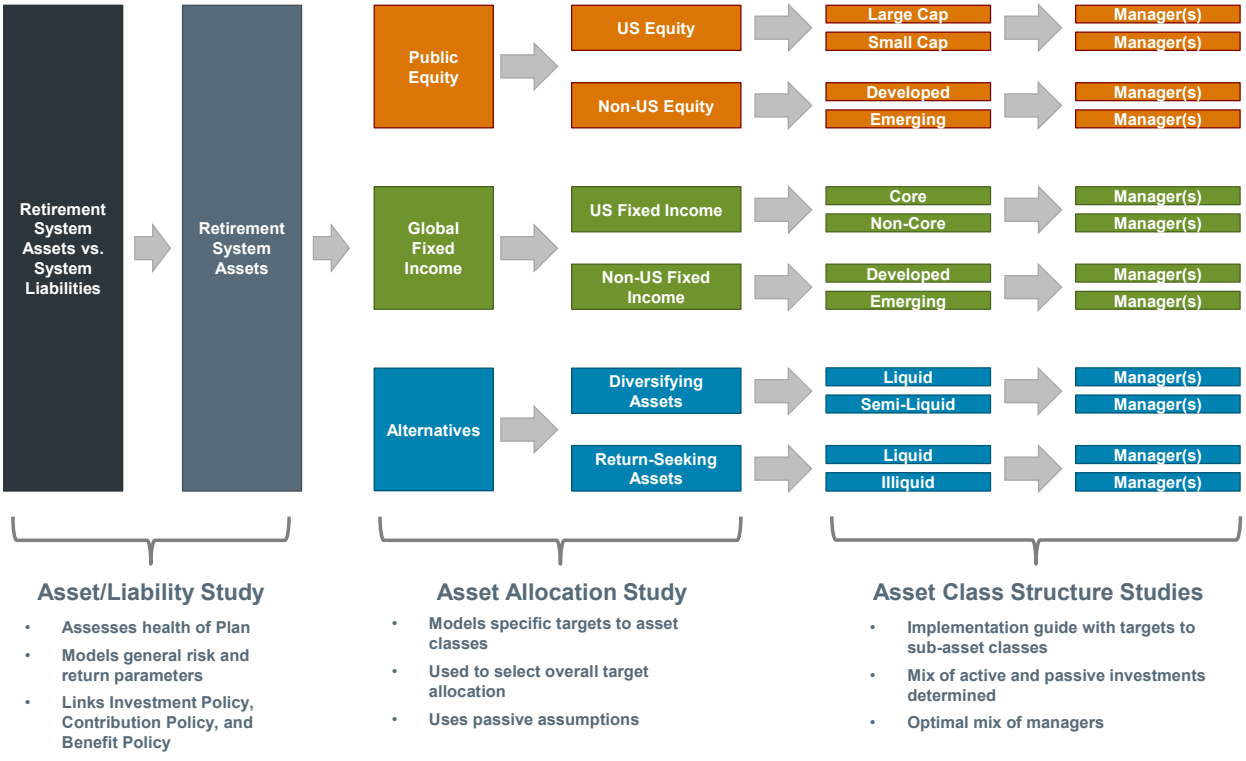
While the System faces a challenging future, as highlighted below, this study suggests that continued diversification in the investment of the System's assets is desirable. The study, however, suggests caution in assuming that increased pursuit of higher expected returns, through even more aggressive (and hence even more volatile) asset allocations, is always beneficial. High expected return and high expected risk approaches also bring increased risk of large declines in the value of the System's assets and increased volatility in required contributions.

The Purpose of an Asset/Liability Study

The central purpose of an A/L study is to examine the probable future consequences, over extended periods of time, of applying alternative asset allocation strategies to the System's investment assets in order to fund the liabilities created by the benefit provisions of the System. A/L studies are unique in their ability to combine in a single analysis the three critical factors that drive the financial health of the System—benefit policy (liabilities), contribution policy, and investment strategy (asset allocation). Certainly, this type of forward-looking study cannot indicate with any reliability what will happen in any given year over this extended period of time, and its insights are dependent on the assumptions used. However, we have high conviction that the results of the study paint a highly reliable view of the core long-term trends in the System's financial health.

Best practice, in our judgment, is to take the general direction suggested as most appropriate by this study with its unique consideration of liabilities, contribution policy, and trending liquidity needs and refine it in an asset allocation study where implementing the System's structure can reflect the pragmatic considerations of investing in the capital markets present at any given point in time.

While this study does not suggest meaningfully modifying the risk profile of the current asset allocation strategy, refinements to asset allocation may be beneficial to the long-term outcomes of the System. Asset allocation and asset class structure will be evaluated as the Board moves through the activities and decision points from left to right in the below investment decision framework.



Deterministic versus Stochastic

In this study, we examined a series of related questions associated with this central purpose, projecting future outcomes under two distinctly different methodologies:

1. a **deterministic** basis (all underlying assumptions, liabilities, contributions, and most critically investment returns, are achieved precisely and without variance in each and every year); and

2. a **stochastic** basis (outcomes for investment returns vary each year according to estimated volatility with contribution *requirements* following suit while *actual* contribution policy and liabilities remain in their current form).

Key Results

Below you will find a series of important findings, forecasts, and conclusions drawn from the body of the study. While the remarks are presented here to allow a quick assessment of some of the key findings, they represent only a sampling of the fundamental elements of the study. We emphasize that a solid understanding of each element requires that they be reviewed as they are presented in the study itself within their surrounding context (please note the frequent page references to the full A/L study). This is especially important to understanding the findings which represent *probable, but not certain*, outcomes as analyzed in the stochastic section of the study.

At the Outset: Before projecting and analyzing possible future paths of the System, it is important to understand the current positioning and circumstances.

- As of July 1, 2024 (the date of the actuarial valuation used to model liabilities), the System's market value funded ratio (available assets to fund benefit obligations) was approximately 70% (page 6).

- The number of active members currently exceeds the number of benefit receiving members by approximately 1.64 to 1.00. The composition of members is expected to change materially over the next 20 years given the Main System is closed to new entrants. We project the number of active members will drop by approximately 75% during the projection period while the number of benefit receiving members increases by about 4%. As the Main System matures, the ratio of active members to benefit receiving members is expected to change to 0.35 to 1.00 over the next 20 years (page 8). This demographic shift is an important factor when considering the findings on System risk/return options and the projected status of the System's liquidity. All else equal, fewer contributing members leads to worsening cash flow profiles potentially limiting opportunities to take advantage of illiquidity premiums.

Deterministic Analysis: A deterministic analysis assumes full certainty about the future, in particular,

certainty of investment returns. Its virtues are that it is simple and that the findings reflect what will happen if the future turns out to be precisely as forecasted—no better, but also no worse.

- Even as the System quickly matures, benefit payments to System participants continue to increase throughout the projection period. We project annual benefit payments will increase by 126% over the next 20 years (page 9). Annual increases are projected to average approximately 4%.

- Annual dollar contributions (employer and employee) based on actuarially required rates are projected to remain relatively constant (increase by 5%) during the projection period (page 10). However, the contributions levels as weighted average of salary are projected to rapidly increase given the Main System is closed. Please note however, that precise actuarially required rates as they unfold are the purview of the System's actuary and are affected by factors other than investment returns and resulting asset values of the System.

- Aggregate benefit payments are expected to increase by about 126% over the next 20 years but remain constant as a percentage of System assets over this same time period (pages 9 and 12). Not only do benefit payments as a percentage of System assets not increase, they are in our judgement also healthy and sustainable on an absolute basis during this period. This is an important and positive indication, because increased payout ratios, if they rise sufficiently high, can potentially impose liquidity constraints on the management of the portfolio. Specifically, high payout ratios can inhibit the ability of the System to invest with a long-term horizon, therefore limiting the opportunity to invest in less liquid asset classes regardless of their potential return or risk reducing diversification benefits. The payout ratio is projected to remain at about 7% for the entire projection period (page 12). These levels do not, in our opinion, materially inhibit investment opportunities for the System. This is an important takeaway from this study. Even though the Main System is closed, it has a significant remaining life meaning investments can continue to take advantage of illiquidity premiums for an extended period of time. However, should the payout ratio begin to rise, or exceed projections, asset liquidity will need to be carefully monitored. RVK considers a payout ratio above 10% as a cause for revaluating alternative asset pacing.

- As assets grow each and every year without exception at the assumed rate of return (6.50%), the funding ratio on a market value basis is expected to gradually increase to approximately 85% by 2044 from the current value of 70% (pages 17-19).

Deterministic Scenario Analysis: One of the key advantages of deterministic analysis is the ability to evaluate scenarios that isolate a particular projection variable. In the context of an A/L study, this allows for insights into how various capital market environments and return profiles change the projected outcomes for the System.

	Value in 2044					
	Baseline	Reduced Return	V	W	Loss then Low	Inflation
Projected Payout Ratio	7%	9%	8%	9%	9%	7%
Projected Employer Contributions (millions)	$244.5	$341.8	$310.9	$352.7	$395.2	$365.2
Projected Benefit Payments/Projected Total Contributions	225%	172%	186%	168%	152%	174%
Projected Actuarial Accrued Liabilities (billions)	$11.2	$11.2	$11.2	$11.2	$11.2	$13.6
Projected Market Value of Assets (billions)	$9.6	$8.2	$8.7	$8.2	$7.5	$10.7
Projected Deficit (billions)	$1.6	$3.0	$2.5	$3.1	$3.7	$2.9
Projected Market Funded Ratio	85%	73%	78%	73%	67%	79%
	20 Year Cumulative Total					
Projected Cumulative Employer Contributions (billions)	$4.2	$4.9	$5.1	$5.6	$5.7	$5.2

- Assuming the current contribution policy remains unchanged, the System would need to experience annual returns in excess of 9.6% over the next 10 years or 7.8% over the next 20 years without exception in each and every year in order to reach full funding (page 18). Many public pension plans require returns well in excess of their assumed rate of return every single year for the next several decades in order to achieve full funding. This can force funds to attempt to reach for return targets that are unrealistic or require taking substantially more risk. The current position of the System allows the Board to consider many more options when making investment decisions when compared to many other public pension funds.

- Experiencing a return of 100 basis points below the System's current assumed rate of return of 6.50% (i.e., 5.50%) each year for the 20-year projection period would result in a significant decline in the projected market funding ratio to 73% in year 20 versus 85% at the current assumed rate of return (page 19). Given the widely shared concerns about the prospects for a low-return environment in the capital markets over the foreseeable future, this is a conclusion that should be thoroughly understood and appreciated. In the event that capital markets do not support returns commensurate with the assumed rate of return, System health may deteriorate quickly. This scenario also shows the payout ratio gradually increasing over the next 20 years. This would need to be closely monitored.

- Investment strategies that introduce increasing volatility in the System's returns over the next 20 years also suggest meaningfully worse outcomes compared to the baseline deterministic projections. Scenarios B and C shown on page 19 of the full A/L study illustrate this point. These scenarios show a decrease in ending projected funded ratios at 78% and 73%, respectively. Scenario B illustrates a V-patterned scenario and assumes a return of -20% in the first projection year and +20% in the second projection year followed by the assumed rate of return thereafter (6.50%). Scenario C projects a W-patterned scenario and assumes a return pattern of -10%, +10%, -10%, +10% followed by the assumed rate of return thereafter (6.50%). The key conclusion from this part of the study is that volatility – specifically declines and subsequent recoveries in the

System's assets – and when they occur can have a significant effect on cumulative contributions.

- Scenario E assumes returns of 6.50% per year, similar to the base case scenario. However, in this scenario, the expected return is met but achieved in an environment where inflation is projected to be 4.00% per year rather than the base projection of 2.50%. This scenario, particularly relevant currently, generates a significantly higher projected actuarial accrued liability, approximately 21% higher than the base case. This scenario shows that inflation also plays a material role in the outcome of the System going forward. Stated more directly, persistently high inflation increases System liabilities and weakens the financial health of the System.

Stochastic Analysis: Unlike a deterministic analysis, a stochastic analysis does not assume an unvarying stream of expected investment returns year after year. Instead, it reflects the realistic view that pension plan investment returns are—like the investment markets themselves—volatile and always uncertain. This means that there are a range of possible outcomes for the System; some are more likely, others less likely, but still possible.

The deterministic approach is useful for gauging the general direction of change and associated consequences, but adding the element of uncertainty—more specifically year to year variability in the performance of the capital markets and the value of the System's assets over time—can offer additional insights, albeit along with considerable complexity.

Uncertainty in future investment returns is taken into account via a stochastic analysis of five different investment approaches (in the table below and on page 24) ranging from highly conservative (low risk, asset protective) to highly aggressive (high return-seeking with substantial associated risk), including the current Target Allocation of the System. The reason for testing such a broad range of approaches is that at the heart of the System's situation is a simple question that is difficult to answer: whether the System is better off following a strategy that:

(A) Falls in the general category of higher prospective return with greater risk (i.e., potential for more widely varying outcomes – good or bad), or
(B) Falls in the general category of lower prospective return with concomitantly lower risk (i.e., a tighter band of likely outcomes).

	100% Fixed Income	Decreased Risk	NEPC Mix 2	Target Allocation	NEPC Mix 1	Increased Risk	100% Equity
Global Equity	0	44	40	51	40	55	100
Private Equity	0	5	10	7	15	10	0
TIPS	0	0	5	0	4	0	0
US Agg Fixed Income	100	25	16	16	12	9	0
High Yield Fixed Income	0	4	3	4	3	4	0
Private Credit	0	4	8	4	8	4	0
Global RE	0	11	11	11	11	11	0
Private Real Assets	0	8	8	8	8	8	0
Total	100	100	100	100	100	100	100
Capital Appreciation	0	59	63	68	68	75	100
Capital Preservation	100	25	16	16	12	9	0
Alpha	0	0	0	0	0	0	0
Inflation	0	16	21	16	20	16	0
Expected Arithmetic Return	**4.50**	**6.56**	**6.81**	**6.84**	**7.07**	**7.10**	**7.09**
Expected Risk (Standard Deviation)	**5.06**	**10.01**	**10.58**	**11.31**	**11.45**	**12.38**	**16.34**
Expected Compound Return	**4.38**	**6.09**	**6.29**	**6.25**	**6.46**	**6.39**	**5.86**
Expected Return (Arithmetic)/Risk Ratio	0.89	0.66	0.64	0.60	0.62	0.57	0.43
RVK Expected Eq Beta (LCUS Eq = 1)	0.09	0.57	0.60	0.65	0.64	0.71	0.98
RVK Liquidity Metric (T-Bills = 100)	85	67	61	66	56	64	90
Allocation to Private Assets	0	28	37	30	42	33	0

Essential to answering this question is to ask precisely how the System and its broader constituencies define what "better off" means. The metrics we use for each to determine whether the System is "better off" under one approach versus another are as follows:

(1) The effect on funding ratio (and thus on contribution rates which decline with higher funding ratios).
(2) The effect on System liquidity (i.e., the System's ability to pay annual benefits without major disruption of its strategic asset allocation, the driver of its investment strategy).
(3) The effect on the trend line and stability of annual contributions.
(4) The risk of large, sudden, and highly disruptive short-term declines in the System's assets over the course of time and the associated effects on contributions and potential investment decisions as well.

The results of this analysis are displayed on pages 26 through 45 of the accompanying A/L study. For purposes of this summary, the consequences of choosing A versus B, as described on the prior page, are summarized most clearly in the tables on pages 29 and 45 of the study (copied below followed by explanatory comments).

20 Years	Probability of Full Funding in 2044	Probability of < 69% (Current) Funding in 2044	Probability of < 50% Funding in 2044	Maximum 1 Year Investment Loss
100% Fixed Income	1%	74%	47%	-7%
Decreased Risk	30%	34%	23%	-23%
NEPC Mix 2	34%	33%	22%	-23%
Target Allocation	35%	34%	24%	-26%
NEPC Mix 1	37%	32%	22%	-26%
Increased Risk	38%	34%	25%	-29%
100% Equity	36%	43%	35%	-38%

20 Years	Market Funded Ratio in Year 20			Cumulative Employer Contributions in Year 20 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 20 Median	Years 1 to 20 Peak	Years 1 to 20 Trough
100% Fixed Income	61%	46%	84%	$5,799	$7,070	$4,118	10%	14%	6%
Decreased Risk	82%	41%	165%	$4,606	$7,297	$1,903	8%	15%	4%
NEPC Mix 2	84%	41%	178%	$4,460	$7,277	$1,827	8%	15%	4%
Target Allocation	84%	38%	191%	$4,499	$7,507	$1,746	8%	17%	3%
NEPC Mix 1	86%	39%	203%	$4,315	$7,437	$1,717	7%	16%	3%
Increased Risk	86%	35%	218%	$4,382	$7,632	$1,646	7%	100%	3%
100% Equity	78%	27%	284%	$4,791	$8,452	$4,382	8%	100%	2%

- The 100% Fixed Income portfolio results in a median expected funding ratio at the end of the 20 year study period that is materially lower than the other portfolios analyzed. Each of the diversified portfolios—including the current Target Allocation—result in expected median funding ratios that are substantially similar to each other at the end of the projection period. This, in our judgement, has two implications. (1) Though highly protective of existing assets, a highly conservative investment strategy is counterproductive, and (2) continued utilization of diversified investment approach remains the best approach.

- None of the diversified portfolios show a significant probability of extreme payout ratios over the next 20 years. Median payout ratios (for all portfolios) are between 7-10%, a level that does not inhibit asset allocation decisions as they relate to illiquid asset classes. Peak payout ratios are in excess of 10%. If investment returns push payout levels to these levels, close attention should be paid to future alternative asset pacing and the overall liquidity profile. High payout ratios severely limit the System's ability to invest in illiquid strategies and may inhibit the System's ability to invest with a long-term focus reducing the potential return opportunities. In short, a heavy reliance on illiquid investments risks could turn even normal asset value declines into disruptive events. Payout ratios of 100% indicate a probability of asset depletion at some point in the projection period. While the probability of this is low, it should be noted as an outcome observed in the models.

- As the expected risk and return of the System are incrementally increased, the outcomes do appear to very marginally improve at the cost of reduced worst-case outcomes. This is a direct

result of significant increases in portfolio volatility associated with diminishing increases in return. The benefits taper off and costs increase though as expected risk increases. This implies the tradeoff for additional upside likely becomes less attractive the more risk is increased. The range or dispersion of potential outcomes—particularly for the market funded ratio and cumulative employer contributions—increases as incremental risk is added to the System. This does not, in our opinion, directly support increasing risk at this time.

Final Comments

Although this A/L study shows that the System currently has a shortfall of approximately $1.85 billion, it also suggests improvements in financial health are possible under the current assumptions. The System can best meet its objectives through the continued use of a well-diversified investment portfolio. However, positive outcomes are extremely dependent on the contribution policy. The incremental cost of additional volatility does not justify the potential increase in median outcomes. Reducing volatility and downside risk, where possible to maintain return, can have a materially positive impact on the long-term health of the System.

The study is not supportive of a long-term, ultra-conservative approach as the protection such a strategy provides to current System assets comes with the heavy cost of considerably higher contributions. Conversely, the increasing potential for large one-year declines suggests that there is likely a limit to the net benefits of adding increased risk in pursuit of additional return.

Progress should be monitored periodically through studies such as these, particularly if the System encounters a sustained period of lower returns in the capital markets (and thus for the System's assets) as well as material changes in contribution policy or benefit levels.

Additionally, this study assumes no further changes are made to the benefit policy at any point during the 20-year projection period. Such changes would fall outside the reach of an Asset/Liability study. However, we do note that even small changes to the benefit policy can have a meaningful long-term impact on the likely future outcomes of the System if they are adopted without a corresponding change in assets or contributions.

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Acknowledgements

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GABRIEL ROEDER SMITH & COMPANY (SYSTEM ACTUARY)

Introduction

RVK, Inc. (RVK) has prepared this report for the North Dakota Public Employees Retirement System (NDPERS) and the North Dakota Highway Patrolmen's Retirement System (Highway Patrolmen) to:

- Present projected valuation results with respect to the funded status of the combined Plans.
- Present projected benefit payments of the combined Plans.
- Investigate asset mixes to determine those which best serve to protect and increase funding levels, while providing adequate liquidity for benefit payments.

The valuation projections are shown using both a deterministic and stochastic process.

The deterministic process provides an closed group analysis (except for the Judges, Public Safety with Prior Main System Service, Public Safety without Prior Main System Service, and Highway Patrolmen's Retirement Systems, which are based on an open group analysis) of projected valuation results based on a fixed set of future assumptions (see summary in the Assumptions and Methods section of this report).

The stochastic process provides an analysis of projected valuation results under many capital market environments based on expected asset returns and inflation, and their expected volatility. Using a Monte Carlo simulation technique, both assets and liabilities are assumed to vary stochastically, linked together by changes in inflation. Expected values, variances of the returns and inflation, and correlations are used to generate 2,000 trials to produce a distribution of potential outcomes. A stochastic analysis can answer questions about the best/worst case outcomes along with the probability of such outcomes.

Introduction (continued)

What is an Asset/Liability Study?

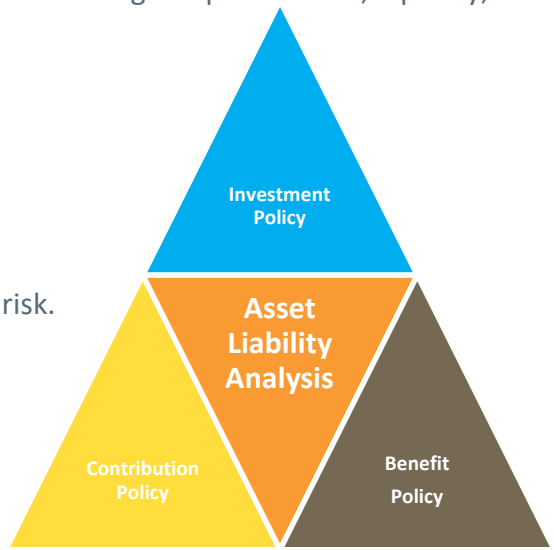
- Investment programs and the strategy they seek to implement (Investment Policy) do not exist in a vacuum. They seek to satisfy one or more investment objectives and operate within a plan framework that includes the investment objectives (Benefit Policy) and plan funding (Contribution Policy).

- The purpose of an Asset/Liability Study is to examine how well alternative investment strategies (i.e., differing asset allocations) address the objectives served by the Plan—the Plan's "liabilities" in the context of the Plan's funding streams—the Plan's Contribution Policy. It is the only standard analysis that fully links all three aspects of the Plan's key financial drivers.

- In doing so, it creates an important "guidepost" for the actual asset allocation for the Plan; the asset allocation chosen by the Plan's fiduciaries will likely reflect the nature of the liabilities but also numerous other factors including risk preferences, liquidity, implementation constraints, etc.

- For the NDPERS Asset/Liability Study, we assume the objectives are:

    1. Fund all participants' benefits over time.
    2. Assure sufficient liquidity to pay benefits at all times.
    3. Foster a stable contribution stream consistent with objectives 1 and 2.
    4. Achieve adequate returns without accepting unnecessary or imprudent levels of risk.



An Asset/Liability Study is NOT . . .

- An actuarial study of the NDPERS liabilities—that is the purview of the Plan's actuary.
- A prescription for Plan benefits—that is the purview of the elected representatives.
- An assessment of the affordability of contribution levels—that is the purview of the elected officials and their constituents.
- The sole determinant of the final asset allocation adopted for the Plan—there are a number of factors, including insights from an Asset/Liability Study, which will bear on the optimal asset allocation.

Introduction (continued)

Asset/Liability Studies in Practice . . .

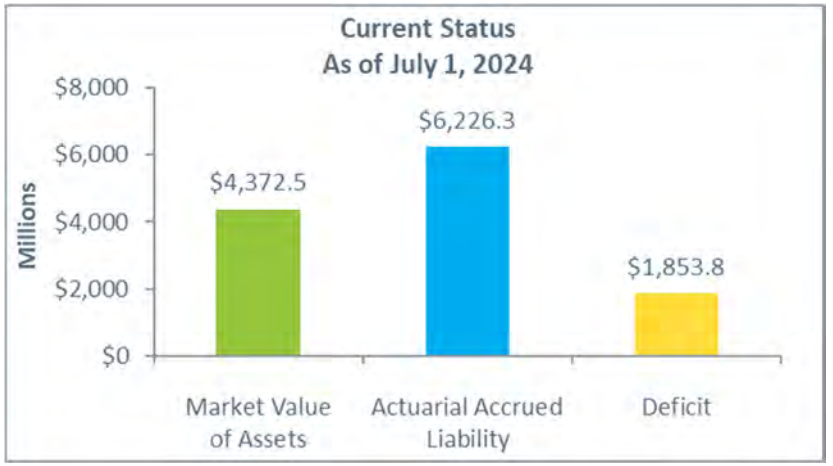
- Begin with a forecast of the financial liabilities (i.e., benefit obligations).
- Include a baseline estimation of the financial contributions to the Plan over time.
- Compare alternative investment strategies (i.e., total fund asset allocations to the Plan's financial needs).
- Draw conclusions regarding how well various investment strategies satisfy the Plan's financial needs.

This Asset/Liability Study . . .

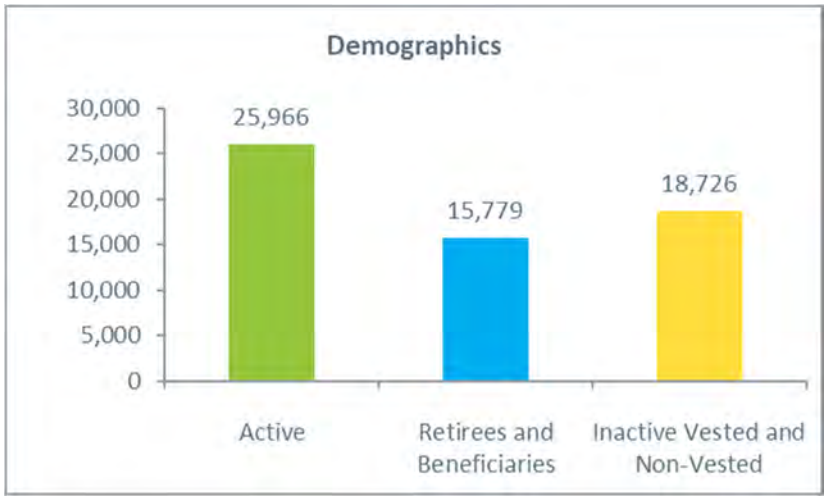
- Uses data from the July 1, 2024 NDPERS and Highway Patrolmen Actuarial Valuations provided by Gabriel Roeder Smith & Company ("GRS") to project pension liabilities.
- Uses the actuarial cost method and the actuarial assumptions described in the July 1, 2024 NDPERS and Highway Patrolmen Actuarial Valuations prepared by GRS, updated with the recommended assumption changes from the 2024 Experience Study prepared by GRS.
- Compares seven specific investment strategies—(as outlined in the Stochastic section of this report).
- Assumes the Plan's current benefit policy throughout the entire projection period—changes to the benefit policy are the purview of the elected representatives.

Current Status

Plan Summary	July 1, 2024 (Valuation Date)
Market Value of Assets	$4,372.5 million
Actuarial Accrued Liability	$6,226.3 million
Deficit	$1,853.8 million
Market Value Funded Ratio	70%



Demographics	Members
Active Members	25,966
Retirees and Beneficiaries	15,779
Inactive Vested and Non-Vested	18,726
Total	60,471



RVK

Deterministic Analysis

This section provides an analysis of the Plans' assets, liabilities, funded status, and benefit payments based on a fixed set of future assumptions. Each analysis that follows in this deterministic section rests on the critical assumptions below and must be read and interpreted with them in mind.

The deterministic assumptions are as follows:

1. Current Plan provisions (see Summary of Plan Provisions in Section F of the July 1, 2024 Actuarial Valuation reports prepared by GRS.)

2. The participant data used in the July 1, 2024 Actuarial Valuation prepared by GRS.

3. Actuarially assumed rate of return of 6.50% on Plan assets.

4. Employer contributions are assumed to follow the Plans' stated funding policies: For Judges, Public Safety and Highway Patrolmen, contributions follow the fixed contribution rates set by statute. For the Main System of PERS, contributions for 2026 and later are determined based on an amortization of the unfunded liability over a closed 30-year period.

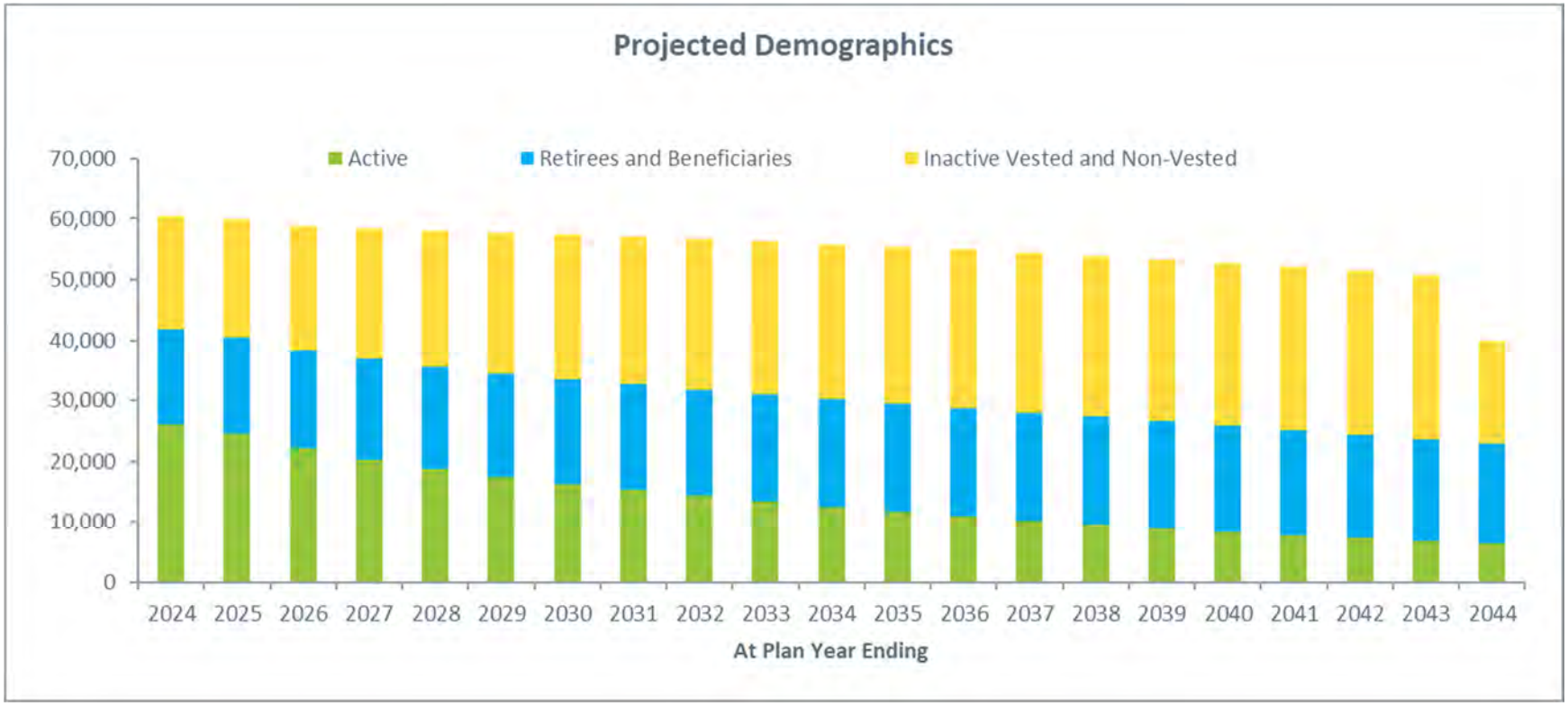
5. Assumes demographic experience projected in accordance with the assumptions used in the July 1, 2024 Actuarial Valuations prepared by GRS, updated with the recommended assumption changes from the 2024 Experience Study prepared by GRS.

6. Closed and Open group analysis: Effective January 1, 2025, the Main System is closed to new participants. For Judges, Public Safety and Highway Patrolmen, the number of active participants is assumed to remain fixed over the projection period. New active participants entering the Plan are assumed to have similar characteristics to recently hired participants.

Deterministic Analysis (continued)

Demographics

Following are the projected number of active and inactive participants at the beginning of each Plan year from 2024 through 2044 (2024 is actual). These projections are based on an open group analysis. Using the actuary's assumptions for death, termination, retirement, and disability, current participants are assumed to leave the Plan in the future. The number of total inactive participants (Retirees and Beneficiaries) increases by approximately 4% during the 20-year projection period shown. The number of total active participants decreases by approximately 75% during the 20-year projection period shown.

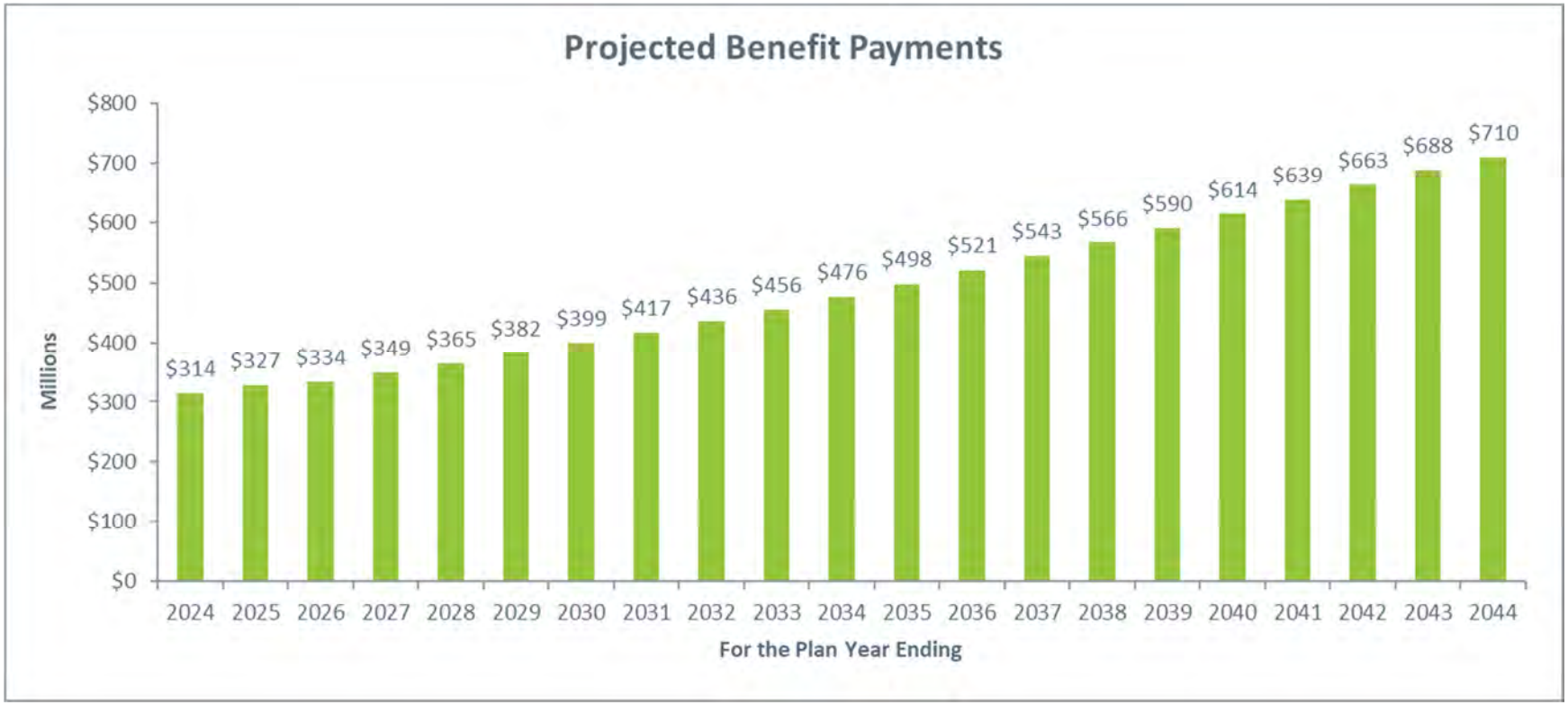


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Total Population																					
Annual Percent Change	N/A	-1%	-2%	-1%	0%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-21%

Deterministic Analysis (continued)

Benefit Payments

The Plan's projected annual benefit payments are shown in the chart below. The projected benefit payments are expected to increase by about 126% over the next 20 years. As a percentage of the market value of Plan assets, benefit payments are expected to fall through the end of the projection period (see page 12).

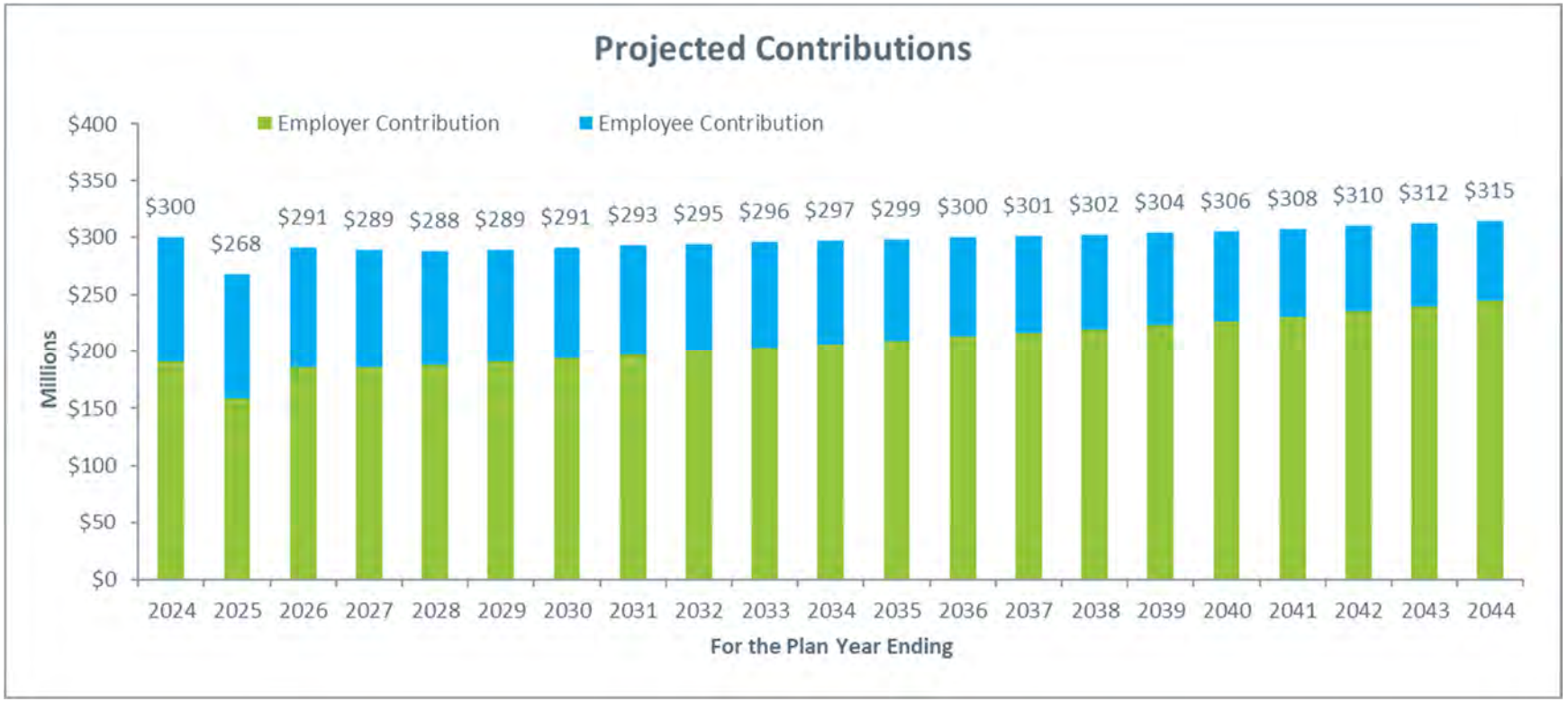


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Annual Percent Change	N/A	4%	2%	4%	5%	5%	5%	4%	5%	5%	5%	5%	5%	4%	4%	4%	4%	4%	4%	4%	3%

Deterministic Analysis (continued)

Contributions

The Plan's projected contributions, expressed as total dollar contributions, are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.

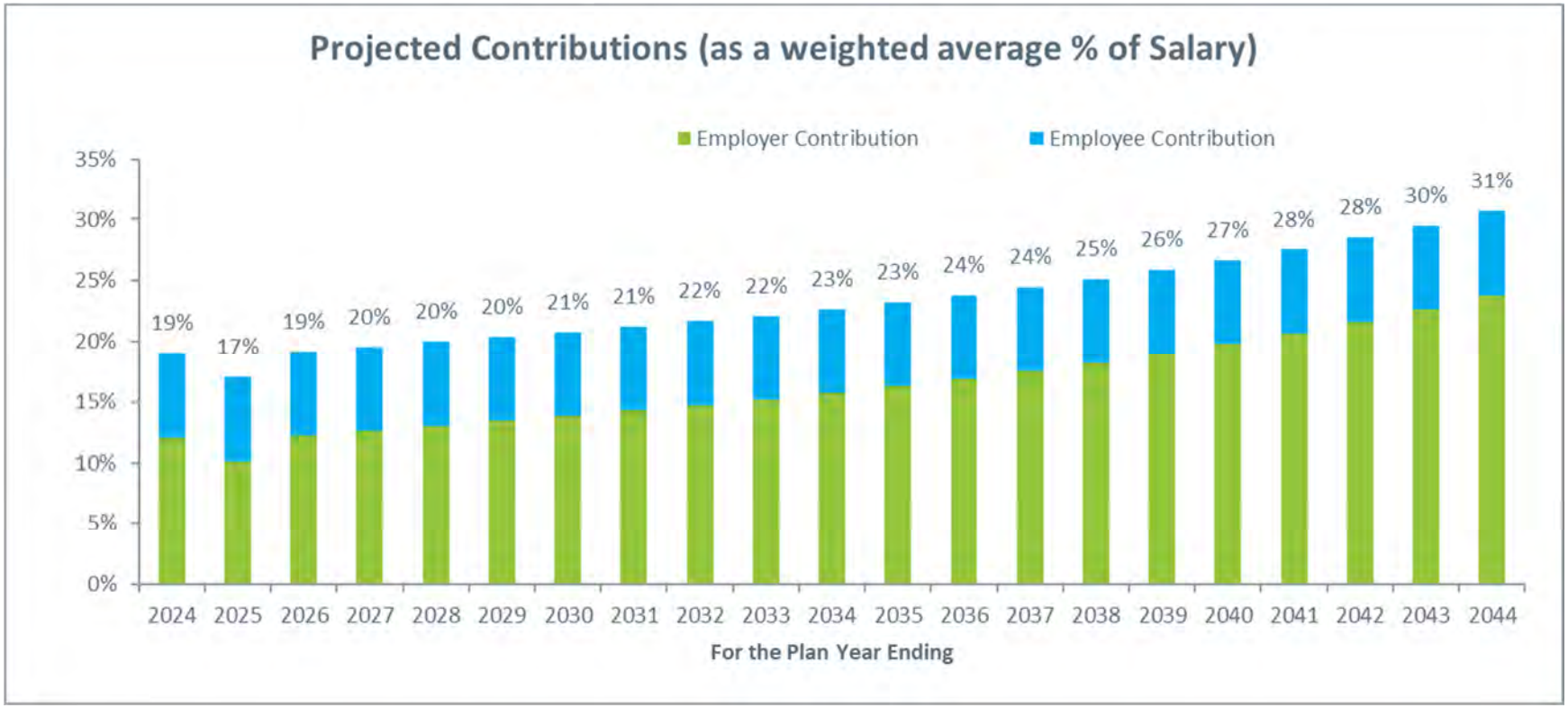


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Annual Percent Change	N/A	-11%	9%	-1%	0%	0%	1%	1%	1%	0%	0%	0%	0%	0%	0%	1%	1%	1%	1%	1%	1%

Deterministic Analysis (continued)

Contributions

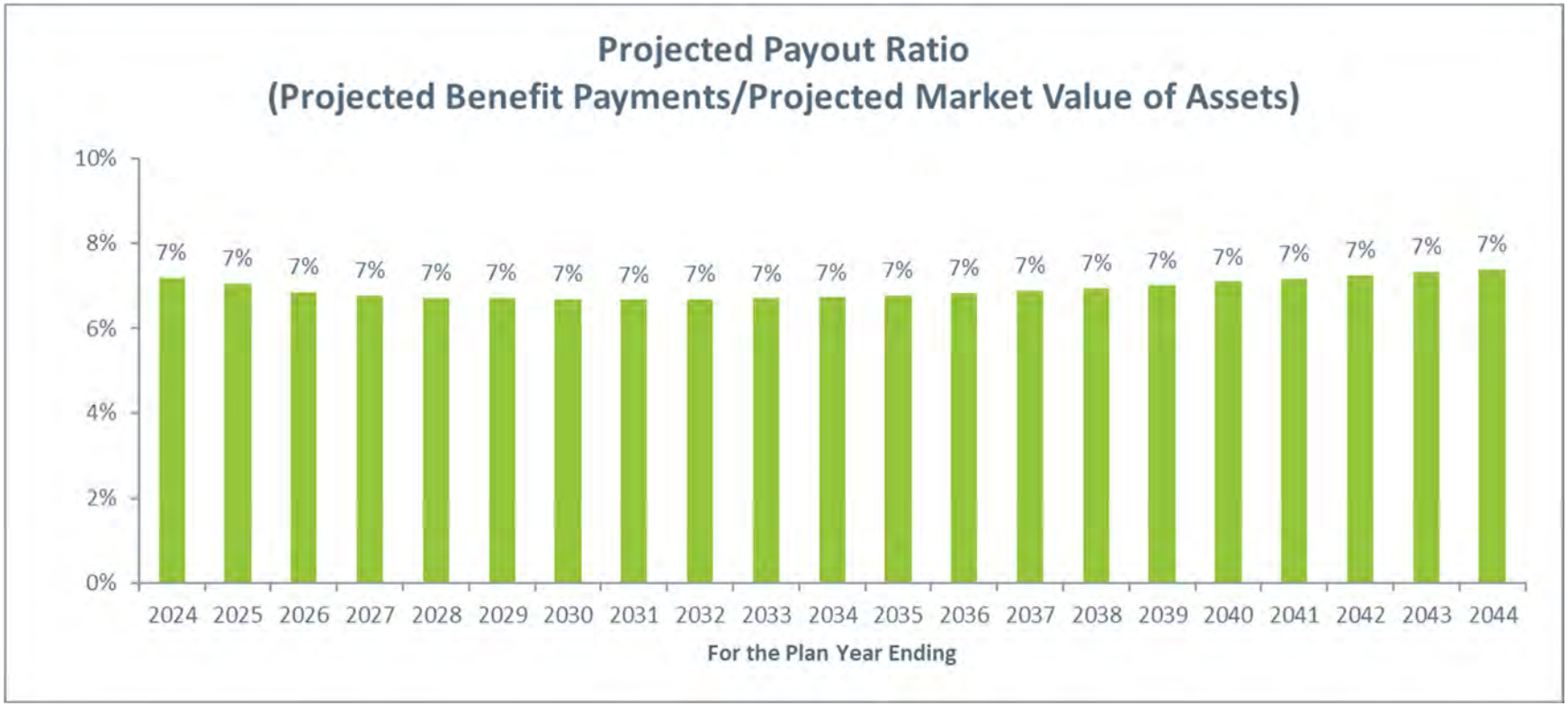
The Plan's projected contributions, expressed as a weighted average percentage of salary, are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Analysis (continued)

Payout Ratio (benefit payments/market value of assets)

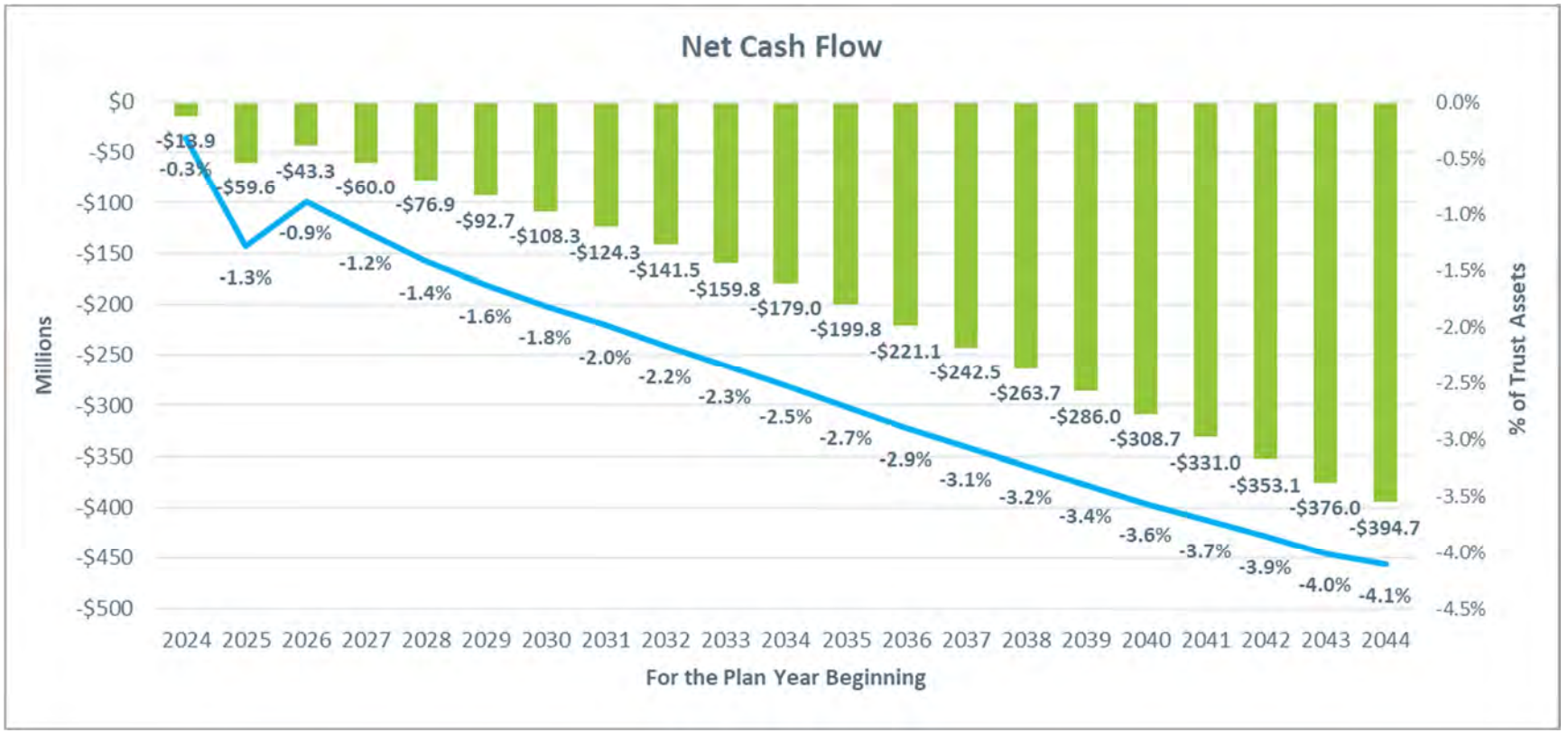
The Plan's projected payout ratios are shown in the chart below. Payout ratio is measured on a "gross" basis defined as benefit payments divided by market values of assets. The payout ratio is expected to gradually fall through the end of the projection period. The results assume the current contribution policy remains unchanged and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Analysis (continued)

Net Cash Flow (Contributions – Benefit Payments)

The Plan's projected net cash flow is shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.

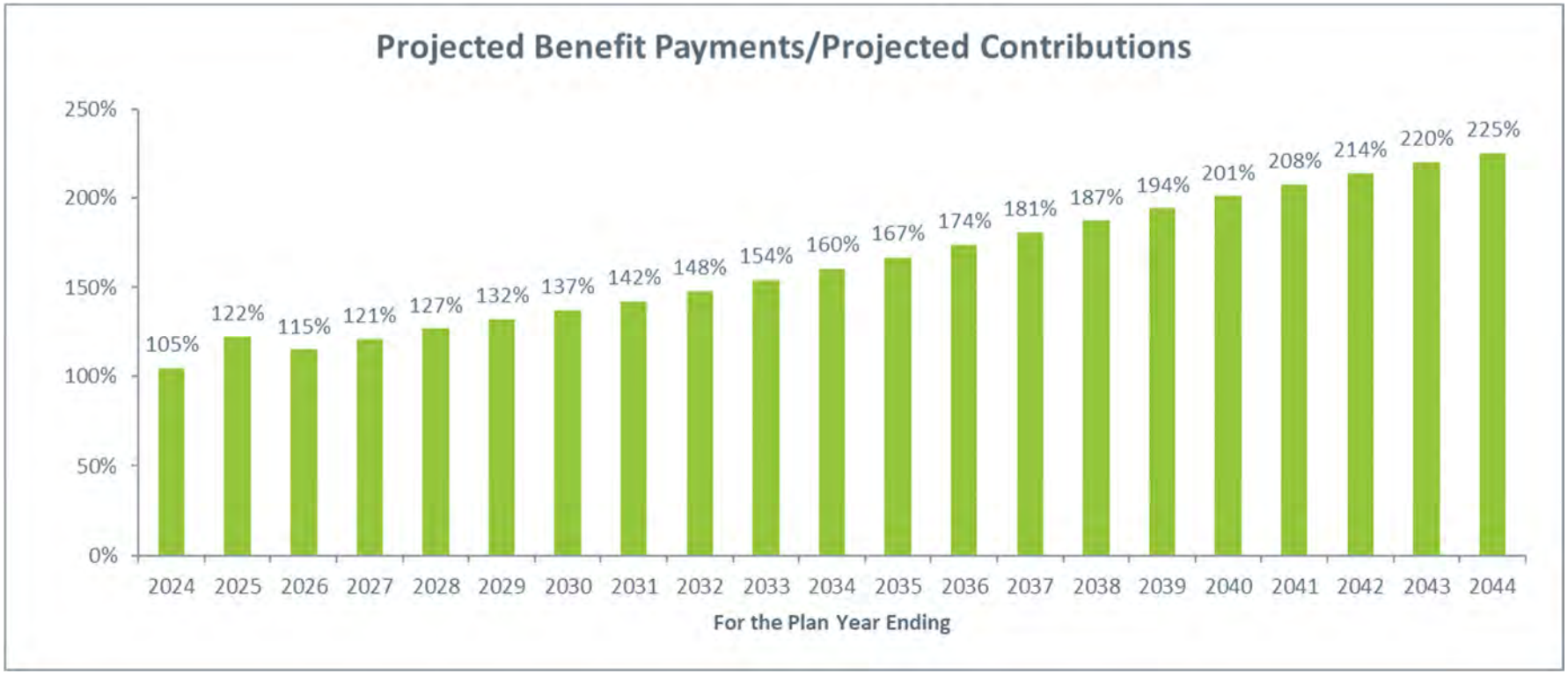


RVK

Deterministic Analysis (continued)

Benefit Payments/Contributions

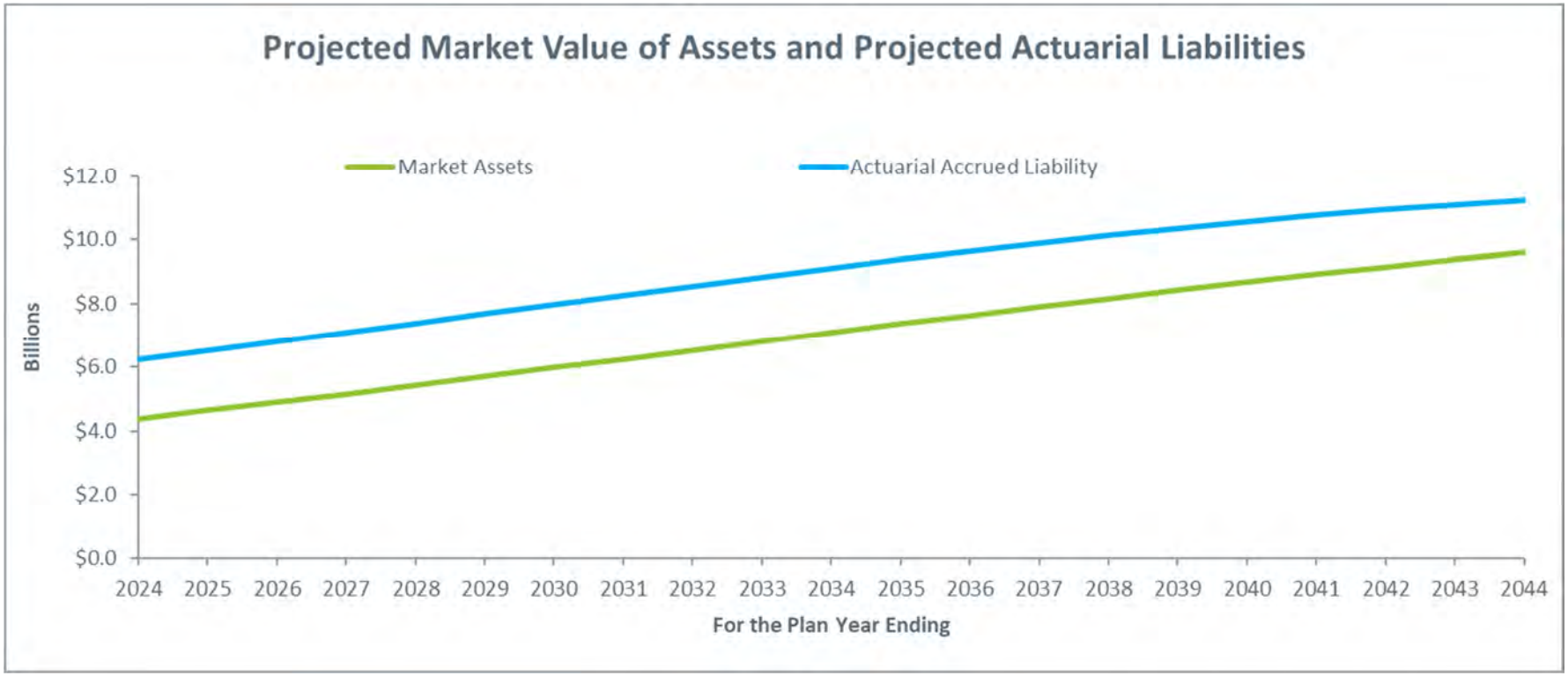
The Plan's projected benefit payments divided by projected contributions are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Analysis (continued)

Actuarial Accrued Liabilities and Market Value of Assets

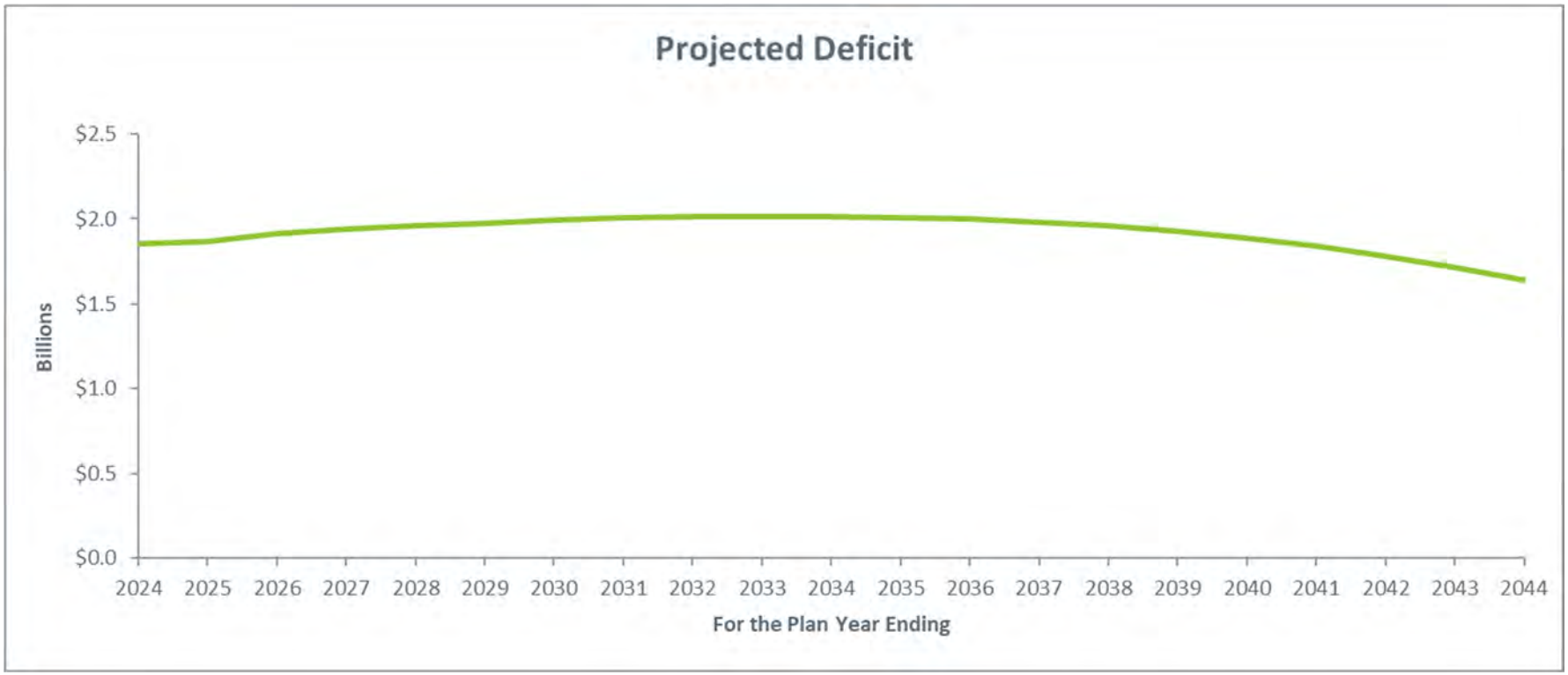
The Plan's projected actuarial accrued liabilities and market value of assets are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years. The relative disparity between the market value of assets and Plan liabilities is expected to remain roughly constant through the projection period. The funded ratio (based on market value of assets) is expected to gradually increase to 85% by the end of the projection period. This is shown more clearly on the following pages.



Deterministic Analysis (continued)

Deficit (market value of assets – actuarial accrued liabilities)

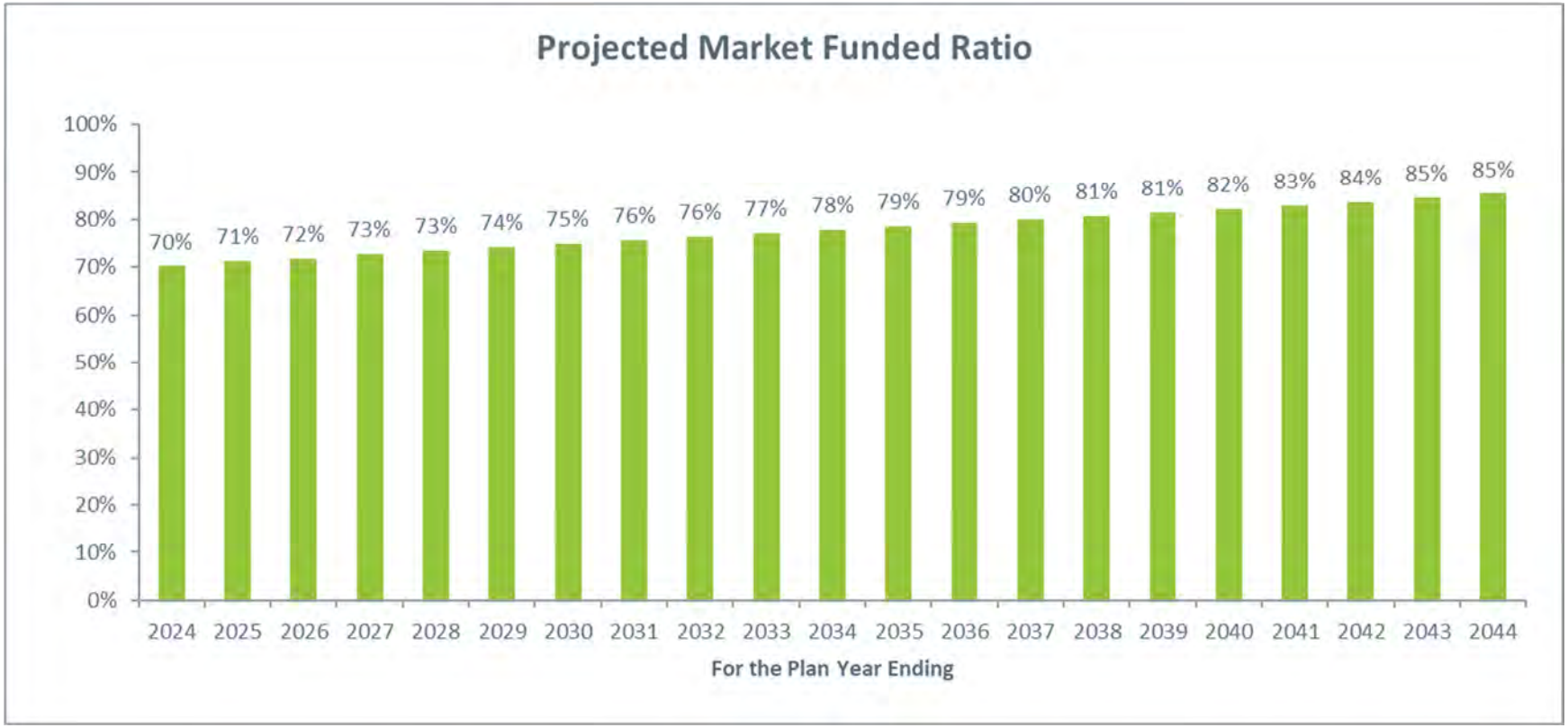
The Plan's projected deficit of assets is shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years. The deficit is expected to remain roughly constant through the projection period.



Deterministic Analysis (continued)

Market Funded Ratio (market value of assets/actuarial accrued liability)

The Plan's projected market funded ratio is shown in the chart below. The Plan is expected to end the projection period at approximately 85% funded. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



RVK

Deterministic Scenario Analysis

Full Funding Implied Returns

The figure below shows the projected investment return for the total fund needed to bring the Plan* to 100% funding (on a market value basis) in 10 and 20 years, respectively. The results assume all other actuarial assumptions are precisely met over the time periods shown and that these returns are earned for every year, without variance.

Actuarially assumed rate of return – **6.50%**

*Projected Investment Return needed to bring the Plan to 100% funding (on a market value basis) shows return needed for the Main Plan only. Forecast excludes the Judges, Public Safety with Prior Main System Service, and Public Safety without Prior Main System Service plans.

Deterministic Scenario Analysis (continued)

Sensitivity Analysis

The table below summarizes the outcomes of the following deterministic scenarios. The Base Case represents the analysis completed in the Deterministic Analysis section of this report and assumes the current actuarially assumed rate of return (6.50%). The results assume all other actuarial assumptions are precisely met over the time periods shown and that these returns are earned for every year, without variance.

A. **Reduced Return** – Assets earn 5.50% each and every year.
B. **V Shaped Market Event** – The V scenario assumes a return of -20% in the first projection year and +20% in the second projection year followed by the assumed rate of return thereafter.
C. **W Shaped Market Event** – The W scenario assumes a return of -10% in the first projection year, +10% in the second, -10% in the third, +10% in the fourth projection year followed by the assumed rate of return thereafter.
D. **Loss then Low** – Immediate 10% loss followed by a lower return environment (5.50%).
E. **Persistent Inflation** – Assets earn the assumed rate of return each and every year but inflation is 4.00% per year during the 20-year projection period.

	Value in 2044					
	Baseline	Reduced Return	V	W	Loss then Low	Inflation
Projected Payout Ratio	7%	9%	8%	9%	9%	7%
Projected Employer Contributions (millions)	$244.5	$341.8	$310.9	$352.7	$395.2	$365.2
Projected Benefit Payments/Projected Total Contributions	225%	172%	186%	168%	152%	174%
Projected Actuarial Accrued Liabilities (billions)	$11.2	$11.2	$11.2	$11.2	$11.2	$13.6
Projected Market Value of Assets (billions)	$9.6	$8.2	$8.7	$8.2	$7.5	$10.7
Projected Deficit (billions)	$1.6	$3.0	$2.5	$3.1	$3.7	$2.9
Projected Market Funded Ratio	85%	73%	78%	73%	67%	79%
	20 Year Cumulative Total					
Projected Cumulative Employer Contributions (billions)	$4.2	$4.9	$5.1	$5.6	$5.7	$5.2

Stochastic Analysis

In the previous section of this report, we assumed the Plan operated going forward with certain knowledge of the future investment returns earned by the Plan's assets. This section introduces the element of uncertainty in those future investment returns. This part of the analysis examines Plan assets and liabilities under many capital market environments based on expected future asset returns and inflation, and their expected volatility. Using a Monte Carlo simulation technique, both assets and liabilities are assumed to vary stochastically, linked together by changes in inflation.

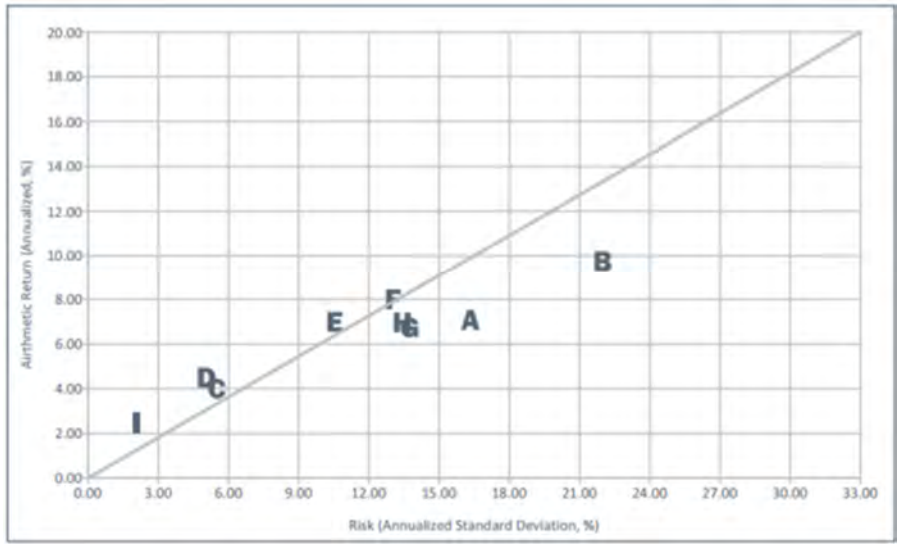
Using the current expected values and variances of the returns and inflation, along with their correlations, 2,000 trials are generated to produce a distribution of results. A stochastic analysis can answer questions about the best/worst case outcomes along with the probability of such outcomes. This is contrasted with the deterministic analysis that provides an expected value if all current Plan assumptions are exactly met.

Stochastic Analysis (continued)

Long-Term Return and Risk Assumptions

In order to perform a stochastic analysis and create asset allocation alternatives, it is necessary to estimate, for each asset class, its probable return and risk. The expected returns are our best estimates of the average annual percentage increases in values of each asset class over a prospective long period of time, and assumed to be normally distributed. The risk of an asset class is measured by its standard deviation, or volatility. If asset returns are normally distributed, two-thirds (67%) of all returns are expected to lie within one standard deviation on either side of the mean. For example, we expect Global Equity to return, annually on average, 7.09% with a standard deviation of 16.34%, meaning that two-thirds of the time we expect its return to lie between -9.25% (= 7.09 – 16.34) and 23.43% (= 7.09 + 16.34). Moreover, we expect 95% of all return outcomes to lie within two standard deviations of the mean return, implying only a one-in-twenty chance that the return on Global Equity will either fall below -25.59% or rise above 39.77%. The risk and return assumptions used in this study are outlined in the below table and chart:

Asset Class	Nominal Return (Arith.)	Standard Deviation
Global Equity	7.09%	16.34%
Private Equity	9.75%	22.00%
TIPS	4.00%	5.50%
US Aggregate Fixed Income	4.50%	5.00%
High Yield	7.00%	10.50%
Private Credit	8.00%	13.00%
Global Real Estate	6.75%	13.74%
Private Real Assets	6.97%	13.42%



Stochastic Analysis (continued)

Correlation Between Asset Classes

Creating a diversified portfolio of asset classes enables the investor to achieve a high rate of return while minimizing volatility of the portfolio. As defined on the previous page, volatility is "risk" or standard deviation. By minimizing the volatility of a portfolio, we produce asset returns that vary less from year to year. Diversification exists because the returns of different asset classes do not always move in the same direction, at the same time, or with the same magnitude. Correlation values are between 1.00 and –1.00. If returns of two asset classes rise or fall at the same time and in the same magnitude, they have a correlation value of 1.00. Conversely, two asset classes that simultaneously move in opposite directions, and in the same magnitude, have a correlation value of –1.00. A correlation of zero indicates no relationship between returns. The assumed correlations are largely based on historical index data, with some qualitative analysis applied. For instance, where appropriate, we have weighted current history more heavily. The correlation matrix used in this study is shown below:

	Global Equity	Private Equity	TIPS	US Agg Fixed Income	High Yield Fixed Income	Private Credit	Global RE	Private Real Assets	Inflation
Global Equity	1.00	0.72	0.38	0.29	0.81	0.85	0.31	0.12	0.02
Private Equity	0.72	1.00	0.22	0.02	0.51	0.73	0.6	0.16	0.00
TIPS	0.38	0.22	1.00	0.77	0.49	0.16	0.19	-0.17	-0.11
US Agg Fixed Income	0.29	0.02	0.77	1.00	0.36	-0.04	0.06	0.01	-0.26
High Yield Fixed Income	0.81	0.51	0.49	0.36	1.00	0.84	0.21	0.02	0.07
Private Credit	0.85	0.73	0.16	-0.04	0.84	1.00	0.19	0.05	0.22
Global RE	0.31	0.60	0.19	0.06	0.21	0.19	1.00	0.53	0.05
Private Real Assets	0.12	0.16	-0.17	0.01	0.02	0.05	0.53	1.00	-0.01
Inflation	0.02	0.00	-0.11	-0.26	0.07	0.22	0.05	-0.01	1.00

The fact that the correlations shown in the table are nearly all positive does not imply that these asset classes do not diversify one another. Their correlations are significantly less than 1.00, meaning we expect a measurable number of instances when the underperformance of one or more of the asset classes will be offset by the outperformance of others. This point is demonstrated on the following pages, which illustrate that diversification into less correlated asset classes can decrease the expected overall volatility of a portfolio.

Stochastic Analysis (continued)

Efficient Portfolios

Each frontier portfolio (optimal allocation) is created using target rates of return both above and below the projected rate of return for the current allocation. This range illustrates the trade-off between return and risk; additional return can only be achieved by undertaking additional risk. The table below shows the possible optimal allocations given the selected asset classes and their constraints listed under "Min" and "Max."

	Min	Max	1	2	3	4	5	6	7	8	9	10
Global Equity	**20**	**60**	35	32	28	25	29	33	36	40	43	60
Private Equity	**0**	**10**	0	3	7	10	10	10	10	10	10	10
TIPS	**0**	**0**	0	0	0	0	0	0	0	0	0	0
US Agg Fixed Income	**10**	**30**	30	30	30	30	26	22	19	15	12	10
High Yield Fixed Income	**0**	**5**	5	5	5	5	5	5	5	5	5	5
Private Credit	**0**	**5**	5	5	5	5	5	5	5	5	5	5
Global RE	**0**	**15**	15	15	15	15	15	15	15	15	15	0
Private Real Assets	**0**	**10**	10	10	10	10	10	10	10	10	10	10
Total			100	100	100	100	100	100	100	100	100	100
Capital Appreciation			49	49	49	49	53	56	60	64	67	80
Capital Preservation			30	30	30	30	26	22	19	15	12	10
Alpha			0	0	0	0	0	0	0	0	0	0
Inflation			21	21	21	21	21	21	21	21	21	10
Expected Arithmetic Return			**6.29**	**6.38**	**6.48**	**6.57**	**6.66**	**6.75**	**6.85**	**6.94**	**7.03**	**7.13**
Expected Risk (Standard Deviation)			**8.53**	**8.58**	**8.67**	**8.84**	**9.31**	**9.79**	**10.27**	**10.77**	**11.27**	**12.85**
Expected Compound Return			**5.95**	**6.04**	**6.13**	**6.21**	**6.26**	**6.30**	**6.36**	**6.40**	**6.44**	**6.37**
Expected Return (Arithmetic)/Risk Ratio			0.74	0.74	0.75	0.74	0.72	0.69	0.67	0.64	0.62	0.55
RVK Expected Eq Beta (LCUS Eq = 1)			0.48	0.47	0.47	0.47	0.50	0.53	0.57	0.60	0.63	0.75
RVK Liquidity Metric (T-Bills = 100)			65	62	59	57	57	57	57	57	57	68
Allocation to Private Assets			30	33	37	40	40	40	40	40	40	25

Stochastic Analysis (continued)

Asset Mixes

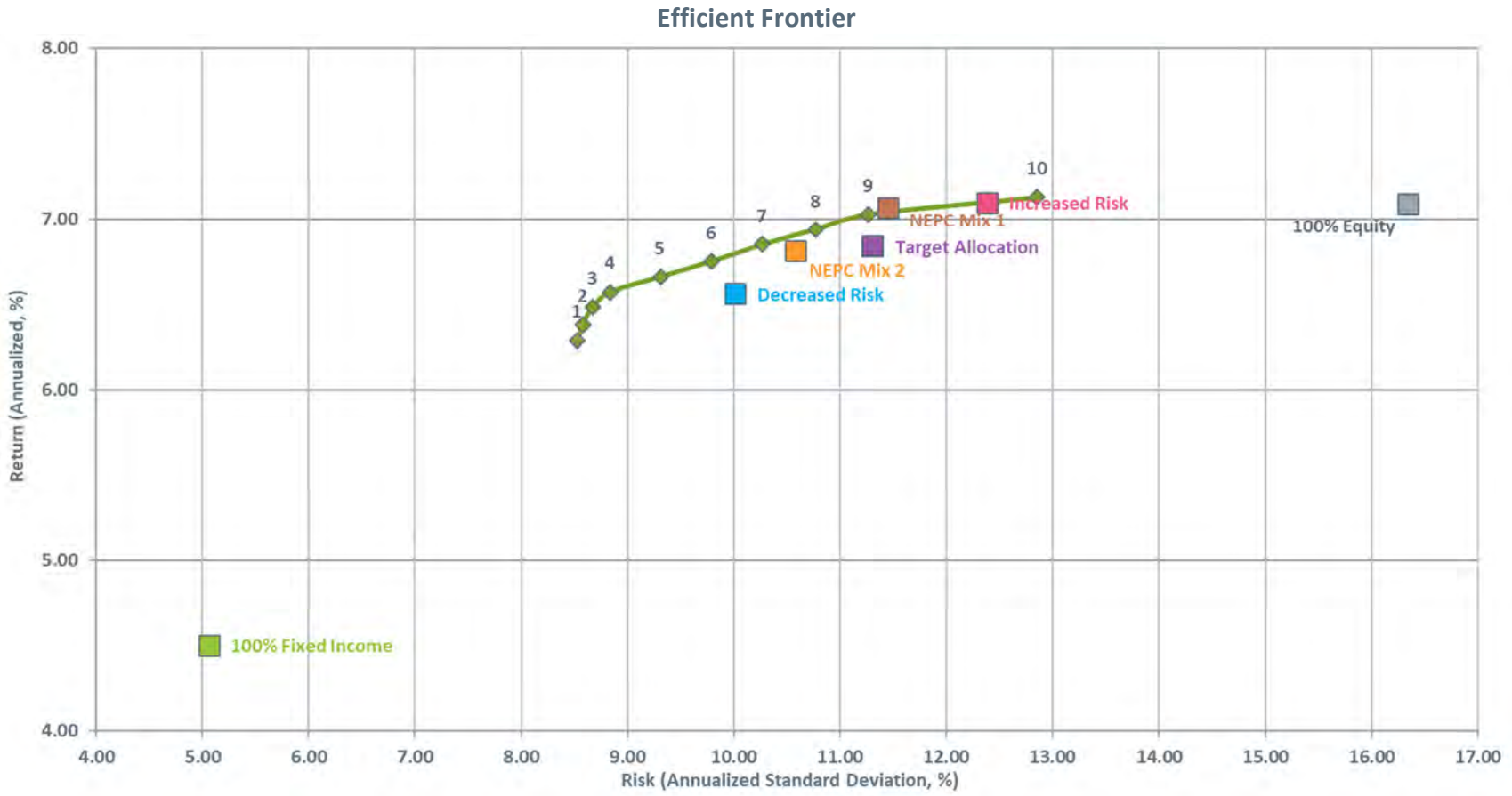
The table shows Target Allocation and highlights seven additional portfolios for consideration throughout this study.

	100% Fixed Income	Decreased Risk	NEPC Mix 2	Target Allocation	NEPC Mix 1	Increased Risk	100% Equity
Global Equity	0	44	40	51	40	55	100
Private Equity	0	5	10	7	15	10	0
TIPS	0	0	5	0	4	0	0
US Agg Fixed Income	100	25	16	16	12	9	0
High Yield Fixed Income	0	4	3	4	3	4	0
Private Credit	0	4	8	4	8	4	0
Global RE	0	11	11	11	11	11	0
Private Real Assets	0	8	8	8	8	8	0
Total	100	100	100	100	100	100	100
Capital Appreciation	0	59	63	68	68	75	100
Capital Preservation	100	25	16	16	12	9	0
Alpha	0	0	0	0	0	0	0
Inflation	0	16	21	16	20	16	0
Expected Arithmetic Return	**4.50**	**6.56**	**6.81**	**6.84**	**7.07**	**7.10**	**7.09**
Expected Risk (Standard Deviation)	**5.06**	**10.01**	**10.58**	**11.31**	**11.45**	**12.38**	**16.34**
Expected Compound Return	**4.38**	**6.09**	**6.29**	**6.25**	**6.46**	**6.39**	**5.86**
Expected Return (Arithmetic)/Risk Ratio	0.89	0.66	0.64	0.60	0.62	0.57	0.43
RVK Expected Eq Beta (LCUS Eq = 1)	0.09	0.57	0.60	0.65	0.64	0.71	0.98
RVK Liquidity Metric (T-Bills = 100)	85	67	61	66	56	64	90
Allocation to Private Assets	0	28	37	30	42	33	0

Stochastic Analysis (continued)

Efficient Frontier

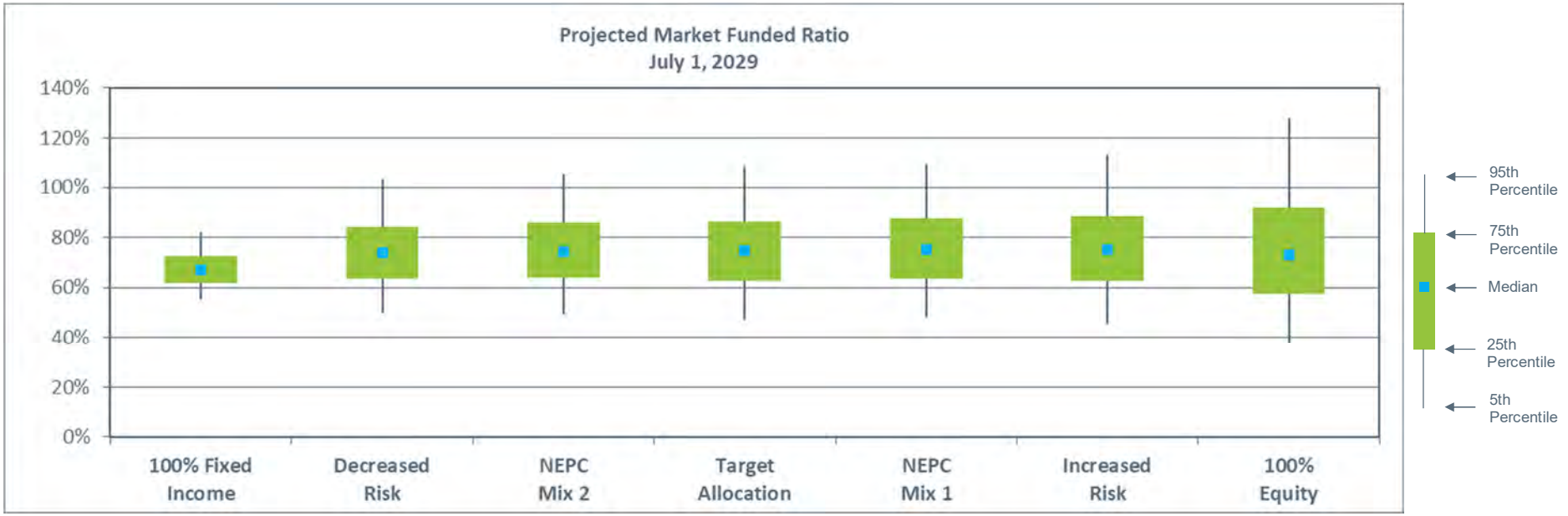
The risk of each alternative allocation is plotted against the horizontal axis, while the return is measured on the vertical axis. The line connecting the points represents all the optimal portfolios subject to the given constraints and is known as the "efficient frontier." The upward slope of the efficient frontier indicates the direct relationship between return and risk.



Stochastic Analysis (continued)

Projected Market Funded Ratio (market value of assets/actuarial accrued liability); **5 Years**

The graph below shows the distribution of possible market funded ratios five years from now, assuming the seven different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.

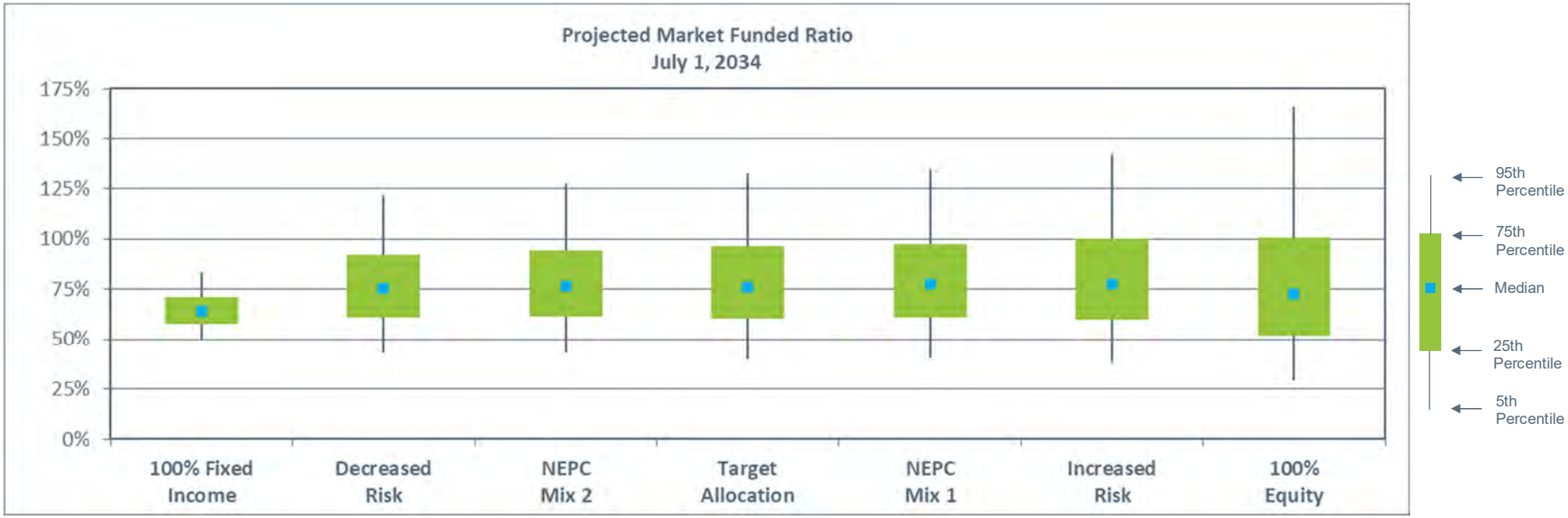


	100% Fixed Income		Decreased Risk		NEPC Mix 2		Target Allocation		NEPC Mix 1		Increased Risk		100% Equity	
	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio
5th Percentile	$3.5	56%	$3.9	50%	$3.9	49%	$4.1	47%	$4.0	48%	$4.2	45%	$4.8	37%
25th Percentile	$2.9	62%	$2.8	64%	$2.8	64%	$2.8	63%	$2.8	63%	$2.9	62%	$3.3	58%
50th Percentile	$2.5	67%	$2.0	74%	$2.0	74%	$2.0	75%	$1.9	75%	$1.9	75%	$2.1	73%
75th Percentile	$2.1	72%	$1.2	84%	$1.1	86%	$1.0	86%	$0.9	88%	$0.9	88%	$0.6	92%
95th Percentile	$1.4	82%	($0.2)	103%	($0.4)	105%	($0.7)	109%	($0.7)	109%	($1.0)	113%	($2.1)	128%

Stochastic Analysis (continued)

Projected Market Funded Ratio (market value of assets/actuarial accrued liability); **10 Years**

The graph below shows the distribution of possible market funded ratios ten years from now, assuming the seven different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.

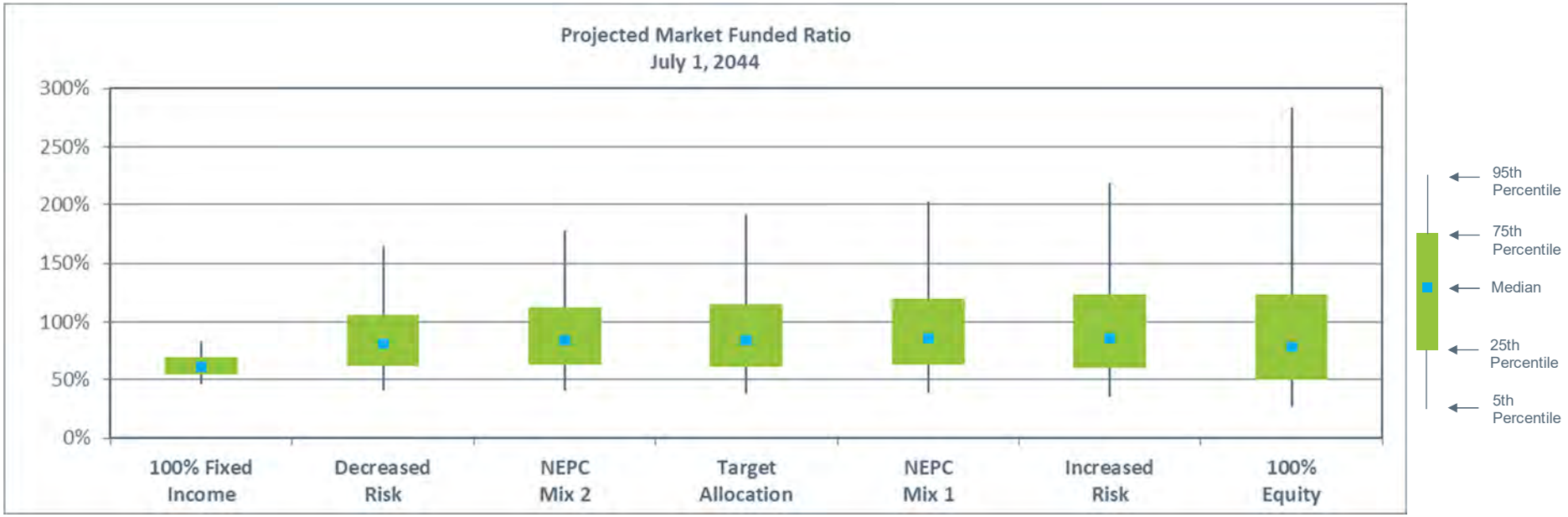


	100% Fixed Income		Decreased Risk		NEPC Mix 2		Target Allocation		NEPC Mix 1		Increased Risk		100% Equity	
	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio
5th Percentile	$4.6	50%	$5.3	43%	$5.3	43%	$5.5	40%	$5.4	41%	$5.7	38%	$6.5	29%
25th Percentile	$3.9	58%	$3.6	61%	$3.5	62%	$3.6	60%	$3.5	61%	$3.7	60%	$4.4	52%
50th Percentile	$3.2	64%	$2.3	75%	$2.1	76%	$2.2	76%	$2.1	78%	$2.1	77%	$2.5	73%
75th Percentile	$2.6	71%	$0.7	92%	$0.5	94%	$0.4	96%	$0.2	97%	$0.0	100%	($0.1)	101%
95th Percentile	$1.5	83%	($2.0)	121%	($2.5)	128%	($2.9)	132%	($3.3)	135%	($3.9)	142%	($6.2)	166%

Stochastic Analysis (continued)

Projected Market Funded Ratio (market value of assets/actuarial accrued liability); **20 Years**

The graph below shows the distribution of possible market funded ratios twenty years from now, assuming the seven different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.



	100% Fixed Income		Decreased Risk		NEPC Mix 2		Target Allocation		NEPC Mix 1		Increased Risk		100% Equity	
	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio	Unfunded Liability (Bil)	Funded Ratio
5th Percentile	$6.3	46%	$6.7	41%	$6.7	41%	$7.0	38%	$6.9	39%	$7.3	35%	$8.4	27%
25th Percentile	$5.2	54%	$4.3	62%	$4.3	63%	$4.4	61%	$4.3	63%	$4.5	60%	$5.6	50%
50th Percentile	$4.4	61%	$2.1	82%	$1.8	84%	$1.8	84%	$1.5	86%	$1.5	86%	$2.4	78%
75th Percentile	$3.4	69%	($0.7)	106%	($1.4)	112%	($1.7)	115%	($2.2)	120%	($2.7)	124%	($2.6)	124%
95th Percentile	$1.7	84%	($7.1)	165%	($8.7)	178%	($10.1)	191%	($11.2)	203%	($12.9)	218%	($20.1)	284%

Stochastic Analysis (continued)

Projected Market Funded Ratio and Maximum 1 Year Investment Loss (market value of assets/actuarial accrued liability)

The tables below show the probability that the Plan will be at various funding levels for each of the seven different asset mixes highlighted on the prior pages. The tables also illustrate the maximum 1 year investment loss each portfolio is expected to experience during the given time period. The results assume the current contribution policy remains unchanged for all projection years.

5 Years	Probability of Full Funding in 2029	Probability of < 70% (Current) Funding in 2029	Probability of < 50% Funding in 2029	Maximum 1 Year Investment Loss
100% Fixed Income	0%	65%	16%	-7%
Decreased Risk	7%	41%	18%	-21%
NEPC Mix 2	8%	40%	18%	-22%
Target Allocation	10%	41%	19%	-25%
NEPC Mix 1	11%	39%	20%	-24%
Increased Risk	12%	40%	21%	-28%
100% Equity	17%	45%	28%	-36%

10 Years	Probability of Full Funding in 2034	Probability of < 70% (Current) Funding in 2034	Probability of < 50% Funding in 2034	Maximum 1 Year Investment Loss
100% Fixed Income	0%	72%	32%	-7%
Decreased Risk	17%	41%	23%	-23%
NEPC Mix 2	19%	39%	23%	-23%
Target Allocation	21%	40%	25%	-26%
NEPC Mix 1	23%	38%	23%	-26%
Increased Risk	25%	39%	26%	-29%
100% Equity	26%	47%	35%	-39%

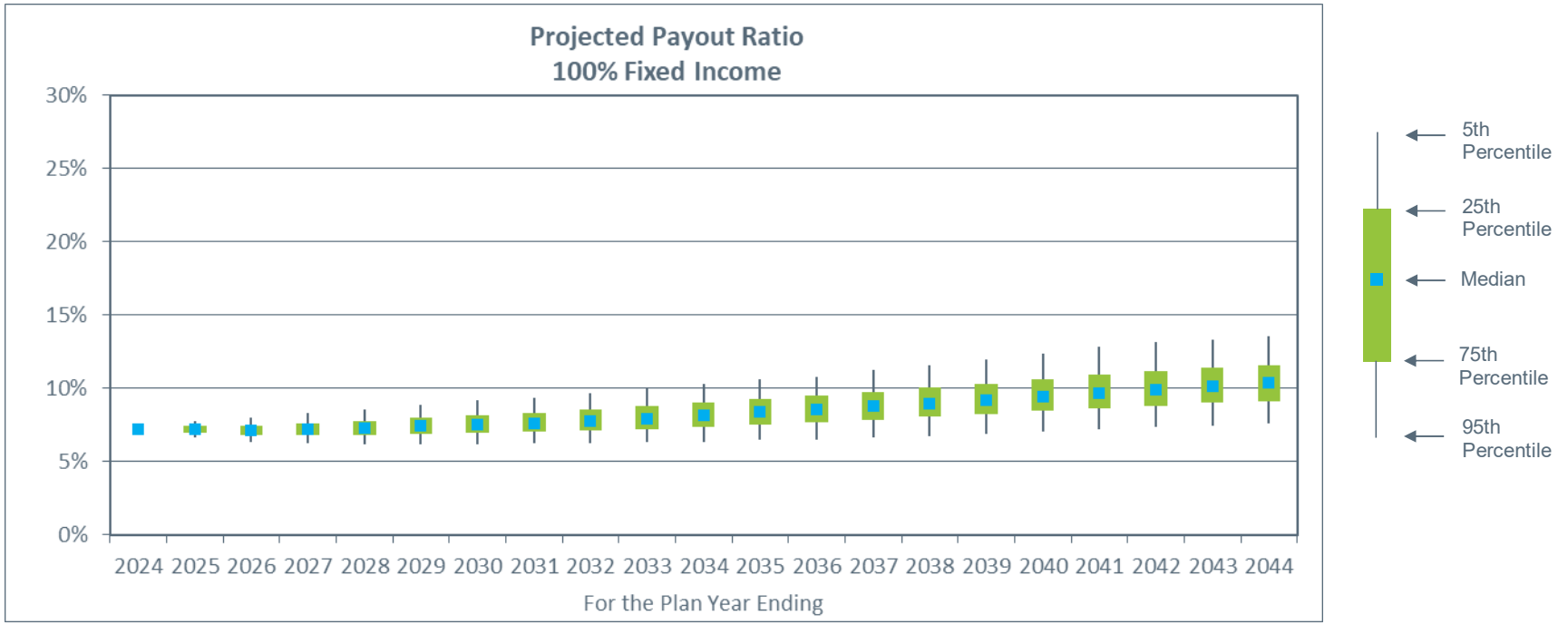
20 Years	Probability of Full Funding in 2044	Probability of < 70% (Current) Funding in 2044	Probability of < 50% Funding in 2044	Maximum 1 Year Investment Loss
100% Fixed Income	1%	77%	47%	-7%
Decreased Risk	30%	35%	23%	-23%
NEPC Mix 2	34%	34%	22%	-23%
Target Allocation	35%	35%	24%	-26%
NEPC Mix 1	37%	33%	22%	-26%
Increased Risk	38%	35%	25%	-29%
100% Equity	36%	43%	35%	-38%

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **100% Fixed Income**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **100% Fixed Income** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 7% and 10%. The worst-case scenario could reach 14% or higher.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	8%	8%	8%	8%	8%	8%	9%	9%	9%	9%	9%	10%	10%	10%	10%

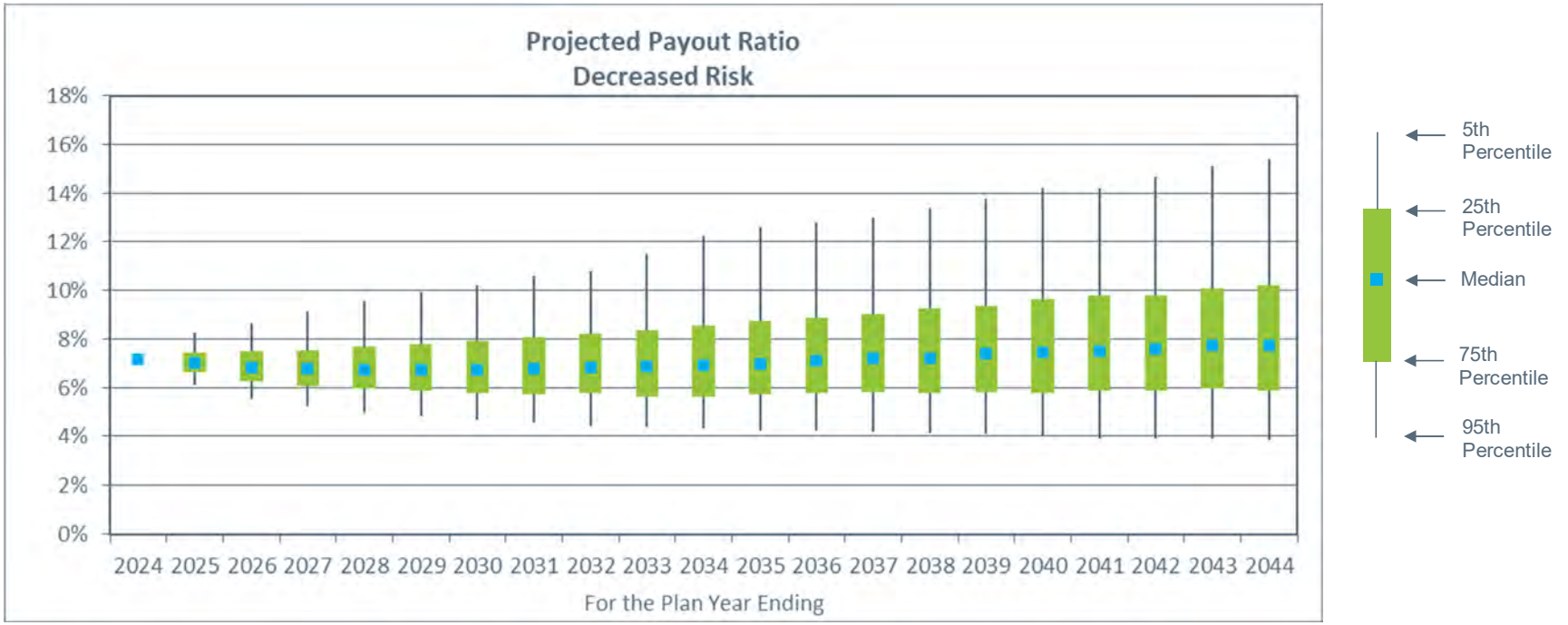
RVK

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **Decreased Risk**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **Decreased Risk** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 7% and 8%. The worst-case scenario could reach 15% or higher.



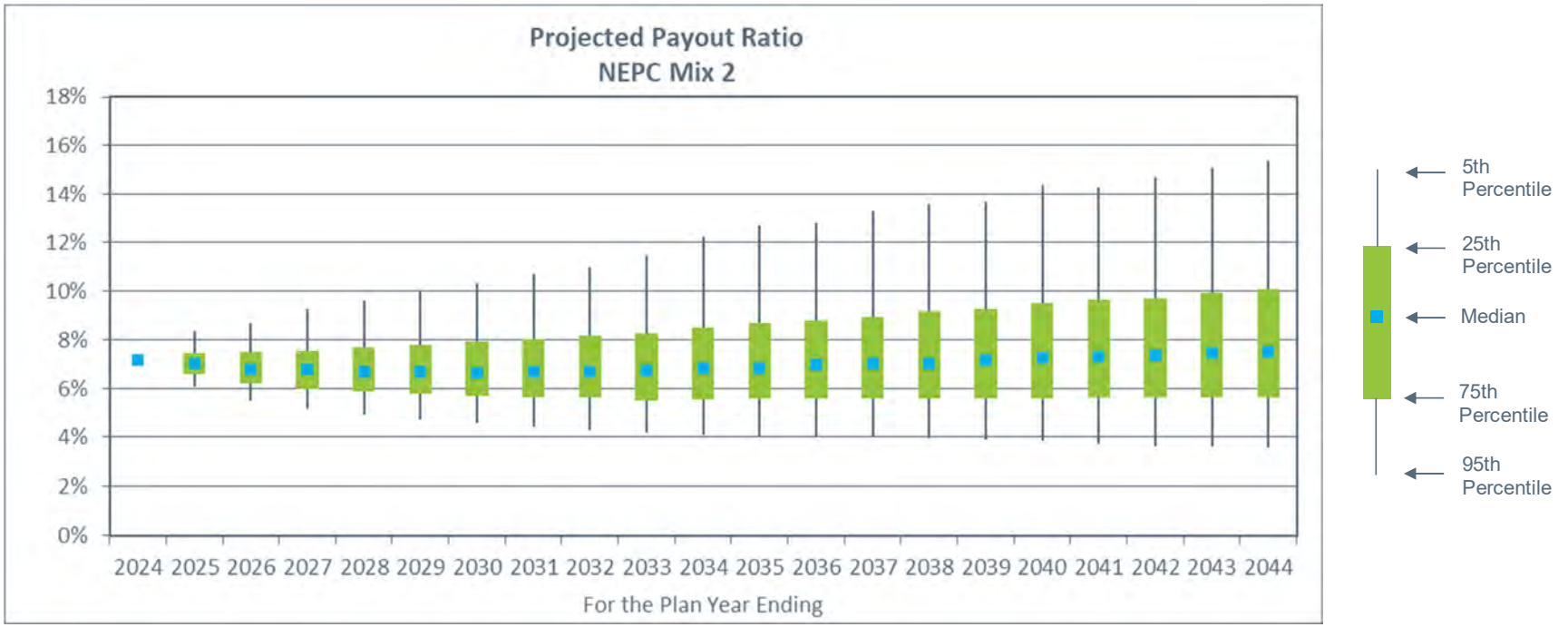
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	8%	8%	8%	8%

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **NEPC Mix 2**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **NEPC Mix 2** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 7% and 8%. The worst-case scenario could reach 15% or higher.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	8%

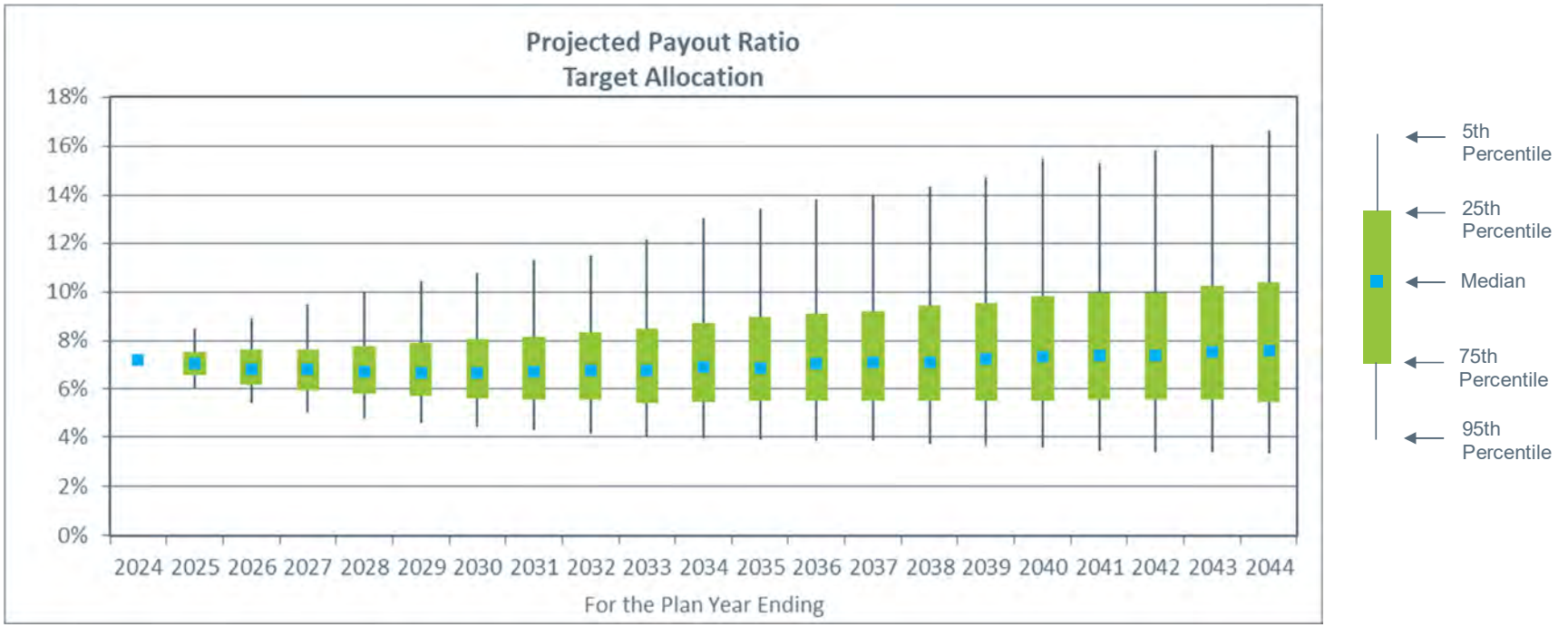
RVK

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **Target Allocation**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **Target Allocation**. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 7% and 8%. The worst-case scenario could reach 17% or higher.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	8%	8%

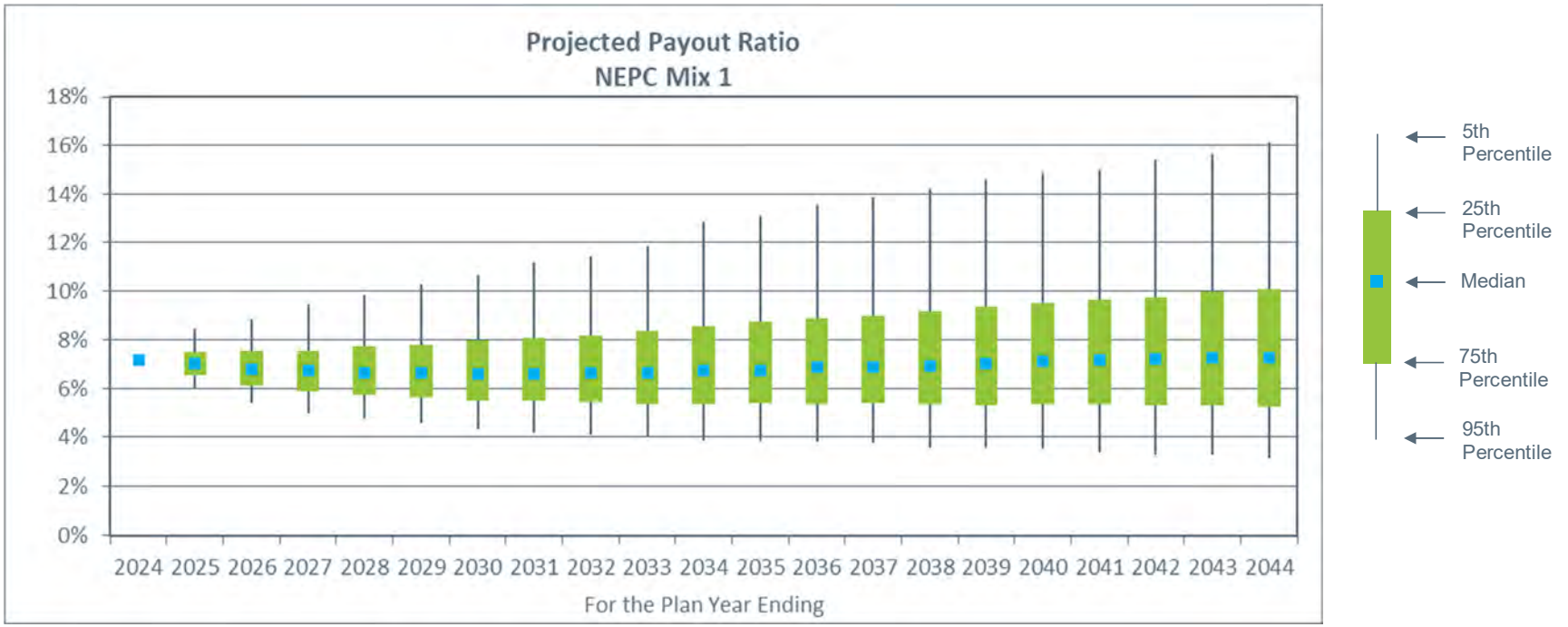
RVK

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **NEPC Mix 1**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **NEPC Mix 1** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to be approximately 7% across the 20-year period shown. The worst-case scenario could reach 16% or higher.



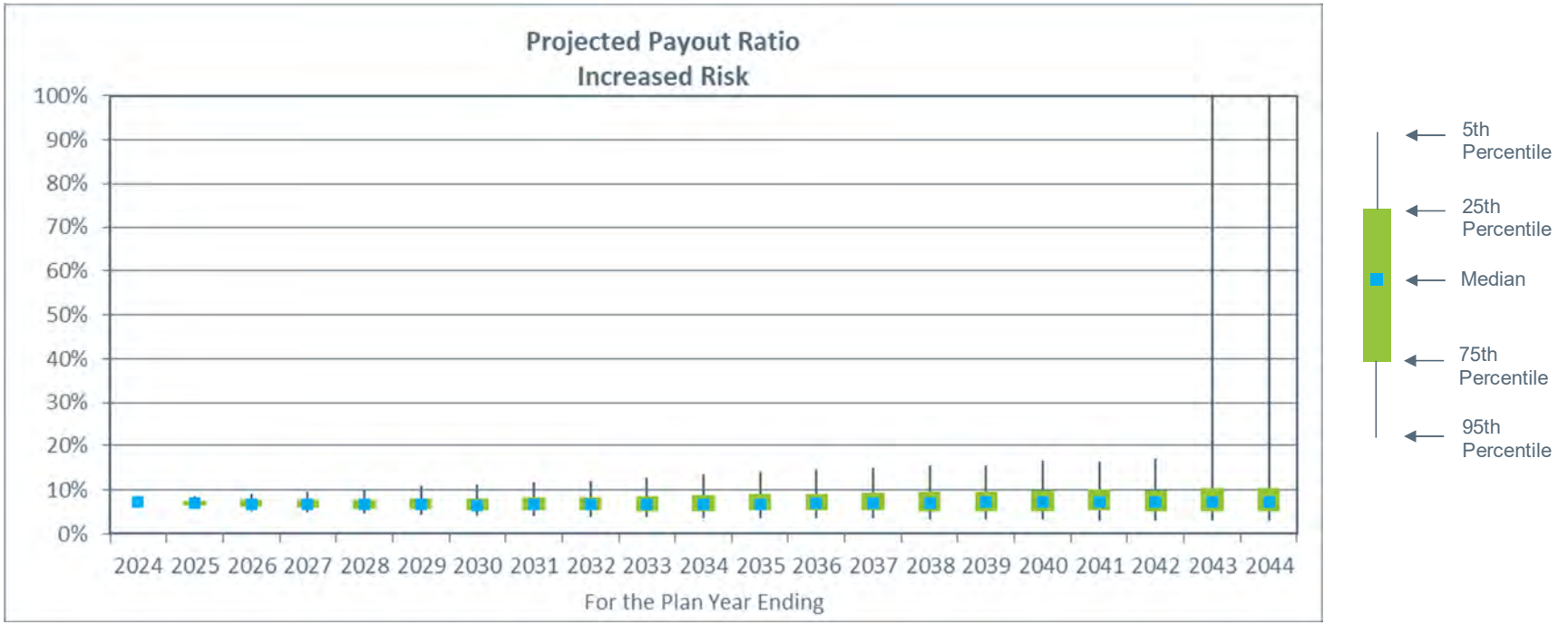
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **Increased Risk**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **Increased Risk** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to be approximately 7% across the 20-year period shown. The worst-case scenario could reach 100%.



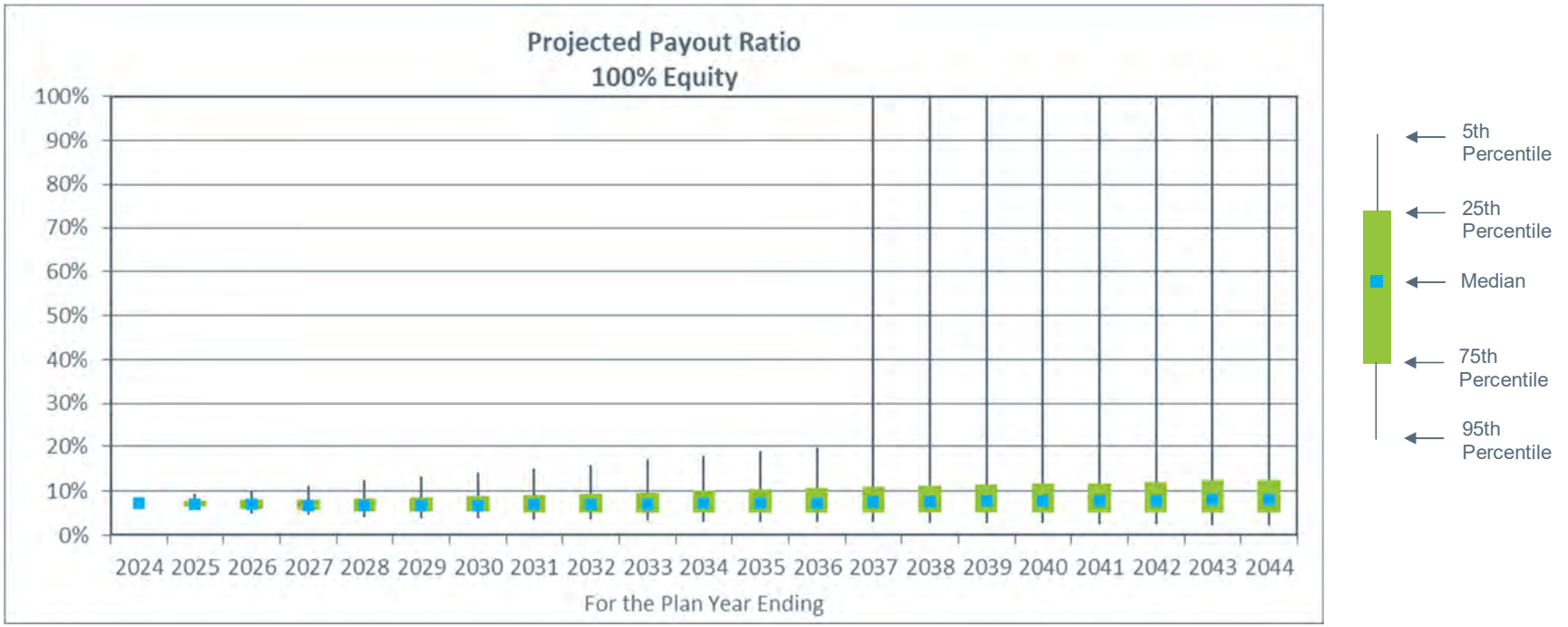
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **100% Equity**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **100% Equity** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 7% and 8%. The worst-case scenario could reach 100%.

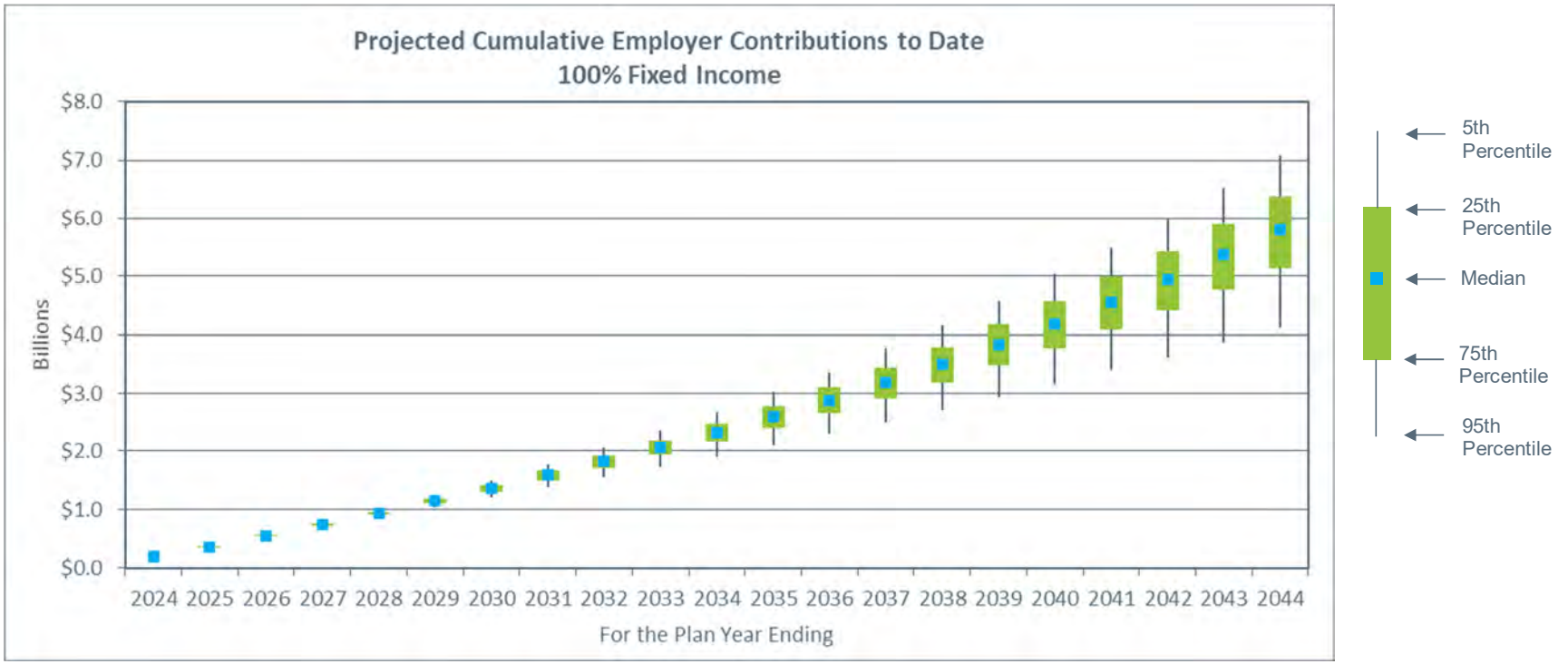


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	8%	8%	8%	8%	8%	8%	8%	8%

Stochastic Analysis (continued)

Cumulative Contributions to Date; 100% Fixed Income

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **100% Fixed Income** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

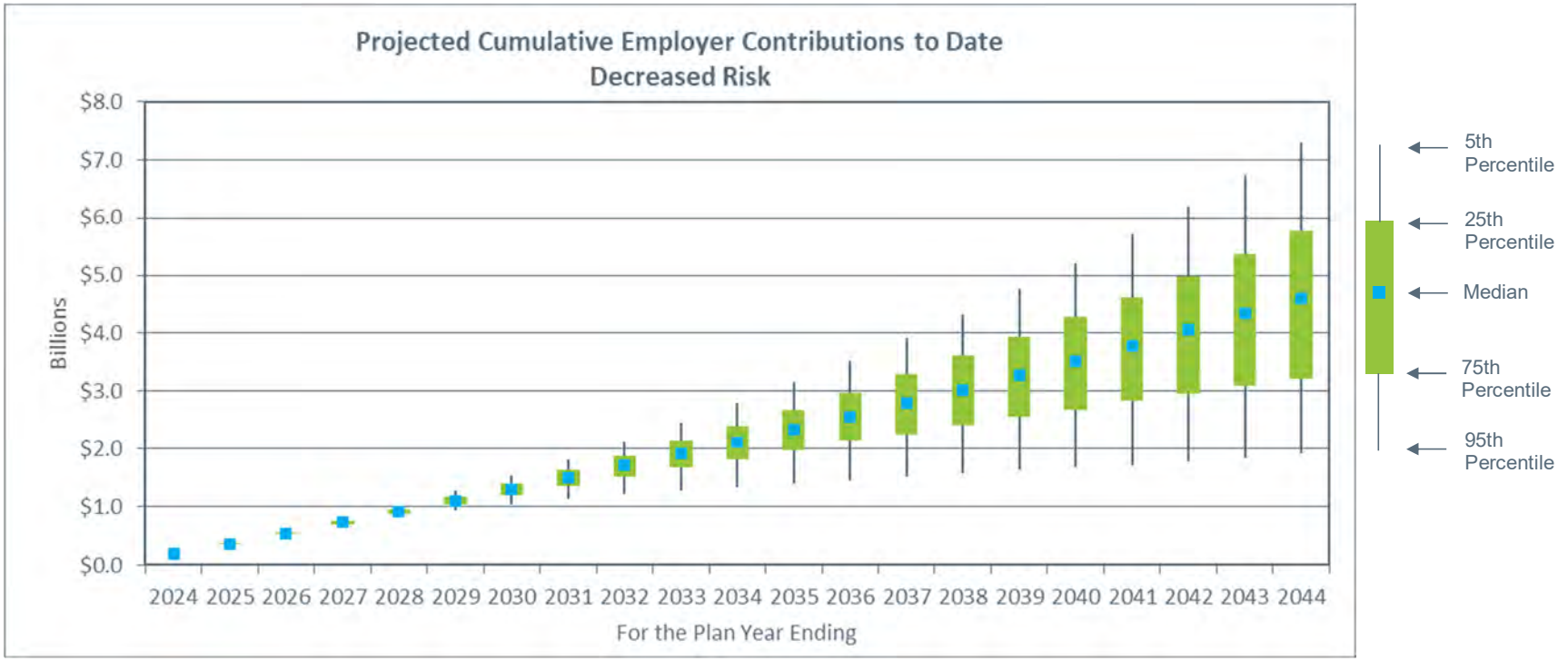


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.2	$1.5	$1.8	$2.1	$2.4	$2.7	$3.0	$3.4	$3.8	$4.2	$4.6	$5.0	$5.5	$6.0	$6.5	$7.1
25th Percentile	$0.2	$0.4	$0.5	$0.7	$1.0	$1.2	$1.4	$1.7	$1.9	$2.2	$2.5	$2.8	$3.1	$3.4	$3.8	$4.2	$4.6	$5.0	$5.4	$5.9	$6.4
Median	$0.2	$0.4	$0.5	$0.7	$0.9	$1.1	$1.4	$1.6	$1.8	$2.1	$2.3	$2.6	$2.9	$3.2	$3.5	$3.8	$4.2	$4.6	$4.9	$5.4	$5.8
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.2	$2.4	$2.7	$2.9	$3.2	$3.5	$3.8	$4.1	$4.4	$4.8	$5.1
95th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.0	$1.2	$1.4	$1.5	$1.7	$1.9	$2.1	$2.3	$2.5	$2.7	$2.9	$3.2	$3.4	$3.6	$3.9	$4.1

Stochastic Analysis (continued)

Cumulative Contributions to Date; Decreased Risk

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **Decreased Risk** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

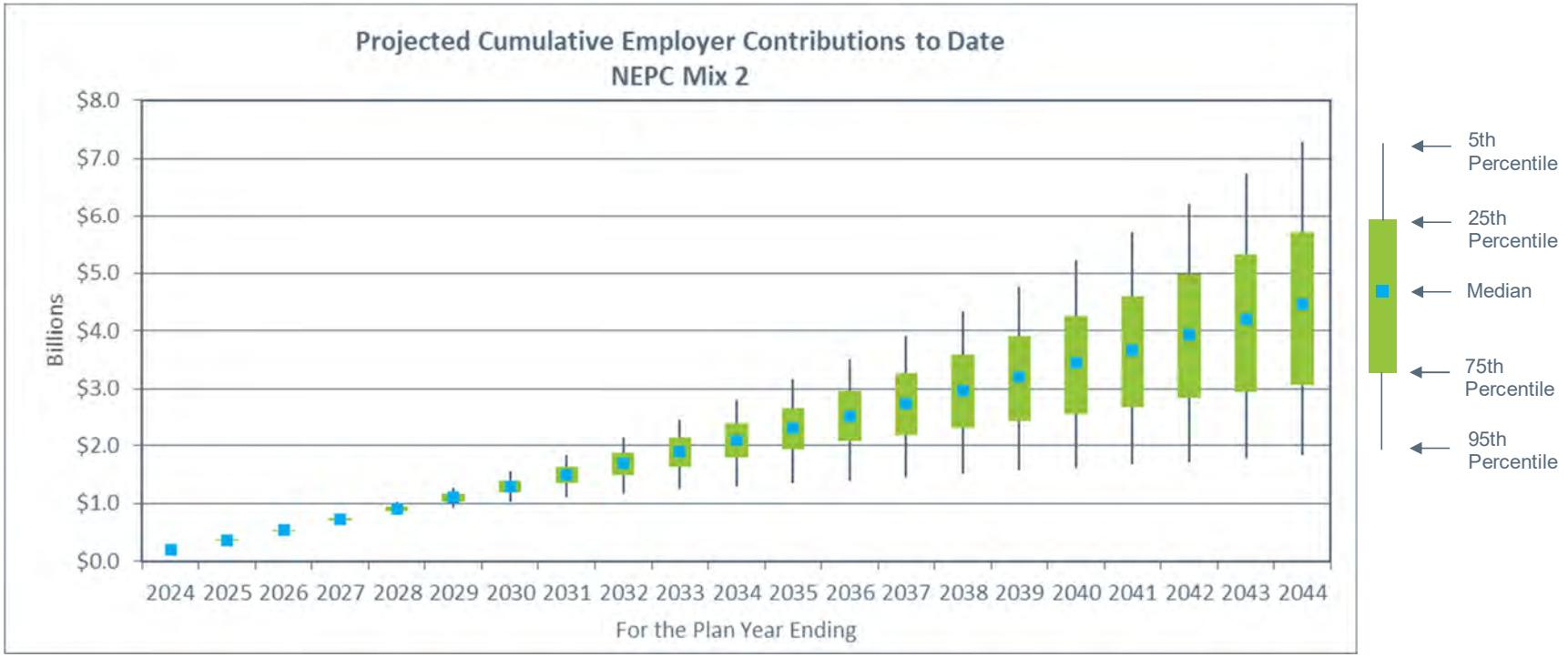


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.3	$1.5	$1.8	$2.1	$2.5	$2.8	$3.2	$3.5	$3.9	$4.3	$4.8	$5.2	$5.7	$6.2	$6.7	$7.3
25th Percentile	$0.2	$0.4	$0.5	$0.7	$0.9	$1.2	$1.4	$1.6	$1.9	$2.1	$2.4	$2.7	$3.0	$3.3	$3.6	$3.9	$4.3	$4.6	$5.0	$5.4	$5.8
Median	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.1	$2.3	$2.6	$2.8	$3.0	$3.3	$3.5	$3.8	$4.1	$4.3	$4.6
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.0	$1.2	$1.4	$1.5	$1.7	$1.8	$2.0	$2.1	$2.3	$2.4	$2.5	$2.7	$2.8	$3.0	$3.1	$3.2
95th Percentile	$0.2	$0.3	$0.5	$0.7	$0.8	$0.9	$1.0	$1.1	$1.2	$1.3	$1.3	$1.4	$1.4	$1.5	$1.6	$1.6	$1.7	$1.7	$1.8	$1.8	$1.9

Stochastic Analysis (continued)

Cumulative Contributions to Date; NEPC Mix 2

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **NEPC Mix 2** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

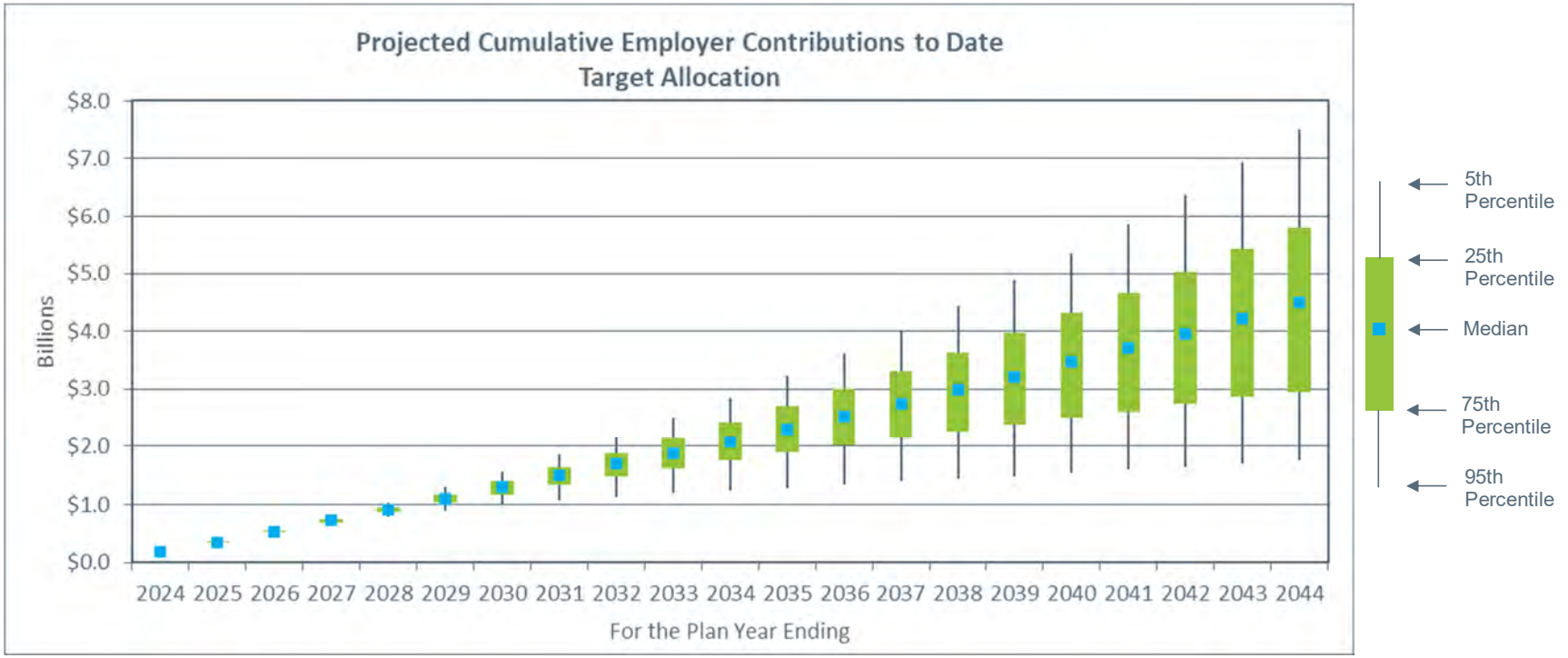


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.3	$1.5	$1.8	$2.1	$2.5	$2.8	$3.2	$3.5	$3.9	$4.3	$4.8	$5.2	$5.7	$6.2	$6.7	$7.3
25th Percentile	$0.2	$0.4	$0.5	$0.7	$0.9	$1.2	$1.4	$1.6	$1.9	$2.1	$2.4	$2.7	$3.0	$3.3	$3.6	$3.9	$4.2	$4.6	$5.0	$5.3	$5.7
Median	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.1	$2.3	$2.5	$2.7	$3.0	$3.2	$3.4	$3.7	$3.9	$4.2	$4.5
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.0	$1.2	$1.3	$1.5	$1.6	$1.8	$1.9	$2.1	$2.2	$2.3	$2.4	$2.6	$2.7	$2.8	$2.9	$3.1
95th Percentile	$0.2	$0.3	$0.5	$0.7	$0.8	$0.9	$1.0	$1.1	$1.2	$1.2	$1.3	$1.3	$1.4	$1.5	$1.5	$1.6	$1.6	$1.7	$1.7	$1.8	$1.8

Stochastic Analysis (continued)

Cumulative Contributions to Date; Target Allocation

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **Target Allocation** (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

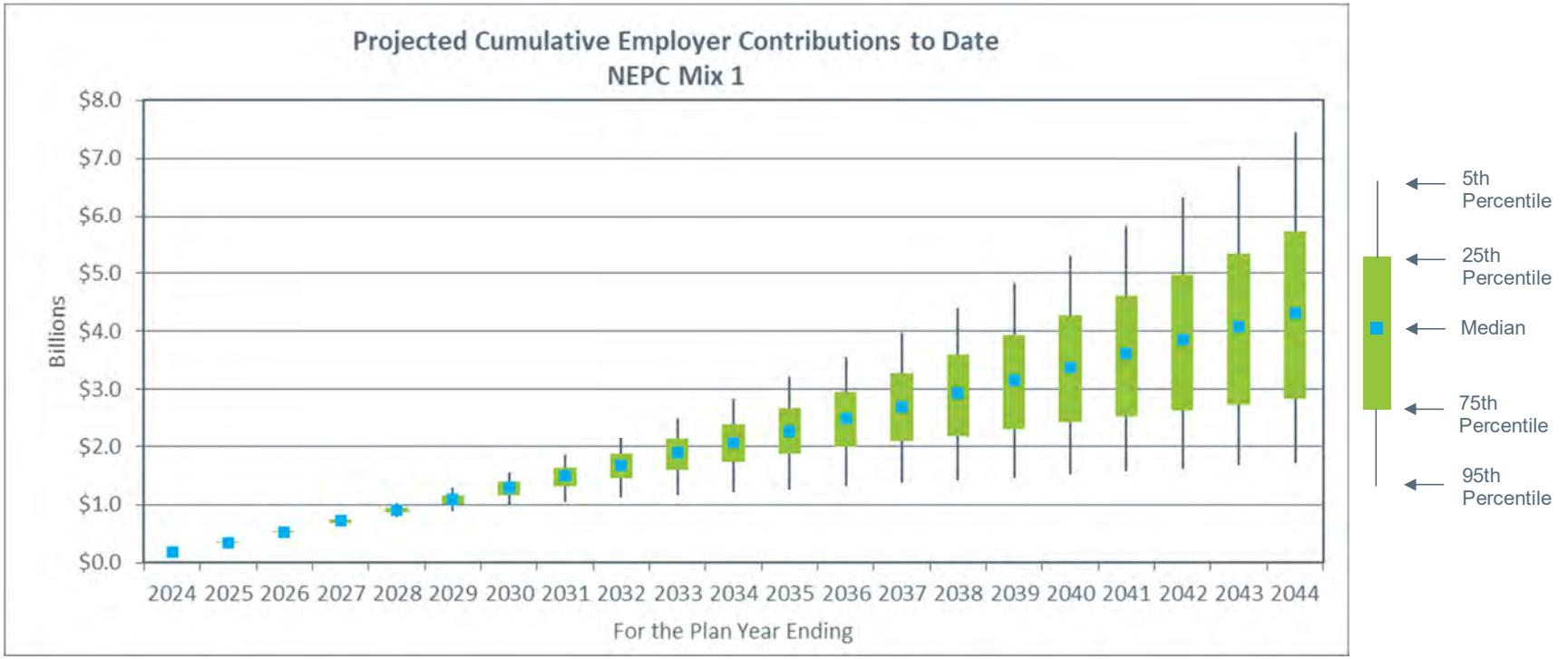


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.3	$1.6	$1.9	$2.2	$2.5	$2.9	$3.2	$3.6	$4.0	$4.4	$4.9	$5.3	$5.8	$6.4	$6.9	$7.5
25th Percentile	$0.2	$0.4	$0.5	$0.7	$1.0	$1.2	$1.4	$1.6	$1.9	$2.1	$2.4	$2.7	$3.0	$3.3	$3.6	$4.0	$4.3	$4.7	$5.0	$5.4	$5.8
Median	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.1	$2.3	$2.5	$2.7	$3.0	$3.2	$3.5	$3.7	$4.0	$4.2	$4.5
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.0	$1.2	$1.3	$1.5	$1.6	$1.8	$1.9	$2.0	$2.1	$2.3	$2.4	$2.5	$2.6	$2.7	$2.9	$3.0
95th Percentile	$0.2	$0.3	$0.5	$0.7	$0.8	$0.9	$1.0	$1.1	$1.1	$1.2	$1.2	$1.3	$1.3	$1.4	$1.4	$1.5	$1.5	$1.6	$1.6	$1.7	$1.7

Stochastic Analysis (continued)

Cumulative Contributions to Date; NEPC Mix 1

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **NEPC Mix 1** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

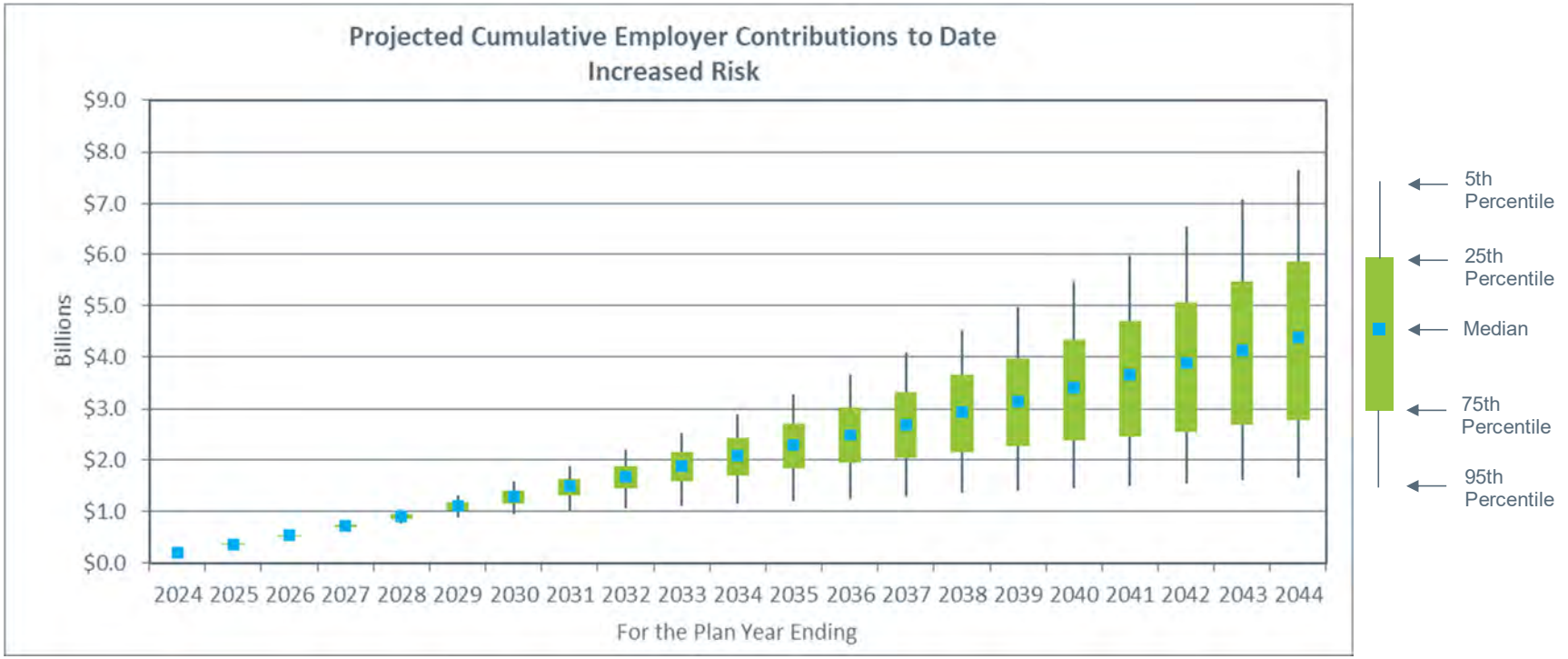


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.3	$1.6	$1.8	$2.1	$2.5	$2.8	$3.2	$3.6	$4.0	$4.4	$4.8	$5.3	$5.8	$6.3	$6.9	$7.4
25th Percentile	$0.2	$0.4	$0.5	$0.7	$1.0	$1.2	$1.4	$1.6	$1.9	$2.1	$2.4	$2.7	$3.0	$3.3	$3.6	$3.9	$4.3	$4.6	$5.0	$5.3	$5.7
Median	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.1	$2.3	$2.5	$2.7	$2.9	$3.2	$3.4	$3.6	$3.8	$4.1	$4.3
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.0	$1.2	$1.3	$1.5	$1.6	$1.7	$1.9	$2.0	$2.1	$2.2	$2.3	$2.4	$2.5	$2.6	$2.7	$2.8
95th Percentile	$0.2	$0.3	$0.5	$0.7	$0.8	$0.9	$1.0	$1.0	$1.1	$1.2	$1.2	$1.3	$1.3	$1.4	$1.4	$1.5	$1.5	$1.6	$1.6	$1.7	$1.7

Stochastic Analysis (continued)

Cumulative Contributions to Date; Increased Risk

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **Increased Risk** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

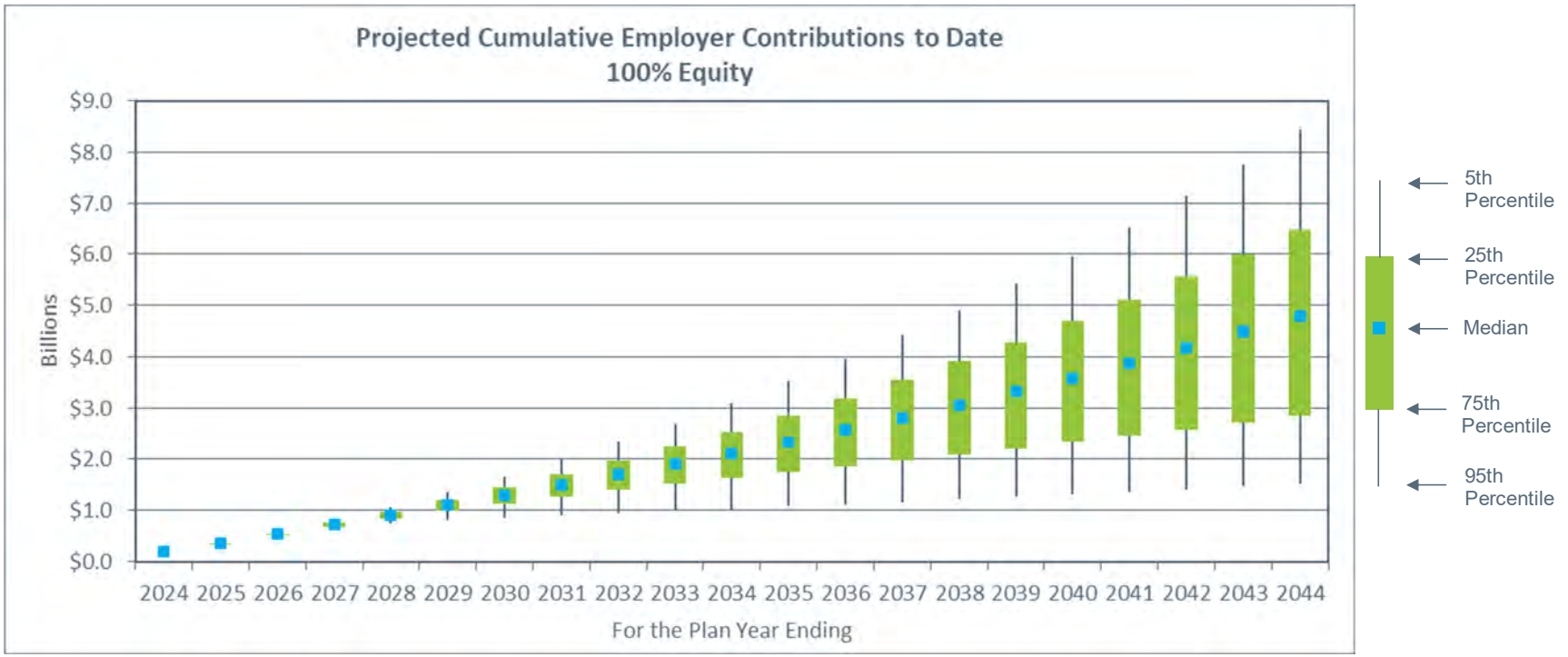


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.3	$1.6	$1.9	$2.2	$2.5	$2.9	$3.3	$3.7	$4.1	$4.5	$5.0	$5.5	$6.0	$6.5	$7.1	$7.6
25th Percentile	$0.2	$0.4	$0.5	$0.7	$1.0	$1.2	$1.4	$1.6	$1.9	$2.1	$2.4	$2.7	$3.0	$3.3	$3.7	$4.0	$4.3	$4.7	$5.1	$5.5	$5.9
Median	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.1	$2.3	$2.5	$2.7	$2.9	$3.2	$3.4	$3.7	$3.9	$4.1	$4.4
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.9	$1.0	$1.2	$1.3	$1.4	$1.6	$1.7	$1.8	$1.9	$2.0	$2.1	$2.2	$2.4	$2.5	$2.6	$2.7	$2.8
95th Percentile	$0.2	$0.3	$0.5	$0.6	$0.8	$0.9	$0.9	$1.0	$1.1	$1.1	$1.2	$1.2	$1.2	$1.3	$1.3	$1.4	$1.4	$1.5	$1.5	$1.6	$1.6

Stochastic Analysis (continued)

Cumulative Contributions to Date; 100% Equity

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **100% Equity** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$0.2	$0.4	$0.6	$0.8	$1.1	$1.4	$1.7	$2.0	$2.3	$2.7	$3.1	$3.5	$4.0	$4.4	$4.9	$5.4	$6.0	$6.5	$7.2	$7.8	$8.5
25th Percentile	$0.2	$0.4	$0.6	$0.8	$1.0	$1.2	$1.4	$1.7	$2.0	$2.2	$2.5	$2.9	$3.2	$3.6	$3.9	$4.3	$4.7	$5.1	$5.6	$6.0	$6.5
Median	$0.2	$0.3	$0.5	$0.7	$0.9	$1.1	$1.3	$1.5	$1.7	$1.9	$2.1	$2.3	$2.6	$2.8	$3.1	$3.3	$3.6	$3.9	$4.2	$4.5	$4.8
75th Percentile	$0.2	$0.3	$0.5	$0.7	$0.8	$1.0	$1.1	$1.3	$1.4	$1.5	$1.6	$1.7	$1.9	$2.0	$2.1	$2.2	$2.3	$2.5	$2.6	$2.7	$2.9
95th Percentile	$0.2	$0.3	$0.5	$0.6	$0.7	$0.8	$0.9	$0.9	$0.9	$1.0	$1.0	$1.1	$1.1	$1.2	$1.2	$1.3	$1.3	$1.3	$1.4	$1.5	$1.5

Stochastic Analysis (continued)

Employer Contributions (as a weighted average percentage of salary)

The tables below show the range of required employer contributions (as a weighted average percentage of salary) assuming the seven different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.

5 Years	Required Employer Contribution for Plan Year Ending 2029				
	5th	25th	50th	75th	95th
100% Fixed Income	17%	15%	15%	14%	12%
Decreased Risk	18%	15%	14%	12%	9%
NEPC Mix 2	18%	15%	13%	11%	8%
Target Allocation	18%	15%	13%	11%	8%
NEPC Mix 1	18%	15%	13%	11%	8%
Increased Risk	18%	15%	13%	13%	7%
100% Equity	20%	16%	13%	10%	5%

10 Years	Required Employer Contribution for Plan Year Ending 2034				
	5th	25th	50th	75th	95th
100% Fixed Income	24%	22%	20%	18%	14%
Decreased Risk	26%	21%	16%	11%	3%
NEPC Mix 2	26%	21%	16%	10%	3%
Target Allocation	27%	21%	16%	10%	3%
NEPC Mix 1	27%	21%	16%	10%	3%
Increased Risk	28%	21%	16%	9%	3%
100% Equity	31%	23%	17%	8%	3%

20 Years	Required Employer Contribution for Plan Year Ending 2044				
	5th	25th	50th	75th	95th
100% Fixed Income	54%	48%	42%	36%	24%
Decreased Risk	58%	42%	27%	8%	4%
NEPC Mix 2	58%	41%	25%	4%	4%
Target Allocation	60%	43%	25%	4%	4%
NEPC Mix 1	59%	41%	23%	4%	4%
Increased Risk	62%	43%	23%	4%	4%
100% Equity	31%	23%	17%	8%	3%

Stochastic Analysis (continued)

Drawing Inferences

The tables below compare the projected market funded ratios five, ten, and twenty years from now, under the median (50th percentile), worst-case (5th percentile), and best-case (95th percentile) scenarios, assuming the seven different asset mixes highlighted on the prior pages. The table also displays for comparative purposes the median, peak, and trough projected payout ratios and cumulative employer contributions for the seven asset mixes being examined.

5 Years	Market Funded Ratio in Year 5			Cumulative Employer Contributions in Year 5 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 5 Median	Years 1 to 5 Peak	Years 1 to 5 Trough
100% Fixed Income	67%	56%	82%	$1,137	$1,234	$1,031	7%	9%	6%
Decreased Risk	74%	50%	103%	$1,101	$1,270	$924	7%	10%	5%
NEPC Mix 2	74%	49%	105%	$1,096	$1,271	$916	7%	10%	5%
Target Allocation	75%	47%	109%	$1,097	$1,285	$897	7%	10%	5%
NEPC Mix 1	75%	48%	109%	$1,092	$1,281	$895	7%	10%	5%
Increased Risk	75%	45%	113%	$1,093	$1,296	$875	7%	11%	4%
100% Equity	73%	37%	128%	$1,099	$1,351	$1,093	7%	13%	4%

10 Years	Market Funded Ratio in Year 10			Cumulative Employer Contributions in Year 10 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 10 Median	Years 1 to 10 Peak	Years 1 to 10 Trough
100% Fixed Income	64%	50%	83%	$2,321	$2,686	$1,906	8%	10%	6%
Decreased Risk	75%	43%	121%	$2,118	$2,794	$1,338	7%	12%	4%
NEPC Mix 2	76%	43%	128%	$2,096	$2,800	$1,291	7%	12%	4%
Target Allocation	76%	40%	132%	$2,088	$2,853	$1,230	7%	13%	4%
NEPC Mix 1	78%	41%	135%	$2,077	$2,835	$1,212	7%	13%	4%
Increased Risk	77%	38%	142%	$2,069	$2,901	$1,157	7%	14%	4%
100% Equity	73%	29%	166%	$2,117	$3,116	$2,069	7%	18%	3%

20 Years	Market Funded Ratio in Year 20			Cumulative Employer Contributions in Year 20 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 20 Median	Years 1 to 20 Peak	Years 1 to 20 Trough
100% Fixed Income	61%	46%	84%	$5,799	$7,070	$4,118	10%	14%	6%
Decreased Risk	82%	41%	165%	$4,606	$7,297	$1,903	8%	15%	4%
NEPC Mix 2	84%	41%	178%	$4,460	$7,277	$1,827	8%	15%	4%
Target Allocation	84%	38%	191%	$4,499	$7,507	$1,746	8%	17%	3%
NEPC Mix 1	86%	39%	203%	$4,315	$7,437	$1,717	7%	16%	3%
Increased Risk	86%	35%	218%	$4,382	$7,632	$1,646	7%	100%	3%
100% Equity	78%	27%	284%	$4,791	$8,452	$4,382	8%	100%	2%

Appendix: Assumptions and Methods

Actuarial Valuation Assumptions and Methods: At the beginning of each projection year, an actuarial valuation is performed to determine employer contributions. The assumptions used in the July 1, 2024 Actuarial Valuations prepared by GRS were utilized in all years. These methods and assumptions are summarized below:

Actuarial Cost Method	Entry-Age Normal (level % of pay). Funding policies and methods are described in the July 1, 2024 Actuarial Valuations prepared by GRS.
Liability Discount Rate	NDPERS: 6.50% per year. Highway Patrolmen: 6.50% per year.
Administrative Expenses	Prior year expenses, adjusted for inflation ($3,094,265 assumed for FY 2025).
Inflation (CPI)	2.25% per year.
Member Contribution Interest	0.5% less than the actuarial interest rate assumption
Payroll Growth	Highway Patrolmen and NDPERS (excl. Judges): 3.50% Judges: 3.00%
Future Pay Increases	Future pay increases as recommended in the 2024 Experience Study prepared by GRS.
Retirement	Rates of retirement as recommended in the 2024 Experience Study prepared by GRS.
Mortality	Rates of mortality as recommended in the 2024 Experience Study prepared by GRS.
Disability	Rates of disability as recommended in the 2024 Experience Study prepared by GRS.

Appendix: Assumptions and Methods (continued)

Actuarial Valuation Assumptions and Methods: (continued)

Termination	Rates of termination as recommended in the 2024 Experience Study prepared by GRS.
COLA	No Cost of Living Adjustments are provided to benefit recipients.
Asset Valuation Method	Market value with a five-year smoothing of the difference between actual and assumed investment returns. Direct offsetting of gains and losses.
Contribution Policy	Statutory rates based on fixed percent of pay for Main System, Judges, Safety and Highway Patrolmen. Beginning January 1, 2026, the Main System's funding policy will be changed to the amount sufficient to fund the Main System on an actuarial basis, with the amortization of the unfunded liability determined on a level percent of payroll basis over a closed period ending June 30, 2056.

Appendix: Assumptions and Methods (continued)

Projection Assumptions (used in the deterministic and stochastic asset/liability projections): These projections begin with the Plans' participant populations as of July 1, 2024, as provided by GRS. The Plans' populations are projected forward and assumed to change as a result of employment separation, death, disability, and retirement, as predicted by the assumptions recommended in the 2024 Experience Study prepared by GRS. New members are assumed to enter the Plan such that the active populations remain level throughout the projection. Employee compensation is projected into the future in accordance with the assumptions described on the prior pages. Investment returns are projected into the future in accordance with the assumptions described below.

Employer Contributions

Employer contributions are based on fixed statutory contribution rates for Main System, Judges, Public Safety and Highway Patrolmen. The expected employer contributions for the fiscal year ending June 30, 2025 are 12.07%.

Beginning January 1, 2026, the Main System's funding policy is assumed to change to the amount sufficient to fund the Main System on an actuarial basis, with the amortization of the unfunded liability determined on a level percent of payroll basis over a closed period ending June 30, 2056.

Member Contributions

Current rate structures that vary by classification.

New Entrants

The Main System is closed to new entrants. For all other groups within NDPERS, new employees are assumed to join the Plan such that the active population remains level throughout the projection. New employees entering the Plan are assumed to have characteristics similar to recently hired participants.

Rate of Return on Assets

Deterministic Analysis: 6.50% all years.

Stochastic Analysis: Returns on the portfolio are based on the expected returns of each asset class and the correlations between each class which are detailed in the Stochastic Analysis section of this report.

Appendix: Assumptions and Methods (continued)

Base Wages	Deterministic Analysis: 2.50% increase per year. Stochastic Analysis: Increases that vary with inflation.
Inflation	2.50% per year with a standard deviation of 2.50%.
Other	All other projection assumptions and methods are the same as those recommended in the 2024 Experience Study prepared by GRS, with some exceptions where system restraints required approximations. Employer and employee contributions were determined on a system-wide basis. With the exception of the changes to the funding policy for the Main System, effective January 1, 2026, employer and employee contribution rates were not assumed to change in the future. Grouping of Main System active employees was used to speed up processing. All other participant data was used without grouping.

Memorandum

To	North Dakota Retiree Health Insurance Credit Fund
From	RVK, Inc.
Subject	Asset/Liability Study – Executive Summary
Date	May 2025

Introduction

The purpose of this memorandum is to summarize the key inferences we draw from the Asset/Liability ("A/L") study of the North Dakota Retiree Health Insurance Credit Fund ("RHIC" or "Fund"). While this memorandum refers directly to points raised within the study, we emphasize that a full understanding of the A/L study and its implications requires a close review of the study in its entirety.

Background and Key Conclusions

As of the July 1, 2024, the date of the most recent actuarial valuation and the start date of the projections in this study, the Fund was approximately 70% funded (on a market value basis). In short, this means that assets were available to cover 70% of the Fund's liabilities as currently estimated by the Fund's actuary. This equates to a shortfall of approximately $79 million.

This study shows that the Fund remains firmly solvent throughout the entire study period. By solvent, we mean that the Fund's assets intended to pre-fund accrued and accruing benefit obligations remain fully capable of doing so. While the Fund's funding ratio will certainly fluctuate during this period, our study suggests the potential for eliminating the funding gap over the next 20 years (likely by 2038). Critical to this conclusion is our assumption that the current contribution policy remains in place and long-term investment returns reach levels near those currently assumed.

This study suggests that continued diversification in the investment of the Fund's assets is desirable. The study, however, suggests caution in assuming that increased pursuit of higher expected returns, through even more aggressive (and hence even more volatile) asset allocations, is always beneficial. High expected return and high expected risk approaches also bring increased risk of large declines in the value of the Fund's assets and increased volatility in required contributions.

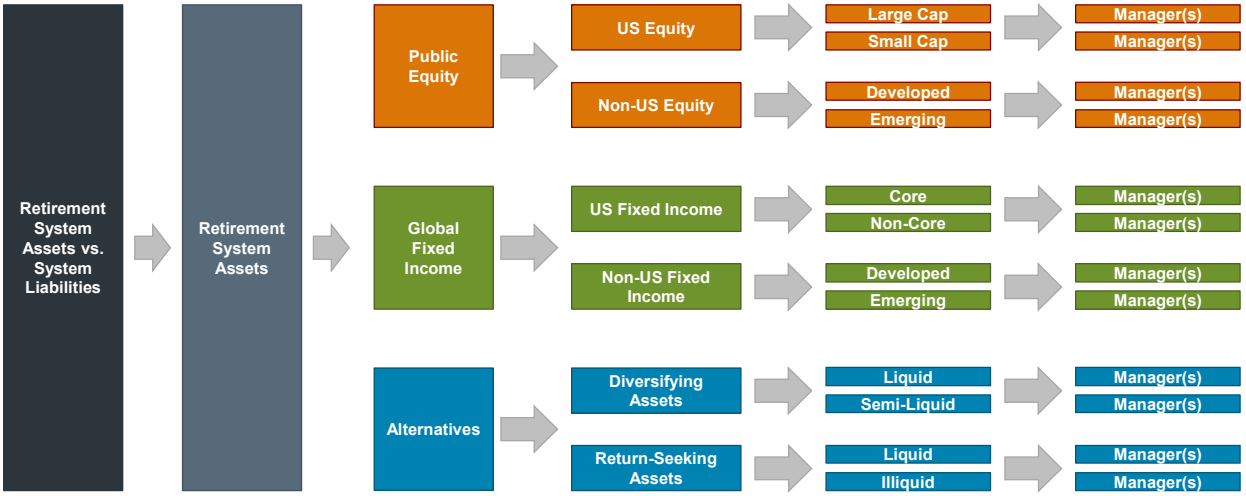
The Purpose of an Asset/Liability Study

The central purpose of an A/L study is to examine the probable future consequences, over extended periods of time, of applying alternative asset allocation strategies to the Fund's investment assets in order to fund the liabilities created by the benefit provisions of the Fund. A/L studies are unique in their ability to combine in a single analysis the three critical factors that drive the financial health of the Fund—benefit policy (liabilities), contribution policy, and investment strategy (asset allocation). Certainly, this type of forward-looking study cannot indicate with any reliability what will happen in any given year over this extended period of time, and its insights are dependent on the assumptions used. However, we have high

conviction that the results of the study paint a highly reliable view of the core long-term trends in the Fund's financial health.

Best practice, in our judgment, is to take the general direction suggested as most appropriate by this study with its unique consideration of liabilities, contribution policy, and trending liquidity needs and refine it in an asset allocation study where implementing the Fund's structure can reflect the pragmatic considerations of investing in the capital markets present at any given point in time.

While this study does not suggest meaningfully modifying the risk profile of the current asset allocation strategy, refinements to asset allocation may be beneficial to the long-term outcomes of the Fund. Asset allocation and asset class structure will be evaluated as the Board moves through the activities and decision points from left to right in the below investment decision framework.



Asset/Liability Study

- Assesses health of Plan
- Models general risk and return parameters
- Links Investment Policy, Contribution Policy, and Benefit Policy

Asset Allocation Study

- Models specific targets to asset classes
- Used to select overall target allocation
- Uses passive assumptions

Asset Class Structure Studies

- Implementation guide with targets to sub-asset classes
- Mix of active and passive investments determined
- Optimal mix of managers

Deterministic versus Stochastic

In this study, we examined a series of related questions associated with this central purpose, projecting future outcomes under two distinctly different methodologies:

1. a **deterministic** basis (all underlying assumptions, liabilities, contributions, and most critically investment returns, are achieved precisely and without variance in each and every year); and

2. a **stochastic** basis (outcomes for investment returns vary each year according to estimated volatility with contribution *requirements* following suit while *actual* contribution policy and liabilities remain in their current form).

Key Results

Below you will find a series of important findings, forecasts, and conclusions drawn from the body of the study. While the remarks are presented here to allow a quick assessment of some of the key findings, they represent only a sampling of the fundamental elements of the study. We emphasize that a solid understanding of each element requires that they be reviewed as they are presented in the study itself within their surrounding context (please note the frequent page references to the full A/L study). This is especially important to understanding the findings which represent *probable, but not certain*, outcomes as analyzed in the stochastic section of the study.

At the Outset: Before projecting and analyzing possible future paths of the Fund, it is important to understand the current positioning and circumstances.

- As of July 1, 2024 (the date of the actuarial valuation used to model liabilities), the Fund's market value funded ratio (available assets to fund benefit obligations) was approximately 70% (page 6).

- The number of active members currently exceeds the number of benefit receiving members by approximately 1.04 to 1.00. The composition of members is expected to change materially over the next 20 years given the Fund is closed to new entrants. We project the number of active members will drop by approximately 74% during the projection period while the number of benefit receiving members increases by about 6%. As the Fund matures, the ratio of active members to benefit receiving members is expected to change to 0.30 to 1.00 over the next 20 years (page 8). This demographic shift is an important factor when considering the findings on Fund risk/return options and the projected status of the Fund's liquidity. All else equal, fewer contributing members leads to worsening cash flow profiles potentially limiting opportunities to take advantage of illiquidity premiums.

Deterministic Analysis: A deterministic analysis assumes full certainty about the future, in particular, certainty of investment returns. Its virtues are that it is simple and that the findings reflect what will

happen if the future turns out to be precisely as forecasted—no better, but also no worse.

- Even as the Fund quickly matures, benefit payments to participants continue to increase throughout the projection period. We project annual benefit payments will increase by 18% over the next 20 years (page 9). Annual increases are projected to average approximately 1%. In the last 3 years of the projection, benefit payments do begin to fall, albeit at a very slow pace.

- Annual dollar contributions are projected to fall as the Fund matures by about 36% over the next 20 years (page 10). Please note however, that precise actuarially required rates as they unfold are the purview of the Fund's actuary.

- Aggregate benefit payments are expected to increase by about 18% over the next 20 years but gradually fall as a percentage of Fund assets over this same time period (pages 9 and 12). Not only do benefit payments as a percentage of Fund assets not increase, they are in our judgement also healthy and sustainable on an absolute basis during this period. This is an important and positive indication, because increased payout ratios, if they rise sufficiently high, can potentially impose liquidity constraints on the management of the portfolio. Specifically, high payout ratios can inhibit the ability of the Fund to invest with a long-term horizon, therefore limiting the opportunity to invest in less liquid asset classes regardless of their potential return or risk reducing diversification benefits. The payout ratio is projected to fall from about 9% today to 7% in 20 years (page 12). These levels do not, in our opinion, materially inhibit investment opportunities for the Fund. This is an important takeaway from this study. Even though the Fund is closed, it has a significant remaining life. However, should the payout ratio begin to rise, or exceed projections, asset liquidity will need to be carefully monitored.

- As assets grow each and every year without exception at the assumed rate of return (5.75%), the funding ratio on a market value basis is expected to gradually increase to approximately 100% by 2038 and continue increasing thereafter, from the current value of 70% (pages 17-19).

Deterministic Scenario Analysis: One of the key advantages of deterministic analysis is the ability to evaluate scenarios that isolate a particular projection variable. In the context of an A/L study, this allows for insights into how various capital market environments and return profiles change the projected outcomes for the Fund.

	Value in 2044					
	Baseline	Reduced Return	V	W	Loss then Low	Inflation
Projected Payout Ratio	7%	10%	10%	13%	14%	6%
Projected Employer Contributions (millions)	$8.0	$8.0	$8.0	$8.0	$8.0	$10.7
Projected Benefit Payments/Projected Total Contributions	242%	242%	242%	242%	242%	181%
Projected Actuarial Accrued Liabilities (millions)	$217.5	$217.5	$217.5	$217.5	$217.5	$217.5
Projected Market Value of Assets (millions)	$268.8	$199.2	$190.3	$153.0	$135.7	$310.7
Projected Deficit (millions)	($51.3)	$18.3	$27.1	$64.5	$81.8	-$93.2
Projected Market Funded Ratio	124%	92%	88%	70%	62%	143%
	20 Year Cumulative Total					
Projected Cumulative Employer Contributions (millions)	$209.1	$209.1	$209.1	$209.1	$209.1	$241.7

- Assuming the current contribution policy remains unchanged, the Fund would need to experience annual returns in excess of 6.75% over the next 10 years or 5.00% over the next 20 years without exception in each and every year in order to reach full funding (page 18). Many public funds require returns well in excess of their assumed rate of return every single year for the next several decades in order to achieve full funding. This can force funds to attempt to reach for return targets that are unrealistic or require taking substantially more risk. The current position of the Fund allows the Board to consider many more options when making investment decisions when compared to many other public funds.

- Experiencing a return of 100 basis points below the Fund's current assumed rate of return of 5.75% (i.e., 4.75%) each year for the 20-year projection period would result in a significant decline in the projected market funding ratio to 92% in year 20 versus 124% at the current assumed rate of return (page 19). Given the widely shared concerns about the prospects for a low-return environment in the capital markets over the foreseeable future, this is a conclusion that should be thoroughly understood and appreciated. In the event that capital markets do not support returns commensurate with the assumed rate of return, Fund health may not improve as rapidly as expected. This scenario also shows the payout ratio gradually increasing over the next 20 years. This would need to be closely monitored.

- Investment strategies that introduce increasing volatility in the Fund's returns over the next 20 years also suggest meaningfully worse outcomes compared to the baseline deterministic projections. Scenarios B and C shown on page 19 of the full A/L study illustrate this point. These scenarios show a decrease in ending projected funded ratios at 88% and 70%, respectively. Scenario B illustrates a V-patterned scenario and assumes a return of -20% in the first projection year and +20% in the second projection year followed by the assumed rate of return thereafter (5.75%). Scenario C projects a W-patterned scenario and assumes a return pattern of -10%, +10%, -10%, +10% followed by the assumed rate of return thereafter (5.75%). The key conclusion from this part of the study is that volatility – specifically declines and subsequent recoveries in the

Fund's assets – when it occurs, can have a significant effect on cumulative contributions.

Stochastic Analysis: Unlike a deterministic analysis, a stochastic analysis does not assume an unvarying stream of expected investment returns year after year. Instead, it reflects the realistic view that pension plan investment returns are—like the investment markets themselves—volatile and always uncertain. This means that there are a range of possible outcomes for the Fund; some are more likely, others less likely, but still possible.

The deterministic approach is useful for gauging the general direction of change and associated consequences, but adding the element of uncertainty—more specifically year to year variability in the performance of the capital markets and the value of the Fund's assets over time—can offer additional insights, albeit along with considerable complexity.

Uncertainty in future investment returns is taken into account via a stochastic analysis of five different investment approaches (in the table below and on page 24) ranging from highly conservative (low risk, asset protective) to highly aggressive (high return-seeking with substantial associated risk), including the current Target Allocation of the Fund. The reason for testing such a broad range of approaches is that at the heart of the Fund's situation is a simple question that is difficult to answer: whether the Fund is better off following a strategy that:

(A) Falls in the general category of higher prospective return with greater risk (i.e., potential for more widely varying outcomes – good or bad), or
(B) Falls in the general category of lower prospective return with concomitantly lower risk (i.e., a tighter band of likely outcomes).

	100% Fixed Income	Decreased Risk	Target Allocation	Increased Risk	100% Equity
Broad US Equity	0	36	39	43	65
Broad International Equity	0	22	26	29	35
US Agg Fixed Income	100	42	35	28	0
Total	100	100	100	100	100
Capital Appreciation	0	58	65	72	100
Capital Preservation	100	42	35	28	0
Alpha	0	0	0	0	0
Inflation	0	0	0	0	0
Expected Arithmetic Return	**4.50**	**6.06**	**6.29**	**6.49**	**7.09**
Expected Risk (Standard Deviation)	**5.00**	**10.34**	**11.34**	**12.34**	**16.36**
Expected Compound Return	**4.38**	**5.56**	**5.69**	**5.78**	**5.86**
Expected Return (Arithmetic)/Risk Ratio	0.90	0.59	0.55	0.53	0.43
RVK Expected Eq Beta (LCUS Eq = 1)	0.09	0.62	0.68	0.75	1.00
RVK Liquidity Metric (T-Bills = 100)	85	90	90	91	93
Allocation to Private Assets	0	0	0	0	0

Essential to answering this question is to ask precisely how the Fund and its broader constituencies define what "better off" means. The metrics we use for each to determine whether the Fund is "better off" under one approach versus another are as follows:

(1) The effect on funding ratio (and thus on contribution rates, which decline with higher funding ratios).
(2) The effect on Fund liquidity (i.e., the Fund's ability to pay annual benefits without major disruption of its strategic asset allocation, the driver of its investment strategy).
(3) The effect on the trend line and stability of annual contributions.
(4) The risk of large, sudden, and highly disruptive short-term declines in the Fund's assets over the course of time and the associated effects on contributions and potential investment decisions.

The results of this analysis are displayed on pages 26 through 41 of the accompanying A/L study. For purposes of this summary, the consequences of choosing A versus B, as described on the prior page, are summarized most clearly in the tables on pages 29 and 41 of the study (copied below followed by explanatory comments).

20 Years	Probability of Full Funding in 2044	Probability of < 70% (Current) Funding in 2044	Probability of < 50% Funding in 2044	Maximum 1 Year Investment Loss
100% Fixed Income	26%	34%	23%	-7%
Decreased Risk	54%	32%	27%	-26%
Target Allocation	54%	33%	28%	-30%
Increased Risk	54%	35%	30%	-33%
100% Equity	50%	42%	38%	-47%

20 Years	Market Funded Ratio in Year 20			Cumulative Employer Contributions in Year 20 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 20 Median	Years 1 to 20 Peak	Years 1 to 20 Trough
100% Fixed Income	82%	39%	139%	$220.7	$238.5	$203.8	11%	23%	6%
Decreased Risk	111%	4%	373%	$221.3	$244.9	$204.2	8%	100%	2%
Target Allocation	114%	0%	429%	$221.7	$249.3	$204.3	8%	100%	2%
Increased Risk	113%	0%	485%	$221.9	$254.1	$204.5	8%	100%	2%
100% Equity	101%	0%	724%	$223.9	$304.0	$205.1	9%	100%	1%

- The 100% Fixed Income portfolio results in a median expected funding ratio at the end of the 20 year study period that is materially lower than the other portfolios analyzed. Each of the diversified portfolios—including the current Target Allocation—result in expected median funding ratios that are substantially similar to each other at the end of the projection period. This, in our judgement, has two implications. (1) Though highly protective of existing assets, a highly conservative investment strategy is counterproductive, and (2) continued utilization of diversified investment approach remains the best approach.

- None of the diversified portfolios show a significant probability of extreme payout ratios over the next 20 years. Median payout ratios (for all portfolios) are between 8-11%, a level that does not inhibit asset allocation decisions. Peak payout ratios are in excess of 100%. If investment returns push payout levels to these levels, close attention should be paid to future alternative asset pacing and the overall liquidity profile. Payout ratios of 100% indicate a probability of asset depletion at some point in the projection period. While the probability of this is low, it should be noted as an outcome observed in the models.

- As the expected risk and return of the Fund are incrementally increased, the outcomes do appear to very marginally improve at the cost of reduced worst-case outcomes. This is a direct result of significant increases in portfolio volatility associated with diminishing increases in return. The benefits taper off and costs increase as expected risk increases. This implies the tradeoff for additional upside likely becomes less attractive the more risk is increased. The range or dispersion of potential outcomes—particularly for the market funded ratio and cumulative employer contributions—increases as incremental risk is added to the Fund. This does not, in our opinion, directly support increasing risk at this time.

Final Comments

Although this A/L study shows that the Fund currently has a shortfall, it also suggests improvements in financial health are possible under the current assumptions. The Fund can best meet its objectives through the continued use of a well-diversified investment portfolio. However, positive outcomes are extremely dependent on the contribution policy. The incremental cost of additional volatility does not justify the potential increase in median outcomes. Reducing volatility and downside risk, where possible to maintain return, can have a materially positive impact on the long-term health of the Fund.

The study is not supportive of a long-term, ultra-conservative approach as the protection such a strategy provides to current Fund assets comes with the heavy cost of considerably higher contributions. Conversely, the increasing potential for large one-year declines suggests that there is likely a limit to the net benefits of adding increased risk in pursuit of additional return.

Progress should be monitored periodically through studies such as these, particularly if the Fund encounters a sustained period of lower returns in the capital markets (and thus for the Fund's assets) as well as material changes in contribution policy or benefit levels.

Additionally, this study assumes no further changes are made to the benefit policy at any point during the 20-year projection period. Such changes would fall outside the reach of an Asset/Liability study. However, we do note that even small changes to the benefit policy can have a meaningful long-term impact on the likely future outcomes of the Fund if they are adopted without a corresponding change in assets or contributions.

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RVK

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Introduction

RVK, Inc. (RVK) has prepared this report for the North Dakota Retiree Health Insurance Credit Fund (RHIC) to:

- Present projected valuation results with respect to the funded status of the Plan.
- Present projected benefit payments of the Plan.
- Investigate asset mixes to determine those which best serve to protect and increase funding levels, while providing adequate liquidity for benefit payments.

The valuation projections are shown using both a deterministic and stochastic process.

The deterministic process provides an analysis of projected valuation results based on a fixed set of future assumptions (see summary in the Assumptions and Methods section of this report).

The stochastic process provides an analysis of projected valuation results under many capital market environments based on expected asset returns and inflation, and their expected volatility. Using a Monte Carlo simulation technique, both assets and liabilities are assumed to vary stochastically, linked together by changes in inflation. Expected values, variances of the returns and inflation, and correlations are used to generate 2,000 trials to produce a distribution of potential outcomes. A stochastic analysis can answer questions about the best/worst case outcomes along with the probability of such outcomes.

Introduction (continued)

What is an Asset/Liability Study?

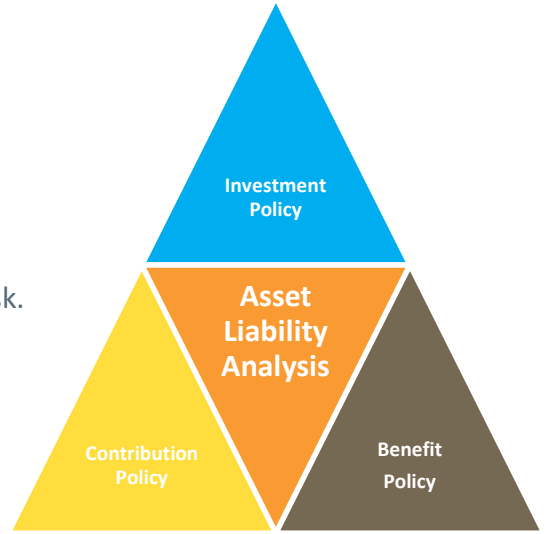
- Investment programs and the strategy they seek to implement (Investment Policy) do not exist in a vacuum. They seek to satisfy one or more investment objectives and operate within a plan framework that includes the investment objectives (Benefit Policy) and plan funding (Contribution Policy).

- The purpose of an Asset/Liability Study is to examine how well alternative investment strategies (i.e., differing asset allocations) address the objectives served by the Plan—the Plan's "liabilities" in the context of the Plan's funding streams—the Plan's Contribution Policy. It is the only standard analysis that fully links all three aspects of the Plan's key financial drivers.

- In doing so, it creates an important "guidepost" for the actual asset allocation for the Plan; the asset allocation chosen by the Plan's fiduciaries will likely reflect the nature of the liabilities but also numerous other factors including risk preferences, liquidity, implementation constraints, etc.

- For the RHIC Asset/Liability Study, we assume the objectives are:

    1. Fund all participants' benefits over time.
    2. Assure sufficient liquidity to pay benefits at all times.
    3. Foster a stable contribution stream consistent with objectives 1 and 2.
    4. Achieve adequate returns without accepting unnecessary or imprudent levels of risk.



An Asset/Liability Study is NOT . . .

- An actuarial study of the RHIC liabilities—that is the purview of the Plan's actuary.
- A prescription for Plan benefits—that is the purview of the elected representatives.
- An assessment of the affordability of contribution levels—that is the purview of the elected officials and their constituents.
- The sole determinant of the final asset allocation adopted for the Plan—there are a number of factors, including insights from an Asset/Liability Study, which will bear on the optimal asset allocation.

Introduction (continued)

Asset/Liability Studies in Practice . . .

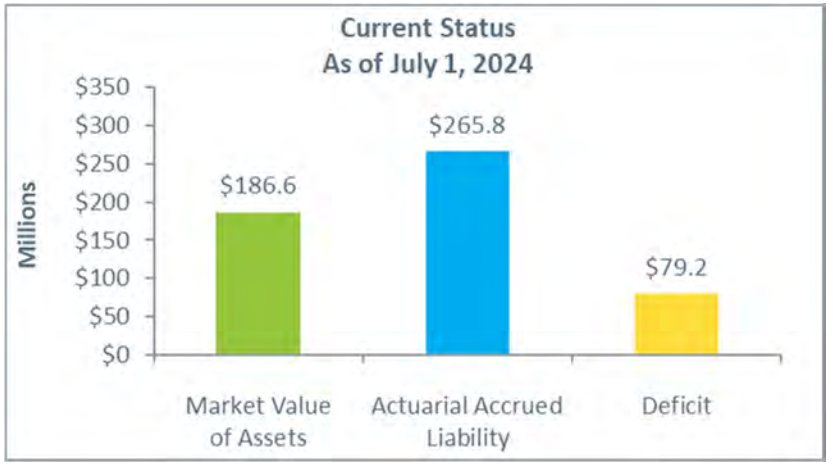
- Begin with a forecast of the financial liabilities (i.e., benefit obligations).
- Include a baseline estimation of the financial contributions to the Plan over time.
- Compare alternative investment strategies (i.e., total fund asset allocations to the Plan's financial needs).
- Draw conclusions regarding how well various investment strategies satisfy the Plan's financial needs.

This Asset/Liability Study . . .

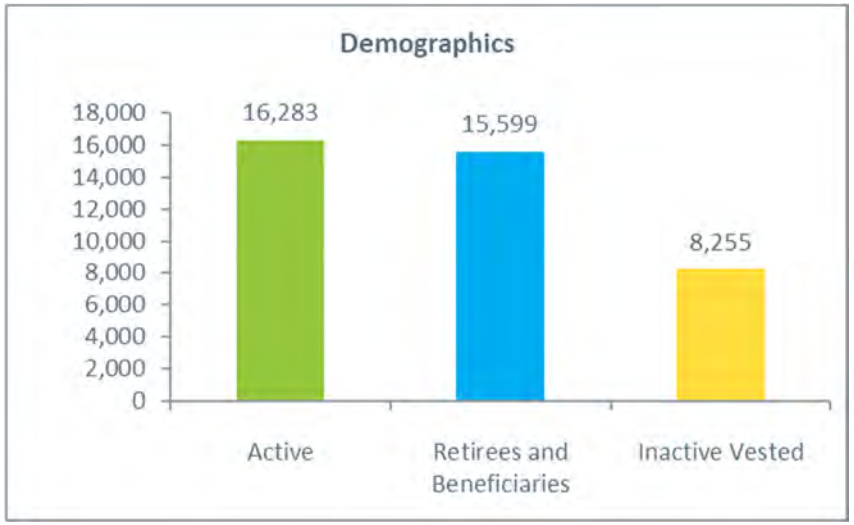
- Uses data from the July 1, 2024 RHIC Actuarial Valuation provided by Gabriel Roeder Smith & Company ("GRS") to project pension liabilities.
- Uses the actuarial cost method and the actuarial assumptions described in the July 1, 2024 RHIC Actuarial Valuation prepared by GRS, updated with the recommended assumption changes from the 2024 Experience Study prepared by GRS.
- Compares five specific investment strategies—(as outlined in the Stochastic section of this report).
- Assumes the Plan's current benefit policy throughout the entire projection period—changes to the benefit policy are the purview of the elected representatives.

Current Status

Plan Summary	July 1, 2024 (Valuation Date)
Market Value of Assets	$186.6 million
Actuarial Accrued Liability	$265.8 million
Deficit	$79.2 million
Market Value Funded Ratio	70%



Demographics	Members
Active Members	16,283
Retirees and Beneficiaries	15,599
Inactive Vested	8,255
Total	**40,137**



Deterministic Analysis

This section provides an analysis of the Plan's assets, liabilities, funded status, and benefit payments based on a fixed set of future assumptions. Each analysis that follows in this deterministic section rests on the critical assumptions below and must be read and interpreted with them in mind.

The deterministic assumptions are as follows:

1. Current Plan provisions (see Summary of Plan Provisions in Section E of the July 1, 2024 Actuarial Valuation report prepared by GRS.)

2. The participant data used in the July 1, 2024 Actuarial Valuation prepared by GRS.

3. Actuarially assumed rate of return of 5.75% on Plan assets.

4. For all years, employer contributions are equal to the statutory rate of 1.14% of payroll.

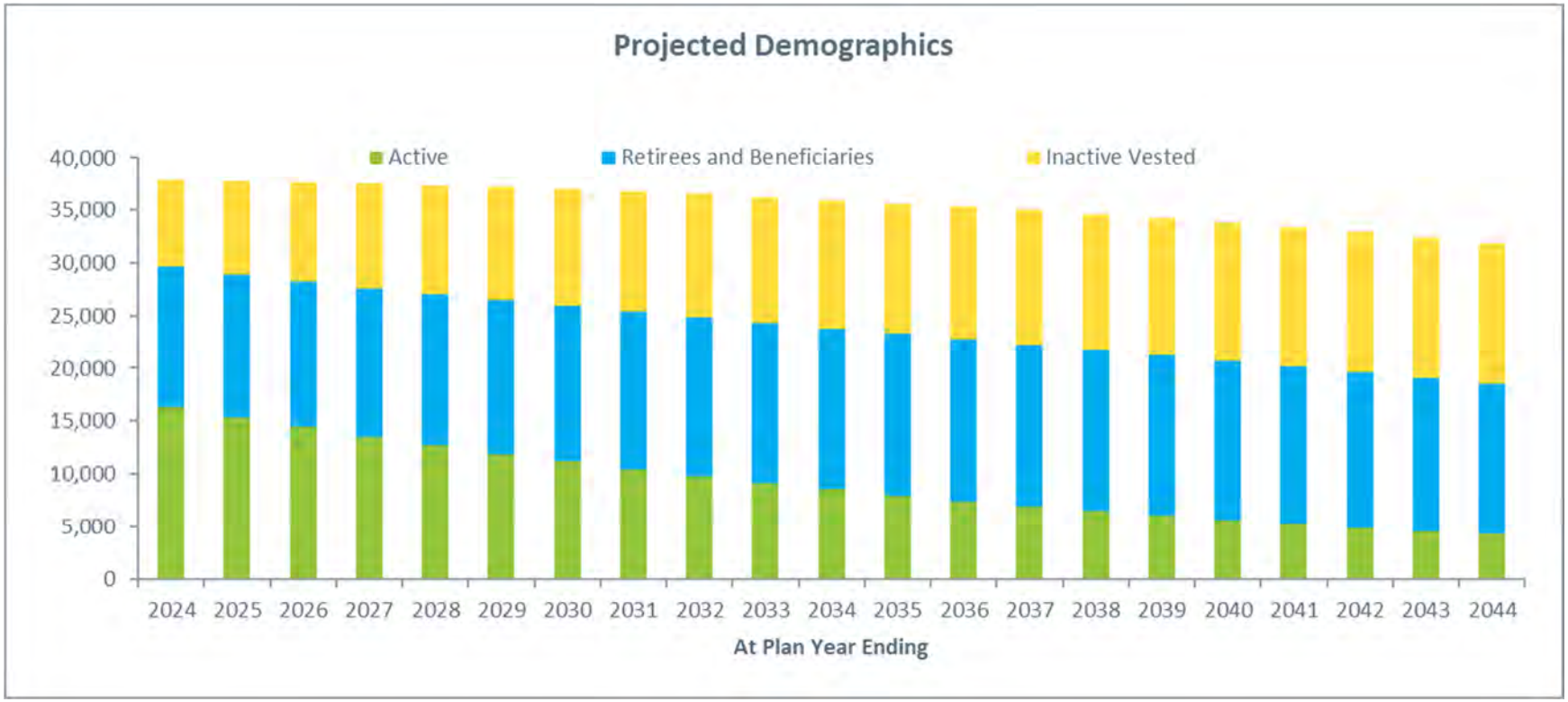
5. Assumes demographic experience projected in accordance with the assumptions used in the July 1, 2024 Actuarial Valuation prepared by GRS.

6. Open and Closed group analysis: The plan is considered closed to new members that enrolled in the NDPERS Main System or Defined Contribution Plan on or after January 1, 2020. For employee groups within RHIC that are still open, new participants are assumed to enter the plan so that the group's active population remains level. New active participants entering the Plan are assumed to have similar characteristics to recently hired participants.

Deterministic Analysis (continued)

Demographics

Following are the projected number of active and inactive participants at the beginning of each Plan year from 2024 through 2044 (2024 is actual). Using the actuary's assumptions for death, termination, retirement, and disability, current participants are assumed to leave the Plan in the future. The number of total inactive participants (Retirees and Beneficiaries) increases by approximately 6% during the 20-year projection period shown. The number of total active participants decreases by approximately 74% during the 20-year projection period shown.

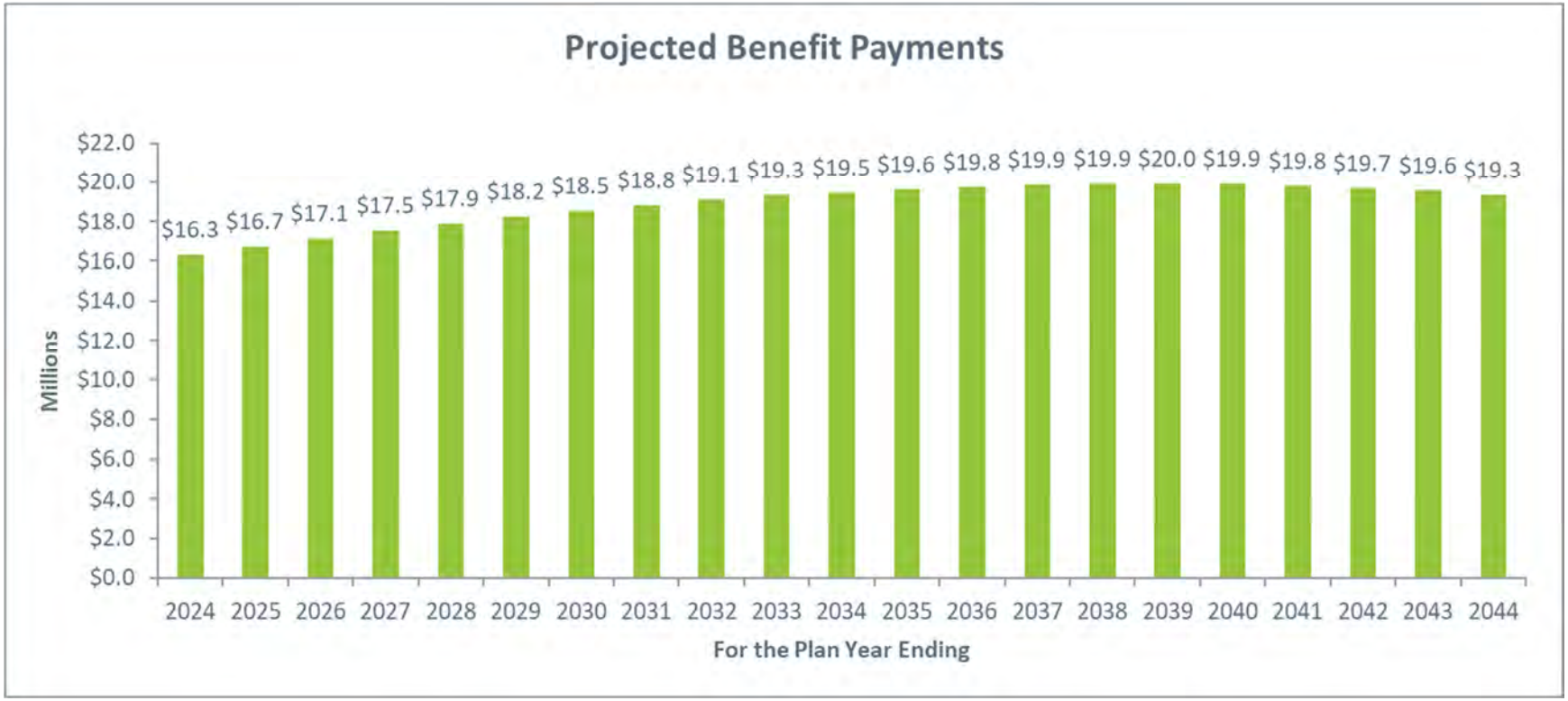


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Total Population																					
Annual Percent Change	N/A	0%	0%	0%	0%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-1%	-2%

Deterministic Analysis (continued)

Benefit Payments

The Plan's projected annual benefit payments are shown in the chart below. The projected benefit payments are expected to increase by about 18% over the next 20 years, peaking at $20.0 million in 2039. As a percentage of the market value of Plan assets, benefit payments are expected to fall through the end of the projection period (see page 12).

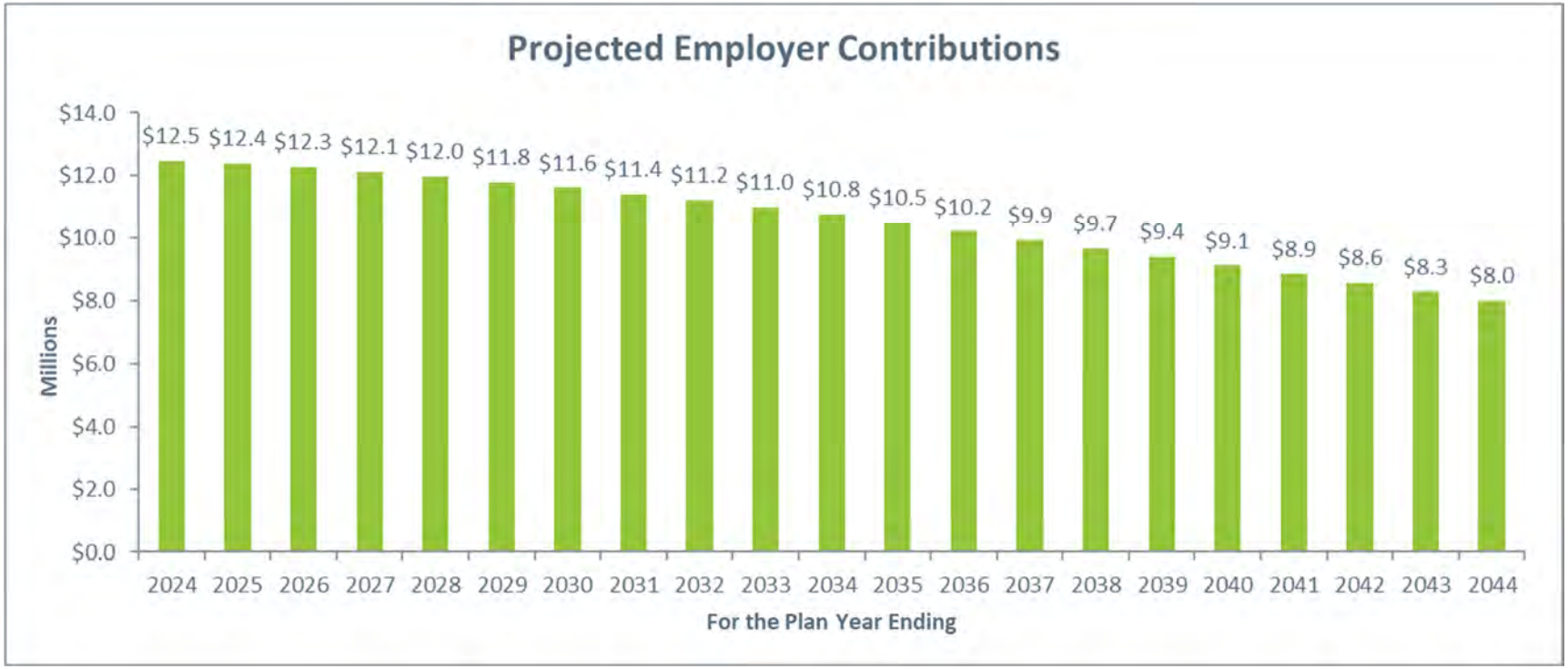


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Annual Percent Change	N/A	2%	3%	2%	2%	2%	2%	2%	1%	1%	1%	1%	1%	0%	0%	0%	0%	0%	-1%	-1%	-1%

Deterministic Analysis (continued)

Contributions

The Plan's projected dollar contributions are shown in the chart below. Contributions are projected to decrease as the number of active members falls. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.

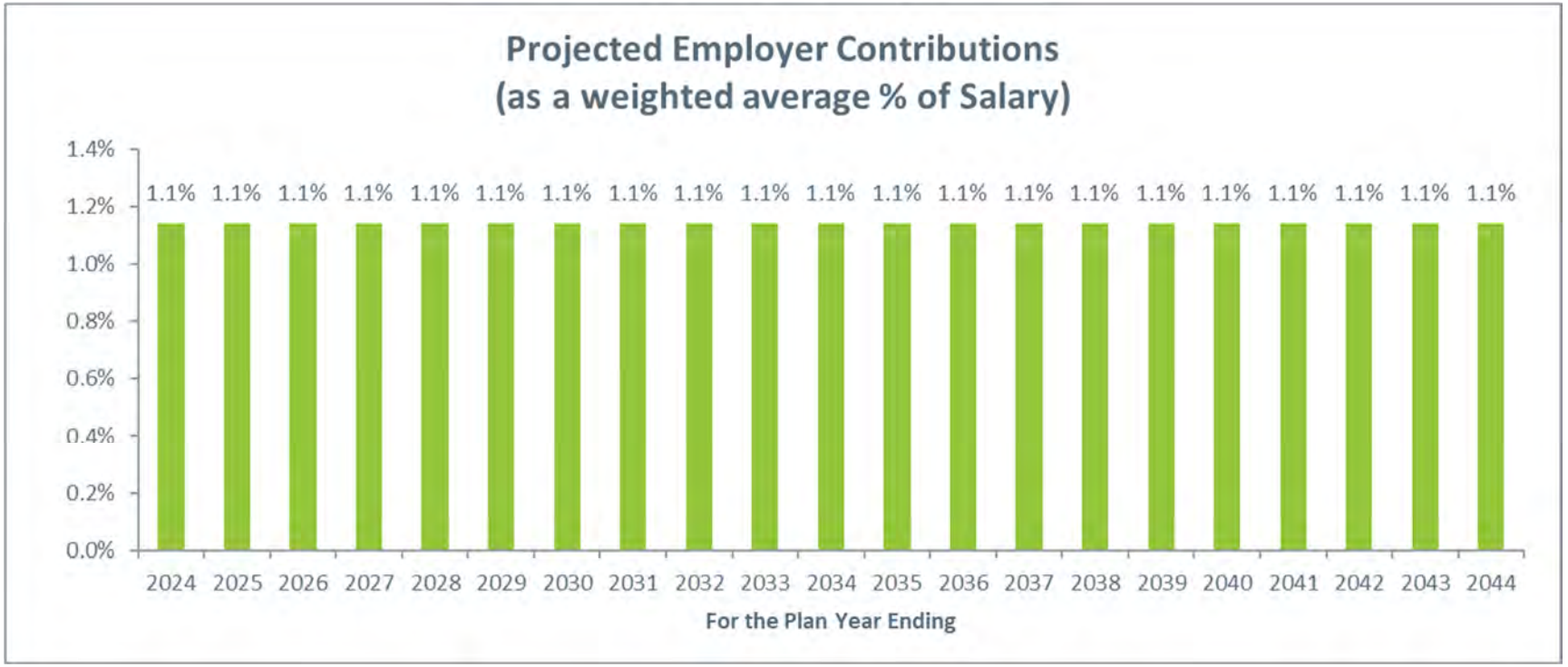


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Annual Percent Change	N/A	-1%	-1%	-1%	-1%	-1%	-1%	-2%	-2%	-2%	-2%	-2%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

Deterministic Analysis (continued)

Contributions

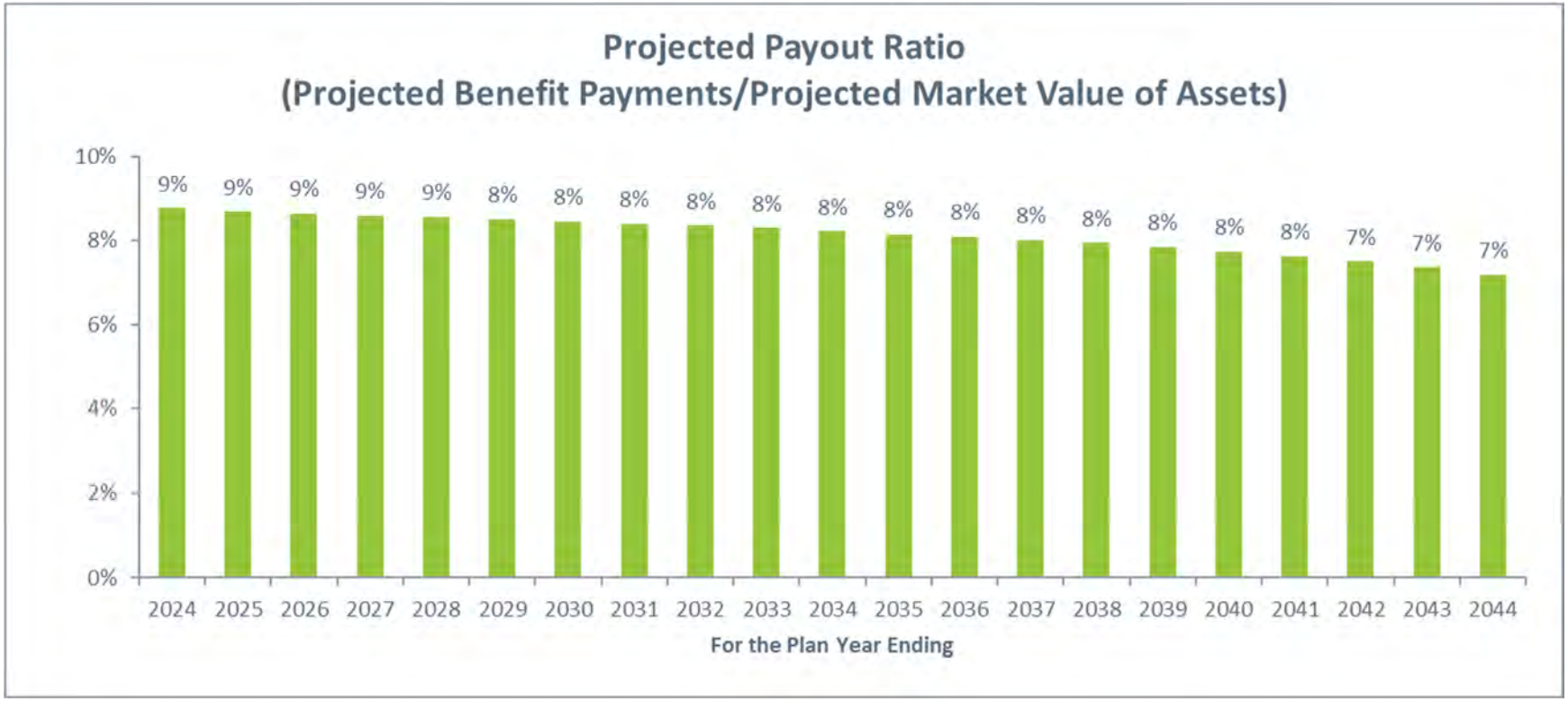
The Plan's projected contributions, expressed as a weighted average percentage of salary, are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Analysis (continued)

Payout Ratio (benefit payments/market value of assets)

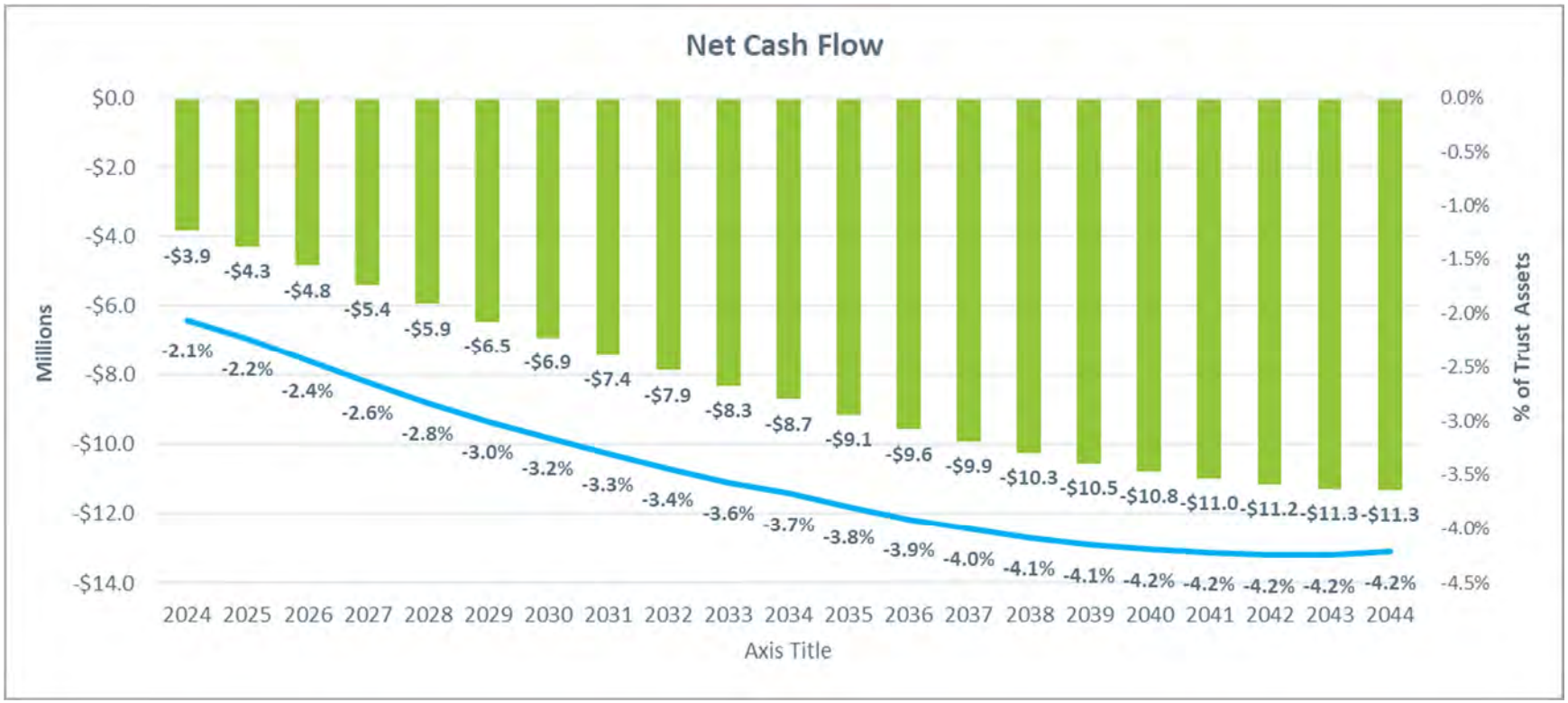
The Plan's projected payout ratios are shown in the chart below. The payout ratio is expected to gradually fall through the end of the projection period. The results assume the current contribution policy remains unchanged and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Analysis (continued)

Net Cash Flow (Contributions – Benefit Payments)

The Plan's projected net cash flow is shown in the chart below. As contributions fall and benefit payments increase, Net Cash Flow is projected to fall both on an absolute bases and as a percentage of Plan Assets. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



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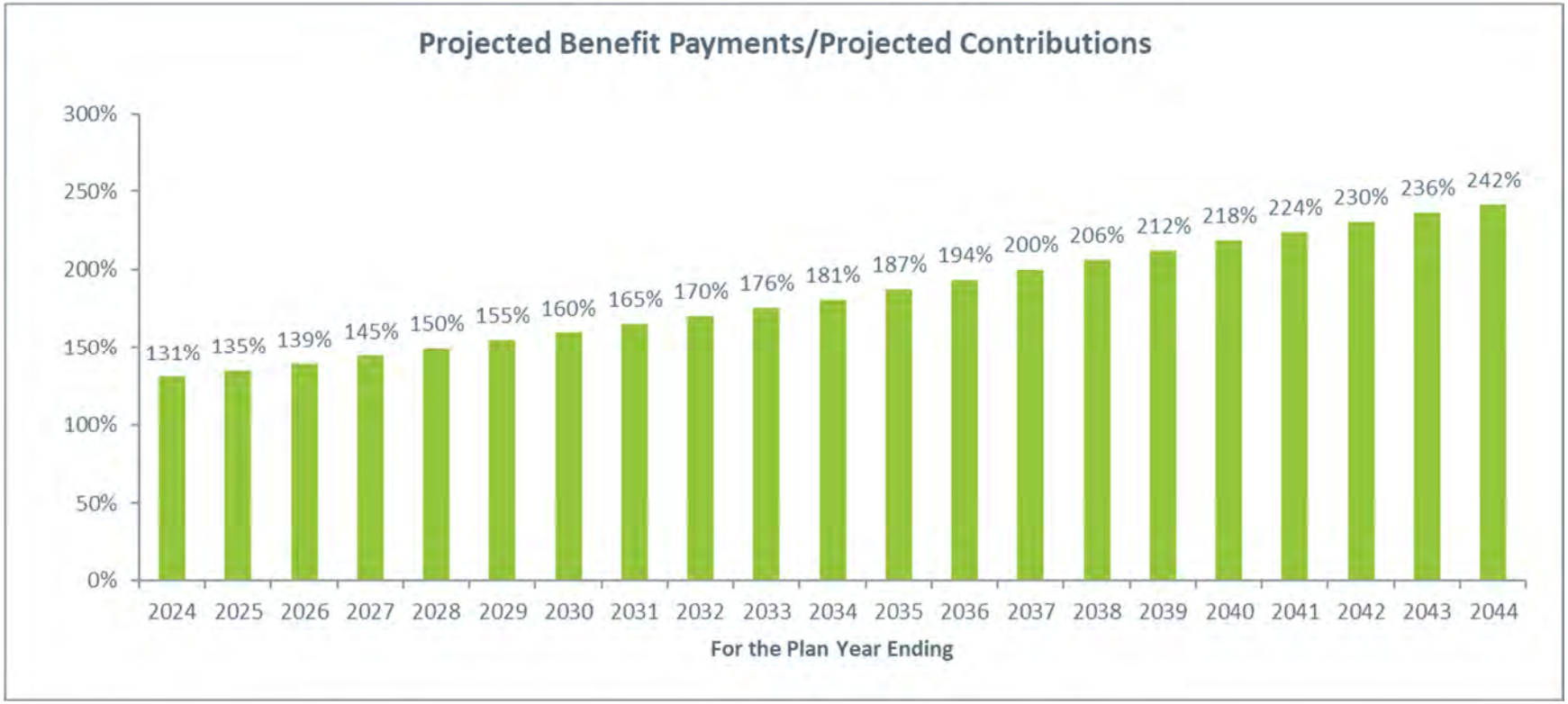
Deterministic Analysis (continued)

Benefit Payments/Contributions

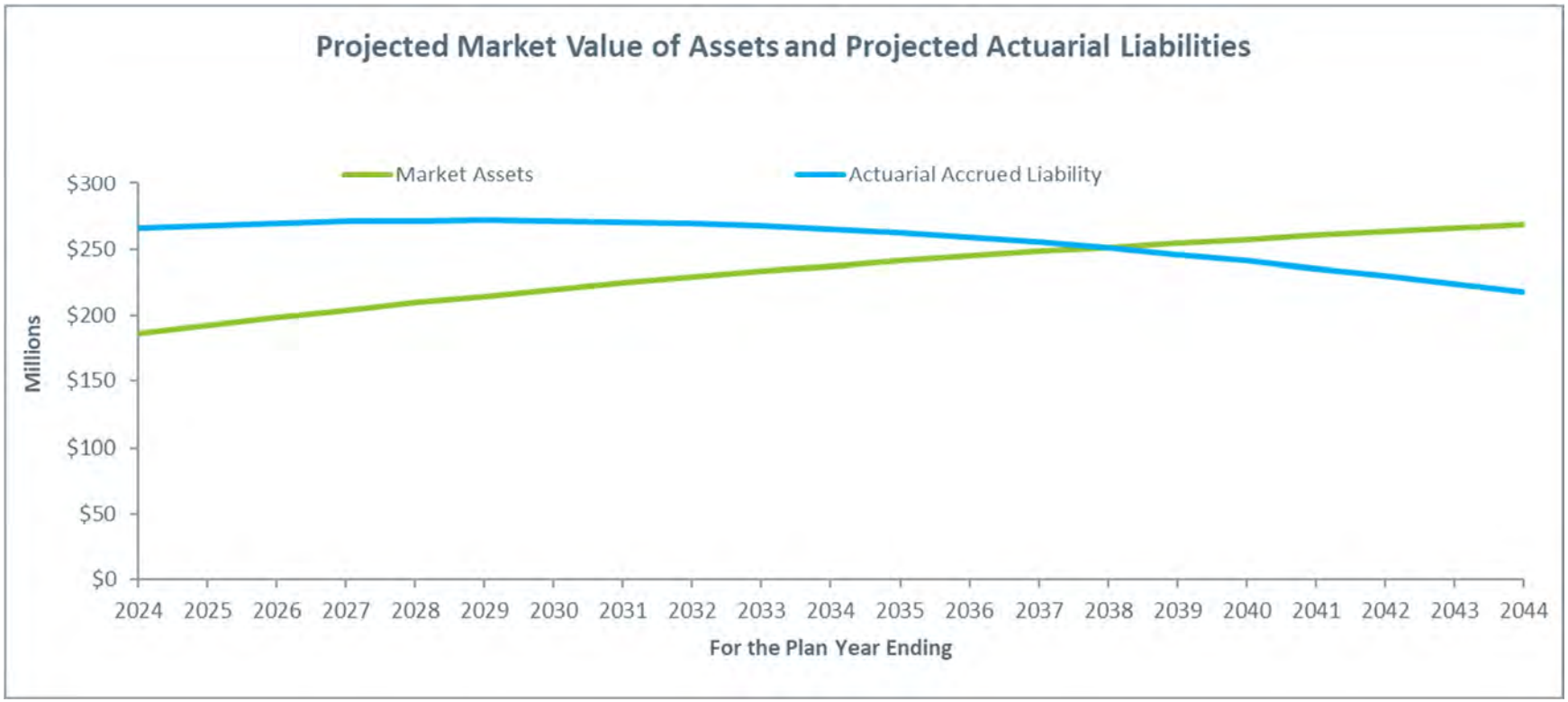
The Plan's projected benefit payments divided by projected contributions are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Analysis (continued)

Actuarial Accrued Liabilities and Market Value of Assets

The Plan's projected actuarial accrued liabilities and market value of assets are shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years. The relative disparity between the market value of assets and Plan liabilities is expected to be eliminated by approximately 2038. The funded ratio (based on market value of assets) is expected to gradually increase to 124% by the end of the projection period. This is shown more clearly on the following pages.



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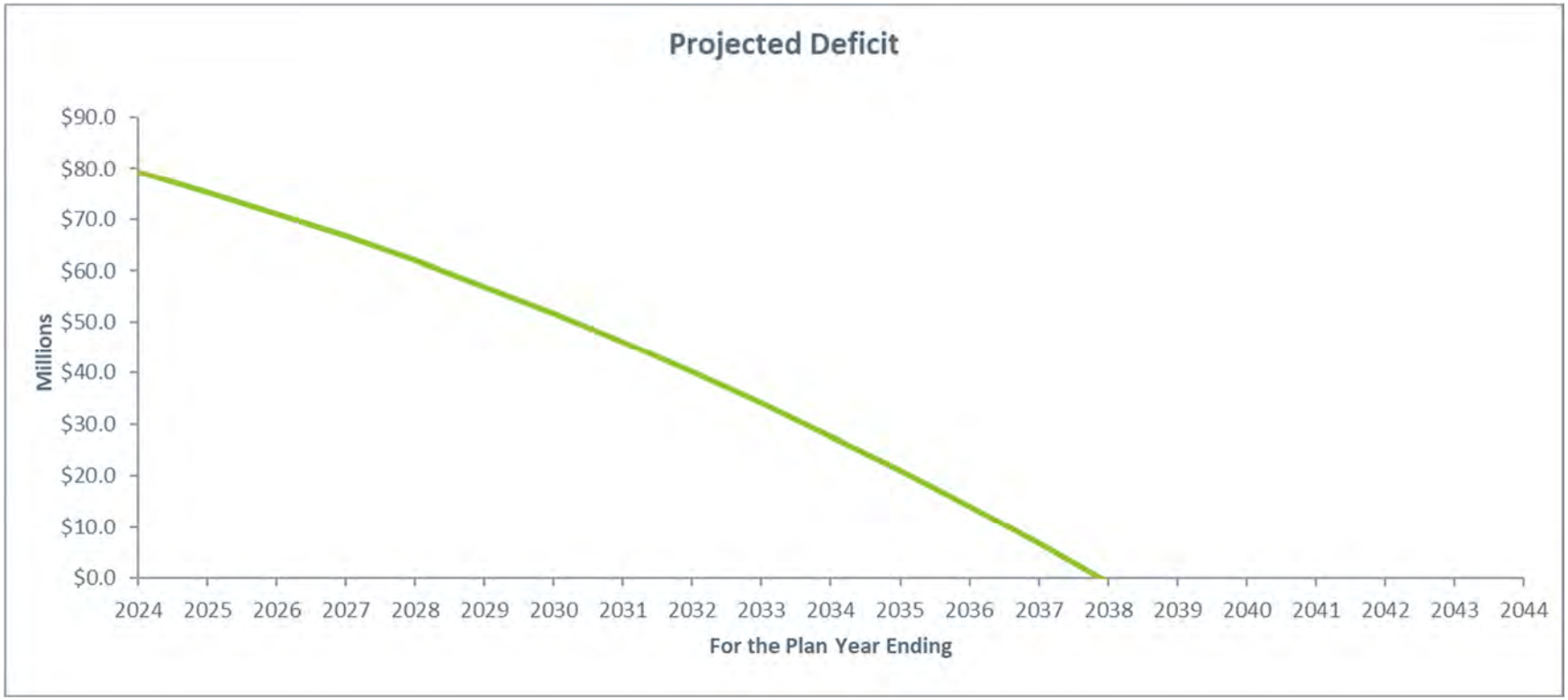
Deterministic Analysis (continued)

Deficit (market value of assets – actuarial accrued liabilities)

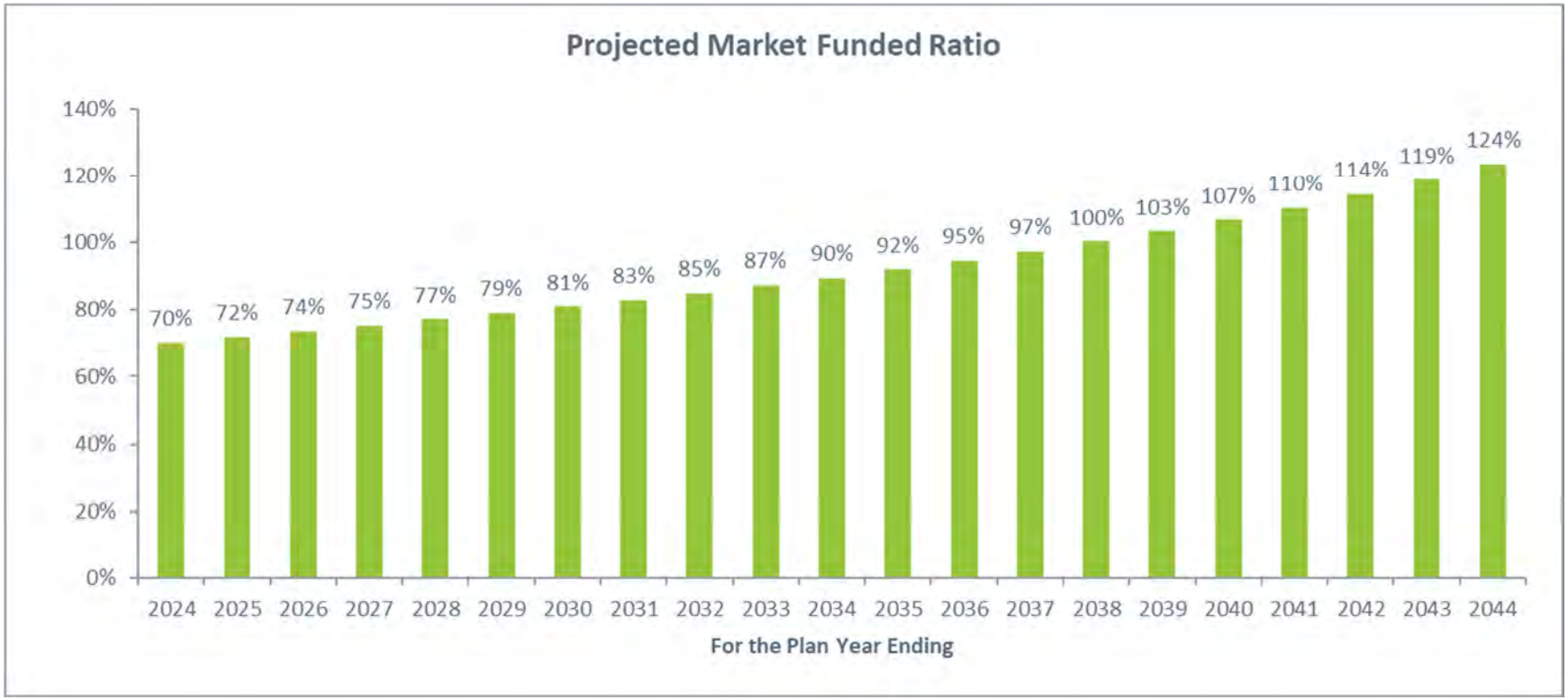
The Plan's projected deficit of assets is shown in the chart below. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years. The deficit is expected to be entirely eliminated by approximately 2038.



Deterministic Analysis (continued)

Market Funded Ratio (market value of assets/actuarial accrued liability)

The Plan's projected market funded ratio is shown in the chart below. The Plan is expected to end the projection period at approximately 124% funded. The results assume the contribution policy remains unchanged, and that the Plan's assets return precisely the actuarially assumed rate each year without exception for all projection years.



Deterministic Scenario Analysis

Full Funding Implied Returns

The figure below shows the projected investment return for the total fund needed to bring the Plan to 100% funding (on a market value basis) in 10 and 20 years, respectively. The results assume all other actuarial assumptions are precisely met over the time periods shown and that these returns are earned for every year, without variance.

Actuarially assumed rate of return – **5.75%**

Deterministic Scenario Analysis (continued)

Sensitivity Analysis

The table below summarizes the outcomes of the following deterministic scenarios. The Base Case represents the analysis completed in the Deterministic Analysis section of this report and assumes the current actuarially assumed rate of return (5.75%). The results assume all other actuarial assumptions are precisely met over the time periods shown and that these returns are earned for every year, without variance.

A. **Reduced Return** – Assets earn 4.75% each and every year.
B. **V Shaped Market Event** – The V scenario assumes a return of -20% in the first projection year and +20% in the second projection year followed by the assumed rate of return thereafter.
C. **W Shaped Market Event** – The W scenario assumes a return of -10% in the first projection year, +10% in the second, -10% in the third, +10% in the fourth projection year followed by the assumed rate of return thereafter.
D. **Loss then Low** – Immediate 10% loss followed by a lower return environment (4.75%).
E. **Persistent Inflation** – Assets earn the assumed rate of return each and every year but inflation is 4.00% per year during the 20-year projection period.

	Value in 2044					
	Baseline	Reduced Return	V	W	Loss then Low	Inflation
Projected Payout Ratio	7%	10%	10%	13%	14%	6%
Projected Employer Contributions (millions)	$8.0	$8.0	$8.0	$8.0	$8.0	$10.7
Projected Benefit Payments/Projected Total Contributions	242%	242%	242%	242%	242%	181%
Projected Actuarial Accrued Liabilities (millions)	$217.5	$217.5	$217.5	$217.5	$217.5	$217.5
Projected Market Value of Assets (millions)	$268.8	$199.2	$190.3	$153.0	$135.7	$310.7
Projected Deficit (millions)	($51.3)	$18.3	$27.1	$64.5	$81.8	-$93.2
Projected Market Funded Ratio	124%	92%	88%	70%	62%	143%
	20 Year Cumulative Total					
Projected Cumulative Employer Contributions (millions)	$209.1	$209.1	$209.1	$209.1	$209.1	$241.7

Stochastic Analysis

In the previous section of this report, we assumed the Plan operated going forward with certain knowledge of the future investment returns earned by the Plan's assets. This section introduces the element of uncertainty in those future investment returns. This part of the analysis examines Plan assets and liabilities under many capital market environments based on expected future asset returns and inflation, and their expected volatility. Using a Monte Carlo simulation technique, both assets and liabilities are assumed to vary stochastically, linked together by changes in inflation.

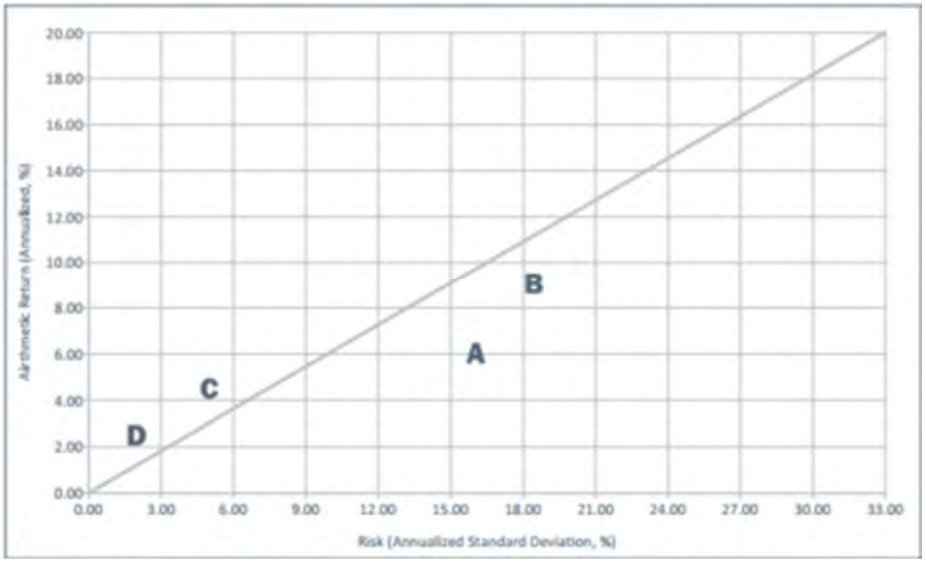
Using the current expected values and variances of the returns and inflation, along with their correlations, 2,000 trials are generated to produce a distribution of results. A stochastic analysis can answer questions about the best/worst case outcomes along with the probability of such outcomes. This is contrasted with the deterministic analysis that provides an expected value if all current Plan assumptions are exactly met.

Stochastic Analysis (continued)

Long-Term Return and Risk Assumptions

In order to perform a stochastic analysis and create asset allocation alternatives, it is necessary to estimate, for each asset class, its probable return and risk. The expected returns are our best estimates of the average annual percentage increases in values of each asset class over a prospective long period of time, and assumed to be normally distributed. The risk of an asset class is measured by its standard deviation, or volatility. If asset returns are normally distributed, two-thirds (67%) of all returns are expected to lie within one standard deviation on either side of the mean. For example, we expect Broad US Equity to return, annually on average, 6.04% with a standard deviation of 16.04%, meaning that two-thirds of the time we expect its return to lie between -10.00% (= 6.04 – 16.04) and 22.08% (= 6.04 + 16.04). Moreover, we expect 95% of all return outcomes to lie within two standard deviations of the mean return, implying only a one-in-twenty chance that the return on Broad US Equity will either fall below -26.04% or rise above 38.12%. The risk and return assumptions used in this study are outlined in the below table and chart:

Asset Class	Nominal Return (Arith.)	Standard Deviation
Broad US Equity	6.04%	16.04%
Broad International Equity	9.07%	18.47%
US Aggregate Fixed Income	4.50%	5.00%



Stochastic Analysis (continued)

Correlation Between Asset Classes

Creating a diversified portfolio of asset classes enables the investor to achieve a high rate of return while minimizing volatility of the portfolio. As defined on the previous page, volatility is "risk" or standard deviation. By minimizing the volatility of a portfolio, we produce asset returns that vary less from year to year. Diversification exists because the returns of different asset classes do not always move in the same direction, at the same time, or with the same magnitude. Correlation values are between 1.00 and –1.00. If returns of two asset classes rise or fall at the same time and in the same magnitude, they have a correlation value of 1.00. Conversely, two asset classes that simultaneously move in opposite directions, and in the same magnitude, have a correlation value of –1.00. A correlation of zero indicates no relationship between returns. The assumed correlations are largely based on historical index data, with some qualitative analysis applied. For instance, where appropriate, we have weighted current history more heavily. The correlation matrix used in this study is shown below:

	Broad US Equity	Broad International Equity	US Agg Fixed Income	Inflation
Broad US Equity	1.00	0.87	0.27	0.01
Broad International Equity	0.87	1.00	0.31	0.03
US Agg Fixed Income	0.27	0.31	1.00	-0.26
Inflation	0.01	0.03	-0.26	1.00

The fact that the correlations shown in the table are nearly all positive does not imply that these asset classes do not diversify one another. Their correlations are significantly less than 1.00, meaning we expect a measurable number of instances when the underperformance of one or more of the asset classes will be offset by the outperformance of others. This point is demonstrated on the following pages, which illustrate that diversification into less correlated asset classes can decrease the expected overall volatility of a portfolio.

Stochastic Analysis (continued)

Efficient Portfolios

Each frontier portfolio (optimal allocation) is created using target rates of return both above and below the projected rate of return for the current allocation. This range illustrates the trade-off between return and risk; additional return can only be achieved by undertaking additional risk. The table below shows the possible optimal allocations given the selected asset classes and their constraints listed under "Min" and "Max."

	Min	Max	1	2	3	4	5	6	7	8	9	10
Broad US Equity	**0**	**50**	50	42	33	25	29	33	38	42	46	50
Broad International Equity	**0**	**50**	0	8	17	25	29	33	38	42	46	50
US Agg Fixed Income	**0**	**50**	50	50	50	50	42	33	25	17	8	0
Total			100	100	100	100	100	100	100	100	100	100
Capital Appreciation			50	50	50	50	58	67	75	83	92	100
Capital Preservation			50	50	50	50	42	33	25	17	8	0
Alpha			0	0	0	0	0	0	0	0	0	0
Inflation			0	0	0	0	0	0	0	0	0	0
Expected Arithmetic Return			**5.27**	**5.52**	**5.78**	**6.03**	**6.29**	**6.54**	**6.79**	**7.05**	**7.30**	**7.56**
Expected Risk (Standard Deviation)			**9.02**	**9.09**	**9.22**	**9.42**	**10.57**	**11.75**	**12.96**	**14.19**	**15.43**	**16.69**
Expected Compound Return			**4.89**	**5.13**	**5.38**	**5.61**	**5.77**	**5.90**	**6.01**	**6.12**	**6.21**	**6.29**
Expected Return (Arithmetic)/Risk Ratio			0.58	0.61	0.63	0.64	0.60	0.56	0.52	0.50	0.47	0.45
RVK Expected Eq Beta (LCUS Eq = 1)			0.55	0.55	0.55	0.55	0.62	0.70	0.77	0.85	0.92	1.00
RVK Liquidity Metric (T-Bills = 100)			90	90	89	89	89	90	91	91	92	93
Allocation to Private Assets			0	0	0	0	0	0	0	0	0	0

*Broad US Equity is constrained to be greater than or equal to Broad International Equity.

Stochastic Analysis (continued)

Asset Mixes

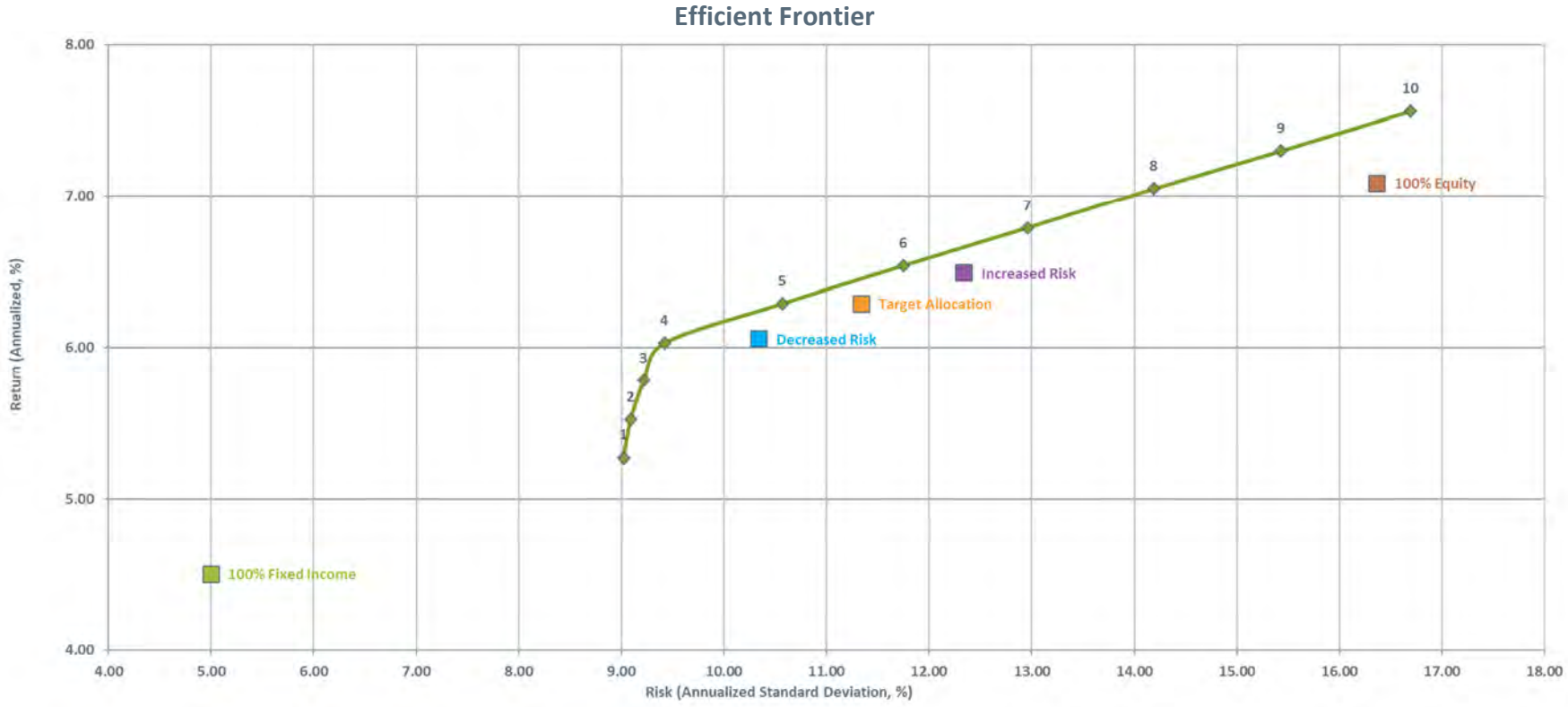
The table shows Target Allocation and highlights five additional portfolios for consideration throughout this study.

	100% Fixed Income	Decreased Risk	Target Allocation	Increased Risk	100% Equity
Broad US Equity	0	36	39	43	65
Broad International Equity	0	22	26	29	35
US Agg Fixed Income	100	42	35	28	0
Total	100	100	100	100	100
Capital Appreciation	0	58	65	72	100
Capital Preservation	100	42	35	28	0
Alpha	0	0	0	0	0
Inflation	0	0	0	0	0
Expected Arithmetic Return	**4.50**	**6.06**	**6.29**	**6.49**	**7.09**
Expected Risk (Standard Deviation)	**5.00**	**10.34**	**11.34**	**12.34**	**16.36**
Expected Compound Return	**4.38**	**5.56**	**5.69**	**5.78**	**5.86**
Expected Return (Arithmetic)/Risk Ratio	0.90	0.59	0.55	0.53	0.43
RVK Expected Eq Beta (LCUS Eq = 1)	0.09	0.62	0.68	0.75	1.00
RVK Liquidity Metric (T-Bills = 100)	85	90	90	91	93
Allocation to Private Assets	0	0	0	0	0

Stochastic Analysis (continued)

Efficient Frontier

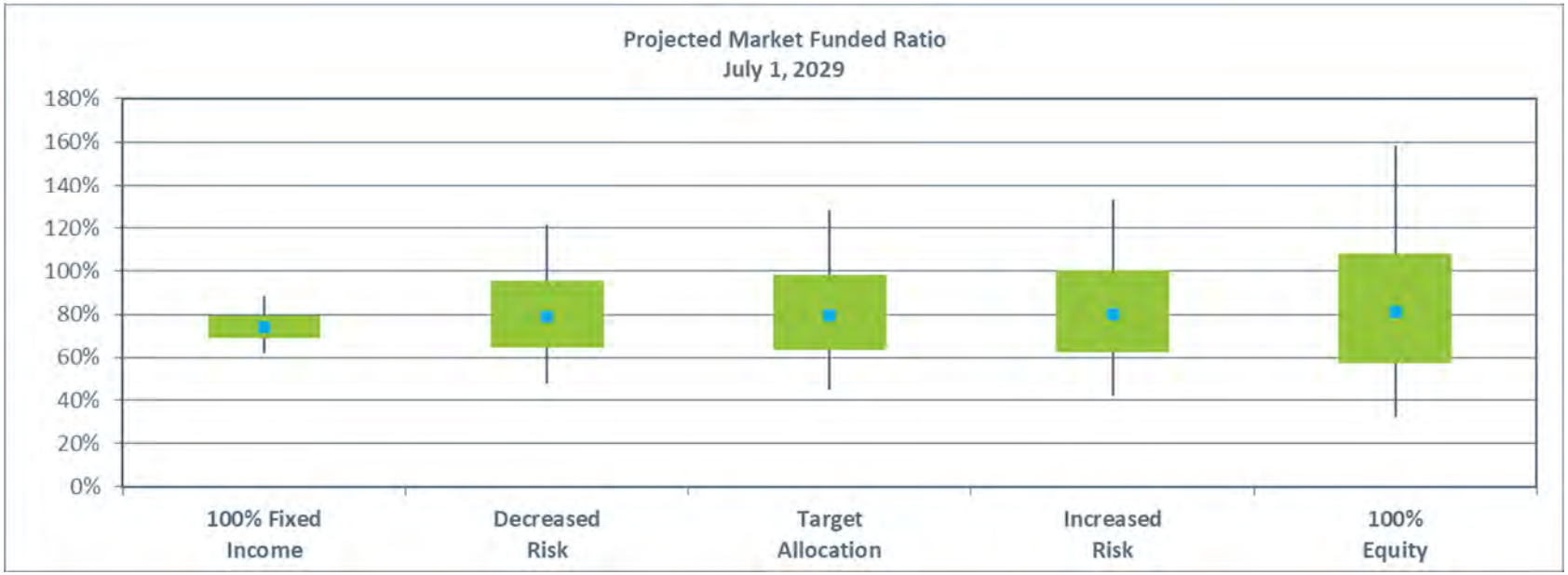
The risk of each alternative allocation is plotted against the horizontal axis, while the return is measured on the vertical axis. The line connecting the points represents all the optimal portfolios subject to the given constraints and is known as the "efficient frontier." The upward slope of the efficient frontier indicates the direct relationship between return and risk.



Stochastic Analysis (continued)

Projected Market Funded Ratio (market value of assets/actuarial accrued liability); **5 Years**

The graph below shows the distribution of possible market funded ratios five years from now, assuming the five different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.

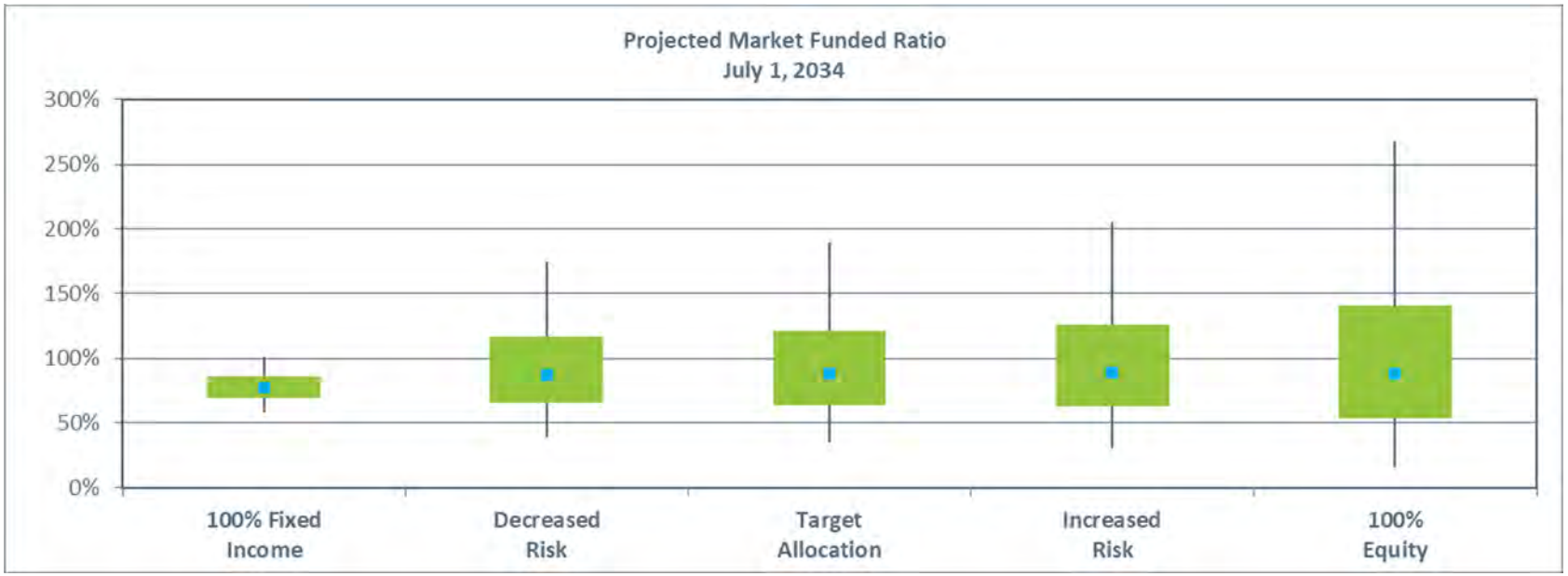


	100% Fixed Income		Decreased Risk		Target Allocation		Increased Risk		100% Equity	
	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio
5th Percentile	$104.1	62%	$142.7	47%	$150.1	45%	$157.3	42%	$184.1	32%
25th Percentile	$84.8	69%	$95.9	65%	$98.7	64%	$101.6	63%	$115.5	57%
50th Percentile	$70.9	74%	$56.6	79%	$55.3	80%	$53.9	80%	$52.0	81%
75th Percentile	$55.5	80%	$12.1	96%	$5.5	98%	($0.7)	100%	($22.2)	108%
95th Percentile	$32.3	88%	($58.4)	121%	($75.6)	128%	($90.3)	133%	($158.9)	159%

Stochastic Analysis (continued)

Projected Market Funded Ratio (market value of assets/actuarial accrued liability); **10 Years**

The graph below shows the distribution of possible market funded ratios ten years from now, assuming the five different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.



	100% Fixed Income		Decreased Risk		Target Allocation		Increased Risk		100% Equity	
	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio
5th Percentile	$111.6	58%	$164.2	38%	$173.8	34%	$184.2	30%	$224.2	15%
25th Percentile	$83.9	68%	$93.0	65%	$96.2	64%	$100.2	62%	$125.3	53%
50th Percentile	$60.7	77%	$33.0	88%	$30.7	88%	$29.0	89%	$32.6	88%
75th Percentile	$35.7	87%	($44.1)	117%	($56.2)	121%	($68.4)	126%	($107.4)	141%
95th Percentile	($2.9)	101%	($198.4)	175%	($236.4)	189%	($277.1)	205%	($444.9)	268%

Stochastic Analysis (continued)

Projected Market Funded Ratio (market value of assets/actuarial accrued liability); **20 Years**

The graph below shows the distribution of possible market funded ratios twenty years from now, assuming the five different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.

	100% Fixed Income		Decreased Risk		Target Allocation		Increased Risk		100% Equity	
	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio	Unfunded Liability (Mil)	Funded Ratio
5th Percentile	$132.8	39%	$209.4	4%	$217.5	0%	$217.5	0%	$217.5	0%
25th Percentile	$83.5	62%	$99.0	54%	$105.9	51%	$116.3	47%	$167.8	23%
50th Percentile	$39.6	82%	($24.0)	111%	($30.7)	114%	($28.2)	113%	($3.0)	101%
75th Percentile	($4.1)	102%	($195.7)	190%	($227.8)	205%	($255.5)	217%	($330.2)	252%
95th Percentile	($84.4)	139%	($594.4)	373%	($715.1)	429%	($837.3)	485%	($1,356.3)	724%

Stochastic Analysis (continued)

Projected Market Funded Ratio and Maximum 1 Year Investment Loss (market value of assets/actuarial accrued liability)

The tables below show the probability that the Plan will be at various funding levels for each of the five different asset mixes highlighted on the prior pages. The tables also illustrate the maximum 1 year investment loss each portfolio is expected to experience during the given time period. The results assume the current contribution policy remains unchanged for all projection years.

5 Years	Probability of Full Funding in 2029	Probability of < 70% (Current) Funding in 2029	Probability of < 50% Funding in 2029	Maximum 1 Year Investment Loss
100% Fixed Income	0%	30%	3%	-6%
Decreased Risk	19%	34%	18%	-26%
Target Allocation	23%	35%	20%	-29%
Increased Risk	25%	35%	21%	-32%
100% Equity	32%	39%	28%	-46%

10 Years	Probability of Full Funding in 2034	Probability of < 70% (Current) Funding in 2034	Probability of < 50% Funding in 2034	Maximum 1 Year Investment Loss
100% Fixed Income	6%	29%	8%	-6%
Decreased Risk	38%	30%	21%	-25%
Target Allocation	39%	32%	22%	-28%
Increased Risk	40%	32%	24%	-32%
100% Equity	43%	37%	31%	-45%

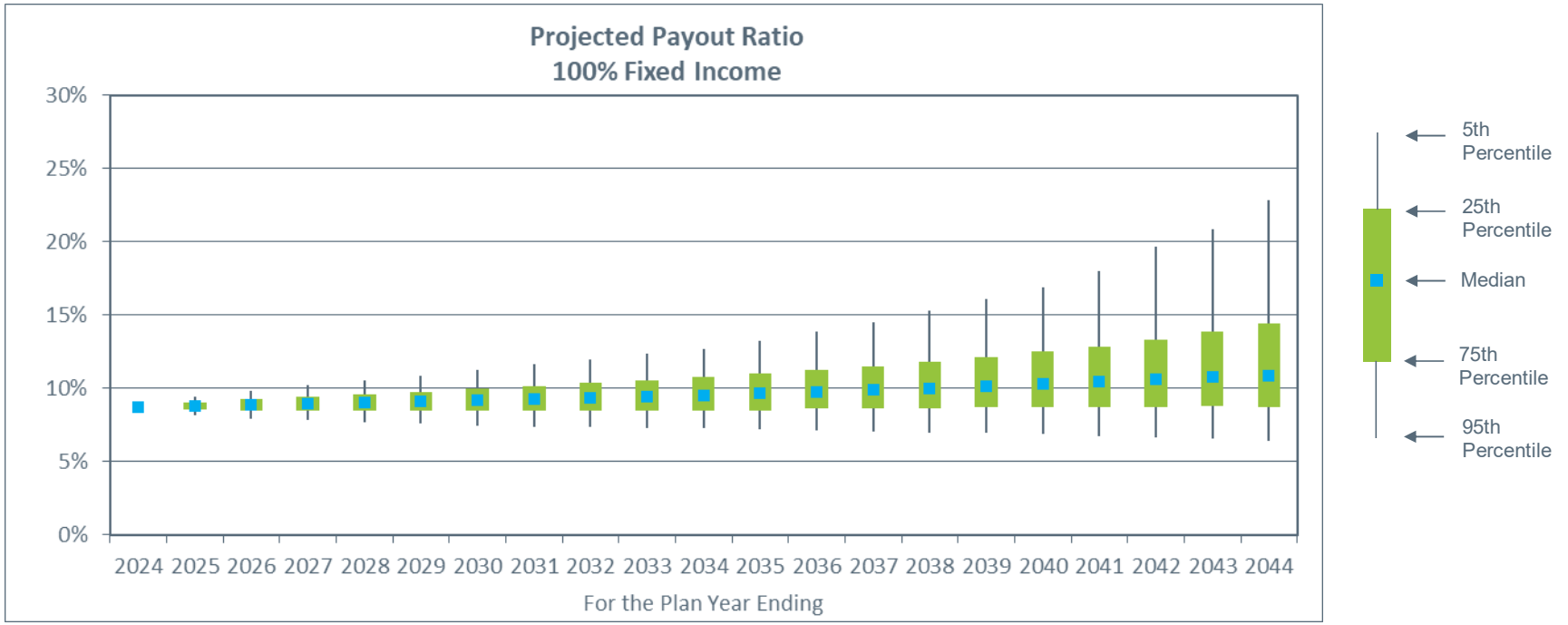
20 Years	Probability of Full Funding in 2044	Probability of < 70% (Current) Funding in 2044	Probability of < 50% Funding in 2044	Maximum 1 Year Investment Loss
100% Fixed Income	26%	34%	23%	-7%
Decreased Risk	54%	32%	27%	-26%
Target Allocation	54%	33%	28%	-30%
Increased Risk	54%	35%	30%	-33%
100% Equity	50%	42%	38%	-47%

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **100% Fixed Income**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **100% Fixed Income** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 9% and 11%. The worst-case scenario could reach 23% or higher.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	10%	10%	10%	10%	10%	10%	10%	10%	11%	11%	11%

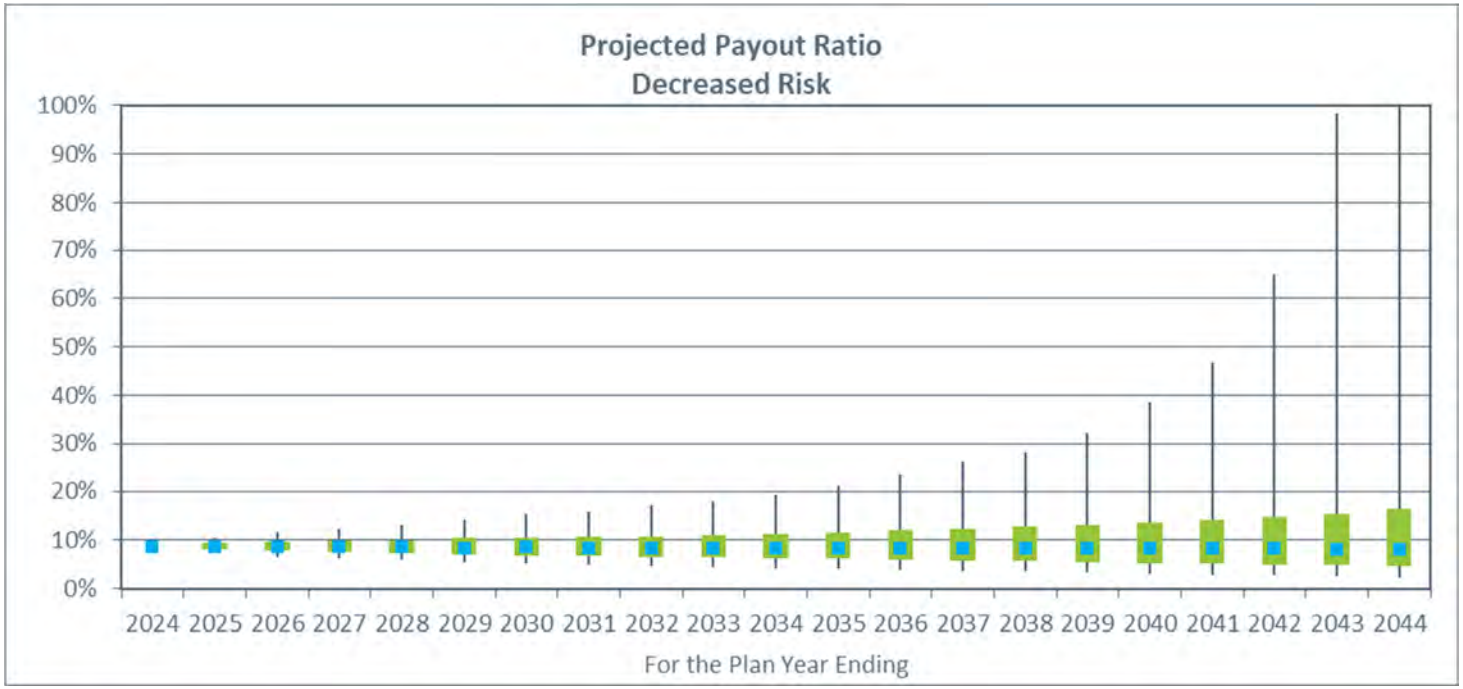
RVK

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **Decreased Risk**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **Decreased Risk** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 8% and 9%. The worst-case scenario could reach up to 100%.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	9%	9%	9%	9%	9%	8%	9%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%

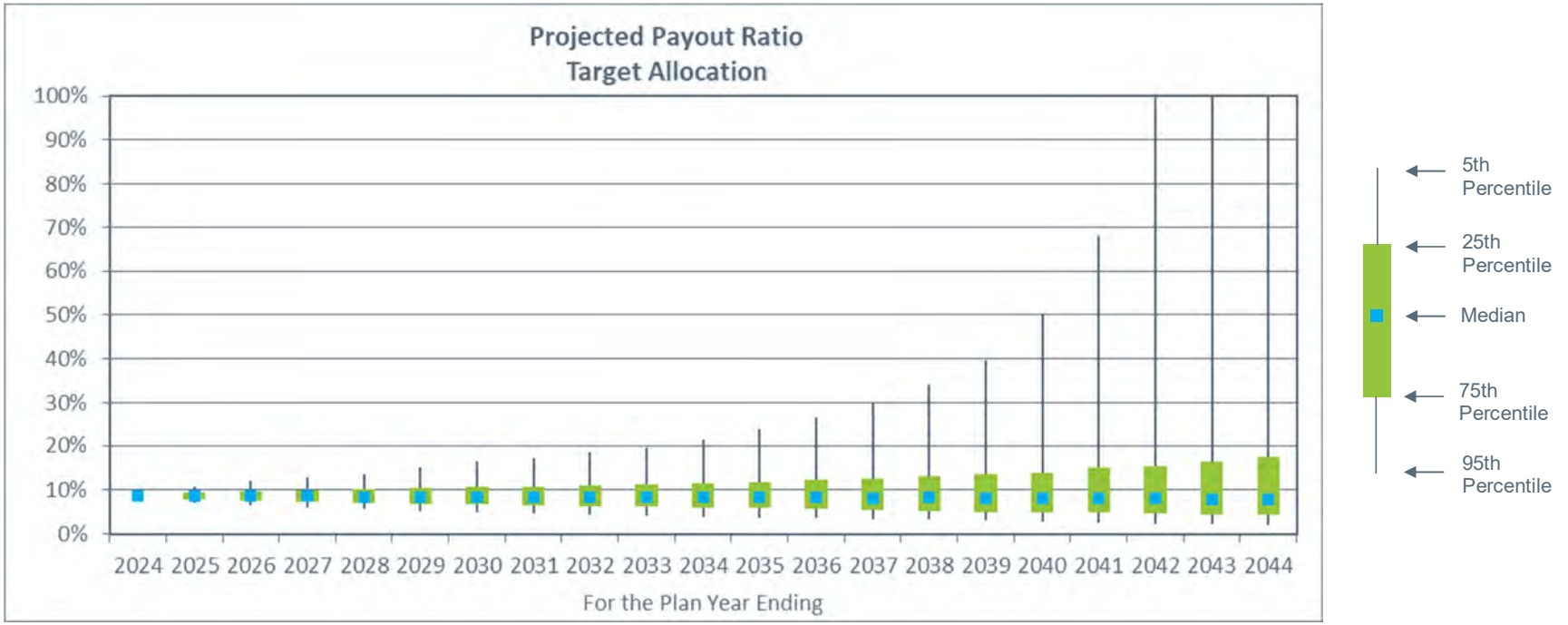
RVK

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **Target Allocation**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **Target Allocation** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 8% and 9%. The worst-case scenario could reach up to 100%.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	9%	9%	9%	9%	9%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%

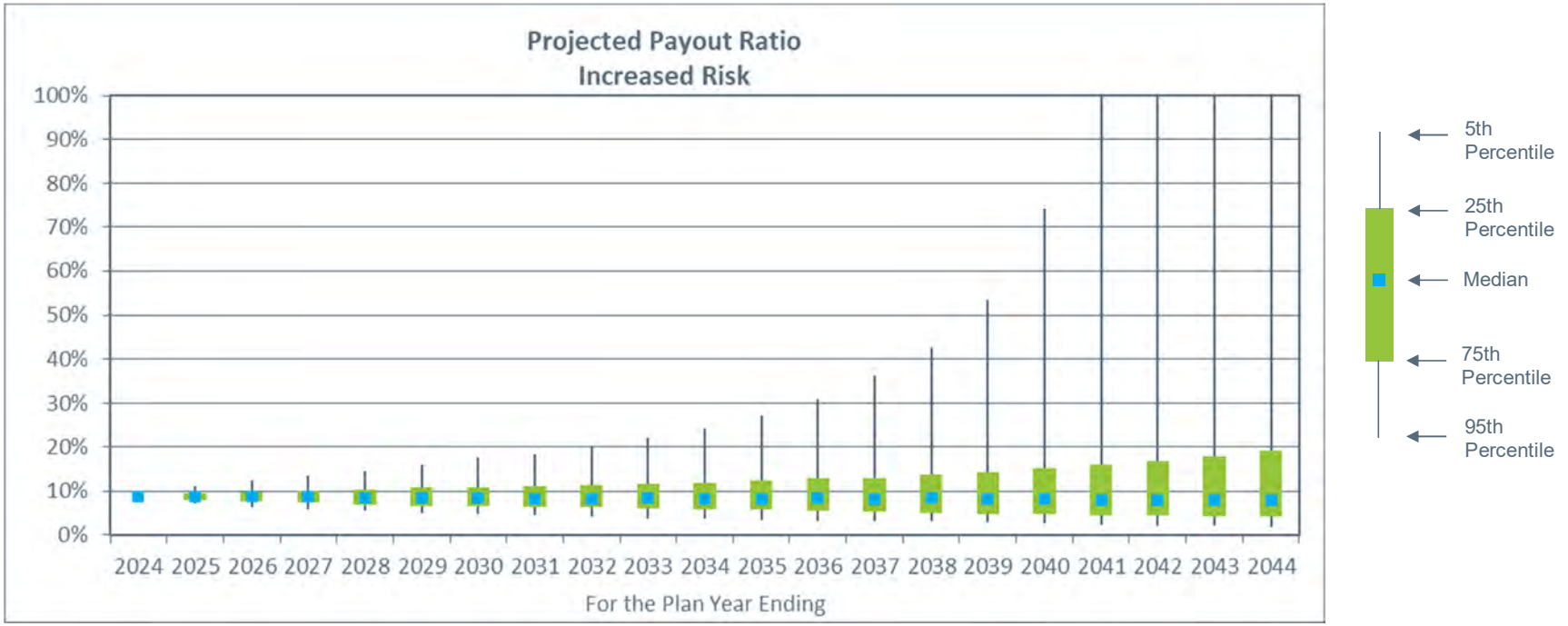
RVK

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **Increased Risk**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **Increased Risk**. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 8% and 9%. The worst-case scenario could reach up to 100%.



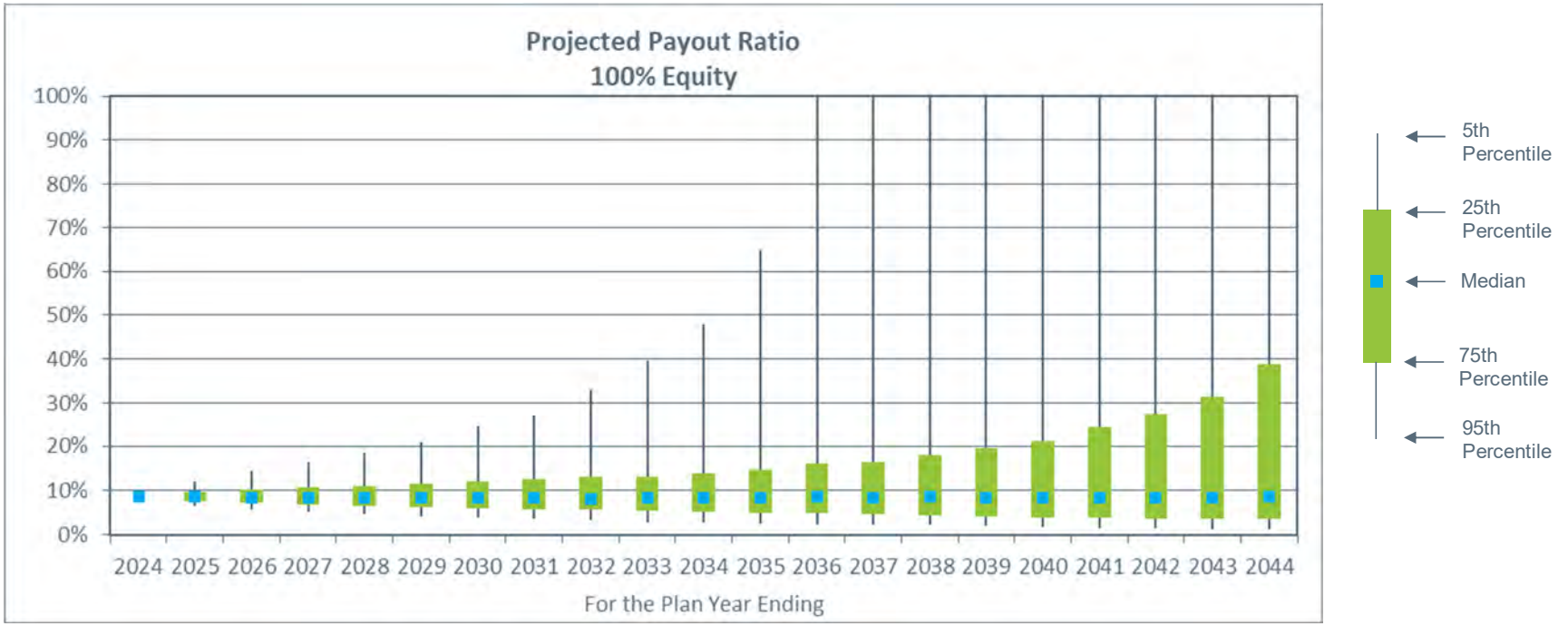
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	9%	9%	9%	9%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%

Stochastic Analysis (continued)

Projected Payout Ratio (expected benefit payments/market value of assets); **100% Equity**

The graph below displays the range of possible payout ratios over the next twenty years, assuming the Plan's assets are allocated according to the **100% Equity** portfolio. The results assume the current contribution policy remains unchanged for all projection years.

The median annual benefit payment as percentage of the market value of assets is expected to range between 8% and 9%. The worst-case scenario could reach up to 100%.

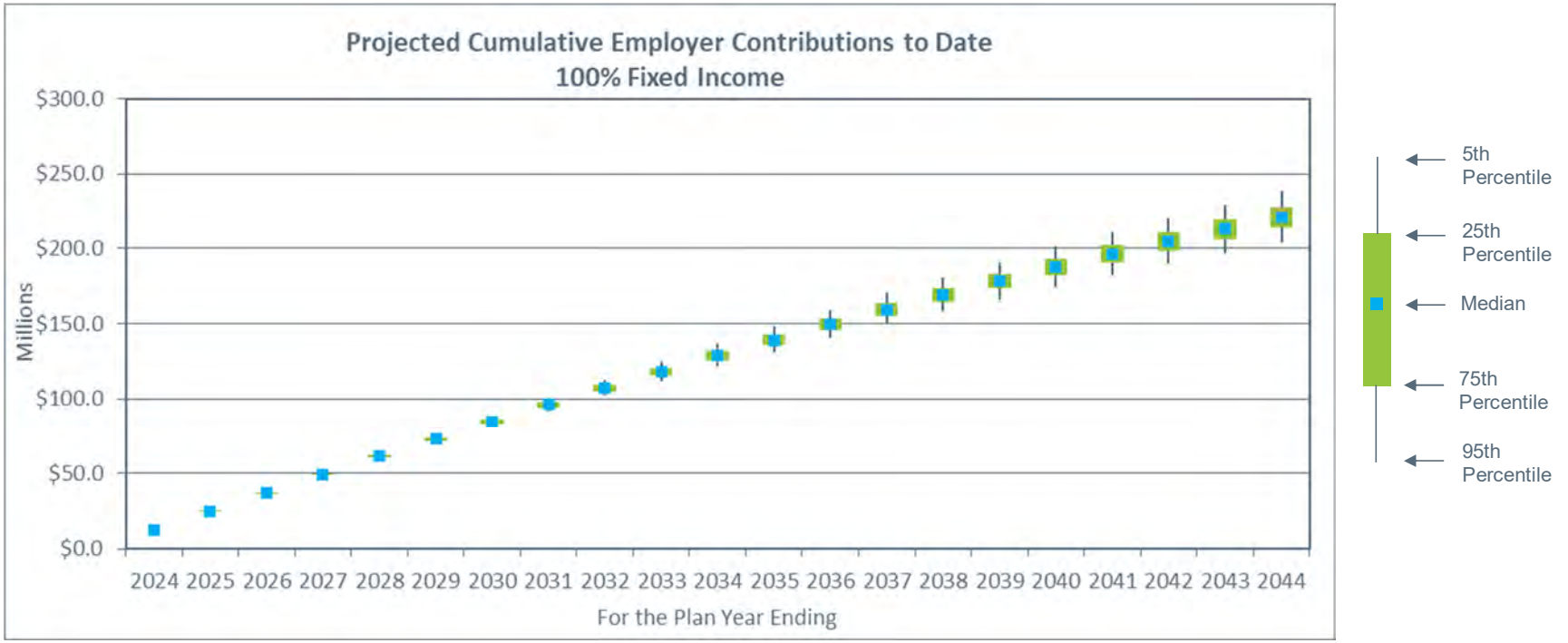


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
Median	9%	9%	8%	9%	8%	8%	8%	8%	8%	8%	8%	8%	9%	9%	9%	8%	8%	8%	8%	9%	9%

Stochastic Analysis (continued)

Cumulative Contributions to Date; 100% Fixed Income

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **100% Fixed Income** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

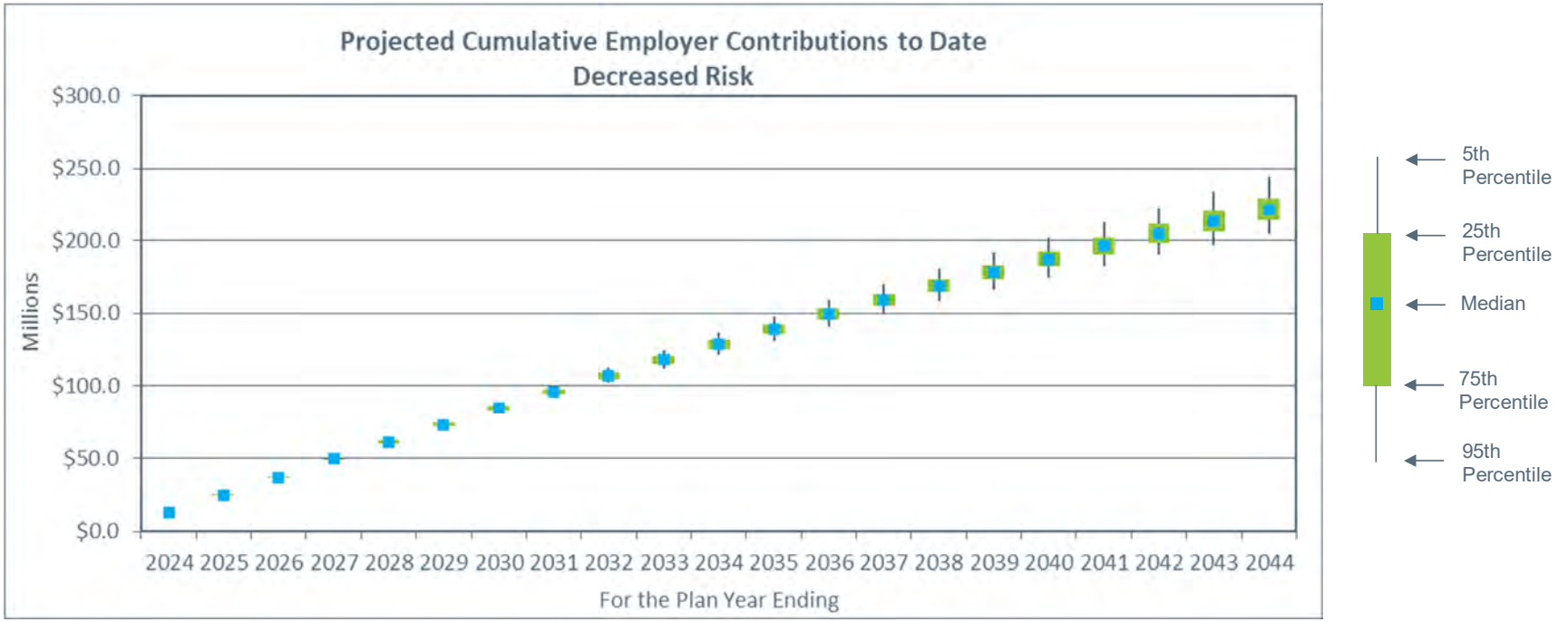


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$12.5	$25.3	$38.0	$50.7	$63.4	$75.9	$88.3	$100.5	$112.8	$124.7	$136.5	$147.8	$159.0	$170.1	$180.7	$190.9	$201.3	$210.9	$220.2	$229.3	$238.5
25th Percentile	$12.5	$25.0	$37.5	$49.8	$62.0	$74.1	$86.0	$97.7	$109.2	$120.5	$131.6	$142.5	$153.1	$163.3	$173.4	$183.2	$192.7	$202.0	$210.9	$219.5	$228.0
Median	$12.5	$24.9	$37.1	$49.2	$61.2	$72.9	$84.4	$95.8	$107.0	$117.9	$128.6	$139.1	$149.2	$159.1	$168.7	$178.0	$187.3	$196.0	$204.5	$212.7	$220.7
75th Percentile	$12.5	$24.7	$36.8	$48.6	$60.3	$71.7	$83.0	$94.1	$104.9	$115.5	$125.8	$135.9	$145.6	$155.0	$164.3	$173.2	$181.9	$190.3	$198.4	$206.2	$213.8
95th Percentile	$12.5	$24.4	$36.2	$47.7	$59.1	$70.2	$81.0	$91.6	$102.0	$111.9	$121.7	$131.1	$140.3	$149.2	$157.8	$166.2	$174.2	$182.0	$189.6	$196.8	$203.8

Stochastic Analysis (continued)

Cumulative Contributions to Date; Decreased Risk

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **Decreased Risk** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

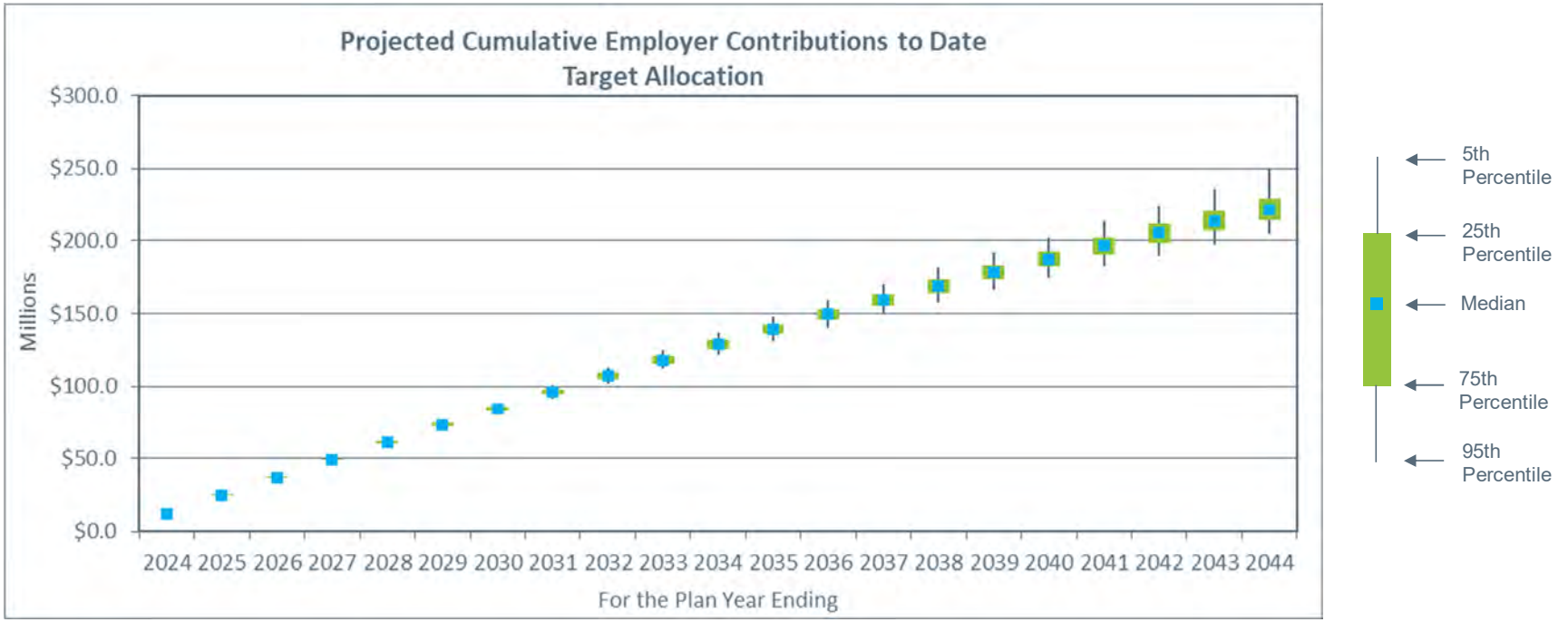


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$12.5	$25.3	$38.0	$50.7	$63.4	$75.9	$88.3	$100.5	$112.8	$124.7	$136.5	$147.8	$159.1	$170.1	$181.0	$191.5	$201.8	$212.4	$222.7	$234.2	$244.9
25th Percentile	$12.5	$25.0	$37.5	$49.8	$62.0	$74.1	$86.0	$97.7	$109.2	$120.5	$131.6	$142.5	$153.1	$163.3	$173.4	$183.3	$192.9	$202.3	$211.4	$220.3	$229.1
Median	$12.5	$24.9	$37.1	$49.2	$61.2	$72.9	$84.4	$95.8	$107.0	$117.9	$128.6	$139.1	$149.2	$159.1	$168.7	$178.1	$187.4	$196.3	$204.9	$213.3	$221.3
75th Percentile	$12.5	$24.7	$36.8	$48.6	$60.3	$71.7	$83.0	$94.1	$104.9	$115.5	$125.8	$135.9	$145.6	$155.0	$164.3	$173.3	$182.0	$190.5	$198.6	$206.5	$214.3
95th Percentile	$12.5	$24.4	$36.2	$47.7	$59.1	$70.2	$81.0	$91.6	$102.0	$111.9	$121.7	$131.1	$140.3	$149.3	$157.9	$166.2	$174.3	$182.1	$189.8	$196.9	$204.2

Stochastic Analysis (continued)

Cumulative Contributions to Date; Target Allocation

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **Target Allocation** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

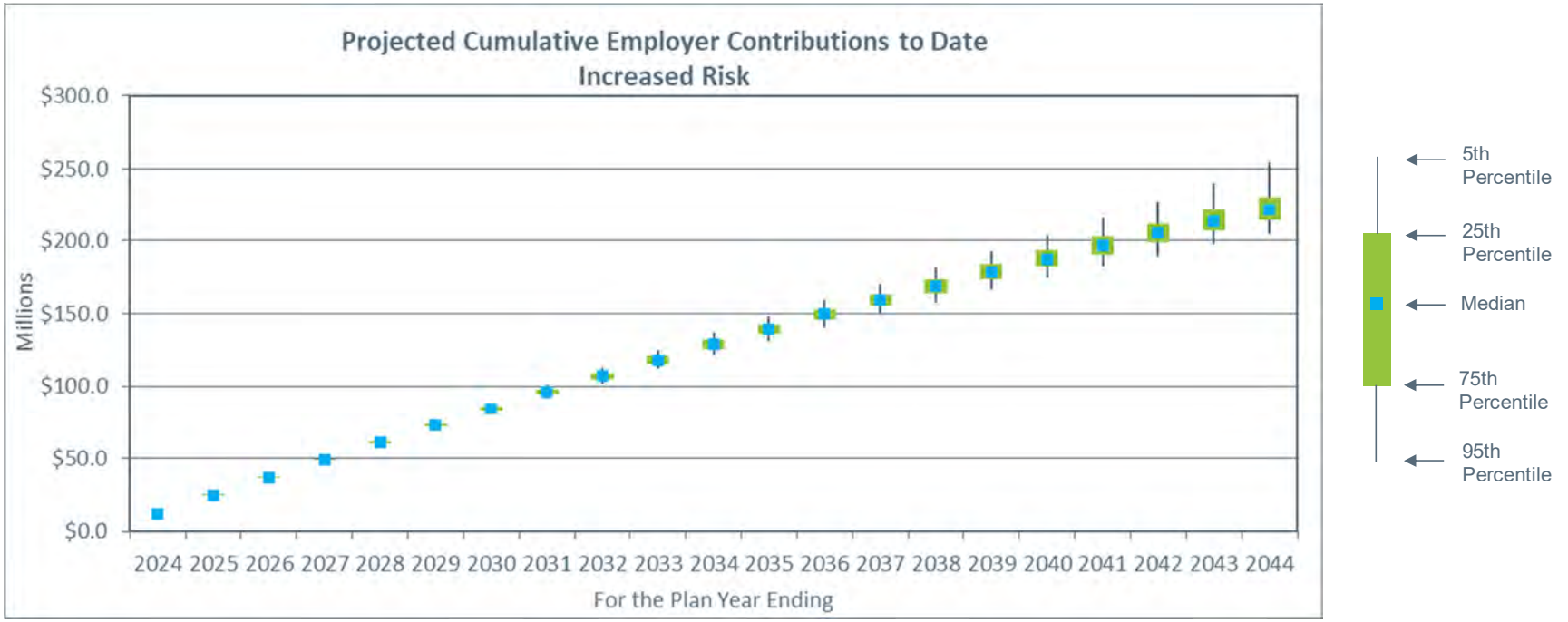


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$12.5	$25.3	$38.0	$50.7	$63.4	$75.9	$88.3	$100.5	$112.8	$124.7	$136.5	$147.8	$159.2	$170.1	$181.2	$191.8	$202.6	$213.6	$225.0	$236.1	$249.3
25th Percentile	$12.5	$25.0	$37.5	$49.8	$62.0	$74.1	$86.0	$97.7	$109.2	$120.5	$131.6	$142.5	$153.1	$163.4	$173.5	$183.4	$193.1	$202.5	$211.7	$220.8	$229.6
Median	$12.5	$24.9	$37.1	$49.2	$61.2	$72.9	$84.4	$95.8	$107.0	$117.9	$128.6	$139.1	$149.2	$159.1	$168.8	$178.2	$187.4	$196.4	$205.1	$213.4	$221.7
75th Percentile	$12.5	$24.7	$36.8	$48.6	$60.3	$71.7	$83.0	$94.1	$104.9	$115.5	$125.8	$135.9	$145.6	$155.1	$164.3	$173.3	$182.1	$190.5	$198.7	$206.8	$214.5
95th Percentile	$12.5	$24.4	$36.2	$47.7	$59.1	$70.2	$81.0	$91.6	$102.0	$111.9	$121.7	$131.1	$140.4	$149.3	$157.9	$166.2	$174.4	$182.1	$189.8	$197.2	$204.3

Stochastic Analysis (continued)

Cumulative Contributions to Date; Increased Risk

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **Increased Risk** (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.

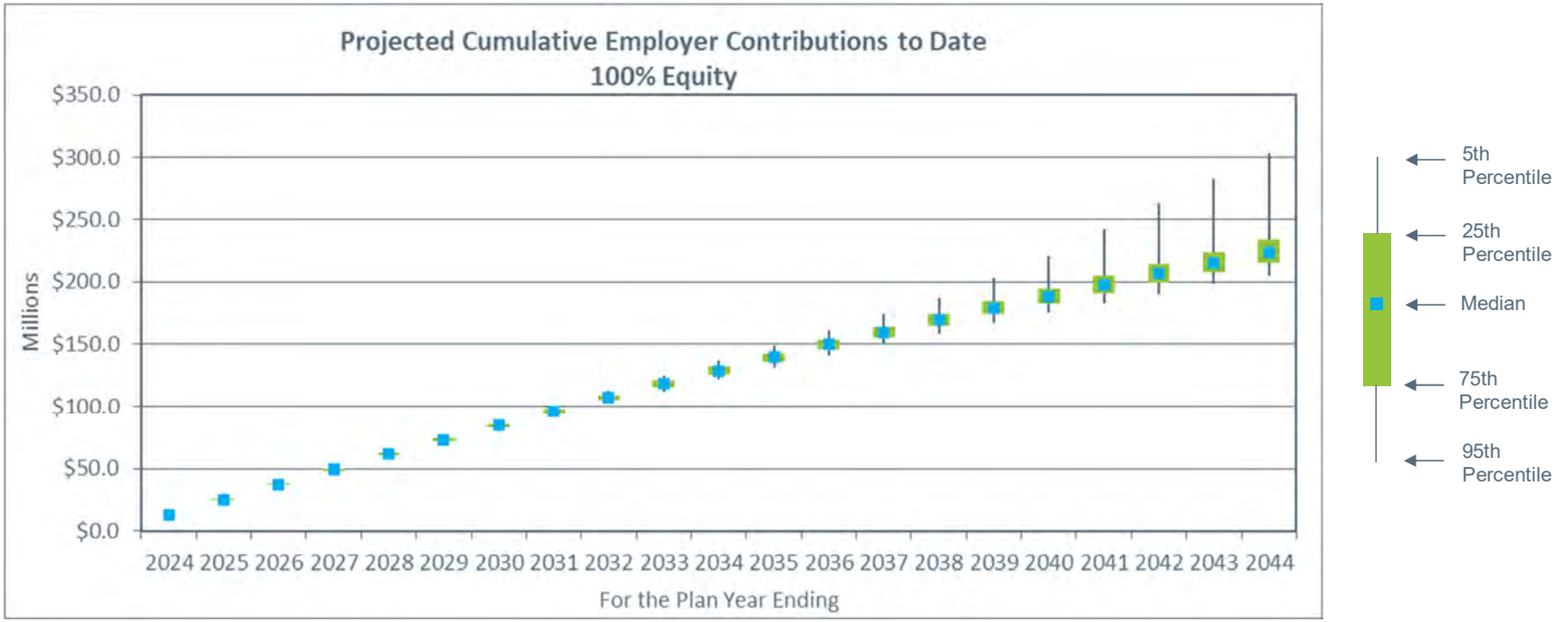


	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$12.5	$25.3	$38.0	$50.7	$63.4	$75.9	$88.3	$100.6	$112.8	$124.7	$136.5	$147.9	$159.2	$170.5	$181.5	$193.1	$203.9	$215.8	$227.1	$239.9	$254.1
25th Percentile	$12.5	$25.0	$37.5	$49.8	$62.0	$74.1	$86.0	$97.7	$109.2	$120.5	$131.6	$142.5	$153.1	$163.4	$173.6	$183.6	$193.3	$202.8	$212.1	$221.2	$230.3
Median	$12.5	$24.9	$37.1	$49.2	$61.2	$72.9	$84.4	$95.8	$107.0	$117.9	$128.6	$139.1	$149.2	$159.1	$168.8	$178.3	$187.5	$196.6	$205.3	$213.7	$221.9
75th Percentile	$12.5	$24.7	$36.8	$48.6	$60.3	$71.7	$83.0	$94.1	$104.9	$115.5	$125.8	$135.9	$145.6	$155.1	$164.3	$173.4	$182.1	$190.7	$198.9	$207.0	$214.5
95th Percentile	$12.5	$24.4	$36.2	$47.7	$59.1	$70.2	$81.0	$91.6	$102.0	$111.9	$121.7	$131.1	$140.4	$149.3	$157.9	$166.2	$174.5	$182.4	$189.9	$197.2	$204.5

Stochastic Analysis (continued)

Cumulative Contributions to Date; 100% Equity

The graph and table below show the range of projected cumulative contributions over the next twenty years, assuming the Plan's assets are allocated according to the **100% Equity** portfolio (highlighted on the prior pages). The results assume the current contribution policy remains unchanged for all projection years.



	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044
5th Percentile	$12.5	$25.3	$38.0	$50.7	$63.4	$75.9	$88.4	$100.7	$113.0	$125.1	$136.9	$149.1	$161.1	$174.2	$187.0	$202.6	$221.1	$241.9	$263.8	$283.6	$304.0
25th Percentile	$12.5	$25.0	$37.5	$49.8	$62.0	$74.1	$86.0	$97.8	$109.3	$120.7	$131.8	$142.8	$153.5	$164.1	$174.6	$184.7	$194.9	$204.7	$214.5	$223.9	$233.6
Median	$12.5	$24.9	$37.1	$49.2	$61.2	$72.9	$84.4	$95.8	$107.0	$118.0	$128.7	$139.2	$149.5	$159.5	$169.3	$178.9	$188.4	$197.6	$206.5	$215.3	$223.9
75th Percentile	$12.5	$24.7	$36.8	$48.6	$60.3	$71.7	$83.0	$94.1	$104.9	$115.6	$125.9	$136.0	$145.9	$155.4	$164.6	$173.7	$182.6	$191.3	$199.6	$207.8	$215.6
95th Percentile	$12.5	$24.4	$36.2	$47.7	$59.1	$70.2	$81.0	$91.6	$102.0	$112.0	$121.7	$131.2	$140.5	$149.5	$158.2	$166.6	$174.7	$182.5	$190.2	$198.0	$205.1

Stochastic Analysis (continued)

Employer Contributions (as a weighted average percentage of salary)

The tables below show the range of required employer contributions (as a weighted average percentage of salary) assuming the five different asset mixes highlighted on the prior pages. The results assume the current contribution policy remains unchanged for all projection years.

5 Years	Required Employer Contribution for Plan Year Ending 2029				
	5th	25th	50th	75th	95th
100% Fixed Income	1.1%	1.1%	1.1%	1.1%	1.1%
Decreased Risk	1.1%	1.1%	1.1%	1.1%	1.1%
Target Allocation	1.1%	1.1%	1.1%	1.1%	1.1%
Increased Risk	1.1%	1.1%	1.1%	1.1%	1.1%
100% Equity	1.1%	1.1%	1.1%	1.1%	1.1%

10 Years	Required Employer Contribution for Plan Year Ending 2034				
	5th	25th	50th	75th	95th
100% Fixed Income	1.1%	1.1%	1.1%	1.1%	1.1%
Decreased Risk	1.1%	1.1%	1.1%	1.1%	1.1%
Target Allocation	1.1%	1.1%	1.1%	1.1%	1.1%
Increased Risk	1.1%	1.1%	1.1%	1.1%	1.1%
100% Equity	1.1%	1.1%	1.1%	1.1%	1.1%

20 Years	Required Employer Contribution for Plan Year Ending 2044				
	5th	25th	50th	75th	95th
100% Fixed Income	1.1%	1.1%	1.1%	1.1%	1.1%
Decreased Risk	1.8%	1.1%	1.1%	1.1%	1.1%
Target Allocation	2.8%	1.1%	1.1%	1.1%	1.1%
Increased Risk	2.8%	1.1%	1.1%	1.1%	1.1%
100% Equity	3.1%	1.1%	1.1%	1.1%	1.1%

Stochastic Analysis (continued)

Drawing Inferences

The tables below compare the projected market funded ratios five, ten, and twenty years from now, under the median (50th percentile), worst-case (5th percentile), and best-case (95th percentile) scenarios, assuming the five different asset mixes highlighted on the prior pages. The table also displays for comparative purposes the median, peak, and trough projected payout ratios and cumulative employer contributions for the five asset mixes being examined.

5 Years	Market Funded Ratio in Year 5			Cumulative Employer Contributions in Year 5 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 5 Median	Years 1 to 5 Peak	Years 1 to 5 Trough
100% Fixed Income	74%	62%	88%	$72.9	$75.9	$70.2	9%	11%	8%
Decreased Risk	79%	47%	121%	$72.9	$75.9	$70.2	8%	14%	6%
Target Allocation	80%	45%	128%	$72.9	$75.9	$70.2	8%	15%	5%
Increased Risk	80%	42%	133%	$72.9	$75.9	$70.2	8%	16%	5%
100% Equity	81%	32%	159%	$72.9	$75.9	$70.2	8%	21%	4%

10 Years	Market Funded Ratio in Year 10			Cumulative Employer Contributions in Year 10 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 10 Median	Years 1 to 10 Peak	Years 1 to 10 Trough
100% Fixed Income	77%	58%	101%	$128.6	$136.5	$121.7	10%	13%	7%
Decreased Risk	88%	38%	175%	$128.6	$136.5	$121.7	8%	19%	4%
Target Allocation	88%	34%	189%	$128.6	$136.5	$121.7	8%	21%	4%
Increased Risk	89%	30%	205%	$128.6	$136.5	$121.7	8%	24%	4%
100% Equity	88%	15%	268%	$128.7	$136.9	$121.7	8%	48%	3%

20 Years	Market Funded Ratio in Year 20			Cumulative Employer Contributions in Year 20 (Millions)			Payout Ratios		
	50th	5th	95th	50th	5th	95th	Year 20 Median	Years 1 to 20 Peak	Years 1 to 20 Trough
100% Fixed Income	82%	39%	139%	$220.7	$238.5	$203.8	11%	23%	6%
Decreased Risk	111%	4%	373%	$221.3	$244.9	$204.2	8%	100%	2%
Target Allocation	114%	0%	429%	$221.7	$249.3	$204.3	8%	100%	2%
Increased Risk	113%	0%	485%	$221.9	$254.1	$204.5	8%	100%	2%
100% Equity	101%	0%	724%	$223.9	$304.0	$205.1	9%	100%	1%

RVK

Appendix: Assumptions and Methods

Actuarial Valuation Assumptions and Methods: At the beginning of each projection year, an actuarial valuation is performed to determine employer contributions. The assumptions used in the July 1, 2024 Actuarial Valuation prepared by GRS were utilized in all years. These methods and assumptions are summarized below:

Actuarial Cost Method	Entry-Age Normal (level % of pay). Funding policies and methods are described in the July 1, 2024 Actuarial Valuation prepared by GRS.
Liability Discount Rate	5.75% per year
Administrative Expenses	Prior year expenses, adjusted for inflation ($379,015 assumed for FY 2025).
Inflation (CPI)	2.25% per year.
Member Contribution Interest	Not applicable
Payroll Growth	Overall payroll growth of 3.50% per year.
Future Pay Increases	Future pay increases as recommended in the 2024 Experience Study prepared by GRS.
Retirement	Rates of retirement as recommended in the 2024 Experience Study prepared by GRS.
Mortality	Rates of mortality as recommended in the 2024 Experience Study prepared by GRS.
Disability	Rates of disability as recommended in the 2024 Experience Study prepared by GRS.
Termination	Rates of termination as recommended in the 2024 Experience Study prepared by GRS.

Appendix: Assumptions and Methods (continued)

Actuarial Valuation Assumptions and Methods: (continued)

COLA	No Cost of Living Adjustments are provided to benefit recipients.
Asset Valuation Method	Market value with a five-year smoothing of the difference between actual and assumed investment returns.
Contribution Policy	Statutory rate of 1.14% of pay.

Appendix: Assumptions and Methods (continued)

Projection Assumptions (used in the deterministic and stochastic asset/liability projections): These projections begin with the Plan's participant population as of July 1, 2024, as provided by GRS. The Plan's population is projected forward and assumed to change as a result of employment separation, death, disability, and retirement, as predicted by the assumptions recommended in the 2024 Experience Study prepared by GRS. New members are assumed to enter the Plan such that the active population remains level throughout the projection. Employee compensation is projected into the future in accordance with the assumptions described on the prior pages. Investment returns are projected into the future in accordance with the assumptions described below.

Employer Contributions	For all years, employer contributions are assumed to equal the statutory contribution rate of 1.14% of payroll.
Member Contributions	None assumed.
New Entrants	The plan is closed to members enrolled in the NDPERS Main System and the Defined Contribution Plan on or after January 1, 2020. For all other employee groups, new employees are assumed to join the Plan such that the active population remains level throughout the projection. New employees entering the Plan are assumed to have characteristics similar to recently hired participants.
Rate of Return on Assets	Deterministic Analysis: 5.75% all years. Stochastic Analysis: Returns on the portfolio are based on the expected returns of each asset class and the correlations between each class which are detailed in the Stochastic Analysis section of this report.

Appendix: Assumptions and Methods (continued)

Base Wages	Deterministic Analysis: 2.50% increase per year. Stochastic Analysis: Increases that vary with inflation.
Inflation	2.50% per year with a standard deviation of 2.50%.
Other	All other projection assumptions and methods are the same as those recommended in the 2024 Experience Study prepared by GRS, with some exceptions where system restraints required approximations. Employer contribution rates were not assumed to change in the future. Grouping of active and terminated vested participants was used to speed up processing. All other participant data was used without grouping.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca Fricke

DATE: June 10, 2025

SUBJECT: 457(b) Deferred Compensation Plan Private Letter Ruling

NDPERS has received notice from Ice Miller of IRS Private Letter Ruling PLR-121332-24, dated March 19, 2025, issued in response to our request. Per Ice Miller, the ruling confirms:

- The Plan qualifies as an eligible deferred compensation plan under Section 457(b) of the Internal Revenue Code
- Compensation deferred under the Plan, and related earnings, are includible in gross income only when distributed to participants or beneficiaries
- Eligible rollover distributions from the Plan will not be taxable if properly rolled over to another eligible retirement plan
- The trust associated with the Plan is treated as a tax-exempt organization under Code § 501(a), assuming it is valid under state law.

In addition, the IRS is required to make Private Letter Rulings publicly available, but the rulings are heavily redacted to protect the confidentiality of the taxpayer involved.

This item is informational and does not require any action by the Board.

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

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Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: 457 Companion Plan & 401(a) Plan 1st Quarter 2025 Report

Attached is the 1st Quarter 2025 investment report for the 401(a) & 457 Companion Plans, which was reviewed by the Investment Subcommittee. The reports are available separately on the NDPERS website. The two plans have 11,604 (10,724 in Q4) participants with $250.1 million ($248.5 million in Q4) in assets.

Assets in the 401(a) plan increased to $25.6 million ($24.2 million in Q4) as of March 31, 2025. The number of active participants slightly decreased and is now at 811 (102 in Q4). In total, this includes 144 individuals that transferred to the Defined Contribution Plan through the special election window for State Employees with less than five years of service. The Target Date funds have 56.6% of the plan assets.

Assets in the 457 Companion Plan increased slightly to $224.5 million ($224.3 in Q4) as of March 31, 2025. The number of active participants increased and is now at 10,793 (10,622 in Q4). The Target Date funds have 65.7% of the plan assets.

Benchmarks:
Fund returns for the quarter were mixed for the funds in the core lineup. 13 core funds had positive returns for the quarter (10 had negative returns). Core fund performance was mixed when compared to benchmarks.

Fund / Investment News:
The Retirement & Investment Office provided an overview of the returns of the Pension Funds. The NDPERS Investment Subcommittee reviewed the 1st Quarter 2025 plan review and field activity report with Empower. Callan gave a market overview and investment performance report. Empower provided information on participant engagement and educational efforts for the members in our plans.

RVK gave a more detailed presentation on the results of the PERS and RHIC asset liability study. SEI gave a presentation on Job Service and RHIC asset allocation recommendations. Finally, discussion was had regarding the implementation of HB 1113 (assessing NDPERS administrative fees to participant accounts).

The actionable items from the investment subcommittee are included as separate items on today's Board agenda.

Statistics on enrollments as of March 27, 2025 in the Defined Contribution 2025 plan are as follows:

Date	Hires	0%	1%	2%	3%	4%	5%	6%	DC Election Total	Def Comp Election Total	DC 2025 + Def Comp Election Total	No election	Forfeited election	Still eligible	% that elected match
1/16/2025	159	5	2	6	28				41		41	118			25.79%
2/7/2025	352	33	12	15	115			1	175	5	181	171			51.42%
2/13/2025	401	44	14	19	139			1	216	9	226	175			56.36%
2/20/2025	477	49	18	24	183			1	274	7	282	195			59.12%
2/28/2025	575	60	25	27	225			2	337	15	354	221			61.57%
3/6/2025	606	66	27	30	245		1	2	371	17	388	234	116	119	64.03%
3/13/2025	650	72	30	35	276		1	2	416	19	435	234	126	108	66.92%
3/20/2025	738	77	39	40	330		1	2	489	19	508	249	148	101	68.83%
3/27/2025	772	79	43	40	356		1	2	521	23	544	251	154	97	70.47%

Attachment #1

NDPERS
Quarterly Investment Report
1st Quarter
1/01/2025 – 3/31/2025

North Dakota Public Employees Retirement System
1600 East Century Ave, Suite 2
Box 1657
Bismarck, ND 58502

New Investment Structure With In-Plan Annuity Options

Tier I: Asset Allocation	Tier II: Passive Core	Tier II: Active Core	Tier III: Specialty
Target Date Funds		**Capital Preservation**	
Nuveen Lifecycle Retirement		Galliard Stable Value	
		Vanguard Treasury MM	
		Empower IFAS VI	
		New York Life Anchor	
	Core Fixed Income	**Core Plus Fixed Income**	
	Vanguard Total Bond Index	Baird Core Plus Bond	
	U.S. Large-Cap Equity		
	Vanguard Institutional Index		
	Broad Non-U.S. Equity	**Broad Non-U.S. Equity**	
	Vanguard Total Intn'l Index	MFS International Diversification	
		U.S. Small/Mid-Cap Equity	
		JP Morgan US SMID Core	
			Real Estate
			Cohen & Steers Realty
			Brokerage Window

Plan Performance Monitoring

As of March 31, 2025

	Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 7 Years
Asset Allocation Funds					
Nuveen Lifecycle Ret. Inc	0.86%	5.05%	3.47%	6.75%	4.87%
LifeCycle Ret Income CB	1.09%	6.00%	3.60%	6.67%	5.39%
Callan Tgt Dt Idx 2010	1.31%	5.74%	3.23%	6.00%	4.94%
Nuveen Lifecycle 2010 Fund	0.91%	5.23%	3.56%	6.80%	4.90%
LifeCycle 2010 CB	1.24%	5.98%	3.42%	6.54%	5.29%
Callan Tgt Dt Idx 2010	1.31%	5.74%	3.23%	6.00%	4.94%
Nuveen Lifecycle 2015 Fund	0.77%	4.98%	3.52%	7.27%	5.09%
LifeCycle 2015 Cust Bnch	1.08%	6.03%	3.64%	7.22%	5.66%
CAI Tgt Dt Idx 2015	1.23%	5.76%	3.31%	6.43%	5.17%
Nuveen Lifecycle 2020 Fund	0.64%	4.88%	3.73%	7.91%	5.39%
LifeCycle 2020 Cust Bnchm	0.86%	6.07%	3.88%	7.96%	6.05%
CAI Tgt Dt Idx 2020	1.09%	5.79%	3.50%	7.14%	5.53%
Nuveen Lifecycle 2025 Fund	0.30%	4.77%	3.97%	8.93%	5.83%
LifeCycle 2025 Cust Bnch	0.64%	6.14%	4.16%	8.98%	6.55%
CAI Tgt Dt Idx 2025	0.88%	5.89%	3.87%	8.40%	6.15%
Nuveen Lifecycle 2030 Fund	(0.10%)	4.58%	4.36%	10.07%	6.35%
LifeCycle 2030 Cust Bnch	0.29%	6.23%	4.58%	10.16%	7.14%
CAI Tgt Dt Idx 2030	0.45%	5.94%	4.42%	9.86%	6.85%
Nuveen Lifecycle 2035 Fund	(0.47%)	4.48%	4.92%	11.31%	6.94%
LifeCycle 2035 Cust Bnch	(0.06%)	6.35%	5.17%	11.45%	7.80%
CAI Tgt Dt Idx 2035	0.02%	6.03%	5.02%	11.37%	7.57%
Nuveen Lifecycle 2040 Fund	(1.09%)	4.16%	5.54%	12.61%	7.53%
LifeCycle 2040 Cust Bnch	(0.57%)	6.48%	5.87%	12.89%	8.51%
CAI Tgt Dt Idx 2040	(0.36%)	6.12%	5.55%	12.59%	8.13%
Nuveen Lifecycle 2045 Fund	(1.49%)	3.93%	5.80%	13.68%	8.00%
LifeCycle 2045 Cust Bnch	(0.91%)	6.58%	6.16%	14.08%	9.05%
CAI Tgt Dt Idx 2045	(0.64%)	6.17%	5.92%	13.44%	8.51%
Nuveen Lifecycle 2050 Fund	(1.72%)	3.82%	5.93%	13.94%	8.13%
LifeCycle 2050 Cust Bnch	(1.08%)	6.63%	6.28%	14.38%	9.21%
CAI Tgt Dt Idx 2050	(0.80%)	6.20%	6.15%	13.84%	8.70%
Nuveen Lifecycle 2055 Fund	(1.79%)	3.79%	5.98%	14.09%	8.19%
LifeCycle 2055 Cust Bnch	(1.13%)	6.65%	6.35%	14.59%	9.31%
CAI Tgt Dt Idx 2055	(0.87%)	6.22%	6.25%	14.01%	8.77%
Nuveen Lifecycle 2060 Fund	(1.80%)	3.85%	6.04%	14.26%	8.28%
LifeCycle 2060 Cust Bnch	(1.19%)	6.67%	6.42%	14.79%	9.40%
Callan Tgt Dt Idx 2060	(0.91%)	6.22%	6.29%	14.09%	8.81%
Nuveen Lifecycle 2065 Fund	(1.84%)	3.74%	6.08%	-	-
LifeCycle 2065Custom Ben	(1.24%)	6.69%	6.50%	-	-
Callan Tgt Dt Idx 2065	(0.92%)	6.21%	6.30%	14.10%	8.82%

Plan Performance Monitoring

As of March 31, 2025

	Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 7 Years
Large Cap U.S. Equity					
Vanguard Institutional Index	(4.28%)	8.21%	9.02%	18.56%	13.22%
S&P 500 Index	(4.27%)	8.25%	9.06%	18.59%	13.25%
Small/Mid Cap U.S. Equity					
JPMorgan SMID Cap Equity R6	(4.87%)	(0.89%)	1.56%	13.19%	5.94%
Russell 2500 Index	(7.50%)	(3.11%)	1.78%	14.91%	7.16%
Non-U.S. Equity					
MFS International Diversification R6	5.86%	8.19%	5.57%	10.67%	5.95%
MSCI ACWI xUS (Net)	5.23%	6.09%	4.48%	10.92%	4.47%
Vanguard Total Int'l Stock Adm	5.51%	6.37%	4.65%	11.44%	4.48%
FTSE GI All Cap ex US Idx	4.55%	5.73%	4.21%	11.30%	4.55%
Fixed Income					
Vanguard Total Bond Index Adm	2.77%	4.87%	0.52%	(0.41%)	1.58%
Blmbg Aggregate Flt Adj	2.75%	4.87%	0.56%	(0.36%)	1.62%
Baird Core Plus Bond Instl	2.60%	5.39%	1.44%	1.07%	2.30%
Blmbg Universal	2.66%	5.24%	1.01%	0.32%	1.87%
Capital Preservation					
Galliard Stable Value C	0.73%	3.03%	2.62%	2.32%	2.27%
3-month Treasury Bill	1.02%	4.97%	4.23%	2.56%	2.45%
New York Life Ins. Co. Anchor Acct. IV	0.80%	3.59%	3.26%	2.76%	2.67%
3-month Treasury Bill	1.02%	4.97%	4.23%	2.56%	2.45%
Vanguard Treasury MM Inv	1.06%	4.97%	4.28%	2.58%	2.40%
3-month Treasury Bill	1.02%	4.97%	4.23%	2.56%	2.45%
Sector Funds					
Cohen & Steers Realty Shares	3.17%	10.42%	(0.40%)	10.76%	8.36%
FTSE NAREIT All Eq Index	2.75%	9.23%	(1.66%)	9.55%	6.92%

Active Manager Monitoring Summary

As of March 31, 2025

Manager	Below Benchmark	Above Benchmark		Above Peer Median		Qualitative Assessment					Overall Eval.
	8 Straight Quarters	3-Year Period	5-Year Period	3-Year Period	5-Year Period	Firm	Team	Process	Perf.	Product	
Small/Mid Cap Equity											
JPMorgan SMID Cap Equity	No	No	No	No	No						Noteworthy
International Equity											
MFS International Diversification	No	Yes	No	No	No						Stable
Fixed Income											
Baird Core Plus Bond	No	Yes	Yes	Yes	No						Stable
Stable Value											
Galliard Stable Value	Yes	No	No	Yes	Yes						Stable
Sector Fund											
Cohen & Steers Realty Shares	No	Yes	Yes	Yes	Yes						Stable

Overall Evaluation	Status and Actions
Stable	Firm, Team, Strategy are performing as expected
Noteworthy	Manager has a qualitative or quantitative factor worth highlighting
In Review	Callan is proposing that the fund be added to the watchlist
Cautionary	Staff is reviewing strategy with consultant and scheduling an update meeting with manager
Terminating	Following staff review and consultant recommendation, manager will be terminated following a successful replacement search

- JPM SMID Cap Equity strategy experienced notable asset decline from $1.3 billion on June 30, 2024 to $520 million on December 31, 2024.
- In March, Galliard Capital Management, LLC, announced Paul Felsch, CCO, is leaving the firm and Amy Stueve has been appointed the new CCO.

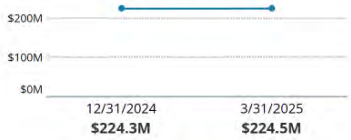
Executive summary

As of 3/31/2025

Participant assets

$224,488,086

Trending



Plan-level assets **$16,048**

Total assets **$224,504,134**

Participants with a balance

10,793

Trending

Active participants with a balance **8,189**

Separated from service participants with a balance **2,604**

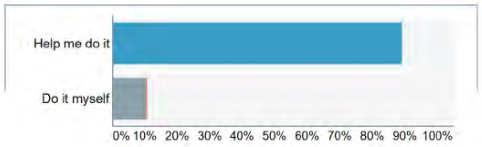
Overview

The assets and participant counts presented are effective as of period end. The assets do not reflect any adjustments, dividends, corrections, or similar that are processed after period end.

Investment strategy utilization

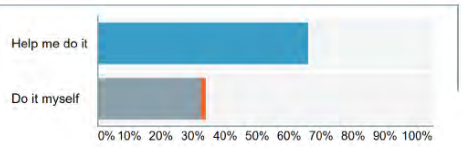
As of 3/31/2025

Participants by strategy



Investment strategy	% of participants	# of participants
Target-date strategy	89.2%	9,624
Risk-based strategy	0.0%	3
Brokerage strategy	0.3%	32
Do-it-yourself strategy	10.5%	1,134

Participant assets by strategy



Investment strategy	% of assets	Assets	Average balance
Target-date strategy	65.7%	$147,555,947	$15,332
Risk-based strategy	0.2%	$420,345	$140,115
Brokerage strategy	1.7%	$3,801,592	$118,800
Do-it-yourself strategy	32.4%	$72,710,202	$64,118

Target-date strategy is the investment strategy utilized by the most participants with **89.2%** of participants using this strategy. However, this strategy holds a smaller share of assets with only **65.7%** of assets.

Overview

The investment strategy utilization is based on all participants that have a balance greater than $0. Each participant is assigned a single investment strategy to provide insights on how investment options, features, and services are being utilized.

When a participant is assigned a strategy, 100% of their balance is grouped within that strategy even if they have a diverse investment mix. Additionally, each participants' strategy is reevaluated and assigned every month so a participant may move in and out of the different strategies from month to month.

For the full list of investment strategies and their definitions, please refer to the glossary.

Executive summary

As of 3/31/2025

Participant assets

$25,644,209

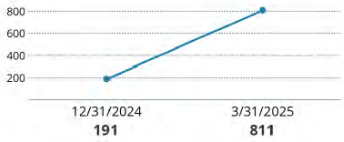
Trending

Plan-level assets	**$36,644**
Total assets	**$25,680,854**

Participants with a balance

811

Trending



Active participants with a balance	**701**
Separated from service participants with a balance	**110**

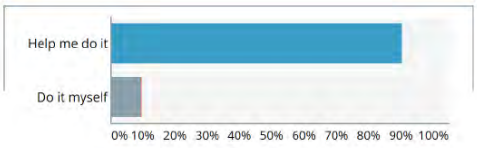
Overview

The assets and participant counts presented are effective as of period end. The assets do not reflect any adjustments, dividends, corrections, or similar that are processed after period end.

Investment strategy utilization

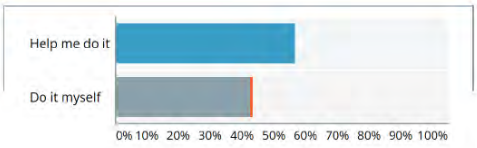
As of 3/31/2025

Participants by strategy



Investment strategy	% of participants	# of participants
Target-date strategy	90.3%	732
Brokerage strategy	0.2%	2
Do-it-yourself strategy	9.5%	77

Participant assets by strategy



Investment strategy	% of assets	Assets	Average balance
Target-date strategy	56.6%	$14,524,152	$19,842
Brokerage strategy	0.8%	$196,278	$98,139
Do-it-yourself strategy	42.6%	$10,923,778	$141,867

Target-date strategy is the investment strategy utilized by the most participants with **90.3%** of participants using this strategy. However, this strategy holds a smaller share of assets with only **56.6%** of assets.

Overview

The investment strategy utilization is based on all participants that have a balance greater than $0. Each participant is assigned a single investment strategy to provide insights on how investment options, features, and services are being utilized.

When a participant is assigned a strategy, 100% of their balance is grouped within that strategy even if they have a diverse investment mix. Additionally, each participants' strategy is reevaluated and assigned every month so a participant may move in and out of the different strategies from month to month.

For the full list of investment strategies and their definitions, please refer to the glossary.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Marcy Aldinger

DATE: June 10, 2025

SUBJECT: 457(b) Deferred Compensation and Companion Plan Documents

In follow-up to the April 2025 Board meeting, Ice Miller has notified NDPERS that they have heard back from the IRS attorneys regarding the modifications made to the 457(b) Deferred Compensation Plan Document (Attachment 1) per their request and that the changes made are accepted.

The revised redline version is attached for your information. The same changes were also made to the 457(b) Deferred Compensation Companion Plan Document so they are consistent. The redlined version of the Companion Plan is also attached (Attachment 2) for your information.

As stated previously, generally, these edits:

- Clarified the definition of "Eligible Retired Public Safety Officer".
- Clarified the process for commencement of participation and for making employer contributions.
- Updated the basic annual limitation and catch-up contribution language, particularly for SECURE 2.0.
- Clarified distribution restrictions, benefit distribution elections, payment options, and distributable events.
- Updated the required distribution rules to comply with Code Section 401(a)(9) and the recently released regulations.
- Moved the language regarding direct rollovers to a different Article of the Plan.

Audra Ferguson of Ice Miller will attend the Board meeting to answer any questions the Board has regarding the edits that were made.

Board Action Requested:

Approve the revised 457(b) Deferred Compensation Plan Document and the 457(b) Deferred Compensation Companion Plan Document.

Attachment 1

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM DEFERRED COMPENSATION 457(b) PLAN

Restated effective ~~October 1, 2024~~ _____, 2025 Revised: ~~10/2024~~04/2025

Adoption Resolution

Resolved, that effective ~~October 1, 2024~~ _____, 2025, the State of North Dakota has restated the Section 457 Plan. The Plan is intended to satisfy the requirements of Section 457(b) of the Internal Revenue Code of 1986, as amended, and its associated regulations.

Signature

~~September 20, 2024~~

Date

Executive Director

Title

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM DEFERRED COMPENSATION 457(B) PLAN

ARTICLE 1 PURPOSE

The North Dakota Public Employees Retirement System Board ("Board") hereby amends, reestablishes and reaffirms the Section 457 Plan and Trust ("the Plan"). The Plan consists of the provisions set forth in this document. The primary purpose of this Plan is to retain present employees and attract new employees for participating employers by providing increased retirement income and other deferred benefits to employees and their beneficiaries in accordance with the provisions of section 457 of the Internal Revenue Code and amendments thereto and by providing additional investment opportunities that are not otherwise available under the North Dakota Section 457 Deferred Compensation Plan. This Plan shall be an agreement solely between the employer and participating employees. The Plan is intended to satisfy the requirements of an eligible deferred compensation plan under Internal Revenue Code section 457(b) and shall be interpreted as such.

Nothing contained in this Plan shall be deemed to constitute an employment contract or agreement for services between participating employees and their employer nor shall it be deemed to give a participating employee any right to be retained in the employ of, or under contract to, an employer. Nothing herein shall be construed to modify the terms of any employment contract or agreement for services between participating employees and their employer as this Plan is intended to be a supplement thereto.

ARTICLE 2 DEFINITIONS

2.1 **Account Balance.** The bookkeeping account maintained with respect to each Participant which reflects the value of the deferred Compensation credited to the Participant, including the Participant's Deferrals, Employer Contributions, the earnings or losses of the Trust Fund (net of Trust Fund expenses) allocable to the Participant, and any distribution made to the Participant or the Participant's Beneficiary. The Account Balance also includes any account established under Article 7 for rollover contributions and plan-to-plan transfers made for a Participant, the account established for a Beneficiary after the Participant's death, and any account established for an alternate payee (as defined in Code section 414(p)(8)).

2.2 **Administrator.** The North Dakota Public Employees Retirement System Board shall serve as the Plan's Administrator; however, the Administrator may designate an entity, person or persons as an administrative services provider to carry out certain nondiscretionary, administrative functions under the Plan, as described in Article 8.

2.3 **Beneficiary.** The person or persons designated by the Participant who is entitled to receive benefits under the Plan after the death of a Participant. If no person is designated by the Participant or if the designated Beneficiary predeceases the Participant, the Participant's estate shall be the Beneficiary.

2.4 **Board.** The North Dakota Public Employees Retirement System Board.

2.5 **Code.** The Internal Revenue Code of 1986, as now in effect or as hereafter amended. All citations to sections of the Code are to such sections as they may from time to time be amended or renumbered.

2.6 **Compensation.** All cash compensation for services to the Employer, including salary, wages, fees, commissions, bonuses and overtime pay, that is includible in the Employee's gross income for the calendar year, plus amounts that would be cash compensation for services to the Employer includible in the Employee's gross income for the calendar year but for a compensation reduction election under section 125, 132(f), 401(k), 403(b) or 457(b) of the Code. Compensation also includes amounts paid to a Participant who has had a Severance from Employment, other than retirement or severance incentive payments, to the extent such amounts are paid by the later of 2½ months after the Participant's Severance from Employment or the end of the calendar year in which the Severance from Employment occurred, in accordance with Treas. Reg. section 1.457-(4)(d)(1) so long as the Employee would have been able to use the leave if employment had continued. Effective for years beginning after December 31, 2008, Compensation shall include military differential wage payments, as defined in Code section 3401(h).

2.7 **Deferral.** The amount of Compensation deferred in any calendar year.

2.8 **Designated Beneficiary.** An individual Beneficiary within the meaning of Code Section 401(a)(9)(E)(i).

2.9 **Eligible Designated Beneficiary.** A Designated Beneficiary who meets the additional criteria under Code Section 401(a)(9)(E)(ii).

~~2.7~~**2.10** **Eligible Retired Public Safety Officer.** An individual who has had a Severance from Employment as a public safety officer, as defined in Code section 402(*l*)(4)(C), with an Employer~~, by reason of either disability or attainment of the age set forth in N.D.C.C. § 54-52-17 at which the Participant has the right to retire and receive unreduced retirement benefits under N.D.C.C. Chapter 54-52~~.

~~2.8~~**2.11** **Employee.** Each person, whether appointed or elected, employed by the Employer as a common law employee who performs services for the Employer for which Compensation is paid, and who has been determined by the Employer to be eligible to participate in the Plan in accordance with Section 3.1. Employee does not include an independent contractor.

~~2.9~~**2.12** **Employer.** The State of North Dakota, which includes any of the State's departments, divisions, agencies or institutions, as well as any city, county, or other political subdivision, agency or instrumentality of the State, within the meaning of section 414(d) of the Code that enters into an agreement with the Board to participate in the Plan.

~~2.10~~2.13 **Employer Contribution.** Any nonelective contribution and/or matching contribution made pursuant to an election of the Employer accepted by the Plan Administrator.

~~2.11~~2.14 **Includible Compensation.** An Employee's actual wages in box 1 of Form W-2 for a year for services to the Employer, but subject to the maximum amount under Code section 401(a)(17), and increased (up to the dollar maximum) by any compensation reduction election under section 125, 132(f), 401(k), 403(b) or 457(b) of the Code. Effective for years beginning after December 31, 2008, Compensation shall include military differential wage payments, as defined in Code section 3401(h). Includible Compensation is determined without regard to any community property laws.

~~2.12~~2.15 **Investment Provider.** Any organization that has been approved by the Board to provide investment products under the Plan.

~~2.13~~2.16 **Normal Retirement Age.** Age 70 ½, or if later, the date the employee incurs a Severance from Employment. For purposes of the special section 457 catch-up limitation under Section 4.3, a Participant may designate, in writing, a Normal Retirement age that is earlier than age 70 ½ but not earlier than the earliest age at which the Participant has a right to retire and receive, under the applicable defined benefit pension plan of the Employer, immediate retirement benefits without actuarial or other reduction because of retirement before some later specified age. If the Participant is not eligible to receive benefits under a defined benefit pension plan maintained by the Employer, the Participant's designated Normal Retirement Age may not be earlier than age 55.

~~2.14~~2.17 **Participant.** An individual who (i) is currently deferring Compensation, or who (ii) is entitled to an Employer Contribution, or (iii) has previously deferred Compensation under the Plan by salary reduction or received an Employer Contribution, and who has not received a distribution of his or her entire benefit under the Plan.

~~2.15~~2.18 **Plan.** The North Dakota Public Employees Retirement System Deferred Compensation 457(b) Plan, as amended or restated from time to time.

~~2.16~~2.19 **Plan Contributions.** Deferrals and Employer Contributions made to the Plan.

~~2.17~~2.20 **Plan Year.** The calendar year.

~~2.18~~2.21 **Qualified Health Insurance Premiums.** Premiums for coverage for an Eligible Retired Public Safety Officer, his spouse, and/or his dependents, as defined in Code section 152, by an accident or health plan or qualified long-term care insurance contract, as defined in Code section 7702B(b).

~~2.19~~2.22 **Required Beginning Date.** April 1 of the calendar year following the later of the calendar year in which the Participant incurs a Severance from Employment or reaches the required minimum distribution age under Code section 401(a)(9).

~~2.20~~2.23 **Severance from Employment.** Thirty-one days after the Employee dies, retires or otherwise has a severance from employment with the Employer, as determined by the Administrator (and taking into account guidance issued under the Code).

~~2.21~~2.24 **Trust Fund.** The trust fund created under and subject to the provisions in Article 9.

~~2.22~~2.25 **Trustee.** The Board, or such other trustee duly appointed and currently serving in accordance with the provisions of Article 9.

~~2.23~~2.26 **Valuation Date.** Each business day or such other valuation date as specified by the Investment Provider for a particular investment product, or as otherwise designated by the Board.

ARTICLE 3 PARTICIPATION AND CONTRIBUTIONS

3.1 **Eligibility.** Each Employee who works a minimum of 20 hours per week for 20 or more weeks per year, who is at least age 18 and who fills a permanent position that is regularly funded and not of limited duration shall be eligible to participate in the Plan and may defer Compensation hereunder immediately upon satisfying the eligibility requirements under this Section 3.1.

3.2 **Election Required for Deferrals.** An Employee may elect to become a Participant by executing an election to defer a portion of his or her Compensation (and have that amount contributed as Deferrals on his or her behalf) and submitting it to the Administrator. This participation election shall be made pursuant to a deferral agreement under which the Employee agrees to be bound by all the terms and conditions of the Plan. The Administrator may establish a minimum deferral amount, and may change such minimums from time to time. Subject to the limits of Article 4, a Participant must currently defer a minimum of $25 per month. The participation election shall include selection of an Investment Provider. Any such election shall remain in effect until a new election is submitted.

3.3 **Commencement of Participation.** An Employee shall become a Participant as soon as administratively practicable following the date the Employee files a participation election pursuant to Section 3.2 or becomes eligible for Employer Contributions under Section 3.9. ~~An~~Such election ~~under Section 3.2~~ shall become effective no earlier than the ~~calendar month following the month in which the~~ date the Employee files a participation election ~~is made,~~ pursuant to Section 3.2 or ~~such other date~~ becomes eligible for Employer Contributions under Section 3.9, as ~~may be~~ permitted under ~~the~~ Code~~.~~ Section 457(b)(4)(A). A new Employee may defer compensation payable in the calendar month during which the Participant first becomes an Employee if an agreement providing for the deferral is entered into on or before the first day on which the Participant performs services for the Employer.

3.4 **Information Provided by the Participant.** Each Employee enrolling in the Plan should provide to the Administrator at the time of initial enrollment, and later if there are any changes, any information necessary or advisable for the Administrator to administer the

Plan, including, without limitation, whether the Employee is a participant in any other eligible plan under Code section 457(b).

3.5 **Contributions Made Promptly.** Deferrals by the Participant under the Plan shall be transferred to the Trust Fund within a period that is not longer than is reasonable for the proper administration of the Participant's Account Balance. For this purpose, Deferrals shall be treated as contributed within a period that is not longer than is reasonable for the proper administration if the contribution is made to the Trust Fund within 15 business days following the end of the month in which the amount would otherwise have been paid to the Participant.

3.6 **Amendment of Deferral Election.** Subject to other provisions of the Plan, a Participant may at any time revise his or her participation election, including a change of the amount of his or her Deferrals, as well as his or her investment direction and his or her designated Beneficiary through the Investment Provider(s). However, the Board retains the authority to limit the frequency of changes to the amount of Deferrals, applied uniformly to all Employees, as it deems appropriate. Unless the election specifies a later effective date, a change in the amount of Deferrals shall take effect as of the first day of the next following month or as soon as administratively practicable if later. A change in the investment direction shall take effect as of the date provided by the Administrator on a uniform basis for all Employees. A change in the Beneficiary designation shall take effect when the election is accepted by the Investment Provider.

3.7 **Leave of Absence.** Unless an election is otherwise revised, if a Participant is absent from work by leave of absence, Deferrals under the Plan shall continue to the extent that Compensation continues. If a Severance from Employment is determined to have occurred, the Participant may elect to receive a distribution of benefits as provided for in Article 5.

3.8 **Disability.** A disabled Participant may elect to make Deferrals during any portion of the period of his or her disability to the extent that he or she has actual Compensation (not imputed compensation and not disability benefits) from which to make contributions to the Plan and has not had a Severance from Employment.

3.9 **Employer Contributions.** A Participant shall become entitled to Employer Contributions as elected by the Employer and communicated to the Plan Administrator in a form acceptable to the Administrator. An Employee who is not a Participant shall become a Participant immediately upon becoming entitled to an Employer Contribution pursuant to the Employer's election, regardless of whether such Employee elects to make Deferrals.

ARTICLE 4

LIMITATIONS ON AMOUNTS DEFERRED

4.1 **Basic Annual Limitation.** ~~The~~In accordance with Code Section 457(b)(2), the maximum annual amount of Plan Contributions for any calendar year shall not exceed the lesser of (1) the ~~Applicable Dollar Amount or (2) the Participant's Includible Compensation for the calendar year. The Applicable Dollar Amount is the~~applicable dollar amount set forth under Code Section 457(e)(15)(A), as indexed ~~in accordance with~~under Code section

~~415(d).~~457(e)(15)(B) or (2) the Participant's Includible Compensation for the calendar year.

4.2 **Age 50 Catch-up Contributions.** A Participant who will attain age 50 or more by the end of the calendar year is permitted to make ~~an~~ additional annual ~~amount of~~ Deferrals~~,~~ up to the ~~maximum age 50 catch-up Deferrals for the year. The maximum annual dollar amount of the age 50 catch-up Deferrals for a year is the amount set forth~~ applicable dollar amount under Code section 414(v)~~(2~~), as indexed in accordance with Code section 414(v)(2)(C~~) and~~). If adopted by the Board, the adjusted dollar amount under Code ~~section 415(d).~~Section 414(v)(2)(E), as increased by the Cost of Living Adjustment in effect for such calendar year, shall apply to a Participant who will attain age 60 but will not attain age 64 by the end of the calendar year.

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4.3 **Special Section 457 Catch-up Limitation.** ~~If~~In accordance with Code Section 457(b)(3), if the applicable year is one of the Participant's last three consecutive calendar years ending before the year in which the Participant attains Normal Retirement Age and the amount determined under this Section 4.3 exceeds the amount computed under Section 4.1 and 4.2, then the annual limit on Plan Contributions under this Article 4 shall be the lesser of:

(a) An amount equal to two times the ~~Applicable Dollar Amount~~applicable dollar amount under Section 4.1 for such year; or

(b) The sum of:

(1) An amount equal to (A) the aggregate limit under Section 4.1 for the current calendar year plus each prior calendar year beginning after December 31, 2001 during which the Participant was an Employee under the Plan, minus (B) the aggregate amount of ~~Plan Contributions under the Plan for~~Compensation that the Participant deferred under the Plan during such years, plus

(2) An amount equal to (A) the aggregate limit under Code section 457(b)(2) for each prior calendar year beginning after December 31, 1978 and before January 1, 2002 during which the Participant was an Employee (determined without regard to Sections 4.2 and 4.3), minus (B) the aggregate contributions to Pre-2002 Coordination Plans (as defined by Treasury Regulations and provided in Section 4.4(c)) for such years.

However, in no event can the deferred amount be more than the Participant's Compensation for the year.

(c) If adopted by the Board, effective January 1, 2026, or such later effective date determined by the Secretary of the Treasury through guidance and subject to such guidance, with respect to a Participant whose wages within the meaning of Code Section 3121(a) for the preceding calendar year from the Employer exceed the

limitation under Code Section 414(v)(7)(A), as indexed, paragraph (b) shall not apply.

4.4 Special Rules. For purposes of this Article 4, the following rules shall apply:

(a) If the Participant is or has been a participant in one or more other eligible plans within the meaning of Code section 457(b), then ~~the~~this Plan and all such other plans shall be considered as one plan for the purposes of applying the foregoing limitation ~~in~~of this Article 4. For this purpose, the Administrator shall take into account any other such eligible plan maintained by the Employer and shall also take into account any other such eligible plan for which the Administrator receives from the Participant sufficient information concerning his or her participation in such other plan.

(b) In applying Section 4.3, a year shall be taken into account only if the Participant was eligible to participate in the Plan during all or a portion of the year and Compensation deferred, if any, under the Plan was subject to the maximum amount described in Section 4.1 or any other plan limit required by Code section 457(b).

(c) For purposes of Section 4.3(b)(2), the term "contributions to Pre-2002 Coordination Plans" means any employer contribution, salary reduction or elective contribution under any other eligible Code section 457(b) plan, or a salary reduction or elective contribution under any other eligible Code section 401(k) qualified cash or deferred arrangement, Code section 402(h)(1)(B) simplified employee pension (SARSEP), Code section 403(b) annuity contract and Code section 408(p) simple retirement account, or under any plan for which a deduction is allowed because of a contribution to an organization described in Code section 501(c)(18), including plans, arrangements or accounts maintained by the Employer or any employer for whom the Participant performed services. However, the contributions for any calendar year are only taken into account for purposes of Section 4.3(b)(2) to the extent that the total of such contributions does not exceed the aggregate limit referred to in Code section 457(b)(2) for that year.

(d) For purposes of Sections 4.1, 4.2 and 4.3, an individual is treated as not having deferred compensation under a plan for a prior taxable year to the extent Excess Deferrals (as defined in Section 4.5) under the plan are distributed. To the extent that the combined deferrals for pre-2002 years exceeded the maximum deferral limitations, the amount is treated as an Excess Deferral for those prior years.

4.5 Correction of Excess Deferrals. If the annual amount of Plan Contributions on behalf of a Participant for any calendar year exceeds the limitations described in this Article 4, or the annual amount of Plan Contributions on behalf of a Participant for any calendar year exceeds the limitations described in this Article 4 when combined with other amounts deferred by the Participant under another eligible deferred compensation plan under Code section 457(b) for which the Participant provides information that is accepted by the

Administrator, then the annual amount of Plan Contributions, to the extent in excess of the applicable limitation ("Excess Deferral"), and adjusted for any income or loss in value, if any, allocable thereto, shall be distributed to the Participant.

4.6 **Protection of Persons Who Serve in a Uniformed Service.** An Employee whose employment is interrupted by qualified military service under Code section 414(u) or who is on a leave of absence for qualified military service under Code section 414(u) may elect to make additional Deferrals upon resumption of employment with the Employer equal to the maximum amount of annual Deferrals that the Employee could have elected during that period if the Employee's employment with the Employer had continued (at the same level of Compensation) without the interruption or leave, reduced by the Deferrals, if any, actually made for the Employee during the period of the interruption or leave. This right applies for five years following the resumption of employment, or if sooner, for a period equal to three times the period of the interruption or leave.

If such Participant elects to make such additional Deferrals, then the Employer shall make up the related matching Employer Contributions which would have been required had such Deferrals actually been made during the period of qualified military service. The make-up contributions by the Employer shall be made as soon as practicable after the Participant makes such make-up contributions.

If the Participant timely resumes employment in accordance with USERRA after a qualified military leave, the Employer shall make any nonelective Employer Contributions that would have been made if the Participant had remained employed during the Participant's qualified military service. Such contributions must be made no later than ninety (90) days after the date of such reemployment or when contributions are normally due for the year in which the qualified military service was performed, if later.

In determining the amount of Deferrals and Employer Contributions, a Participant shall be treated as receiving compensation from the Employer during such period of qualified military service equal to: (i) the compensation the Participant would have received during such period if the Participant were not in qualified military service, determined based on the rate of pay the Participant would have received from the Employer but for the absence during the period of qualified military service; or (ii) if the compensation the Participant would have received during such period is not reasonably certain, the Participant's average compensation from the Employer during the twelve (12) month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

In addition, effective for deaths occurring on or after January 1, 2007, if a Participant dies while performing qualified military service (as defined in Code section 414(u)(5)), this Plan shall provide all applicable benefits required in accordance with Code section 401(a)(37), but the provisions of Code section 414(u)(9) shall not apply to this Plan.

ARTICLE 5 DISTRIBUTION OF BENEFITS

5.1 ~~Benefit Distributions.~~ ~~A Participant's Account Balance may not be paid to the Participant (~~Distribution Restrictions.

(a) In accordance with Code section 457(d), a Participant, or, if applicable, ~~the Participant's~~a Beneficiary~~), until one~~, shall be eligible to receive a distribution of ~~the following events~~ his or her Account Balance if the Participant:

~~5.1~~ has ~~occurred:~~

~~(a)~~(1) ~~the Participant's~~a Severance from Employment;

~~(b) the Participant's death;~~

(2) ~~an unforeseeable emergency, within the meaning of and subject to~~dies;

~~(c)~~(3) is eligible for a distribution under Section 5.~~5~~4;

~~(d)~~(4) ~~the Participant~~ has a Severance from Employment and is subject to the mandatory distribution of ~~his~~the Account Balance under Section 5.~~6~~7.

(b) ~~If a Participant has a separate~~ Paragraph (a) notwithstanding, a Participant's account attributable to rollover contributions ~~to the Plan~~made pursuant to Section 7.1~~, the~~ may be distributed to a Participant ~~may~~ at any time ~~elect to receive a distribution of all or any portion of the amount held in~~, to the extent that the rollover ~~account~~contributions made pursuant to Section 7.1 have been separately accounted for by the Administrator.

~~5.2~~ **Benefit Distribution Election.**

~~(a)~~**5.2** A Participant may elect to commence distribution of his or her Account Balance any time after retirement or other Severance of Employment by filing an application for a distribution with the Administrator. ~~However, in no event may distribution of benefits to the Participant commence later than the Required Beginning Date. The amount of such required minimum distribution shall be determined in accordance with Code section 401(a)(9) and the regulations thereunder, as applicable to a governmental plan as defined in Code section 414(d).~~

5.3 Payment Options.

(a) A Participant (or, if applicable, ~~the Participant's~~a Beneficiary) ~~may elect~~entitled to a distribution under this Article 5 may elect to receive payment in ~~the form~~any of the following forms of distribution:

(1) a lump sum ~~or systematic distribution option~~ payment of the total Account Balance;

(2) annual, monthly, or quarterly installment payments as permitted under the terms of the investment product(s~~),~~); or ~~may elect~~

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(3) a direct rollover to an Eligible Retirement Plan as described in Section ~~5.~~7. ~~Notwithstanding any other provision~~2.

(b) A lump sum payment of a Participant's Account may be made without the ~~Plan,~~consent of the ~~elected form of~~ Participant or Beneficiary if their Account Balance does not exceed $1,000 taking into account their Rollover Contribution Account, unless the Participant elects to have such distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover or to receive the distribution directly in a lump sum.

5.4 Distribution Events.

(a) Unforeseeable Emergency Distributions. ~~shall comply with required~~ In accordance with Code section 457(d)(1)(A)(iii) and Treasury Regulation § 1.457-6(c)(1), if the Participant has an unforeseeable emergency before Severance from Employment, the Participant may elect to receive a lump sum distribution equal to the amount requested or, if less, the maximum amount determined by the Administrator to be permitted to be distributed under this Section 5.4(a).

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(1) For this purpose, an unforeseeable emergency is defined as a severe financial hardship of the Participant resulting from an illness or accident of the Participant, the Participant's spouse or dependents (as defined in Code section 152(a) without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B)); loss of the Participant's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, e.g., as a result of natural disaster); the need to pay for the funeral expenses of the Participant's spouse or dependent (as defined in Code section 152(a) without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B)); or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant. For example, the imminent foreclosure of or eviction from the Participant's primary residence may constitute an unforeseeable emergency. In addition, the need to pay for medical expenses, including nonrefundable deductibles, as well as for the cost of prescription drug medication, may constitute an unforeseeable emergency. ~~rules under Code section 401(a)(9) and the regulations thereunder, as applicable to a governmental plan as defined~~Except as otherwise specifically provided in this Section 5.4(a), neither the purchase of a home nor the payment of college tuition is an unforeseeable emergency.

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(2) A distribution on account of unforeseeable emergency may not be made to the extent that such emergency is or may be relieved through reimbursement of compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under the Plan.

(3) ~~Code section 414(d), including~~Distributions because of an unforeseeable emergency may not exceed the amount reasonably necessary to satisfy the emergency (which may include any amounts necessary to pay any ~~minimum distribution~~federal, state, or local income taxes or penalties reasonably anticipated to results from the distribution).

(b) Voluntary Distribution of Small Amounts. Upon proper written request to the Administrator, a Participant may elect to receive a distribution of his or her total Account Balance in a lump sum if the Account Balance does not exceed $7,000 (or the dollar limit under Code section 411(a)(11), if greater) without regard to amounts attributable to rollover contributions under Section 7.1, no Plan Contributions have been made for the Participant during the two-year period immediately prior to the date of distribution, and the Participant has not previously received a distribution of his or her Account Balance under this Section 5.4.

5.5 Death Benefit. If a Participant dies before the distribution of his or her entire Account Balance, the remaining Account Balance shall be distributed to the Beneficiary(ies) as soon as administratively practicable after the Participant's death, unless the Beneficiary elects a later payment date, subject to Code section 401(a)(9). A Beneficiary may elect to receive the Participant's Account Balance under any distribution option available under Section 5.3, subject to Code section 401(a)(9).

5.6 Required Distribution Rules.

(a) The provisions of this Section 5.6 take precedence over any inconsistent provisions of the Plan. As required by Code section 457(d)(2), the Plan shall comply with the minimum distribution requirements of Code section 401(a)(9), as applicable to an eligible governmental plan described in Treasury Regulation § 1.457-2(f). All distributions under this Plan shall be made in accordance with a reasonable and good faith interpretation of Code section 401(a)(9) and the regulations promulgated thereunder, including the incidental death benefit ~~requirements~~rules under Code Section 401(a)(9)(G) and the changes under the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019, SECURE 2.0 of 2022, and Treasury Regulation Sections 1.401(a)(9)-1 through -9, as each may be amended from time to time.

(b) A Participant's Accounts will be distributed, beginning not later than as required under paragraph (c), over one of the following periods (or a combination thereof):

(1) The life of the Participant;

(2) The life of the Participant and a Designated Beneficiary;

(3) A period certain not extending beyond the life expectancy of the Participant; or

(4) A period certain not extending beyond the joint and last survivor life expectancy of the Participant and Designated Beneficiary;

(c) A Participant's Account shall be distributed to the Participant beginning no later than April 1 of the calendar year following the later of (i) the calendar year in which the Participant attains the applicable age within the meaning of Code Section 401(a)(9)(C)(v) or (ii) the calendar year in which the Participant has a Severance from Employment.

(d) Subject to regulations or other guidance issued under Code Section 401(a)(9), upon the death of the Participant before distribution of their Account has begun under paragraph (c), the following distribution provisions shall take effect:

(1) The portion of the Participant's Account payable to a Beneficiary that is not a Designated Beneficiary shall be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(2) The portion of the Participant's Account payable to a Designated Beneficiary who is not an Eligible Designated Beneficiary shall be distributed by December 31 of the calendar year containing the tenth anniversary of the Participant's death.

(3) The portion of the Participant's Account payable to an Eligible Designated Beneficiary shall be distributed, pursuant to the election of the Eligible Designated Beneficiary, either (i) by December 31 of the calendar year containing the tenth anniversary of the Participant's death, or (ii) beginning no later than December 31 of the calendar year immediately following the calendar year in which the Participant died, over the life of the Eligible Designated Beneficiary or over a period not exceeding the life expectancy of the Eligible Designated Beneficiary. If the Eligible Designated Beneficiary is the surviving Spouse, the Eligible Designated Beneficiary may elect to delay payment under item (ii) until December 31 of the calendar year in which the Participant would have attained the applicable age within the meaning of Code Section 401(a)(9)(C)(v). If the Eligible Designated Beneficiary does not elect a method of distribution as provided above, the Participant's Accounts shall be distributed in accordance with item (i).

(e) Subject to regulations or other guidance issued under Code Section 401(a)(9), upon the death of the Participant after distribution of their Account has begun under paragraph (c), any remaining portion of their Account shall continue to be distributed at least as rapidly as under the method of distribution in effect at the time of the Participant's death; provided, however, that the portion of the Participant's Account payable to a Designated Beneficiary who is not an Eligible Designated Beneficiary shall be distributed in its entirety by December 31 of the calendar year containing the tenth anniversary of the Participant's death.

(f) Upon the death of an Eligible Designated Beneficiary, or the attainment of age 21 of an Eligible Designated Beneficiary who is a minor child of the Participant, before distribution of the Participant's entire Account under paragraphs (d) or (e), the remainder of the Participant's Account shall be distributed by December 31 of the calendar year containing the tenth anniversary of the Eligible Designated Beneficiary's death, or by December 31 of the calendar year in which the child attains age 31, as applicable.

~~(b)~~(g) Any distribution required under the incidental death benefit requirements of Code Section 401(a) shall be treated as a distribution required under this Section 5.6.

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~~(c)~~(h) Effective in 2009, notwithstanding subsections (a) and (b) above, a Participant (or, if applicable, the Participant's Beneficiary) who would have been required to receive required minimum distributions for 2009 but for the enactment of Code section 401(a)(9)(H) ("2009 RMDs"), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2009 RMDs or (2) one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancy) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years ("Extended 2009 RMDs"), will receive those distributions for 2009 unless the Participant or Beneficiary chooses not to receive such distributions. Participants and Beneficiaries described in the preceding sentence will be given the opportunity to elect to stop receiving the distributions described in the preceding sentence. In addition, notwithstanding Section 5.6(a)(3) of the Plan, and solely for the purpose of applying the direct rollover provisions of the Plan, the Board shall only offer direct rollover of 2009 RMDs and Extended 2009 RMDs that are received by a Participant or Beneficiary to the extent such distributions that would be Eligible Rollover Distributions without regard to Code section 401(a)(9)(H).

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~~(d)~~(i) Effective 2020, notwithstanding any other provisions of this Plan, a Participant who would have been required to receive required minimum distributions in 2020 (or paid in 2021 for the 2020 calendar year for a recipient with a Required Beginning Date of April 1, 2021) but for the enactment of section 401(a)(9)(I) of the Code ("2020 RMD"), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2020 RMDs, or (2) one or more payments (that include the 2020 RMDs) in a series of substantially equal periodic payments made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancies) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years ("Extended 2020 RMDs"), will receive those 2020 distributions unless the Participant or Beneficiary elects not to receive such distribution. Notwithstanding the preceding sentence, a Participant or Beneficiary will be given an opportunity to make an election as to whether or not to receive such 2020 RMD distributions.

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5.3 Death Benefit Distributions prior to January 1, 2022. For Participant deaths prior to January 1, 2022, this Section 5.3 shall apply. Upon the death of the Participant, the Participant's Beneficiary may elect to receive the Participant's Account Balance in any form permitted under Section 5.2. However, if the Beneficiary of the Participant is the Participant's estate, the benefit will be payable only in a single lump sum. Such Beneficiary may also designate his or her own beneficiary, or if none is designated, the Beneficiary's estate will receive any benefits payable upon the Beneficiary's death. Notwithstanding any other provision in the Plan to the contrary, distributions upon the death of a Participant shall be made in accordance with the following requirements and shall otherwise comply with Code section 401(a)(9) and the regulations thereunder, as applicable to a governmental plan as defined in Code section 414(d), including any minimum distribution incidental benefit requirements.

(a) If the designated Beneficiary is not the Participant's surviving spouse, distributions after the Participant's death must either (1) begin to be distributed no later than December 31st of the calendar year immediately following the year of the Participant's death, payable over a period not to exceed the Beneficiary's life expectancy; or (2) be distributed no later than December 31st of the calendar year containing the fifth anniversary of the Participant's death.

(b) If the designated Beneficiary is the Participant's surviving spouse, distributions after the Participant's death must begin to be distributed by the later of December 31st of the calendar year immediately following the year of the Participant's death or December 31st of the calendar year in which the Participant would have attained age seventy-two (72) (or age 70 ½ with respect to a Participant who was born before July 1, 1949), or other applicable age under Code section 401(a)(9). Payments to a surviving spouse must be made over a period not to exceed the surviving spouse's life expectancy. Alternatively, the surviving spouse may elect to receive a total distribution of the Participant's Account Balance by no later than December 31st of the calendar year containing the fifth anniversary of the Participant's death.

(c) If distributions have begun prior to the death of the Participant, the remaining portion of the Participant's Account Balance shall be distributed to the Beneficiary at least as rapidly as under the method of distribution in effect prior to the Participant's death.

5.4 Death Benefit Distributions After December 31, 2021. Notwithstanding any contrary provisions, effective for Participant deaths after December 31, 2021, the following distribution provisions in this section 5.4 shall take effect; provided, however, that such provisions shall be subject to any regulations or other guidance issued under the SECURE Act.

(a) Death with a **Designated Beneficiary.** If the Participant dies before the distribution of his or her entire account (regardless of whether any distributions had begun before the Participant's death) and the Participant has a designated Beneficiary:

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(1) The entire account shall be distributed to the designated Beneficiary by December 31 of the calendar year containing the tenth anniversary of the Participant's death.

(2) Notwithstanding the paragraph above, if the designated Beneficiary is surviving spouse, then the surviving spouse may elect for the Participant's account(s) to be distributed (i) by December 31 of the calendar year containing the tenth (10th) anniversary of the Participant's death, or (ii) the later of December 31 of the calendar year immediately following the calendar year in which the Participant died or December 31 of the calendar year in which the Participant would have attained age seventy-two (72) (or age 70 ½ with respect to a Participant who was born before July 1, 1949), or other applicable age under Code section 401(a)(9).

(3) For calendar years beginning after December 31, 2023, if the designated Beneficiary is the Participant's surviving spouse, the surviving spouse may elect to be treated as if he or she were the Participant, pursuant to Code Section 401(a)(9)(B)(iv).

(b) Death without a Designated Beneficiary. If the Participant dies before distributions of his or her account begins and the Participant has no designated Beneficiary, the Participant's account under the Plan shall be distributed by December 31 of the calendar year containing the fifth (5th) anniversary of the Participant's death. If the Participant dies after distribution of his or her account begins and the Participant has no designated Beneficiary, any remaining portion of the account shall continue to be distributed at least as rapidly as under the method of distribution in effect at the time of the Participant's death.

5.5 Unforeseeable Emergency Distributions. If the Participant has an unforeseeable emergency before Severance from Employment, the Participant may elect to receive a lump sum distribution equal to an amount not to exceed the amount reasonably necessary to satisfy the emergency need, which may include amounts necessary to pay federal, state or local income taxes or penalties reasonably anticipated to result from the distribution, as determined by the Administrator.

(1) For this purpose, an unforeseeable emergency is defined as a severe financial hardship of the Participant resulting from an illness or accident of the Participant, the Participant's spouse or dependents (as defined in Code section 152(a) without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B)); loss of the Participant's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, e.g., as a result of natural disaster); the need to pay for the funeral expenses of the Participant's spouse or dependent (as defined in Code section 152(a) without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B)); or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant. For example, the imminent foreclosure of or eviction from the

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Participant's primary residence may constitute an unforeseeable emergency. In addition, the need to pay for medical expenses, including nonrefundable deductibles, as well as for the cost of prescription drug medication, may constitute an unforeseeable emergency. Except as otherwise specifically provided in this Section 5.5, neither the purchase of a home nor the payment of college tuition is an unforeseeable emergency.

(1) A distribution on account of unforeseeable emergency may not be made to the extent that such emergency is or may be relieved through reimbursement of compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under the Plan.

5.6 Distribution of Small Account Balances. Upon proper written request to the Administrator, a Participant may elect to receive a distribution of his or her total Account Balance in a lump sum if the Account Balance does not exceed $7,000 (or the dollar limit under Code section 411(a)(11), if greater) without regard to amounts attributable to rollover contributions under Section 7.1, no Plan Contributions have been made for the Participant during the two-year period immediately prior to the date of distribution, and the Participant has not previously received a distribution of his or her Account Balance under this Section 5.6.

5.7 Direct Rollovers. Notwithstanding any provision of the Plan to the contrary, a Distributee shall be permitted to elect to have an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan in a direct rollover, at the time and in the manner prescribed by the Administrator.

(a) An "Eligible Rollover Distribution" means any distribution of all or a portion of a Participant's Account Balance, except that an Eligible Rollover Distribution does not include:

(1) any distribution that is one of series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies)

of the Distributee and a designated Beneficiary, or for a specified period of 10 years or more;

(2) any distribution made under Section 5.5 as a result of an unforeseeable emergency; or

(3) any distribution to the extent such distribution is a required minimum distribution under Code section 401(a)(9).

(b) An "Eligible Retirement Plan" means an individual retirement account described in Code section 408(a), an individual retirement annuity described in Code section 408(b), an annuity plan described in Code section 403(a), a qualified trust described

~~in Code section 401(a), an eligible deferred compensation plan described in Code section 457(b) that is maintained by a governmental entity described in Code section 457(e)(1)(A), an annuity contract described in Code section 403(b), a Roth IRA described in Code section 408A, and effective December 18, 2015, a SIMPLE IRA as described in Code section 408(p), provided that the rollover contribution is made after the two-year period beginning on the date the Distributee first participated in any qualified salary reduction arrangement maintained by the Distributee's employer under Code Section 408(p)(2), as described in Code Section 72(t)(6). However, for an Eligible Rollover Distribution to a designated Beneficiary other than the surviving spouse, an Eligible Retirement Plan is only an individual retirement account described in Code section 408(a) or an individual retirement annuity described in Code section 408(b) that is treated as an inherited IRA in accordance with Code section 402(c)(11).~~

~~(c) A "Distributee" includes a Participant or former Participant or the Participant's or former Participant's designated Beneficiary. In addition, the Participant's or former Participant's spouse or former spouse are Distributees with regard to the interest of the spouse or former spouse.~~

~~5.8~~5.7 **Amount of Account Balance.** For all purposes under the Plan, the amount of any payment under this Article 5 shall be based on the amount of the Account Balance on the preceding Valuation Date, plus Plan Contributions made to the Plan from the Valuation Date to the date of distribution.

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~~5.9~~5.8 **Retired Public Safety Officer Health Premiums.** Pursuant to Code section 457(a)(3), Eligible Retired Public Safety Officers may elect an annual distribution of the lesser of the amount paid by such Eligible Retired Public Safety Officer, or $3,000, for the payment of Qualified Health Insurance Premiums.

ARTICLE 6 LOANS

This Plan does not permit loans from the Account Balances of Participants.

ARTICLE 7 ROLLOVERS AND TRANSFERS

7.1 **Rollover Contributions to the Plan.** A Participant who has enrolled and is currently eligible to defer Compensation under this Plan and who is entitled to receive an Eligible Rollover Distribution (as defined in Section ~~5.7~~7.2(~~a~~b) but excluding any after-tax employee contributions) from another Eligible Retirement Plan (as defined in Code section 402(c)(8)) may request to have all or a portion of such Eligible Rollover Distribution paid to the Plan. The Administrator may require such documentation from the distributing plan as it deems necessary to effectuate the rollover in accordance with Code section 402 and to confirm that such plan is an Eligible Retirement Plan within the meaning of Code section 402(c)(8).

The Plan shall establish and maintain for the Participant a separate account for any Eligible Rollover Distribution paid to the Plan from any Eligible Retirement Plan that is not an eligible governmental plan under Code section 457(b). In addition, the Plan shall establish

and maintain for the Participant a separate account for any Eligible Rollover Distribution paid to the Plan from any Eligible Retirement Plan that is an eligible governmental plan under Code section 457(b).

7.2 Direct Rollovers.

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(a) Notwithstanding any provision of the Plan to the contrary, a Distributee may elect to have an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan as specified by the Distributee in a Direct Rollover, at the time and in the manner prescribed by the Administrator.

(b) For purposes of this Section 7.2, the following definitions shall apply:

(1) "Direct Rollover" means an Eligible Rollover Distribution that is paid directly to an Eligible Retirement Plan for the benefit of the Distributee.

(2) "Distributee" means a Participant, the spouse of the Participant, the Participant's former spouse who is an alternate payee under a qualified domestic relations order as defined in Code section 414(p), and a Participant's non-spouse Beneficiary, any of whom is eligible to receive a distribution from the Plan.

(3) "Eligible Retirement Plan" as defined under Code section 402(c)(8)(B), means (i) an individual retirement account described in Code section 408(a); (ii) an individual retirement annuity described in Code section 408(b); (iii) a simple retirement account described in Code section 408(p)(1) following the two year period described in Code section 72(t)(6); (iv) an annuity plan described in Code section 403(a); (v) a plan described in Code section 403(b); (vi) a qualified plan described in Code section 401(a); (vii) a Code section 457(b) eligible deferred compensation plan that is maintained by a governmental entity described in Code section 457(e)(1)(A); and (viii) effective January 1, 2008, a Roth individual retirement account described in Code section 408A(e), provided the Distributee's adjusted gross income does not exceed any limit applicable under federal law for the tax year in which the distribution occurs.

In the case of a distribution to a Participant's non-spouse Beneficiary, an Eligible Retirement Plan means the plans described in subparagraphs (1) and (2) only, to the extent consistent with the provisions under Code section 402(c)(11) and any successor provisions thereto or additional guidance issued thereunder.

(4) "Eligible Rollover Distribution," as defined in Code section 402(f)(2)(A), means any distribution of all or any portion of the balance to the credit of the Distributee under the Plan, excluding the following:

i. any distribution that is one of series of substantially equal periodic payments (not less frequently than annually) made for the life (or

life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and a designated Beneficiary, or for a specified period of 10 years or more;

ii. any distribution made under Section 5.4(a) as a result of an unforeseeable emergency;

iii. any distribution to the extent such distribution is a required minimum distribution under Code section 401(a)(9); or

~~i.~~iv. other items designated by regulations, or by the Commissioner in revenue rulings, notices, or other guidance, as items that do not constitute an eligible rollover distribution.

~~7.2~~7.3 **Plan-to-Plan Transfers to the Plan.** Participants who are participants in another eligible governmental plan under Code section 457(b) may transfer assets to this Plan as provided in this Section 7.~~2~~3, but only if the other plan provides for the direct transfer of each Participant's interest therein to the Plan. The Administrator may require such documentation from the other plan as it deems necessary to effectuate the transfer in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b) and to confirm that the other plan is an eligible governmental plan as defined in Treas. Reg. section 1.457-2(f). The amount so transferred shall be credited to the Participant's Account Balance and shall be held, accounted for, administered and otherwise treated in the same manner as Plan Contributions under the Plan, except that transferred amounts shall not be considered a Plan Contribution under the Plan in determining the maximum deferral under Article 4.

~~7.3~~7.4 **Plan-to-Plan Transfers from the Plan.** Participants and Beneficiaries may elect to have all or any portion of their Account Balance transferred to another eligible governmental plan within the meaning of Code section 457(b) and Treas. Reg. section 1.457-2(f). A transfer is permitted for a Participant under this Section 7.~~3~~4 only if the Participant has had a Severance from Employment with the Employer and is an employee of the entity that maintains the other eligible governmental plan. Further, a transfer is permitted only if the other eligible governmental plan provides for the acceptance of plan-to-plan transfers with respect to Participants and Beneficiaries and for each Participant or Beneficiary to have an amount deferred under the other plan immediately after the transfer at least equal to the amount transferred.

Upon the transfer of assets under this Section 7.~~3~~4, the Plan's liability to pay benefits to the Participant or Beneficiary under this Plan shall be discharged to the extent of the amount so transferred. The Administrator may require such documentation from the receiving plan as it deems appropriate or necessary to comply with this Section 7.~~3~~4 (e.g., to confirm that the receiving plan is an eligible governmental plan and to assure that the transfer is permitted under the receiving plan) or to effectuate the transfer pursuant to Treas. Reg. section 1.457-10(b).

~~7.4~~7.5 **Permissive Service Credit Transfers.** ~~A~~Pursuant to Treas. Reg. § 1.457-10(b)(8), a Participant may elect to have any portion of his or her Account Balance transferred to a tax-qualified, governmental defined benefit plan (as defined in Code section 414(d)) that provides for the acceptance of plan-to-plan transfers for the purchase of permissive service credit (as defined in Code section 415(n)(3)(A)) under the receiving governmental defined benefit plan or a repayment to which Code section 415 does not apply by reason of Code section 415(k)(3). A transfer for such purpose may be made before the Participant has had a Severance from Employment.

ARTICLE 8 ADMINISTRATION

This Plan shall be administered by the Administrator, as directed by the Board, in accordance with Code section 457 and applicable regulations thereunder. The Board shall have the authority to make all discretionary decisions affecting the rights or benefits of the Participants which may be required in administration of this Plan. The Board's decisions shall be afforded the maximum deference permitted by applicable law. The Board shall exercise all rights, powers and duties granted to it by law and as necessary to administer the Plan. The Board shall approve or disapprove Investment Providers and may contract with Investment Providers to offer investment products under the Plan and provide services to the Plan as the Board deems appropriate.

The Board may delegate specific duties and responsibilities under the Plan, including by contracting with an administrative service provider to perform specific, nondiscretionary administrative functions under the Plan, including the maintenance of Participants' Account Balances, the provision of periodic reports on the status of each Account Balance, the disbursement of benefits on behalf of the Board in accordance with the terms of this Plan, and the maintenance of Beneficiary designations. The Board shall supervise the operation of the Plan, maintain records and supply information to the Participants or other parties.

ARTICLE 9 TRUST FUND

9.1 **Establishment of Trust.** The assets of the Plan, including all Plan Contributions, property, rights purchased with Plan Contributions, and all income attributable to such assets, are held in insurance annuity contracts or custodial account contracts that have been entered into with one or more investment Providers by the Board that meet the exclusive benefit and other requirements of Code sections 457(g) and 401(f). Under the terms of the insurance annuity and custodial account contracts under this Section 9.1 it shall be impossible, prior to the satisfaction of all liabilities with respect to the Accounts of Participants and Beneficiaries, for any part of the assets or income of the contracts to be used for, or diverted to, any purpose other than for the exclusive benefit of the Participants and Beneficiaries of the Plan and Trust. For purposes of this Article 9, custodial accounts and annuity contracts shall be treated as held in trust so long as such custodial accounts and annuity contracts satisfy the requirements set forth in Treas. Reg. section 1.457-8(a)(3).

9.2 **Trustee.** The Board shall be the Trustee for the Plan, unless the Board duly appoints another individual or entity to serve as trustee and such individual or entity agrees to act in that capacity hereunder. The Trustee shall ensure that all investments, amounts, property and rights held under the Trust Fund are held for the exclusive benefit of Participants and

their Beneficiaries. The Trust Fund shall be liable to pay benefits under this Plan only to the extent of amounts that are available under the investment products selected by Participants and Beneficiaries, and neither the Board nor Employers shall be responsible for the investment or performance results of such investment products.

9.3 **Specific Powers and Duties.** The Board shall:

(a) Exercise exclusive authority to invest and manage assets of the Plan. However, the Board may permit Participants to direct and control the investment of their contributions, together with accumulated earnings, among the investment options established by the Board.

(b) Establish and adopt a statement of investment objectives and policies setting forth the manner and parameters of the investment of the assets of the Plan. The statement of investment objectives and policies shall be established in a manner consistent with the purposes of the Plan. The Board shall monitor the performance of the investments of the Plan to ensure such remain consistent with the investment policy established by the Board.

(c) Establish an administrative budget sufficient to perform the duties under the Plan and to draw upon authorized sources to fund the budget.

(d) Pay Plan benefits and related taxes from the assets of the Plan.

(e) Obtain by employment or contract all the services necessary or appropriate to administer the Plan, including actuarial, auditing, custodial, investment, legal and recordkeeping services.

(f) Procure and dispose of the goods and property of the Plan necessary for its proper administration.

(g) Represent the Employers in all matters concerning the administration of the Plan.

(h) Have full power and authority to adopt rules and regulations for the administration of the Plan and to interpret, alter, amend, or revoke any rules and rules and regulations so adopted.

9.4 **Accounting.** For accounting purposes, the Board will maintain a summary of the individual Account Balances of all Participants of the Plan whose benefits have not been annuitized. The accounting summary shall be identified as the general account of the North Dakota Section 457 Plan and Trust and will reflect from time to time the total deferred liability of the Plan as well as the individual balances for all Participants of the Plan.

ARTICLE 10 MISCELLANEOUS

10.1 **Nonassignability.** Except as provided in Sections 10.2 and 10.3, the interests of each Participant or Beneficiary under this Plan are not subject to the claims of creditors. Participants and Beneficiaries shall not have any right to sell, assign, transfer or otherwise

convey the right to receive any payments hereunder or any interest under the Plan, which payments and interest are expressly declared to be nonassignable and nontransferable. Nor shall any unpaid benefits be subject to attachment, garnishment or execution for the payment of any debts or judgments or be transferable by operation of law in the event of bankruptcy or insolvency of the Participant or any other person.

10.2 **Domestic Relations Orders.** A Participant's benefit may be subject to division under a domestic relations orders between the Participant and the alternate payee (as defined in Code section 414(p)(8)) if the order is determined to be a qualified domestic relations order (as defined in Code section 414(p)(1) and modified by Code section 414(p)(11)). The Administrator shall establish reasonable procedures for determining the qualified status of a domestic relations order and for effectuating distribution pursuant to a qualified domestic relations order. Distribution shall be made to an alternate payee in a single lump sum pursuant to a domestic relations order within 21 days after the later of the date the order is deemed to be qualified pursuant to the Plan policies and procedures or the date the order is entered by the court, without regard to whether the Participant is eligible for a distribution of benefits under the Plan.

10.3 **IRS Levy.** Notwithstanding Section 10.1, the Administrator may pay from a Participant's or Beneficiary's Account Balance the amount that the Administrator finds is lawfully demanded under a levy issued by the Internal Revenue Service with respect to that Participant or Beneficiary or is sought to be collected by the United States government under a judgment resulting from an unpaid tax assessment against the Participant or Beneficiary.

10.4 **Mistaken Contributions.** If any contribution is made to the Plan by a good faith mistake of fact, then within one year after payment of the contribution, and upon receipt in good order of a proper request approved by the Administrator, the amount of the mistaken contribution (adjusted for any income or loss in value, if any, allocable thereto) shall be returned directly to the Participant or, to the extent required or permitted by the Administrator, to the Employer.

10.5 **Payments to Minors and Incompetents.** If a Participant or Beneficiary entitled to receive any benefits hereunder is a minor or is adjudged to be legally incapable of giving valid receipt and discharge for such benefits, or is deemed so by the Investment Provider, benefits will be paid to such person as the Investment Provider may designate for the benefit of such Participant or Beneficiary. Such payments shall be considered a payment to such Participant or Beneficiary and shall, to the extent made, be deemed a complete discharge of any liability for such payments under the Plan.

10.6 **Distributee Cannot be Located.** If the Administrator does not have current contact information for or is unable to identify a Participant or Beneficiary, the Administrator shall make reasonable attempts to determine the address and identity of the Participant or Beneficiary entitled to benefits under the Plan. A reasonable attempt to locate a missing or lost Participant or Beneficiary shall include (a) providing notice to the Participant at the Participant's last known address via certified mail; (b) determining whether the Employer's records or the records of another plan maintained by the Employer has a more current

address for the Participant; (c) attempting to contact any named Beneficiary of the Participant; and (d) searching for the missing Participant via free electronic search tools, such as internet search engines, public record databases, obituaries, and social media. If such search methods are unsuccessful, based on the facts and circumstances, the Administrator may use other search methods, including using internet search tools, commercial locator services, credit reporting agencies, information brokers, investigation databases, and analogous services that may involve charges. The Administrator may charge missing Participants and Beneficiaries reasonable expenses for efforts to find them. In the event that the Administrator is unable to locate a Participant or Beneficiary entitled to benefits under the Plan, the Trustee shall continue to hold the benefits due to such person under the Plan in the Participant's Account.

10.7 **Applicable Law.** This Plan and Trust shall be construed under the laws of the State of North Dakota with the intent that it meets the requirements of an eligible deferred compensation plan under Code section 457(b), as amended. The provisions of this Plan and Trust shall be interpreted whenever possible in conformity with the requirements of that Code section.

10.8 **Gender and Number.** The masculine pronoun, whenever used herein, shall include the feminine pronoun, and the singular shall include the plural, except where context requires otherwise.

ARTICLE 11 AMENDMENT OR TERMINATION

11.1 **Amendment or Termination of the Plan.** The Board may terminate (with 60 days notice to the Employer and the Participants and Beneficiaries) or amend the provisions of this Plan at any time; provided, however, no termination or amendment shall affect the rights of a Participant or a Beneficiary to the receipt of benefits with respect to any Compensation deferred before termination or amendment, as adjusted for the investment experience of the Participant's or Beneficiary's Account Balance prior to or subsequent to the termination or amendment of the Plan. An Employer who has entered into agreement with the Board to participate in this Plan may, with 60 days notice to the Board and their Participants and Beneficiaries, terminate their participation agreement in a manner consistent with and in the same manner as described in the preceding sentence.

11.2 **Distribution Upon Termination.** Upon termination of the Plan, the Board shall direct distribution of the assets of the Plan and Trust Fund to Participants and Beneficiaries in a manner that is consistent with and satisfies the provisions of ~~Section~~Article 5~~.2~~ as soon as administratively practicable after a resolution to terminate the Plan is adopted.

Attachment 2

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM DEFERRED COMPENSATION 457(b) COMPANION PLAN

~~Restated effective October 1, 2024~~

Restated effective _____, 2025 Revised: ~~10~~05/~~2024~~2025

Adoption Resolution

Resolved, that effective ~~October 1, 2024~~ _____, 2025, the State of North Dakota has restated the Section 457 Companion Plan. The Plan is intended to satisfy the requirements of Section 457(b) of the Internal Revenue Code of 1986, as amended, and its associated regulations.

_____ _____

Signature

Date

_____Executive Director

Title

4912-7377-7218.2

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
DEFERRED COMPENSATION 457(B) COMPANION PLAN

~~ARTICLE 1~~

ARTICLE 1 PURPOSE

The North Dakota Public Employees Retirement System Board (~~"~~"Board~~"~~") hereby amends, reestablishes and reaffirms the Section 457 Companion Plan and Trust (~~"~~"the Plan~~"~~"). The Plan consists of the provisions set forth in this document. The primary purpose of this Plan is to retain present employees and attract new employees for participating employers by providing increased retirement income and other deferred benefits to employees and their beneficiaries in accordance with the provisions of section 457 of the Internal Revenue Code and amendments thereto and by providing additional investment opportunities that are not otherwise available under the North Dakota Section 457 Deferred Compensation Plan. This Plan shall be an agreement solely between the employer and participating employees. The Plan is intended to satisfy the requirements of an eligible deferred compensation plan under Internal Revenue Code section 457(b) and shall be interpreted as such.

Nothing contained in this Plan shall be deemed to constitute an employment contract or agreement for services between participating employees and their employer nor shall it be deemed to give a participating employee any right to be retained in the employ of, or under contract to, an employer. Nothing herein shall be construed to modify the terms of any employment contract or agreement for services between participating employees and their employer as this Plan is intended to be a supplement thereto.

~~ARTICLE 2~~
ARTICLE 2 DEFINITIONS

2.1 ~~**2.1**~~ **Account Balance.** The bookkeeping account maintained with respect to each Participant which reflects the value of the deferred Compensation credited to the Participant, including the ~~Participant's~~Participant's Deferrals, Employer Contributions, the earnings or losses of the Trust Fund (net of Trust Fund expenses) allocable to the Participant, and any distribution made to the Participant or the ~~Participant's~~Participant's Beneficiary. The Account Balance also includes any account established under Article 7 for rollover contributions and plan-to-plan transfers made for a Participant, the account established for a Beneficiary after the ~~Participant's~~Participant's death, and any account established for an alternate payee (as defined in Code section 414(p)(8)).

2.2 ~~**2.2**~~ **Administrator.** The North Dakota Public Employees Retirement System Board shall serve as the Plan's Administrator; however, the Administrator may designate an entity, person or persons as an administrative services provider to carry out certain nondiscretionary, administrative functions under the Plan, as described in Article 8.

2.3 ~~**2.3**~~ **Beneficiary.** The person or persons designated by the Participant who is entitled to receive benefits under the Plan after the death of a Participant. If no person is designated

by the Participant or if the designated Beneficiary predeceases the Participant, the Participant's estate shall be the Beneficiary.

2.4 ~~2.4~~ **Board.** The North Dakota Public Employees Retirement System Board.

2.5 ~~2.5~~ **Code.** The Internal Revenue Code of 1986, as now in effect or as hereafter amended. All citations to sections of the Code are to such sections as they may from time to time be amended or renumbered.

2.6 ~~2.6~~ **Compensation.** All cash compensation for services to the Employer, including salary, wages, fees, commissions, bonuses and overtime pay, that is includible in the Employee's gross income for the calendar year, plus amounts that would be cash compensation for services to the Employer includible in the Employee's gross income for the calendar year but for a compensation reduction election under section 125, 132(f), 401(k), 403(b) or 457(b) of the Code. Compensation also includes amounts paid to a Participant who has had a Severance from Employment, other than retirement or severance incentive payments, to the extent such amounts are paid by the later of 2½ months after the Participant's Severance from Employment or the end of the calendar year in which the Severance from Employment occurred, in accordance with Treas. Reg. section 1.457-(4)(d)(1) so long as the Employee would have been able to use the leave if employment had continued. Effective for years beginning after December 31, 2008, Compensation shall include military differential wage payments, as defined in Code section 3401(h).

2.7 ~~2.7~~ **Deferral.** The amount of Compensation deferred in any calendar year.

2.8 **Designated Beneficiary.** An individual Beneficiary within the meaning of Code Section 401(a)(9)(E)(i).

2.9 **Eligible Designated Beneficiary.** A Designated Beneficiary who meets the additional criteria under Code Section 401(a)(9)(E)(ii).

2.10 ~~2.8~~ **Eligible Retired Public Safety Officer.** An individual who has had a Severance from Employment as a public safety officer, as defined in Code section 402(*l*)(4)(C), with an Employer~~, by reason of either disability or attainment of the age set forth in N.D.C.C. § 54-52-17 at which the Participant has the right to retire and receive unreduced retirement benefits under N.D.C.C. Chapter 54-52~~.

2.11 ~~2.9~~ **Employee.** Each person, whether appointed or elected, employed by the Employer as a common law employee who performs services for the Employer for which Compensation is paid, and who has been determined by the Employer to be eligible to participate in the Plan in accordance with Section 3.1. Employee does not include an independent contractor.

2.12 ~~2.10~~ **Employer.** The State of North Dakota, which includes any of the State's departments, divisions, agencies or institutions, as well as any city, county, or other political subdivision, agency or instrumentality of the State, within the meaning of section 414(d) of the Code that enters into an agreement with the Board to participate in the Plan.

2.13 ~~**2.11**~~ **Employer Contribution.** Any nonelective contribution and/or matching contribution made pursuant to an election of the Employer accepted by the Plan Administrator.

2.14 ~~**2.12**~~ **Includible Compensation.** An Employee's actual wages in box 1 of Form W-2 for a year for services to the Employer, but subject to the maximum amount under Code section 401(a)(17), and increased (up to the dollar maximum) by any compensation reduction election under section 125, 132(f), 401(k), 403(b) or 457(b) of the Code. Effective for years beginning after December 31, 2008, Compensation shall include military differential wage payments, as defined in Code section 3401(h). Includible Compensation is determined without regard to any community property laws.

2.15 ~~**2.13**~~ **Investment Provider.** Any organization that has been approved by the Board to provide investment products under the Plan.

2.16 ~~**2.14**~~ **Normal Retirement Age.** Age 70 ½, or if later, the date the employee incurs a Severance from Employment. For purposes of the special section 457 catch-up limitation under Section 4.3, a Participant may designate, in writing, a Normal Retirement age that is earlier than age 70 ½ but not earlier than the earliest age at which the Participant has a right to retire and receive, under the applicable defined benefit pension plan of the Employer, immediate retirement benefits without actuarial or other reduction because of retirement before some later specified age. If the Participant is not eligible to receive benefits under a defined benefit pension plan maintained by the Employer, the Participant's designated Normal Retirement Age may not be earlier than age 55.

2.17 ~~**2.15**~~ **Participant.** An individual who (i) is currently deferring Compensation, or who (ii) is entitled to an Employer Contribution, or (iii) has previously deferred Compensation under the Plan by salary reduction or received an Employer Contribution, and who has not received a distribution of his or her entire benefit under the Plan.

2.18 ~~**2.16**~~ **Plan.** The North Dakota Public Employees Retirement System Deferred Compensation 457(b) Companion Plan, as amended or restated from time to time.

2.19 ~~**2.17**~~ **Plan Contributions.** Deferrals and Employer Contributions made to the Plan.

2.20 ~~**2.18**~~ **Plan Year.** The calendar year.

2.21 ~~**2.19**~~ **Qualified Health Insurance Premiums.** Premiums for coverage for an Eligible Retired Public Safety Officer, his spouse, and/or his dependents, as defined in Code section 152, by an accident or health plan or qualified long-term care insurance contract, as defined in Code section 7702B(b).

2.22 ~~**2.20**~~ **Required Beginning Date.** April 1 of the calendar year following the later of the calendar year in which the Participant incurs a Severance from Employment or reaches the required minimum distribution age under Code section 401(a)(9).

2.23 ~~2.21~~ **Severance from Employment.** Thirty-one days after the Employee dies, retires or otherwise has a severance from employment with the Employer, as determined by the Administrator (and taking into account guidance issued under the Code).

2.24 ~~2.22~~ **Trust Fund.** The trust fund created under and subject to the provisions in Article 9.

2.25 ~~2.23~~ **Trustee.** The Board, or such other trustee duly appointed and currently serving in accordance with the provisions of Article 9.

2.26 ~~2.24~~ **Valuation Date.** Each business day or such other valuation date as specified by the Investment Provider for a particular investment product, or as otherwise designated by the Board.

~~ARTICLE 3~~
ARTICLE 3 PARTICIPATION AND CONTRIBUTIONS

3.1 ~~3.1~~ **Eligibility.** Each Employee who works a minimum of 20 hours per week for 20 or more weeks per year, who is at least age 18 and who fills a permanent position that is regularly funded and not of limited duration shall be eligible to participate in the Plan and may defer Compensation hereunder immediately upon satisfying the eligibility requirements under this Section 3.1.

3.2 ~~3.2~~ **Election Required for Deferrals.** An Employee may elect to become a Participant by executing an election to defer a portion of his or her Compensation (and have that amount contributed as Deferrals on his or her behalf) and submitting it to the Administrator. This participation election shall be made pursuant to a deferral agreement under which the Employee agrees to be bound by all the terms and conditions of the Plan. The Administrator may establish a minimum deferral amount, and may change such minimums from time to time. Subject to the limits of Article 4, a Participant must currently defer a minimum of $25 per month. The participation election shall include selection of an Investment Provider. Any such election shall remain in effect until a new election is submitted.

3.3 ~~3.3~~ **Commencement of Participation.** An Employee shall become a Participant as soon as administratively practicable following the date the Employee files a participation election pursuant to Section 3.2 or becomes eligible for Employer Contributions under Section 3.9. ~~An~~Such election ~~under Section 3.2~~ shall become effective no earlier than the ~~calendar month following the month in which the election is made, or such other date as may be~~date the Employee files a participation election pursuant to Section 3.2 or becomes eligible for Employer Contributions under Section 3.9, as permitted under ~~the~~ Code~~.~~ Section 457(b)(4)(A). A new Employee may defer compensation payable in the calendar month during which the Participant first becomes an Employee if an agreement providing for the deferral is entered into on or before the first day on which the Participant performs services for the Employer.

3.4 ~~3.4~~ **Information Provided by the Participant.** Each Employee enrolling in the Plan should provide to the Administrator at the time of initial enrollment, and later if there are

any changes, any information necessary or advisable for the Administrator to administer the Plan, including, without limitation, whether the Employee is a participant in any other eligible plan under Code section 457(b).

3.5 ~~**3.5**~~ **Contributions Made Promptly.** Deferrals by the Participant under the Plan shall be transferred to the Trust Fund within a period that is not longer than is reasonable for the proper administration of the Participant's Account Balance. For this purpose, Deferrals shall be treated as contributed within a period that is not longer than is reasonable for the proper administration if the contribution is made to the Trust Fund within 15 business days following the end of the month in which the amount would otherwise have been paid to the Participant.

3.6 ~~**3.6**~~ **Amendment of Deferral Election.** Subject to other provisions of the Plan, a Participant may at any time revise his or her participation election, including a change of the amount of his or her Deferrals, as well as his or her investment direction and his or her designated Beneficiary through the Investment Provider(s). However, the Board retains the authority to limit the frequency of changes to the amount of Deferrals, applied uniformly to all Employees, as it deems appropriate. Unless the election specifies a later effective date, a change in the amount of Deferrals shall take effect as of the first day of the next following month or as soon as administratively practicable if later. A change in the investment direction shall take effect as of the date provided by the Administrator on a uniform basis for all Employees. A change in the Beneficiary designation shall take effect when the election is accepted by the Investment Provider.

3.7 ~~**3.7**~~ **Leave of Absence.** Unless an election is otherwise revised, if a Participant is absent from work by leave of absence, Deferrals under the Plan shall continue to the extent that Compensation continues. If a Severance from Employment is determined to have occurred, the Participant may elect to receive a distribution of benefits as provided for in Article 5.

3.8 ~~**3.8**~~ **Disability.** A disabled Participant may elect to make Deferrals during any portion of the period of his or her disability to the extent that he or she has actual Compensation (not imputed compensation and not disability benefits) from which to make contributions to the Plan and has not had a Severance from Employment.

3.9 ~~**3.9**~~ **Employer Contributions.** A Participant shall become entitled to Employer Contributions as elected by the Employer and communicated to the Plan Administrator in a form acceptable to the Administrator. An Employee who is not a Participant shall become a Participant immediately upon becoming entitled to an Employer Contribution pursuant to the ~~Employer's~~Employer's election, regardless of whether such Employee elects to make Deferrals.

ARTICLE 4 ~~ARTICLE 4~~

LIMITATIONS ON AMOUNTS DEFERRED

4.1 ~~**4.1**~~ **Basic Annual Limitation.** ~~The~~In accordance with Code Section 457(b)(2), the maximum annual amount of Plan Contributions for any calendar year shall not exceed the lesser of (1) the ~~Applicable Dollar Amount or (2) the Participant's Includible Compensation~~

~~for the calendar year. The Applicable Dollar Amount is the~~applicable dollar amount set forth under Code Section 457(e)(15)(A), as indexed ~~in accordance with~~under Code section ~~415~~457(~~d~~e)(15)(B) or (2) the Participant's Includible Compensation for the calendar year.

4.2 ~~**4.2**~~ **Age 50 Catch-up Contributions.** A Participant who will attain age 50 or more by the end of the calendar year is permitted to make ~~an~~ additional annual ~~amount of~~ Deferrals~~,~~ up to the ~~maximum age 50 catch-up Deferrals for the year. The maximum annual~~applicable dollar amount ~~of the age 50 catch-up Deferrals for a year is the amount set forth~~ under Code section 414(v)~~(2)~~, as indexed in accordance with Code section 414(v)(2)(C) ~~and Code section 415(d).~~. If adopted by the Board, the adjusted dollar amount under Code Section 414(v)(2)(E), as increased by the Cost of Living Adjustment in effect for such calendar year, shall apply to a Participant who will attain age 60 but will not attain age 64 by the end of the calendar year.

4.3 ~~**4.3**~~ **Special Section 457 Catch-up Limitation.** ~~If~~In accordance with Code Section 457(b)(3), if the applicable year is one of the ~~Participant's~~Participant's last three consecutive calendar years ending before the year in which the Participant attains Normal Retirement Age and the amount determined under this Section 4.3 exceeds the amount computed under Section 4.1 and 4.2, then the annual limit on Plan Contributions under this Article 4 shall be the lesser of:

(a) ~~(a)~~ An amount equal to two times the ~~Applicable Dollar Amount~~applicable dollar amount under Section 4.1 for such year; or

(b) ~~(b)~~ The sum of:

(1) ~~(1)~~ An amount equal to (A) the aggregate limit under Section 4.1 for the current calendar year plus each prior calendar year beginning after December 31, 2001 during which the Participant was an Employee under the Plan, minus (B) the aggregate amount of ~~Plan Contributions~~Compensation that the Participant deferred under the Plan ~~for the Participant~~ during such years, plus

(2) ~~(2)~~ An amount equal to (A) the aggregate limit under Code section 457(b)(2) for each prior calendar year beginning after December 31, 1978 and before January 1, 2002 during which the Participant was an Employee (determined without regard to Sections 4.2 and 4.3), minus (B) the aggregate contributions to Pre-2002 Coordination Plans (as defined by Treasury Regulations and provided in Section 4.4(c)) for such years.

However, in no event can the deferred amount be more than the ~~Participant's~~Participant's Compensation for the year.

(c) If adopted by the Board, effective January 1, 2026, or such later effective date determined by the Secretary of the Treasury through guidance and subject to such guidance, with respect to a Participant whose wages within the meaning of Code Section 3121(a) for the preceding calendar year from the Employer exceed the

limitation under Code Section 414(v)(7)(A), as indexed, paragraph (b) shall not apply.

4.4 ~~4.4~~ **Special Rules.** For purposes of this Article 4, the following rules shall apply:

(a) ~~(a)~~ If the Participant is or has been a participant in one or more other eligible plans within the meaning of Code section 457(b), then ~~the~~this Plan and all such other plans shall be considered as one plan for the purposes of applying the foregoing limitation ~~in~~of this Article 4. For this purpose, the Administrator shall take into account any other such eligible plan maintained by the Employer and shall also take into account any other such eligible plan for which the Administrator receives from the Participant sufficient information concerning his or her participation in such other plan.

(b) ~~(b)~~ In applying Section 4.3, a year shall be taken into account only if the Participant was eligible to participate in the Plan during all or a portion of the year and Compensation deferred, if any, under the Plan was subject to the maximum amount described in Section 4.1 or any other plan limit required by Code section 457(b).

(c) ~~(c)~~ For purposes of Section 4.3(b)(2), the term "contributions to Pre-2002 Coordination Plans" means any employer contribution, salary reduction or elective contribution under any other eligible Code section 457(b) plan, or a salary reduction or elective contribution under any other eligible Code section 401(k) qualified cash or deferred arrangement, Code section 402(h)(1)(B) simplified employee pension (SARSEP), Code section 403(b) annuity contract and Code section 408(p) simple retirement account, or under any plan for which a deduction is allowed because of a contribution to an organization described in Code section 501(c)(18), including plans, arrangements or accounts maintained by the Employer or any employer for whom the Participant performed services. However, the contributions for any calendar year are only taken into account for purposes of Section 4.3(b)(2) to the extent that the total of such contributions does not exceed the aggregate limit referred to in Code section 457(b)(2) for that year.

(d) ~~(d)~~ For purposes of Sections 4.1, 4.2 and 4.3, an individual is treated as not having deferred compensation under a plan for a prior taxable year to the extent Excess Deferrals (as defined in Section 4.5) under the plan are distributed. To the extent that the combined deferrals for pre-2002 years exceeded the maximum deferral limitations, the amount is treated as an Excess Deferral for those prior years.

4.5 ~~4.5~~ **Correction of Excess Deferrals.** If the annual amount of Plan Contributions on behalf of a Participant for any calendar year exceeds the limitations described in this Article 4, or the annual amount of Plan Contributions on behalf of a Participant for any calendar year exceeds the limitations described in this Article 4 when combined with other amounts deferred by the Participant under another eligible deferred compensation plan under Code section 457(b) for which the Participant provides information that is accepted by the

Administrator, then the annual amount of Plan Contributions, to the extent in excess of the applicable limitation (""Excess Deferral"), and adjusted for any income or loss in value, if any, allocable thereto, shall be distributed to the Participant.

4.6 ~~**4.6**~~ **Protection of Persons Who Serve in a Uniformed Service.** An Employee whose employment is interrupted by qualified military service under Code section 414(u) or who is on a leave of absence for qualified military service under Code section 414(u) may elect to make additional Deferrals upon resumption of employment with the Employer equal to the maximum amount of annual Deferrals that the Employee could have elected during that period if the ~~Employee's~~Employee's employment with the Employer had continued (at the same level of Compensation) without the interruption or leave, reduced by the Deferrals, if any, actually made for the Employee during the period of the interruption or leave. This right applies for five years following the resumption of employment, or if sooner, for a period equal to three times the period of the interruption or leave.

If such Participant elects to make such additional Deferrals, then the Employer shall make up the related matching Employer Contributions which would have been required had such Deferrals actually been made during the period of qualified military service. The make-up contributions by the Employer shall be made as soon as practicable after the Participant makes such make-up contributions.

If the Participant timely resumes employment in accordance with USERRA after a qualified military leave, the Employer shall make any nonelective Employer Contributions that would have been made if the Participant had remained employed during the ~~Participant's~~Participant's qualified military service. Such contributions must be made no later than ninety (90) days after the date of such reemployment or when contributions are normally due for the year in which the qualified military service was performed, if later.

In determining the amount of Deferrals and Employer Contributions, a Participant shall be treated as receiving compensation from the Employer during such period of qualified military service equal to: (i) the compensation the Participant would have received during such period if the Participant were not in qualified military service, determined based on the rate of pay the Participant would have received from the Employer but for the absence during the period of qualified military service; or (ii) if the compensation the Participant would have received during such period is not reasonably certain, the ~~Participant's~~Participant's average compensation from the Employer during the twelve (12) month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

In addition, effective for deaths occurring on or after January 1, 2007, if a Participant dies while performing qualified military service (as defined in Code section 414(u)(5)), this Plan shall provide all applicable benefits required in accordance with Code section 401(a)(37), but the provisions of Code section 414(u)(9) shall not apply to this Plan.

~~ARTICLE 5~~

ARTICLE 5 DISTRIBUTION OF BENEFITS

~~5.1 **Benefit Distributions.** A Participant's Account Balance may not be paid to the Participant (or, if applicable, the Participant's Beneficiary), until one of the following events has occurred:~~

5.1 Distribution Restrictions.

(a) In accordance with Code section 457(d), a Participant, or, if applicable, a Beneficiary, shall be eligible to receive a distribution of his or her Account Balance if the Participant:

(1) ~~(a) the Participant's~~has a Severance from Employment;

(2) ~~(b) the Participant's death~~dies;

(3) is eligible for a distribution under Section 5.4;

~~(c) an unforeseeable emergency, within the meaning of and subject to Section 5.5;~~

~~(d) the Participant elects a small Account Balance distribution in accordance with Section 5.6(a).~~

(4) ~~(c) The Participant~~ has a Severance from Employment and is subject to the mandatory distribution of ~~his~~the Account Balance under Section ~~5.6~~5.3(b).

~~If a Participant has a separate account attributable to rollover contributions to the Plan pursuant to Section 7.1, the Participant may at any time elect to receive a distribution of all or any portion of the amount held in the rollover account.~~

(b) Paragraph (a) notwithstanding, a Participant's account attributable to rollover contributions made pursuant to Section 7.1 may be distributed to a Participant at any time, to the extent that the rollover contributions made pursuant to Section 7.1 have been separately accounted for by the Administrator.

5.2 ~~5.2~~ Benefit Distribution Election.

~~(a)~~ A Participant may elect to commence distribution of his or her Account Balance any time after retirement or other Severance of Employment by filing an application for a distribution with the Administrator. ~~However, in no event may distribution of benefits to the Participant commence later than the Required Beginning Date. The amount of such required minimum distribution shall be determined in accordance with Code section 401(a)(9) and the regulations thereunder, as applicable to a governmental plan as defined in Code section 414(d).~~

5.3 Payment Options.

(a) ~~(b)~~ A Participant (or, if applicable, ~~the Participant's~~a Beneficiary) ~~may elect~~entitled to a distribution ~~in the form of a lump sum~~ under this Article 5 may elect to receive payment in any of the following forms of distribution:

(1) a lump sum payment of the total Account Balance;

(2) ~~or systematic distribution option~~annual, monthly, or quarterly installment payments as permitted under the terms of the investment product(s)~~,~~; or ~~may elect~~

(3) a direct rollover to an Eligible Retirement Plan as described in Section ~~5.7. Notwithstanding any other provision of the Plan, the elected form of distribution shall comply with required distribution rules under Code section 401(a)(9) and the regulations thereunder, as applicable to a governmental plan as defined in Code section 414(d), including any minimum distribution incidental benefit requirements.~~7.2.

(b) A lump sum payment of a Participant's Account may be made without the consent of the Participant or Beneficiary if their Account Balance does not exceed $1,000 taking into account their Rollover Contribution Account, unless the Participant elects to have such distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover or to receive the distribution directly in a lump sum.

~~(c) Effective in 2009, notwithstanding subsections (a) and (b) above, a Participant (or, if applicable, the Participant's Beneficiary) who would have been required to receive required minimum distributions for 2009 but for the enactment of Code section 401(a)(9)(H) ("2009 RMDs"), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2009 RMDs or (2) one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancy) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years ("Extended 2009 RMDs"), will receive those distributions for 2009 unless the Participant or Beneficiary chooses not to receive such distributions. Participants and Beneficiaries described in the preceding sentence will be given the opportunity to elect to stop receiving the distributions described in the preceding sentence. In addition, notwithstanding Section 5.7(a)(3) of the Plan, and solely for the purpose of applying the direct rollover provisions of the Plan, the Board shall only offer direct rollover of 2009 RMDs and Extended 2009 RMDs that are received by a Participant or Beneficiary to the extent such distributions that would be Eligible Rollover Distributions without regard to Code section 401(a)(9)(H).~~

~~(d) Effective 2020, notwithstanding any other provisions of this Plan, a Participant who would have been required to receive required minimum distributions in 2020 (or paid in 2021 for the 2020 calendar year for a recipient with a Required Beginning Date of April 1, 2021) but for the enactment of section 401(a)(9)(I) of the Code ("2020 RMD"), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2020 RMDs, or (2) one or more payments (that include the 2020 RMDs) in a series of substantially equal periodic payments made at least annually and expected to last for the life (or life expectancy) of the~~

Participant, the joint lives (or joint life expectancies) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years ("Extended 2020 RMDs"), will receive those 2020 distributions unless the Participant or Beneficiary elects not to receive such distribution. Notwithstanding the preceding sentence, a Participant or Beneficiary will be given an opportunity to make an election as to whether or not to receive such 2020 RMD distributions.

5.3 **Death Benefit Distributions prior to January 1, 2022.** For Participant deaths prior to January 1, 2022, this Section 5.3 shall apply. Upon the death of the Participant, the Participant's Beneficiary may elect to receive the Participant's Account Balance in any form permitted under Section 5.2. However, if the Beneficiary of the Participant is the Participant's estate, the benefit will be payable only in a single lump sum. Such Beneficiary may also designate his or her own beneficiary, or if none is designated, the Beneficiary's estate will receive any benefits payable upon the Beneficiary's death. Notwithstanding any other provision in the Plan to the contrary, distributions upon the death of a Participant shall be made in accordance with the following requirements and shall otherwise comply with Code section 401(a)(9) and the regulations thereunder, as applicable to a governmental plan as defined in Code section 414(d), including any minimum distribution incidental benefit requirements.

(a) If the designated Beneficiary is not the Participant's surviving spouse, distributions after the Participant's death must either (1) begin to be distributed no later than December 31st of the calendar year immediately following the year of the Participant's death, payable over a period not to exceed the Beneficiary's life expectancy; or (2) be distributed no later than December 31st of the calendar year containing the fifth anniversary of the Participant's death.

(b) If the designated Beneficiary is the Participant's surviving spouse, distributions after the Participant's death must begin to be distributed by the later of December 31st of the calendar year immediately following the year of the Participant's death or December 31st of the calendar year in which the Participant would have attained age seventy-two (72) (or age 70 ½ with respect to a Participant who was born before July 1, 1949), or other applicable age under Code section 401(a)(9). Payments to a surviving spouse must be made over a period not to exceed the surviving spouse's life expectancy. Alternatively, the surviving spouse may elect to receive a total distribution of the Participant's Account Balance by no later than December 31st of the calendar year containing the fifth anniversary of the Participant's death.

(c) If distributions have begun prior to the death of the Participant, the remaining portion of the Participant's Account Balance shall be distributed to the Beneficiary at least as rapidly as under the method of distribution in effect prior to the Participant's death.

5.4 **Distribution Events.**

5.4 **Death Benefit Distributions After December 31, 2021.** Notwithstanding any contrary provisions, effective for Participant deaths after December 31, 2021, the following distribution provisions in this section 5.4 shall take effect; provided, however, that such

~~provisions shall be subject to any regulations or other guidance issued under the SECURE Act.~~

~~(a) Death with a Designated Beneficiary. If the Participant dies before the distribution of his or her entire account (regardless of whether any distributions had begun before the Participant's death) and the Participant has a designated Beneficiary:~~

~~(1) The entire account shall be distributed to the designated Beneficiary by December 31 of the calendar year containing the tenth anniversary of the Participant's death.~~

~~(2) Notwithstanding the paragraph above, if the designated Beneficiary is surviving spouse, then the surviving spouse may elect for the Participant's account(s) to be distributed (i) by December 31 of the calendar year containing the tenth (10th) anniversary of the Participant's death, or (ii) the later of December 31 of the calendar year immediately following the calendar year in which the Participant died or December 31 of the calendar year in which the Participant would have attained age seventy-two (72) (or age 70 ½ with respect to a Participant who was born before July 1, 1949), or other applicable age under Code section 401(a)(9).~~

~~(3) For calendar years beginning after December 31, 2023, if the designated Beneficiary is the Participant's surviving spouse, the surviving spouse may elect to be treated as if he or she were the Participant, pursuant to Code Section 401(a)(9)(B)(iv).~~

~~(b.) Death without a Designated Beneficiary. If the Participant dies before distributions of his or her account begins and the Participant has no designated Beneficiary, the Participant's account under the Plan shall be distributed by December 31 of the calendar year containing the fifth (5th) anniversary of the Participant's death. If the Participant dies after distribution of his or her account begins and the Participant has no designated Beneficiary, any remaining portion of the account shall continue to be distributed at least as rapidly as under the method of distribution in effect at the time of the Participant's death.~~

(a) ~~5.5~~ Unforeseeable Emergency Distributions**.** ~~If~~In accordance with Code section 457(d)(1)(A)(iii) and Treasury Regulation § 1.457-6(c)(1), if the Participant has an unforeseeable emergency before Severance from Employment, the Participant may elect to receive a lump sum distribution equal to ~~an amount not to exceed the amount reasonably necessary to satisfy the emergency~~ need, which may include amounts necessary to pay federal, state or local income taxes or penalties reasonably anticipated to result from the distribution, as~~the amount requested or, if less, the maximum amount determined by the Administrator to be permitted to be distributed under this Section 5.4(a).

(1) For this purpose, an unforeseeable emergency is defined as a severe financial hardship of the Participant resulting from an illness or accident of the Participant, the Participant's spouse or dependents (as defined in

Code section 152(a) without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B)); loss of the Participant's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, e.g., as a result of natural disaster); the need to pay for the funeral expenses of the Participant's spouse or dependent (as defined in Code section 152(a) without regard to Code section 152(b)(1), (b)(2) and (d)(1)(B)); or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant. For example, the imminent foreclosure of or eviction from the Participant's primary residence may constitute an unforeseeable emergency. In addition, the need to pay for medical expenses, including nonrefundable deductibles, as well as for the cost of prescription drug medication, may constitute an unforeseeable emergency. Except as otherwise specifically provided in this Section ~~5.5~~5.4(a), neither the purchase of a home nor the payment of college tuition is an unforeseeable emergency.

(2) A distribution on account of unforeseeable emergency may not be made to the extent that such emergency is or may be relieved through reimbursement of compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship, or by cessation of deferrals under the Plan.

~~**5.6 Distribution of Small Account Balances.**~~

(3) Distributions because of an unforeseeable emergency may not exceed the amount reasonably necessary to satisfy the emergency (which may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to results from the distribution).

(b) ~~(a)~~ Voluntary Distribution of Small Amounts. Upon proper written request to the Administrator, a Participant may elect to receive a distribution of his or her total Account Balance in a lump sum if the Account Balance does not exceed $7,000 (or the dollar limit under Code section 411(a)(11), if greater) without regard to amounts attributable to rollover contributions under Section 7.1, no Plan Contributions have been made for the Participant during the two-year period immediately prior to the date of distribution, and the Participant has not previously received a distribution of his or her Account Balance under this Section ~~5.6~~5.4.

~~(b) Notwithstanding any other provision of the Plan, in the event a Participant has a Severance from Employment with an Account Balance that does not exceed $1,000, including amounts attributable to rollover contributions under Section 7.1, the following small account balance automatic distribution rules will apply:~~

~~(1) Subject to any procedures adopted by the Administrator, including but limited to any advance notice of the application of the provisions of this Section 5.6(b) as may be prescribed by the Administrator, if the~~

Participant shall not have elected, in accordance with Sections 5.2(b) and 5.7 and related procedures, to have such Account Balance paid directly to an Eligible Retirement Plan (as defined in Section 5.7(b)) specified by the Participant in a direct rollover or otherwise distributed from the Plan, then the Administrator will distribute such benefit in a lump sum, without the written consent of the Participant.

(2) The provisions of this Section 5.6(b) shall apply to any Account Balance of a Participant who has had a Severance from Employment prior to the effective date of this Section 5.6(b).

5.7 Direct Rollovers. Notwithstanding any provision of the Plan to the contrary, a Distributee shall be permitted to elect to have an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan in a direct rollover, at the time and in the manner prescribed by the Administrator.

(a) An "Eligible Rollover Distribution" means any distribution of all or a portion of a Participant's Account Balance, except that an Eligible Rollover Distribution does not include:

(1) any distribution that is one of series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and a designated Beneficiary, or for a specified period of 10 years or more;

(2) any distribution made under Section 5.5 as a result of an unforeseeable emergency; or

5.5 Death Benefit. If a Participant dies before the distribution of his or her entire Account Balance, the remaining Account Balance shall be distributed to the Beneficiary(ies) as soon as administratively practicable after the Participant's death, unless the Beneficiary elects a later payment date, subject to Code section 401(a)(9). A Beneficiary may elect to receive the Participant's Account Balance under any distribution option available under Section 5.3(a), subject to Code section 401(a)(9).

5.6 Required Distribution Rules.

(a) The provisions of this Section 5.6 take precedence over any inconsistent provisions of the Plan. As required by Code section 457(d)(2), the Plan shall comply with the minimum distribution requirements of Code section 401(a)(9), as applicable to an eligible governmental plan described in Treasury Regulation § 1.457-2(f). All distributions under this Plan shall be made in accordance with a reasonable and good faith interpretation of Code section 401(a)(9) and the regulations promulgated thereunder, including the incidental death benefit rules under Code Section 401(a)(9)(G) and the changes under the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019, SECURE 2.0 of 2022, and Treasury Regulation Sections 1.401(a)(9)-1 through -9, as each may be amended from time to time.

(b) A Participant's Accounts will be distributed, beginning not later than as required under paragraph (c), over one of the following periods (or a combination thereof):

(1) The life of the Participant;

(2) The life of the Participant and a Designated Beneficiary;

(3) A period certain not extending beyond the life expectancy of the Participant; or

(4) A period certain not extending beyond the joint and last survivor life expectancy of the Participant and Designated Beneficiary;

(c) A Participant's Account shall be distributed to the Participant beginning no later than April 1 of the calendar year following the later of (i) the calendar year in which the Participant attains the applicable age within the meaning of Code Section 401(a)(9)(C)(v) or (ii) the calendar year in which the Participant has a Severance from Employment.

(d) Subject to regulations or other guidance issued under Code Section 401(a)(9), upon the death of the Participant before distribution of their Account has begun under paragraph (c), the following distribution provisions shall take effect:

(1) The portion of the Participant's Account payable to a Beneficiary that is not a Designated Beneficiary shall be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(2) The portion of the Participant's Account payable to a Designated Beneficiary who is not an Eligible Designated Beneficiary shall be distributed by December 31 of the calendar year containing the tenth anniversary of the Participant's death.

(3) The portion of the Participant's Account payable to an Eligible Designated Beneficiary shall be distributed, pursuant to the election of the Eligible Designated Beneficiary, either (i) by December 31 of the calendar year containing the tenth anniversary of the Participant's death, or (ii) beginning no later than December 31 of the calendar year immediately following the calendar year in which the Participant died, over the life of the Eligible Designated Beneficiary or over a period not exceeding the life expectancy of the Eligible Designated Beneficiary. If the Eligible Designated Beneficiary is the surviving Spouse, the Eligible Designated Beneficiary may elect to delay payment under item (ii) until December 31 of the calendar year in which the Participant would have attained the applicable age within the meaning of Code Section 401(a)(9)(C)(v). If the Eligible Designated Beneficiary does not elect a method of distribution as provided above, the Participant's Accounts shall be distributed in accordance with item (i).

(e) Subject to regulations or other guidance issued under Code Section 401(a)(9), upon the death of the Participant after distribution of their Account has begun under paragraph (c), any remaining portion of their Account shall continue to be distributed at least as rapidly as under the method of distribution in effect at the time of the Participant's death; provided, however, that the portion of the Participant's Account payable to a Designated Beneficiary who is not an Eligible Designated Beneficiary shall be distributed in its entirety by December 31 of the calendar year containing the tenth anniversary of the Participant's death.

(f) Upon the death of an Eligible Designated Beneficiary, or the attainment of age 21 of an Eligible Designated Beneficiary who is a minor child of the Participant, before distribution of the Participant's entire Account under paragraphs (d) or (e), the remainder of the Participant's Account shall be distributed by December 31 of the calendar year containing the tenth anniversary of the Eligible Designated Beneficiary's death, or by December 31 of the calendar year in which the child attains age 31, as applicable.

(g) ~~(3) any~~Any distribution ~~to the extent such distribution is a~~ required ~~minimum distribution under~~under the incidental death benefit requirements of Code ~~section~~Section 401(a)~~(9)~~ shall be treated as a distribution required under this Section 5.6.

(h) Effective in 2009, notwithstanding subsections (a) and (b) above, a Participant (or, if applicable, the Participant's Beneficiary) who would have been required to receive required minimum distributions for 2009 but for the enactment of Code section 401(a)(9)(H) ("2009 RMDs"), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2009 RMDs or (2) one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancy) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years ("Extended 2009 RMDs"), will receive those distributions for 2009 unless the Participant or Beneficiary chooses not to receive such distributions. Participants and Beneficiaries described in the preceding sentence will be given the opportunity to elect to stop receiving the distributions described in the preceding sentence. In addition, notwithstanding Section 5.6(a)(3) of the Plan, and solely for the purpose of applying the direct rollover provisions of the Plan, the Board shall only offer direct rollover of 2009 RMDs and Extended 2009 RMDs that are received by a Participant or Beneficiary to the extent such distributions that would be Eligible Rollover Distributions without regard to Code section 401(a)(9)(H).

(i) Effective 2020, notwithstanding any other provisions of this Plan, a Participant who would have been required to receive required minimum distributions in 2020 (or paid in 2021 for the 2020 calendar year for a recipient with a Required Beginning Date of April 1, 2021) but for the enactment of section 401(a)(9)(I) of the Code ("2020 RMD"), and who would have satisfied that requirement by

receiving distributions that are (1) equal to the 2020 RMDs, or (2) one or more payments (that include the 2020 RMDs) in a series of substantially equal periodic payments made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancies) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years ("Extended 2020 RMDs"), will receive those 2020 distributions unless the Participant or Beneficiary elects not to receive such distribution. Notwithstanding the preceding sentence, a Participant or Beneficiary will be given an opportunity to make an election as to whether or not to receive such 2020 RMD distributions.

~~(b) An "Eligible Retirement Plan" means an individual retirement account described in Code section 408(a), an individual retirement annuity described in Code section 408(b), an annuity plan described in Code section 403(a), a qualified trust described in Code section 401(a), an eligible deferred compensation plan described in Code section 457(b) that is maintained by a governmental entity described in Code section 457(e)(1)(A), an annuity contract described in Code section 403(b), a Roth IRA described in Code section 408A, and effective December 18, 2015, a SIMPLE IRA as described in Code section 408(p), provided that the rollover contribution is made after the two-year period beginning on the date the Distributee first participated in any qualified salary reduction arrangement maintained by the Distributee's employer under Code Section 408(p)(2), as described in Code Section 72(t)(6). However, for an Eligible Rollover Distribution to a designated Beneficiary other than the surviving spouse, an Eligible Retirement Plan is only an individual retirement account described in Code section 408(a) or an individual retirement annuity described in Code section 408(b) that is treated as an inherited IRA in accordance with Code section 402(c)(11).~~

~~(c) A "Distributee" includes a Participant or former Participant or the Participant's or former Participant's designated Beneficiary. In addition, the Participant's or former Participant's spouse or former spouse are Distributees with regard to the interest of the spouse or former spouse.~~

5.7 ~~5.8~~ **Amount of Account Balance.** For all purposes under the Plan, the amount of any payment under this Article 5 shall be based on the amount of the Account Balance on the preceding Valuation Date, plus Plan Contributions made to the Plan from the Valuation Date to the date of distribution.

5.8 ~~5.9~~ **Retired Public Safety Officer Health Premiums.** Pursuant to Code section 457(a)(3), Eligible Retired Public Safety Officers may elect an annual distribution of the lesser of the amount paid by such Eligible Retired Public Safety Officer, or $3,000, for the payment of Qualified Health Insurance Premiums.

~~ARTICLE 6~~
ARTICLE 6 LOANS

This Plan does not permit loans from the Account Balances of Participants.

~~ARTICLE 7~~
ARTICLE 7 ROLLOVERS AND TRANSFERS

7.1 ~~**7.1**~~ **Rollover Contributions to the Plan.** A Participant who has enrolled and is currently eligible to defer Compensation under this Plan and who is entitled to receive an Eligible Rollover Distribution (as defined in Section ~~5.7~~7.2(~~a~~b) but excluding any after-tax employee contributions) from another Eligible Retirement Plan (as defined in Code section 402(c)(8)) may request to have all or a portion of such Eligible Rollover Distribution paid to the Plan. The Administrator may require such documentation from the distributing plan as it deems necessary to effectuate the rollover in accordance with Code section 402 and to confirm that such plan is an Eligible Retirement Plan within the meaning of Code section 402(c)(8).

The Plan shall establish and maintain for the Participant a separate account for any Eligible Rollover Distribution paid to the Plan from any Eligible Retirement Plan that is not an eligible governmental plan under Code section 457(b). In addition, the Plan shall establish and maintain for the Participant a separate account for any Eligible Rollover Distribution paid to the Plan from any Eligible Retirement Plan that is an eligible governmental plan under Code section 457(b).

7.2 Direct Rollovers.

(a) Notwithstanding any provision of the Plan to the contrary, a Distributee may elect to have an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan as specified by the Distributee in a Direct Rollover, at the time and in the manner prescribed by the Administrator.

(b) For purposes of this Section 7.2, the following definitions shall apply:

(1) "Direct Rollover" means an Eligible Rollover Distribution that is paid directly to an Eligible Retirement Plan for the benefit of the Distributee.

(2) "Distributee" means a Participant, the spouse of the Participant, the Participant's former spouse who is an alternate payee under a qualified domestic relations order as defined in Code section 414(p), and a Participant's non-spouse Beneficiary, any of whom is eligible to receive a distribution from the Plan.

(3) "Eligible Retirement Plan" as defined under Code section 402(c)(8)(B), means (i) an individual retirement account described in Code section 408(a); (ii) an individual retirement annuity described in Code section 408(b); (iii) a simple retirement account described in Code section 408(p)(1) following the two year period described in Code section 72(t)(6); (iv) an annuity plan described in Code section 403(a); (v) a plan described in Code section 403(b); (vi) a qualified plan described in Code section 401(a); (vii) a Code section 457(b) eligible deferred compensation plan that is maintained by a governmental entity described in Code section

457(e)(1)(A); and (viii) effective January 1, 2008, a Roth individual retirement account described in Code section 408A(e), provided the Distributee's adjusted gross income does not exceed any limit applicable under federal law for the tax year in which the distribution occurs.

In the case of a distribution to a Participant's non-spouse Beneficiary, an Eligible Retirement Plan means the plans described in subparagraphs (1) and (2) only, to the extent consistent with the provisions under Code section 402(c)(11) and any successor provisions thereto or additional guidance issued thereunder.

(4) "Eligible Rollover Distribution," as defined in Code section 402(f)(2)(A), means any distribution of all or any portion of the balance to the credit of the Distributee under the Plan, excluding the following:

i. any distribution that is one of series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and a designated Beneficiary, or for a specified period of 10 years or more;

ii. any distribution made under Section 5.4(a) as a result of an unforeseeable emergency;

iii. any distribution to the extent such distribution is a required minimum distribution under Code section 401(a)(9); or

iv. other items designated by regulations, or by the Commissioner in revenue rulings, notices, or other guidance, as items that do not constitute an eligible rollover distribution.

7.3 ~~7.2~~ **Plan-to-Plan Transfers to the Plan.** Participants who are participants in another eligible governmental plan under Code section 457(b) may transfer assets to this Plan as provided in this Section ~~7.2~~7.3, but only if the other plan provides for the direct transfer of each ~~Participant's~~Participant's interest therein to the Plan. The Administrator may require such documentation from the other plan as it deems necessary to effectuate the transfer in accordance with Code section 457(e)(10) and Treas. Reg. section 1.457-10(b) and to confirm that the other plan is an eligible governmental plan as defined in Treas. Reg. section 1.457-2(f). The amount so transferred shall be credited to the ~~Participant's~~Participant's Account Balance and shall be held, accounted for, administered and otherwise treated in the same manner as Plan Contributions under the Plan, except that transferred amounts shall not be considered a Plan Contribution under the Plan in determining the maximum deferral under Article 4.

7.4 ~~7.3~~ **Plan-to-Plan Transfers from the Plan.** Participants and Beneficiaries may elect to have all or any portion of their Account Balance transferred to another eligible governmental plan within the meaning of Code section 457(b) and Treas. Reg. section 1.457-2(f). A transfer is permitted for a Participant under this Section ~~7.3~~7.4 only if the

Participant has had a Severance from Employment with the Employer and is an employee of the entity that maintains the other eligible governmental plan. Further, a transfer is permitted only if the other eligible governmental plan provides for the acceptance of plan-to-plan transfers with respect to Participants and Beneficiaries and for each Participant or Beneficiary to have an amount deferred under the other plan immediately after the transfer at least equal to the amount transferred.

Upon the transfer of assets under this Section ~~7.3~~7.4, the Plan's liability to pay benefits to the Participant or Beneficiary under this Plan shall be discharged to the extent of the amount so transferred. The Administrator may require such documentation from the receiving plan as it deems appropriate or necessary to comply with this Section ~~7.3~~7.4 (e.g., to confirm that the receiving plan is an eligible governmental plan and to assure that the transfer is permitted under the receiving plan) or to effectuate the transfer pursuant to Treas. Reg. section 1.457-10(b).

7.5 ~~**7.4**~~ **Permissive Service Credit Transfers.** ~~A~~Pursuant to Treas. Reg. § 1.457-10(b)(8), a Participant may elect to have any portion of his or her Account Balance transferred to a tax-qualified, governmental defined benefit plan (as defined in Code section 414(d)) that provides for the acceptance of plan-to-plan transfers for the purchase of permissive service credit (as defined in Code section 415(n)(3)(A)) under the receiving governmental defined benefit plan or a repayment to which Code section 415 does not apply by reason of Code section 415(k)(3). A transfer for such purpose may be made before the Participant has had a Severance from Employment.

~~ARTICLE 8~~
ARTICLE 8 ADMINISTRATION

This Plan shall be administered by the Administrator, as directed by the Board, in accordance with Code section 457 and applicable regulations thereunder. The Board shall have the authority to make all discretionary decisions affecting the rights or benefits of the Participants which may be required in administration of this Plan. The Board's decisions shall be afforded the maximum deference permitted by applicable law. The Board shall exercise all rights, powers and duties granted to it by law and as necessary to administer the Plan. The Board shall approve or disapprove Investment Providers and may contract with Investment Providers to offer investment products under the Plan and provide services to the Plan as the Board deems appropriate.

The Board may delegate specific duties and responsibilities under the Plan, including by contracting with an administrative service provider to perform specific, nondiscretionary administrative functions under the Plan, including the maintenance of Participants' Account Balances, the provision of periodic reports on the status of each Account Balance, the disbursement of benefits on behalf of the Board in accordance with the terms of this Plan, and the maintenance of Beneficiary designations. The Board shall supervise the operation of the Plan, maintain records and supply information to the Participants or other parties.

~~ARTICLE 9~~
ARTICLE 9 TRUST FUND

9.1 ~~**9.1**~~ **Establishment of Trust.** The assets of the Plan, including all Plan Contributions, property, rights purchased with Plan Contributions, and all income attributable to such assets, are held in insurance annuity contracts or custodial account contracts that have been entered into with one or more investment Providers by the Board that meet the exclusive benefit and other requirements of Code sections 457(g) and 401(f). Under the terms of the insurance annuity and custodial account contracts under this Section 9.1 it shall be impossible, prior to the satisfaction of all liabilities with respect to the Accounts of Participants and Beneficiaries, for any part of the assets or income of the contracts to be used for, or diverted to, any purpose other than for the exclusive benefit of the Participants and Beneficiaries of the Plan and Trust. For purposes of this Article 9, custodial accounts and annuity contracts shall be treated as held in trust so long as such custodial accounts and annuity contracts satisfy the requirements set forth in Treas. Reg. section 1.457-8(a)(3).

9.2 ~~**9.2**~~ **Trustee.** The Board shall be the Trustee for the Plan, unless the Board duly appoints another individual or entity to serve as trustee and such individual or entity agrees to act in that capacity hereunder. The Trustee shall ensure that all investments, amounts, property and rights held under the Trust Fund are held for the exclusive benefit of Participants and their Beneficiaries. The Trust Fund shall be liable to pay benefits under this Plan only to the extent of amounts that are available under the investment products selected by Participants and Beneficiaries, and neither the Board nor Employers shall be responsible for the investment or performance results of such investment products.

9.3 ~~**9.3**~~ **Specific Powers and Duties.** The Board shall:

(a) ~~(a)~~ Exercise exclusive authority to invest and manage assets of the Plan. However, the Board may permit Participants to direct and control the investment of their contributions, together with accumulated earnings, among the investment options established by the Board.

(b) ~~(b)~~ Establish and adopt a statement of investment objectives and policies setting forth the manner and parameters of the investment of the assets of the Plan. The statement of investment objectives and policies shall be established in a manner consistent with the purposes of the Plan. The Board shall monitor the performance of the investments of the Plan to ensure such remain consistent with the investment policy established by the Board.

(c) ~~(c)~~ Establish an administrative budget sufficient to perform the duties under the Plan and to draw upon authorized sources to fund the budget.

(d) ~~(d)~~ Pay Plan benefits and related taxes from the assets of the Plan.

(e) ~~(e)~~ Obtain by employment or contract all the services necessary or appropriate to administer the Plan, including actuarial, auditing, custodial, investment, legal and recordkeeping services.

(f) ~~(f)~~ Procure and dispose of the goods and property of the Plan necessary for its proper administration.

(g) ~~(g)~~ Represent the Employers in all matters concerning the administration of the Plan.

(h) ~~(h)~~ Have full power and authority to adopt rules and regulations for the administration of the Plan and to interpret, alter, amend, or revoke any rules and rules and regulations so adopted.

9.4 ~~**9.4**~~ **Accounting.** For accounting purposes, the Board will maintain a summary of the individual Account Balances of all Participants of the Plan whose benefits have not been annuitized. The accounting summary shall be identified as the general account of the North Dakota Section 457 Companion Plan and Trust and will reflect from time to time the total deferred liability of the Plan as well as the individual balances for all Participants of the Plan.

~~ARTICLE 10~~
ARTICLE 10 MISCELLANEOUS

10.1 ~~**10.1**~~ **Nonassignability.** Except as provided in Sections 10.2 and 10.3, the interests of each Participant or Beneficiary under this Plan are not subject to the claims of creditors. Participants and Beneficiaries shall not have any right to sell, assign, transfer or otherwise convey the right to receive any payments hereunder or any interest under the Plan, which payments and interest are expressly declared to be nonassignable and nontransferable. Nor shall any unpaid benefits be subject to attachment, garnishment or execution for the payment of any debts or judgments or be transferable by operation of law in the event of bankruptcy or insolvency of the Participant or any other person.

10.2 ~~**10.2**~~ **Domestic Relations Orders.** A Participant's benefit may be subject to division under a domestic relations orders between the Participant and the alternate payee (as defined in Code section 414(p)(8)) if the order is determined to be a qualified domestic relations order (as defined in Code section 414(p)(1) and modified by Code section 414(p)(11)). The Administrator shall establish reasonable procedures for determining the qualified status of a domestic relations order and for effectuating distribution pursuant to a qualified domestic relations order. Distribution shall be made to an alternate payee in a single lump sum pursuant to a domestic relations order within 21 days after the later of the date the order is deemed to be qualified pursuant to the Plan policies and procedures or the date the order is entered by the court, without regard to whether the Participant is eligible for a distribution of benefits under the Plan.

10.3 ~~**10.3**~~ **IRS Levy.** Notwithstanding Section 10.1, the Administrator may pay from a Participant's or Beneficiary's Account Balance the amount that the Administrator finds is lawfully demanded under a levy issued by the Internal Revenue Service with respect to that Participant or Beneficiary or is sought to be collected by the United States government under a judgment resulting from an unpaid tax assessment against the Participant or Beneficiary.

10.4 ~~**10.4**~~ **Mistaken Contributions.** If any contribution is made to the Plan by a good faith mistake of fact, then within one year after payment of the contribution, and upon receipt in

good order of a proper request approved by the Administrator, the amount of the mistaken contribution (adjusted for any income or loss in value, if any, allocable thereto) shall be returned directly to the Participant or, to the extent required or permitted by the Administrator, to the Employer.

10.5 ~~**10.5**~~ **Payments to Minors and Incompetents.** If a Participant or Beneficiary entitled to receive any benefits hereunder is a minor or is adjudged to be legally incapable of giving valid receipt and discharge for such benefits, or is deemed so by the Investment Provider, benefits will be paid to such person as the Investment Provider may designate for the benefit of such Participant or Beneficiary. Such payments shall be considered a payment to such Participant or Beneficiary and shall, to the extent made, be deemed a complete discharge of any liability for such payments under the Plan.

10.6 ~~**10.6**~~ **Distributee Cannot be Located.** If the Administrator does not have current contact information for or is unable to identify a Participant or Beneficiary, the Administrator shall make reasonable attempts to determine the address and identity of the Participant or Beneficiary entitled to benefits under the Plan. A reasonable attempt to locate a missing or lost Participant or Beneficiary shall include (a) providing notice to the Participant at the ~~Participant's~~Participant's last known address via certified mail; (b) determining whether the ~~Employer's~~Employer's records or the records of another plan maintained by the Employer has a more current address for the Participant; (c) attempting to contact any named Beneficiary of the Participant; and (d) searching for the missing Participant via free electronic search tools, such as internet search engines, public record databases, obituaries, and social media. If such search methods are unsuccessful, based on the facts and circumstances, the Administrator may use other search methods, including using internet search tools, commercial locator services, credit reporting agencies, information brokers, investigation databases, and analogous services that may involve charges. The Administrator may charge missing Participants and Beneficiaries reasonable expenses for efforts to find them. In the event that the Administrator is unable to locate a Participant or Beneficiary entitled to benefits under the Plan, the Trustee shall continue to hold the benefits due to such person under the Plan in the Participant's Account.

10.7 ~~**10.7**~~ **Applicable Law.** This Plan and Trust shall be construed under the laws of the State of North Dakota with the intent that it meets the requirements of an eligible deferred compensation plan under Code section 457(b), as amended. The provisions of this Plan and Trust shall be interpreted whenever possible in conformity with the requirements of that Code section.

10.8 ~~**10.8**~~ **Gender and Number.** The masculine pronoun, whenever used herein, shall include the feminine pronoun, and the singular shall include the plural, except where context requires otherwise.

~~ARTICLE 11~~
ARTICLE 11 AMENDMENT OR TERMINATION

11.1 ~~**11.1**~~ **Amendment or Termination of the Plan.** The Board may terminate (with 60 days notice to the Employer and the Participants and Beneficiaries) or amend the provisions of

this Plan at any time; provided, however, no termination or amendment shall affect the rights of a Participant or a Beneficiary to the receipt of benefits with respect to any Compensation deferred before termination or amendment, as adjusted for the investment experience of the Participant's or Beneficiary's Account Balance prior to or subsequent to the termination or amendment of the Plan. An Employer who has entered into agreement with the Board to participate in this Plan may, with 60 days notice to the Board and their Participants and Beneficiaries, terminate their participation agreement in a manner consistent with and in the same manner as described in the preceding sentence.

11.2 ~~**11.2**~~ **Distribution Upon Termination.** Upon termination of the Plan, the Board shall direct distribution of the assets of the Plan and Trust Fund to Participants and Beneficiaries in a manner that is consistent with and satisfies the provisions of ~~Section 5.2~~Article 5 as soon as administratively practicable after a resolution to terminate the Plan is adopted.

Summary report: Litera Compare for Word 11.5.0.74 Document comparison done on 5/14/2025 11:06:27 AM	
Style name: IM Default	
Intelligent Table Comparison: Active	
Original DMS: nd://4912-7377-7218/1/ND 457(b) Deferred Compensation Companion Plan Document 2025.docx	
Modified DMS: nd://4912-7377-7218/2/ND 457(b) Deferred Compensation Companion Plan Document 2025.docx	
Changes:	
Add	292
~~Delete~~	234
~~Move From~~	43
Move To	43
Table Insert	0
~~Table Delete~~	0
Table moves to	0
~~Table moves from~~	0
Embedded Graphics (Visio, ChemDraw, Images etc.)	0
Embedded Excel	0
Format changes	0
Total Changes:	612

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
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Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Marcy Aldinger

DATE: June 10, 2025

SUBJECT: SECURE 2.0 and 457(b) Deferred Compensation Plan Options

Setting Every Community Up for Retirement Enhancement (SECURE) 2.0 Act of 2022, which builds on the original SECURE Act of 2019, defined both required and optional provisions for various types of retirement plans.

Staff would like to discuss various provisions of SECURE 2.0 related to the 457(b) Deferred Compensation Plan and specifically ask the Board's direction related to one SECURE 2.0 provision, along with an update related to Empower.

Roth Catch-Up Contributions for High Earners

The Board has previously explored the option of allowing Roth contributions into our 457 plans. However, due to the complexities associated with IRS regulations concerning the purchase of service credit within defined benefit plans, this was not pursued further at that time.

At the most recent strategic planning meeting, the Board requested that this position be revisited. This renewed interest is due in part to the fact that most new hires will now be part of a defined contribution plan, where purchasing service is not applicable.

Simply electing to offer a Roth option does not, in itself, present significant operational challenges. The existing PERSLink file feeds from our employers are already capable of supporting a Roth feature, as are the daily file transmissions to our recordkeeper. The primary burden of implementation would fall on individual employers, specifically in configuring their payroll systems to accommodate Roth contributions.

If our plan were to offer a Roth option, it would introduce certain complexities with respect to mandatory provisions under SECURE 2.0. Specifically, offering a Roth option would trigger the requirement to implement Roth catch-up contributions for all high-income earners. There are three key questions that need to be answered to accurately administer this provision of SECURE 2.0, two of which present significant challenges.

1) Is the employee age 50 or older? This is information we have housed in our business system, and does not create any concerns to accurately administer.

2) Is the entity subject to Social Security?
    a. Entities not subject to Social Security are not subject to this provision. (for example, Highway Patrol is not subject to Social Security). NDPERS reached out to Job Service who maintains the State of ND Section 218 Agreement to see if they have a list of employers not subject to Social Security. In order to possibly obtain this information, a formal request for a Release of Information needs to be made to Job Service. This request has not yet been made, and staff is unsure if the release would provide the information necessary to implement this SECURE 2.0 requirement.

    b. Job Service made NDPERS aware of some additional complexities of Section 218.
        i. While a group may be covered by an agreement, there may be exclusions such as for specific part-time positions.
        ii. The entity may also have entered into an agreement under a retirement plan other than PERS and the best information Job Service would have is what the agreement lists at the time it was implemented.
        iii. If ABC entity has an agreement under XYZ coverage group, Job Service may not know whether the entity changed retirement plans to PERS at a later date.
        iv. Some entities may not have an agreement but are covered and required to pay into Social Security if positions were not covered in a qualifying retirement plan at the time of the initial agreement in 1955.

3) This provision of SECURE 2.0 applies only to individuals who made gross wages over an indexed threshold set by the IRS each year. Because NDPERS isn't the employer, we do not know what any member's W2 wage was in a given year. Without a way of identifying the employees that would be required to contribute their catch-up contributions on a Roth basis, staff cannot comfortably say we can accurately administer this provision of SECURE 2.0 in our office.

Given the complexities related to this provision and the need for staff to learn more regarding responsibilities in moving the option forward, staff request the Board defer direction on this to a future meeting once we have additional details for the Board's consideration.

Super Catch-Up Contribution

Super catch-up allows eligible individuals aged 60-63 to contribute more than the standard catch-up limit for those 50 and older. Individuals can couple the standard reduction plus $10,000 or 150% of the catch-up limit for Age 50+. If the super catch-up is offered, SECURE 2.0 makes mandatory that these contributions be made using a Roth for high income earners (those with prior-year FICA wages exceeding $145,000).

If the super catch-up option is adopted by the NDPERS Board, then beginning January 2026, a Roth option is mandatory for high income earners as defined by the IRS. We cannot offer this provision of SECURE 2.0 if we do not also incorporate Roth contributions into our plan.

Again, due to the complexities related to this provision and the need for staff to learn more regarding responsibilities in moving the option forward, staff request the Board defer direction on this to a future meeting once we have additional details for the Board's consideration.

Self-Certification of Unforeseeable Financial Hardship

SECURE 2.0 allows plan administrators to rely on a participant's written self-certification for unforeseeable financial hardship distribution. The certification must confirm that:

1. The participant is experiencing a qualifying hardship or emergency,
2. The amount requested does not exceed the amount necessary to satisfy the need, **and**
3. The participant has no other reasonably available means to meet the financial need.

However, reliance on self-certification is not permitted if the plan administrator has actual knowledge that contradicts the participant's certification.

Ice Miller did not have concerns regarding fiduciary responsibilities of the Board and said that the majority of entities are moving to this, and if this is a provision of SECURE 2.0 the Board would like to move forward on, Ice Miller has offered sample forms to ensure compliance with IRS requirements.

Work effort: Update forms, legal review, communications.

Empower List for Roth Programming

To make a Roth available to NDPERS members based upon future Board action, Empower requires that their plan sponsors are put on a list to program Roth deferrals.

Being on the list does not bind NDPERS to offering Roth deferrals; it only assures NDPERS is in line for the programming with Empower should the Board adopt Roth deferrals. This is not a contract and there is no penalty if the Board determines they do not want to proceed with the catch-ups or Roth deferrals as of January 2026.

BOARD ACTION REQUESTED:

1. Consider implementing a self-certification for 457 unforeseeable financial hardship withdrawals.
2. Consider being added to the Empower wait list to implement the Roth and Super Catch-up should the Board decide to make the options available in the future once more information regarding administration requirements are determined.

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Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: RHIC & Job Service Asset Allocation

At the May 2025 Investment Subcommittee meeting, SEI presented recommendations for Asset Allocation updates on the RHIC and Job Service Plans.

RHIC is an underfunded plan and currently has a 60% equity and 40% fixed income mix. Because the plan is underfunded, we do need to continue forward with growth strategies regarding our investments, and SEI is not recommending any portfolio changes on RHIC.

Job Service is an overfunded plan and currently has 20% equity and 80% fixed income. Having a heavy fixed income allocation protects against drawdowns in the market. SEI is recommending to further derisk the Job Service Plan as excess returns are not necessary to pay off the future liabilities of the Plan.

The Investment Subcommittee is recommending updating the Job Service Plan to be 87% fixed income and 13% equity – represented as "Portfolio B" in SEI's presentation. The changes from current to the recommended asset allocation include:

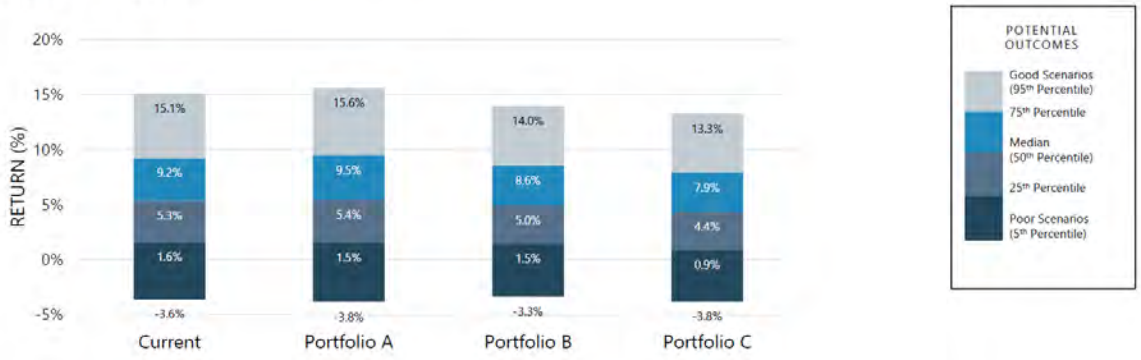
1) Removing diversified short-term fixed income – which has very low interest rate sensitivity but has more credit exposure.
2) Core fixed income (Barclay's Aggregate) – based on market projections, SEI is recommending "overweighting" core fixed income.
3) Reducing the equity allocation – keep 13% in Low Beta Global Equities.

The move to Portfolio B's asset allocation provides expected returns that continue to exceed the expected long-term rate of return, but offers additional protection against drawdowns in the market.

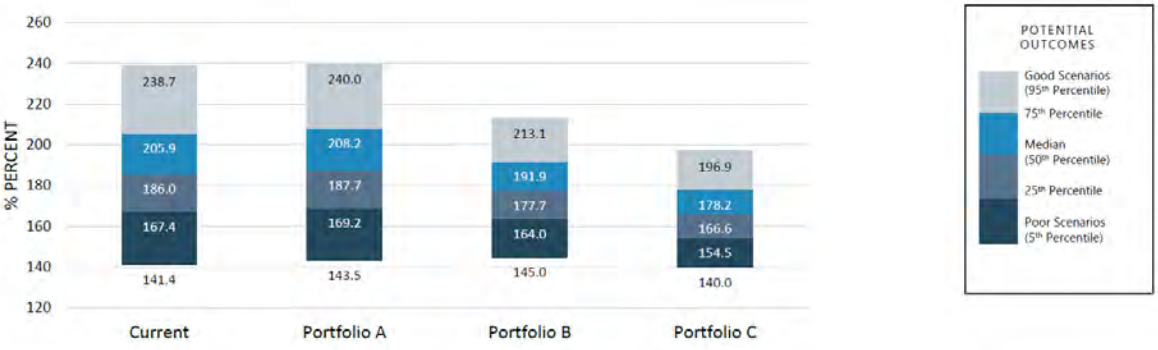
Job Service: Modeled Portfolios

Asset Class	Current	Portfolio A	Portfolio B	Portfolio C
US Low Beta Equities	2.0	2.0	-	-
Global Low Beta Equities	18.0	18.0	13.0	-
U.S. High Yield	3.0	3.0	-	-
Emerging Markets Debt	3.0	3.0	-	-
Total Return Enhancement	**26.0**	**26.0**	**13.0**	**-**
Diversified Short Term Fixed Income	5.0	-	-	-
Short Term Corporate Fixed Income	15.0	10.0	12.0	14.0
Limited Duration Fixed Income	16.0	16.0	19.0	21.0
Core Fixed Income	38.0	48.0	56.0	65.0
Total Risk Management	**74.0**	**74.0**	**87.0**	**100.0**
Portfolio Metrics(%) - Net of Fees				
Expected Return (Short Term)	5.3	5.4	5.0	4.4
Expected Return (Equilibrium)	6.4	6.6	6.2	5.7
Standard Deviation	5.7	5.9	5.3	5.2
Poor Scenario (Short Term)	-3.6	-3.8	-3.3	-3.8
Poor Scenario (Equilibrium)	-2.5	-2.7	-2.1	-2.5

Expected Return Distributions Short-Term



Funded Ratio Projections – 10 Years



SEI's full report for both plans is included as an attachment.

BOARD ACTION:

Approve the asset allocations for the RHIC and Job Service Plans.

Attachment

North Dakota Retirement & Investment

SEI Fiduciary Management

May 27, 2025

Mark Morgan, CFA
mmorgan@seic.com

Jonathan Waite, FSA, EA
jbwaite@seic.com

Astrid Rau
arau@seic.com

We help make institutions better investors.

The value we deliver is by:

- Saving our clients time
- Improving outcomes
- Reducing workflow error

30+ years
of managing institutional assets through a variety of market cycles

315
Technical and investment professionals focused on understanding client needs

415+ institutional strategic partners
with custom investment solutions built to help achieve their goals

$83 billion
institutional assets under management

All data as of March 31, 2025. Clients represent a partial list of current institutional clients, selected from SEI's complete client roster, all of which are global institutional clients, have assets over $50 million and have provided SEI with permission to use their names in marketing materials. It is not known whether the listed clients approve of SEI or the advisory services provided. The inclusion of particular clients on this list does not constitute an endorsement or recommendation of SEI's products or services by such clients.

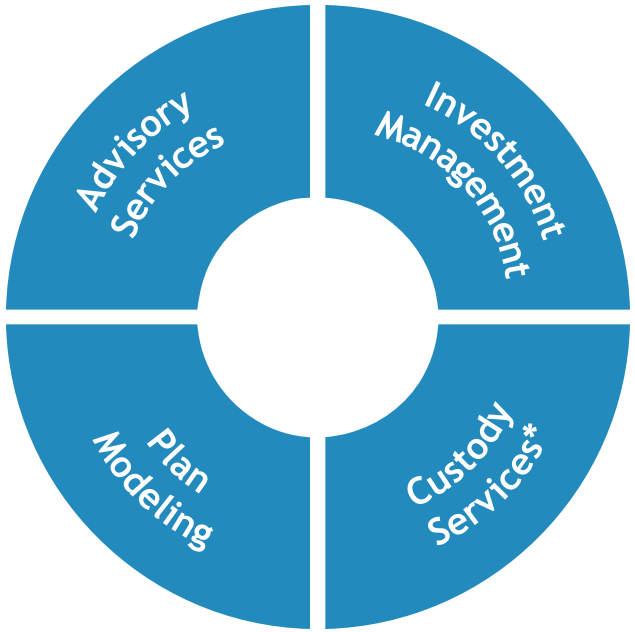
SEI's discretionary investment management model for public plans

Advisory services
- Asset/liability studies
- Investment policy analysis and development
- Capital market assumptions
- Metric reporting
- Co-fiduciary

Investment management
- Diversified portfolios
- New investment strategies
- Manager research and selection
- Manager oversight and replacement
- Dynamic asset management
- Risk management
- Transition management
- Exclusive fiduciary

Custody services
- Daily account access
- Rebalancing

Plan modeling
- Coordination with your actuary
- Customized planning tools



*Optional services. Services provided by SEI Private Trust Company, a limited purpose federal savings association and subsidiary of SEI Investments Company.

North Dakota Retirement & Investment
Executive summary – April 30, 2025

Account Strategy

- Fully diversified investment approach
- Retiree Health Insurance: 60/40 equity/fixed income mix
  - ➢ Commitment to growth strategies in equity and credit will drive investment results
- Job Service: 20/80 equity/fixed income mix
  - ➢ Low volatility equity

Results

- 4/30/2025 valuations: Retiree Health Insurance $192,425,420, Job Service $83,631,631
- Retiree Health Insurance returns: One year 11.44%, 5 year 8.93%, 10 year 6.98%
- Job Service returns: One year 9.92%, 5 year 4.09%, since 12/31/2015 4.71%
- Both plans comfortably outpacing benchmarks

Market Outlook

- Tariffs are inefficient way to raise revenues and are likely to cause higher prices while restricting consumer choice
- Inflation risks remain biased to the upside on protectionist policies and fiscal stimulus
- Growth data is softening, but we do not foresee recession in 2025
- It has become easier for investors to defend both diversification outside the U.S. and a tilting toward value

Please refer to the important disclosures accompanying your portfolio performance in this presentation for information on performance calculations.

Advice Update

North Dakota Retiree Health Insurance Credit Fund: Key characteristics

Plan Overview

- Active members: 16,283
- Status: Closed
- Demographic profile: Inactively Dominated
- Valuation rate: 5.75%

Liability Overview

- Liability Growth: 1.0%
- Benefit Payments/Assets: 8.9%

Hurdle Rate: 9.9%
- Contribution: 7.3%
= Net Hurdle: 2.6%

Pension Metrics:

Funded Status

Funded status changes driven by portfolio returns relative to liability returns.

Market Value of Assets:	$186.6MM
Actuarial Value of Assets	$183.3MM
AAL:	$273.0MM

7/1/2024
AAL/AVA deficit/ratio: $89.6M/67.2%

Contribution

Contribution driven by benefit accruals and funded ratio volatility.

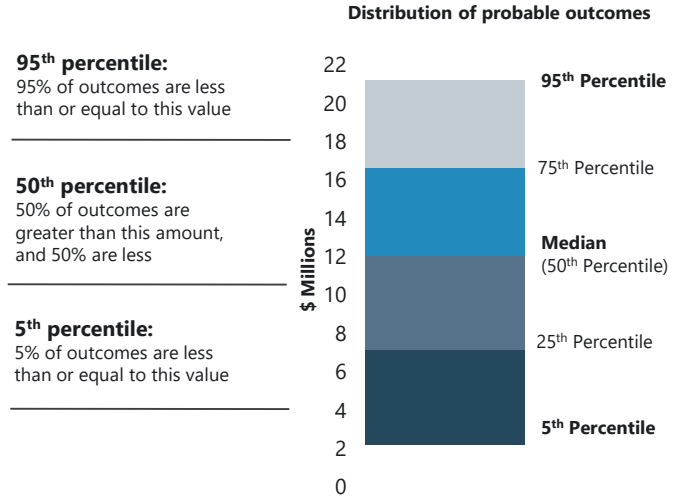
Normal Cost:	$4.4MM +
Amortization	$10.3MM

= Actuarial contribution $14.7M

Statutory contribution of $12.5M (1.14% of payroll)

How we create probability distributions and what they mean

- The probability distribution graphs and/or tables that follow are meant to provide an overview of the range of possible outcomes for a given variable (e.g. returns, expense) for a given asset allocation.
- The probability distributions are generated using SEI's proprietary modeling tool and simulated capital market behavior.
- Capital market behavior is simulated for 1,000 possible scenarios based on expected performance of each asset class and reflecting current economic conditions. Capital market assumptions such as return, standard deviation and covariances are inputs into this process, combining with model parameters to create market scenarios.
- We use these 1,000 capital market scenarios to create 1,000 output scenarios for each variable being considered.
- A 90% confidence interval should be interpreted as 90% of the projected output variables, falling between the 5% and 95% results, based on SEI Capital Market Assumptions.
- This projection is hypothetical in nature, does not reflect actual investment results and is not a guarantee of future results.



About capital market assumptions

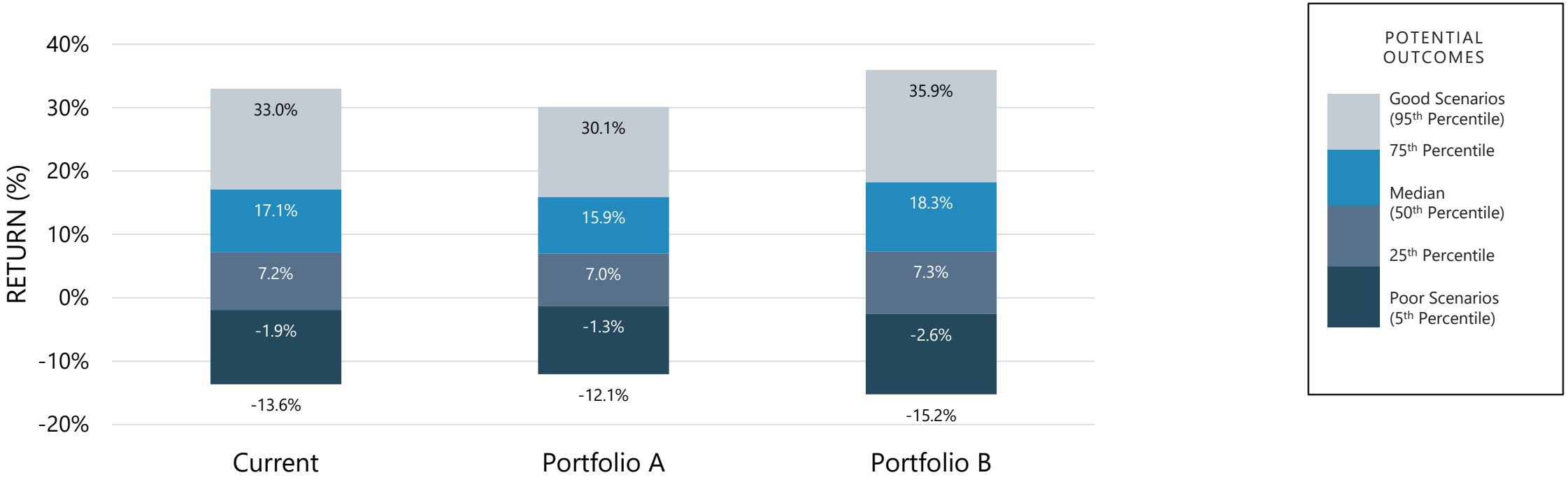
- SEI Investments Management Corporation develops forward-looking, long-term capital market assumptions for risk, return and correlations for a variety of global asset classes, currencies, interest rates, and inflation.
- These assumptions are created using a combination of historical analysis, future market environment expectations and by applying our own judgment. In certain cases, alpha and tracking error estimates for a particular asset class are also factored into the assumptions.
- We believe this approach is less biased than using pure historical data, which may be affected by unsustainable trends or permanent material shifts in market conditions.

RHIC: Modeled Portfolios

Asset Class	Current	Portfolio A	Portfolio B
Large Cap Equity Index	33.0	29.0	37.0
US Small Cap Equity	6.0	5.0	7.0
World Equity ex-US	26.0	23.0	29.0
U.S. High Yield	3.0	3.0	3.0
Emerging Markets Debt	4.0	4.0	4.0
Total Return Enhancement	**72.0**	**64.0**	**80.0**
Core Fixed Income	28.0	36.0	20.0
Total Risk Management	**28.0**	**36.0**	**20.0**
Portfolio Metrics(%) - Net of Fees			
Expected Return (Short Term)	7.2	7.0	7.3
Expected Return (Equilibrium)	8.3	8.1	8.5
Standard Deviation	14.2	12.9	15.7
Poor Scenario (Short Term)	-13.6	-12.1	-15.2
Expected Return (Equilibrium)	-12.5	-10.9	-14.2

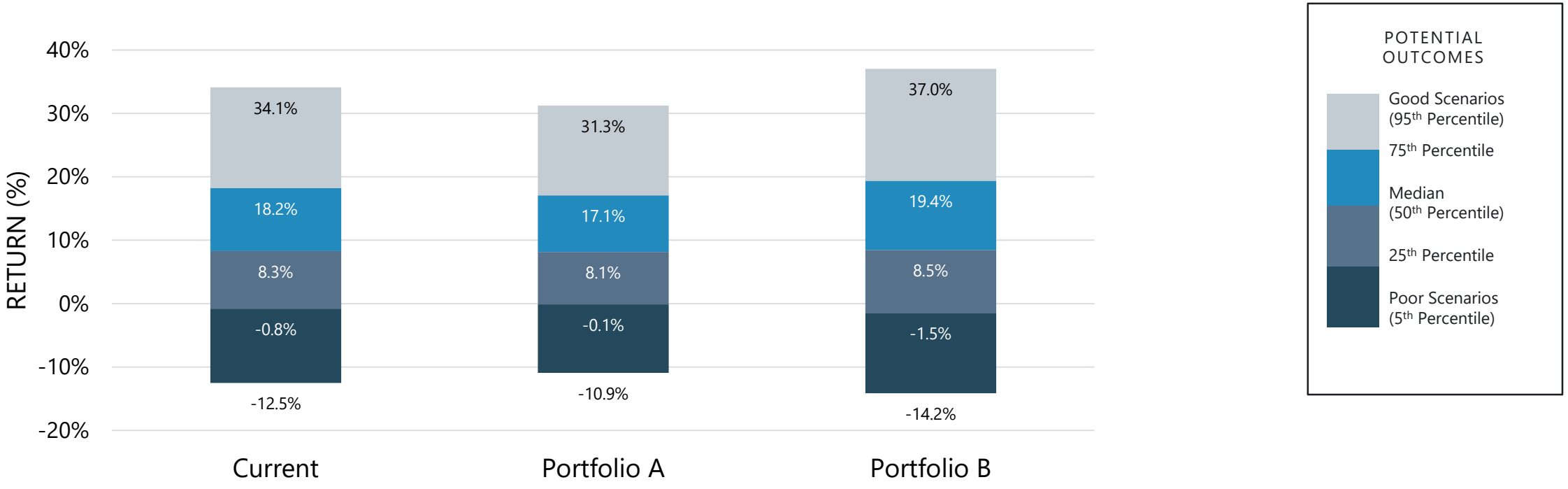
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Expected Return Distributions
Short-Term



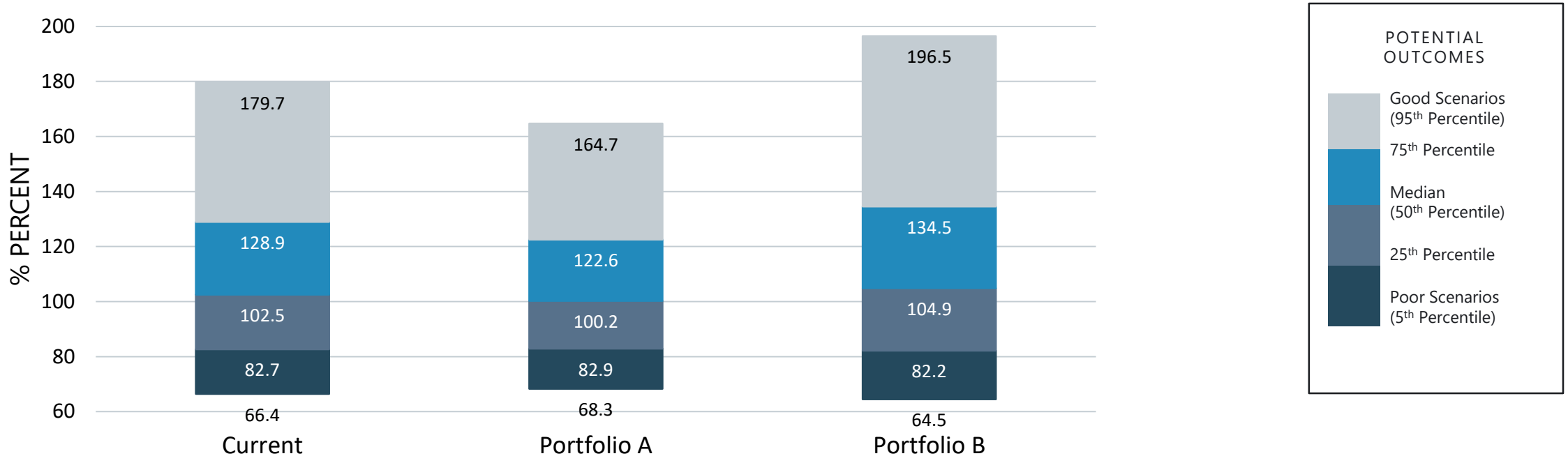
Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Expected Return Distributions Equilibrium



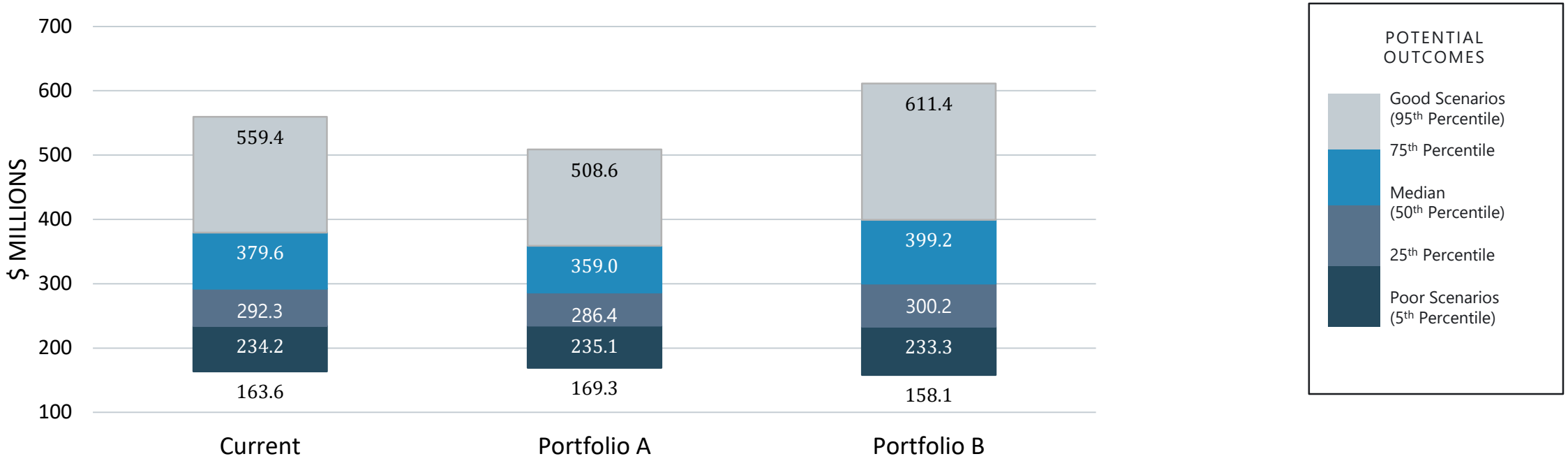
Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Funded Ratio Projections – 10 Years



Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Market Value Projections – 10 Years



Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Retirement Plan of Employees of Job Service North Dakota: Key characteristics

Plan Overview

- Active members: 1
- Status: Frozen to new entrants
- Demographic profile: Inactively Dominated
- Valuation rate: 3.0%

Liability Overview

- Liability Growth: (4.8%)
- Benefit Payments/Assets: 6.6%

Hurdle Rate: 1.8%

Pension Metrics:

Funded Status

Funded status changes driven by portfolio returns relative to liability returns.

Market Value of Assets:	$82.8MM
Actuarial Value of Assets	$84.3MM
AAL:	$70.3MM

7/1/2024
AAL/MVA surplus/ratio: $14.0M/119.9%

Actuarial Contribution

Scheduled contribution driven by funded ratio volatility. Contribution will be zero as long as the Plan's actuarial value of assets exceeds the actuarial present value of projected benefits

Normal Cost:	$0

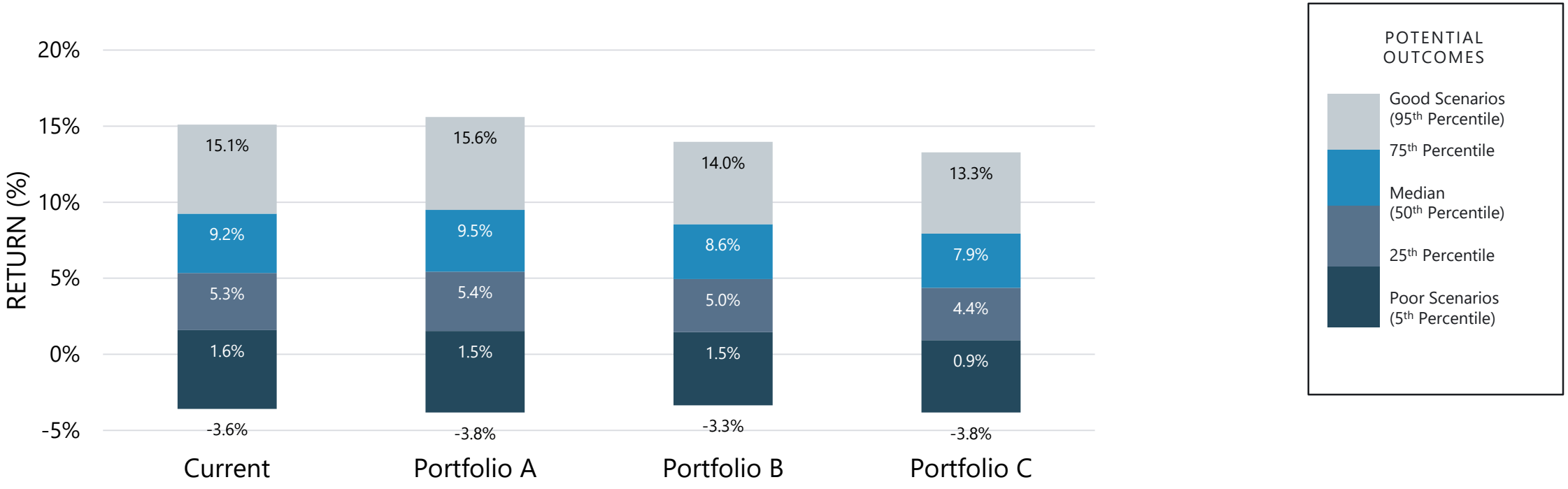
No Contribution Required

Job Service: Modeled Portfolios

Asset Class	Current	Portfolio A	Portfolio B	Portfolio C
US Low Beta Equities	2.0	2.0	-	-
Global Low Beta Equities	18.0	18.0	13.0	-
U.S. High Yield	3.0	3.0	-	-
Emerging Markets Debt	3.0	3.0	-	-
Total Return Enhancement	**26.0**	**26.0**	**13.0**	**-**
Diversified Short Term Fixed Income	5.0	-	-	-
Short Term Corporate Fixed Income	15.0	10.0	12.0	14.0
Limited Duration Fixed Income	16.0	16.0	19.0	21.0
Core Fixed Income	38.0	48.0	56.0	65.0
Total Risk Management	**74.0**	**74.0**	**87.0**	**100.0**
Portfolio Metrics(%) - Net of Fees				
Expected Return (Short Term)	5.3	5.4	5.0	4.4
Expected Return (Equilibrium)	6.4	6.6	6.2	5.7
Standard Deviation	5.7	5.9	5.3	5.2
Poor Scenario (Short Term)	-3.6	-3.8	-3.3	-3.8
Poor Scenario (Equilibrium)	-2.5	-2.7	-2.1	-2.5

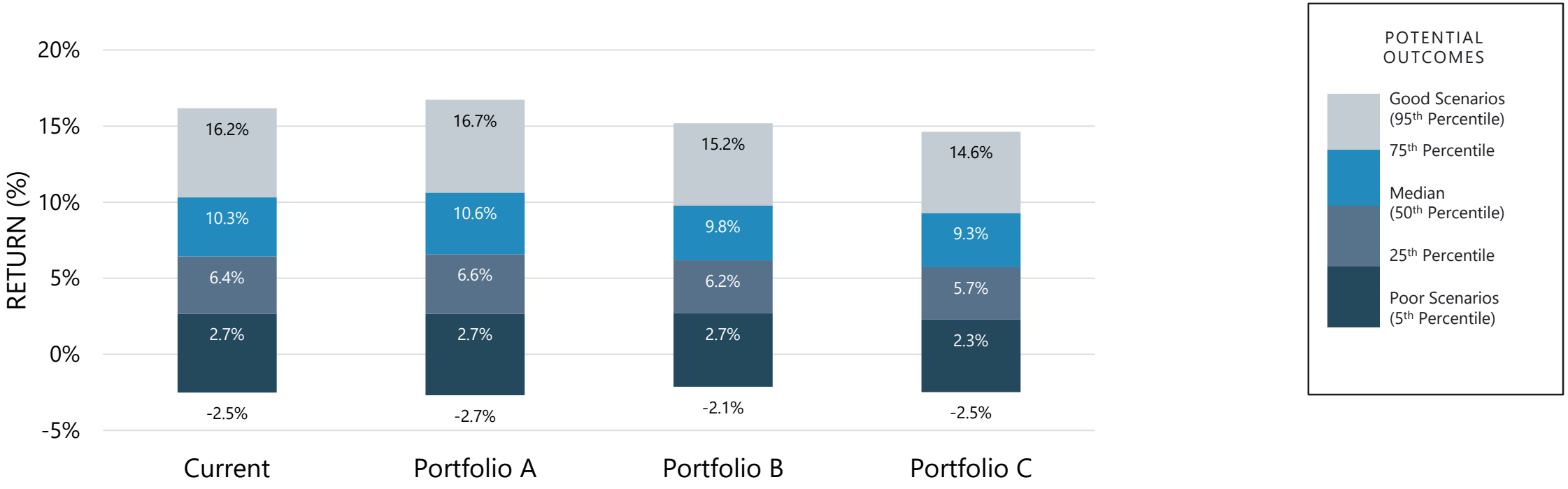
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Expected Return Distributions
Short-Term



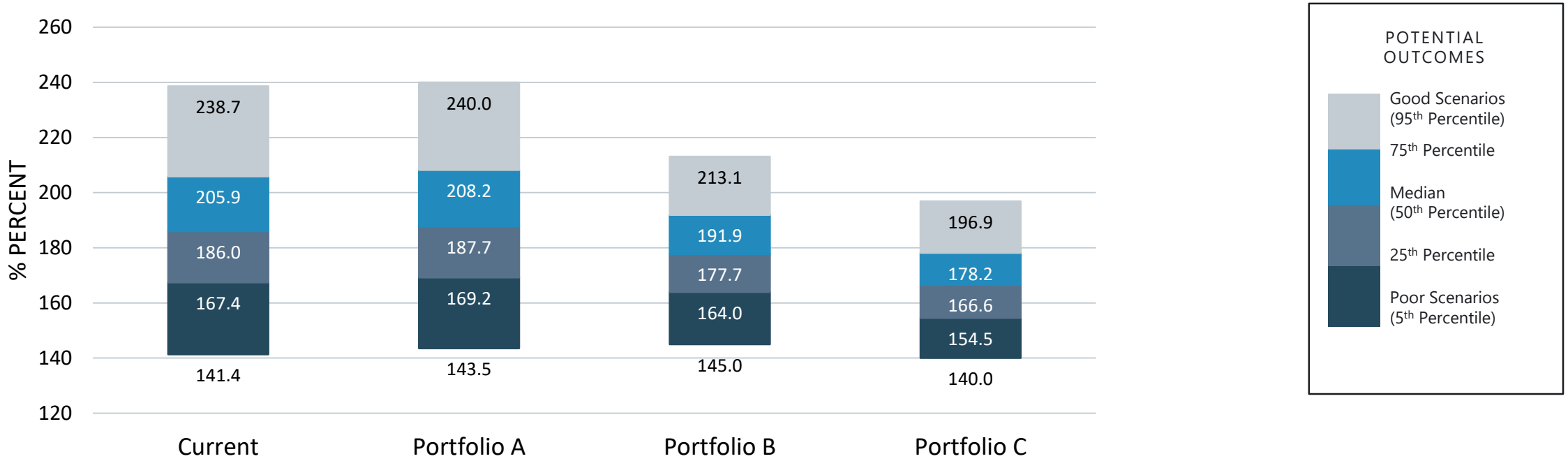
Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Expected Return Distributions Equilibrium



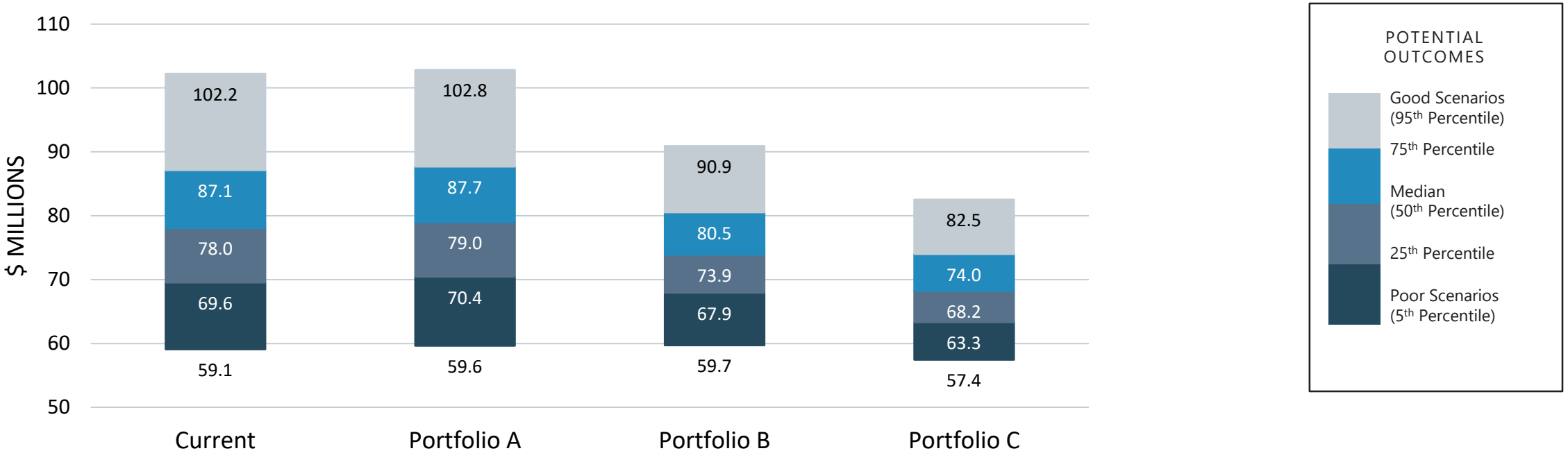
Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Funded Ratio Projections – 10 Years



Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Market Value Projections – 10 Years



Net of fees.
Source: SEI Capital Market Assumptions. Please see important disclosures at the beginning of this section and at the back of the presentation.

Portfolio Reviews

Important information: asset valuation and portfolio returns

ND-Retiree Health Insurance Credit Fund

Inception date 7/31/2009. Historical Total Index can be provided upon request.

The Portfolio Return and fund performance numbers are calculated using Gross Fund Performance, using a true time-weighted performance method (prior to 6/30/2012, the Modified Dietz method of calculation was used). Gross Fund Performance reflects the effective performance of the underlying mutual funds that are selected or recommended by SIMC to implement an institutional client's investment strategy. Gross Fund Performance does not reflect the impact of fund level management fees, fund administration or shareholder servicing fees, all of which, if applicable, are used to offset the account level investment management fees the client pays to SIMC. Gross Fund Performance does reflect certain operational expenses charged by the funds and the reinvestment of dividends and other earnings. The inclusion of the fund level expenses that the client incurs but that are offset against the client's account level investment management fees would reduce the Gross Fund Performance of the mutual funds. For additional information about how performance is calculated, please see your monthly performance report.

Net Portfolio Returns since 6/30/12 reflect the deduction of SIMC's investment management fee and the impact that fee had on the client's portfolio performance. Prior to 6/30/12, Net Portfolio Returns deduct a proxy annual fee for all periods to demonstrate the impact that SIMC's investment management fee had on the portfolio performance. However, this is a hypothetical calculation, as it does not reflect the actual fees paid by the client during the period. Please see your client invoice for actual fees paid.

Total Portfolio Index Composition

The current composition of the "Total Portfolio Index" is as follows. This composition went into effect at the close of business on 3/31/2021.

33.00%	Russell 1000 Index
28.00%	Bloomberg Barclays US Agg Bond Index
26.00%	MSCI All Country World ex US Index (Net)
6.00%	Russell 2000 Index
4.00%	Hist Blnd: Emerging Markets Debt Index
3.00%	Hist Blnd: High Yield Bond Index

ND – Retiree Health Insurance Credit Fund
Annualized investment returns : April 30, 2025

	Total Assets ($)	Actual Alloc (%)	1 Month	3 Months	Fiscal YTD	1 Year	3 Years	5 Years	7 Years	10 Years
Total Portfolio Return	192,425,420	100.0	0.67	-1.59	6.35	11.44	7.83	8.93	7.29	6.98
Standard Deviation Portfolio							*12.64*	*11.95*		
Total Portfolio Index			0.77	-1.49	5.41	10.18	7.37	8.19	6.69	6.46
Standard Deviation Index							*12.42*	*11.72*		
Total Equity	124,820,156	64.8	0.73	-3.64	6.42	12.65	10.29	13.60	9.70	9.43
US Equity	72,462,223	37.6	-0.85	-8.54	2.82	10.66	10.83	15.00	11.90	11.22
Large Cap Index Fund	61,756,528	32.0	-0.62	-8.02	3.39	11.81	11.81	15.37	12.75	11.99
Russell 1000 Index			*-0.60*	*-7.99*	*3.48*	*11.94*	11.87	15.42	*12.80*	*12.03*
Small Cap Fund	10,705,695	5.6	-2.12	-11.46	-0.51	4.05	5.21	12.56	6.72	6.93
Russell 2000 Index			*-2.31*	*-13.83*	*-3.05*	*0.87*	3.27	9.88	*4.93*	*6.32*
World Equity x-US	52,357,933	27.2	2.99	4.01	11.71	15.22	9.27	11.23	5.77	5.82
World Equity Ex-US Fund	52,357,933	27.2	2.99	4.01	11.71	15.22	9.27	11.23	5.77	5.82
MSCI All Country World ex US Index (Net)			*3.61*	*4.81*	*8.87*	*11.93*	8.04	10.09	*4.76*	*4.83*
Total Fixed Income	67,605,265	35.2	0.55	2.44	6.15	9.04	3.18	1.23	2.64	2.56
Core Fixed Income Fund	53,836,646	28.0	0.47	2.78	5.67	8.81	2.26	-0.11	2.25	2.08
Bloomberg US Aggregate Bond Index			*0.39*	*2.64*	*5.22*	*8.02*	1.95	-0.67	*1.74*	*1.54*
Emerging Markets Debt Fund	7,893,332	4.1	1.48	2.38	8.71	10.35	7.40	4.55	2.04	2.89
Hist Blnd: Emerging Markets Debt Index			*1.51*	*3.04*	*7.72*	*9.31*	5.70	2.62	*1.37*	*2.19*
High Yield Bond Fund	5,875,287	3.1	-0.02	-0.57	7.23	9.46	6.09	8.84	5.70	5.70
Hist Blnd: High Yield Bond Index			*0.00*	*-0.43*	*6.48*	*8.69*	6.14	6.40	*4.69*	*4.79*

Return time periods less than 12 months are cumulative, over 12 months are annualized.

ND – Retiree Health Insurance Credit Fund
Calendar year investment returns : April 30, 2025

	Total Assets ($)	Actual Alloc (%)	YTD	Year 2024	Year 2023	Year 2022	Year 2021	Year 2020	Year 2019	Year 2018
Total Portfolio Return	192,425,420	100.0	1.15	11.80	16.78	-16.43	11.47	15.69	21.15	-5.81
Total Portfolio Index			0.99	10.69	16.18	-15.98	10.45	13.90	20.31	-5.48
Total Equity	124,820,156	64.8	-0.02	16.89	21.48	-17.82	19.00	18.27	28.13	-9.26
US Equity	72,462,223	37.6	-5.78	23.36	24.32	-18.78	26.42	20.06	30.31	-5.66
Large Cap Index Fund	61,756,528	32.0	-5.11	24.43	26.53	-19.13	26.39	20.87	31.39	-4.80
Russell 1000 Index			*-5.06*	*24.51*	*26.53*	*-19.13*	*26.45*	*20.96*	*31.43*	*-4.78*
Small Cap Fund	10,705,695	5.6	-9.46	17.17	12.24	-16.83	25.94	13.54	24.32	-10.55
Russell 2000 Index			*-11.57*	*11.54*	*16.93*	*-20.44*	*14.82*	*19.96*	*25.52*	*-11.01*
World Equity x-US	52,357,933	27.2	9.11	7.49	17.23	-16.42	7.61	14.90	24.10	-15.76
World Equity Ex-US Fund	52,357,933	27.2	9.11	7.49	17.23	-16.42	7.61	14.90	24.10	-15.76
MSCI All Country World ex US Index (Net)			*9.03*	*5.53*	*15.62*	*-16.00*	*7.82*	*10.65*	*21.51*	*-14.20*
Total Fixed Income	67,605,265	35.2	3.36	2.55	8.22	-13.79	-0.54	9.22	10.74	-0.78
Core Fixed Income Fund	53,836,646	28.0	3.40	1.61	6.60	-14.03	-1.27	9.59	9.65	0.20
Bloomberg US Aggregate Bond Index			*3.18*	*1.25*	*5.53*	*-13.01*	*-1.54*	*7.51*	*8.72*	*0.01*
Emerging Markets Debt Fund	7,893,332	4.1	5.01	3.54	15.12	-14.21	-4.58	5.03	15.97	-7.77
Hist Blnd: Emerging Markets Debt Index			*4.84*	*2.01*	*11.94*	*-14.74*	*-5.30*	*4.03*	*14.29*	*-5.15*
High Yield Bond Fund	5,875,287	3.1	0.91	10.13	13.97	-11.14	10.41	6.23	14.25	-1.80
Hist Blnd: High Yield Bond Index			*0.95*	*8.22*	*13.46*	*-11.21*	*5.35*	*6.07*	*14.41*	*-2.25*

Return time periods less than 12 months are cumulative, over 12 months are annualized.

Important information: asset valuation and portfolio returns

North Dakota St. Inv Bd - Job Service Pension

Inception date 12/31/2015. Historical Total Index can be provided upon request.

The Portfolio Return and fund performance numbers are calculated using Gross Fund Performance, using a true time-weighted performance method (prior to 6/30/2012, the Modified Dietz method of calculation was used). Gross Fund Performance reflects the effective performance of the underlying mutual funds that are selected or recommended by SIMC to implement an institutional client's investment strategy. Gross Fund Performance does not reflect the impact of fund level management fees, fund administration or shareholder servicing fees, all of which, if applicable, are used to offset the account level investment management fees the client pays to SIMC. Gross Fund Performance does reflect certain operational expenses charged by the funds and the reinvestment of dividends and other earnings. The inclusion of the fund level expenses that the client incurs but that are offset against the client's account level investment management fees would reduce the Gross Fund Performance of the mutual funds. For additional information about how performance is calculated, please see your monthly performance report.

Net Portfolio Returns since 6/30/12 reflect the deduction of SIMC's investment management fee and the impact that fee had on the client's portfolio performance. Prior to 6/30/12, Net Portfolio Returns deduct a proxy annual fee for all periods to demonstrate the impact that SIMC's investment management fee had on the portfolio performance. However, this is a hypothetical calculation, as it does not reflect the actual fees paid by the client during the period. Please see your client invoice for actual fees paid.

Total Portfolio Index Composition

The current composition of the "Total Portfolio Index" is as follows. This composition went into effect at the close of business on 2/15/2023.

38.00%	Bloomberg Barclays US Agg Bond Index
18.00%	MSCI World Minimum Volatility Index (Net)
16.00%	ICE BofA ML 1-3 Year Treasury Index
15.00%	Blmbrg Barcl 9-12 Month Short Treas Index
5.00%	ICE BofA 3Mo Deposit Offer Rt Const Mat IX
3.00%	Hist Blnd: Emerging Markets Debt Index
3.00%	Hist Blnd: High Yield Bond Index
2.00%	25% Russell 3000 Val / 75% MSCI US Min Vol

ND – Job Service Pension
Annualized investment returns : April 30, 2025

	Total Assets ($)	Actual Alloc (%)	1 Month	3 Months	Fiscal YTD	1 Year	3 Years	5 Years	10 Years	Inception 12/31/2015
Total Portfolio Return	83,631,631	100.0	0.44	2.29	7.52	9.92	5.11	4.09	-	4.71
Standard Deviation Portfolio							*5.69*	*5.00*		
Total Portfolio Index			0.54	2.52	7.11	9.34	4.27	2.78	-	3.99
Standard Deviation Index							*5.55*	*4.93*		
Total Equity	16,685,973	19.9	0.14	3.08	14.80	17.92	10.12	12.34	-	9.59
US Equity	1,629,559	1.9	-1.82	-1.19	11.16	13.46	8.27	11.89	-	9.48
U.S. Managed Volatility Fund	1,629,559	1.9	-1.82	-1.19	11.16	13.46	8.27	11.89	-	9.48
Global Equity	15,056,414	18.0	0.36	3.56	15.20	18.42	10.32	12.14	-	9.23
Global Managed Volatility Fund	15,056,414	18.0	0.36	3.56	15.20	18.42	10.32	12.14	-	9.23
Total Fixed Income	66,945,658	80.1	0.51	2.08	5.74	7.97	3.85	2.07	-	2.87
Core Fixed Income Fund	31,945,244	38.2	0.47	2.79	5.68	8.83	2.27	-0.10	-	2.29
Bloomberg US Aggregate Bond Index			*0.39*	*2.64*	*5.22*	*8.02*	1.95	-0.67	-	*1.73*
Limited Duration Fund	13,365,384	16.0	0.69	1.97	5.74	7.26	4.10	2.35	-	2.43
ICE BofA ML 1-3 Year Treasury Index			*0.79*	*1.95*	*5.28*	*6.60*	3.27	1.31	-	*1.69*
Ultra Short Duration Fund	12,486,820	14.9	0.39	1.28	4.89	5.99	4.77	3.06	-	2.65
Blmbrg Barcl 9-12 Month Short Treas Index			*0.42*	*1.18*	*4.45*	*5.41*	3.96	2.24	-	*2.04*
Opportunistic Income Fund	4,153,497	5.0	0.35	0.89	5.80	7.03	6.65	5.93	-	4.43
ICE BofA 3Mo Deposit Offer Rt Const Mat IX			*0.36*	*1.07*	*4.21*	*5.12*	4.43	2.71	-	*2.23*
Emerging Markets Debt Fund	2,509,588	3.0	1.48	2.38	8.71	10.35	7.40	4.55	-	4.28
Hist Blnd: Emerging Markets Debt Index			*1.51*	*3.04*	*7.72*	*9.31*	5.70	2.62	-	*3.30*
High Yield Bond Fund	2,485,126	3.0	-0.02	-0.58	7.28	9.53	6.14	8.88	-	7.09
Hist Blnd: High Yield Bond Index			*0.00*	*-0.43*	*6.48*	*8.69*	6.14	6.40	-	*6.09*

Return time periods less than 12 months are cumulative, over 12 months are annualized.

ND – Job Service Pension
Calendar year investment returns : April 30, 2025

	Total Assets ($)	Actual Alloc (%)	YTD	Year 2024	Year 2023	Year 2022	Year 2021	Year 2020	Year 2019	Year 2018
Total Portfolio Return	83,631,631	100.0	3.48	6.20	7.51	-6.75	3.98	4.31	9.69	0.88
Total Portfolio Index			3.72	4.76	6.16	-7.51	2.67	4.43	9.34	1.26
Total Equity	16,685,973	19.9	6.48	15.69	8.70	-2.91	19.79	-2.26	21.86	-3.29
US Equity	1,629,559	1.9	2.27	16.17	4.95	-0.26	20.58	-1.71	24.16	-3.46
U.S. Managed Volatility Fund	1,629,559	1.9	2.27	16.17	4.95	-0.26	20.58	-1.71	24.16	-3.46
Global Equity	15,056,414	18.0	6.95	15.62	9.11	-3.20	19.12	-2.51	20.86	-4.23
Global Managed Volatility Fund	15,056,414	18.0	6.95	15.62	9.11	-3.20	19.12	-2.51	20.86	-4.23
Total Fixed Income	66,945,658	80.1	2.75	3.90	7.19	-7.74	0.21	5.59	6.88	0.87
Core Fixed Income Fund	31,945,244	38.2	3.40	1.63	6.61	-14.04	-1.28	9.59	9.69	0.17
Bloomberg US Aggregate Bond Index			*3.18*	*1.25*	*5.53*	*-13.01*	*-1.54*	*7.51*	*8.72*	*0.01*
Limited Duration Fund	13,365,384	16.0	2.47	4.94	5.48	-3.42	0.15	4.15	4.00	1.93
ICE BofA ML 1-3 Year Treasury Index			*2.39*	*4.10*	*4.25*	*-3.65*	*-0.55*	*3.10*	*3.55*	*1.58*
Ultra Short Duration Fund	12,486,820	14.9	1.69	5.84	6.46	-0.81	0.34	2.14	3.55	1.91
Blmbrg Barcl 9-12 Month Short Treas Index			*1.53*	*5.05*	*5.02*	*-0.40*	*0.00*	*1.69*	*2.88*	*1.91*
Opportunistic Income Fund	4,153,497	5.0	1.54	8.59	10.10	-0.94	2.89	2.85	6.05	2.04
ICE BofA 3Mo Deposit Offer Rt Const Mat IX			*1.44*	*5.50*	*5.10*	*1.20*	*0.17*	*1.08*	*2.60*	*2.08*
Emerging Markets Debt Fund	2,509,588	3.0	5.01	3.54	15.12	-14.21	-4.58	5.03	15.97	-7.74
Hist Blnd: Emerging Markets Debt Index			*4.84*	*2.01*	*11.94*	*-14.74*	*-5.30*	*4.03*	*14.29*	*-5.15*
High Yield Bond Fund	2,485,126	3.0	0.92	10.22	14.05	-11.16	10.46	6.28	14.28	-1.75
Hist Blnd: High Yield Bond Index			*0.95*	*8.22*	*13.46*	*-11.21*	*5.35*	*6.07*	*14.41*	*-2.25*

Return time periods less than 12 months are cumulative, over 12 months are annualized.

SEI's representative institutional investment strategies

Domestic equity

Large Cap Equity Strategy
Acadian Asset Management LLC
Copeland Capital Management, LLC
Cullen Capital Management LLC
Fred Alger Management
LSV Asset Management
PineStone Asset Management Inc.

U.S. Small Cap II Equity Strategy
Copeland Capital Management LLC
The Informed Momentum Company
Easterly Investment Partners LLC
Leeward Investments LLC
Los Angeles Capital Management LLC

SEI Extended Markets Index Strategy
SSGA Funds Management, Inc.

U.S. Equity Factor Allocation Strategy
SEI Investments Management Corporation

U.S. Large Cap Disciplined Equity Strategy
Acadian Asset Management LLC
Brandywine Global Investment Management LLC
Copeland Capital Management, LLC
Mackenzie Investments
PineStone Asset Management Inc.

U.S. Small Cap Equity Strategy
Axiom International Investors, LLC
The Informed Momentum Company
Los Angeles Capital Management
LSV Asset Management LP
Martingale Asset Management, LP

Large Cap Index Strategy
SSGA Funds Management, Inc.

S&P 500 Index Strategy
SSGA Funds Management, Inc.

U.S. Small/Mid Cap Equity Strategy
Axiom International Investors
Copeland Capital Management, LLC
Geneva Capital Management, LLC
Jackson Creek Investment Advisors LLC
LSV Asset Management*

Real Estate Strategy
CenterSquare Investment Management

U.S. Managed Volatility Strategy
Allspring Global Investments
LSV Asset Management*

Global equity

World Equity ex-U.S. Strategy
Acadian Asset Management
Brickwood Asset Management
Lazard Asset Management
Macquarie Investment Management
Pzena Investment Management

Global Managed Volatility Strategy
Acadian Asset Management
Allspring Global Investments
LSV Asset Management*

Emerging Markets Equity Strategy
Aikya Investment Management
JOHCM (USA) Inc.
Robeco Asset Management

Screened World Equity ex-U.S. Strategy
Acadian Asset Management
Brickwood Asset Management
Lazard Asset Management LLC

World Select Equity Strategy
Brickwood Asset Management
Lazard Asset Management LLC
LSV Asset Management
PineStone Asset Management Inc.
Poplar Forest Capital, LLC
Rhicon Currency Management Pte LTD
Towle & Co

Sub-Adviser Diversification as of March 31, 2025. The strategies above are not an exhaustive list, but represent those that are typically utilized by SEI Institutional clients. Certain strategies are currently available only in registered mutual fund products. References to specific SEI funds are designed to illustrate SEI's manager selection process, which is implemented by SEI Investments Management Corporation (SIMC). The managers may be offered exclusively through mutual funds. References to specific securities do not constitute an offer or recommendation to buy, sell or hold such securities. *As of December 31, 2023, SEI Investments Company has a 38.6% minority ownership interest in LSV Asset Management.

SEI's representative institutional investment strategies (continued)

Fixed income

Cash Management Strategies
Money Market Funds
Custom Separate Accounts

Opportunistic Income Strategy
Ares Management
Manulife Investment Management
Wellington Management Company

Ultra Short Duration Bond Strategy
MetLife Investment Management, LLC
Wellington Management Company

Short Gov't Bond Strategy
Wellington Management Company

Limited Duration Bond Strategy
MetLife Investment Management, LLC
Metropolitan West Asset Management LLC

High Yield Bond Strategy
Ares Management
Benefit Street Partners
Brigade Capital Management
J.P. Morgan Asset Management
T. Rowe Price Associates

Emerging Markets Debt Strategy
Artisan Partners
Colchester Global Investors
Grantham Mayo van Otterloo
Invesco Advisers, Inc.
Marathon Asset Management, LP

Core Fixed Income Plus Strategy
U.S. Core Fixed Income Strategy
High Yield Strategy
Emerging Debt Strategy

U.S. Core Fixed Income Strategy
Allspring Global Investments
Jennison Associates
MetLife Investment Management, LLC
Metropolitan West Asset Management

Intermediate Duration Credit Strategy
Income Research & Management
Legal & General Inv. Mgmt. America
MetLife Investment Management, LLC

Long Duration Credit Strategy
Income Research & Management
Jennison Associates
Legal & General Inv. Mgmt. America
MetLife Investment Management, LLC
Metropolitan West Asset Management

Long Duration Bond Strategy
Income Research & Management
Jennison Associates
Legal & General Inv. Mgmt. America
Metropolitan West Asset Management

Alternative investments

Alternative Investments
Equity Long/Short Strategies
Event Driven Strategies
Global Macro Strategies
Relative Value Strategies
Venture Capital Strategies
Buyout Strategies
Private Debt Strategies
Private Real Assets Strategies
Private Real Estate Strategies
Structured Credit Strategies
Energy Debt Strategies

Other

Dynamic Asset Allocation Strategy
State Street Global Advisors

Multi-Asset Real Return Strategy
AllianceBernstein L.P.
Columbia Management Investments
Credit Suisse
Franklin Advisers, Inc.

Sub-Adviser Diversification as of March 31, 2025. The strategies above are not an exhaustive list, but represent those that are typically utilized by SEI Institutional clients. Certain strategies are currently available only in registered mutual fund products. References to specific SEI funds are designed to illustrate SEI's manager selection process, which is implemented by SEI Investments Management Corporation (SIMC). The managers may be offered exclusively through mutual funds. References to specific securities do not constitute an offer or recommendation to buy, sell or hold such securities.

2024 Manager changes

Funds	Manager Addition and Rationale	Manager Termination and Rationale
Emerging Markets Debt	Artisan Partners (December 2024) Artisan EMSights' competitive advantage lies in its ability to identify and access local currency frontier markets within vigilant risk management processes. Adding Artisan's EMSights to the Fund is designed to increase exposure to a high-growth subset of emerging market debt, as a return and diversification enhancer. Artisan's broad coverage emphasizes under-researched frontier markets undergoing institutional and financial reformation to exploit inefficiencies effectively. Additionally, their integrated trading setup reduces costs and improves liquidity management by fostering close relationships with local counterparties. Invesco Advisers (December 2024) The philosophy behind Invesco's Emerging Market Bond strategy lies in bringing the developed market investment toolkit to emerging market mandates. We believe Invesco will have an attractive diversifying role within the Fund. The manager takes a disciplined approach to risk management, seeking to mitigate downturns. By carefully balancing risk and making thoughtful trade-offs, they aim to deliver consistent results without exposing the portfolio to excessive risk, which we believe provides a strong competitive advantage.	Neuberger Berman Investment Advisers (December 2024) The decision to remove Neuberger Berman's Emerging Markets Debt strategy was motivated by portfolio construction considerations. Neuberger Berman was selected for the blend allocation, leveraging their dual expertise in hard and local currency markets with expectations of generating excess returns in each sleeve as well as through tactical asset allocation. The performance and portfolio characteristics have shown robust results, however with little added value through asset allocation. With the investor landscape for emerging market debt maturing and becoming more intricate, the opportunity to add value from top-down decisions has become increasingly challenged. The Fund is transitioning to include specialized managers to enhance diversification and leverage unique strengths, aiming to improve the overall risk/return profile. Ninety One UK Limited (December 2024) The decision to remove Ninety One's Local Currency Emerging Markets Debt strategy was motivated by risk management considerations. Ninety One's competitive advantage to risk management and downside capture has since been competed away with peers adopting and advancing on approaches that offer similar risk management and downside features, combined with clearer competitive advantages in a particular area of emerging local debt. Rather than a deterioration of Ninety One's approach, it is the advancement of peers and the sum contribution peers can bring to the SEI emerging debt strategy which drives our removal of Ninety One.
World Equity ex-US	Brickwood Asset Management (November 2024) We believe Brickwood's edge is in the commitment to a disciplined and well-structured investment process, emphasizing lowly valued stocks (based on normalized earnings) that are facing temporary setbacks, while mitigating the risks of value-traps. Brickwood's International Value strategy will take Jupiter Asset Management Ltd's ("Jupiter") place in the Fund as lead portfolio managers Ben Whitmore and Dermot Murphy departed Jupiter to start Brickwood.	Jupiter Asset Management (November 2024) The key portfolio managers on the International Value strategy, Ben Whitmore and Dermot Murphy, have left Jupiter to start their own investment management firm, Brickwood Asset Management. Given our confidence and conviction in the portfolio managers, we plan to move our assets to the new firm.
Core Fixed Income		Western Asset Management (November 2024) A number of uncertainties surround Western Asset Management Company (Western) as it faces investigations by both the U.S. Securities and Exchange Commission and the Department of Justice. In addition, co-CIO Kenneth Leech has received a Wells notice and is currently on a leave of absence. Mr. Leech had been a key decision-maker and was instrumental in the growth of Western from his hiring in 1990. As such, Mr. Leech's leave adds to existing concerns about the development of Western's investment strategy following the recent exit of John Bellows, former head of its broad markets team. This, combined with the elevated enterprise risk, has led to the decision to remove Western from the SEI Funds range.

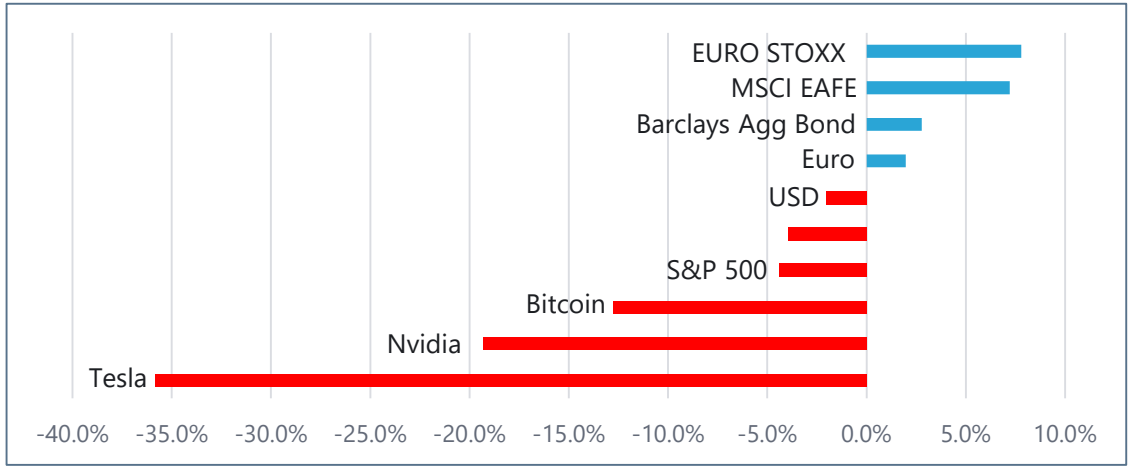
Global Markets Review & Outlook

US equities experienced a 180

Consensus investment themes year end 2024

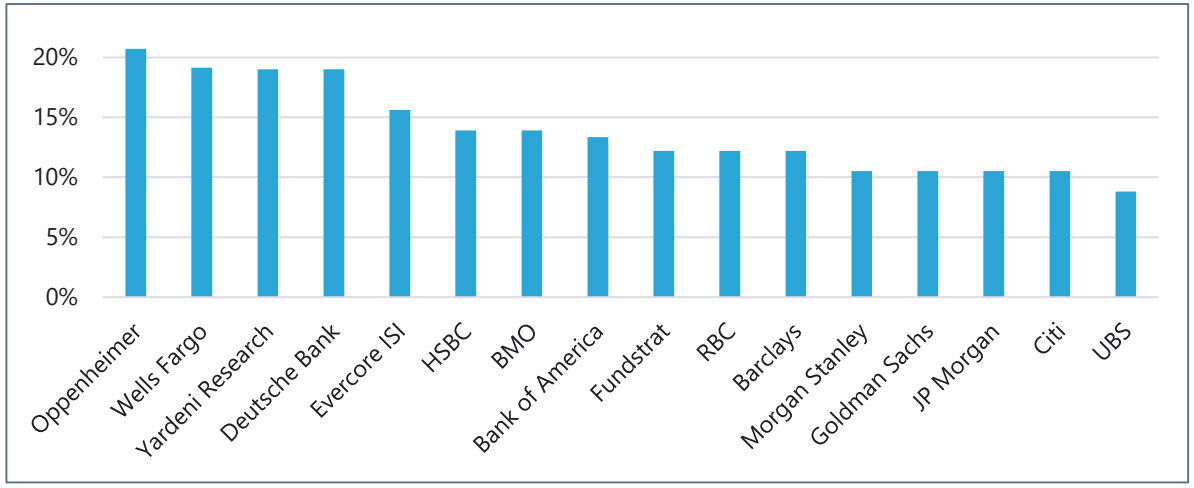
- Equities over bonds
- US over international equities
- Dollar strength
- Favorable for crypto currencies – strong proxy for risk
- Low probability of recession

YTD Returns (3/31/2025)



Source: Bloomberg 3/31/2025

Analyst Forecasts for S&P 500 2025 Returns



Source: Bloomberg 12/31/2024

Potential causes of reversal in sentiment?

- High incoming prices left markets vulnerable
- Sequencing of administrative policies has rattled markets causing transitory downturn
- Market embedding new risks from policy shifts and elevated probability of recession – JP Morgan increased recession probability in 2025 to 40%

Q1 has provided some useful reminders

- Markets are difficult to forecast
- Portfolio risk is ever present even in apparently favorable markets
- Diversification is useful within portfolio to buffer market downturns

Don’t Panic During Volatile Markets

More than 75% of the market’s highest percentage gaining days occur during highly volatile or negative markets. To add to the conundrum, the highest positive days are often commingled with the largest negative days.

Volatile Markets Provide Opportunities to:

1) **Re-confirm:** Does the Committee feel comfortable with the portfolio level of risk and liquidity?

2) **Re-balance:** Is this an opportunity to sell winners and buy losers in alignment with strategic targets?

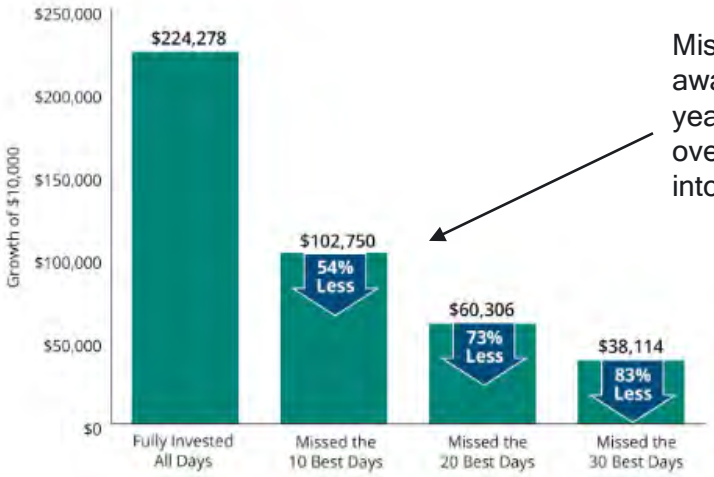
3) **Re-act:** Are active strategies able to benefit on a relative basis by taking advantage of market dislocations?

Good Days Happen in Bad Markets

S&P 500 Index Best Days: 1995–2024

Missing the Market’s Best Days Has Been Costly

S&P 500 Index Average Annual Total Returns: 1995–2024



Missing the best days can wipe away all or the bulk of an entire year’s returns, and compound over time, drastically cutting into annualized performance.

Past performance does not guarantee future results. For illustrative purposes only. Data Sources: Ned Davis Research, Morningstar, and Hartford Funds, 1/25.

Macro environment path will test investors
Summary views

Macro/Cross-asset

- Inflation risks remain biased to the upside on protectionist policies and fiscal stimulus
- Growth data is softening, but we do not foresee a recession in 2025
- We believe commodities remain an attractive inflation hedge
- Our view on risk assets is broadly neutral

Equity

- Diversity in equity markets remains a focus, particularly in geographies and capitalizations
- Strategic holdings in value, quality and momentum remain intact; emphasis on value
- Active management should benefit as concentration subsides and volatility remains elevated

Fixed Income

- Higher long-term yields are expected around the globe
- We anticipate continued steepening in the U.S. and European yield curves
- We remain defensively positioned in credit, favoring securitized versus corporate debt

Strategic Asset Allocation has guided investors through "Known- and Unknown-Unknowns"

- ❖ Housing crisis
- ❖ GFC/2008-09 deep recession
- ❖ Billions in central bank bailouts
- ❖ Zero-interest rate policy
- ❖ Greek debt crisis
- ❖ Negative interest rates in Europe
- ❖ Rise of populism
- ❖ BREXIT
- ❖ COVID/Global pandemic
- ❖ Oil reaches negative prices
- ❖ Russia-Ukraine conflict
- ❖ SVB bank collapse
- ❖ Surging inflation
- ❖ Most aggressive Fed hikes in decades
- ❖ Trump's re-orienting of global trade

	Annualized Return 1/1/2008 - 4/10/2025
S&P 500 Index	***9.7%***

Source: Morningstar Direct

Capital Market Assumptions

SEI Capital Market Assumptions - Short Term - June 2024

	Compound Return	Risk	Arithmetic Return
Core Fixed Income	5.20%	6.62%	5.42%
U.S. High Yield	7.03%	12.75%	7.84%
Emerging Markets Debt	7.56%	15.52%	8.77%
US Small Cap Equity	8.71%	23.44%	11.46%
Short Term Corporate Fixed Income	3.85%	4.07%	3.93%
Diversified Short Term Fixed Income	5.14%	5.72%	5.30%
US Low Beta Equities	7.99%	15.20%	9.15%
Global Low Beta Equities	8.45%	14.05%	9.44%
S&P 500 Index	6.81%	19.00%	8.61%
Limited Duration Fixed Income	4.07%	2.62%	4.10%

Inflation: 2.30%

Please see important disclosures at the beginning of this section and at the back of the presentation

SEI Capital Market Assumptions - Short Term - June 2024

Correlations	Core Fixed Income	U.S. High Yield	Emerging Markets Debt	US Small Cap Equity	Short Term Corporate Fixed Income	Diversified Short Term Fixed Income	US Low Beta Equities	Global Low Beta Equities	S&P 500 Index	Limited Duration Fixed Income
Core Fixed Income	1.00									
U.S. High Yield	0.45	1.00								
Emerging Markets Debt	0.45	0.75	1.00							
US Small Cap Equity	0.15	0.65	0.60	1.00						
Short Term Corporate Fixed Income	0.65	0.60	0.40	0.25	1.00					
Diversified Short Term Fixed Income	0.35	0.80	0.50	0.45	0.89	1.00				
US Low Beta Equities	0.25	0.65	0.65	0.90	0.25	0.45	1.00			
Global Low Beta Equities	0.24	0.61	0.61	0.86	0.22	0.43	0.95	1.00		
S&P 500 Index	0.25	0.65	0.65	0.90	0.25	0.45	1.00	0.95	1.00	
Limited Duration Fixed Income	0.92	0.55	0.45	0.10	0.65	0.45	0.30	0.28	0.30	1.00

Please see important disclosures at the beginning of this section and at the back of the presentation

SEI Capital Market Assumptions - Equilibrium - June 2024

	Compound Return	Risk	Arithmetic Return
Core Fixed Income	6.54%	6.62%	6.76%
U.S. High Yield	7.82%	12.75%	8.63%
Emerging Markets Debt	8.75%	15.52%	9.95%
US Small Cap Equity	10.15%	23.44%	12.90%
Short Term Corporate Fixed Income	4.90%	4.07%	4.98%
Diversified Short Term Fixed Income	5.52%	5.72%	5.68%
US Low Beta Equities	8.50%	15.20%	9.66%
Global Low Beta Equities	8.83%	14.05%	9.82%
S&P 500 Index	8.00%	19.00%	9.81%
Limited Duration Fixed Income	5.65%	2.62%	5.68%

Inflation: 2.50%

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SEI Capital Market Assumptions - Equilibrium - June 2024

Correlations	Core Fixed Income	U.S. High Yield	Emerging Markets Debt	US Small Cap Equity	Short Term Corporate Fixed Income	Diversified Short Term Fixed Income	US Low Beta Equities	Global Low Beta Equities	S&P 500 Index	Limited Duration Fixed Income
Core Fixed Income	1.00									
U.S. High Yield	0.45	1.00								
Emerging Markets Debt	0.45	0.75	1.00							
US Small Cap Equity	0.15	0.65	0.60	1.00						
Short Term Corporate Fixed Income	0.65	0.60	0.40	0.25	1.00					
Diversified Short Term Fixed Income	0.35	0.80	0.50	0.45	0.89	1.00				
US Low Beta Equities	0.25	0.65	0.65	0.90	0.25	0.45	1.00			
Global Low Beta Equities	0.24	0.61	0.61	0.86	0.22	0.43	0.95	1.00		
S&P 500 Index	0.25	0.65	0.65	0.90	0.25	0.45	1.00	0.95	1.00	
Limited Duration Fixed Income	0.92	0.55	0.45	0.10	0.65	0.45	0.30	0.28	0.30	1.00

Please see important disclosures at the beginning of this section and at the back of the presentation

Important information

This presentation is provided by SEI Investments Management Corporation (SIMC), a registered investment adviser and wholly owned subsidiary of SEI Investments Company. The material included herein is based on the views of SIMC. Statements that are not factual in nature, including opinions, projections and estimates, assume certain economic conditions and industry developments and constitute only current opinions that are subject to change without notice. Nothing herein is intended to be a forecast of future events, or a guarantee of future results. This presentation should not be relied upon by the reader as research or investment advice (unless SIMC has otherwise separately entered into a written agreement for the provision of investment advice).

There are risks involved with investing including loss of principal. There is no assurance that the objectives of any strategy or fund will be achieved or will be successful. No investment strategy, including diversification, can protect against market risk or loss. Current and future portfolio holdings are subject to risk. Past performance does not guarantee future results.

For those SEI funds which employ a "manager of managers" structure, SIMC is responsible for overseeing the sub-advisers and recommending their hiring, termination, and replacement. References to specific securities, if any, are provided solely to illustrate SIMC's investment advisory services and do not constitute an offer or recommendation to buy, sell or hold such securities.

Any presentation of gross mutual fund performance of underlying mutual fund investments or gross account level performance is only intended for one-on-one presentations with clients and may not be duplicated in any form by any means or redistributed without SIMC's prior written consent.

Annual performance is calculated based on monthly return streams, geometrically linked as of the end of the specified month end.

Performance results do not reflect the effect of certain account level advisory fees. The inclusion of such fees would reduce account level performance, particularly when compounded over a period of years. The following hypothetical illustration shows the compound effect fees have on investment return: For an account charged 1% with a stated annual return of 10%, the net total return before taxes would be reduced from 10% to 9%. A ten year investment of $100,000 at 10% would grow to $259,374, and at 9%, to $236,736 before taxes. For a complete description of all fees and expenses, please refer to SIMC's Form ADV Part 2A, the investment management agreement between SIMC and each client, and quarterly client invoices.

Certain economic and market information contained herein has been obtained from published sources prepared by other parties, which in certain cases have not been updated through the date hereof. While such sources are believed to be reliable, neither SEI nor its affiliates assumes any responsibility for the accuracy or completeness of such information and such information has not been independently verified by SEI.

Index returns are for illustrative purposes only and do not represent actual fund performance. Index performance returns do not reflect any management fees, transaction costs, or expenses, which would reduce returns. Indexes are unmanaged and one cannot invest directly in an index. Any presentation of gross mutual fund performance of underlying mutual fund investments or gross account level performance is only intended for one-on-one presentations with clients and may not be duplicated in any form by any means or redistributed without SIMC's prior written consent.

Important information

SIMC develops forward-looking, long-term capital market assumptions for risk, return, and correlations for a variety of global asset classes, interest rates, and inflation. These assumptions are created using a combination of historical analysis, current market environment assessment and by applying our own judgment. In certain cases, alpha and tracking error estimates for a particular asset class are also factored into the assumptions. We believe this approach is less biased than using pure historical data, which is often biased by a particular time period or event.

The asset class assumptions are aggregated into a diversified portfolio, so that each portfolio can then be simulated through time using a monte-carlo simulation approach. This approach enables us to develop scenarios across a wide variety of market environments so that we can educate our clients with regard to the potential impact of market variability over time. Ultimately, the value of these assumptions is not in their accuracy as point estimates, but in their ability to capture relevant relationships and changes in those relationships as a function of economic and market influences.

The projections or other scenarios in this presentation are purely hypothetical and do not represent all possible outcomes. They do not reflect actual investment results and are not guarantees of future results. All opinions and estimates provided herein, including forecast of returns, reflect our judgment on the date of this report and are subject to change without notice. These opinions and analyses involve a number of assumptions which may not prove valid. The performance numbers are not necessarily indicative of the results you would obtain as a client of SIMC.

We believe our approach enables our clients to make more informed decisions related to the selection of their investment strategies.

For more information on how SIMC develops capital market assumptions, please refer to the SEI paper entitled "Executive Summary: Developing Capital Market Assumptions for Asset Allocation Modeling." For more information on how SIMC develops capital market assumptions or the actual assumptions utilized, please contact your SEI representative.

Thank you.

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Memorandum

TO: NDPERS Board

FROM: Katheryne

DATE: June 10, 2025

SUBJECT: Health Insurance Plan Administrative Services Agreement & Exhibits

Staff has been working with Sanford Heath Plan to finalize the various exhibits referenced within the Administrative Services Agreement that was approved at the January 2025 meeting. We are bringing the Exhibit information forward for the Board's review and approval.

Sanford Health Plan has also requested a correction to the Administrative Service Agreement approved at the January 2025 meeting. The edit changes the date refunds will be paid to NDPERS as defined by 7.2 from August 31, 2027, to August 31, 2028. Please see Section 7.2.8 on the updated agreement which is provided as Attachment 1.

Exhibit A: Certificate of Insurance (COI) and Summary of Benefits & Coverage (SBC) Updates

Sanford Health Plan is working on updates to the COI and SBC for each NDPERS health plan. Attachment 2 is provided to reflect the material changes that are included in the updates. Once finalized, the updated documents must be submitted to the Department of Insurance for review and approval. Upon approval, Sanford Heath Plan will be distributing updated versions to the membership. These final versions approved by the Department of Insurance will then be incorporated into the Administrative Services Agreement as Exhibit A.

Exhibit B - Performance Guarantees
Exhibit B (Attachment 3) outlines the Performance Guarantees that are being offered for this biennium.

Exhibit C – Rates
Exhibit C (Attachment 4) provides the final rates that were previously approved by the NDPERS Board at the May Board meeting.

Exhibit D – Settlement
Exhibit D (Attachment 5) illustrates how the settlement is calculated.

Exhibit E – About the Patient Coordination
Exhibit E (Attachment 6) provides the agreement between Sanford Health Plan and NDPERS as it relates to the coordination of services for the About the Patient Diabetes Management Program.

Exhibit G – Wellness Program
Exhibit G (Attachment 7) outlines the coordination of the employer wellness funding program and administration of reimbursement to employers for eligible wellness expenses.

Exhibit H – Business Associate Agreement
Exhibit H (Attachment 8) is the required Business Associate Agreement.

Exhibit I – Health Savings Account (HSA) Administration Agreement
Exhibit I (Attachment 9) relates to the administration of the Health Savings Accounts by Sanford Health Plan for members that enroll in the High Deductible Health Plan.

Exhibit J – Fitness Center & Virtual Wellness Terms
Exhibit J (Attachment 10) outlines fitness center and virtual wellness terms for Medicare Supplement Members.

Board Action Requested:

Approve the Health Insurance Plan Administrative Services Agreement Amendment and Exhibits A, B, C, D, E, G, H, I, and J.

Attachments

Attachment 1

THIRD AMENDMENT AND RESTATEMENT TO THE ADMINISTRATIVE SERVICE AGREEMENT

THIS THIRD AMENDMENT TO ADMINISTRATIVE SERVICE AGREEMENT (the "Amendment"), effective as of July 1, 2025, (the "Amendment Date"), is by and between the State of North Dakota, acting through its Public Employees Retirement System ("the Plan Sponsor"); the North Dakota Public Employees Retirement System (NDPERS) ("the Plan Administrator"); and Sanford Health Plan, a South Dakota non-profit corporation ("SHP").

WHEREAS, the parties entered into an Administrative Services Agreement, with an effective term of July 1, 2021, through June 30, 2023 (the "Agreement"); and

WHEREAS, the parties restated and renewed their Administrative Services Agreement by executing a Second Amendment and Restatement to the Administrative Services Agreement, with an effective term of July 1, 2023 through June 30, 2025; and

WHEREAS, the parties now desire to renew their Administrative Services Agreement by executing this Third Amendment and Restatement to the Administrative Services Agreement, with an effective term of July 1, 2025, through June 30, 2027.

NOW, THEREFORE, the parties agree as follows:

1. The parties have restated the original Agreement along with all amendments previously made to the Agreement.

2. As modified by this Third Amendment and Restatement, the parties agree to the terms and conditions of the Agreement.

3. In the event of any conflict between this Third Amendment and Restatement to the Administrative Services Agreement, and any previous Administrative Service Agreements and Amendments, this Third Amendment and Restatement to the Administrative Services Agreement shall prevail.

TABLE OF CONTENTS

ADMINISTRATIVE SERVICE AGREEMENT

This Administrative Service Agreement ("Agreement") is entered into between the State of North Dakota, acting through its Public Employees Retirement System ("the Plan Sponsor"); the North Dakota Public Employees Retirement System (NDPERS) ("the Plan Administrator"); and Sanford Health Plan, a South Dakota non-profit corporation ("SHP").

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

WHEREAS, in consideration of payment of required premium and acceptance of membership applications, SHP enters into this Agreement with the Plan Sponsor and the Plan Administrator. SHP agrees to provide plan Members the benefits set forth in the Certificate of Insurance, in accordance with its terms and conditions.

WHEREAS, the Plan Administrator is the sole party with authority to make plan design changes to the Plan.

WHEREAS, SHP is an affiliate of Sanford, a North Dakota non-profit organization and integrated delivery system; however, SHP and Sanford maintain a firewall such that (i) SHP maintains a team that negotiates participating provider agreements with hospitals, physicians and other providers, (ii) Sanford provider entities maintain a team that negotiates agreements with third party payers, and (iii) fee schedules, discounts, pricing and other competitively sensitive data are not shared between those teams.

The terms of this Agreement are as follows:

1. EFFECTIVE DATE AND PLAN YEAR

This Agreement is effective July 1, 2025, through June 30, 2027, unless terminated as provided.

For the purposes of the costs of any and all benefits and services extended through this Benefit Plan, including the implementation of any benefit changes required under federal or state law, the Plan Administrator agrees that the Plan Year shall commence on July 1, unless it is terminated by one of the parties as specified in Section 8. TERM AND TERMINATION OF AGREEMENT.

2. DEFINITIONS

This section defines the terms used in this Agreement.

A. CERTIFICATE OF CREDITABLE COVERAGE - a certificate disclosing information relating to an individual's creditable coverage under a health care benefit program for purposes of reducing any preexisting condition waiting period imposed by any group health plan coverage.

B. CLAIM - notification in a form acceptable to SHP that service has been provided or furnished to a Member.

C. DRG - shall mean diagnostic related groups.

D. DATA AGGREGATION - the combining of Protected Health Information that SHP creates or receives for or from the Plan for or from other health plans or health care providers for which SHP is acting as a business associate to permit data analysis that relate to Health Care Operations of the Plan and those other health plans or providers.

E. FEES AND CHARGES - the amounts the Plan Administrator must pay SHP for the administrative services described in Section 6.

F. HEALTH CARE OPERATIONS - any of the activities of a health plan to the extent the activities relate to functions that make it a health plan.

G. HEALTH CARE PROVIDER- any eligible provider that has provided care, diagnosis, or treatment to or for a Member for which benefits are sought under the Plan.

H. HEALTH CLUB/WELLNESS CREDIT PROGRAM - means a member-based fitness center reimbursement and wellness (points) reward program.

I. HSA PROGRAM - means the Health Savings Account Program administered by SHP through a subcontractor pursuant to the terms and conditions of a separate agreement between SHP and NDPERS and acknowledged by said subcontractor.

J. MEMBER - the Subscriber and any eligible dependent of a Subscriber who is enrolled in the Plan. The term also includes eligible employees of other governmental units as permitted by state law.

K. PARTICIPATING PROVIDER- A healthcare provider who, under a contract with SHP, or with its contractor or subcontractor, has agreed to provide health care services to Members with an expectation of

receiving payment, other than coinsurance, copays, or deductibles, directly or indirectly, from the Plan.

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

M. PHARMACY BENEFITS MANAGER (PBM)- shall mean OptumRx, Inc., or such other pharmacy benefits manager as is engaged by SHP after prior consultation with NDPERS. Said PBM is responsible for maintaining the network of participating pharmacies.

N. PHARMACY DISEASE MANAGEMENT PROGRAM - shall mean the diabetes disease management program through which Members receive services and support provided by the North Dakota Pharmacy Service Corporation, which program is jointly administered by NDPERS and SHP hereunder.

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

P. PLAN SPONSOR -The State of North Dakota, acting through its Public Employees Retirement System (NDPERS) is the Plan Sponsor of an employee benefit plan established under NDCC Ch. 54-52.1.

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

    a. is created by or received from a Health Care Provider, health care employer, or health care clearinghouse;

    b. relates to a Member's past, present or future physical or mental health or condition;

c. relates to the provision of health care to a Member;

d. relates to the past, present, or future payment for health care to or on behalf of a Member; or

e. identifies a Member or could reasonably be used to identify a Member.

f. educational records and employment records are not considered PHI under federal law.

R. SANFORD HEALTH PLAN (SHP) - is a health maintenance organization that provides fully-insured, prepaid group health care and pharmacy benefits through an organized health care delivery system.

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

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

U. SUBSCRIBER- any eligible employee of the Plan Sponsor, employee of a participating employer or other eligible individual as prescribed by NDCC CH. 54-52.1 whose application for membership has been accepted, whose coverage is in force with SHP and in whose name the ID Card is issued.

V. SUCCESSFUL SECURITY INCIDENTS - Security Incidents that result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

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

X. WELLNESS BENEFIT PROGRAM - shall mean the NDPERS employer- based Wellness Benefit Program related to health and wellness promotion for Members under which funding is made available to State agencies or political subdivisions, as jointly administered by NDPERS and SHP hereunder.

3.12 Provide assistance to NDPERS for the conduct of enrollment, servicing and education.

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

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

3.14 Provide NDPERS with reporting to include but not limited to:

a. Annual group reporting of membership and utilization by group segments and product.

b. Estimates of future claim reserves and premium to claim ratio.

c. Such other special claims reports as requested from time-to- time by NDPERS, subject to the availability of data and appropriate cost considerations.

d. Interest calculation monthly report, including supporting documentation as reasonably requested.

e. Performance objectives as described in Exhibit B of this Agreement.

3.15 Provide NDPERS with claims specific data on a monthly basis in agreed upon medium. This information shall be in a format acceptable to NDPERS and subject to all federal and state laws on confidentiality and open records; and provide at least monthly to any NDPERS designated third party administrator of a pretax benefits program, for purposes of claim reimbursement for any member pretax medical spending account, an electronic claims data file as reasonably requested, such file to include at least the following: member eligibility and demographic information, provider/pharmacy demographic information (i.e. NPI), applicable member liability (i.e. copay, deductible, and coinsurance), and prescription NOC number.

3.16 Provide support to NDPERS for the establishment of a

Preferred Provider Network consistent with objectives established by NDPERS. SHP shall determine Participating Provider eligibility in accordance with its policies and accreditation standards.

SHP will provide technical and administrative advice to NDPERS relative to the appropriateness of PPO arrangements for the Plan. SHP shall pursue in good faith participating provider agreements with those providers who were historically in the NDPERS PPO but are not currently SHP Participating Providers. The parties agree that participation and reimbursement information

a. may contain trade secret, proprietary, commercial, and financial information under ND Cent. Code 44-04-18.4 or any other applicable law. To the extent that NDPERS determines that such information is confidential under applicable state law, NDPERS shall maintain the confidentiality of the same.

   Further, NDPERS shall notify SHP of any request for release of information and, upon NDPERS' determination to release, shall allow SHP a reasonable opportunity to respond prior to disclosure, upon request. The duty of NDPERS to maintain the confidentiality of information under this section continues beyond the term of this Agreement as is commercially reasonable.

b. SHP will enforce strict Prospective Review/Prior Authorization, utilization review and quality assurance criteria to assure attainment of Preferred Provider program objectives.

c. SHP will, upon NDPERS reasonable direction, terminate a Provider's NDPERS PPO participation agreement in accordance with terms of the agreement, when a PPO Provider is noncompliant with NDPERS/SHP policies and procedures. Said policies and procedures shall be documented and communicated to the Participating Provider prior to implementation.

3.17 Neither SHP nor its contracted PBM will engage in any practice that effectively reduces network pharmacy reimbursement for medication cost and dispensing fees when such reimbursement claims have been properly

submitted by a network pharmacy at the time of adjudication. Such practices include directing a contractor, such as a PSAO, to engage in such a practice. SHP will include language in its PBM (and PSAO, if applicable) contracts explicitly prohibiting the aforementioned practices

3.18 Jointly administer the Pharmacy Disease Management Program, and Wellness Benefit Program substantially in accordance with Exhibit E, and Exhibit G, respectively.

3.19 Reasonably respond to requests for service meetings from NDPERS administration or its Board upon request.

3.20 SHP shall maintain a risk-based capital level of 300%.

4. NDPERS SHALL:

4.1 Prepare and distribute monthly billings to participating employers and retirees participating in the Plan. NDPERS shall respond to the participating employer's inquiries concerning eligibility rules, billing, etc.

4.2 Prepare weekly eligibility file by participating employer and premium classification for both active and retired employees and provide the file to SHP to be used for eligibility certification purposes. Along with the eligibility file, NDPERS will furnish a full- file listing of participants (incorporating additions or terminations during the month). Such listing will reflect the name of the employee, dependents, Social Security Number, the effective date of coverage for a new employee or the termination date of a terminated employee and the coverage classification. NDPERS will submit enrollment, billing and premium remittance via a centralized electronic system. NDPERS will provide enrollment/eligibility information on a data file that follows the HIPAA 834 file specifications and SHP's companion guide. Premium payment information will be provided on a data file that follows the HIPAA 820 file specifications. Files will be transmitted using a mutually agreed upon secure file transmission process

4.3 Use best efforts to notify SHP of terminated members no later than 30 days after the event that rendered the Member ineligible for coverage. Regardless of whether or not NDPERS provides notice to SHP of the terminated

Member, SHP intends to recoup payments for all paid claims from applicable providers incurred after the last date of eligibility. It then becomes the duty and discretion of said providers to bill the Member accordingly. Similarly, SHP intends to recoup from terminated Members prescription claims paid after the last date of eligibility.

4.4 Provide enrollment files, obtain completed classifications or addresses, etc. from participants and furnish SHP with enrollment files or request for coverage or address changes and retain the original copy.

4.5 Be responsible for the administration of and compliance with COBRA or State-mandated continuation of coverage. SHP will forward requests for COBRA or State law continuation of coverage participation by membership to NDPERS upon notification.

4.6 Comply with SHP's established administrative policies which are reasonable and consistent with the NDPERS Health Plan, and the bid specifications agreed to by the parties, including, but not limited to: enrollment and eligibility policies, standard adjudication and Medical Policy Guidelines, Payable Provider Guidelines, Prospective Review/Prior Authorization Guidelines and claim payment procedures as such materials are modified from time to time.

4.7 Pay premiums to SHP according to the schedule in Section 6.

4.8 NDPERS acknowledges that the administration of the Benefit Plan that is the subject of this Agreement may be subject to regulation under federal and/or state law. NDPERS agrees to furnish SHP with any and all information necessary to comply with any applicable federal and/or state laws and to certify that this information is accurate. If there are any changes in the employer contribution rate for benefits and services available under this Agreement, NDPERS agrees that it is its obligation to provide information related to the change in contribution rates immediately to SHP.

4.9 NDPERS agrees to timely provide the information as specified in Section 3.1.

4.10 Perform those functions or duties regarding the Pharmacy Disease Management Program, and Wellness

Benefit Program substantially in accordance with Exhibit E, and Exhibit G, respectively.

4.11 NDPERS will provide electronic 834 compliant files from the Plan Administrator to maintain accurate membership records of Members.

5. PRIVACY USE AND DISCLOSURE RESPONSIBILITIES

5.1 RESPONSIBILITIES OF SHP

A. Privacy of Protected Health Information (PHI)

1. SHP will keep confidential all Claim records and all other PHI that SHP creates or receives in the performance of its duties under this Agreement. Except as permitted or required by this Agreement for SHP to perform its duties under this Agreement, SHP will not use or disclose such Claim information or other PHI without the authorization of the Member who is the subject of such information or as required by law.

2. SHP will neither use nor disclose Members' PHI (including any Members' PHI received from a business associate of the Plan) except (1) as permitted or required by this Agreement, (2) as permitted in writing by the Plan Administrator, (3) as authorized by Members, (4) in accordance with the Business Associate Agreement **("BAA")** between the parties materially in form and substance provided in Exhibit H hereto, or (5) as required by law.

3. SHP will be permitted to use or disclose Members' PHI only as follows:

   a. SHP will be permitted to use and disclose Members' PHI (a) for the management, operation and administration of the Plan the Plan Administrator offers Members, and (b) for the services set forth in the Plan, which include Payment Activities, Health Care Operations, and Data Aggregation as these terms are defined under federal law.

1. SHP will be permitted to use Members' PHI as necessary for SHP's proper management and administration or to carry out SHP's legal responsibilities.

2. SHP will be permitted to disclose Members' PHI as necessary for SHP's proper management and administration or to carry out SHP's legal responsibilities only if (i) the disclosure is required by law, or (ii) before the disclosure, SHP obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by a written contract, that the entity will hold Members' PHI in confidence, use or further disclose Members' PHI only for the purposes for which SHP disclosed it to the entity or as required by law, and notify SHP of any instance the entity becomes aware of where the confidentiality of any Members' PHI was breached as required by 45 CFR 164.410.

b. SHP will make reasonable efforts in accordance with its written privacy policies and procedures to use, disclose, or request only the minimum necessary amount of Members' PHI to accomplish the intended purpose. SHP will make its written privacy policies and procedures available to the Plan Sponsor.

4. Other than disclosures permitted by Section 5.1(A)3, SHP will not disclose Members' PHI to the Plan Administrator or to the Plan's business associate except as directed by the Plan Administrator in writing and as permitted by applicable law.

5. SHP will require each subcontractor and agent to which SHP is permitted by this Agreement or in writing by the Plan Administrator to disclose Members' PHI to provide reasonable assurance, evidenced by written contract, that such other entity will comply with the same privacy and security obligations with respect to Members' PHI as this Agreement applies to SHP.

6. SHP will report to the Plan Administrator any use or

disclosure of Members' PHI not permitted by this Agreement, including incidents that constitute breaches of unsecured PHI as required by 45 CFR 164.410. SHP will make any such report to the Plan Administrator after SHP learns of such nonpermitted use or disclosure.

7. SHP will report to the Plan Administrator attempted or successful unauthorized access, use, disclosure, modification or destruction of a Member's electronic PHI or interference with SHP's system operations in SHP's information systems ("Security Incident"), of which SHP becomes aware.

   With regard to attempted unauthorized access, use, etc., SHP and the Plan Administrator recognize and agree that the significant number of meaningless attempts to, without authorization, access, use, disclose, modify or destroy electronic PHI will make real-time reporting formidable. Therefore, SHP and the Plan Administrator agree to the following reporting procedures for Security Incidents that result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

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

   1. Pings on SHP's firewall,

   2. Port scans,

3. Attempts to log on to a system or enter a database with an invalid password or username,

4. Denial-of-service attacks that do not result in a server being taken off-line, and

5. Malware (e.g., worms, viruses).

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

8. Disposition of Protected Health Information

The parties agree that upon termination, cancellation, expiration or other conclusion of this Agreement, SHP will return or destroy all PHI received or created by SHP on the Plan Administrator's behalf as soon as feasible. Due to various regulatory and legal requirements, the Plan Administrator acknowledges that immediate return or destruction of all such information is not feasible.

SHP agrees that upon conclusion of this Agreement for any reason, it will use or disclose the PHI it received or created on the Plan's behalf only as necessary to meet SHP's regulatory and legal requirements and for no other purposes unless permitted in writing by the Plan Administrator. SHP will destroy PHI received or created by SHP on the Plan Administrator's behalf that is in SHP's possession under such circumstances and upon such schedule as SHP deems consistent with its regulatory and other legal obligations.

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

9. To the extent SHP is to carry out one or more of Plan Administrator's obligations under the HIPAA Privacy Regulations, it shall comply with the

requirements of the Privacy Regulations that apply to the Plan Administrator in the performance of such obligations.

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

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

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

3. The Plan Administrator may meet its disclosure accounting obligations under federal law or state law, SHP will do the following:

   a. SHP will record each disclosure of Members' PHI which is not excepted from disclosure accounting under Section 5.1(8) 3.b, that SHP makes to the Plan Administrator or to a third party.

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

      For repetitive disclosures of Members' PHI that

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

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

(1) for Payment Activities or Health Care Operations,

(2) to the Member who is the subject of the PHI or to that Members' personal representative,

(3) to persons involved in that Members' health care or payment for health care, as provided under federal law,

(4) for notification for disaster relief purposes or national security or intelligence purposes as provided under federal law,

(5) to law enforcement officials or correctional institutions regarding inmates,

(6) for incidental uses or disclosures,

(7) as part of a limited data set in accordance with federal law,

(8) that occurred prior to the HIPM Privacy Compliance Date,

(9) pursuant to a valid authorization, or

(10) as may be required by law.

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

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

C. Information Safeguards

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

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

D. Inspection of Books and Records

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

E. Plan Disclosures

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

F. Information Privacy and Safeguard Provisions Survive Termination of Agreement. These responsibilities agreed to by SHP and related to protecting the privacy of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and where applicable, shall govern SHP's receipt, use and disclosure of PHI obtained pursuant to the terms of this Agreement.

5.2 RESPONSIBILITIES OF THE PLAN SPONSOR

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

B. Except with respect to services provided by SHP set forth in this agreement, the Plan Sponsor will have the sole responsibility for and will bear the entire cost of compliance with all federal, state and local laws, rules, and regulations concerning the privacy of PHI, including any licensing, filing, reporting, and disclosure requirements, which may apply to the Plan.

SHP will have no responsibility for the Plan's compliance or noncompliance with any applicable federal, state, or local law, rule, or regulation that the Plan Sponsor is responsible for under this subsection.

By executing this Agreement, the Plan Sponsor certifies to SHP that it has amended the Plan documents to incorporate the provisions required by and under federal law and agrees to comply with the Plan Administrator's plan documents as amended. SHP may rely on Plan Sponsor's certification and Plan Administrator's written authorization and will have no obligation to verify (1) the Plan Administrator's plan documents have been amended to comply with the requirements of federal law or this Agreement or (2) the Plan Sponsor is complying with the Plan Administrator's plan document as amended.

C. For any high deductible health plan offered by the Plan Sponsor, the Plan Sponsor assumes sole responsibility for determining whether the Plan qualifies as a high deductible health plan under Section 223(c)(2) of the

U.S. Internal Revenue Code. SHP MAKES NO WARRANTY, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE REGARDING THE **PLAN.**

For any high deductible health plan offered by the Plan Sponsor, SHP does not provide legal or tax advice, and expressly disclaims responsibility for determining, on behalf of any individual or group, the legal and tax implications of: (1) establishing a health savings account; (2) eligibility for a health savings account; (3) the contributions made to a health savings account; (4) the deductibility of contributions to a health savings account; and (5) withdrawals from a health savings account and related taxation.

6. **FEES AND CHARGES:**

6.1 SHP agrees to the provisions and premium rates, for the Effective Date of this Agreement, in the attached Premium Rate Structure Table (Exhibit C).

6.2 SHP and NDPERS agree to the Health Plan Performance Guarantees, as outlined in the attached Exhibit B.

6.3 NDPERS will use best efforts to pay SHP, on or before the twentieth day of each month (but not later than the last day of the month), for the current month's premium income based on the amount identified in Exhibit C.

NDPERS will also maintain funds in a Programs Cash Reserve Account held by SHP for purposes of funding the Pharmacy Disease Management Program, the Wellness Benefit Program and any other programs funded outside of premium. NDPERS will maintain a balance reasonably estimated to anticipate experience of such programs. This Programs Cash Reserve Account shall earn interest at a rate to be determined monthly, based on US Treasury Notes quoted by the Wall Street Journal. The monthly rate will be established at the close of the first trading day each month based on the closing yield to maturity of US Treasury Notes maturing 24 months hence. If there are multiple notes for that maturity, the rate will be based on an average. If there are no notes with that maturity, the next subsequent maturity will be used.

6.4 SHP will retain any surplus funds from the amounts

identified as such in a schedule to the Premium Rate Table attached as Exhibit C. Surplus funds retained by SHP shall earn interest at a rate to be determined monthly, based on US Treasury Notes quoted by the Wall Street Journal. The monthly rate will be established at the close of the first trading day each month based on the closing yield to maturity of US Treasury Notes maturing 24 months hence. If there are multiple notes for that maturity, the rate will be based on an average. If there are no notes with that maturity, the next subsequent maturity will be used.

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

6.5 In the event any Federal or State authority imposes any changes to plan design, plan benefits or other mandate affecting the Plan, SHP and NDPERS shall reasonably cooperate to anticipate material increased expenses or other material effects and negotiate in good faith to incorporate consequent premium rate or other contractual changes.

In the event the parties are unable to reach agreement, either party may terminate this Agreement pursuant to Section 8.2(b) hereof. SHP reserves the right to adjust premium rates, with a 90-day notice, for any such changes in taxes and/or benefits imposed upon SHP for the NDPERS health plan. SHP further reserves the right to adjust premium rates for any health plan design, plan benefit changes or other mandates imposed by the STATE or Federal legislative action or NDPERS Board mandate when such changes become effective.

7. FINAL ACCOUNTING

7.1 A continual accounting of NDPERS Health Plan experience will take place during the 2025-2027 biennium. Monthly reports of earned income less incurred claims and retention will be produced during the biennium and the twenty-four months following the biennium.

7.2 Within 31 days of 12 months after the end of the biennium (by July 31, 2028 SHP will provide an accounting which will result in an initial settlement of the biennium agreement as follows:

1. Earned Premium Income (net of the NDPERS $2.80 PCPM retention fee) during the Biennium.

2. Plus, interest on Surplus Funds.

3. Less Claims Incurred during the Biennium and paid July 1, 2025 - June 30, 2027. These include:

    - Claims paid directly through SHP's claims system
    - Any capitated payments for medical services
    - Payments/receivables to/from providers for value-based contracts
    - Direct fee for service payments outside SHP's claims system

4. Less Estimated Claims Incurred and unpaid on June 30, 2028, as calculated using standard actuarial completion factors.

5. Less non-claims system claims cost reduction expense. This includes:

    - Network access fees: Whereby SHP accesses deeper discounts than a direct contract thereby lowering total claims costs.
    - Subrogation fees: Whereby SHP reimburses a portion of the claim recouped by our subrogation partner.
    - Claims payment integrity reviews: Whereby incentive based contracts lower total claims cost with a percentage of the savings paid to our contracted partner.

6. Less Administrative Expense during the Biennium ($99.04 per PPO contract per month and $20.57 per Medicare contract per month). This fee is inclusive of the Wellness program expenses and service charges for reinsurance that had been itemized in prior biennium.

7. If 1+2-3-4-5-6 of 7.2 is positive, the refund will be paid to NDPERS.

8. Within 62 days of 12 months after the end of the biennium (by August 31, 2028) refunds will be paid to NDPERS as defined by 7.2.

9. All amounts, other than #4, the Estimated Claims

Incurred and unpaid, will be included in the interest calculation referenced in #2.

10. All amounts in #3 & #5 will be based on date of service, where applicable, instead of date invoiced or paid.

7.3 Within 31 days of 24 months after the end of the biennium (by July 31, 2029) SHP will provide an accounting which will result in a final settlement of the biennium agreement as follows:

1. Earned Premium Income (net of the NDPERS $2.80 PCPM retention fee) during the Biennium.

2. Plus, interest on Surplus Funds.

3. Less Claims Incurred during the Biennium and paid July 1, 2025 - June 30, 2027. These include:

    - Claims paid directly through SHP's claims system
    - Any capitated payments for medical services
    - Payments/receivables to/from providers for value- based contracts
    - Direct fee for service payments outside SHP's claims system

4. Less Estimated Claims Incurred and unpaid on June 30, 2029, as calculated using standard actuarial completion factors.

5. Less non-claims system claims cost reduction expense. This includes:

    - Network access fees: Whereby SHP accesses deeper discounts than a direct contract thereby lower lowering total claims costs.
    - Subrogation fees: Whereby SHP reimburses a portion of the claim recouped by our subrogation partner.
    - Claims payment integrity reviews: Whereby incentive based contracts lower total claims cost with a percentage of the savings paid to our contracted partner.

6. Less Administrative Expense during the Biennium ($99.04 per PPO contract per month and $20.57 per Medicare contract per month). This fee is inclusive of

the Wellness program expenses and service charges for reinsurance that had been itemized in prior biennium.

7. If 1+2-3-4-5-6 of 7.3 is positive, the refund will be paid to NDPERS.

8. Within 62 days of 24 months after the end of the biennium (by August 31, 2027), the final settlement will be paid to NDPERS as defined by 7.2 and 7.3. Sample illustrations of Sections 7.2 and 7.3 are attached as Exhibit D.

9. All amounts, other than #4, the Estimated Claims Incurred and unpaid, will be included in the interest calculation referenced in #2.

10. All amounts in #3 & #5 will be based on date of service, where applicable, instead of date invoiced or paid.

8. TERM AND TERMINATION OF AGREEMENT

8.1 The term of this Agreement shall be for a two-year period from July 1, 2025, to June 30, 2027.

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

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

a. If funding from federal, state, or other sources is not obtained and continued at levels sufficient to allow for purchase of the services or supplies in the indicated quantities or term. The Agreement may be modified by agreement of the parties in writing to accommodate a reduction of funds.

b. If federal or state laws, rules, or regulations are modified, changed, or interpreted in such a way that the services are no longer allowable or appropriate for purchase under this Agreement or are no longer eligible for the funding proposed for payments authorized by this Agreement.

c. If any license, permit or certificate required by law, rule or regulation, or by the terms of this Agreement, is for any reason denied, revoked, suspended or not renewed.

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

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

9. PROVIDER NETWORK DISCOUNT PROGRAMS

SHP has a variety of relationships with regional and national PPO discount Programs. Whenever a Member accesses health care services outside of the geographic area SHP serves, the claim for those services may be processed through one of these discount Programs and presented to SHP for payment in accordance with the rules of the discount program policies then in effect. The discount programs available to Members under this Agreement are described generally below.

Typically, when accessing care outside the SHP service area, a Member will obtain care from health care providers that have a contractual agreement (i.e., "participating agreement") with the discount program. In some instances, a Member may obtain care from health care providers who have not entered into a "participating agreement" with SHP directly. SHP payment practices in both instances are described below.

A. Regional and National Network Discount Program

When Members access health care services outside the geographic area served by SHP, SHP will adjudicate claims with the health care providers who have entered a "participating agreement" with any one of SHP's discount network programs (participating health care providers). The financial terms of the Regional or National Network Discount Program are described below. Individual circumstances may arise that are not directly

covered by this description; however, in those instances, SHP's action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim - The calculation of Member liability on claims for Covered Services processed through the Regional or National Network Discount Program will be based on the negotiated price made available to SHP by the Regional or National Network Discount program.

The Regional or National Network discount program may use various methods to determine a negotiated price, depending on the terms of each health care provider contracts. The negotiated price made available to SHP represents a payment negotiated by a Regional or National Network discount program with a health care provider.

The difference between the applicable contract rate and the participating provider's billed charges is the discount amount. The amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, SHP would then calculate the Member's liability in accordance with applicable law.

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

B. Nonparticipating Providers Outside the SHP Service Area

When Covered Services are provided outside of SHP's service area by health care providers who have not entered into a "participating agreement" with SHP or SHP- contracted Regional or National Network Discount Programs (nonparticipating health care providers), the amount the Member pays for such services will be based on SHP's maximum allowed amount, which is the lesser of (a) the

amount charged for a covered service or supply, or (b) reasonable costs as established by SHP or its Regional or National Network Discount Programs. Members are responsible for any difference between the amount charged and SHP's payment for covered services unless the services fall under the No Surprises Act which became effective January 1, 2022. The No Surprises Act prohibits providers from billing the patient the difference between SHP's payment for Covered Services and the provider's share if the services relate to a medical emergency, air ambulance, or services rendered by a nonparticipating provider practicing at a participating facility.

In certain situations, SHP may pay claims based on the payment SHP would make if the Covered Services had been obtained within the SHP service area by a Participating Provider. Such situations include where a Member did not have reasonable access to a participating health care provider, as determined by SHP in its sole and absolute discretion or by applicable state law. SHP may also in its sole and absolute discretion, negotiate a payment with such a health care provider on an exception basis. In any of these situations, the Member may be responsible for the difference between the amount that the nonparticipating health care provider bills and payment SHP will make for the Covered Services as set forth in this paragraph.

10. **REBATE PAYMENTS**

Sanford Health Plan agrees that all rebates collected as a result of medication utilization is applied in two ways, both to reduce the cost of the agreement with NDPERS. First, the claim experience is reduced by the use of the savings caused by rebates, resulting in a premium reduction.

Second, rebate savings are used to reduce the member cost share paid by the member at the point of sale for all generic medications in the formulary.

11. GENERAL PROVISIONS

11.1 SHP is an independent entity under this Agreement and is not a State employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. SHP retains sole and absolute discretion in the manner and means of carrying out SHP'S activities and responsibilities under This Agreement, except to the extent specified in this Agreement.

11.2 This Agreement, including the following documents, constitutes the entire agreement between the parties. There are no understandings, agreements, or representations, oral or written, not specified within this Agreement. This Agreement may not be modified, supplemented or amended, in any manner, except by written agreement signed by both parties.

Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Agreement, the documents must control in this order of precedence:

a. The terms of this Agreement as may be amended;

b. State's Request for Proposal fully Insured Group Medical and Prescription; and

c. SHP's Formal Health Insurance Proposal for 2021- 2023 and all amendments thereto.

11.3 This Agreement shall be governed by and construed according to the laws of the State of North Dakota. Any action to enforce this Agreement must be adjudicated exclusively in the State District Court of Burleigh County, North Dakota.

11.4 Failure of either party at any time to require performance by the other party of any provision of this Agreement shall not be deemed to be a continuing waiver of that provision or a waiver of any other provision of this Agreement.

11.5 No assignment of this Agreement in whole or in part may be made by either party without written agreement approved by both parties. SHP may not assign or otherwise

transfer or delegate any right or duty hereunder without NDPERS express written consent, or as otherwise set forth in this Agreement.

However, SHP may enter into subcontracts for the provision of services under this Agreement provided that any subcontract acknowledges the binding nature of this Agreement and incorporates this Agreement, including any attachments. SHP is solely responsible for the performance of any subcontractor. Notwithstanding the foregoing, NDPERS acknowledges and agrees that SHP is a party to existing subcontracts with the PBM and other entities and may be bound by, or subject to, exclusivity or other limiting provisions under such existing subcontracts. SHP does not have authority to contract for or incur obligations on behalf of the Plan Sponsor or Plan Administrator.

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

North Dakota Public Employees Retirement
System PO Box 1657
Bismarck, North Dakota 58502

Sanford Health Plan
4800 W 57th St
Sioux Falls, South Dakota
57108

11.7 Neither Party shall be held responsible for delay or default caused by fire, riot, terrorism, pandemic (excluding COVID-19), acts of God, or war if the event was not foreseeable through the exercise of reasonable diligence by the affected Party, the event is beyond the Party's reasonable control, and the affected Party gives notice to the other Party promptly upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default. If SHP is the affected Party and does not resume performance within fifteen (15) days or another period agreed between the Parties, then NDPERS may seek all available remedies, up to and including termination of this Contract pursuant to its Termination Section, and NDPERS shall be entitled to a pro-rata refund of any amounts paid for which the full value has not been realized, including amounts paid toward software subscriptions, maintenance, or licenses.

11.8 Scope of Services: SHP agrees, represents, and warrants, to provide the services as specified in this agreement, State's Request for Proposal Fully Insured Group Medical and Prescription, SHP's Formal Health Insurance Proposal for 2021- 2023 and all amendments thereto; additionally, the parties agree to be bound by the terms contained in the following exhibits (incorporated by reference):

[The parties agree to negotiate in good faith to finalize the applicable exhibits and will execute an amendment to add a reference such exhibits here once they are finalized.]

11.9 SHP will prepare Summaries of Benefits and Coverage for distribution to applicants and Members by NDPERS so that SHP, the Plan and NDPERS may all satisfy related disclosure obligations under federal law. It shall be the sole responsibility of NDPERS to distribute the Summaries of Benefits and Coverage in accordance with federal law, and the Plan Administrator acknowledges and agrees that SHP will rely upon NDPERS for compliance with the requirements for distribution of the Summaries of Benefits and Coverage to applicants and Members.

11.10 When coverage under this Agreement is terminated, SHP will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the Subscriber to the extent the certificate is required under state and/or federal law. Upon notification by the Subscriber of the ineligibility of a dependent, a Certificate of Creditable Coverage will be issued to the affected Member within a reasonable period of time. Certificates of Creditable Coverage may also be obtained from SHP upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through SHP.

11.11 SEVERABILITY: If any term in this Agreement is declared by a court having jurisdiction to be illegal or unenforceable, the validity of the remaining terms must not be affected, and, if possible, the rights and obligations of the parties are to be construed and enforced as if the Agreement did not contain that term.

11.12 ALTERNATIVE DISPUTE RESOLUTION - JURY TRIAL: Neither Plan Sponsor nor Plan Administrator agree to

binding arbitration, mediation, or any other form of mandatory Alternative Dispute Resolution. The parties may enforce the rights and remedies in judicial proceedings. Neither Plan Sponsor nor Plan Administrator waive any right to a jury trial.

11.13 PAYMENT OF TAXES BY PLAN SPONSOR and ADMINISTRATOR: Neither Plan Sponsor nor Plan Administrator will pay local, state, or federal taxes. State sales tax exemption number is E-2001, and certificates will be furnished upon request by the Plan Administrator.

11.14 Upon the effective date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan Sponsor, the Plan Administrator and SHP remain in compliance with such regulations, unless SHP elects to terminate this Agreement by providing the Plan Sponsor and the Plan Administrator notice of termination in accordance with this Agreement at least thirty-one (31) days before the effective date of such final regulation or amendment to final regulations.

11.15 The parties agree that all participation by Members in programs administered by NDPERS is confidential under North Dakota law. SHP may request and NDPERS shall provide directly to SHP upon such request, confidential information necessary for SHP to provide the services described herein. SHP shall keep confidential all NDPERS information obtained in the course of delivering services in accordance with law and the BAA and shall not use any PHI or other Member information for any marketing purposes without express consent. Failure of SHP to maintain the confidentiality of such information may be considered a material breach of the contract and may constitute the basis for additional civil and criminal penalties under North Dakota law.

SHP shall not disclose any individual employee or dependent information unless otherwise permitted by the terms of this Agreement or the BAA without the prior written consent of the employee or family member. SHP has exclusive control over the direction and guidance of the persons rendering services under this Agreement.

Upon termination of this Agreement, for any reason, SHP shall return or destroy all confidential information received from NDPERS or created or received by SHP on behalf of NDPERS except as provided in the BAA. This provision applies to confidential information that may be in the possession of subcontractors or agents of SHP.

SHP shall retain no copies of the confidential information except as provided in the BAA. In the event that SHP asserts that returning or destroying the confidential information is not feasible, SHP shall provide to NDPERS notification of the conditions that make return or destruction infeasible.

Upon explicit written agreement of NDPERS that return, or destruction of confidential information is not feasible, SHP shall extend the protections of this Agreement to that confidential information and limit further uses and disclosures of any such confidential information to those purposes that make the return or destruction infeasible, for so long as SHP maintains the confidential information.

SHP understands that, except for disclosures prohibited in this Agreement, NDPERS must disclose to the public upon request any records it receives from SHP unless such disclosure is not permitted by law. SHP further understands that any records that are obtained or generated by SHP under this Agreement, except for records that are confidential under this Agreement, may, under certain circumstances, be open to the public upon request under the North Dakota open records law. SHP agrees to contact NDPERS immediately upon receiving a request for information under the open records law and to comply with NDPERS's instructions on how to respond to the request.

The parties acknowledge and agree that the provisions of N.D.C.C. § 54-52.1-12 apply with respect to Member information. In compliance with Law, SHP shall not discriminate on the basis of age, gender, gender identity, sex, color, race, national origin, disability, marital status, sexual preference, religious affiliation, public assistance status, a person's status as a victim of domestic violence or whether an advance directive has been executed. SHP shall not, with respect to any person and based upon any health factor or the results of genetic screening or test (a) refuse to issue or renew a Certificate of Insurance, (b) terminate coverage, (c) limit benefits, or (d) charge a

different Premium.

11.16 SHP agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes and unemployment compensation and workers' compensation premiums. SHP shall have and keep current at all times during the term of this Agreement all licenses and permits required by law.

11.17 All records, regardless of physical form, and the accounting practices and procedures of SHP relevant to this Agreement are subject to examination by the North Dakota State Auditor, the Auditor's designee, or Federal auditors. SHP shall maintain all of these records for at least three (3) years following completion of this Agreement and be able to provide them at any reasonable time. Plan Sponsor, State Auditor, or Auditor's designee shall provide reasonable notice to SHP prior to conducting examination.

11.18 INDEPENDENT ENTITY: SHP is an independent entity under this Agreement and is not a State employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. SHP retains sole and absolute discretion in the manner and means of carrying out SHP's activities and responsibilities under this Agreement, except to the extent specified in this Agreement.

11.19 SHP agrees to comply with all applicable federal state laws, rules, and policies, including those relating to nondiscrimination, accessibility, and civil rights (See N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women).

SHP agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.

SHP shall have and keep current all licenses and permits required by law during the Term of this Contract.

SHP is prohibited from boycotting Israel for the duration of this Agreement. (See N.D.C.C § 54-44.4-15.) SHP represents that it does not and will not engage in a boycotting Israel during the term of this Agreement. If NDPERS receives evidence that

SHP boycotts Israel, NDPERS shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if SHP has fewer than ten (10) full-time employees.

SHP's failure to comply with this section may be deemed a material breach by SHP entitling NDPERS to terminate in accordance with the Termination for Cause section of this Agreement.

12 DISPUTES AND INDEMNIFICATION

12.1 If litigation is filed regarding denial of benefits or otherwise, and SHP is named as the sole defendant, SHP will have the right to manage and have full control of litigation and to determine whether to pay, compromise, litigate or appeal litigation. If Plan Sponsor and Plan Administrator are named as parties, and SHP represent either, the legal defense provided by SHP to the Plan Sponsor and Plan Administrator under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for Plan Sponsor and Plan Administrator is necessary. The legal defense must meet the requirements of N.D.C.C. §54- 12-08. Except as otherwise provided in this Agreement, the Plan Sponsor, Plan Administrator, and SHP each agree to assume their own liability for any and all legal equitable claims of any nature including all costs, expenses and attorneys' fees which may in any manner result from or arise out of this Agreement.

12.2 SHP shall secure and keep in force during the term of this Agreement, from insurance companies, government self-insurance pools or government self-retention funds, the

following insurance coverages:

1. Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $2,000,000 per occurrence.

2. Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 per occurrence.

3. Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.

4. Employer's liability or "stop gap" insurance of not less than $2,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

5. Professional errors and omissions with minimum limits of $1,000,000 per claim and in the aggregate, Contractor shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, Contractor shall purchase an extended reporting period to meet the time periods required in this section.

12.3 The insurance coverages listed above must meet the following additional requirements:

1. Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of SHP. The amount of any deductible or self-retention is subject to approval by NDPERS, upon request.

2. This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A" rating must be approved by NDPERS. The policies shall be in form and terms approved by NDPERS.

3. SHP shall furnish a certificate of insurance to the undersigned NDPERS representative.

4. Failure to provide insurance as required in this Agreement is a material breach of contract entitling NDPERS to terminate this Agreement immediately.

12.4 SHP shall not cancel insurance coverage required by this Agreement or modify the insurance coverage below limits required by this Agreement without thirty (30) days' prior written notice to the undersigned NDPERS representative.

12.5 New insurance shall be promptly furnished in the event of insolvency, bankruptcy, or failure of any insurance company. SHP shall notify NDPERS thirty (30) days in advance of any cancellation, termination, or alteration of insurance policies required hereunder. A renewal policy or certificate shall be delivered to NDPERS at least thirty (30) days prior to the expiration date of each expiring policy.

12.6 After a period of a right to cure, failure to provide insurance as required in this Agreement is a material breach of contract entitling NDPERS to terminate this Agreement immediately.

13 DOCUMENTS NECESSARY TO EFFECTUATE THE AGREEMENT

In the event the parties mutually determine the need to complete other documentation, including contract amendments, to complete this transaction, the parties agree to reasonable cooperate to execute such documents to effectuate the agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed, In their names by their undersigned officers, the same being duly authorized to do so.

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

By: _____
Title: _____
Date: 1/6/2025

SANFORD HEALTH PLAN
4800 W 57th St, Sioux Falls, SD 57108

By: _____
Title: CEO
Date: 12/19/24

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

By: _____
Title: _____
Date: 1/6/2025

Attachment 2

North Dakota Public Employees Retirement System (NDPERS)

2025-2027 Certificate of Insurance

Dakota Plan

Grandfathered PPO/Basic

Help understanding this document is free.

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: 711*(toll-free)*.

Help in a language other than English is also free.

Please call (800) 752-5863 *(toll-free)* | TTY/TDD: 711*(toll-free)* to connect with us using free translation services.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

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FREE HELP IN OTHER LANGUAGES

This Policy replaces any prior policies you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it.

If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us toll-free at the number below.

For help in a language other than English, please call us toll-free at (800) 752-5863. Both oral and written translation services are available for free in at least 150 languages.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-752-5863 (رقم هاتف الصم والبكم: 711).

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-752-5863 (መስማት ለተሳናቸው: 711).

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-752-5863 (TTY: 711）。

Cushite (Oromo) - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-752-5863 (TTY: 711).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-752-5863 (TTY: 711).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-752-5863 (TTY: 711).

Karen - ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 800-752-5863 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-752-5863 (TTY: 711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-752-5863 (ATS: 711).

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-752-5863 (телетайп: 711).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-752-5863 (TTY: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-752-5863 (TTY: 711).

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-752-5863 (TTY: 711).

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-752-5863 (TTY: 711).

Notice

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description/Certificate of Insurance (COI) is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Every attempt has been made to provide concise and accurate information.

This COI and the NDPERS Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance/Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

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

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

Plan Name

North Dakota Public Employees Retirement System Dakota Plan

Name and Address of Employer (Plan Sponsor)

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503

Plan Sponsor's IRS Employer Identification Number

45-0282090

Plan Number Assigned By the Plan Sponsor

N/A

Type of Welfare Plan

Health

Type of Administration

This employee welfare benefit plan is fully insured by Sanford Health Plan and issued by Sanford Health Plan. Sanford Health Plan is the Claims Administrator for this employee welfare benefit plan.

Name and Address of Sanford Health Plan

Sanford Health Plan
4800 W 57th St.
Sioux Falls, SD 57108
(877) 305-5463 *(toll-free)*
TTY/TDD: 711 *(toll-free)*

Plan Administrator's Name, Business Address and Business Telephone Number

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503
(701) 328-3900

Name and Address of Agent for Service of Legal Process

Plan Administrator	Sanford Health Plan
North Dakota Public Employees Retirement System Executive Director 1600 E. Century Avenue, Suite 2 PO Box 1657 Bismarck, ND 58503	Sanford Health Plan ATTN: President 4800 W 57th St. PO Box 91110 Sioux Falls, SD 57109-1110

Title of Employees Authorized To Receive Protected Health Information

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

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business.

These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

Statement of Eligibility to Receive Benefits
As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1,2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

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 if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. Eligible employees may also include Medicare eligible retirees who enrolled in the Dakota Retiree Plan and lost eligibility to participate in the Dakota Retiree Plan due to the loss of Medicare Part B. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

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

Description of Benefits

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

Sources of Premium Contributions to the Plan and the Method by Which the Amount of Contribution Is Calculated

The contributions for single or family for state employees are paid at 100% by the State. The contributions for employees of participating political subdivisions are at the discretion of the subdivision and subject to the minimum contribution requirements and participation requirements of Sanford Health Plan. Either the contributions for temporary employees are at their own expense or their employer may pay the premium subject to its budget authority.

End of the Year Date for Purposes of Maintaining the Plan's Fiscal Records

June 30

Clerical Error

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in

force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and NDPERS retain contractual rights to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

Recovery of Benefit Payments
Pursuant to N.D.A.C. §71-03-05-06, whenever benefits are paid in noncompliance with the Contract, NDPERS, which is the Plan Administrator, or an agent of the Plan Administrator, retains the right to recover the payments from the party responsible.

If Sanford Health Plan, which is the Claims Administrator and Payor, or an agent of Sanford Health Plan, is at fault, the amount of overpayment will be withheld from the administrative fees paid by NDPERS.

If overpayments are made because of false or misleading information provided by a Member, Sanford Health Plan, or an agent of Sanford Health Plan, shall attempt to recover the amount. Any moneys recovered shall be credited to NDPERS.

If an overpayment is made because of a mistake or deliberate act by a Health Care Provider, Sanford Health Plan shall collect the money from the Provider and credit that amount to NDPERS.

If fraud is suspected, Sanford Health Plan shall inform NDPERS and NDPERS may turn the evidence over to the North Dakota State's Attorney or Attorney General's office for possible prosecution.

Amending and Terminating this Benefit Plan
As Plan Administrator, NDPERS has delegated responsibility for determinations regarding covered benefits, and the amount and manner of the payment of benefits, including the appeal of denied claims, to Sanford Health Plan, the insurer of the plan.

NDPERS reserves the right to terminate the plan, or amend or eliminate benefits under the North Dakota Public Employees Retirement System Dakota Plan, as insured and issued by Sanford Health Plan, at any time and at its discretion, upon mutual agreement between NDPERS and Sanford Health Plan. Should this Benefit Plan be amended or terminated, such action shall be by a written instrument duly adopted by both NDPERS and Sanford Health Plan, or the aforementioned entities' designees

Fiduciary Duties

Claims Administrator Is a Fiduciary

Except for direct member appeals regarding an infertility services deductible, the North Dakota Public Employees Retirement Board has delegated to the Claims Administrator, herein known as Sanford Health Plan, benefit claims and appeals. Sanford Health Plan is a Plan fiduciary for these benefit claims and appeals only. As such, the Claims Administrator has the final and discretionary authority to determine these claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the Claims Administrator on review is final and binding, subject to your right to file a lawsuit under other applicable laws. This decision making authority is limited only by the duties imposed. Any determination by the Claims Administrator is intended to be given deference by courts to the maximum extent allowed under applicable

laws.

Summary Notice and Important Phone Numbers

This COI describes in detail your Employer's health care benefit Plan and governs the Plan's coverage. This COI, any amendments, and related documents comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this COI carefully. If you have any questions about the benefits, please contact Sanford Health Plan's Customer Service. For contact information, See "Introduction; How to Contact Sanford Health Plan [The "Plan"].

This COI describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan including Align powered by Sanford Health Plan and Great Plains Medicare Advantage. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD 711.
This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Member under a policy or contract, or a prospective Member, obtained by Sanford Health Plan from that person or from a health care Provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive**: We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services**: We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Practitioner and/or Provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the Premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family**: We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- **Disaster Relief**: We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law**: We will share information about you if State or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law.
- **For public health and safety**: We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Organ and tissue donation**: We can share information about you with organ procurement

organizations.

- **Medical examiner or funeral director**: We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation and other government requests**: We can share information to employers for workers' compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement**: We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **Lawsuits and legal actions**: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research**: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

We may contact you in the following situations:

- **Treatment options**: To provide information about treatment alternatives or other health related benefits or Sanford Health Plan services that may be of interest to you.
- **Fundraising**: We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights.

- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within thirty (30) calendar days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of

Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

Contact Information:
Sanford Health Plan
Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 *(toll-free)* | TTY/TDD 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and online at www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective February 1, 2022.

INTRODUCTION

HOW TO CONTACT SANFORD HEALTH PLAN [THE "PLAN"]

Method	Sanford Health Plan Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
TRANSLATION SERVICES	(800) 752-5863
WRITE	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
PHYSICAL ADDRESS	Sanford Health Plan 4800 W 57th St. Sioux Falls, SD 57108

How to contact Customer Service

For assistance with claim inquiries/status, eligibility and enrollment, provider access, and order ID cards, please call or write to Customer Service. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Customer Service Contact Information
CALL	(800) 499-3416 *calls to this number are free*
TTY	711
FAX	(605) 328-6812
HOURS	7:30 a.m. to 5:00 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
WRITE	Sanford Health Plan Customer Service PO Box 91110 Sioux Falls, SD 57109-1110

How to contact us with questions about Certification (prior authorization)

Some of the services listed in this document are covered only if your doctor or other network provider gets approval in advance (called Certification or prior authorization) from us. The Utilization Management department handles all certification requests. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Utilization Management Contact Information
CALL	(800) 805-7938 *calls to this number are free*
TTY	711
FAX	(605) 328-6813
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Utilization Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Pharmacy Management

For assistance with pharmacy benefit questions, formularies, or drug pre-authorization, please call or write to Pharmacy Management.

Method	Pharmacy Management Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
FAX	(701) 234-4568
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Pharmacy Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Appeals and Grievances

For assistance with Complaints (grievances) and appeal rights, contact the Appeals and Grievances department. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Appeals and Grievances Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Appeals and Grievances Department PO Box 91110 Sioux Falls, SD 57109-1110

How do I request an external review

Members may file a request for Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review with Sanford Health Plan or with the Division of Insurance. Refer to Section 10 PROBLEM RESOLUTION for more information.

Members have the right to contact the North Dakota Insurance Department at any time.

Method	North Dakota Insurance Department Contact Information
CALL	(800) 247-0560 (toll-free)
TTY	(800) 366-6888 (toll-free)
WRITE	North Dakota Insurance Department 600 E. Boulevard Ave. Bismarck, ND 58505-0320
EMAIL	insurance@nd.gov

MEMBER RIGHTS

Sanford Health Plan is committed to treating Members in a manner that respects their rights. In this regard, Sanford Health Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) has the right to the following:

- Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; color; gender; gender identity; age; sex; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.
- Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
- Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
- Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
- Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable North Dakota law.
- Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
- Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or Medically Necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.
- Members have the right to give informed consent before the start of any procedure or treatment.
- When Members do not speak or understand the predominant language of the community, Sanford Health Plan will make its best efforts to access an interpreter. Sanford Health Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
- Members have the right to receive printed materials that describe important information about Sanford Health Plan in a format that is easy to understand and easy to read.
- Members have the right to a clear Grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
- Members have the right to Appeal any decision regarding Medical Necessity made by Sanford Health Plan.
- Members have the right to terminate coverage, in accordance with Employer and/or Plan guidelines.

- Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
- Members have the right to receive information about Sanford Health Plan, its services, its Practitioners and Providers, and Members' rights and responsibilities.

MEMBER RESPONSIBILITIES

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

- Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- Members are responsible for following all access and availability procedures.
- Members are responsible for seeking emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that the Member must use the nearest emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
- Members are responsible for notifying Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
- Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
- Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
- Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- Members are responsible for notifying NDPERS within *thirty-one (31)* days of name, address, or telephone number changes.
- Members are responsible for notifying NDPERS of any changes of eligibility that may affect their membership or access to services. The Plan Sponsor is responsible for notifying the Plan.

DISCLOSURE OF GRANDFATHERED STATUS

This employer group health plan 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 dol.gov/ebsa/healthreform. The Department of Labor website has a table summarizing which protections do and do not apply to grandfathered health plans.

SERVICE AREA

The Service Area for **SOUTH DAKOTA** and **NORTH DAKOTA** includes all counties in the state.

The Service Area for **IOWA** includes the following counties

Clay	Emmet	Lyon	Osceola	Plymouth
Dickinson	Ida	O'Brien	Sioux	Woodbury

The Service Area for **MINNESOTA** includes the following counties

Becker	Clearwater	Kittson	Martin	Otter Tail	Redwood	Stevens
Beltrami	Cottonwood	Lac Qui Parle	McLeod	Pennington	Renville	Swift
Big Stone	Douglas	Lake of the Woods	Meeker	Pipestone	Rock	Traverse
Blue Earth	Grant	Lincoln	Murray	Polk	Roseau	Wilkin
Brown	Hubbard	Lyon	Nicollet	Pope	Sibley	Watonwan
Chippewa	Jackson	Mahnomen	Nobles	Red Lake	Stearns	Yellow Medicine
Clay	Kandiyohi	Marshall	Norman			

MEDICAL TERMINOLOGY

All medical terminology referenced in this Certificate of Insurance follows the industry standard definitions of the American Medical Association.

DEFINITIONS

Capitalized terms are defined in Section 11 of this Policy.

CONFORMITY WITH STATE AND FEDERAL STATUTES

Any provision in this Policy not in conformity with North Dakota laws or rules may not be rendered invalid but must be construed and applied as if it were in full compliance with any applicable State and Federal statutes. If, on the effective date of this policy, any provision of this policy is in conflict with federal statutes, or the statutes

of the State of North Dakota, then this Policy shall be considered amended to conform to the minimum requirements of such laws and regulations.

GOVERNING LAW

To the extent not superseded by the laws of the United States, this Policy will be construed in accordance with and governed by the laws and rules of the United States of America and the state of North Dakota. Any action brought because of a claim under this Policy will be litigated in state or federal courts located in the state of North Dakota and in no other.

SPECIAL COMMUNICATION NEEDS

Please call the Plan if you need help understanding written information at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services. Anyone with any disability, who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at (701) 328-3900.

TRANSLATION SERVICES

The Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 752-5863 *(toll-free)* | TTY/TDD 711 *(toll-free)* for help and to access translation services.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 752-5863 *(toll-free)*.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 752-5863 *(toll-free)*.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 752-5863 *(toll-free)*.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 752-5863 *(toll-free)*.

SERVICES FOR THE DEAF, HEARING IMPAIRED, and/or VISUALLY IMPAIRED

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: 711*(toll-free)*. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

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

FRAUD

Fraud is a crime that can be prosecuted. Any Member who willfully and knowingly engages in an activity intended to defraud Sanford Health Plan is guilty of fraud.
As a Member, you must:

- File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
- Review the Explanation of Benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and

- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are uncertain or concerned about any information or charge that appears on a bill, form, or Explanation of Benefits; or if you know of, or suspect, any illegal activity, call Sanford Health Plan at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. All calls are strictly confidential.
In the absence of fraud, all statements made by applicants, the Group or a Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall avoid such coverage or reduce benefits unless contained in a written instrument signed by the Group or Member, a copy of which has been furnished to such Group or Member or the Member's representative.

PHYSICAL EXAMINATION

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

CLERICAL ERROR

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and NDPERS retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

VALUE-ADDED PROGRAM

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may receive rewards, access discounted rates from certain vendors for products and services available to the general public, or other incentives to engage in a healthy lifestyle or to adopt healthy habits. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

SUMMARY OF THIS PLAN DESCRIPTION

- This Certificate of Insurance serves as your health benefits policy and describes in detail your Employer's health care benefit plan and governs the coverage. The Certificate of Insurance, and any amendments and/or riders, comprise the entire contract between the Employer and Sanford Health Plan.
- A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate of Insurance carefully. If you have any questions about the benefits as presented in the Certificate of Insurance, please contact your Employer or Sanford Health Plan Customer Service.
- This Certificate of Insurance describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF NON-DISCRIMINATION

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Insurance, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Sanford Health Plan at (800) 752-5863.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Section 504 Coordinator.

Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57104
Phone: (877) 473-0911 | TTY: 711
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax, phone, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you.

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

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

SECTION 1.
ENROLLMENT

1.1 ELIGIBILITY AND WHEN TO ENROLL

As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1,2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

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 if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. Eligible employees may also include Medicare eligible retirees who enrolled in the Dakota Retiree Plan and lost eligibility to participate in the Dakota Retiree Plan due to the loss of Medicare Part B. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

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

A “Late Entrant” is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. A Late Entrant can only enroll during the next

scheduled Open Enrollment Period. A Member is not a "Late Entrant" if "special enrollment rights" apply, as described later in this section.

1.2 HOW TO ENROLL

Both the Group and Eligible Group Member are involved in the enrollment process.

The Eligible Group Member must:

1. Complete the enrollment process, as designated by NDPERS for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

The Group must:

- Provide all information needed by Sanford Health Plan to determine eligibility; and
- Agree to pay the required premium payments on behalf of the Eligible Group Member.

1.3 WHEN COVERAGE BEGINS

Coverage generally becomes effective on the first day of the month that follows the date of hire, as designated by NDPERS.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, we will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this Certificate. Payment of benefits is subject to any obligations under a previous plan or coverage arrangement in accordance with state law and applicable regulations.

For more information, see Section 8, "*Extension of Benefits for Total Disability*".

1.4 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

The following Dependents are eligible for coverage ("Dependent coverage"):
Spouse - The Subscriber's spouse under a legally existing marriage. A Spouse is eligible for coverage, subject to eligibility requirements as designated by NDPERS.

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

1) Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2) Be one of the following:
   - under twenty-six (26) years old; or
   - incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within *thirty-one (31)* days of the Plan's request. Such a request may be no more than annually following the two year period of the disabled dependent child's attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]; If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled

dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent Child - To be eligible for coverage, a Dependent of the Dependent Child must be the Subscriber's grandchild or the grandchild of the Subscriber's living, covered Spouse if (1) the parent of the grandchild is a Member and (2) both the parent of the grandchild and the grandchild are primarily dependent on the Subscriber for financial support. The term grandchild means any of the following:

- natural child of a Dependent Child;
- child placed with a Dependent Child for adoption;
- child legally adopted by a Dependent Child;
- child for whom a Dependent Child has legal guardianship;
- stepchild of a Dependent Child; or
- foster child of a Dependent Child.

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

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

1.5 NONCUSTODIAL SUBSCRIBERS

Whenever a Dependent Child receives coverage through the noncustodial parent who is the Subscriber, Sanford Health Plan shall do all of the following:

- Provide necessary information to the custodial parent in order for the Dependent Child to receive benefits under this Contract;
- Allow the custodial parent or Provider, with the custodial parent's approval, to submit claims for Covered Services without approval from the noncustodial parent; and
- Make payment on the submitted claims directly to the custodial parent or Provider.

1.6 STATUS OF MEMBER ELIGIBILITY

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

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

A Member making a statement (including the omission of information) on the membership application or in relation to any of the terms of this Benefit Plan constituting fraud or an intentional misrepresentation of a material fact will result in the rescission of this Benefit Plan by Sanford Health Plan. A rescission is a cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding this Benefit Plan or any benefits paid under the terms of this Benefit Plan.

1.7 WHEN AND HOW TO ENROLL DEPENDENTS

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "Coverage from Birth" and "*Adoption or Children Placed for Adoption*" section below. There is also an exception for Spouses; see "*New Spouses*" section below.

How to Enroll Dependents

The Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and

2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

1.8 WHEN DEPENDENT COVERAGE BEGINS

A. **General**

If a Dependent is enrolled at the same time the Subscriber enrolls for coverage through NDPERS, the Dependent's effective date of coverage will be the same as the Subscriber's effective date as described in Section *"When Coverage Begins"* above.

B. **Delayed Effective Date of Dependent Coverage**

Except for newborns (see "*Coverage from Birth*" section below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits under any prior coverage exists, the Plan coordinates benefits. For more details on Coordination of Benefits, see Section 6.

C. **Coverage from Birth**

If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth. Depending on the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

- **a. Subscribers with Single Coverage:** Newborns are covered under a Single Coverage Plan through the date of mother's discharge from the hospital in which the child was born. For coverage to extend after the mother's hospital discharge, Subscribers must submit application to NDPERS within thirty-one (31) days of the newborn's date of birth. Coverage will then be applied retroactively back to the date of birth.
- **b. Subscribers with Family Coverage:** Newborn children will be added to the Certificate automatically if the Subscriber is enrolled in Family Coverage.

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

An Eligible Group Member who failed to enroll during a previous enrollment period shall be covered under this Contract from the date of the child's birth, provided that coverage is applied for through NDPERS within *thirty-one (31)* days of the birth. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse. The Spouse may be added if application is made within thirty-one (31) days of a child's birth if otherwise eligible for coverage under the Plan, provided that coverage is applied through NDPERS for the Spouse and, if applicable, the Group Member.

D. **Adoption or Children Placed for Adoption**

If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as an Eligible Dependent as of the date specified within a court order or other legal adoption papers. Regardless of the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

a. **Subscribers with either Single or Family Coverage:** For coverage to continue beyond thirty-one (31) days of the date specified within the court order or other legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage, the Subscriber must submit an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or other legal adoption papers that granted initial eligibility.

An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, who failed to enroll during a previous enrollment period, shall be covered as of the date specified within a court order or other legal adoption papers, if the Eligible Group Member, and any other Eligible Dependents, submits an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that an application for coverage is submitted to NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

Coverage at the time of placement for adoption includes the necessary care and treatment of medical conditions existing prior to the date of placement.

E. **New Spouses and Dependent Children**

If a Subscriber gets married, his or her Spouse, and any of the Spouse's Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for with NDPERS for the Spouse and/or Eligible Dependents within thirty-one (31) days of the date of marriage. If the Subscriber does not submit an application for coverage to NDPERS for the Spouse and/or any Eligible Dependent(s) within thirty-one (31) days of the date of marriage, then Late Enrollee provisions apply and the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st. This includes marriages for which coverage was effective on or after June 26, 2015, regardless of the Spouses' gender/sex.

If an Eligible Group Member, who is an Employee eligible to enroll in the Plan, but who did not do so during a previous enrollment period, gets married, the employee becomes an eligible Subscriber under the following conditions:

a. The Subscriber, his or her Spouse, and any Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty-one (31) days of the date of marriage or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.
b. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

**** NOTE:** Per Federal laws, guidance, and regulations, the sexual orientation and sex/gender of Spouses, married in a jurisdiction with legal authority to authorize their marriage, is not a factor in the issuance of coverage or benefit determinations. Sanford Health Plan, in compliance with federal guidance for all states, offers coverage to all legally married Spouses, and any Eligible Dependents as a result of marriage, regardless of the jurisdiction in which the marriage occurred. The provisions in this contract regarding Spousal eligibility and Late Enrollees continue to apply, regardless of Spouses' sex/gender.

1.9 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROVISION

A QMCSO is an order that creates the right of a Subscriber's Dependent Child to be enrolled in coverage under this Contract. If a QMCSO is issued, Sanford Health Plan will provide benefits to the Dependent Child(ren) of a Subscriber regardless of whether the Dependent Child(ren) reside with the Subscriber. In the event that a QMCSO is issued, each named Dependent Child(ren) will be covered by this Certificate of Insurance in the same manner as any other Dependent Child(ren).

When Sanford Health Plan is in receipt of a medical child support order, Sanford Health Plan will notify the Subscriber and each Dependent Child named in the order, whether or not it is a QMCSO. A QMCSO must contain the following information:

1. Name and last known address of the Subscriber and the Dependent Child(ren) to be covered by the Plan.
2. A description of the type of coverage to be provided to each Dependent Child.
3. The applicable period determined by the order.
4. The plan determined by the order.

In order for the Dependent Child's coverage to become effective as of the date of the court order issued, the Subscriber must apply for coverage as defined previously in this section. Each named Dependent Child may designate another person, such as a custodial guardian, to receive copies of explanation of benefits, checks, and other materials.

Exceptions
If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements under *Dependent Child* need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Certificate of Insurance. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be terminated unless Sanford Health Plan is provided satisfactory written evidence of any of the following:
1. The court or administrative order is no longer in effect;
2. The Dependent Child(ren) currently receive(s) or will be enrolled in comparable health coverage through a health insurance issuer which will take effect not later than the effective date of the termination; or

3. The Group has eliminated family coverage for all of its Eligible Group Members.

1.10 SPECIAL ENROLLMENT PROCEDURES AND RIGHTS

A Special Enrollment Period may apply when an individual becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption or when an Eligible Group Member or an Eligible Dependent involuntarily loses other health coverage.

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within thirty-one (31) days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within thirty-one (31) days of the change or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.

1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

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

2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan due to legal separation, divorce, annulment, or death, coverage for the Subscriber's Spouse and/or Dependents under Family Coverage will cease, effective the first of the month immediately following timely notice of the event causing ineligibility.

   If living in the Sanford Health Plan Service Area (see *Service Area* in Introduction Section), a Member has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

   There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and Sanford Health Plan of any change in family status within thirty-one (31) days of the change. The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement, or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

   The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within thirty-one (31) days of the date of birth for

coverage to continue beyond the first thirty (30) days beginning with the child's birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to NDPERS within thirty-one (31) days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
3. Children who have been placed under the care Subscriber, or the Subscriber's living, covered spouse due to the Subscriber, or the Subscriber's living, covered spouse being appointed legal guardian, may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
5. If any of the Subscriber's children, or those of the Subscriber's living, covered spouse, who are Eligible Dependents under the Plan, beyond the age of 26, incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance, shall have coverage remain in effect as long as such disabled child remains dependent upon the Certificate holder/Subscriber or the Subscriber's spouse for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.
6. If a child is no longer an Eligible Dependent under this Benefit Plan, and the child is living in the Sanford Health Plan Service Area (see *Service Area* in the above Introduction Section), the Dependent has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*. There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.
7. At the time of birth or adoption, other Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to NDPERS within thirty-one (31 days) of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date. Pursuant to N.D.A.C. §71-03-03-01, an Employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:
   1. During the initial enrollment period the employee or dependent states, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
   2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
      a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special

enrollment under the Benefit Plan but again choosing not to enroll, or employer contributions toward such coverage were terminated; or

b. was under COBRA and the coverage was exhausted.

3. The employee requests such enrollment within thirty-one (31) days after the exhaustion or termination of coverage.

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

If the membership application is not received in accordance with this provision, and the Employee or Dependent is a Late Enrollee, the Late Enrollee's effective date of coverage will be the Group's anniversary date.

E. Employees and/or Dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:

1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and the employee's or dependent's coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within sixty (60) days of the date of termination of coverage; or
2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within sixty (60) days of the date the employee or dependent is determined to be eligible for premium assistance.

   The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

F. In accordance with the decision of the Supreme Court of the United States on June 26, 2015, in *Obergefell v. Hodges*, 576 U.S. (2015), regarding same-sex marriage:

1. **Same-sex marriages that occurred prior to June 26, 2015:** NDPERS will have a special enrollment period from July 1, 2015 through September 30, 2015. Coverage will be effective retroactive to July 1, 2015. If the Subscriber does not enroll during this eligibility period, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.
2. **Same-sex marriages that occur on or after June 26, 2015:** The Subscriber must submit an application for coverage within the first thirty-one (31) days of the event. If the Subscriber does not enroll when initially eligible, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.

Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent is enrolled.

* *Loss of coverage due to failure to make premium payment and/or allowable rescissions of coverage does not qualify for a Special Enrollment Period.*

* *Voluntarily terminating/dropping COBRA coverage before it runs out outside Annual Enrollment does not qualify for a Special Enrollment Period.*

COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment.

1.11 CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 grants special enrollment rights to employees and Dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

In order to qualify for special enrollment, an eligible employee or dependent must request coverage within *sixty (60) days* of either being terminated from Medicaid or CHIP coverage, or being determined to be eligible for federal premium assistance. In either situation, the Plan will also require the eligible employee to enroll in Plan coverage. Special enrollment rights extend to all benefit packages available under the Plan. If you have questions about enrolling in your employer plan under CHIPRA special enrollment rights, contact the U.S. Department of Labor at www.askebsa.dol.gov or call (866) 444-3272 *(toll-free)*.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

1.12 MICHELLE'S LAW

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance Certificate prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a written and signed certification from the Dependent Child's treating Practitioner and/or Provider stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary and the effective date of the leave.

SECTION 2
HOW YOU GET CARE

2.1 IDENTIFICATION CARDS

Sanford Health Plan will send you an identification (ID) card when you enroll. Each Subscriber will receive their own Member ID card after enrollment, which should be used when you receive care. You must show it whenever you receive services from a Provider, a health care Facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive Health Care Services or prescription medications, you will be responsible for payment of the claim after the Participating Practitioner and/or Provider's timely filing period of *one-hundred-eighty* (180) calendar days has expired. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

If you do not receive your ID card within *thirty* (30) calendar days after the effective date of your enrollment, you need a temporary card or replacement cards, please call us at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* or write to us at Sanford Health Plan, ATTN: NDPERS, PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards by signing into your account at sanfordhealthplan.com/memberlogin. Information on creating an account is available at sanfordhealthplan.com/ndpers.

2.2 CONDITIONS FOR COVERAGE

Members are entitled to coverage for the Health Care Services (listed in the "Covered Services," in Section 3)that are:

- Medically Necessary and/or Preventive;
- Received from or provided under the orders or direction of a Participating Provider;
- Approved by the Plan, including Preauthorization/Prior Approval where required; and
- Within the scope of health care benefits covered by the Plan.

However, this specific condition does not apply to Emergency Medical Conditions or urgent care in and out of the Service Area. In such cases, the services will be covered if they are provided by a Non-Participating or Out-of-Network Provider.

If during an emergency or Urgent care situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest Participating Practitioner and/or Provider.

Members are not required, but strongly encouraged, to select a Primary Care Physician and use that Physician to coordinate their Health Care Services.

In addition, all Health Care Services are subject to:

- The exclusions and limitations described in Sections 3 and 4; and
- Any applicable Copay, Deductible, and Coinsurance amount as stated in your Summary of Benefits and Coverage (SBC), and Pharmacy Handbook.

2.3 IN-NETWORK COVERAGE

In-Network coverage is provided under two (2) plan levels. For more information, see *Selecting a Health Care Provider* in Section 3.7 In-Network benefit payments pay according to coverage under:

1. Basic Plan; or
2. PPO Plan

Note: If you travel out of the Plan's Service Area for the purpose of seeking medical treatment outside the Plan's Service Area, as defined in this COI, without Preauthorization/Prior Approval for a service that requires such authorization/approval, your claims will be paid according to the Basic Plan benefits and stipulations set forth in Section 3.7.
Additionally, the Member will receive Basic Plan benefits if: 1) a PPO Health Care Provider is not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO).

For *Appropriate Access* standards, see below.

In the following circumstances, Medically Necessary Health Care Services received from Non-Participating Providers may be Covered Services subject to In Network Cost Sharing, although Members may be responsible for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services.

1. **Ancillary Health Care Services**. Health Care Services received from a Non-Participating Provider that are ancillary to a Covered Service being provided by In-Network Participating Practitioner and/or Provider, such as anesthesiology or radiology, if rendered in an In-Network Facility. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.
2. **Termination of a Participating Provider.** Health Care Services received from a Participating Provider by a Member who is under an Active Course of Treatment and we terminate the Participating Provider's status as a Participating Provider without cause. The Member or the terminated Participating Provider must request and receive written approval from us. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will not count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.

2.4 APPROPRIATE ACCESS

Primary Care Physicians and Hospital Providers
Appropriate access for Participating Practitioner and/or Providers who provide primary care services and Hospital Provider sites is within *fifty* (50) miles of a Member's city of legal residence.

Specialty Practitioners and Providers
For other Participating Practitioner and/or Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within *fifty* (50) miles of a Member's city of legal residence. If you are traveling within the Service Area where other Participating Practitioner and/or Providers are available, then you must use Participating Practitioner and/or Providers.

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Practitioners and Providers as indicated in the Plan's Provider Directory. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If a Member chooses to go to a Non-Participating Practitioner or Provider when appropriate access (within *fifty (50)* miles of a Member's city of legal residence) is available, claims will be processed at the Basic Plan (Out-of-Network) level.

Transplant Services

Transplant Services must be performed at designated participating facilities and are not subject to the appropriate access standards outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations and terms of Sanford Health Plan's transplant policy.

2.5 CASE MANAGEMENT

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

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

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

Sanford Health Plan's case management process allows professional case managers to assist Members with certain complex and/or chronic health issues by coordinating treatment and/or other types patient care plans.

In consultation with case managers, Sanford Health Plan may approve coverage that extends beyond the limited time period and/or scope of treatment initially approved. This consultation also includes utilization management processes as described below.

All decisions made through case management are based on the individual circumstances of a Member's case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) of the Member.

NOTE: For certain transplant procedures, case management services will be provided by the Plan's transplant vendor, *not* Sanford Health Plan. For benefit details on transplant services, see Section 3.2.

2.6 BENEFIT DETERMINATION REVIEW PROCESS

Sanford Health Plan Appeals and Grievances Department reviews all non-medical benefit determinations through review of Certificate of Insurance language, contractual terms, administrative policies related to benefits as defined by this Policy, and benefits requests. All benefit determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

The date of receipt for non-urgent (standard) requests received outside of normal business hours will be the next business day.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances department.

2.7 ROUTINE (NON-URGENT) PRE-SERVICE BENEFIT REQUESTS

All pre-service benefit determination (approval) requests will be determined within fifteen (15) business days of receipt of the request. When a preauthorization (pre-approval) request is received before a service occurs, the date of receipt for non-urgent (standard) requests is the date the Plan receives the Member's request. If the request is made outside of business hours, the date or receipt will be next business day. If Sanford Health Plan denies a benefit (an Adverse Benefit Determination) the Plan will contact the Member via mail.

2.8 ROUTINE POST-SERVICE BENEFIT REQUESTS

Retrospective (post-service) requests occur when a Member has already utilized healthcare services and did not inquire about coverage pre-service. Post-service requests are not related documentation, coding or reimbursement from the Plan. Sanford Health Plan will review and approve or deny the service based on Medical Necessity within thirty (30) calendar days of receipt of the request. A letter will be sent to the Member within those 30 calendar days with the Plan's determination

2.9 UTILIZATION MANAGEMENT REVIEW PROCESS

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Utilization Management department.

The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it is during normal business hours.

All Utilization Review Adverse Determinations will be made by the Sanford Health Plan Chief Medical Officer or appropriate Practitioner.

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This part of Section 2 explains how we process different types of claims.

Designating an Authorized Representative

You may act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. An Authorized Representative is someone you designate in writing to act on your behalf. We have developed a form that you must complete if you wish to designate an Authorized Representative. You can get the form by calling Customer Service. You can also log into your account at www.sanfordhealthplan.com/memberlogin and download a copy of the form. If a person is not properly designated as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your Provider is your Authorized Representative unless you tell us otherwise in writing.

Your Right to Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as Medical Necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 business days of a request. We will not charge you for any information that you request regarding our decision.

Your Complaint (Grievance) & Appeal Rights

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write the Appeals and Grievances Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received; or
- You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 10 for more information on the Appeals Process.

The Plan's claims procedures are designed to comply with the requirements of ERISA. We will process your claim according to ERISA standards. In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), criteria for Medical Necessity determinations is available upon request to any current or potential Member, beneficiary, or contracting provider. For details on the complaint and appeals process, see Section 10.

NOTE: If you receive an Adverse Determination, you have the right to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not (and is not) considered a request for an Internal Appeal and/or External Review.

2.10 PROSPECTIVE (PRE-SERVICE) REVIEW OF SERVICES (CERTIFICATION PRIOR AUTHORIZATION)

Prior Authorization (also referred to as Certification) is a decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary and appropriate. Preauthorization is required for services as defined above, except in urgent or emergent situations. Although the Plan may authorize a health care service as medically necessary, it is not a guarantee the Plan will cover the cost.

Determination of the appropriateness of care is based on standard review criteria and assessment of the following factors:

- The Member's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
- Consultation with the treating Practitioner and/or Provider, as appropriate.
- Availability of resources and alternate modes of treatment. For admissions to Facilities, other than Hospitals, additional information may include but is not limited to history of present illness, patient

treatment plan and goals, prognosis, staff qualifications and *twenty-four* (24) hour availability of qualified medical staff.

- Sanford Health Plan does not compensate Practitioners, Providers or other individuals conducting Utilization Review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Review decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

Prior authorization is required for all inpatient admissions.

This requirement applies, but is not limited to, the following:

1. Acute care Hospitalizations (including medical, surgical, and non-emergency mental health or substance use disorder inpatient admissions);
2. Residential Treatment Facility admissions; and
3. Rehabilitation center admissions.

Admission before the day of non-Emergency surgery will not be authorized unless the early admission is Medically Necessary and specifically approved by Sanford Health Plan. Coverage for Hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

Referrals to Recommended Providers
Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

Prior Authorization is the responsibility of your Practitioner and/or Provider. For an up to date list or more information on all things that require prior authorization, please visit:
https://www.sanfordhealthplan.com/members/prior-authorization.

2.11 PHARMACY PRE-APPROVAL (CERTIFICATION) REQUESTS

Certain specialty drugs, or those which require frequent dosing adjustments, close monitoring, special training, compliance assistance, or need special handling and/or administration, require preauthorization by the Pharmacy Management Department.

To acquire preauthorization for a medication, ask the prescribing Practitioner and/or Provider to contact us by phone, complete the Formulary Exception Form found online at sanfordhealthplan.com, or provide a letter of Medically Necessity. This applies to any request of:

1) A non-covered medication or drug; or
2) A medication, or drug not currently listed in the Formulary.

Sanford Health Plan will use appropriate practitioners to consider requests and grant an exceptions to the Formulary when the prescribing Practitioner and/or Provider of the drug attests the Formulary drug causes an adverse reaction, is considered contraindicated, or must be dispensed as written to provide maximum medical benefit to the Member.

The Pharmacy Management department will review the request and make a decision based on:

1. Medical records showing trial and failure of a formulary drug or reasons why a formulary drug trial should be avoided;
2. Clinical information (such as diagnosis, disease progression and/or medication history); and
3. Medical Necessity.

If the reason for the exception is not clear, the reviewing clinician will contact the prescribing Practitioner and/or Provider to discuss the request. Additionally, if necessary, a clinical consultant of the appropriate specialty may be consulted for review.

If a Formulary exception is granted, the Pharmacy Management Department will provide authorization to the Plan's Pharmacy Benefit Manager so the Member is able to obtain the requested medication immediately. Additionally, coverage of the non-Formulary drug will be provided for the duration of the prescription, including refills.

For more information on drugs that may require prior authorization including oral medications, step therapy and injectable medications, refer to the formulary and Section 3.5 of this document.

Routine/Standard Pharmacy Pre-Approval Requests

Routine/Standard (non-urgent) pharmacy pre-approval requests will be reviewed within **fifteen (15) days after receipt of the request.** If the request is made outside of business hours, the date or receipt will be next business day.

Urgent Pharmacy Pre-Approval Requests

Urgent pharmacy pre-approval requests be reviewed as soon as possible and no later than **twenty-four (24) hours** of receipt of the request. Sanford Health Plan in alignment with the Standard and Expedited Exception Request requirements. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision.

How to Request Pre-Approval for a Drug

You or your authorized representative can request a medication pre-approval by:

- Contacting Pharmacy Management
- Complete Formulary Exception Form found online at sanfordhealthplan.com
- Ask the prescribing Practitioner and/or Provider for a letter of medical necessity
- Ask the prescribing Practitioner and/or Provider to contact the Plan by phone

What to Include with the Request Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision.

2.12 ADDITIONAL INFORMATION REGARDING FORMULARY EXCEPTION REQUESTS

1. For contraceptives not in the Formulary, if the prescribing Practitioner and/or Provider determines that a drug/device is Medically Necessary and an exception to the formulary is granted, the contraceptive drug/device will be covered at Member's cost-share.
2. If the decision is to approve a standard (routine) Formulary exception request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription, including refills. If a request is granted based on an emergent circumstance, Sanford Health Plan will provide coverage of for the duration of the incident.
3. In the event that an exception request is granted, Sanford Health Plan will treat the excepted drug(s) as an essential health benefit, including, if applicable per the Member's Policy, counting any cost-sharing towards the Member's annual limitation on cost-sharing and when calculating the actuarial value.

In determining whether to grant an exception, Sanford Health Plan adheres to, procedures, as outlined above, allowing Members to request and gain access to clinically appropriate drugs not covered under the Plan's Formulary.

2.13 MEDICAL PRE-APPROVAL (CERTIFICATION) REQUESTS

All requests for Prior Authorization (Certification) are to be made by the Member or Physician/Practitioner's office at least *three (3)* business days prior to the scheduled admission or requested service. The Utilization Management Department will review the Member's medical request against standard criteria.

Determination of the appropriateness of an admission is based on standard review criteria and assessment of:

1. Member medical information including:
    a. diagnosis;
    b. medical history;
    c. presence of complications and/or co-morbidities;
2. Consultation with the treating Practitioner, as appropriate;
3. Availability of resources and alternate modes of treatment; and
4. For admissions to Facilities other than acute general Hospitals, additional information may include but is not limited to the following:
    a. history of present illness;
    b. patient treatment plan and goals;
    c. prognosis;
    d. staff qualifications; and
    e. twenty-*four (24)* hour availability of qualified medical staff.

Routine Pre-Service Pre-Approval Requests

Routine/Standard (non-urgent) pre-service requests for services that require pre-approval from the Plan will be made within **fifteen (15) calendar days from the date** the Plan receives the request. If the request is made outside of business hours, the date or receipt will be next business day. If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **five (5) calendar days** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Urgent Pre-Service Pre-Approval Requests

Urgent pre-service requests for services that require pre-approval from the Plan will be reviewed as soon as possible and no later than **seventy-two (72) hours** after receipt of the request. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision. If the request does not meet the definition of urgent, or is for a service that has already occurred, (post-service/retrospective) the request will be processed as a routine/standard request.

If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **twenty-four (24) hours** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Emergent Medical Conditions

Pre-approval is not required if a prudent layperson that possesses an average knowledge of health and medicine determines urgent or emergent care is necessary in a particular situation. Members should notify Sanford Health Plan as soon as reasonably possible and no later than **forty-eight (48) hours** after physically or mentally able to do so. A Member's Authorized Representative may also notify the Plan on the Member's behalf.

How to Request Pre-Approval for a Medical Item or Health Care Service
Refer to the Introduction section at the beginning of this document for instructions on contacting the Utilization Management department to request a medical pre-approval request.

What to Include with a Pre-Approval Request

Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary medical information, we will notify the Member, their Authorized Representative (if applicable) and their Practitioner and/or Provider regarding what information is necessary to approve the request. If request was received from a Practitioner and/or Provider, the Plan will communicate solely with the requesting Practitioner and/or Provider regarding information needed to approve the request. The Plan will notify the appropriate party(ies) regarding the information needed to make a decision within:

- **Twenty-four (24) hours** of the receipt of the request if the request meets the definition of Urgent. The Plan will provide **forty-eight (48) hours** to supply the requested information. If not received by the end of the 48-hour extension, the request will be denied.
- **Fifteen (15) calendar days** of receipt of a routine/standard request. The Plan will provide forty-five (45) calendar days to supply the requested information. If not received by the end of the forty-five day extension, the request will be denied.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision:

- By phone no later than **forty-eight (48) hours** after the decision is made for Urgent requests. The Plan will also provide electronic or written notification of the decision as soon as possible, but no later than within **three (3) calendar days** of the phone notification if the request is deemed urgent.
- By mail within the **fifteen (15) calendar days** after receipt of the request.

Routine/Standard (Non-Urgent) Post-Service Pre-Approval Request

If a claim is denied for a service that has already occurred or item that has already been received (post-service or retrospective), the Member may file an appeal as outlined in Section 10 as the denied claim serves as the initial adverse determination.

2.14 ONGOING (CONCURRENT) PREAUTHORIZATION REQUESTS (CERTIFICATION) OF HEALTH CARE SERVICES

Concurrent Review is utilized when a request for an extension of an approved ongoing course of treatment for medical care, including care for behavioral, mental health, and/or substance use disorders, over a period of time or number of treatments, is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.

Determinations by us to Limit or Reduce Previously Approved Care

If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow the rules we establish for the filing of your appeal, such as the time limits within which the appeal must be filed (See Section 10 for more information on the Appeals Process). Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow you to appeal and obtain a review determination before the benefit is reduced or terminated. In addition, individuals in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

Prior Authorization (Certification) of inpatient care stays will terminate on the date the Member is to be discharged from the Hospital or other Facility (as ordered by the attending Physician), or when the Member's coverage is terminated, whichever occurs first. Hospital/Facility days accumulated beyond ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioner and/or Providers associated with these non-certified days are non-covered.

The health care service or treatment that is the subject of the Adverse Determination shall be continued without liability to the Member until the Member or the Member's Authorized Representative has been notified of the determination with respect to the internal review request made pursuant to the Appeal Procedures.

Any reduction or termination during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination.

Requests to Extend Previously Approved Care

A Provider who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request Prior Authorization from Sanford Health Plan at least *twenty-four (24) hours* in advance of the termination of such continuing services. Your Provider may make this request in writing or orally directly to us. To request a concurrent review determination, call Utilization Management. Refer to the Introduction section for Utilization Management contact information.

If Utilization Management denies the extension of treatment, it will advise the Member and Practitioners and/or Providers within twenty-four (24) hours of receiving the request. If the Member decides to appeal this denial, the health care services or treatment subject to the Adverse Determination shall be continued without cost to the Member while the determination is under review as specified by the Appeal procedures outlined in Section 10.

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Member may pursue the appeal rights described in Section 10.

Any reduction or termination by the Plan during the course of treatment before the end of the period or number of treatments shall constitute an Adverse Determination.

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, Sanford Health Plan shall make a determination and orally notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service, of the determination as soon as possible, taking into account the Member's medical condition, but in no event more than seventy-two (72) hours after the date of Sanford Health Plan's receipt of the request.

Sanford Health Plan will provide electronic or written notification of an authorization to the Member, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the oral notification.

We shall provide written or electronic notification of the Adverse Determination to the Member and those Providers involved in the provision of the service sufficiently in advance (but no later than within three (3) calendar days of the telephone notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file a Grievance request to review of the Adverse Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. Sanford Health Plan will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination unless the decision has the potential to adversely affect the Member, in terms of coverage or financially, whether immediate or in the future.

Non-Urgent (Standard) Concurrent Reviews

If your request is non-urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service timeframes as outlined in this Section.

Urgent (Expedited) Concurrent Reviews

If your request for additional care is urgent, and if your Provider submits it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, Sanford Health Plan will make the decision as soon as possible (taking into account the medical exigencies) but no later than seventy-two (72) hours after receiving the request]. For authorizations and denials, we will give telephone notification of the decision to Members, Practitioners and those Providers involved in the provision of the service within seventy-two (72) hours of receipt of the request. We will give oral, written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within three (3) calendar days of the oral notification.

If your Provider attempt to file an urgent concurrent review but fails to follow our procedures for doing so, we will notify you and your Provider of the failure within twenty-four (24) hours. Our notification may be oral, unless asked for in writing.

Adverse Determinations

If the determination is an Adverse Determination, we shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedures outlined below. At this point, the Member can request an appeal of Adverse Determinations. Refer to the "Appeal Procedures" in Section 10 for details.

Lack of Necessary Information

If we need more information, we will let you know within twenty (24) hours of your claim. Sanford Health Plan will tell you what further information is needed. You will then have forty-eight (48) hours to provide us with the additional information. Sanford Health Plan will notify you of our decision within forty-eight (48) hours after we receive all requested information.

Our notification may be oral; if it is, we will follow it up in writing within three (3) days. If we do not receive the information, your claim will be considered denied at the expiration of the forty-eight (48) hours we gave you for furnishing the information to us.

2.15 WRITTEN NOTIFICATION PROCESS FOR ADVERSE DETERMINATIONS

The written notifications for Adverse Determinations will include the following:

1. The specific reason for the Adverse Determination in easily understandable language;

2. Reference to the specific provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual provisions, guidelines, and protocols free of charge upon request. Reasons for any denial or reimbursement or payment for services with respect to benefits under the plan will be provided within 30 business days of a request;

3. Notice of an Adverse Determination will include information sufficient to identify the claim involved, including the date of service the Provider, the claim amount (if applicable) and a statement notifying

members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review;

4. If the Adverse Determination is based in whole or in part upon the Member failing to submit necessary information, the notice shall include a description of any additional material or information, which the Member failed to provide to support the request, including an explanation of why the material is necessary;

5. If the Adverse Determination is based on Medical Necessity or an Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the coverage to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;

6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Determinations, if information on any Medical Necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 business days of a Member/Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the plan, in compliance with MHPAEA;

7. If the Adverse Determination is based on Medical Necessity, a written statement of clinical rationale, including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision;

8. A description of appeal procedures, including how to obtain an expedited review if necessary (and any time limits applicable to those procedures) including:

    - the right to submit written comments, documents or other information relevant to the appeal;
    - an explanation of the Appeal process including the right to Member representation;
    - notification that Expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and
    - the timeframe the Member has to make an appeal and the amount of time the Plan has to decide it (including the different timeframes for Expedited Appeals);

9. If the Adverse Determination is based on Medical Necessity, notification and instructions on how the Practitioner can contact the Practitioner to discuss the determination;

10. You have the right to contact the North Dakota Insurance Commissioner at any time.
(Refer to the Introduction section at the beginning of this document for contact information.)

SECTION 3
COVERED SERVICES – OVERVIEW

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides coverage for the following Covered Services. Payment for Covered Services is limited by or subject to any applicable Coinsurance, Copay, or Deductible set forth in this Contract including the Summary of Benefits and Coverage. To receive maximum coverage for Covered Services, the terms of this Contract must be followed, including receipt of care from In-Network Participating Practitioner and/or Providers as well as obtaining any required Certification. You are responsible for all expenses incurred for Non-Covered Services. Health Care Services received from Non-Participating Providers or Out-of-Network Participating Providers are Non-Covered Services unless otherwise indicated in this Contract.

3.1 HEALTH CARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

Here are some important things you should keep in mind about these benefits:

- *All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.*
- *Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided. Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Your Practitioner and/or Provider must get Certification of some services in this Section.* ***Receipt of Prior Authorization (Certification) does not guarantee payment of benefits.*** *The benefit description will say "**NOTE**: Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services Requiring Certification in Section 2.).*

3.1.1 ARTIFICIAL NUTRITION

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.).* Coverage is subject to Sanford Health Plan Guidelines.

- Parenteral nutrition formula and supplies
- Enteral nutrition formula and supplies

3.1.2 ALLERGY CARE BENEFITS

- Testing and treatment
- Allergy injections
- Allergy serum

3.1.3 CHIROPRACTIC SERVICES

Covered when provided on an inpatient or outpatient basis when Medically Necessary as determined by Sanford Health Plan and within the scope of licensure and practice of a Chiropractor, to the extent

services would be covered if provided by a Physician. Benefits are not available for Maintenance Care.

3.1.4 CLINICAL TRIALS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.
- Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.
    - The Health Care Service that is the subject of the Approved Clinical Trial.
    - Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
    - Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
    - An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
    - Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
    - A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
    - A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

3.1.5 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits.

Item	Information
Blood glucose test strips, glucagon, glucometers, glucose agents, lancets and lancet devices, prescribed oral agents for controlling blood sugars, syringes, urine testing strips	**Must be obtained at:** Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit; deductible/coinsurance may apply
Custom diabetic shoes and inserts; Limited to one (1) pair of depth-inlay shoes and three (3) pairs of inserts; or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts	**Must be obtained at:** Durable Medical Provider **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply
Continuous Glucose Monitor (CGM)	**Prior Authorization may be required** **Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit (must be on formulary and available through a pharmacy) or Medical Benefit (if obtained through a Durable Medical Provider); deductible/coinsurance may apply
Insulin Pump	**Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply

Coverage for the treatment of diabetes includes:

- Routine foot care, including toenail trimming is covered.
- Diabetes self-management training and education shall only be covered if:
    - the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner and/or Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator; and
    - the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the North Dakota Department on Health.

3.1.6 DIAGNOSTIC AND TREATMENT SERVICES

Professional services from Practitioners, Providers, Physicians, nurse practitioners, and Physician's assistants are covered when provided in Practitioner and/or Provider's offices and urgent care centers. Medical office consultations and second surgical opinions are also covered per Medical Necessity.

3.1.7 DIALYSIS BENEFIT

- Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under the End Stage Renal Disease (ESRD) program.
- Services include equipment, training, and medical supplies required for effective dialysis care. See Outpatient Nutrition Care Services in this Section for additional Chronic Renal Failure benefits. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 6.

3.1.8 DURABLE MEDICAL EQUIPMENT (DME) BENEFITS

- Coverage is available for DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Sanford Health Plan policy guidelines apply.
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan policy.
- Prior Approval is required for certain items. For updated information refer to: https://www.sanfordhealthplan.com/members/prior-authorization

3.1.9 EYE CARE SERVICES

- Cataract Surgery.
    - One (1) pair of eyeglasses or contact lenses per Member when purchased within 6 months following a covered cataract surgery the surgery
- Eyeglasses or contact lenses for Members diagnosed with aphakia (the absence of the lens of the eye, due to surgical removal, a perforated wound or ulcer, or a congenital condition resulting in complications which include the detachment of the vitreous or retina, and glaucoma)
    - Eyeglasses, including lenses and one frame per lifetime up to a net allowance of $200 or clear contact lenses for the aphakia eye will be covered for two (2) single lens per Calendar Year
    - Scleral Shells: Soft shells limited to two (2) per Calendar Year. Hard shells limited to one (1) per lifetime
- Non-routine vision exams relating to disease or injury of the eye.
- Vision therapy for Members 17 and under; limited to 16 visits per calendar year

3.1.10 FOOT CARE SERVICES

- Routine foot care covered for Members with diabetes only.
- Non-routine diagnostic testing and treatment of the foot due to illness or injury

NOTE: See Section on Orthotic and prosthetic devices for information on podiatric shoe inserts

3.1.11 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Coverage is limited to diagnostic testing and treatment related to illness or injury only.

- Benefit is limited to one hearing aid, per ear, per Adult Member, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines with prior approval *(certification required)*.
    - External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors. *This is a DME that requires Preauthorization/Prior Approval.*
        - The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:
            - provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by the Plan; or
            - help maintain or prevent deterioration in physical, cognitive, or behavioral function.
- Cochlear implants and bone-anchored (hearing aid) implants. *This is an Implant/Stimulator that requires Preauthorization/Prior Approval*
- Hearing aids for Members under age 18.
- Sudden sensorineural hearing loss (SSNHL), and diagnostic testing and treatment related to acute illness or injury.

NOTE: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. *(See Services requiring Certification in Section 2.).*

3.1.12 HOME HEALTH SERVICES

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.).*

Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lieu of Hospital or Skilled Nursing Facility:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only
- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized

3.1.13 IMPLANTS/STIMULATORS

- Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per medical appropriate guidelines apply (available upon request).
- The following Implants/Stimulators may be covered with prior approval *(certification*);
    - Bone Growth (external)
    - Cochlear Implant (Device and Procedure)
    - Deep Brain Stimulation
    - Gastric Stimulator
    - Spinal Cord Stimulator (Device and Procedure)
    - Vagus Nerve Stimulator

3.1.14 INFERTILITY BENEFITS

Benefits are available for services, supplies and medications related to artificial insemination (AI) and assisted reproductive technology (ART), includes gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) or in vitro fertilization (IVF). Preauthorization/Prior Approval *is required for assisted reproductive technology for GIFT, ZIFT, ICSI and IVF.*

NOTE: Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.

3.1.15 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

Coverage includes, but is not limited to, the following

- Blood tests
- Urinalysis
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- X-rays
- PET Scans
- DEXA Scans
- Non-routine mammograms
- CT Scans/MRI
- Ultrasound
- Electrocardiogram (EKG)
- Electroencephalography (EEG)

NOTE: Some of these services fall under High End Imaging and may require Certification. Failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

3.1.16 NEWBORN CARE BENEFITS

A newborn is eligible to be covered from birth. Members must complete and sign the Plan's enrollment application form requesting coverage for the newborn within *thirty-one (31)* days of the infant's birth. For more information, see Section 1 on Enrollment and "*When and How Dependent Coverage Begins"*.

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3.2 for coverage information on correcting congenital defects).

3.1.17 ONCOLOGY TREATMENT BENEFITS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Radiation Therapy. *This is an Oncology Service/Treatment that requires Certification.*
- Chemotherapy, regardless of whether the Member has separate prescription drug benefit

coverage. *This is an Oncology Service/Treatment that requires Certification.*

- The same cost-sharing amounts apply for intravenously administered or injected cancer chemotherapy agents as for prescribed, orally-administered, anticancer medications used to kill or slow the growth of cancerous cells

3.1.18 ORTHOTIC AND PROSTHETIC DEVICES

NOTE: Select items may require prior approval *(certification*). For up to date information, please refer to https://www.sanfordhealthplan.com/members/prior-authorization

- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Member's condition or to improve the function are eligible for coverage and do not require Prior Authorization.
- Cranial Prosthesis, including wigs up to $200 (limited to one per benefit period). .
- Devices permanently implanted that are not Experimental or Investigational Services such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. *This is a DME that requires Certification*
- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *four (*4) bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year. These do not require prior authorization.
- Prosthetic limbs, sockets and supplies, and prosthetic eyes. *This is a DME that requires Certification.*
- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 3.2 for payment information. Insertion of the device is paid under the surgery benefit.

3.1.19 OTHER TREATMENT THERAPIES NOT SPECIFIED ELSEWHERE

- Inhalation Therapy
- Non-Surgical, medically necessary treatment, of Gender Dysphoria (Gender Identity Disorder), including hormone therapy, mental/behavioral services, and laboratory testing to monitor the safety of continuous hormone therapy, per Plan guidelines (available upon request).
- Pheresis Therapy

3.1.20 OUTPATIENT NUTRITIONAL CARE SERVICES

Benefits are available for the following medical conditions:

- **Anorexia Nervosa** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Bulimia** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Chronic Renal Failure** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Diabetes Mellitus** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Gestational Diabetes** – Maximum Benefit Allowance of two (2) Office Visits per Member per Benefit Period.
- **Hyperlipidemia** – Maximum Benefit Allowance of two (2) Office Visits per Member per Benefit Period.
- **PKU** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.

3.1.21 OUTPATIENT REHABILITATIVE AND HABILITATIVE THERAPY SERVICES

Coverage is as follows for outpatient rehabilitative and habilitative therapy services, which include the management of limitations and disabilities, and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function:

- **Physical Therapy:** Benefits are subject to medical necessity and performed by or under the direct supervision of a licensed Physical Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Occupational Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Speech Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Respiratory/Pulmonary Therapy:** Available when services are performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of Members with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.

- **Cardiac Rehabilitation Services:** Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital. Twelve (12) visits per Member per episode, limited to the following diagnosed medical conditions:
  - Myocardial Infarction
  - Coronary Artery Bypass Surgery
  - Coronary Angioplasty and Stenting
  - Heart Valve Surgery
  - Heart Transplant Surgery

3.1.22 PEDIATRIC (CHILD) HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

See section 3.1.11 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES).

3.1.23 PEDIATRIC (CHILD) VISION SERVICES

Not Covered

3.1.24 PHENYLKETONURIA (PKU) AND AMINO ACID-BASED ELEMENTAL ORAL FORMULAS COVERAGE BENEFITS

Phenylketonuria (PKU) Coverage is as follows:

- Testing, diagnosis and treatment of Phenylketonuria (PKU) including dietary management, formulas, Case Management, intake and screening, assessment, comprehensive care planning and service referral.

Amino acid-based elemental oral formula coverage is as follows:

- Coverage for medical foods and low-protein modified food products determined by a Practitioner and/or Provider to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

3.1.25 PRENATAL AND MATERNITY SERVICES

NOTE: Due to the inability to predict admission, you or your Practitioner and/or Provider are encouraged to notify us of your expected due date when the pregnancy is confirmed. You are also encouraged to notify us of the date of scheduled C-sections when it is confirmed.

Covered maternity services include:

- Screening for gestational diabetes mellitus during pregnancy
  - Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.
  - Outpatient Nutrition Care Services available for gestational diabetes and diabetes mellitus. See
- Anemia screening
- Bacteruria (bacteria in urine) screening
- Hepatitis B screening
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Genetic counseling or testing that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force unless excluded under "Not Covered" conditions below. *This is considered an Outpatient Service that requires Preauthorization/Prior Approval.*
- Prenatal vitamins without Cost Sharing if prescribed by a Practitioner
- Deductible for delivery services is waived if services are rendered at a PPO Provider, and the Member is enrolled in Sanford Health Plan's *Healthy Pregnancy Program*.

Maternity care includes prenatal through postnatal maternity care and delivery, and care for complications of pregnancy in the mother. We cover up to two (2) routine ultrasounds per pregnancy to determine fetal age, size, and development, per plan guidelines.

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48)* hours for a vaginal delivery to a minimum of *ninety-six (96)* hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner and/or Provider, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Practitioners and/or Providers competent in postpartum care and newborn assessments.

Healthy Pregnancy Program

The *Healthy Pregnancy Program* is designed to provide you with the tools and support you need to give your baby the healthiest start possible. Participation in the *Healthy Pregnancy Program* is voluntary and free to all Plan Members.

As a program participant you will receive:

- Educational information on pregnancy, childbirth and postpartum
- Access to Text4baby, a tool to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more
- Deductible waiver*
- Free prenatal vitamins
- Access to RN case manager to answer questions

After your first prenatal visit, Members may enroll in Sanford Health Plan's Healthy Pregnancy program starting their 8th week of pregnancy, but no later than the 34th week at **sanfordhealthplan.com/ndpers/healthy-pregnancy-program**. Members will need their Member

number, health care provider name, and expected due date. If you have questions, please contact our care management team Monday through Friday from 8 a.m. to 5 p.m. CST at (888) 315-0884 (TTY: 711).

NOTE: When a Member is enrolled under the Healthy Pregnancy Program, the Deductible Amount is waived for delivery services received from a PPO Health Care Provider. High Deductible Health Plan members may enroll in the program but will not receive the deductible waiver benefit.

Newborns' and Mothers' Health Protection Act Disclosure

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours for a vaginal delivery to a minimum of ninety-six (96) hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by a Participating Practitioner and/or Providers competent in postpartum care and newborn assessments within forty-eight (48) hours after discharge to verify the condition of the mother and newborn. If such an inpatient stay lasts longer than the minimum required hours, Sanford Health Plan will not set the level of benefits or out-of-pocket costs so that the later portion of the stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call (888) 315-0884 (toll-free) or TTY/TDD: 711 (toll-free) to enroll.

3.1.26 PREVENTIVE CARE, ADULTS & CHILDREN

A Health Care Provider will counsel Members as to how often preventive services are need based on the age**,** gender and medical status of the Member. Services include:

- **Well Child Care to the Member's 6th birthday**
  - Seven (7) visits for Members from birth through 12 months;
  - Three (3) visits for Members from 13 months through 24 months; and
  - One (1) visit per Benefit Period for Members 25 months through 72 months.
- **Well Child Care Immunizations to the Member's 6th Birthday**
  - Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus, Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease, Influenza Virus.
- **Preventive Screening Services for Members age 6 and older**
  - One routine physical examination per Member per Benefit Period.
  - Routine diagnostic screenings.
  - Routine screening procedures for cancer.
  - **Note:** The Plan will pay up to a Maximum Benefit Allowance of $200 per Member per Benefit Period for any *non-diagnostic screening services* not listed below. Such *non-diagnostic screening services* will be subject to Copayment, Deductible and Coinsurance amounts after the $200 Benefit Allowance has been met.
- **Mammography Screening Services**
  - One (1) screening service for Members between the ages of 35 and 40.
  - One (1) screening service per year per Members ages 40 and older.

    - Covered non-diagnostic mammography screening services are subject to deductible/coinsurance and are eligible for $200 routine screening benefit allowance.
- **Routine Pap Smear**
    - One (1) Pap smear per Member per Benefit Period. Office Visit Copay applies.
    - Additional benefits will be available for Pap smears when Medically Necessary and ordered by a Professional Health Care Provider.
- **Prostate Cancer Screening for the following: Asymptomatic Males Ages 50 and Older; Males ages 40 and Older of African American descent; and Males Ages 40 with a Family History of Prostate Cancer**
    - One (1) digital rectal examination annually per Member. Office Visit Copay applies.
    - One (1) prostate-specific antigen test annually per Member. Office Visit Copay applies.
    - Additional benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Professional Health Care Provider.
- **Fecal Occult Blood Testing for Colorectal Cancer Screening for Members age 45 and older**
    - One (1) test per Member per benefit period.
    - Covered non-diagnostic colonoscopies are subject to deductible/coinsurance and are eligible for $200 routine screening benefit allowance.
- **Immunizations other than Well Child Care**
- Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster), Meningococcal Disease, and Human Papillomavirus (HPV). Certain age restrictions may apply

3.1.27 PRIVATE DUTY NURSING

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Private Duty Nursing is nursing care that is provided to a Member on a one-to-one basis by licensed nurse in an inpatient or home setting when any of the following are true:
    - No skilled services are already being provided.
    - Skilled nursing resources are available in the facility.
    - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
    - The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

3.1.28 TELEHEALTH SERVICES (VIRTUAL VISITS)

Services for telehealth are covered when the following conditions are met:

- The encounter involves a qualifying CPT code that the Health Plan has approved to be conducted by telehealth.
- The services are medically necessary and meet the definition of Covered Health Services as described in this Plan document.
- The technology platform used for the encounter is HIPAA compliant.
- The technology platform used for the encounter allows for fully synchronous, real-time, audio-video connection between the patient and the provider for the duration of the encounter.

- If the patient is physically present with one provider (host location) and is being connected to a remote (distant) provider, charges by the host provider as an originating site to facilitate the connection with the distant provider performing the service are also eligible for coverage, as well as the qualifying charges from the distant provider for conducting the telehealth encounter.

These services shall be available only when services are provided by Participating Providers. Cost share may be subject to applicable Deductible and/or Cost Sharing Amounts and vary based on platform used to complete the visit. For more information, please refer to the Virtual Care Policy at sanfordhealthplan.com.

3.2 SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

Here are some important things you should keep in mind about these benefits:

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Policy and are payable only when we determine they are Medically Necessary.*
- *In-Network Participating Practitioner and/or Providers must provide or arrange your care and you must be hospitalized in a Network Facility.*
- *Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3.4).*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES.*

3.2.1 ADMISSIONS

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits.

The following Hospital Services are covered:

- Room and board
- Critical care services
- Use of the operating room and related facilities
- General Nursing Services, including special duty Nursing Services if approved by the Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the United States Pharmacopoeia.
- Special diets during Hospitalization, when specifically ordered
- Other services, supplies, biologicals, drugs and medicines prescribed by a Practitioner and/or Provider during Hospitalization

NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital up to 48 hours after the procedure.

3.2.2 ANESTHESIA

SHP covers services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized/approved procedure or treatment.

3.2.3 HOSPICE CARE

- A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, when the following circumstances apply:
    - The Member has been diagnosed with a terminal disease and has a life expectancy of six (6) months or less;
    - The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);and
    - The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Chief Medical Officer over the course of hospice care.
- The following Hospice Services are Covered Services:

- Admission to a hospice Facility, Hospital, or Skilled Nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
- In-home hospice care per Plan guidelines (available upon request)
- Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for Member care up to eight (8) hours per day
- Social services under the direction of an In-Network Participating Practitioner and/or Provider
- Psychological and dietary counseling
- Physical or occupational therapy, as described under Section 3.1
- Consultation and Case Management services by an In-Network Participating Practitioner and/or Provider
- Medical supplies, DME and drugs prescribed by an In-Network Participating Practitioner and/or Provider Expenses for In-Network Participating Practitioner and/or Providers for consultant or Case Management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of coverage for these services as listed in Section 3.1, but only where the hospice retains responsibility for the care of the Member

3.2.3 ORAL AND MAXILLOFACIAL SURGERY

NOTE: Some services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*
    1. Care must be received within *twelve* (12) months of the occurrence
    2. Associated radiology services are included
    3. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    4. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Orthognathic Surgery per Sanford Health Plan guidelines. *This is an Outpatient Surgery that requires Certification*
    1. Associated radiology services are included
    2. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    3. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    1. Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    2. Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
    3. TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period.
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    1. is a child age nine (9) or older- *(Certification is not required for children under 9)*; or
    2. is severely disabled or otherwise suffers from a developmental disability; or
    3. has a high-risk medical condition(s) as determined by a licensed Physician that places the

Member at serious risk.

3.2.4 OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

Health Care Services furnished in connection with a surgical procedure performed at an In-Network Participating Surgical Center include:

- Outpatient Hospital surgical center
- Outpatient Hospital services such as diagnostic tests
- Ambulatory Surgical Center (same day surgery)

3.2.5 RECONSTRUCTIVE SURGERY

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Surgery to restore bodily function or correct a deformity caused by illness or injury
- If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Coverage for mastectomy related benefits will be provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. **For single mastectomy:** coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see *Orthotic and Prosthetic devices* in this Section). Deductible and Coinsurance applies as outlined in your Summary of Benefits and Coverage.

3.2.6 SKILLED NURSING CARE FACILITY BENEFITS

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Skilled Nursing Facility Services are covered if approved by the Plan in lieu of continued or anticipated Hospitalization. The following Skilled Nursing Facility Services are covered when provided through a state-licensed nursing Facility or program:
    1. Skilled nursing care, whether provided in an inpatient skilled nursing unit, a Skilled Nursing Facility, or a subacute (swing bed) Facility
    2. Room and board in a skilled nursing Facility
    3. Special diets in a Skilled Nursing Facility, if specifically ordered

Skilled nursing care in a Hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or Facility within a thirty-mile (30) radius of the Hospital.

3.2.7 TRANSPLANT SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

To be eligible for coverage, Transplants must meet United Network for Organ Sharing (UNOS) criteria and/or Sanford Health Plan Medical Criteria. Transplants must be performed at contracted Centers of Excellence or otherwise identified and accepted by Sanford Health Plan as qualified facilities.

Coverage is provided for transplants according to our medical coverage guidelines (available upon request) for the following services:

- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Drugs (including immunosuppressive drugs)
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan or other coverage arrangement
- Organ acquisition costs including:
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
- Post-transplant care and treatment
- Pre-operative care
- Psychological testing
- Second Opinions
    - SHP will notify the Member if a second opinion is required at any time during the determination of benefits period. If a Member is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second transplant facility for evaluation. If the second facility determines, for any reason, that the Member is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Member for the procedure.
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Supplies (must be Prior Authorized)
- Transplant procedure, Facility and professional fees

3.3 EMERGENCY SERVICES/ACCIDENTS

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.

3.3.1 BENEFIT DESCRIPTION

What is an Emergency Medical Condition?
An Emergency Medical Condition is the sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

What is a Prudent Layperson?
A **Prudent Layperson** is a person who is without medical training and who possess an average knowledge of health and medicine and who draws on his/her practical experience when making a decision regarding the need to seek Emergency medical treatment.
What is an urgent care situation?
An urgent care situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger.

If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to an urgent care or after-hours clinic.

We cover worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

3.3.2 EMERGENCY WITHIN OUR SERVICE AREA

Emergency services from Basic Plan-level Providers will be covered at the same benefit and Cost Sharing level as services provided by PPO-level Providers both within and outside of the Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. If the Plan determines the condition did not meet Prudent Layperson definition of an emergency, then the Basic Plan-level cost-sharing amounts will apply and the Member is responsible for charges above the Maximum Allowed Amount.

If an Emergency Condition arises, Members should proceed to the nearest emergency Facility that is an In-Network Participating Practitioner and/or Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency Facility, then the Member should seek care at the nearest emergency Facility. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

The Practitioner and/or Provider must notify the Plan and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.

3.3.3 PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize Members without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.4 NON- PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize a Member and may not require Prospective (Pre-Service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Emergency, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

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

3.3.5 EMERGENCY OUTSIDE OUR SERVICE AREA

If an Emergency occurs when traveling outside of the Service Area, Members should go to the nearest emergency Facility to receive care. The Member or a designated relative or friend must notify us and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.
Coverage will be provided for Emergency Medical Conditions outside of the Service Area unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

3.3.6 URGENT CARE SITUATION

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

NOTE: If the Plan determines the condition did not meet Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, and the Member is responsible for charges

above the Maximum Allowed Amount.

If an **Urgent Care Situation** occurs, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Member should contact the Plan and follow the Plan's instructions. A Member may always go directly to a participating urgent care or after-hours clinic. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)*.

3.3.7 PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.8 NON- PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval requirements if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Urgent Care Situation, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

3.3.9 AMBULANCE AND TRANSPORTATION SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

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

1. Medically Necessary; and
2. To the nearest In-Network Participating Practitioner and/or Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Here are some important things to keep in mind about these benefits:

- *All benefits are subject to the definitions, limitations, and exclusions in this Certificate of* Insurance *and are payable only when we determine they are Medically Necessary.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES. See the benefits description below.*

3.4.1 MENTAL HEALTH BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to Sanford Health Plan's mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate cost sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

Coverage is provided for mental health conditions which current prevailing medical consensus affirms substantially impairs perception, cognitive function, judgment, and/or emotional stability, and limits the life activities of the person with the condition(s). This includes but is not limited to the following conditions: schizophrenia; schizoaffective disorders; bipolar disorder; major depressive disorders (single episode or recurrent); obsessive-compulsive disorders; attention-deficit/hyperactivity disorder; autism spectrum disorders; post-traumatic stress disorders (acute, chronic, or with delayed onset); and anxiety disorders that cause significant impairment of function.

Mental health benefits are covered with the same Cost Sharing and restrictions as other medical/surgical benefits under the Contract. Coverage for mental health conditions includes:

- Diagnostic tests
- Electroconvulsive therapy (ECT)
- Inpatient services, including Hospitalizations
- Intensive Outpatient Programs
- Medication management
- Outpatient Professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health professionals

For outpatient treatment services, the **first five (5) visits of treatment** of any calendar year will be covered at 100% (no charge).

If you are having difficulty obtaining an appointment with a mental health practitioner and/or Provider, or for mental health needs or assessment services by phone, call the Sanford USD Medical Center Triage Line toll-free at (888) 996-4673.

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Applied Behavior Analysis (ABA) is a covered service for the treatment of Members diagnosed with Autism Spectrum Disorder.

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits.

- Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
- ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
- ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
- Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
- Limits are subject to the Plan's medical management policies and determinations of Medical Necessity.

3.4.3 SUBSTANCE USE DISORDER BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate Cost Sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD).

Substance use disorder benefits are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for substance use disorders includes:

1. Addiction treatment, including for alcohol, drug-dependence, and gambling issues
2. Inpatient services, including Hospitalization
3. Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, Licensed Chemical Dependency Counselors, or other qualified mental health and substance use disorder treatment professionals
4. Partial Hospitalization
5. Intensive Outpatient Programs

For outpatient treatment services, **the first five (5) visits of treatment** of any calendar year will be covered at 100% (no charge).

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

Here are some important things to keep in mind about these benefits:

- *Always refer to your Summary of Benefits (SBC), Formulary and other plan documents for specific details on your coverage.*
- *SHP covers prescribed drugs and medications, as described in this Section and in your Summary of Benefits/Formulary documents.*
- *All benefits are subject to definitions, limitations and exclusions listed in this document and are only payable when considered Medically Necessary.*
- *You must receive prior approval (authorization) for some medications. See the Summary of Benefits and Formulary for information.*

Refer to the Introduction section at the beginning of this document for instructions on how to contact Pharmacy Management.

3.5.1 BENEFIT DESCRIPTION

You must fill the prescription at a Plan Participating pharmacy for Cost Sharing amounts to apply. A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims from a Participating Pharmacy must be submitted by the Participating Pharmacy. A listing of the Plan's Participating pharmacies is available by contacting the Plan or online at sanfordhealthplan.com/ndpers. Specialty pharmacy options include any in network pharmacy, there is no specialty pharmacy requirement.

If a Member receives Prescription Medications from a Non-Participating Pharmacy, the Member is responsible for submitting a Claim for Benefits. Charges in excess of the Allowed Charge are the Member's responsibility.

- To fill a prescription, you must present your ID card to your pharmacy, if you do not, you will be responsible for all (100%) of the costs of the prescription to the pharmacy. Additionally, if you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.

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

- Sanford Health Plan uses a formulary: a list of prescription drug products, which are covered by the Plan for dispensing to Members when appropriate. The formulary will be reviewed regularly, and medications may be added or removed from the Formulary throughout the year. The Plan will notify you of the changes as they occur. For a copy of the Plan Formulary, contact Pharmacy Management or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- Sanford Health Plan reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per Plan medical necessity and limitation guidelines. Payment for excluded medications will be the Member's responsibility in full. Members may request an appeal

(review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this Certificate of Insurance.

- Sanford Health Plan will use appropriate Pharmacists and Practitioner and/or Providers to review formulary exception requests and promptly grant an exception to the formulary for a Member when that the prescriber indicates:
  - the Formulary drug causes an adverse reaction in the Member;
  - the Formulary drug is contraindicated for the Member; or
  - the prescription drug must be dispensed as written to provide maximum medical benefit to the Member.
- **NOTE**: To request a Formulary exception, please call Pharmacy Management or send a request by logging into the provider portal at www.sanfordhealthplan.com/memberlogin.
- Members must first try formulary medications before an exception to the formulary will be made unless the prescriber and the plan determine that use of the formulary drug may cause an adverse reaction or be contraindicated for the Member. If an exception is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.
- With certain medications, the Plan requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect is achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization (pre-approval) Review. Request Prior Authorization by contacting Pharmacy Management. Refer to the Formulary for a complete list of medications that require step therapy.
- To be covered by the Plan, certain medications require prior authorization (pre-approval) to ensure medical necessity. This can be in the form of written or verbal certification by a prescriber. To request certification, contact Pharmacy Management. Refer to the formulary for a complete list of medications that require Prior Authorization.
- Certain medications have a quantity limit to ensure the medication is being used as prescribed and the member is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your formulary for a complete list of medications with quantity limits.

There are dispensing limitations.

- One (1) Copayment Amount, plus any applicable coinsurance amount, applies per Prescription Order or refill for a *1 – 34-day* supply.
- Two (2) Copayment Amounts, plus any applicable coinsurance amounts, apply 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.
- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.
- Specialty Medications can be filled to a 30-day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan).

- If you traveling on vacation and need an extra supply of medication, you may request a "vacation override" to receive up to a three (3) month's supply of medication. Vacation supplies are limited to the time period that the Member is enrolled in the plan and one vacation override per medication per calendar year. Please contact Pharmacy Management to request a vacation override.
- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic equivalent or biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.

3.5.2 COVERED MEDICATIONS AND SUPPLIES

To be covered by the Plan, prescriptions must be:

a. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
b. Listed in the Plan Formulary, unless certification (authorization) is given by the Plan;
c. Provided by an In-Network Participating Pharmacy except in the event of urgent or emergent medical situations (if a prescription is filled at a Non-Participating and/or Out-of-Network Pharmacy in non-urgent or emergent medication situations, the Member will be responsible for the cost of the prescription medication in full.);
d. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

3.5.3 COVERED TYPES OF PRESCRIPTIONS

1. Federal Legend Drugs. Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to applicable laws and regulations.
2. Self-Administered medications- medications such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a Network Pharmacy
3. Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations
4. Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
5. Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, continuous glucose monitor receiver, diabetic needles and syringes are covered when medically necessary. (See section 3.1 for Diabetic supplies, equipment, and self-management training benefits.)
6. Generic oral contraceptives, injections and/or devices will be subject to Member's cost-share.

3.6 DENTAL BENEFITS

Here are some important things to keep in mind about these benefits:

1. *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of* Insurance *and are payable only when we determine they are Medically Necessary.*
2. *We cover Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the Member. See Section 3.2 for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.*
3. *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
4. *YOU MUST GET CERTIFICATION OF THESE SERVICES.*

3.6.1 BENEFIT DESCRIPTION

NOTE: The following benefits are Outpatient Surgeries, Services, or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. See Prospective (Pre-Services) Review of Services (Certification Prior Authorization) in Section 2.

- Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
  - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
  - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period.
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is a child age nine (9) or over; (Certification not required for children under 9) or
  - is severely disabled or otherwise suffers from a developmental disability; or
  - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage applies to stabilization related to accident or injury only and not restoration.

3.6.2 PEDIATRIC (CHILD) DENTAL CARE

Not covered

3.7 SCHEDULE OF BENEFITS

3.7.1 GENERAL

This section outlines the payment provisions for Covered Services described in Sections 3 and 5, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

3.7.2 OVERVIEW OF COST SHARING AMOUNTS AND HOW THEY ACCUMULATE

Cost Sharing Amounts include Coinsurance, Copayment, and Deductibles; as well as the Prescription Drug Coinsurance Maximum, Infertility Services Deductible and Out-of-Pocket Maximum Amounts. See *Cost Sharing Amounts – Details & Definitions* later in this Section for more information.

- The Deductible Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, accumulate jointly up to the PPO Deductible Amount.
- The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider or on the Basic Plan, accumulate jointly up to the Out-of-Pocket Maximum Amount.
- When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. Covered Services sought under the Basic Plan will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.
- Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amounts.
- Prescription Medication Copayment Amounts do not apply toward the Prescription Drug Coinsurance Maximum Amount.

A Member is responsible for Cost Sharing Amounts. All Members in the family contribute to Deductible and Coinsurance Amounts. However, a Member's contribution cannot be more than the Single Coverage amount. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. For the specific benefits and limitations that apply to this Plan, please see Section 3.8, *Outline of Covered Services*; Section 3, *Covered Services*; Section 4, *Limited and Non-Covered Services*; and your Summary of Benefits and Coverage.

If Sanford Health Plan pays amounts to the Health Care Provider that are the Member's responsibility, such as Deductibles, Copayments or Coinsurance Amounts, Sanford Health Plan may collect such amounts directly from the Member. The Member agrees that Sanford Health Plan has the right to collect such amounts from the Member.

3.7.3 BENEFIT SCHEDULE

Benefit Schedule	PPO Plan	Basic Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$500 per Benefit Period	$500 per Benefit Period
Family Coverage	$1,500 per Benefit Period	$1,500 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$1,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$2,000 per Benefit Period	$3,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$1,500 per Benefit Period	$2,000 per Benefit Period
Family Coverage	$3,500 per Benefit Period	$4,500 per Benefit Period
Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:		
$1,200 per Member per Benefit Period Coinsurance for non-formulary medications does not apply to the $1,200 coinsurance		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
$500 per Member		

The benefit payment available under this Benefit Plan differs depending on the Subscriber's choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with Sanford Health Plan. Providers that are contracted with Sanford Health Plan, and participate in the Plan's Network, will be paid at either the PPO Plan or Basic Plan level.

Members should refer to the Sanford Health Plan website (sanfordhealthplan.com/ndpers) for the Provider Directory, which lists Participating Health Care Providers. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Health Care Providers. Members may also call Customer Service at (800) 499-3416 *(toll-free)* or TTY/TDD: 711 *(toll-free)* to request a provider directory.

3.7.4 HOW PPO VS. BASIC PLAN DETERMINES BENEFIT PAYMENT

PPO Plan

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

To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing at sanfordhealthplan.com/ndpers.

NOTE: Benefits for Covered Services received by Eligible Dependents, as outlined in Section 2, *Eligibility Requirements for Dependents*, who are residing out of the state of North Dakota will be paid at the Basic Plan level. If the Subscriber, or the Subscriber's spouse, is required by court order to provide health coverage for that Eligible Dependent, you may be asked to provide a copy of the court order to the Plan.

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

3.7.5 PARTICIPATING HEALTH CARE PROVIDERS

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

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

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

3.7.6 NON- PARTICIPATING HEALTH CARE PROVIDERS

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

3.7.7 NON-PARTICIPATING HEALTH CARE PROVIDERS WITHIN THE STATE OF NORTH DAKOTA

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

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

Benefit payments will be made directly to the Provider for Covered Services received from a Non-Participating Health Care Provider. Sanford Health Plan may designate a Health Care Provider as Non-Payable.

3.7.8 NON-PARTICIPATING HEALTH CARE PROVIDERS OUTSIDE THE STATE OF NORTH DAKOTA

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

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

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

3.7.9 NON-PARTICIPATING PROVIDERS OUTSIDE THE SANFORD HEALTH PLAN SERVICE AREA

When Covered Services are provided outside of Sanford Health Plan's Service Area by health care providers who have not entered into a "participating agreement" with Sanford Health Plan (Non-Participating Health Care Providers), the amount the Member pays for such services will generally be based on either Sanford Health Plan's Non-Participating Health Care Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

In certain situations, Sanford Health Plan may use other payment bases, such as the payment Sanford Health Plan would make if the Covered Services had been obtained within the Sanford Health Plan Service Area, or a special negotiated payment, as permitted, to determine the amount Sanford Health Plan will pay for Covered Services provided by Non-Participating Health Care Providers. In these situations, a Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

3.7.10 HEALTH CARE PROVIDERS OUTSIDE THE UNITED STATES

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

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

3.7.11 NON-PAYABLE HEALTH CARE PROVIDERS

If Sanford Health Plan designates a Health Care Provider as *Non-Payable*, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the *Non-Payable Health Care Provider*. Notice of designation as a Non-Payable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Non-Payable Health Care Provider.

As of the date of termination, all charges incurred by a Member for services received from the Non-Payable Health Care Provider will be the Subscriber's responsibility.

3.7.12 MEDICARE PRIVATE CONTRACTS

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services, and indicate that 1) neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider; and 2) the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge.

Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and Sanford Health Plan will limit its payment to the amount Sanford Health Plan would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by Sanford Health Plan.

3.7.13 COST SHARING AMOUNTS- DETAILS

A Cost Sharing Amount is the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Applicable Cost Sharing Amounts are identified in Section 2 and the Member's Summary of Benefits and Coverage. See the schedule above in *Overview of Cost Sharing Amounts and how they accumulate* for the specific Cost Sharing Amounts that apply to this Benefit Plan.

3.7.14 COINSURANCE

Sanford Health Plan shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the Sanford Health Plan contracted provider network on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

If Covered Services are obtained by a Member out of the Sanford Health Plan contracted provider network, the coinsurance calculation may be based on the Health Care Provider's billed charges. This may result in a significantly higher Coinsurance Amount for certain services a Member incurs out of the Sanford Health Plan contracted provider network. It is not possible to provide specific information for each Health Care Provider outside of Sanford Health Plan's Service Area because of the many different arrangements between Health Care Providers. However, if a Member contacts Sanford Health Plan prior to receiving services from a Health Care Provider outside of Sanford Health Plan's Service Area, Sanford Health Plan may be able to provide information regarding specific Health Care Providers.

3.7.15 COINSURANCE MAXIMUM AMOUNTS

The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amounts renew on January 1 of each consecutive Benefit Period.

3.7.16 DEDUCTIBLES

The Deductible Amounts renew on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward the Deductible Amount.

NOTE: The deductible amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Deductible Amount.

3.7.17 OUT-OF-POCKET MAXIMUM AMOUNTS

When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1st of each consecutive Benefit Period. Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

NOTE: The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Out-of-Pocket Maximum Amount.

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

3.7.18 PRESCRIPTION DRUG COINSURANCE MAXIMUM AMOUNTS

When the Prescription Drug Coinsurance Maximum Amount that is a Member's responsibility during a Benefit Period is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications, less Copayment Amounts incurred during the remainder of the Benefit Period. This Prescription Drug Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period.

NOTE: Copayment Amounts do not apply toward this Coinsurance Maximum Amount.

3.7.19 INFERTILITY SERVICES COINSURANCE/DEDUCTIBLE

Neither the Infertility Services Lifetime Deductible Amount nor any Member-paid coinsurance for infertility services applies toward the annual Out-of-Pocket Maximum Amounts. Infertility services are limited per Member to a lifetime benefit maximum of $20,000.

3.8 OUTLINE OF COVERED SERVICES

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Inpatient Hospital and Medical Services		
• **Inpatient Hospital Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Medical Care Visits**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Consultations**	80% of Allowed Charge.	75% of Allowed Charge.
• **Concurrent Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Initial Newborn Care**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
Inpatient and Outpatient Surgical Services		
• **Professional Health Care Provider Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Assistant Surgeon Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ambulatory Surgical Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospital Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Anesthesia Services**	80% of Allowed Charge.	75% of Allowed Charge.
Transplant Services		
• **Inpatient and Outpatient Hospital and Medical Services**	80% of Allowed Charge *Preauthorization/Prior Approval required.*	75% of Allowed Charge *Preauthorization/Prior Approval required.*
• **Transportation Services**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are subject to a Maximum Benefit Allowance of $1,000 per transplant procedure.	
Dental Services	*Covered Dental Services Benefit is for stabilization related to accident or injury only and not restoration.*	
• **Temporomandibular (TMJ) or**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Craniomandibular (CMJ) Joint Treatment	*Benefits are subject to a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.*	
• **Dental Services Related to Accidental Injury**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dental Anesthesia and Hospitalization**	80% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*	75% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*
Outpatient Hospital and Medical Services		
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Emergency Services**	$60 Copayment Amount, then deductible and 80% of coinsurance applies for emergency room facility fee billed by a Hospital.	$60 Copayment Amount, then deductible and 80% of coinsurance applies for emergency room facility fee billed by a Hospital.
	The Copayment Amount for the emergency room facility fee is waived when a Member is admitted directly as an Inpatient to a Hospital.	
	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. (*Deductible Amount is waived)*	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. (*Deductible Amount is waived*
	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Ambulance Services**	80% of Allowed Charge.	80% of Allowed Charge.
• **Radiation Therapy and Chemotherapy**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dialysis Treatment**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Infusion Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Visual Training for Members under age 17**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are subject to an Annual Maximum of 16 visits per Member.	
• **Allergy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Phenylketonuria (PKU)** - *Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)*	80% of Allowed Charge.	75% of Allowed Charge.
Wellness Services		
• **Well Child Care to the Member's 6th birthday**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *7 visits for Members from birth through 12 months;* • *3 visits for Members from 13 months through 24 months; and* • *1 visit per Benefit Period for Members 25 months through 72 months.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Well Child Care Immunizations to the Member's 6th birthday**	100% of Allowed Charge. *Deductible Amount is waived.* *Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus); MMR (Measles-Mumps-Rubella); Hemophilus; Influenza B; Hepatitis; Polio; Varicella (Chicken Pox); Pneumococcal Disease; and Influenza Virus.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Preventive Screening Services for Members age 6 and older**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits include:* • *One routine physical examination per Member per Benefit Period.* • *Routine diagnostic screenings.* • *Routine screening procedures for cancer.* *A Health Care Provider will counsel Members as to how often preventive services are needed based on the age, gender and medical status of the Member. The Plan will pay up to a Maximum Benefit Allowance of $200 per Member per Benefit Period for any non-diagnostic screening services not listed below. Such non-diagnostic screening services will be subject to Copayment, Deductible and Coinsurance amounts after the $200 Benefit Allowance has been met.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Mammography Screening Services**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *One service for Members between the ages of 35 and 40* • *One service per year for Members age 40 and older.* *Additional benefits will be available for mammography services when Medically appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 3.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Routine Pap Smear**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period.*	100% of Allowed Charge. *Deductible Amount is waived.*
Related Office Visit	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Additional benefits will be available for Pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 3.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Prostate Cancer Screening**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. Deductible Amount is waived.
Related Office Visit	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of Africa American descent; and a male age 40 with a family history of prostate cancer *Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 3.*		
• **Fecal Occult Blood Testing for Colorectal Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Benefits are available for Members age 45 and older, subject to a Maximum Benefit Allowance for 1 test per Benefit Period.		
• **Immunizations other than Well Child Care**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster) Vaccine, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.		
• **Outpatient Nutritional Care Services**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions: • *Hyperlipidemia – Two (2) Office Visits per Member per Benefit Period.* • *Gestational Diabetes – Two (2) Office Visits per Member per Benefit Period.* • *Chronic Renal Failure – Four (4) Office Visits per Member per Benefit Period.* • *Diabetes Mellitus – Four (4) Office Visits per Member per Benefit Period.* • *Anorexia Nervosa – Four (4) Office Visits per Member per Benefit Period.* • *Bulimia – Four (4) Office Visits per Member per Benefit Period.* • *PKU – Four (4) Office Visits per Member per Benefit Period.* • *Obesity – One (1) Office Visit per Member per Benefit Period.*		

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Diabetes Education Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Dilated Eye Examination** *(for diabetes related diagnosis)*	$30 Copayment Amount, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount, then 75% of Allowed Charge. *Deductible Amount is waived.*
Outpatient Therapy Services Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.		
• **Physical Therapy**	$30 Copayment Amount per Office Visit/Evaluation or $25 Copayment Amount Per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit/Evaluation or $30 Copayment Amount Per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	$25 Copayment Amount per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	$25 Copayment Amount per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Respiratory Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Cardiac Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions:* • *Myocardial Infarction* • *Coronary Artery Bypass Surgery* • *Coronary Angioplasty and Stenting* • *Heart Valve Surgery* • *Heart Transplant Surgery* *Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Pulmonary Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
Chiropractic Services	Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.	
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Therapy and Manipulations**	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
Maternity Services	The Deductible Amount is waived for delivery services received from a PPO Health Care Provider when the Member is enrolled in the *Healthy Pregnancy* Program.	
• **Inpatient Hospital and Medical Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Prenatal and Postnatal Care**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **One (1) Prenatal Nutritional Counseling visit per pregnancy**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Lactation Counseling**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Infertility Services		
• **Diagnostics, Treatment, Office Visits, and Other Services**	80% of Allowed Charge. *Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.*	80% of Allowed Charge.
Mental Health and Substance Use Disorder Treatment Services		
• **Mental Health Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of the Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*
Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
➢ **Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*
Other Services Not Previously Listed Above		
• **Skilled Nursing Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Health Care Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospice Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Private Duty Nursing Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Medical Supplies and Equipment**	80% of Allowed Charge.	75% of Allowed Charge.
- Home Medical Equipment - Prosthetic Appliances and Limbs - Orthotic Devices - Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Prescription Drug Benefit – See Section 3.5 - Oxygen Equipment and Supplies - Ostomy Supplies - External Hearing aids	*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.*	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Eyeglasses or Contact Lenses** *(following a covered cataract surgery)*	80% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.*	75% of Allowed Charge.

Prescription Drug and Diabetes Supplies Benefits

Retail and Mail Order

Insulin and medical supplies for insulin dosing and administration

➢ **Insulin and Glucagon** Formulary or Non-Formulary

1-30 day supply	$25 copayment *Deductible amount is waived*	$25 copayment *Deductible amount is waived*
31-60 day supply	$50 copayment *Deductible amount is waived*	$50 copayment *Deductible amount is waived*
61-100 day supply	$75 copayment *Deductible amount is waived*	$75 copayment *Deductible amount is waived*

➢ **Testing Supplies** Formulary

1-30 day supply	25% coinsurance with maximum of $25	25% coinsurance with maximum of $25
31-60 day supply	25% coinsurance with maximum of $50	25% coinsurance with maximum of $50
61-100 day supply	25% coinsurance with maximum of $75	25% coinsurance with maximum of $75

➢ **Testing Supplies** Non-Formulary

1-30 day supply	50% coinsurance with maximum of $25	50% coinsurance with maximum of $25
31-60 day supply	50% coinsurance with maximum of $50	50% coinsurance with maximum of $50
61-100 day supply	50% coinsurance with maximum of $75	50% coinsurance with maximum of $75

➢ **Insulin pen needles and syringes** Formulary or Non-Formulary

1-30 day supply	12% coinsurance with maximum of $25	12% coinsurance with maximum of $25
31-60 day supply	12% coinsurance with maximum of $50	12% coinsurance with maximum of $50
61-100 day supply	12% coinsurance with maximum of $75	12% coinsurance with maximum of $75

Formulary Prescription Medication

➢ Generic	$7.50 Copayment Amount, then 88% of Allowed Charge. Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*
➢ Brand Name	$25 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*

Non-Formulary Medication

Generic and Brand Name	$30 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount

Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount for Formulary Medications is:

——————————————$1,200 per Member per Benefit Period ——————————————

Copayment Amount Application

- One Copayment Amount per Prescription Order or refill for a 1 - 34-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 35 - 100-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 2- or 3-month supply of Non-Formulary contraceptives.

Formulary contraceptive medications obtainable with a Prescription Order are subject to Member cost share; this includes over-the-counter Plan-B, if obtained with a Prescription Order. Cost share will be applied equal to other drugs-Generic, Preferred and Non-preferred.

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.

If a Generic Prescription Medication is the therapeutic equivalent for a Brand Name Prescription Medication, and is authorized by a Member's Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent, the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication and applicable Cost Sharing Amounts. For details, see Section 3.5.

Prescription Medication Cost Sharing Amounts do not apply toward the Member's Out-of-Pocket Maximum Amounts. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

Cost Sharing Amounts are waived for generic federal legend prenatal vitamins when the member is enrolled in the Healthy Pregnancy program. Member will be responsible for copayment plus co-insurance for all brand name federal legend prenatal vitamins and generic federal legend vitamins, if not enrolled in the Healthy Pregnancy Program. For details, see Section 3.

SECTION 4
LIMITED AND NON-COVERED SERVICES

This section describes services that are subject to limitations or NOT covered under this Contract. The Plan is not responsible for payment of non-covered or excluded benefits.

4.1 GENERAL MEDICAL EXCLUSIONS

1. A service that would similarly not be charged for in a regular office visit
2. Abortions, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation.
3. Additional refractive procedure (including lens) after coverage of initial lens at time of cataract correction.
4. Admissions to Hospitals performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider
5. Adult vision exams (routine)
6. All other hearing related supplies, purchases, examinations, testing or fittings
7. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, massage therapy unless covered per plan guidelines under Women's Health and Cancer Rights Act of 1998 (WHCRA) for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, or therapeutic touch.
8. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.
9. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this COI.
10. Any expenses related to surrogate parenting, unless the surrogate is a Member
11. Any fraudulently billed charges or services received under fraudulent circumstances.
12. Any other equipment and supplies which the Plan determines are not eligible for coverage
13. Any services or supplies for the treatment of obesity that do not meet the Plan's medical necessity coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling), nutritional supplements or food supplements; and weight loss or exercise programs.
14. Appointment scheduling
15. Artificial organs, any transplant or transplant services not listed above
16. Autopsies, unless the autopsy is at the request of the Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense
17. Bifocal contact lenses
18. Blood and blood derivatives replaced by the Member
19. Breastfeeding equipment and supplies (personal use)
20. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by the Plan.
21. Charges for professional sign language and foreign language interpreter services.
22. Charges for sales tax, mailing, interest and delivery.
23. Charges for services determined to be duplicate services by the Plan's Chief Medical Officer or designee.
24. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations
25. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers.
26. Chemical peel for acne
27. Clarification of simple instructions
28. Cleaning and polishing of prosthetic eye(s)

29. Clinical ecology, orthomolecular therapy, vitamins (unless otherwise specified as covered in this COI) or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.
30. Compact (portable) travel hemodialyzer system
31. Complications from a non-covered or denied procedure or service.
32. Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
33. Consultative message exchanges
34. Contraceptives that do not require a Prescription Order or dispensed by a Health Care Provider , including medications, devices, appliances, supplies and related services for contraception. All contraceptives requiring a Prescription Order or dispensed by a Healthcare Provider are covered, subject to Member's Cost Share.
35. Convalescent care
36. Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
37. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services, body contouring procedures, and body lift procedures, with the exception of WHCRA for coverage related to breast cancer.
38. Costs related to locating and/or screening organ donors
39. Coverage is limited to one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
40. Custodial or Convalescent care
41. Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized/approved corrective surgery (except as stated above and in Section 3 "Diabetes supplies, equipment, and education")
42. Deluxe equipment
43. Dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD)
44. Dental x-rays or dental appliances
45. Diagnosis and treatment of weak, strained, or flat feet
46. Dietary desserts and snack items
47. Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined
48. Domiciliary care or Maintenance Care
49. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of embryos sperm or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing;
50. Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless of whether the donor is covered as a Member under this Plan
51. Duplicate or similar items
52. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management.
53. Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services provided under the Individuals with Disabilities Education

Act (IDEA)

54. Elective health services received outside of the United States.
55. Expenses incurred by a Member as a donor, unless the recipient is also a Member
56. Experimental and Investigational Services.
57. Experimental and/or Investigational services or devices
58. Extra care costs related to taking part in a clinical trial such as additional tests that a Member may need as part of the trial, but not as part of the Member's routine care.
59. Extraction of wisdom teeth
60. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as Covered elsewhere in this Certificate of Insurance
61. Fees associated with Room and Board, unless Prior Authorization is received pursuant to Medical Necessity guidelines
62. First aid or precautionary equipment such as standby portable oxygen units
63. Food items for medical nutrition therapy
64. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Insurance).
65. For Members ages 18 and older, external hearing aids; non-implant devices; or equipment to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors
66. Formula and supplements available Over the Counter
67. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Member's Practitioner and/or Provider.
68. Hair plugs or hair transplants
69. Health Care Services Covered by Any Governmental Agency/Unit for military service-related injuries/diseases, unless applicable law requires the Plan to provide primary coverage for the same.
70. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition
71. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition.
72. Health Care Services ordered by a court or as a condition of parole or probation
73. Health Care Services performed by any Provider who is the Member or a member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the Member may go to a Non-Participating Provider and receive In-Network coverage (Section 4). If the immediate family member is not the only Participating Provider in the area, the Member must go to another Participating Provider in order to receive coverage at the In-Network level.
74. Health Care Services prohibited state or federal rule, law, or regulation
75. Health Care Services provided either before the effective date of the Member's coverage with the Plan or after the Member's coverage is terminated.
76. Health Care Services that the Plan determines are not Medically Necessary.
77. Hemodialysis machine (not separately payable)
78. Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
79. Home Traction Units
80. Hospitalization for extraction of teeth if not otherwise specified as Covered in this Certificate of Insurance
81. Hot/cold pack therapy including polar ice therapy and water circulating devices

82. Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
83. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
84. Iatrogenic condition, illness, or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to Iatrogenic illness or injury are not the responsibility of the Member.
85. Incidental cholecystectomy performed at the time of weight loss surgery.
86. Independent nursing, homemaker services, respite care
87. Installation or maintenance of any telecommunication devices or systems
88. Intermediate level or Domiciliary care
89. Items which are primarily educational in nature or for vocation, comfort, convenience or recreation
90. LASIK eye surgery
91. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics.
92. Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
93. Maintenance and service fee for capped-rental items
94. Maintenance care
95. Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or initiated by Members without symptoms in order to promote health and to prevent further problems
96. Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling
97. Methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy (unless otherwise specified as covered in this COI).
98. Milieu therapy
99. Natural teeth replacements including crowns, bridges, braces or implants
100. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events. not to be eligible for coverage
101. Newborn delivery and nursery charges for adopted dependents prior to the adoption bonding period (See Section 1, “When and How Dependent Coverage Begins.”)
102. Nursing care requested by, or for the convenience of the Member or the Member’s family (rest cures)
103. Orthopedic shoes; over-the-counter orthotics and appliance, except if covered elsewhere in this Certificate of Insurance
104. Osseointegrated implant surgery (dental implants)
105. Personal comfort items (telephone, television, guest meals and guest beds)
106. Physical examinations, including but not limited to: pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for drivers’ licenses)
107. PKU dietary desserts and snack items
108. Procedures to evaluate and reverse sterilization
109. Provider-initiated e-mail
110. Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere
111. Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of

altering, modifying, or correcting myopia, hyperopia, or stigmatic error
112. Refractive errors of the eye
113. Refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses
114. Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other health care services
115. Reminders of scheduled office visits
116. Remote control devices as optional accessories
117. Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; patient desire for change of implant; patient fear of possible negative health effects; or removal of ruptured saline implants that do not meet medical necessity criteria
118. Replacement of lost, stolen, broken, or damaged lenses or glasses
119. Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
120. Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness, lost, or stolen
121. Requests for a referral
122. Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
123. Residential care
124. Rest cures
125. Reversals of prior sterilization procedures; and
126. Revision of durable medical equipment, except when made necessary by normal wear or use
127. Revision/replacement of prosthetics (except as noted per Plan guidelines (available upon request)
128. Routine cleaning of Scleral Shells
129. Routine dental care and treatment
130. Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
131. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
132. Sensitivity training
133. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction).
134. Service call charges, labor charges, charges for repair estimates
135. Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty
136. Services and/or travel expenses relating to a Non-Emergency Medical Condition
137. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home.
138. Services for excluded benefits
139. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
140. Services not medically appropriate or necessary
141. Services not medically appropriate to do via telehealth
142. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.
143. Services provided in the Member's home for convenience
144. Services related to environmental change
145. Services that are not Health Care Services.
146. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
147. Services to assist in activities of daily living (ADLs)
148. Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies,

medications and aftercare for, or related to, artificial or non-human organ transplants
149. Services, chemotherapy, supplies, medications and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee
150. Services, chemotherapy, supplies, medications and aftercare for, or related to, transplants performed at a non-Plan Participating Center of Excellence
151. Shortening of the mandible or maxillae for cosmetic purposes
152. Sleep studies performed at a facility not accredited by the American Academy of Sleep Medicine
153. Smoking deterrents.
154. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability.
155. Special lens coating or lens treatments for prosthetic eyewear
156. Storage of stem cells, including storing umbilical cord blood of non-diseased persons, for possible future use
157. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
158. Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)
159. Take-home medications (Prescription medications provided to a Member at discharge are paid under the Prescription Drug Benefit. See Sections 2 and 3.5 for payment amount details.)
160. Telephone assessment and management services
161. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.
162. Therapy and service animals, including those used for emotional or anxiety support
163. Thermograms or thermography
164. Tinnitus Maskers
165. Tobacco cessation medication
166. Transfers performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider
167. Transmission fees
168. Transplant evaluations with no end organ complications
169. Transplants and pre and post-transplant services at Non-Participating Center Of Excellence Facilities
170. Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria
171. Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening services, testing and supplies
172. Unspecified complication of kidney transplant
173. Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
174. Virtual colonoscopies
175. Vitamins (unless otherwise specified as covered in this COI), minerals, therabands, cervical pillows, and hot/cold pack therapy including polar ice therapy and water circulating devices
176. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
177. Wearable artificial kidney, each

4.2 GENERAL PHARMACY EXCLUSIONS

1. Any medication equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider
2. B-12 injection (except for pernicious anemia)

3. Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine
4. Compound medications with no legend (prescription) medication
5. Drug Efficacy Study Implementation ("DESI") drugs
6. Experimental or Investigational medications or medication usage pursuant to the Plan's medical coverage policies
7. Excluded medications from coverage that provide little or no evidence of therapeutic advantage over other products available.
8. Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances
9. Medical Cannabis and/or its equivalents
10. Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of Medical Necessity)
11. Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
12. Medications not listed in the Plans Formulary
13. Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;
14. Medications that are obtained without Prior Authorization or a Formulary exception from the Plan
15. Medications that may be received without charge under a government program, unless coverage is required for the medication
16. Medications that provide little or no evidence of therapeutic advantage over other products available
17. Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Member's medical benefit;
18. Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document
19. Over-the-counter (OTC) medications vitamins and/or supplements, equipment or supplies (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by Federal or State law do not require a prescription order
20. Refills of any prescription older than one (1) year
21. Repackaged medications
22. Replacement of a prescription medication due to loss, damage, or theft
23. Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
24. Unit dose packaging
25. Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia

4.3 SPECIAL SITUATIONS AFFECTING COVERAGE

Neither Sanford Health, nor any Participating Provider, shall have any liability or obligation because of a delay or a Participating Provider's inability to provide services as a result of the following circumstances:

- Complete or partial destruction of the Provider's facilities;
- Declared or undeclared acts of War or Terrorism;
- Riot;
- Civil insurrection;
- Major disaster;
- Disability of a significant portion of the Participating Providers;

- Epidemic; or
- A labor dispute not involving Participating Providers, we will use our best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services is delayed due to a labor dispute involving Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

Additionally, non-Emergency care may be deferred until after resolution of the above circumstances.

4.4 SERVICES COVERED BY OTHER PAYORS

The following are excluded from coverage:

- Health Care Services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by Worker's compensation, no-fault auto insurance, medical payments coverage or similar legislation.
- The Plan is not issued in lieu of nor does it affect any requirements for coverage by Worker's Compensation. This Plan contains a limitation, which states that health services for injuries or sickness, which are job, employment or work, related for which benefits are paid under any Worker's Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid under the Plan, and it is determined that Member is eligible to receive Worker's Compensation for the same incident; Sanford Health Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse Sanford Health Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Worker's Compensation Division Hearing. Sanford Health Plan reserves its right to recover against Member even though:
    - The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise; or
    - No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
    - The amount of Worker's Compensation for medical or health care is not agreed upon or defined by Member or the Worker's Compensation carrier; or
    - The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.
- Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Worker's Compensation insurer, without the express written agreement of Sanford Health Plan.
- Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or Group.
- Health Care Services for injury or sickness for which there is other non-Group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
- Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.
- Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and TRICARE, unless applicable law requires the Plan to provide primary coverage for the same.

4.5 SERVICES AND PAYMENTS THAT ARE THE RESPONSIBILITY OF MEMBER

- Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Benefits and Coverage and Summary of Pharmacy Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;
- Finance charges, late fees, charges for missed appointments and other administrative charges; and
- Services for which a Member is neither legally, nor as customary practice, is required to pay in the absence of a group health plan or other coverage arrangement.

SECTION 5
HOW SERVICES ARE PAID FOR UNDER THE CERTIFICATE OF INSURANCE

5.1 REIMBURSEMENT OF CHARGES BY PARTICIPATING PROVIDERS

- When you see Participating Practitioner and/or Providers, receive services at Participating Practitioner and/or Provider Providers and facilities, or obtain your prescription drugs at Network Pharmacies, you will not have to file claims. You must present your current identification card and pay your Copay.
- When a Member receives Covered Services from a Participating Practitioner and/or Provider, Sanford Health Plan will pay the Participating Practitioner and/or Provider directly, and the Member will not have to submit claims for payment. The Member's only payment responsibility, in this case, is to pay the Participating Practitioner and/or Provider, at the time of service, any Copay, Deductible, or Coinsurance amount that is required for that service. Participating Practitioner and/or Providers agree to accept either Sanford Health Plan's payment arrangements or the negotiated contract amounts.

Time Limits. Participating Practitioner and/or Providers must file claims to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If the Member fails to show his/her ID card at the time of service, then the Member may be responsible for payment of claim after Practitioner and/or Provider's timely filing period of one hundred eighty (180) days has expired.

In any event, the claim must be submitted to Sanford Health Plan no later than one hundred eighty (180) days after the date that the cost was incurred, unless the claimant was legally incapacitated.

5.2 REIMBURSEMENT OF CHARGES BY NON-PARTICIPATING PROVIDERS

Sanford Health Plan does not have contractual relationships with Non-Participating Providers and they may not accept the Sanford Health Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount that is required for that service, Members are responsible for any difference between the amount charges and Sanford Health Plan's payment for Covered Services. Non-Participating Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

- the amount charged for a Covered Service or supply; or
- inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
- outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    - Fees typically reimbursed to providers for same or similar professionals; or
    - Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Providers. Sometimes these Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to Sanford Health Plan within one-hundred-eighty (180) days after the date that the cost was incurred.

If you, or the Non-Participating Provider, does not file the claim within 180 days after the date that the cost was incurred you will be responsible for payment of the claim.

If you need to file the claim, here is the process:

The Member must give Sanford Health Plan written notice of the costs to be reimbursed. Claim forms are available from the Customer Service Department to aid in this process. Bills and receipts should be itemized and show:

- Covered Member's name and ID number;
- Name and address of the Physician or Facility that provided the service or supply;
- Dates Member received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Time Limits: Claims must be submitted to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If you, or the Non-Participating Provider, file the claim after the one-hundred-eighty (180) timely filing limit has expired, you will be responsible for payment of the claim.

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

5.3 PAYMENTS FOR AIR AMBULANCE CHARGES

As a safeguard for Members, the reimbursement rate for Out-of-Network air ambulance services is equal to the average of Sanford Health Plan's In-Network rates for air ambulance providers licensed by the North Dakota Department of Health.

A claim made by the Member for Out-of-Network air ambulance services provided by an air ambulance provider licensed by the North Dakota Health Department will be paid in accordance with Sanford Health Plan's above mentioned policy. A payment made in accordance with this policy is the same as an In-Network payment for services.

If you have questions, please call our Customer Service Department.

5.4 BALANCE BILLING FROM NON-PARTICIPATING PROVIDERS

Balance billing, sometimes referred to as surprised billing, is the practice of a medical provider charging a patient for the difference between the total cost of services being billed and the amount the insurance pays. When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, the Member is protected from balance billing because the provider cannot attempt to collect charges above what Sanford Health Plan reimburses. When Sanford Health Plan does not have a contractual relationship in place and the provider is a Non-Participating Provider, they may not accept Sanford Health Plan's payment arrangements and members may be balanced billed for services received.

Members may be balance billed in emergency situations even when Sanford Health Plan covers all of the charges at an In-Network Level if the provider is a Non-Participating Provider who will not accept our payment as full and final. In such circumstances, the Non-Participating Provider must satisfy the Notice and Consent Process and Requirements before sending surprise bills. Out-of-Network facilities and providers are prohibited from sending surprise bills for out-of-network cost sharing without signed consent from the Member. Please check the Sanford Health Plan provider directory before receiving services to make sure you are seeing an In-Network Participating Practitioner and/or Provider.

If you think you've been wrongly billed, contact the No Surprises Help Desk (NSHD) at 1-800-985-3059 or visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law. For Minnesota residents, you may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 for more information about your rights under Minnesota law.

5.5 HEALTH CARE SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

Deductible and applicable cost-share will apply for Medically Necessary emergency and urgent care services received in a foreign country. There is no coverage for elective or preventive Health Care Services if a Member or their dependent(s) travels to another country for the purpose of seeking medical treatment outside the United States. There is no coverage for any non-emergent Health Care Services if a Member or their dependent(s) resides in another country.

5.6 TIMEFRAME FOR PAYMENT OF CLAIMS

- The payment for reimbursement of the Member's costs will be made within *fifteen (15)* days of when Sanford Health Plan receives a complete written claim with all required supporting information.
- When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to our guidelines, Sanford Health Plan will arrange for direct payment to either the Non-Participating Provider or the Member. If the Provider refuses direct payment, the Member will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of This Contract. The Member will be responsible for any expenses that exceed Maximum Allowed Amount, as well as any Copay, Deductible, or Coinsurance required for the Covered Service.

5.7 WHEN WE NEED ADDITIONAL INFORMATION

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond

5.8 MEMBER BILL AUDIT PROGRAM

Upon receiving notice of a claims payment, or Explanation of Benefits (EOB), from Sanford Health Plan, Members are encouraged to audit their medical bills and notify the Plan of any services which are improperly billed or of services that the Member did not receive.

If, upon audit of a bill, an error of $40 or more is found, the Member will receive a minimum payment of $20 or 50% of the resulting savings for paid Covered Services up to a maximum payment of $500.

To obtain payment through the Member Bill Audit Program, the Member must complete a *Member Bill Audit Refund Request Form*. To obtain a form, sign into your account at sanfordhealthplan.com/memberlogin or call Sanford Health Plan Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* and request a form be mailed to you.

NOTE: This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim. For more information on claims with more than one payor, see Section 6, *Coordination of Benefits*.

SECTION 6
COORDINATION OF BENEFITS

NOTE: Sanford Health Plan follows North Dakota Administrative Code §45-08-01.2-03 regarding Coordination of Benefits (COB). The COB provision applies when a person has health care coverage under more than one "plan" as defined for COB purposes.

If a Member is covered by another health plan, insurance, or other coverage arrangement, the plans and/or insurance companies will share or allocate the costs of the Member's health care by a process called "Coordination of Benefits" so that the same care is not paid for twice.

The Member has two obligations concerning Coordination of Benefits ("COB"):

- The Member must tell Sanford Health Plan about any other plans or insurance that cover health care for the Member, and
- The Member must cooperate with Sanford Health Plan by providing any information requested by Sanford Health Plan.

The rest of the provisions under this section explain how COB works.

6.1 APPLICABILITY

This Coordination of Benefits (COB) provision applies to Sanford Health Plan when a Member has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan.

The benefits of this Plan:

- shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section below entitled: *"Effect of COB on the Benefits of this Plan."*

6.2 DEFINITIONS (FOR COB PURPOSES ONLY)

"**Plan**" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a) Group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of Group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in Group, Group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts; and Medicare or any other federal governmental plan, as permitted by law.

b) "Plan" may include coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title MX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time). Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified

disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"**This Plan**" refers to this certificate, which provides benefits for health care expenses and means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

"**Primary Plan/Secondary Plan**": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

a) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
b) When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
c) When there are more than two (2) plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"**Allowable Expense**" means a necessary, reasonable and customary health care service or expense including Deductibles, Coinsurance, or Copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:

a) The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the Member's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
b) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that compute the benefit payments on the basis of reasonable costs, any amount in excess of the highest of the reasonable costs for a specified benefit is not an allowable expense;
c) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;
d) If a person is covered by one plan that calculates its benefits or services on the basis of reasonable costs and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be allowable expense for all plans; or
e) When benefits are reduced under a Primary Plan because a Member does not comply with The Plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, Certification of admissions or because the person has a lower benefit because the person did not use a preferred Practitioner and/or Provider.

"**Claim**" means a request that benefits of a plan be provided or paid in the form of services (including supplies), payment for all or portion of the expenses incurred, or an indemnification.

"**Claim Determination Period**" means a Calendar Year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if over-insurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or similar provision takes effect.

"**Closed Panel Plan**" is a plan that provides health benefits to Members primarily in the form of services through a panel of Practitioner and/or Providers that have contracted with or are employed by The Plan, and that limits or excludes benefits for services provided by other Practitioner and/or Providers, except in cases of emergency or Plan authorized referral by an In-Network Participating Practitioner and/or Provider.

"**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

6.3 ORDER OF BENEFIT DETERMINATION RULES

General. When two or more plans pay benefits, the rules for determining the order of payment is as follows:

a) The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan;
c) If multiple contracts providing coordinated coverage are treated as a single plan under North Dakota State law, inclusive, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this law;
d) If a person is covered by more than one secondary plan, this order of benefit determination provisions decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of any primary plan and the benefits of any other plan, which has its benefits determined before those of that secondary plan;
e) Except as provided in subdivision (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with North Dakota State law, inclusive, is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary;
f) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The plan which covers the person as a Group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:

- secondary to the Plan covering the person as a Dependent; and

- primary to the Plan covering the person as other than a Dependent, for example a retired Group Member; then the order of benefits between the two plans is reversed so that the plan covering the person as a Group Member, Member, or Subscriber is secondary and the other plan is primary.

Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
- The parents are not separated (whether or not they even have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after The Plan is given notice of the court decree.

If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the Spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the Spouse of the noncustodial parent.

Active/Inactive Group Member. The benefit of a plan, which covers a person as a Group Member who is neither laid off nor retired (or as that Group Member's Dependent), is primary. If the other plan does not have this rule, and if as a result the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule *"**Child Covered Under More Than One Plan"*** above.

Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

- primary, the benefits of a plan covering the person as a Group Member, Member or Subscriber (or as that person's Dependent);
- secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered a Group Member, Member or Subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

6.4 EFFECT OF COB ON THE BENEFITS OF THIS PLAN

When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules," section above, this Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph "b(ii)" immediately below.

Reduction in this Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than 100% of those Allowable Expenses.

If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a Non-Participating Provider, benefits are not payable by one closed panel plan, COB shall not apply between this plan and any other closed panel plans.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Plan's Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.5 CALCULATION OF BENEFITS, SECONDARY PLAN

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should The Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under The Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

6.6 COORDINATION OF BENEFITS WITH GOVERNMENT PLANS AND BENEFITS

After Sanford Health Plan, Medicare (if applicable), and/or any Medicare Supplementary Insurance (Medigap) have paid claims, then Medicaid and/or TRICARE pay last. Sanford Health Plan will pay primary to TRICARE and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is **NOT** a Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance. This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

6.7 COORDINATION OF BENEFITS WITH MEDICARE

The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:

- determining whether these individuals are eligible to participate in the Plan; or
- providing benefits under the Plan.

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, Sanford Health Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. Sanford Health Plan reserves the right to coordinate benefits with respect to Medicare Part D. Sanford Health Plan will make this determination based on the information available through CMS.

When MSP Rules Apply to COB

Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Insurance and is enrolled for insurance under Medicare, Parts A and BThis provision applies before any other Coordination of Benefits Provision of this Certificate of Insurance.

Coordination with Medicare Part D

This Certificate of Insurance shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage.

The following provisions apply to Sanford Health Plan's COB with Medicare:

When Medicare is the primary payer for a Member's claims:

- If you're 65, or older, and have group health plan coverage based on your or your spouse's current employment
- If you have retiree insurance (insurance from former employment)

NOTE: The hospital or doctor will first file claims with Medicare. Once Medicare processes the claim, an Explanation Of Medicare Benefits (EOMB) form will be mailed to the Member explaining what charges were covered by Medicare. Then the health care professional will generally file the claim with us. If a professional does not do so, the Member may file the claim by sending a copy of the EOMB, together with his or her member identification number, to the address shown on his or her member ID card.

When Medicare is primary despite the MSP rules:

- A Medicare-entitled person refuses coverage under the Plan;*
- Medical services or supplies are covered by Medicare but are excluded under the group health plan;
- A Medicare-entitled person has exhausted his or her benefits under the group health plan;
- A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
- A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

  *** NOTE:** *Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual's Medicare benefits.*

When this Certificate of Insurance is the primary payer for a Member's claims:

- If you're under 65 and disabled, and have coverage based on your or a family member's current employment
- When coverage is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- The Member (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
- A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Member/Employee.

NOTE: The Member's claim is filed with us by Practitioner or Provider. After the claim is processed, we send the Member an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the Practitioner or Provider of the covered charges. If there are remaining charges covered by Medicare, the Practitioner or Provider may file a claim with Medicare. If the Practitioner or Provider will not do so, the Member can file the claim with Medicare. Members may contact their local Social Security office to find out where and how to file claims with the appropriate "Medicare intermediary" (a private insurance company that processes Medicare claims).

If a Practitioner and/or Provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Sanford Health Plan's allowable expense is the Medicare

allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.

6.8 MEMBERS WITH END STAGE RENAL DISEASE (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD. Benefits covered by Medicare, because of ESRD, are for all Covered Services, not only those related to the kidney failure condition.

Sanford Health Plan does not differentiate in the benefits it provides to individuals who have ESRD, e.g. terminating coverage, imposing benefit limitations, or charging higher premiums.

How Primary vs. Secondary is Determined:

The Plan will pay first for thirty (30) months after the Member becomes eligible to join Medicare, starting with the first dialysis month or transplant month. This applies regardless of employment status and includes COBRA or retirement plan coverage. After the 30-month coordination period where the Member should enroll in Medicare, Medicare is the primary payer for a Member's claims under ESRD.

When Medicare is the primary payer for a Member's claims under ESRD:

- If the Member is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

6.9 COORDINATION OF BENEFITS WITH MEDICAID

- A Covered Individual's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the applicable State's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state's Medicaid program; and Sanford Health Plan will honor any subrogation rights the State may have with respect to benefits that are payable under this Certificate of Insurance.
- When an individual covered by Medicaid also has coverage under this Certificate of Insurance, Medicaid is the payer of last resort. If also covered under Medicare, Sanford Health Plan pays primary, then Medicare, and Medicaid is tertiary.

See provisions below on Coordination of Benefits with TRICARE, if a Member is covered by both Medicaid and TRICARE.

6.10 COORDINATION OF BENEFITS WITH TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent that the service provided is also covered under the other plan.

- Sanford Health Plan pays first if an individual is covered by both TRICARE and Sanford Health Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
- TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
- When a TRICARE beneficiary is covered under Sanford Health Plan, and also entitled to either Medicare or Medicaid, Sanford Health Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).

- TRICARE-eligible employees and beneficiaries receive primary coverage under this Certificate of Insurance in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

The Plan does not:

- Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
- Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this health benefit plan.

SECTION 7
SUBROGATION AND RIGHT OF REIMBURSEMENT

Sanford Health Plan will provide Health Care Services to the Member for the illness or injury, just as it would in any other case. However, if the Member accepts the services from Sanford Health Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

Subrogation Defined

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, Sanford Health Plan may be able to "step into the shoes" of the Member to recover health care costs from the party responsible for the injury or illness. This is called "Subrogation."

Reimbursement Defined

Sanford Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Member. This is called "Reimbursement."

Covered Individuals

Each and every Covered Individual hereby authorizes Sanford Health Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 6 and 7.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges. This Plan may give or obtain needed information from another insurer or any other organization or person.

7.1 SANFORD HEALTH PLAN'S RIGHTS OF SUBROGATION

In the event of any payments for benefits provided to a Member under this Plan, Sanford Health Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, Member's parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and Workers' Compensation insurance or substitute coverage.

Sanford Health Plan shall be entitled to receive from any such recovery an amount up to the Maximum Allowed Amount for the services provided by Sanford Health Plan. In providing benefits to a Member, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the reasonable costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under this Certificate of Insurance for an illness or injury, Sanford Health Plan is subrogated to the Member's right to recover the reasonable costs of the benefits it provides on account of such illness or injury, even if those reasonable costs exceed the amount paid by Sanford Health Plan.

Sanford Health Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. Sanford Health Plan's first priority right applies whether or not the Member has been made whole by any recovery. Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for any past, present, or future

Health Care Services provided to the Member. Sanford Health Plan may give notice of that lien to any party who may have contributed to the loss.

If Sanford Health Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits provided or to be provided under this Plan. This includes Sanford Health Plan's right to bring suit against the third party in the Member's name.

7.2 SANFORD HEALTH PLAN'S RIGHT TO REDUCTION AND REIMBURSEMENT

Sanford Health Plan shall have the right to reduce or deny benefits otherwise payable by Sanford Health Plan, or to recover benefits previously paid by Sanford Health Plan, to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

To the extent that federal or state statutes or courts, eliminate or restrict any such right of reduction or reimbursement provided to Sanford Health Plan under this Policy; such rights shall thus either be limited or no longer apply, or be limited by the extent of federal and state actions.

Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount for the Health Care Services provided to the Member.

7.3 ERRONEOUS PAYMENTS

To the extent payments made by Sanford Health Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of this Certificate of Insurance, Sanford Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which Sanford Health Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

7.4 MEMBER'S RESPONSIBILITIES

The Member, Member's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as Sanford Health Plan requires to facilitate enforcement of its rights under this Certificate of Insurance. The Member shall take no action prejudicing the rights and interests of Sanford Health Plan under this provision.

Neither a Member nor Member's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of Sanford Health Plan, to negotiate or compromise Sanford Health Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without Sanford Health Plan's express written consent.

Any Member who fails to cooperate in Sanford Health Plan's administration of this Part shall be responsible for the reasonable cost for services subject to this section and any legal costs incurred by Sanford Health Plan to enforce its rights under this section. Sanford Health Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with Sanford Health Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as Sanford Health Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, Sanford Health Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness

caused by a third-party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of Sanford Health Plan's 100%, first-dollar Subrogation and refund rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by Sanford Health Plan. Failure to comply will entitle Sanford Health Plan to withhold benefits, services, payments, or credits due under Sanford Health Plan.

7.5 SEPARATION OF FUNDS

Benefits paid by Sanford Health Plan, funds recovered by the Covered Individual(s), and funds held in trust over which Sanford Health Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect Sanford Health Plan's equitable lien, the funds over which Sanford Health Plan has a lien, or Sanford Health Plan's right to subrogation and reimbursement.

7.6 PAYMENT IN ERROR

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

SECTION 8
HOW COVERAGE ENDS

8.1 TERMINATION BY THE SUBSCRIBER

Upon a qualifying event, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. Sanford Health Plan must receive a written request from the Group to end coverage. The Subscriber will be responsible for any Service Charges through the date of termination or the end of the calendar month in which termination occurs, whichever is later.

8.2 TERMINATION, NONRENEWAL, OR MODIFICATION OF MEMBER COVERAGE

A Member or Dependent's coverage will automatically terminate at the earliest of the following events below. Such action by Sanford Health Plan is called "Termination" of the Member.

- **Failure to Pay Service Charge Payments**. Failure to make any required Service Charge payments when due. A grace period of thirty-one (31) days, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period.
- **Termination of Employment**. The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s).
- **Termination of this Contract**. In the event this Contract terminates, the last day of the month for which Service Charge Payments were made is the date benefits will cease for the Member(s).
- **Loss of Eligibility**. The last day of the month in which the Member is no longer an Eligible Group Member is the date benefits will cease for the Member(s).
- **Movement Outside the Service Area**. The last day of the month in which the Member no longer resides in the Service Area is the date benefits will cease for the Member(s).
- **Death.** The date the Member dies is the date benefits will cease for the Member(s).
- **Fraudulent Information**. An act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, may be used to rescind this application or Certificate of Insurance, terminate coverage and deny claims. The date identified on the notice of termination is the date benefits will cease for the Member(s).
- **Use of ID Card by Another.** The use of a Member's ID Card by someone other than the Member is considered fraud. The date a Member allows another individual to use his or her ID card to obtain services is the date benefits will cease for the Member(s).
- **Product Discontinuance.** Sanford Health Plan discontinues a particular product provided that Sanford Health Plan provides the Group and all Group Members with written notice at least 90 days before the date the product will be discontinued, Sanford Health Plan offers the Group and all Group Members the option to purchase any other coverage currently being offered by Sanford Health Plan to group health plans, and Sanford Health Plan acts uniformly without regard to claims experience of the Group or any health status-related factor relating to particular Group Members covered or who may be eligible for coverage. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s)

- **Discontinuance of All Coverage in Group Market or All Markets.** Sanford Health Plan discontinues offering all coverage in the group market or in all markets in Minnesota provided that Sanford Health Plan provides the Group and all Group Members and the Minnesota Department of Insurance with written notice of the discontinuance at least 180 calendar days prior to the date the coverage will be discontinued and all coverage issued or delivered by Sanford Health Plan in the group market in Minnesota are discontinued and not renewed. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s).
- **Any other reason permitted by State or federal law**.

Notification

Sanford Health Plan must notify all covered persons of the termination at least 30 days before the effective termination date for the termination to be effective

Uniform Modification of Coverage

Sanford Health Plan may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with State law and is effective uniformly for all persons who have coverage under this type of contract.

8.3 MEMBER APPEAL OF TERMINATION

A Member may Appeal Sanford Health Plan's decision to terminate, cancel, or refuse to renew the Member's coverage. The Appeal will be considered a Member Grievance and the Sanford Health Plan's Policy on Member Grievances and Appeals will govern the process.

Pending the Appeal decision, coverage will terminate on the date that was set by Sanford Health Plan. However, the Member may continue coverage, if entitled to do so, by complying with the "Continuation of Coverage" provisions in Section 9. If the Appeal is decided in favor of the Member, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

NOTE: A Member may not be terminated due to the status of the Member's health or because the Member has exercised his or her rights to file a complaint or appeal.

8.4 TERMINATION OF MEMBER COVERAGE

For the purposes of this Benefit Plan, upon termination of Member Coverage, the following provisions control:

1. **Determining Ineligibility.** Eligibility for benefits subsequent to retirement or termination will be determined pursuant to N.D.C.C. §54-52.1-03.
2. **Continuation of health, dental, vision, or prescription drug coverage after termination.** An employee who terminates employment and is not receiving a monthly retirement benefit from one of the eligible retirement systems, and applies for continued coverage with the health, dental, vision, or prescription drug plan may continue such coverage for a maximum of eighteen (18) months by remitting timely payments to the Board. The employee desiring coverage shall notify the Board within sixty (60) days of the termination. Coverage will become effective on the first day of the month following the last day of coverage by the employing agency, if an application is submitted within sixty (60) days. An individual who fails to timely notify the board is not eligible for coverage. [N.D.A.C. §71-03-03-06]
3. **Continuation of health, dental, vision, or prescription drug coverage for dependents.** Dependents of employees with family coverage may continue coverage with the group after their eligibility would ordinarily

cease. This provision includes divorced or widowed spouses and children when they are no longer dependent on the employee. Coverage is contingent on the prompt payment of the premium, and in no case will coverage continue for more than thirty-six (36) months. Dependents desiring coverage shall notify the board within sixty (60) days of the qualifying event and must submit an application in a timely manner. An individual who fails to notify the Board within the sixty (60) days, and who desires subsequent coverage, will not be eligible for coverage. [N.D.A.C. §71-03-03-07]

4. **Leave without pay.** An employee on an approved leave without pay may elect to continue coverage for the periods specified in the plans for life insurance, health, dental, vision, or prescription drug coverages by paying the full premium to the agency. An eligible employee electing not to continue coverage during a leave of absence is entitled to renew coverage for the first of the month following the month that the employee has returned to work if the employee submits an application for coverage within the first thirty-one (31) days of returning to work. An eligible employee failing to submit an application for coverage within the first thirty-one (31) days of returning to work or eligibility for a special enrollment period, may enroll during the annual open enrollment. Upon a showing of good cause, the executive director may waive the thirty-one day application requirement. [N.D.A.C. §71-03-03-09]
    a. In the event an enrolled eligible employee is not entitled to receive salary, wages, or other compensation for a particular calendar month, that employee may make direct payment of the required premium to the board to continue the employee's coverage, and the employing department, board, or agency shall provide for the giving of a timely notice to the employee of that person's right to make such payment at the time the right arises. [N.D.C.C. §54-52.1-06]

NOTE: A Member's coverage may not be terminated due to the status of the Member's health, or because the Member has exercised his or her rights, under the Plan's policy on member complaints, or the policy on appeal procedures for medical review determinations.

8.5 CONTINUATION

1. If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet NDPERS requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:
    a. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion, the Plan Administrator through which the Subscriber is eligible has terminated coverage with Sanford Health Plan, and the Plan Administrator has enrolled with another insurance carrier.
    b. The Plan Administrator no longer meets Sanford Health Plan's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.
    c. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.
    d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under the group (NDPERS). The Subscriber may elect conversion (individual) coverage on a nongroup basis, subject to premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for nongroup coverage within 31 days after the termination date of the previous group health plan coverage.

If a Member becomes otherwise ineligible for group membership under this Benefit Plan, Sanford Health Plan must at least offer the Subscriber its conversion (individual) benefit plan, if the Member lives in the Sanford Health Plan Service Area. There may be other coverage options for the Subscriber and/or Eligible Dependents through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." The cost of these options may vary

depending on a Subscriber's individual circumstances. To learn more, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

8.6 EXTENSION OF BENEFITS FOR TOTAL DISABILITY

An extension of benefits is provided Covered Members/Subscribers who become totally disabled while enrolled under this Benefit Plan and whom continue to be totally disabled at the date of termination of this Certificate. Upon payment applicable premium charges at the current Group rate, coverage will remain in full force and effect until the first of the following occurs:

- The end of a period of twelve (12) months starting with the date of termination of the Group contract;
- The date the Member is no longer totally disabled; or
- The date a succeeding plan provides replacement coverage to that Member without limitation as to the disabling condition.

Upon termination of the extension of benefits, the Member/Subscriber will have continuation and conversion rights as stated in Sections 9 and 10.

8.7 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

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

8.8 NOTICE OF CREDITABLE COVERAGE

You may request a Certificate of Creditable Coverage for you and your covered family Members upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*. Written requests can be sent to memberservices@sanfordhealth.org or:

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

8.9 NOTICE OF GROUP TERMINATION OF COVERAGE

- **Termination due to Non-Renewal**

The Group will give thirty (30) days written notice of the termination to the Members. For purposes of This Contract, "give written notice" means to present the notice to the Member or mail it to the Member's last known address.

This notice will set forth at least the following:

- The effective date and hour of termination or of the decision to not renew coverage;
- The reason(s) for the termination or nonrenewal; and
- The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
    - the availability of Continuation of Coverage, if any; and

- the fact that the Member may have rights under federal COBRA provisions, independent from any provisions of This Contract, and should contact the Group for information on the COBRA provisions.

- **Termination due to Non-Payment of Premiums**

If an employer fails to submit Premium payment to Sanford Health Plan resulting in loss of coverage to the Members, switches plans or cancels the coverage, The Group is required to give written notice of the termination to the Members as soon as reasonably possible but no later than ten (10) days after the date of termination.

SECTION 9
OPTIONS AFTER COVERAGE ENDS

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

Notice of Continuation Coverage Rights Under COBRA for employer groups with twenty (20) or more employees

Introduction

You are getting this notice because you recently gained coverage under an employer sponsored group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when employer sponsored group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Plan Document (Policy) or contact the Plan Administrator (your Employer).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept "Late Entrants".

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If the Plan is subject to COBRA, your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring coverage under the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The employer is responsible for the timely mailing of applicable COBRA notices to Members (the "COBRA Notification Letter"). The employer must notify Sanford Health Plan when qualifying events occur. Sanford Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after being notified by the employer that a qualifying event has occurred. The employer must notify the Plan of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to:

North Dakota Public Employees Retirement System
PO Box 1657
Bismarck, ND 58502
(701) 328-3900

How is COBRA Coverage Provided?

Upon notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of coverage.**There are also ways in which this 18-month period of COBRA continuation coverage can be extended:**

Disability extension of 18-month period of COBRA continuation coverage

- If you or a covered Dependent is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your covered Dependents may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

- If you or your covered Dependents experience another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if your employer is properly notified about the second qualifying event.
- This extension may be available to your Spouse and any Dependent Children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit healthcare.gov.

Keep Sanford Health Plan Informed of Address Changes

To protect your family's rights, let Sanford Health Plan know about any changes in the addresses of covered Dependents. You should also keep a copy, for your records, of any notices you send to Sanford Health Plan.

Plan Contact Information

Mail:	Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.
Phone:	(800) 752-5863 (toll-free) | TTY/TDD: 711 (toll-free)
	For free help in a language other than English: (800) 752-5863 (toll-free)
Fax:	(605) 328-6812
Online:	www.sanfordhealthplan.com/memberlogin

Or contact your employer.

SECTION 10
PROBLEM RESOLUTION

10.1 MEMBER APPEAL PROCEDURES - OVERVIEW

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Benefits under this Certificate of Insurance will be paid only if Sanford Health Plan decides, at Sanford Health Plan's discretion, that the applicant is entitled to them.

Claims for benefits under this Certificate of Insurance can be post-service, pre-service, or concurrent. This Section of your Summary Plan Description explains how you can file a complaint regarding services provided by Sanford Health Plan; or appeal a partial or complete denial of a claim. The appeal procedures outlined below are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For information on medication/drug Formulary exception requests, see Sections 2.12 and 3.5, *Pharmaceutical Review Requests and Exception to the Formulary Process*.

The following parties may request a review of any Adverse Determination by Sanford Health Plan: the Member and/or legal guardian; a health care Practitioner and/or Provider with knowledge of the Member's medical condition; an Authorized Representative of the Member; and/or an attorney representing the Member or the Member's estate.

NOTE: The Member or his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. In cases where the Member wishes to exercise this right, a written designation of representation from the Member should accompany a Member's complaint or request to Appeal an Adverse Determination. See *Designating an Authorized Representative* below for further details. For urgent (expedited) appeals, written designation of an Authorized Representative is not required.

Special Communication and Language Access Services

For Members who request language services, Sanford Health Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Members submit a complaint or appeal, and Sanford Health Plan will communicate with Members free of charge about their complaint or appeal in the Member's preferred language, upon request. To get help in a language other than English, call (800) 752-5863.

For Members who are deaf, hard of hearing, or speech-impaired

To contact Sanford Health Plan, a TTY/TDD line is available free of charge by calling toll-free 711. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

Help to understand this policy and your rights is free.
If you would like it in a different format (for example, in a larger font size),
please call us at (800) 499-3416 (toll-free).
If you are deaf, hard of hearing, or speech-impaired,
reach us at TTY/TDD: 711(toll-free).

Help in a language other than English is also free.
Please call (800) 752-5863 (toll-free) to connect with us using free translation services.

Maximum Appeal Timelines			
Type of Notice	**Emergency**	**Pre-Service**	**Post-Service**
Initial Determinations	72 Hours	15 days	30 Days
Extension for Initial Plan Determinations	NONE	15 days	15 Days
Additional Information Request (Plan)	24 Hours	15 days	15 Days
Response to Request For Additional Information (Member)	48 Hours	45 Days	45 Days
Request for Internal Appeal (Member)	180 Days	180 Days	180 Days
Internal Appeal Determinations	72 Hours	30 Days	60 Days
Request for External Appeal (Member)	N/A	4 months	4 Months
External Appeal Determinations	72 Hours	45 Days	45 Days

10.2 DESIGNATING AN AUTHORIZED REPRESENTATIVE

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service toll-free at (800) 499-3416; or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your provider is your Authorized Representative unless you tell us otherwise, in writing.

10.3 AUDIT TRAILS

Audit trails for Complaints, Adverse Determinations and Appeals are provided by Sanford Health Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal.
The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If Sanford Health Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

10.4 DEFINITIONS

Adverse Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) based on:

- A determination of an individual's eligibility to participate in a plan;

- A determination that a benefit is not a Covered Benefit;
- The imposition of a source-of-injury exclusion, network exclusion, application of any Utilization Review, or other limitation on otherwise covered benefits;
- A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or
- A rescission of coverage. Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void application or policy and deny claims.

Appeal: A request to change a previous Adverse Determination made by Sanford Health Plan.

Inquiry: A telephone call regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address Member and Practitioner and/or Provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written Complaint.

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with Sanford Health Plan, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or non-renewals of coverage; administrative operations; discrimination based on race, color, national origin, sex, age, or disability; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a Complaint. The Member and his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the Complaint.

External Review: An External Review is a request for an Independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

Urgent Care Situation: A degree of illness or injury that is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. An Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

- Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
- In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is "Urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson as defined in Section 8. A Practitioner, with knowledge of the Member's medical condition, who determines a request to be "Urgent," as defined in Section 8, shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

10.5 COMPLAINT (GRIEVANCE) PROCEDURES

A Member has the right to file a Complaint either by telephone or in writing to The Appeals and Grievances Department. The Appeals and Grievances Department will make every effort to investigate and resolve all Complaints. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

10.6 ORAL COMPLAINTS

A complainant may orally submit a Complaint to Customer Service. If the oral Complaint is not resolved to the complainant's satisfaction within ten (10) business days of receipt of the Complaint, Sanford Health Plan will provide a Complaint form to the complainant, which must be completed and returned to the Appeals and Grievances Department for further consideration. Upon request, Customer Service will provide assistance in submitting the Complaint form.

10.7 WRITTEN COMPLAINTS

A complainant can seek further review of a Complaint not resolved by phone by submitting a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

Complaints based on discrimination must be sent to the attention of the Civil Rights Coordinator.

The Appeals and Grievances Department will notify the complainant within *ten* (10) business days upon receipt of the Complaint form, unless the Complaint has been resolved to the complainant's satisfaction within those ***ten* (10) business days**.

Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.

10.8 COMPLAINT INVESTIGATIONS

The Appeals and Grievances Department will investigate and review the Complaint and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:

- A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within *thirty* (30) calendar days from the date Sanford Health Plan receives your request.
- In certain circumstances, the time period may be extended by up to *fourteen* (14) days upon agreement. In such cases, Sanford Health Plan will notify the complainant in advance, of the reasons for the extension.

Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within *twenty-four* (24) hours.

If the complaint is not resolved to the Member's satisfaction, the Member, or his/her Authorized Representative, has the right to Appeal any Adverse Determination made by Sanford Health Plan. Appeal Rights may be requested by calling the Appeals and Grievances Department.

Sanford Health Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in the complaint or appeals process.

All notifications described above will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in your written response.

10.9 APPEAL PROCEDURES

Types of Appeals
Types of appeals include:

- **A Pre-service Appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- **A Post-service Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
- An **Expedited Appeal** for Urgent Care is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of urgent, their review will generally be conducted within 24 hours.

10.10 CONTINUED COVERAGE FOR CONCURRENT CARE

A Member is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to Appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within twenty-four (24) hours.

10.11 INTERNAL APPEALS OF ADVERSE DETERMINATION (DENIAL)

Appeals can be made for up to 180 days from notification of the Adverse Determination.

Within one-hundred-eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. To Appeal, the Member may sign into their account at sanfordhealthplan.com/memberlogin and complete the "Appeal Filing Form" under the *Forms* tab. The Member or their Authorized Representative may also send a written Appeal to the Plan.

If the Member, Authorized Representative, Practitioner/Provider, and/or attorney, has questions, they are encouraged to contact the Plan. Customer Service is available to help with understanding information and processes. Alternate formats are also available and translation is available free of charge for written materials and Member communication with the Plan.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Customer Service Department.

10.12 APPEAL RIGHTS AND PROCEDURES

If the Member or their Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

- The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members do not have the right to attend or have a representative attend the review.
- The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
- Confirm with the Member whether additional information will be provided for appeal review. Sanford Health Plan will document if additional information is provided or no new information is provided for appeal review.
- Before Sanford Health Plan can issue a final Adverse Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date. Members shall have the right to review all evidence and present evidence and testimony.
- The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
- The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the Appeals and Grievances Department.
- Sanford Health Plan will document the substance of the Appeal, including but not limited to, the Member's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. Sanford Health Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
- The review shall not afford deference to the initial Adverse Determination and shall be conducted by a Sanford Health Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, Sanford Health Plan shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Sanford Health Plan shall identify the medical or vocational experts whose advice was obtained on behalf of Sanford Health Plan in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.

- In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
- The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) working days of receipt of the Appeal.
- Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

10.13 APPEAL NOTIFICATION TIMELINES

For Prospective (Pre-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **thirty (30) calendar days** of receipt of the Appeal.

For Retrospective (Post-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **sixty (60) calendar days** of receipt of the Appeal.

For Appeals Based on Discrimination: Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing within **thirty (30) calendar days** of receipt of the Appeal.

If the Member does not receive the decision within the time periods stated above, the Member may be entitled to file a request for External Review.

10.14 EXPEDITED INTERNAL APPEAL PROCEDURE

An Expedited Appeal procedure is used when the Member's condition is emergent or urgent in nature, as defined in this Certificate. An Expedited Appeal of a Prior Authorization (Pre-service) Denial must be utilized if the Practitioner acting on behalf of the Member believes that the request is warranted. This can be done by oral or written notification to Sanford Health Plan. We will accept all necessary information (electronic or by telephone) for review from the Practitioner of care. A designated Physician advisor will conduct the review and will be available to discuss the case with the attending Practitioner on request. For Medical Necessity reviews only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

If the Expedited Review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member or the Representative has been notified of the determination.

NOTE: For procedures, rights, and notification timelines related to an Appeal of Adverse Determination regarding pharmacy services, certification of a non-covered medication, or Formulary design issues, see External Procedures for Adverse Determinations of Pharmaceutical Exception Requests in this Section.

10.15 WRITTEN NOTIFICATION PROCESS FOR INTERNAL APPEALS

The written decision for the Appeal reviews will contain the following information:

- The results and date of the Appeal Determination;
- The specific reason for the Adverse Determination in easily understandable language;
- The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
- Reference to the evidence, benefit provision, guideline, protocol and/or other similar criterion on which the determination was based and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, protocols and other similar criterion free of charge;
- Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
- Statement of the reviewer's understanding of the Member's Appeal;
- The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
- Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate specialist to discuss the determination;
- If the Adverse Determination is based on Medical Necessity or Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Certificate of Insurance to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
- If applicable, instructions for requesting:
    a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination; or
    b. The written statement of the scientific or clinical rationale for the determination;
- For Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review a statement indicating:
    1. The written procedures governing the standard internal review, including any required timeframe for the review; and
    2. The Member's right to bring a civil action in a court of competent jurisdiction;
    3. Notice of the Member's right to contact the Division of Insurance for assistance at any time.
    4. Notice of the right to initiate the External Review process for Adverse Determinations based on Medical Necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Determination letters will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights.
    5. If the Adverse Determination is completely overturned, the decision notice will state the decision and the date.

10.16 EXTERNAL PROCEDURES FOR ADVERSE DETERMINATIONS OF PHARMACEUTICAL EXCEPTION REQUESTS

Sanford Health Plan follows all requirements for denials and appeals as it relates to any Adverse Determination when there has been a Medical Necessity determination based on pharmacy service, certification of non-covered medication or Formulary design issue. This applies to requests for coverage of non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols.

External Exception Review (Appeal) of a Standard Exception Request:

- If we deny a request for a Standard Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- The Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following the Plan's receipt of the request if the original request was a Standard Exception Request.
- If the Plan grants an External Exception Review of a Standard Exception Request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription.

External Exception Review (Appeal) of an Expedited (Urgent) Exception Request:

- If Sanford Health Plan denies a request for an Expedited Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- Sanford Health Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following our receipt of the request if the original request as an expedited exception.
- If Sanford Health Plan grants an External Exception Review of an Expedited Exception Request, we will provide coverage of the non- Formulary drug for the duration of the exigency.

10.17 STANDARD EXTERNAL REVIEW REQUEST PROCESSES & PROCEDURES

1. The Plan will follow the procedure for providing independent, external review of final determinations as outlined by federal ERISA regulations and rules governing the Plan in the Patient Protection and Affordable Care Act. Accordingly, an Independent External Review is not available for a Benefit Denial when it does not involve medical judgment.

NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding.

External Appeal Review Program – OVERVIEW

Members may file a request for External Review with Sanford Health Plan or with the North Dakota Insurance Commissioner. Refer to the Introduction section at the beginning of this document for contact information.

An expedited Appeal procedure is used when the condition is an Urgent Care Situation, as defined previously in this Certificate of Insurance.

An expedited review involving Urgent Care Requests for Adverse Determinations of Pre-service or Concurrent claims must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believe that an expedited determination is warranted. All of the procedures of a standard review described apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via oral notification by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than twenty-four (24) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within three (3) calendar days of the oral notification. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-urgent Pre-service or a Non-urgent post-service appeal, depending upon the circumstances.

If the expedited review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

10.18 EXTERNAL APPEAL REVIEW PROGRAM PROCEDURES

For independent, External Review of a final Adverse Determination, Sanford Health Plan will provide:

- Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
    - The Member is Appealing an Adverse Determination that is based on Medical Necessity (benefits Adverse Determinations are not eligible);
    - Sanford Health Plan has completed the internal Appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the available internal level of Appeal with the Member's permission;
    - The request for independent, External Review is filed within four (4) months of the date that Sanford Health Plan's Adverse Determination was made.
- Notification to Members about the independent, External Review program and decision are as follows:
    - General communications to Members, at least annually, to announce the availability of the right to independent, External Review.

    - Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, External Appeal rights, directions on how to use the process, contact information for the independent, External Review organization, and a statement that the Member does not bear any costs of the independent, External Review organization, unless otherwise required by state law.

- The External Review organization will communicate its decision in clear terms in writing to the Member and Sanford Health Plan. The decision will include:

    - a general description of the reason for the request for external review;
    - the date the independent review organization received the assignment from Sanford Health Plan to conduct the external review;
    - the date the external review was conducted;
    - the date of its decision;
    - the principal reason(s) for the decision, including any, Medical Necessity rationale or evidence-based standards that were a basis for its decision; and
    - the list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision.
    - The External Review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.

- Conduct of the External Appeal Review program as follows:

    - A Member will contact Sanford Health Plan with an external review request.
    - Within five (5) business days following the date of receipt of the external review request, Sanford Health Plan shall complete a preliminary review of the request to determine whether:
    - The Member is or was a covered person at the time the health care service was requested or, in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
    - The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
    - The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust Sanford Health Plan's internal Appeal process as defined above; and
    - The Member has provided all the information and forms required to process an external review.

- Within one (1) business day after completion of the preliminary review, Sanford Health Plan shall notify the Member and, if applicable, the Member's authorized representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include in the notice what information or materials are needed to make the request complete; or if the request is not eligible for external review, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include the reasons for its ineligibility. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

- If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an

independent review organization and notify in writing the Member, and, if applicable, the Member's Authorized Representative of the request's eligibility and acceptance for external review. The Member may submit in writing to the assigned Independent Review Organization within five (5) business days following the date of receipt of the notice provided by the NDID any additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.

- Within five (5) business days after the date the NDID determines the request is eligible for external review, of receipt, the NDID shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final Adverse Determination.

- The North Dakota Insurance Department contracts with the independent, external review organization that:
  - is accredited by a nationally recognized private accrediting entity;
  - conducts a thorough review, in which it considers all previously determined facts; allows the introduction of new information; considers and assesses sound medical evidence; and makes a decision that is not bound by the decisions or conclusions of Sanford Health Plan or determinations made in any prior appeal.
  - completes their review and issues a written final decision for non-urgent appeals within forty-five (45) calendar days of the request. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Member's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. Within forty-eight (48) hours after the date of providing the oral notification, the assigned independent review organization will provide written confirmation of the decision to the Member, or if applicable, the Member's Authorized Representative, and their treating Practitioner and/or Provider.
  - has no material professional, familial or financial conflict of interest with Sanford Health Plan.

- With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

- Sanford Health Plan will provide the Independent Review Organization with all relevant medical records as permitted by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including Sanford Health Plan's decision, criteria used and clinical reasons, utilization management criteria, communication from the Member to Sanford Health Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.

- The Member is not required to bear costs of the Independent Review Organization's review, including any filing fees. However, Sanford Health Plan is not responsible for costs associated with an attorney, physician or other expert, or the costs of travel to an independent, External Review hearing.

- The Member or his/her legal guardian may designate in writing a representative to act on his/her behalf. A Practitioner and/or Provider may not file an Appeal without explicit, written designation by the Member.

- The Independent Review Organization's decision is final and binding to Sanford Health Plan and Sanford Health Plan implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Member, because the Member has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Member may not file a subsequent request for external review involving the same Adverse Determination

for which the Member has already received an external review decision.

- Sanford Health Plan maintains and tracks data on each appeal case, including descriptions of the denied item(s), reasons for denial, Independent, External Review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its Medical Necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

NOTE: All notifications and procedures described in this Section, in addition to those related to both Benefit and Medical Care Determinations in Section 2, will comply with applicable law. Should a conflict exist between Plan procedures and federal regulations, federal regulations shall control.

A complete description of your Complaint (Grievance) and Appeal Rights and the Appeal process will be included in determination responses and decisions made by Sanford Health Plan. Additionally, an overview of your Complaint (Grievance) and Appeal Rights, along with an Appeal Filing Form, is included in all Explanation of Benefits (EOBs) generated by Sanford Health Plan.

10.19 EXPEDITED EXTERNAL REVIEW REQUESTS

- A Member or the Member's Authorized Representative may request an expedited external review of an Adverse Determination if the Adverse Determination involves an Urgent Care requests for Prospective (pre-service) or Concurrent Review request for which
    - the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Member; or would jeopardize the Member's ability to regain maximum function; or
    - in the case of a request for Experimental or Investigational Services, the treating Provider certifies, in writing, that the requested Health Care Services or treatment would be significantly less effective if not promptly initiated.
- The Member has the right to contact the North Dakota Insurance Commissioner for assistance at any time.

- Immediately upon receipt of the request from the Member or the Member's Representative, the NDID shall determine whether the request is eligible for Expedited External Review. If the request is ineligible for an Expedited External Review as described in (1) above, the NDID will give notification to the Member or the Member's Representative that they may appeal to the state insurance department.

- Upon determination that the Expedited External Review request meets the reviewability requirements, the NDID shall assign a contracted, independent review organization to conduct the expedited external review. The assigned independent review organization is not bound by any decisions or conclusions reached during Sanford Health Plan's utilization review or internal appeal process.

- Sanford Health Plan will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.

- The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Member, and, if applicable, the Member's

Authorized Representative, and the treating Practitioners and/or Providers as expeditiously as the Member's medical condition or circumstances requires but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within forty-eight (48) hours of the oral notification.

- At the same time a Member, or the Member's Authorized Representative, files a request for an internal Expedited Review of an Appeal involving an Adverse Determination, the Member, or the Member's Authorized Representative, may also file a request for an external Expedited External Review if the Member has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Member or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is an Experimental or Investigational Service and the Member's treating Practitioner and/or Provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated.
- Upon Sanford Health Plan's receipt of the independent review organization's decision to reverse the Adverse Determination, Sanford Health Plan shall immediately approve the coverage that was the subject of the Adverse Determination

SECTION 11
DEFINITIONS OF TERMS WE USE IN THIS CERTIFICATE OF INSURANCE

Adverse Determination	Any of the following determinations: The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination of a Member's eligibility to participate in the Plan; Any prospective review or retrospective Utilization Review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage determination.
Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
Admission	Entry into a facility as an Inpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Member is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by Sanford Health Plan.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: 1. Has an organized staff of Practitioners; 2. Has permanent facilities that are equipped and operated mostly for performing surgery; 3. Has continuous Practitioner services and Nursing Services when a patient is in the Facility; and Does not have services for an overnight stay.
Annual Enrollment	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
Authorized Representative	A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Members for services related to Avoidable Hospital Conditions.

Basic Plan	The Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level. Health Care Providers accessed at the Basic Plan level are also Participating Providers.
Benefit Period	A specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a Calendar Year (January 1st through December 31st) Benefit Period.
Benefit Plan	The agreement with Sanford Health Plan, including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
[The] Board	Means the North Dakota Public Employees Retirement System (NDPERS) board.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Certification	Certification is a determination by Sanford Health Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness.
Claims Administrator or Claims Payor	Sanford Health Plan
Class of Coverage	The type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage under this Benefit Plan are Single Coverage and Family Coverage.
Coinsurance Amount	A percentage of the Allowed Charge for Covered Services that is a Member's responsibility.
Coinsurance Maximum Amount	The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital inpatient care including care received at a Residential Treatment Facility and ongoing outpatient services, including ongoing ambulatory care.
[This] Contract or [The] Contract	This Certificate of Insurance, which is a statement of the essential features and services given to the Subscriber by the Plan, including all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.
Copayment (Copay)	A specified dollar amount payable by the Member for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.

Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Cost Sharing	The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes coinsurance, copayments, or similar charges, but it doesn't include premiums, balance-billing amounts for non-network providers, or the cost of non-covered services.
Covered Services	Those Health Care Services to which a Member is entitled under the terms of This Contract.
Creditable Coverage	Benefits or coverage provided under: 1. A group health benefit plan (as such term is defined under North Dakota law); 2. A health benefit plan (as such term is defined under North Dakota law); 3. Medicare; 4. Medicaid; 5. Civilian health and medical program for uniformed services; 6. A health plan offered under 5 U.S.C. 89; 7. A medical care program of the Indian Health Service or of a tribal organization; 8. A state health benefits risk pool, including coverage issued under N.D.C.C. Chapter 26.1-08; 9. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; 10. A health benefit plan under Section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and 11. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
Custodial Care	Care designed to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.
Deductible Amount	A specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period.
Dependent	The Spouse and any Dependent Child of a Subscriber.
Dependent Child	The definition of a Dependent Child of a Subscriber includes a child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and The Dependent Child must be chiefly dependent on the Subscriber for support [N.D.C.C. §26.1-36-22 (3)(4)] .
Domiciliary Care	Domiciliary Care consists of a protected situation in a community or Facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require a 24-hour Facility or nursing care.
Eligible Dependent	An Eligible Dependent includes: (1) The Spouse of the Subscriber; (2) A Dependent child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility; and (3) a Dependent of Dependent (a) Is the natural child of the Subscriber's Dependent child, a child placed with the Subscriber's Dependent child for adoption, a legally adopted child by the Subscriber's Dependent child, a child for whom the Subscriber's Dependent child has legal guardianship, a stepchild of the Subscriber's Dependent child, or foster child of the Subscriber's Dependent child. These same definitions apply to dependents of the Dependent child(ren) of the Subscriber's living, covered Spouse; and (b) the Subscriber's Dependent child must be a Covered Dependent under this Certificate of Coverage for the dependent of the Dependent child to be eligible; and (c) The Dependent Child must be chiefly dependent on the Subscriber for support. [N.D.C.C. §26.1-36-22 (3)(4)].
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of NDPERS.

Emergency Care Services	Emergency Care Services means: (1) Within the Service Area: covered health care services rendered by Participating or Non-Participating Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Service Area include covered health care services from Non-Participating Providers only when delay in receiving care from Participating Providers could reasonably be expected to cause severe jeopardy to the Member's condition or (2) Outside the Service Area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the Plan's Service Area.
Emergency Medical Condition	A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.
Enrollee	An individual who is covered by this Plan.
ESRD	The federal End Stage Renal Disease program.
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews must be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: 1. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Family Coverage	The Class Of Coverage identifying that the Subscriber and Eligible Dependents are enrolled to received benefits for Covered Services under this Plan.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.

Gestational Carrier	An adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.
Grievance	A written complaint submitted in accordance with the Plan's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Member.
[The] Group or [This] Group	NDPERS has signed an agreement with Sanford Health Plan to provide health care benefits for its eligible employees, retirees, and Eligible Dependents.
Group Contract Holder	The individual to whom a Group Contract has been issued.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Practitioner and/or Provider's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities.
Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes an overnight stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
Iatrogenic Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
Infertility Services Deductible Amount	A specified dollar amount payable by the Member during their lifetime for infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.
In-Network Benefit Level	The PPO Plan level of benefits when a Member seeks services from a Participating Practitioner and/or Provider.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.

Intermediate Care	Intermediate Care means care in a Facility, corporation or association licensed or regulated by the State for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day.
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. *Exception: periodic reassessments are not considered Maintenance Care.*
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of (a)the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or Costs for facilities providing the same or similar services, plus a margin factor.
Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and A. help restore or maintain the Members health; or B. prevent deterioration of the Member's condition; or C. prevent the reasonably likely onset of a health problem or detect an incipient problem; or D. not considered Experimental or Investigative
Member	The Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents
Mental Health and/or Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
NDPERS	the North Dakota Public Employees Retirement System.

Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill the Plan or Members for services related to Never Events.
Non-Covered Services	Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of This Contract.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by the Plan. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Non-Payable Health Care Provider.
Nursing Services	Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family.
Open Enrollment or Open Enrollment Period	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan
Out-of-Network Benefit Level	The Basic Plan level of benefits provided when a Member seeks services from a Non-Participating Practitioner and/or Provider. This is most often referred to as benefits received under the Basic Plan level but may include services received from Practitioners and/or Providers that have not signed a contract with the Plan.
Out-of-Pocket Maximum Amount	The total Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility during a Benefit Period. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Medical and prescription drug Copayment amounts do not apply toward the Out-of-Pocket Maximum Amount.
Partial Hospitalization	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment.
Participating [Health Care] Provider	A Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan. A Participating Provider includes Providers at either the Basic or PPO Plan level.
Physician	An individual licensed to practice medicine or osteopathy.

[The] Plan or [This] Plan	Sanford Health Plan.
Plan Administrator	North Dakota Public Employees Retirement System (NDPERS)
PPO (Preferred Provider Organization) Plan	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. Health Care Providers accessed at the PPO level are also Participating Providers.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization	The process of the Member or the Member's representative notifying Sanford Health Plan to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Sections 2, 4 and 5. Preauthorization does not guarantee payment of benefits.
Prescription Drug Coinsurance Maximum Amount	The total Formulary Coinsurance Amount for Prescription Medications that is a Member's responsibility during a Benefit Period. When this Coinsurance Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications, less Copayment Amounts incurred during the remainder of the Benefit Period. This Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward this Coinsurance Maximum Amount.
Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care Practitioner and/or Provider (PCP)	A Participating Practitioner and/or Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist, who is a Participating Practitioner, and who has been chosen to be designated as a Primary Care Practitioner and/or Provider as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.
Prior Approval	The process of the Member or Member's representative providing information to Sanford Health Plan substantiating the medical appropriateness of specified services in order to receive benefits for such service. This information must be submitted in writing from the Member's Health Care Provider. Sanford Health Plan reserves the right to deny benefits if Preauthorization/Prior Approval is not obtained.
Prospective (Pre-service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a Health Care Service or a course of treatment.

[Health Care] Provider	An individual, institution or organization that provides services for Plan Members. Examples of Providers include but are not limited to Hospitals, Physicians, Practitioners and/or Providers, and home health agencies.
Prudent Layperson	A person who is without medical training and who possess an average knowledge of health and medicine and who draws on his/her practical experience when making a decision regarding the need to seek Emergency medical treatment.
Qualifying Event	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby) and gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
Qualified Mental Health Professional	A licensed Physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service providers in psychology; a licensed certified social worker who is a board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Provider without certification or prior-authorization when certification/prior-authorization is required.
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Retrospective (Post-service) Review	Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.
Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Members or the Plan for services related to Serious Reportable Events.

[NDPERS] Service Agreement and/or [Group] Contract	The Service Agreement between NDPERS and Sanford Health Plan that is a contract for Health Care Services, which by its terms limits eligibility to enrollees of a specified group. The Group Contract may include coverage for Dependents.
Service Area	The geographic Service Area approved by the State's Insurance Department.
Single Coverage	The Class Of Coverage identifying that only the Subscriber is enrolled to received benefits for Covered Services under this Plan.
Skilled Nursing Facility	A Facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly-licensed Physician.
Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
[This] State or [The] State	The State of North Dakota.
Subscriber	An Eligible Group Member who is enrolled in the Plan whose employment or other status (except family dependency) is the basis for eligibility for enrollment in the Plan. A Subscriber is also a Member and Enrollee.
Surrogate	An adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.
Summary of Benefits and Coverage or SBC	Attachment I of this Contract that sets forth important information on coverage and Cost Sharing.
Urgent Care Request	Means a request for a Health Care Service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination which: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24)* hours, such as stitches for a cut finger. Urgent care means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Us/We/Our	Refers to Sanford Health Plan

Utilization Review	A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Preauthorization/Prior Approval, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
You	Refers to the Subscriber or Member, as applicable.

ATTACHMENT I. SUMMARY OF BENEFITS AND COVERAGE

This page is intentionally left blank. Your Summary of Benefits and Coverage is an attachment to this Certificate of Coverage.

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - o $300,000 in death benefits
  - o $100,000 in cash surrender or withdrawal values

- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $300,000 in disability income insurance benefits
  - o $300,000 in long-term care insurance benefits
  - o $100,000 in other types of health insurance benefits

- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

HP-3203 6-19

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://ndpers.nd.gov/image/cache/shp-coi-gf.pdf or by calling 1-800-499-3416 *(toll free)* | TTY/TDD: 711 *(toll-free)*. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call NDPERS Customer Service at 1-800-499-3416 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO Providers: $500 individual / $1,500 family. Basic Providers: $500 individual / $1,500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services in your Summary Plan Description (SPD).
Are there other deductibles for specific services?	Yes. $500 for infertility services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	PPO Providers: $1,500 individual / $3,500 family. Basic Providers: $2,000 individual / $4,500 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, copay amounts, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.com or call 1-800-752-5863 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit	$35 copay / visit	Deductible is waived.
	Specialist visit	$30 copay / visit	$35 copay / visit	
	Preventive care/screening/ Immunization	$30 copay / visit	$35 copay / visit	Deductible is waived.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	25% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/ pharmacy	Generic Formulary Drugs 0-34 days 35-100 days	 $7.50 copay / prescription $15 copay/prescription Then 12% coinsurance	 $7.50 copay / prescription $15 copay/prescription Then 12% coinsurance	Covers up to a 34-day supply. Two copays for a 35-100 day supply. Specialty medications are limited to a 30-day supply. Insulin and medical supplies for insulin dosing and administration maximum $25 cost-share per 30-day supply. The Prescription Drug coinsurance maximum amount for Formulary medications is $1,200 per person per benefit period. Cost-share for non-formulary drugs do not accumulate toward any Out-of-Pocket Maximums. Refer to your Formulary to determine which benefit applies to your medication.
	Brand Name Formulary Drugs 0-34 days 35-100 days	 $25 copay / prescription $50 copay / prescription Then 25% coinsurance	 $25 copay / prescription $50 copay / prescription Then 25% coinsurance	
	Non-Formulary Drugs 0-34 days 35-100 days	$30 copay / prescription	$30 copay / prescription	

		$60 copay / prescription Then 50% coinsurance	$60 copay / prescription Then 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	25% coinsurance after deductible	These services may require preauthorization / prior approval by the Health Plan.
	Physician/surgeon fees	20% coinsurance after deductible	25% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$60 copay / visit, then subject to deductible and then 20% coinsurance	$60 copay / visit, then subject to deductible and then 20% coinsurance	Emergency room copay waived if directly admitted. Additional services done during an Urgent care visit may be subject to deductible / coinsurance.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	$30 copay / visit	$30 copay / visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	25% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services Office visit: Other outpatient services:	$30 copay / visit 20% coinsurance after deductible	$35 copay / visit 20% coinsurance after deductible	For outpatient services, the first 5 visits of any calendar year will be covered at 100% (no charge). For full details, please refer to your plan document.
	Inpatient services	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Office visits	20% coinsurance	25% coinsurance	

If you are pregnant	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	Deductible is waived for prenatal and postnatal care. Deductible is waived on delivery services from a PPO healthcare provider when enrolled in the Healthy Pregnancy Program.
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Rehabilitation services Therapy: Other outpatient services:	 $25 copay / visit 20% coinsurance after deductible	 $30 copay / visit 25% coinsurance after deductible	For full details, please refer to your plan document.
	Habilitation services Therapy: Other outpatient services:	 $25 copay / visit 20% coinsurance after deductible	 $30 copay / visit 25% coinsurance after deductible	For full details, please refer to your plan document.
	Skilled nursing care	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization may be required.
	Hospice services	20% coinsurance after deductible	25% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Coverage provided outside the United States. For full details, refer to your plan document	• Private-duty nursing
• Chiropractic Care	• Hearing aids	• Routine foot care (for diabetics only)
	• Infertility treatment. $20,000 lifetime maximum	• Telehealth / e-visits / video visits

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: North Dakota Insurance Department at 1-800-247-0560. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Grievances at 1-800-499-3416 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-752-5863 (*toll-free).*
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-5863 (*toll-free).*
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-752-5863 (*toll-free).*
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-5863 (*toll-free).*

———To see examples of how this plan might cover costs for a sample medical situation, see the next section. ———

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,570

Cost Sharing	
Deductibles	$100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,120

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

The plan would be responsible for the other costs of these EXAMPLE covered services.

North Dakota Public Employees Retirement System (NDPERS)

2025-2027 Certificate of Insurance

Dakota Plan

Non-Grandfathered PPO/Basic

Help understanding this document is free.

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: 711*(toll-free)*.

Help in a language other than English is also free.

Please call (800) 752-5863 *(toll-free)* | TTY/TDD: 711*(toll-free)* to connect with us using free translation services.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

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FREE HELP IN OTHER LANGUAGES

This Policy replaces any prior policies you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it.

If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us toll-free at the number below.

For help in a language other than English, please call us toll-free at (800) 752-5863. Both oral and written translation services are available for free in at least 150 languages.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-752-5863 (رقم هاتف الصم والبكم: 711).

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-752-5863 (መስማት ለተሳናቸው: 711).

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-752-5863 (TTY: 711）。

Cushite (Oromo) - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-752-5863 (TTY: 711).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-752-5863 (TTY: 711).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-752-5863 (TTY: 711).

Karen - ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 800-752-5863 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-752-5863 (TTY: 711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-752-5863 (ATS: 711).

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-752-5863 (телетайп: 711).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-752-5863 (TTY: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-752-5863 (TTY: 711).

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-752-5863 (TTY: 711).

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-752-5863 (TTY: 711).

Notice

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description/Certificate of Insurance (COI) is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Every attempt has been made to provide concise and accurate information.

This COI and the NDPERS Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance/Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

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

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

Plan Name

North Dakota Public Employees Retirement System Dakota Plan

Name and Address of Employer (Plan Sponsor)

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503

Plan Sponsor's IRS Employer Identification Number

45-0282090

Plan Number Assigned By the Plan Sponsor

N/A

Type of Welfare Plan

Health

Type of Administration

This employee welfare benefit plan is fully insured by Sanford Health Plan and issued by Sanford Health Plan. Sanford Health Plan is the Claims Administrator for this employee welfare benefit plan.

Name and Address of Sanford Health Plan

Sanford Health Plan
4800 W 57th St.
Sioux Falls, SD 57108
(877) 305-5463 *(toll-free)*
TTY/TDD: 711 *(toll-free)*

Plan Administrator's Name, Business Address and Business Telephone Number

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503
(701) 328-3900

Name and Address of Agent for Service of Legal Process

Plan Administrator	Sanford Health Plan
North Dakota Public Employees Retirement System 1600 E. Century Avenue, Suite 2 PO Box 1657 Bismarck, ND 58503	Sanford Health Plan ATTN: President 4800 W 57th St. PO Box 91110 Sioux Falls, SD 57109-1110

Title of Employees Authorized To Receive Protected Health Information

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

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business.

These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

Statement of Eligibility to Receive Benefits

As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

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 if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. For a comprehensive description of eligibility, refer to the NDPERS web site at nd.gov/ndpers.

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

Description of Benefits

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

Sources of Premium Contributions to the Plan and the Method by Which the Amount of Contribution Is Calculated

The contributions for single or family for state employees are paid at 100% by the State. The contributions for employees of participating political subdivisions are at the discretion of the subdivision and subject to the minimum contribution requirements and participation requirements of Sanford Health Plan. Either the contributions for temporary employees are at their own expense or their employer may pay the premium subject to its budget authority.

End of the Year Date for Purposes of Maintaining the Plan's Fiscal Records

June 30

Clerical Error

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and

NDPERS retain contractual rights to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

Recovery of Benefit Payments
Pursuant to N.D.A.C. §71-03-05-06, whenever benefits are paid in noncompliance with the Contract, NDPERS, which is the Plan Administrator, or an agent of the Plan Administrator, retains the right to recover the payments from the party responsible.

If Sanford Health Plan, which is the Claims Administrator and Payor, or an agent of Sanford Health Plan, is at fault, the amount of overpayment will be withheld from the administrative fees paid by NDPERS.

If overpayments are made because of false or misleading information provided by a Member, Sanford Health Plan, or an agent of Sanford Health Plan, shall attempt to recover the amount. Any moneys recovered shall be credited to NDPERS.

If an overpayment is made because of a mistake or deliberate act by a Health Care Provider, Sanford Health Plan shall collect the money from the Provider and credit that amount to NDPERS.

If fraud is suspected, Sanford Health Plan shall inform NDPERS and NDPERS may turn the evidence over to the North Dakota State's Attorney or Attorney General's office for possible prosecution.

Amending and Terminating this Benefit Plan
As Plan Administrator, NDPERS has delegated responsibility for determinations regarding covered benefits, and the amount and manner of the payment of benefits, including the appeal of denied claims, to Sanford Health Plan, the insurer of the plan.

NDPERS reserves the right to terminate the plan, or amend or eliminate benefits under the North Dakota Public Employees Retirement System Dakota Plan, as insured and issued by Sanford Health Plan, at any time and at its discretion, upon mutual agreement between NDPERS and Sanford Health Plan. Should this Benefit Plan be amended or terminated, such action shall be by a written instrument duly adopted by both NDPERS and Sanford Health Plan, or the aforementioned entities' designees

Fiduciary Definitions

Claims Administrator Is a Fiduciary

Except for direct member appeals regarding an infertility services deductible, the North Dakota Public Employees Retirement Board has delegated to the Claims Administrator, herein known as Sanford Health Plan, benefit claims and appeals. Sanford Health Plan is a Plan fiduciary for these benefit claims and appeals only. As such, the Claims Administrator has the final and discretionary authority to determine these claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the Claims Administrator on review is final and binding, subject to your right to file a lawsuit under other applicable laws. This decision making authority is limited only by the duties imposed. Any determination by the Claims Administrator is intended to be given deference by courts to the maximum extent allowed under applicable laws.

Summary Notice and Important Phone Numbers

This COI describes in detail your Employer's health care benefit Plan and governs the Plan's coverage. This COI, any amendments, and related documents comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this COI carefully. If you have any questions about the benefits, please contact Sanford Health Plan's Customer Service.

This COI describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan including Align powered by Sanford Health Plan and Great Plains Medicare Advantage. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD 711.
This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Member under a policy or contract, or a prospective Member, obtained by Sanford Health Plan from that person or from a health care Provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive**: We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services**: We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Practitioner and/or Provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the Premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family**: We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- **Disaster Relief**: We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law**: We will share information about you if State or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law.
- **For public health and safety**: We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.

- **Organ and tissue donation**: We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director**: We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation and other government requests**: We can share information to employers for workers' compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement**: We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **Lawsuits and legal actions**: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research**: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

We may contact you in the following situations:
- **Treatment options**: To provide information about treatment alternatives or other health related benefits or Sanford Health Plan services that may be of interest to you.
- **Fundraising**: We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION
When it comes to your health information, you have certain rights.
- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within thirty (30) calendar days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.
  Contact Information:
  Sanford Health Plan
  Customer Service
  PO Box 91110
  Sioux Falls, SD 57109-1110
  (800) 752-5863 *(toll-free)* | TTY/TDD 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and online at www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective February 1, 2022.

INTRODUCTION

HOW TO CONTACT SANFORD HEALTH PLAN [THE "PLAN"]

Method	Sanford Health Plan Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
TRANSLATION SERVICES	(800) 752-5863
WRITE	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
PHYSICAL ADDRESS	Sanford Health Plan 4800 W 57th St. Sioux Falls, SD 57108

How to contact Customer Service

For assistance with claim inquiries/status, eligibility and enrollment, provider access, and order ID cards, please call or write to Customer Service. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Customer Service Contact Information
CALL	(800) 499-3416 *calls to this number are free*
TTY	711
FAX	(605) 328-6812
HOURS	7:30 a.m. to 5:00 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
WRITE	Sanford Health Plan Customer Service PO Box 91110 Sioux Falls, SD 57109-1110

How to contact us with questions about Certification (prior authorization)

Some of the services listed in this document are covered only if your doctor or other network provider gets approval in advance (called Certification or prior authorization) from us. The Utilization Management department handles all certification requests. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Utilization Management Contact Information
CALL	(800) 805-7938 *calls to this number are free*
TTY	711
FAX	(605) 328-6813
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Utilization Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Pharmacy Management

For assistance with pharmacy benefit questions, formularies, or drug pre-authorization, please call or write to Pharmacy Management.

Method	Pharmacy Management Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
FAX	(701) 234-4568
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Pharmacy Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Appeals and Grievances

For assistance with Complaints (grievances) and appeal rights, contact the Appeals and Grievances department. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Appeals and Grievances Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Appeals and Grievances Department PO Box 91110 Sioux Falls, SD 57109-1110

How do I request an external review

Members may file a request for Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review with Sanford Health Plan or with the Division of Insurance. Refer to Section 10 PROBLEM RESOLUTION for more information.

Members have the right to contact the North Dakota Insurance Department at any time.

Method	North Dakota Insurance Department Contact Information
CALL	(800) 247-0560 (toll-free)
TTY	(800) 366-6888 (toll-free)
WRITE	North Dakota Insurance Department 600 E. Boulevard Ave. Bismarck, ND 58505-0320
EMAIL	insurance@nd.gov

MEMBER RIGHTS

Sanford Health Plan is committed to treating Members in a manner that respects their rights. In this regard, Sanford Health Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) has the right to the following:

- Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; color; gender; gender identity; age; sex; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.
- Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
- Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
- Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
- Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable North Dakota law.
- Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
- Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or Medically Necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.
- Members have the right to give informed consent before the start of any procedure or treatment.
- When Members do not speak or understand the predominant language of the community, Sanford Health Plan will make its best efforts to access an interpreter. Sanford Health Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
- Members have the right to receive printed materials that describe important information about Sanford Health Plan in a format that is easy to understand and easy to read.
- Members have the right to a clear Grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
- Members have the right to Appeal any decision regarding Medical Necessity made by Sanford Health Plan.
- Members have the right to terminate coverage, in accordance with Employer and/or Plan guidelines.

- Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
- Members have the right to receive information about Sanford Health Plan, its services, its Practitioners and Providers, and Members' rights and responsibilities.

MEMBER RESPONSIBILITIES

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

- Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- Members are responsible for following all access and availability procedures.
- Members are responsible for seeking emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that the Member must use the nearest emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
- Members are responsible for notifying Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
- Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
- Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
- Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- Members are responsible for notifying NDPERS within *thirty-one (31)* days of name, address, or telephone number changes.
- Members are responsible for notifying NDPERS of any changes of eligibility that may affect their membership or access to services. The Plan Sponsor is responsible for notifying Sanford Health Plan.

GRANDFATHERED VERSUS NON-GRANDFATHERED PLANS

A "Grandfathered" health plan is a health plan that was in place prior to March 23, 2010. Grandfathered plans are able to make routine changes to policies but are exempt from some of the Affordable Care Act's (ACA) health insurance reforms.

A "Non-Grandfathered" health plan is a health plan that must comply with all the Patient Protection and Affordable Care Act's health insurance reforms.

Please refer to your Summary of Benefits and Coverage (SBC) to find out if you have a grandfathered or non-grandfathered health plan.

SERVICE AREA

The Service Area for **SOUTH DAKOTA** and **NORTH DAKOTA** includes all counties in the state.

The Service Area for **IOWA** includes the following counties:

Clay	Emmet	Lyon	Osceola	Plymouth
Dickinson	Ida	O'Brien	Sioux	Woodbury

The Service Area for **MINNESOTA** includes the following counties:

Becker	Clearwater	Kittson	Martin	Otter Tail	Redwood	Stevens
Beltrami	Cottonwood	Lac Qui Parle	McLeod	Pennington	Renville	Swift
Big Stone	Douglas	Lake of the Woods	Meeker	Pipestone	Rock	Traverse
Blue Earth	Grant	Lincoln	Murray	Polk	Roseau	Wilkin
Brown	Hubbard	Lyon	Nicollet	Pope	Sibley	Watonwan
Chippewa	Jackson	Mahnomen	Nobles	Red Lake	Stearns	Yellow Medicine
Clay	Kandiyohi	Marshall	Norman			

MEDICAL TERMINOLOGY

All medical terminology referenced in this Certificate of Insurance follows the industry standard definitions of the American Medical Association.

DEFINITIONS

Capitalized terms are defined in Section 11 of this Policy.

CONFORMITY WITH STATE AND FEDERAL STATUTES

Any provision in this Policy not in conformity with North Dakota laws or rules may not be rendered invalid but must be construed and applied as if it were in full compliance with any applicable State and Federal statutes. If, on the effective date of this policy, any provision of this policy is in conflict with federal statutes, or the statutes of the State of North Dakota, then this Policy shall be considered amended to conform to the minimum requirements of such laws and regulations.

GOVERNING LAW

To the extent not superseded by the laws of the United States, this Policy will be construed in accordance with and governed by the laws and rules of the United States of America and the state of North Dakota. Any action brought because of a claim under this Policy will be litigated in state or federal courts located in the state of North Dakota and in no other.

SPECIAL COMMUNICATION NEEDS

Please call the Plan if you need help understanding written information at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services. Anyone with any disability, who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at (701) 328-3900.

TRANSLATION SERVICES

The Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 752-5863 *(toll-free)* | TTY/TDD 711 *(toll-free)* for help and to access translation services.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 752-5863 *(toll-free)*.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 752-5863 *(toll-free)*.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 752-5863 *(toll-free)*.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 752-5863 *(toll-free)*.

SERVICES FOR THE DEAF, HEARING IMPAIRED, and/or VISUALLY IMPAIRED

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: 711*(toll-free)*. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

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

FRAUD

Fraud is a crime that can be prosecuted. Any Member who willfully and knowingly engages in an activity intended to defraud Sanford Health Plan is guilty of fraud.
As a Member, you must:

- File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
- Review the Explanation of Benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and

- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are uncertain or concerned about any information or charge that appears on a bill, form, or Explanation of Benefits; or if you know of, or suspect, any illegal activity, call Sanford Health Plan at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. All calls are strictly confidential. In the absence of fraud, all statements made by applicants, the Group or a Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall avoid such coverage or reduce benefits unless contained in a written instrument signed by the Group or Member, a copy of which has been furnished to such Group or Member or the Member's representative.

PHYSICAL EXAMINATION

We may have, at our own expense, a physician examine you when, and as often as we may reasonably require, during the pendency of a claim under this Policy.

CLERICAL ERROR

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and NDPERS retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

AMENDING AND TERMINATING THIS CONTRACT

If this Contract is terminated, the rights of the Members are limited to expenses incurred before termination unless specifically stated in this Contract.

VALUE-ADDED PROGRAM

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may receive rewards, access discounted rates from certain vendors for products and services available to the general public, or other incentives to engage in a healthy lifestyle or to adopt healthy habits. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

SUMMARY OF THIS PLAN DESCRIPTION

- This Certificate of Insurance serves as your health benefits policy and describes in detail your Employer's health care benefit plan and governs the coverage. The Certificate of Insurance, and any amendments and/or riders, comprise the entire contract between the Employer and Sanford Health Plan.
- A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate of Insurance carefully. If you have any questions about the benefits as presented in the Certificate of Insurance, please contact your Employer or Sanford Health Plan Customer Service.
- This Certificate of Insurance describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF NON-DISCRIMINATION

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Insurance, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Sanford Health Plan at (800) 752-5863.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Section 504 Coordinator.

Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57104
Phone: (877) 473-0911 | TTY: 711
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax, phone, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you.

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

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

SECTION 1.
ENROLLMENT

1.1 ELIGIBILITY AND WHEN TO ENROLL

As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

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 if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

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

A “Late Entrant” is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. A Late Entrant can only enroll during the next scheduled Open Enrollment Period. A Member is not a “Late Entrant” if “special enrollment rights” apply, as described later in this section.

1.2 HOW TO ENROLL

Both the Group and Eligible Group Member are involved in the enrollment process.

The Eligible Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

The Group must:

- Provide all information needed by Sanford Health Plan to determine eligibility; and
- Agree to pay the required premium payments on behalf of the Eligible Group Member.

1.3 WHEN COVERAGE BEGINS

Coverage generally becomes effective on the first day of the month that follows the date of hire, as designated by NDPERS.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, we will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this Certificate. Payment of benefits is subject to any obligations under a previous plan or coverage arrangement in accordance with state law and applicable regulations.

For more information, see Section 8, "*Extension of Benefits for Total Disability*".

1.4 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

The following Dependents are eligible for coverage ("Dependent coverage"):
Spouse - The Subscriber's spouse under a legally existing marriage. A Spouse is eligible for coverage, subject to eligibility requirements as designated by NDPERS.

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

1) Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2) Be one of the following:
    - under twenty-six (26) years old; or
    - incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within *thirty-one (31)* days of the Plan's request. Such a request may be no more than annually following the two year period of the disabled dependent child's attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]; If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be

added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent Child - To be eligible for coverage, a Dependent of the Dependent Child must be the Subscriber's grandchild or the grandchild of the Subscriber's living, covered Spouse if (1) the parent of the grandchild is a Member and (2) both the parent of the grandchild and the grandchild are primarily dependent on the Subscriber for financial support. The term grandchild means any of the following:

- natural child of a Dependent Child;
- child placed with a Dependent Child for adoption;
- child legally adopted by a Dependent Child;
- child for whom a Dependent Child has legal guardianship;
- stepchild of a Dependent Child; or
- foster child of a Dependent Child.

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

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

1.5 NONCUSTODIAL SUBSCRIBERS

Whenever a Dependent Child receives coverage through the noncustodial parent who is the Subscriber, Sanford Health Plan shall do all of the following:

- Provide necessary information to the custodial parent in order for the Dependent Child to receive benefits under this Contract;
- Allow the custodial parent or Provider, with the custodial parent's approval, to submit claims for Covered Services without approval from the noncustodial parent; and
- Make payment on the submitted claims directly to the custodial parent or Provider.

1.6 STATUS OF MEMBER ELIGIBILITY

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

Statements made on membership applications are deemed representations and not warranties. No statements made on the membership application may be used in any contest unless a copy has been furnished to that person,

or in the event of the death or incapacity of that person, to the individual's beneficiary or personal representative. The Subscriber is provided a copy of the membership application at the time of completion.

A Member making a statement (including the omission of information) on the membership application or in relation to any of the terms of this Benefit Plan constituting fraud or an intentional misrepresentation of a material fact will result in the rescission of this Benefit Plan by Sanford Health Plan. A rescission is a cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding this Benefit Plan or any benefits paid under the terms of this Benefit Plan.

1.7 WHEN AND HOW TO ENROLL DEPENDENTS

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "Coverage from Birth" and "*Adoption or Children Placed for Adoption*" section below. There is also an exception for Spouses; see "*New Spouses*" section below.

How to Enroll Dependents
The Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

1.8 WHEN DEPENDENT COVERAGE BEGINS

A. **General**

If a Dependent is enrolled at the same time the Subscriber enrolls for coverage through NDPERS, the Dependent's effective date of coverage will be the same as the Subscriber's effective date as described in Section *"When Coverage Begins"* above.

B. **Delayed Effective Date of Dependent Coverage**

Except for newborns (see "*Coverage from Birth*" section below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits under any prior coverage exists, the Plan coordinates benefits. For more details on Coordination of Benefits, see Section 6.

C. **Coverage from Birth**

If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth. Depending on the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

- **a. Subscribers with Single Coverage:** Newborns are covered under a Single Coverage Plan through the date of mother's discharge from the hospital in which the child was born. For coverage to extend after the mother's hospital discharge, Subscribers must submit application to NDPERS within thirty-one (31) days of the newborn's date of birth. Coverage will then be applied retroactively back to the date of birth.
- **b. Subscribers with Family Coverage:** Newborn children will be added to the Certificate automatically if the Subscriber is enrolled in Family Coverage.

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must

be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

An Eligible Group Member who failed to enroll during a previous enrollment period shall be covered under this Contract from the date of the child's birth, provided that coverage is applied for through NDPERS within *thirty-one (31)* days of the birth. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse. The Spouse may be added if application is made within thirty-one (31) days of a child's birth if otherwise eligible for coverage under the Plan, provided that coverage is applied through NDPERS for the Spouse and, if applicable, the Group Member.

D. **Adoption or Children Placed for Adoption**
If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as an Eligible Dependent as of the date specified within a court order or other legal adoption papers. Regardless of the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

a. **Subscribers with either Single or Family Coverage:** For coverage to continue beyond thirty-one (31) days of the date specified within the court order or other legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage, the Subscriber must submit an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or other legal adoption papers that granted initial eligibility.

An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, who failed to enroll during a previous enrollment period, shall be covered as of the date specified within a court order or other legal adoption papers, if the Eligible Group Member, and any other Eligible Dependents, submits an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that an application for coverage is submitted to NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

Coverage at the time of placement for adoption includes the necessary care and treatment of medical conditions existing prior to the date of placement.

E. **New Spouses and Dependent Children**
If a Subscriber gets married, his or her Spouse, and any of the Spouse's Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for with NDPERS for the Spouse and/or Eligible Dependents within thirty-one (31) days of the date of marriage. If the Subscriber does not submit an application for coverage to NDPERS for the Spouse and/or any Eligible Dependent(s) within thirty-one (31) days of the date of marriage, then Late Enrollee provisions apply and the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st. This includes marriages for which coverage was effective on or

after June 26, 2015, regardless of the Spouses' gender/sex.

If an Eligible Group Member, who is an Employee eligible to enroll in the Plan, but who did not do so during a previous enrollment period, gets married, the employee becomes an eligible Subscriber under the following conditions:

a. The Subscriber, his or her Spouse, and any Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty-one (31) days of the date of marriage or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.
b. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

**** NOTE:** Per Federal laws, guidance, and regulations, the sexual orientation and sex/gender of Spouses, married in a jurisdiction with legal authority to authorize their marriage, is not a factor in the issuance of coverage or benefit determinations. Sanford Health Plan, in compliance with federal guidance for all states, offers coverage to all legally married Spouses, and any Eligible Dependents as a result of marriage, regardless of the jurisdiction in which the marriage occurred. The provisions in this contract regarding Spousal eligibility and Late Enrollees continue to apply, regardless of Spouses' sex/gender.

1.9 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROVISION

A QMCSO is an order that creates the right of a Subscriber's Dependent Child to be enrolled in coverage under this Contract. If a QMCSO is issued, Sanford Health Plan will provide benefits to the Dependent Child(ren) of a Subscriber regardless of whether the Dependent Child(ren) reside with the Subscriber. In the event that a QMCSO is issued, each named Dependent Child(ren) will be covered by this Certificate of Insurance in the same manner as any other Dependent Child(ren).

When Sanford Health Plan is in receipt of a medical child support order, Sanford Health Plan will notify the Subscriber and each Dependent Child named in the order, whether or not it is a QMCSO. A QMCSO must contain the following information:

1. Name and last known address of the Subscriber and the Dependent Child(ren) to be covered by the Plan.
2. A description of the type of coverage to be provided to each Dependent Child.
3. The applicable period determined by the order.
4. The plan determined by the order.

In order for the Dependent Child's coverage to become effective as of the date of the court order issued, the Subscriber must apply for coverage as defined previously in this section. Each named Dependent Child may designate another person, such as a custodial guardian, to receive copies of explanation of benefits, checks, and other materials.

Exceptions
If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements under *Dependent Child* need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Certificate of Insurance. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be terminated unless Sanford Health Plan is provided satisfactory written evidence of any of the following:

1. The court or administrative order is no longer in effect;
2. The Dependent Child(ren) currently receive(s) or will be enrolled in comparable health coverage through a health insurance issuer which will take effect not later than the effective date of the termination; or
3. The Group has eliminated family coverage for all of its Eligible Group Members.

1.10 SPECIAL ENROLLMENT PROCEDURES AND RIGHTS

A Special Enrollment Period may apply when an individual becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption or when an Eligible Group Member or an Eligible Dependent involuntarily loses other health coverage.

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within thirty-one (31) days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within thirty-one (31) days of the change or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.
   1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

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

   2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan due to legal separation, divorce, annulment, or death, coverage for the Subscriber's Spouse and/or Dependents under Family Coverage will cease, effective the first of the month immediately following timely notice of the event causing ineligibility.
      If living in the Sanford Health Plan Service Area (see *Service Area* in Introduction Section), a Member has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

      There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and Sanford Health Plan of any change in family status within thirty-one (31) days of the change. The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement, or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective

date of coverage will be the Group's anniversary date.

The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within thirty-one (31) days of the date of birth for coverage to continue beyond the first thirty (30) days beginning with the child's birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to NDPERS within thirty-one (31) days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
3. Children who have been placed under the care Subscriber, or the Subscriber's living, covered spouse due to the Subscriber, or the Subscriber's living, covered spouse being appointed legal guardian, may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
5. If any of the Subscriber's children, or those of the Subscriber's living, covered spouse, who are Eligible Dependents under the Plan, beyond the age of 26, incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance, shall have coverage remain in effect as long as such disabled child remains dependent upon the Certificate holder/Subscriber or the Subscriber's spouse for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.
6. If a child is no longer an Eligible Dependent under this Benefit Plan, and the child is living in the Sanford Health Plan Service Area (see *Service Area* in the above Introduction Section), the Dependent has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*. There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.
7. At the time of birth or adoption, other Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to NDPERS within thirty-one (31 days) of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date. Pursuant to N.D.A.C. §71-03-03-01, an Employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:

1. During the initial enrollment period the employee or dependent states, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
   a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special enrollment under the Benefit Plan but again choosing not to enroll, or employer contributions toward such coverage were terminated; or
   b. was under COBRA and the coverage was exhausted.
3. The employee requests such enrollment within thirty-one (31) days after the exhaustion or termination of coverage.

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

If the membership application is not received in accordance with this provision, and the Employee or Dependent is a Late Enrollee, the Late Enrollee's effective date of coverage will be the Group's anniversary date.

E. Employees and/or Dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:
   1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and the employee's or dependent's coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within sixty (60) days of the date of termination of coverage; or
   2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within sixty (60) days of the date the employee or dependent is determined to be eligible for premium assistance.

      The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

F. In accordance with the decision of the Supreme Court of the United States on June 26, 2015, in *Obergefell v. Hodges*, 576 U.S. (2015), regarding same-sex marriage:
   1. **Same-sex marriages that occurred prior to June 26, 2015:** NDPERS will have a special enrollment period from July 1, 2015 through September 30, 2015. Coverage will be effective retroactive to July 1, 2015. If the Subscriber does not enroll during this eligibility period, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.
   2. **Same-sex marriages that occur on or after June 26, 2015:** The Subscriber must submit an application for coverage within the first thirty-one (31) days of the event. If the Subscriber does not enroll when initially eligible, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.

Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent is enrolled.

* *Loss of coverage due to failure to make premium payment and/or allowable rescissions of coverage does not qualify for a Special Enrollment Period.*

* *Voluntarily terminating/dropping COBRA coverage before it runs out outside Annual Enrollment does not qualify for a Special Enrollment Period.*

COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment.

1.11 CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 grants special enrollment rights to employees and Dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

In order to qualify for special enrollment, an eligible employee or dependent must request coverage within *sixty (60) days* of either being terminated from Medicaid or CHIP coverage, or being determined to be eligible for federal premium assistance. In either situation, the Plan will also require the eligible employee to enroll in Plan coverage. Special enrollment rights extend to all benefit packages available under the Plan. If you have questions about enrolling in your employer plan under CHIPRA special enrollment rights, contact the U.S. Department of Labor at www.askebsa.dol.gov or call (866) 444-3272 *(toll-free)*.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

1.12 MICHELLE'S LAW

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance Certificate prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a written and signed certification from the Dependent Child's treating Practitioner and/or Provider stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary and the effective date of the leave.

SECTION 2
HOW YOU GET CARE

2.1 IDENTIFICATION CARDS

Sanford Health Plan will send you an identification (ID) card when you enroll. Each Subscriber will receive their own Member ID card after enrollment, which should be used when you receive care. You must show it whenever you receive services from a Provider, a health care Facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive Health Care Services or prescription medications, you will be responsible for payment of the claim after the Participating Practitioner and/or Provider's timely filing period of *one-hundred-eighty* (180) calendar days has expired. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

If you do not receive your ID card within *thirty* (30) calendar days after the effective date of your enrollment, you need a temporary card or replacement cards, please call us at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* or write to us at Sanford Health Plan, ATTN: NDPERS, PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards by signing into your account at sanfordhealthplan.com/memberlogin. Information on creating an account is available at sanfordhealthplan.com/ndpers.

2.2 CONDITIONS FOR COVERAGE

Members are entitled to coverage for the Health Care Services (listed in the "Covered Services," in Section 3)that are:

- Medically Necessary and/or Preventive;
- Received from or provided under the orders or direction of a Participating Provider;
- Approved by the Plan, including Preauthorization/Prior Approval where required; and
- Within the scope of health care benefits covered by the Plan.

However, this specific condition does not apply to Emergency Medical Conditions or urgent care in and out of the Service Area. In such cases, the services will be covered if they are provided by a Non-Participating or Out-of-Network Provider.

If during an emergency or Urgent care situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest Participating Practitioner and/or Provider.

Members are not required, but strongly encouraged, to select a Primary Care Physician and use that Physician to coordinate their Health Care Services.

In addition, all Health Care Services are subject to:

- The exclusions and limitations described in Sections 3 and 4; and
- Any applicable Copay, Deductible, and Coinsurance amount as stated in your Summary of Benefits and Coverage (SBC).

2.3 IN-NETWORK COVERAGE

In-Network coverage is provided under two (2) plan levels. For more information, see *Selecting a Health Care Provider* in Section 3.7 In-Network benefit payments pay according to coverage under:

1. Basic Plan; or
2. PPO Plan

Note: If you travel out of the Plan's Service Area for the purpose of seeking medical treatment outside the Plan's Service Area, as defined in this COI, without Preauthorization/Prior Approval for a service that requires such authorization/approval, your claims will be paid according to the Basic Plan benefits and stipulations set forth in Section 3.7.
Additionally, the Member will receive Basic Plan benefits if: 1) a PPO Health Care Provider is not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO).

For *Appropriate Access* standards, see below.

In the following circumstances, Medically Necessary Health Care Services received from Non-Participating Providers may be Covered Services subject to In Network Cost Sharing, although Members may be responsible for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services.

1. **Ancillary Health Care Services**. Health Care Services received from a Non-Participating Provider that are ancillary to a Covered Service being provided by In-Network Participating Practitioner and/or Provider, such as anesthesiology or radiology, if rendered in an In-Network Facility. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.
2. **Termination of a Participating Provider.** Health Care Services received from a Participating Provider by a Member who is under an Active Course of Treatment and we terminate the Participating Provider's status as a Participating Provider without cause. The Member or the terminated Participating Provider must request and receive written approval from us. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will not count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.

2.4 APPROPRIATE ACCESS

Primary Care Physicians and Hospital Providers

Appropriate access for Participating Practitioner and/or Providers who provide primary care services and Hospital Provider sites is within *fifty* (50) miles of a Member's city of legal residence.

Specialty Practitioners and Providers

For other Participating Practitioner and/or Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within *fifty* (50) miles of a Member's city of legal residence. If you are traveling within the Service Area where other Participating Practitioner and/or Providers are available, then you must use Participating Practitioner and/or Providers.

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Practitioners and Providers as indicated in the Plan's Provider Directory. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If a Member chooses to go to a Non-Participating Practitioner or Provider when appropriate access (within *fifty (50)* miles of a Member's city of legal residence) is available, claims will be processed at the Basic Plan (Out-of-Network) level.

Transplant Services

Transplant Services must be performed at designated participating facilities and are not subject to the appropriate access standards outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations and terms of Sanford Health Plan's transplant policy.

2.5 CASE MANAGEMENT

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

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

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

Sanford Health Plan's case management process allows professional case managers to assist Members with certain complex and/or chronic health issues by coordinating treatment and/or other types of patient care plans.

In consultation with case managers, Sanford Health Plan may approve coverage that extends beyond the limited time period and/or scope of treatment initially approved. This consultation also includes utilization management processes as described below.

All decisions made through case management are based on the individual circumstances of a Member's case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) of the Member.

NOTE: For certain transplant procedures, case management services will be provided by the Plan's transplant vendor, *not* Sanford Health Plan. For benefit details on transplant services, see Section 3.2.

2.6 BENEFIT DETERMINATION REVIEW PROCESS

Sanford Health Plan Appeals and Grievances Department reviews all non-medical benefit determinations through review of Certificate of Insurance language, contractual terms, administrative policies related to benefits

as defined by this Policy, and benefits requests. All benefit determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

The date of receipt for non-urgent (standard) requests received outside of normal business hours will be the next business day.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances department.

2.7 ROUTINE (NON-URGENT) PRE-SERVICE BENEFIT REQUESTS

All pre-service benefit determination (approval) requests will be determined within fifteen (15) business days of receipt of the request. When a preauthorization (pre-approval) request is received before a service occurs, the date of receipt for non-urgent (standard) requests is the date the Plan receives the Member's request. If the request is made outside of business hours, the date or receipt will be next business day. If Sanford Health Plan denies a benefit (an Adverse Benefit Determination) the Plan will contact the Member via mail.

2.8 ROUTINE POST-SERVICE BENEFIT REQUESTS

Retrospective (post-service) requests occur when a Member has already utilized healthcare services and did not inquire about coverage pre-service. Post-service requests are not related documentation, coding or reimbursement from the Plan. Sanford Health Plan will review and approve or deny the service based on Medical Necessity within thirty (30) calendar days of receipt of the request. A letter will be sent to the Member within those 30 calendar days with the Plan's determination

2.9 UTILIZATION MANAGEMENT REVIEW PROCESS

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Utilization Management department.

The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it is during normal business hours.

All Utilization Review Adverse Determinations will be made by the Sanford Health Plan Chief Medical Officer or appropriate Practitioner.

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This part of Section 2 explains how we process different types of claims.

Designating an Authorized Representative

You may act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. An Authorized Representative is someone you designate in writing to act on your behalf. We have developed a form that you must complete if you wish to designate an Authorized Representative. You can get the form by calling Customer Service. You can also log into your account at www.sanfordhealthplan.com/memberlogin and download a copy of the form. If a person is not properly

designated as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your Provider is your Authorized Representative unless you tell us otherwise in writing.

Your Right to Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as Medical Necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 business days of a request. We will not charge you for any information that you request regarding our decision.

Your Complaint (Grievance) & Appeal Rights

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write the Appeals and Grievances Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received; or
- You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 10 for more information on the Appeals Process.

The Plan's claims procedures are designed to comply with the requirements of ERISA. We will process your claim according to ERISA standards. In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), criteria for Medical Necessity determinations is available upon request to any current or potential Member, beneficiary, or contracting provider. For details on the complaint and appeals process, see Section 10.

NOTE: If you receive an Adverse Determination, you have the right to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not (and is not) considered a request for an Internal Appeal and/or External Review.

2.10 PROSPECTIVE (PRE-SERVICE) REVIEW OF SERVICES (CERTIFICATION PRIOR AUTHORIZATION)

Prior Authorization (also referred to as Certification) is a decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary and appropriate. Preauthorization is required for services as defined above, except in urgent or emergent situations. Although the Plan may authorize a health care service as medically necessary, it is not a guarantee the Plan will cover the cost.

Determination of the appropriateness of care is based on standard review criteria and assessment of the following factors:

- The Member's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
- Consultation with the treating Practitioner and/or Provider, as appropriate.
- Availability of resources and alternate modes of treatment. For admissions to Facilities, other than Hospitals, additional information may include but is not limited to history of present illness, patient treatment plan and goals, prognosis, staff qualifications and *twenty-four* (24) hour availability of qualified medical staff.
- Sanford Health Plan does not compensate Practitioners, Providers or other individuals conducting Utilization Review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Review decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

Prior authorization is required for all inpatient admissions.

This requirement applies, but is not limited to, the following:

1. Acute care Hospitalizations (including medical, surgical, and non-emergency mental health or substance use disorder inpatient admissions);
2. Residential Treatment Facility admissions; and
3. Rehabilitation center admissions.

Admission before the day of non-Emergency surgery will not be authorized unless the early admission is Medically Necessary and specifically approved by Sanford Health Plan. Coverage for Hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

Referrals to Recommended Providers
Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

Prior Authorization is the responsibility of your Practitioner and/or Provider. For an up to date list or more information on all things that require prior authorization, please visit:
https://www.sanfordhealthplan.com/members/prior-authorization.

2.11 PHARMACY PRE-APPROVAL (CERTIFICATION) REQUESTS

Certain specialty drugs, or those which require frequent dosing adjustments, close monitoring, special training, compliance assistance, or need special handling and/or administration, require preauthorization by the Pharmacy Management Department.

To acquire preauthorization for a medication, ask the prescribing Practitioner and/or Provider to contact us by phone, complete the Formulary Exception Form found online at sanfordhealthplan.com, or provide a letter of Medically Necessity. This applies to any request of:

1) A non-covered medication or drug; or
2) A medication, or drug not currently listed in the Formulary.

Sanford Health Plan will use appropriate practitioners to consider requests and grant an exceptions to the Formulary when the prescribing Practitioner and/or Provider of the drug attests the Formulary drug causes an adverse reaction, is considered contraindicated, or must be dispensed as written to provide maximum medical benefit to the Member.

The Pharmacy Management department will review the request and make a decision based on:

1. Medical records showing trial and failure of a formulary drug or reasons why a formulary drug trial should be avoided;
2. Clinical information (such as diagnosis, disease progression and/or medication history); and
3. Medical Necessity.

If the reason for the exception is not clear, the reviewing clinician will contact the prescribing Practitioner and/or Provider to discuss the request. Additionally, if necessary, a clinical consultant of the appropriate specialty may be consulted for review.

If a Formulary exception is granted, the Pharmacy Management Department will provide authorization to the Plan's Pharmacy Benefit Manager so the Member is able to obtain the requested medication immediately. Additionally, coverage of the non-Formulary drug will be provided for the duration of the prescription, including refills.

For more information on drugs that may require prior authorization including oral medications, step therapy and injectable medications, refer to the formulary and Section 3.5 of this document.

Routine/Standard Pharmacy Pre-Approval Requests

Routine/Standard (non-urgent) pharmacy pre-approval requests will be reviewed within **fifteen (15) days after receipt of the request.** If the request is made outside of business hours, the date or receipt will be next business day.

Urgent Pharmacy Pre-Approval Requests

Urgent pharmacy pre-approval requests be reviewed as soon as possible and no later than **twenty-four (24) hours** of receipt of the request. Sanford Health Plan in alignment with the Standard and Expedited Exception Request requirements. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision.

How to Request Pre-Approval for a Drug

You or your authorized representative can request a medication pre-approval by:

- Contacting Pharmacy Management
- Complete Formulary Exception Form found online at sanfordhealthplan.com
- Ask the prescribing Practitioner and/or Provider for a letter of medical necessity
- Ask the prescribing Practitioner and/or Provider to contact the Plan by phone

What to Include with the Request

Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision.

2.12 ADDITIONAL INFORMATION REGARDING FORMULARY EXCEPTION REQUESTS

1. For contraceptives not in the Formulary, if the prescribing Practitioner and/or Provider determines that a drug/device is Medically Necessary and an exception to the formulary is granted, the contraceptive drug/device will be covered at 100% (no charge).
2. If the decision is to approve a standard (routine) Formulary exception request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription, including refills. If a request is granted based on an emergent circumstance, Sanford Health Plan will provide coverage for the duration of the incident.
3. In the event that an exception request is granted, Sanford Health Plan will treat the excepted drug(s) as an essential health benefit, including, if applicable per the Member's Policy, counting any cost-sharing towards the Member's annual limitation on cost-sharing and when calculating the actuarial value.

In determining whether to grant an exception, Sanford Health Plan adheres to, procedures, as outlined above, allowing Members to request and gain access to clinically appropriate drugs not covered under the Plan's Formulary.

2.13 MEDICAL PRE-APPROVAL (CERTIFICATION) REQUESTS

All requests for Prior Authorization (Certification) are to be made by the Member or Physician/Practitioner's office at least *three (3)* business days prior to the scheduled admission or requested service. The Utilization Management Department will review the Member's medical request against standard criteria.

Determination of the appropriateness of an admission is based on standard review criteria and assessment of:

1. Member medical information including:
    a. diagnosis;
    b. medical history;
    c. presence of complications and/or co-morbidities;
2. Consultation with the treating Practitioner, as appropriate;
3. Availability of resources and alternate modes of treatment; and
4. For admissions to Facilities other than acute general Hospitals, additional information may include but is not limited to the following:
    a. history of present illness;
    b. patient treatment plan and goals;
    c. prognosis;

d. staff qualifications; and
e. twenty-*four (24)* hour availability of qualified medical staff.

Routine Pre-Service Pre-Approval Requests

Routine/Standard (non-urgent) pre-service requests for services that require pre-approval from the Plan will be made within **fifteen (15) calendar days from the date** the Plan receives the request. If the request is made outside of business hours, the date or receipt will be next business day. If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **five (5) calendar days** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Urgent Pre-Service Pre-Approval Requests

Urgent pre-service requests for services that require pre-approval from the Plan will be reviewed as soon as possible and no later than **seventy-two (72) hours** after receipt of the request. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision. If the request does not meet the definition of urgent, or is for a service that has already occurred, (post-service/retrospective) the request will be processed as a routine/standard request.

If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **twenty-four (24) hours** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Emergent Medical Conditions

Pre-approval is not required if a prudent layperson that possesses an average knowledge of health and medicine determines urgent or emergent care is necessary in a particular situation. Members should notify Sanford Health Plan as soon as reasonably possible and no later than **forty-eight (48) hours** after physically or mentally able to do so. A Member's Authorized Representative may also notify the Plan on the Member's behalf.

How to Request Pre-Approval for a Medical Item or Health Care Service
Refer to the Introduction section at the beginning of this document for instructions on contacting the Utilization Management department to request a medical pre-approval request.

What to Include with a Pre-Approval Request
Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary medical information, we will notify the Member, their Authorized Representative (if applicable) and their Practitioner and/or Provider regarding what information is necessary to approve the request. If request was received from a Practitioner and/or Provider, the Plan will communicate solely with the requesting Practitioner and/or Provider regarding information needed to approve the request. The Plan will notify the appropriate party(ies) regarding the information needed to make a decision within:

- **Twenty-four (24) hours** of the receipt of the request if the request meets the definition of Urgent. The Plan will provide **forty-eight (48) hours** to supply the requested information. If not received by the end of the 48-hour extension, the request will be denied.
- **Fifteen (15) calendar days** of receipt of a routine/standard request. The Plan will provide forty-five (45) calendar days to supply the requested information. If not received by the end of the forty-five day extension, the request will be denied.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision:

- By phone no later than **forty-eight (48) hours** after the decision is made for Urgent requests. The Plan will also provide electronic or written notification of the decision as soon as possible, but no later than within **three (3) calendar days** of the phone notification if the request is deemed urgent.
- By mail within the **fifteen (15) calendar days** after receipt of the request.

Routine/Standard (Non-Urgent) Post-Service Pre-Approval Request

If a claim is denied for a service that has already occurred or item that has already been received (post-service or retrospective), the Member may file an appeal as outlined in Section 10 as the denied claim serves as the initial adverse determination.

2.14 ONGOING (CONCURRENT) PREAUTHORIZATION REQUESTS (CERTIFICATION) OF HEALTH CARE SERVICES

Concurrent Review is utilized when a request for an extension of an approved ongoing course of treatment for medical care, including care for behavioral, mental health, and/or substance use disorders, over a period of time or number of treatments, is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.

Determinations by us to Limit or Reduce Previously Approved Care

If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you advance written notice to permit you to initiate an appeal and obtain a decision before the date

on which care or treatments are no longer approved. You must follow the rules we establish for the filing of your appeal, such as the time limits within which the appeal must be filed (See Section 10 for more information on the Appeals Process). Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow you to appeal and obtain a review determination before the benefit is reduced or terminated. In addition, individuals in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

Prior Authorization (Certification) of inpatient care stays will terminate on the date the Member is to be discharged from the Hospital or other Facility (as ordered by the attending Physician), or when the Member's coverage is terminated, whichever occurs first. Hospital/Facility days accumulated beyond ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioner and/or Providers associated with these non-certified days are non-covered.

The health care service or treatment that is the subject of the Adverse Determination shall be continued without liability to the Member until the Member or the Member's Authorized Representative has been notified of the determination with respect to the internal review request made pursuant to the Appeal Procedures.

Any reduction or termination during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination.

Requests to Extend Previously Approved Care

A Provider who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request Prior Authorization from Sanford Health Plan at least *twenty-four (24) hours* in advance of the termination of such continuing services. Your Provider may make this request in writing or orally directly to us. To request a concurrent review determination, call Utilization Management. Refer to the Introduction section for Utilization Management contact information.

If Utilization Management denies the extension of treatment, it will advise the Member and Practitioners and/or Providers within twenty-four (24) hours of receiving the request. If the Member decides to appeal this denial, the health care services or treatment subject to the Adverse Determination shall be continued without cost to the Member while the determination is under review as specified by the Appeal procedures outlined in Section 10.

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Member may pursue the appeal rights described in Section 10.

Any reduction or termination by the Plan during the course of treatment before the end of the period or number of treatments shall constitute an Adverse Determination.

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, Sanford Health Plan shall make a determination and orally notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service, of the determination as soon as possible, taking into account the Member's medical condition, but in no event more than seventy-two (72) hours after the date of Sanford Health Plan's receipt of the request.

Sanford Health Plan will provide electronic or written notification of an authorization to the Member, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the oral notification.

We shall provide written or electronic notification of the Adverse Determination to the Member and those Providers involved in the provision of the service sufficiently in advance (but no later than within three (3) calendar days of the telephone notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file a Grievance request to review of the Adverse Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. Sanford Health Plan will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination unless the decision has the potential to adversely affect the Member, in terms of coverage or financially, whether immediate or in the future.

Non-Urgent (Standard) Concurrent Reviews

If your request is non-urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service timeframes as outlined in this Section.

Urgent (Expedited) Concurrent Reviews

If your request for additional care is urgent, and if your Provider submits it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, Sanford Health Plan will make the decision as soon as possible (taking into account the medical exigencies) but no later than seventy-two (72) hours after receiving the request]. For authorizations and denials, we will give telephone notification of the decision to Members, Practitioners and those Providers involved in the provision of the service within seventy-two (72) hours of receipt of the request. We will give oral, written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within three (3) calendar days of the oral notification.

If your Provider attempt to file an urgent concurrent review but fails to follow our procedures for doing so, we will notify you and your Provider of the failure within twenty-four (24) hours. Our notification may be oral, unless asked for in writing.

Adverse Determinations

If the determination is an Adverse Determination, we shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedures outlined below. At this point, the Member can request an appeal of Adverse Determinations. Refer to the "Appeal Procedures" in Section 10 for details.

Lack of Necessary Information

If we need more information, we will let you know within twenty (24) hours of your claim. Sanford Health Plan will tell you what further information is needed. You will then have forty-eight (48) hours to provide us with the additional information. Sanford Health Plan will notify you of our decision within forty-eight (48) hours after we receive all requested information.

Our notification may be oral; if it is, we will follow it up in writing within three (3) days. If we do not receive the information, your claim will be considered denied at the expiration of the forty-eight (48) hours we gave you for furnishing the information to us.

2.15 WRITTEN NOTIFICATION PROCESS FOR ADVERSE DETERMINATIONS

The written notifications for Adverse Determinations will include the following:

1. The specific reason for the Adverse Determination in easily understandable language;

2. Reference to the specific provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual provisions, guidelines, and protocols free of charge upon request. Reasons for any denial or reimbursement or payment for services with respect to benefits under the plan will be provided within 30 business days of a request;

3. Notice of an Adverse Determination will include information sufficient to identify the claim involved, including the date of service the Provider, the claim amount (if applicable) and a statement notifying members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review;

4. If the Adverse Determination is based in whole or in part upon the Member failing to submit necessary information, the notice shall include a description of any additional material or information, which the Member failed to provide to support the request, including an explanation of why the material is necessary;

5. If the Adverse Determination is based on Medical Necessity or an Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the coverage to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;

6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Determinations, if information on any Medical Necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 business days of a Member/Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the plan, in compliance with MHPAEA;

7. If the Adverse Determination is based on Medical Necessity, a written statement of clinical rationale, including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision;

8. A description of appeal procedures, including how to obtain an expedited review if necessary (and any time limits applicable to those procedures) including:

    - the right to submit written comments, documents or other information relevant to the appeal;

- an explanation of the Appeal process including the right to Member representation;
- notification that Expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and
- the timeframe the Member has to make an appeal and the amount of time the Plan has to decide it (including the different timeframes for Expedited Appeals);

9. If the Adverse Determination is based on Medical Necessity, notification and instructions on how the Practitioner can contact the Practitioner to discuss the determination;

10. You have the right to contact the North Dakota Insurance Commissioner at any time. (Refer to the Introduction section at the beginning of this document for contact information.)

SECTION 3
COVERED SERVICES – OVERVIEW

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides coverage for the following Covered Services. Payment for Covered Services is limited by or subject to any applicable Coinsurance, Copay, or Deductible set forth in this Contract including the Summary of Benefits and Coverage. To receive maximum coverage for Covered Services, the terms of this Contract must be followed, including receipt of care from In-Network Participating Practitioner and/or Providers as well as obtaining any required Certification. You are responsible for all expenses incurred for Non-Covered Services. Health Care Services received from Non-Participating Providers or Out-of-Network Participating Providers are Non-Covered Services unless otherwise indicated in this Contract.

3.1 HEALTH CARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

Here are some important things you should keep in mind about these benefits:

- *All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.*
- *Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Your Practitioner and/or Provider must get Certification of some services in this Section. Receipt of Certification (Prior Authorization) does not guarantee payment of benefits. The benefit description will say "Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 2."*

3.1.1 ARTIFICIAL NUTRITION

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.)*. Coverage is subject to Sanford Health Plan Guidelines.

- Parenteral nutrition formula and supplies
- Enteral nutrition formula and supplies

3.1.2 ALLERGY CARE BENEFITS

- Testing and treatment
- Allergy injections
- Allergy serum

3.1.3 CHIROPRACTIC SERVICES

Covered when provided on an inpatient or outpatient basis when Medically Necessary as determined by Sanford Health Plan and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician. Benefits are not available for Maintenance Care.

3.1.4 CLINICAL TRIALS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. A Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.
- Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.
    - The Health Care Service that is the subject of the Approved Clinical Trial.
    - Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
    - Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
    - An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
    - Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
    - A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
    - A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

3.1.5 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits.

Item	Information
Blood glucose test strips, glucagon, glucometers, glucose agents, lancets and lancet devices, prescribed oral agents for controlling blood sugars, syringes, urine testing strips	**Must be obtained at:** Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit; deductible/coinsurance may apply
Custom diabetic shoes and inserts; Limited to one (1) pair of depth-inlay shoes and three (3) pairs of inserts; or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts	**Must be obtained at:** Durable Medical Provider **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply
Continuous Glucose Monitor (CGM)	**Prior Authorization may be required** **Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit (must be on formulary and available through a pharmacy) or Medical Benefit (if obtained through a Durable Medical Provider); deductible/coinsurance may apply
Insulin Pump	**Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply

Coverage for the treatment of diabetes includes:

- Routine foot care, including toenail trimming is covered.
- Diabetes self-management training and education shall only be covered if:
  - the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner and/or Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator; and
  - the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the North Dakota Department on Health.

3.1.6 DIAGNOSTIC AND TREATMENT SERVICES

Professional services from Practitioners, Providers, Physicians, nurse practitioners, and Physician's assistants are covered when provided in Practitioner and/or Provider's offices and urgent care centers. Medical office consultations and second surgical opinions are also covered per Medical Necessity.

3.1.7 DIALYSIS BENEFIT

- Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under the End Stage Renal Disease (ESRD) program.
- Services include equipment, training, and medical supplies required for effective dialysis care. See Outpatient Nutrition Care Services in this Section for additional Chronic Renal Failure benefits. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 6.

3.1.8 DURABLE MEDICAL EQUIPMENT (DME) BENEFITS

- Coverage is available for DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Sanford Health Plan policy guidelines apply.
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan policy.

Prior Approval is required for certain items. For updated information refer to:
https://www.sanfordhealthplan.com/members/prior-authorization

3.1.9 EYE CARE/VISION SERVICES

Eye Care services are as follows:

Exams and Services	**Child** (age 0-18)	**Adult** (age 19+)
Routine eye exam	Not covered	Not covered
Dilated eye examination for diabetes-related diagnosis	Covered with a limit of one exam per Member per year	Covered with a limit of one exam per Member per year
Vision therapy	Covered for Members 17 and under; limited to 16 visits per calendar year	Not covered
Services required because of injury, accident or cancer that damages the eye	Covered if the Member was covered under this Contract during the time of the injury or illness causing the damage	Covered if the Member was covered under this Contract during the time of the injury or illness causing the damage
Cataract surgery	Covered	Covered

Eye Wear (frames, lenses, contacts)	**Child** (age 0-18)	**Adult** (age 19+)
Aphakia patients: Eyeglasses or contact lenses or soft contact lenses	Up to $200 for eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Member per calendar year	Up to $200 for eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Member per calendar year
Scleral shells intended for the use in the treatment of a disease or injury	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime
Prescribed lenses and frames, unless otherwise listed the plan documents	Not covered	Not covered

3.1.10 FAMILY PLANNING BENEFITS

Family Planning Services include consultations, and pre-pregnancy planning. The following medications, services, and devices are covered:

- Barrier methods: diaphragm and cervical cap fitting and purchase.
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years if obtained with a written prescription order, per Plan guidelines.
- Generic contraceptives are covered at 100% (no cost). If no generic equivalent exists for a formulary brand-name contraceptive, then that contraceptive is covered at 100% (no cost) per the Affordable Care Act. (See your Pharmacy Handbook/Formulary)
- Other contraceptives including injectable medroxyprogesterone acetate and emergency contraception with a written prescription (generic Plan B) are also covered at 100% (no cost).
- We cover implantable devices; including Mirena and ParaGard intrauterine devices. Placement and removal is covered once every five (5) years or as medically necessary.
- We cover sterilizations, including voluntary tubal ligations and vasectomies:
    - Medical – Occlusion of the fallopian tubes by use of permanent implants (e.g. Essure).
    - Surgical – Tubal ligation covered at 100% of allowed only when performed as the primary procedure. When performed as part of a maternity delivery or for any other medical reason, it will be covered as a medical benefit with the applicable cost-share applied.

3.1.11 FOOT CARE SERVICES

Routine foot care covered for Members with diabetes only.

- Non-routine diagnostic testing and treatment of the foot due to illness or injury.

NOTE: See Section on Orthotic and prosthetic devices for information on podiatric shoe inserts

3.1.12 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Hearing service coverage is as follows:

Exams and Services	**Child**	**Adult**
Routine care	Covered for ages 0-21 as outlined in Sanford Health Plan Preventive Health Guidelines	Not covered
Emergency and acute hearing services	Covered	Covered
Diagnosis and treatment of sudden sensorineural hearing loss (SSNHL)	Covered	Covered
Hearing Devices	**Child** (age 0-18)	**Adult** (age 19+)
Cochlear implants and bone-anchored (hearing-aid) implants	Certification required	Certification required
External Hearing Aids or devices	Hearing aids, communication aids or devices for Members 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Sanford Health Plan policy guidelines apply.	External hearing aids when medically necessary for conditions including, but not limited to: sudden sensorineural hearing loss (SSNHL), accident, injury or related illness.*
Hearing aid limits	Benefit is limited to one hearing aid, per ear, per Member under 19, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines	Benefit is limited to one hearing aid, per ear, per Adult Member, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines. This is a DME that requires prior approval (Certification).

* The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:

- provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by Sanford Health Plan; or
- help maintain or prevent deterioration in physical, cognitive, or behavioral function.

NOTE: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits.*(See Services requiring Certification in Section 2.).*

3.1.13 HOME HEALTH SERVICES

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.).*

Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lieu of Hospital or Skilled Nursing Facility:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only
- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
- medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized

3.1.14 IMPLANTS/STIMULATORS

- Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per medical appropriate guidelines apply (available upon request).
- The following Implants/Stimulators may be covered with prior approval *(certification*);
  - Bone Growth (external)
  - Cochlear Implant (Device and Procedure)
  - Deep Brain Stimulation
  - Gastric Stimulator
  - Insertion, Removal, and Revisions of all Implants
  - Spinal Cord Stimulator (Device and Procedure)
  - Vagus Nerve Stimulator

3.1.15 INFERTILITY BENEFITS

Benefits are available for services, supplies and medications related to artificial insemination (AI) and assisted reproductive technology (ART), includes gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) or in vitro fertilization (IVF). Preauthorization/Prior Approval *is required.*

Note: Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.

3.1.16 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

Coverage includes, but is not limited to, the following

- High End Imaging services
  - CT Scans/MRI
  - PET Scans
- Blood tests
- DEXA Scans
- Electrocardiogram (EKG)
- Electroencephalography (EEG)
- Non-routine mammograms
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- Ultrasound
- Urinalysis
- X-rays

NOTE: Some of these services fall under High End Imaging and may require Certification. Failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

3.1.17 ONCOLOGY TREATMENT BENEFITS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Radiation Therapy.
- Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage.
  - The same cost-sharing amounts apply for intravenously administered or injected cancer chemotherapy agents as for prescribed, orally-administered, anticancer medications used to kill or slow the growth of cancerous cells

3.1.18 NEWBORN CARE BENEFITS

A newborn is eligible to be covered from birth. Members must complete NDPERS designated enrollment for the newborn within *thirty-one (31)* days of the infant's birth if enrolled in Single Coverage.

If the Subscriber is already enrolled in Family Coverage, the newborn will automatically be added to the Certificate if the Plan was aware of the pregnancy. The Subscriber should confirm enrollment of the new child with the Plan. For further details, see Section 1.

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3.2 for coverage information on correcting congenital defects).

3.1.19 ORTHOTIC AND PROSTHETIC DEVICES

Note: Select items may require prior approval *(certification*). For up to date information, please refer to https://www.sanfordhealthplan.com/members/prior-authorization

- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Member's condition or to improve the function are eligible for coverage and do not require Prior Authorization.
- Cranial Prosthesis, including wigs up to $200 (limited to one per benefit period). .
- Devices permanently implanted that are not Experimental or Investigational Services such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. *This is a DME that requires Certification*
- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *four (*4) bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year. These do not require prior authorization.
- Prosthetic limbs, sockets and supplies, and prosthetic eyes. *This is a DME that requires Certification*
- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 3.2 for payment information. Insertion of the device is paid under the surgery benefit.

3.1.20 OTHER TREATMENT THERAPIES NOT SPECIFIED ELSEWHERE

- Inhalation Therapy
- Non-Surgical, medically necessary treatment, of Gender Dysphoria (Gender Identity Disorder), including hormone therapy, mental/behavioral services, and laboratory testing to monitor the safety of continuous hormone therapy, per Plan guidelines (available upon request).
- Pheresis Therapy

3.1.21 OUTPATIENT NUTRITIONAL CARE SERVICES

Benefits are available for the following medical conditions:

- **Anorexia Nervosa** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Bulimia** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Chronic Renal Failure** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **PKU** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.

3.1.22 PEDIATRIC (CHILD) HEARING SERVICES

Refer to HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES

3.1.23 PEDIATRIC (CHILD) VISION SERVICES

Refer to EYE CARE/VISION SERVICES

3.1.24 PHENYLKETONURIA (PKU) AND AMINO ACID-BASED ELEMENTAL ORAL FORMULAS COVERAGE BENEFITS

Phenylketonuria (PKU) Coverage is as follows:

- Testing, diagnosis and treatment of Phenylketonuria including dietary management, formulas, Case Management, intake and screening, assessment, comprehensive care planning and service referral.

Amino acid-based elemental oral formula coverage is as follows:

- Coverage for medical foods and low-protein modified food products determined by a Practitioner and/or Provider to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

3.1.25 PHYSICAL, CARDIAC SPEECH AND OCCUPATIONAL THERAPIES

Coverage is as follows for outpatient rehabilitative and habilitative therapy services, which include the management of limitations and disabilities, and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function:

- **Physical Therapy:** Benefits are subject to medical necessity and performed by or under the direct supervision of a licensed Physical Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
    - Physical therapy and Vitamin D supplements with a prescription order are covered at 100% (no cost) for Members ages 65 and older who are at increased risk for falls. Benefits are subject to medical necessity.
- **Occupational Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Speech Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Respiratory/Pulmonary Therapy:** Available when services are performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of Members with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.

- **Cardiac Rehabilitation Services:** Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital. Twelve (12) visits per Member per episode, limited to the following diagnosed medical conditions:
  - Myocardial Infarction
  - Coronary Artery Bypass Surgery
  - Coronary Angioplasty and Stenting
  - Heart Valve Surgery
  - Heart Transplant Surgery

3.1.26 PRENATAL AND MATERNITY SERVICES

NOTE: Due to the inability to predict admission, you or your Practitioner and/or Provider are encouraged to notify us of your expected due date when the pregnancy is confirmed. You are also encouraged to notify us of the date of scheduled C-sections when it is confirmed. The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of 48 hours for a vaginal delivery or of up to 96 hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner and/or Provider, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Practitioners and/or Providers competent in postpartum care and newborn assessments.

All pre or post-natal care falling outside the routine care limits below will be covered per applicable cost sharing based on a Member's Plan. Routine prenatal care (as outlined below) will be covered at 100%:

- Anemia screening
- Bacteruria (bacteria in urine) screening
- Deductible for delivery services is waived if services are rendered at a PPO Provider, and the Member is enrolled in Sanford Health Plan's *Healthy Pregnancy Program*.
- Genetic counseling or testing that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. *This is considered an Outpatient Service that requires Preauthorization/Prior Approval.*
- Hepatitis B screening
- Outpatient Nutrition Care Services available for gestational diabetes and diabetes mellitus. See *Wellness Nutritional Counseling* in this Section.
- Preeclampsia prevention
  Prenatal vitamins without Cost Sharing if prescribed by a Practitioner
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Screening for gestational diabetes mellitus during pregnancy
- Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.

Maternity care includes prenatal through postnatal maternity care and delivery and care for complication of pregnancy of mother. We cover up to four (4) routine ultrasounds per pregnancy to determine fetal age, size, and development, per plan guidelines.

Breastfeeding support, supplies and counseling are covered in the following manner:

- Sanford Health Plan will allow one breast pump (electric or manual, non-Hospital grade) per pregnancy.
- Breast pump replacement supplies, including tubing, adapters, locking rings, breast shields, splash protectors, and breast pump bottles and caps, are covered.
- Breast milk storage bags are covered.
- Bottles which are not specific to breast pump operation and all associated supplies are NOT covered.
- Pumps and supplies are covered only when obtained from a Sanford Health Plan Participating durable medical equipment Provider. This does NOT include drugstores or department stores.

In addition to pumps, consultation with a lactation (breastfeeding) specialist is also covered.

Healthy Pregnancy Program

The *Healthy Pregnancy Program* is designed to provide you with the tools and support you need to give your baby the healthiest start possible. Participation in the *Healthy Pregnancy Program* is voluntary and free to all Plan Members.

As a program participant, you will receive

- Educational information on pregnancy, childbirth and postpartum
- Access to Text4baby, a tool to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more
- Deductible waiver*
- Free prenatal vitamins
- Access to RN case manager to answer questions

After your first prenatal visit, Members may enroll in Sanford Health Plan's Healthy Pregnancy program starting their 8th week of pregnancy, but no later than the 34th week at **sanfordhealthplan.com/ndpers/healthy-pregnancy-program**. Members will need their Member number, health care provider name, and expected due date. If you have questions, please contact our care management team Monday through Friday from 8 a.m. to 5 p.m. CST at (888) 315-0884 (TTY: 711).

***Note:** When a Member is enrolled under the Healthy Pregnancy Program, the deductible Amount is waived for delivery services received from a PPO Health Care Provider. High Deductible Health Plan members may enroll in the program but will not receive the deductible waiver benefit.

Newborns' and Mothers' Health Protection Act Disclosure

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours for a vaginal delivery to a minimum of ninety-six (96) hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by a Participating Practitioner and/or Providers competent in postpartum care and newborn assessments within forty-eight (48) hours after discharge to verify the condition of the mother and newborn. If such an inpatient stay lasts longer than the minimum required hours, Sanford Health Plan will not set the level of benefits or out-of-pocket costs so that the later portion of the stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

3.1.27 PREVENTIVE CARE, ADULTS & CHILDREN

The following preventive services, received from In-Network Participating Practitioner and/or Provider are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply:

- 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 (USPSTF); except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009. Which includes;
    - One baseline mammogram for women who are at least thirty-five (35) years of age but less than forty (40) years of age, and one mammogram every year, or more frequently if ordered by a physician, for women who are at least forty (40) years of age;
    - One prostate screening for asymptomatic men aged fifty (50) and over, African American men aged forty (40) and over, and men aged forty (40) and over with a family history of prostate cancer.
- Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
- With respect to covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to covered persons who are women, such additional preventive care and screenings not described in paragraph (1) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. You do not need prior authorization from Sanford Health Plan or any other person in order to obtain access to obstetrical and/or gynecological care through an In-Network Participating Practitioner and/or Provider.

The above is an overview of preventive services covered by Sanford Health Plan. As recommendations change, your coverage may also change. To view Sanford Health Plan's Preventive Health Guidelines, visit www.sanfordhealthplan.com/memberlogin. You may also request a copy by calling Customer service at (800) 499-3416 (toll-free) | TTY/TDD: 711 (toll-free).

3.1.28 PRIVATE DUTY NURSING

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Private Duty Nursing is nursing care that is provided to a Member on a one-to-one basis by licensed nurse in an inpatient or home setting when any of the following are true:
    - No skilled services are already being provided.
    - Skilled nursing resources are available in the facility.
    - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
    - The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

3.1.29 TELEHEALTH SERVICES (VIRTUAL VISITS)

Services for telehealth are covered when the following conditions are met:

- The encounter involves a qualifying CPT (Current Procedural Terminology) code that the Health Plan has approved to be conducted by telehealth.
- The services are medically necessary and meet the definition of Covered Health Services as described in this Plan document.
- The technology platform used for the encounter is HIPAA (Health Insurance Portability and Accountability Act) compliant.
- The technology platform used for the encounter allows for fully synchronous, real-time, audio-video connection between the patient and the provider for the duration of the encounter.
- If the patient is physically present with one provider (host location) and is being connected to a remote (distant) provider, charges by the host provider as an originating site to facilitate the connection with the distant provider performing the service are also eligible for coverage, as well as the qualifying charges from the distant provider for conducting the telehealth encounter.

These services shall be available only when services are provided by Participating Providers. Cost share may be subject to applicable Deductible and/or Cost Sharing Amounts and vary based on platform used to complete the visit. For more information, please refer to the Virtual Care Policy at sanfordhealthplan.com.

3.1.30 TOBACCO CESSATION TREATMENT BENEFITS

Tobacco cessation treatment coverage is as follows:

- 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 an In-Network provider are covered without payment of any Deductible, Copay, or Coinsurance requirement that would otherwise apply.
- Tobacco cessation treatment includes:
    - Screening for tobacco use; and
    - At least two (2) tobacco cessation attempts per year (for Members who use tobacco products).
        - Covering a cessation attempt is defined to include coverage for:
            - Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and
            - One ninety (90) day treatment regimen of 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 without prior authorization.

3.1.31 WELLNESS NUTRITIONAL COUNSELING SERVICES

Wellness nutritional counseling services coverage is as follows:

Benefits are available for the following medical conditions:

- **Diabetes Mellitus** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Gestational Diabetes** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Hyperlipidemia** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Hypertension** – Maximum Benefit Allowance of two (2) Office Visits per Member per Benefit Period.
- **Obesity** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period

3.2 SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

Here are some important things you should keep in mind about these benefits:

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Policy and are payable only when we determine they are Medically Necessary.*
- *In-Network Participating Practitioner and/or Providers must provide or arrange your care and you must be hospitalized in a Network Facility.*
- *Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3.4).*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES.*

3.2.1 ADMISSIONS

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits.

The following Hospital Services are covered:

- Room and board
- Critical care services
- Use of the operating room and related facilities
- General Nursing Services, including special duty Nursing Services if approved by the Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the United States Pharmacopoeia.
- Special diets during Hospitalization, when specifically ordered
- Other services, supplies, biologicals, drugs and medicines prescribed by a Practitioner and/or Provider during Hospitalization

NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital up to 48 hours after the procedure.

3.2.2 ANESTHESIA

SHP covers services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized/approved procedure or treatment.

3.2.3 HOSPICE CARE

- A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, when the following circumstances apply:
    - The Member has been diagnosed with a terminal disease and has a life expectancy of six (6) months or less;

- The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);and
- The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Chief Medical Officer over the course of hospice care.

- The following Hospice Services are Covered Services:
  - Admission to a hospice Facility, Hospital, or Skilled Nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
  - In-home hospice care per Plan guidelines (available upon request)
  - Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for Member care up to eight (8) hours per day
  - Social services under the direction of an In-Network Participating Practitioner and/or Provider
  - Psychological and dietary counseling
  - Physical or occupational therapy, as described under Section 3.1
  - Consultation and Case Management services by an In-Network Participating Practitioner and/or Provider
  - Medical supplies, DME and drugs prescribed by an In-Network Participating Practitioner and/or Provider Expenses for In-Network Participating Practitioner and/or Providers for consultant or Case Management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of coverage for these services as listed in Section 3.1, but only where the hospice retains responsibility for the care of the Member

3.2.4 ORAL AND MAXILLOFACIAL SURGERY

NOTE: Some services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.* .
  1. Care must be received within *twelve* (12)months of the occurrence
  2. Associated radiology services are included
  3. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
  4. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Orthognathic Surgery per Sanford Health Plan guidelines. *This is an Outpatient Surgery that requires Certification*
  1. Associated radiology services are included
  2. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
  3. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  1. Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  2. Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  3. TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
     - Splint limited to one (1) per Member per benefit period.

- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    1. is a child age nine (9) or older- *(Certification is not required for children under 9)*; or
    2. is severely disabled or otherwise suffers from a developmental disability; or
    3. has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

    Note: For more information on Dental Services, see Section 3.6.

3.2.5 OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

Health Care Services furnished in connection with a surgical procedure performed at an In-Network Participating Surgical Center include:

- Outpatient Hospital surgical center
- Outpatient Hospital services such as diagnostic tests
- Ambulatory Surgical Center (same day surgery)

3.2.6 RECONSTRUCTIVE SURGERY

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Surgery to restore bodily function or correct a deformity caused by illness or injury
- If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Coverage for mastectomy related benefits will be provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. **For single mastectomy:** coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see *Orthotic and Prosthetic devices* in this Section). Deductible and Coinsurance applies as outlined in your Summary of Benefits and Coverage.

3.2.7 SKILLED NURSING CARE FACILITY BENEFITS

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Skilled Nursing Facility Services are covered if approved by the Plan in lieu of continued or anticipated Hospitalization. The following Skilled Nursing Facility Services are covered when provided through a state-licensed nursing Facility or program:
    1. Skilled nursing care, whether provided in an inpatient skilled nursing unit, a Skilled Nursing Facility, or a subacute (swing bed) Facility
    2. Room and board in a skilled nursing Facility
    3. Special diets in a Skilled Nursing Facility, if specifically ordered

Skilled nursing care in a Hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or Facility within a thirty-mile (30) radius of the Hospital.

3.2.8 TRANSPLANT SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

To be eligible for coverage, Transplants must meet United Network for Organ Sharing (UNOS) criteria and/or Sanford Health Plan Medical Criteria. Transplants must be performed at contracted Centers of Excellence or otherwise identified and accepted by Sanford Health Plan as qualified facilities.

Coverage is provided for transplants according to our medical coverage guidelines (available upon request) for the following services:

- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Drugs (including immunosuppressive drugs)
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan or other coverage arrangement
- Organ acquisition costs including:
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
- Post-transplant care and treatment

- Pre-operative care
- Psychological testing
- Second Opinions
    - SHP will notify the Member if a second opinion is required at any time during the determination of benefits period. If a Member is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second transplant facility for evaluation. If the second facility determines, for any reason, that the Member is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Member for the procedure.
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Supplies (must be Prior Authorized)
- Transplant procedure, Facility and professional fees

3.3 EMERGENCY SERVICES/ACCIDENTS

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.

3.3.1 BENEFIT DESCRIPTION

What is an Emergency Medical Condition?
An Emergency Medical Condition is the sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

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

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

If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to an urgent care or after-hours clinic.

We cover worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

3.3.2 EMERGENCY WITHIN OUR SERVICE AREA

Emergency services from Basic Plan-level Providers will be covered at the same benefit and Cost Sharing level as services provided by PPO-level Providers both within and outside of the Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. If the Plan determines the condition did not meet Prudent Layperson definition of an emergency, then the Basic Plan-level cost-sharing amounts will apply and the Member is responsible for charges above the Maximum Allowed Amount.

If an Emergency Condition arises, Members should proceed to the nearest emergency Facility that is an In-Network Participating Practitioner and/or Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency Facility, then the Member should seek care at the nearest emergency Facility. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

The Practitioner and/or Provider must notify the Plan and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.

3.3.3 PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize Members without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.4 NON- PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize a Member and may not require Prospective (Pre-Service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Emergency, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

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

3.3.5 EMERGENCY OUTSIDE OUR SERVICE AREA

If an Emergency occurs when traveling outside of the Service Area, Members should go to the nearest emergency Facility to receive care. The Member or a designated relative or friend must notify us and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.
Coverage will be provided for Emergency Medical Conditions outside of the Service Area unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

3.3.6 URGENT CARE SITUATION

Treatment provided in Urgent Care Situations from Basic Plan-level Providers will be covered at the same benefit and cost sharing level as services provided by PPO-level Providers both within and outside of the

Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the condition did not meet Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, and the Member is responsible for charges above the Maximum Allowed Amount.

If an **Urgent Care Situation** occurs, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Member should contact the Plan and follow the Plan's instructions. A Member may always go directly to a participating urgent care or after-hours clinic. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

3.3.7 PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.8 NON- PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval requirements if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Urgent Care Situation, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

3.3.9 AMBULANCE AND TRANSPORTATION SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

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

1. Medically Necessary; and
2. To the nearest In-Network Participating Practitioner and/or Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Here are some important things to keep in mind about these benefits:

- *All benefits are subject to the definitions, limitations, and exclusions in this Certificate of* Insurance *and are payable only when we determine they are Medically Necessary.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES. See the benefits description below*.

3.4.1 MENTAL HEALTH BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to Sanford Health Plan's mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate cost sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

Coverage is provided for mental health conditions which current prevailing medical consensus affirms substantially impairs perception, cognitive function, judgment, and/or emotional stability, and limits the life activities of the person with the condition(s). This includes but is not limited to the following conditions: schizophrenia; schizoaffective disorders; bipolar disorder; major depressive disorders (single episode or recurrent); obsessive-compulsive disorders; attention-deficit/hyperactivity disorder; autism spectrum disorders; post-traumatic stress disorders (acute, chronic, or with delayed onset); and anxiety disorders that cause significant impairment of function.

Mental health benefits are covered with the same Cost Sharing and restrictions as other medical/surgical benefits under the Contract. Coverage for mental health conditions includes:

- Diagnostic tests
- Electroconvulsive therapy (ECT)
- Inpatient services, including Hospitalizations
- Intensive Outpatient Programs
- Medication management
- Outpatient Professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health professionals

For outpatient treatment services, the **first five (5) visits of treatment** of any calendar year will be covered at 100% (no charge). For Members enrolled in a High Deductible Health Plan (HDHP), coverage of the first five (5) hours will not apply when you elect an HSA.

If you are having difficulty obtaining an appointment with a mental health practitioner and/or Provider, or for mental health needs or assessment services by phone, call the Sanford USD Medical Center Triage Line toll-free at (888) 996-4673.

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Applied Behavior Analysis (ABA) is a covered service for the treatment of Members diagnosed with Autism Spectrum Disorder.

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits.

- Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
- ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
- ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
- Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
- Limits are subject to the Plan's medical management policies and determinations of Medical Necessity.

3.4.3 SUBSTANCE USE DISORDER BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate Cost Sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD).

Substance use disorder benefits are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for substance use disorders includes:

1. Addiction treatment, including for alcohol, drug-dependence, and gambling issues
2. Inpatient services, including Hospitalization
3. Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, Licensed Chemical Dependency Counselors, or other qualified mental health and substance use disorder treatment professionals
4. Partial Hospitalization

5. Intensive Outpatient Programs

For outpatient treatment services, **the first five (5) visits of treatment** of any calendar year will be covered at 100% (no charge). For Members enrolled in a High Deductible Health Plan (HDHP), coverage of the first five (5) visits will not apply when you elect an HSA.

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

Here are some important things to keep in mind about these benefits:

- *Always refer to your Summary of Benefits (SBC), Formulary and other plan documents for specific details on your coverage.*
- *SHP covers prescribed drugs and medications, as described in this Section and in your Summary of Benefits/Formulary documents.*
- *All benefits are subject to definitions, limitations and exclusions listed in this document and are only payable when considered Medically Necessary.*
- *You must receive prior approval (authorization) for some medications. See the Summary of Benefits and Formulary for information.*

Refer to the Introduction section at the beginning of this document for instructions on how to contact Pharmacy Management.

3.5.1 BENEFIT DESCRIPTION

You must fill the prescription at a Plan Participating pharmacy for Cost Sharing amounts to apply. A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims from a Participating Pharmacy must be submitted by the Participating Pharmacy. A listing of the Plan's Participating pharmacies is available by contacting the Plan or online at sanfordhealthplan.com/ndpers. Specialty pharmacy options include any in network pharmacy, there is no specialty pharmacy requirement.

If a Member receives Prescription Medications from a Non-Participating Pharmacy, the Member is responsible for submitting a Claim for Benefits. Charges in excess of the Allowed Charge are the Member's responsibility.

- To fill a prescription, you must present your ID card to your pharmacy, if you do not, you will be responsible for all (100%) of the costs of the prescription to the pharmacy. Additionally, if you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.

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

- Sanford Health Plan uses a formulary: a list of prescription drug products, which are covered by the Plan for dispensing to Members when appropriate. The formulary will be reviewed regularly, and medications may be added or removed from the Formulary throughout the year. The Plan will notify you of the changes as they occur. For a copy of the Plan Formulary, contact Pharmacy or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- Sanford Health Plan reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per Plan medical necessity and limitation guidelines. Payment for

excluded medications will be the Member's responsibility in full. Members may request an appeal (review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this Certificate of Insurance.

- Sanford Health Plan will use appropriate Pharmacists and Practitioner and/or Providers to review formulary exception requests and promptly grant an exception to the formulary for a Member when that the prescriber indicates:
  - the Formulary drug causes an adverse reaction in the Member;
  - the Formulary drug is contraindicated for the Member; or
  - the prescription drug must be dispensed as written to provide maximum medical benefit to the Member.
- **NOTE**: To request a Formulary exception, please call Pharmacy or send a request by logging into the provider portal at www.sanfordhealthplan.com/memberlogin.
  - Members must first try formulary medications before an exception to the formulary will be made unless the prescriber and the plan determine that use of the formulary drug may cause an adverse reaction or be contraindicated for the Member. If an exception is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.
- With certain medications, the Plan requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization (pre-approval) Review. Request Prior Authorization by contacting Pharmacy Management. Refer to the Formulary for a complete list of medications that require step therapy.
- To be covered by the Plan, certain medications require prior authorization (pre-approval) to ensure medical necessity. This can be in the form of written or verbal certification by a prescriber. To request certification, contact Pharmacy Management. Refer to the formulary for a complete list of medications that require Prior Authorization.
  Certain medications have a quantity limit to ensure the medication is being used as prescribed and the member is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your formulary for a complete list of medications with quantity limits.

There are dispensing limitations.

- One (1) Copayment Amount, plus any applicable coinsurance amount, applies per Prescription Order or refill for a *1 – 34-day* supply.
- Two (2) Copayment Amounts, plus any applicable coinsurance amounts, apply 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.
- Specialty medications can be filled up to a 30-day supply per copay (or less, of prescribed) at one time (unless otherwise approved by the Plan).
- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the

previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.

- If you are traveling on vacation and need an extra supply of medication, you may request a "vacation override" to receive up to a three (3) month's supply of medication. Vacation supplies are limited to the time period that the Member is enrolled in the plan and one vacation override per medication per calendar year. Please contact Pharmacy Management to request a vacation override.
- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic equivalent or biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.

3.5.2 COVERED MEDICATIONS AND SUPPLIES

To be covered by the Plan, prescriptions must be:

a. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
b. Listed in the Plan Formulary, unless certification (authorization) is given by the Plan;
c. Provided by an In-Network Participating Pharmacy except in the event of urgent or emergent medical situations (if a prescription is filled at a Non-Participating and/or Out-of-Network Pharmacy in non-urgent or emergent medication situations, the Member will be responsible for the cost of the prescription medication in full.);
d. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

3.5.3 COVERED TYPES OF PRESCRIPTIONS

1. Federal Legend Drugs. Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to applicable laws and regulations.
2. Self-Administered medications- medications such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a Network Pharmacy
3. Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations
4. Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
5. Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, continuous glucose monitor receiver, diabetic needles and syringes are covered when medically necessary. (See section 3.1 for Diabetic supplies, equipment, and self-management training benefits.)
6. Generic oral contraceptives, injections and/or devices will be covered by the Plan at 100% (no charge)
7. The following preventive medications/supplies are covered at 100% (no charge) with a written prescription order:
    - Folic Acid Supplements for women planning to become pregnant or in their childbearing years
    - Vitamin D Supplements for Members ages 65 and older at risk for falls
    - Formulary breast cancer preventive medications for women at increased risk for breast cancer

3.6 DENTAL BENEFITS

Here are some important things to keep in mind about these benefits:

1. *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of* Insurance *and are payable only when we determine they are Medically Necessary.*
2. *We cover Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the Member. See Section 3.2 for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.*
3. *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
4. *YOU MUST GET CERTIFICATION OF THESE SERVICES.*

3.6.1 BENEFIT DESCRIPTION

NOTE: The following benefits are Outpatient Surgeries, Services, or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. See Prospective (Pre-Services) Review of Services (Certification Prior Authorization) in Section 2.

1. Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
   - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
   - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
   - Associated radiology services are included

   "Injury" does not include injuries to Natural Teeth caused by biting or chewing
2. Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:

   a. Services for the Treatment and Diagnosis of TMJ/TMD subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
   b. Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers and is Medically Necessary pursuant to Sanford Health Plan's medical coverage guidelines.
   c. TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
      - Splint limited to one (1) per Member per benefit period.
3. Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
4. Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service that requires Certification.*
   - is a child under age nine (9); or
   - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or
   - has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

   - Coverage applies regardless of whether the services are provided in a Hospital or a dental office

- Coverage applies to stabilization related to accident or injury only and not restoration.

3.6.2 PEDIATRIC (CHILD) DENTAL CARE

Not covered

3.7 SCHEDULE OF BENEFITS

3.7.1 GENERAL

This section outlines the payment provisions for Covered Services described in Sections 3 and 5, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

3.7.2 OVERVIEW OF COST SHARING AMOUNTS AND HOW THEY ACCUMULATE

Cost Sharing Amounts include Coinsurance, Copayments, and Deductibles, which accumulate to the separate Prescription Drug Out-of-Pocket Maximum Amount; Infertility Services Deductible and Out-of-Pocket Maximum Amount; and the Medical Out-of-Pocket Maximum Amount. See *Cost Sharing Amounts – Details & Definitions* later in this Section for more information.

NOTE:

- A Member must meet the annual Deductible Amount before Coinsurance Amounts apply to the cost of Covered Services, unless otherwise specified in this Certificate of Insurance and/or the Member's Summary of Benefits and Coverage (SBC).
- The Deductible Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, accumulate jointly up to the PPO Deductible Amount.
- The Out-of-Pocket Maximum Amounts for Covered Services, whether received under the PPO Plan or the Basic Plan, accumulate jointly up to the PPO Medical Out-of-Pocket Maximum Amount. Medical Out-of-Pocket Maximum Amounts are separate from the Prescription Drug Out-of-Pocket Maximum Amount.
- Covered Services sought on a Basic Plan basis will continue to be paid at 75% of the Allowed Charge until the Medical Out-of-Pocket Maximum Amount for Basic Plan services is met. Medical Out-of-Pocket Maximum Amounts are separate from the Prescription Drug Out-of-Pocket Maximum Amount.
- Prescription Medication Copayments and Coinsurance costs accumulate toward a Member's cumulative annual Prescription Drug Out-of-Pocket Maximum.

A Member is responsible for Cost Sharing Amounts. All Members in the family contribute to Deductible and Coinsurance Amounts. However, a Member's contribution cannot be more than the Single Coverage amount. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. For the specific benefits and limitations that apply to this Plan, please see Section 3.8, *Outline of Covered Services*; Section 3, *Covered Services*; Section 4, *Limited and Non-Covered Services*; and your Summary of Benefits and Coverage.

If Sanford Health Plan pays amounts to the Health Care Provider that are the Member's responsibility, such as Deductibles, Copayments or Coinsurance Amounts, Sanford Health Plan may collect such amounts directly from the Member. The Member agrees that Sanford Health Plan has the right to collect such amounts from the Member.

3.7.3 BENEFIT SCHEDULE

Benefit Schedule	PPO Plan	Basic Plan
Under this Benefit Plan the Medical Deductible Amounts are:		
Single Coverage	$500 per Benefit Period	$500 per Benefit Period
Family Coverage	$1,500 per Benefit Period	$1,500 per Benefit Period
Under this Benefit Plan the Coinsurance and Copay Maximum Amounts are:		
Single Coverage	$1,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$2,000 per Benefit Period	$3,000 per Benefit Period
Under this Benefit Plan the Medical Out-of-Pocket Maximum Amounts are:		
Single Coverage	$1,500 per Benefit Period	$2,000 per Benefit Period
Family Coverage	$3,500 per Benefit Period	$4,500 per Benefit Period
Under this Benefit Plan the Prescription Drug Out-of-Pocket Maximum Amount is:		
—— $1,200 per Member per Benefit Period ——		
Coinsurance for non-formulary medications does not apply to the $1,200 coinsurance maximum amount		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
—— $500 per Member ——		

The benefit payment available under this Benefit Plan differs depending on the Subscriber's choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with Sanford Health Plan. Providers that are contracted with Sanford Health Plan, and participate in the Plan's Network, will be paid at either the PPO Plan or Basic Plan level.

Members should refer to the Sanford Health Plan website (sanfordhealthplan.com/ndpers) for the Provider Directory, which lists Participating Health Care Providers. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Health Care Providers. Members may also call Customer Service to request a provider directory.

3.7.4 HOW PPO VS. BASIC PLAN DETERMINES BENEFIT PAYMENT

PPO Plan

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

To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing at sanfordhealthplan.com/ndpers.

Note: Benefits for Covered Services received by Eligible Dependents, as outlined in Section 2, *Eligibility Requirements for Dependents*, who are residing out of the state of North Dakota will be paid at the Basic Plan level. If the Subscriber, or the Subscriber's spouse, is required by court order to provide health coverage for that Eligible Dependent, you may be asked to provide a copy of the court order to the Plan.

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

Health Care Providers

3.7.5 PARTICIPATING HEALTH CARE PROVIDERS

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

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

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

3.7.6 NON-PARTICIPATING HEALTH CARE PROVIDERS

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

3.7.7 NON-PARTICIPATING HEALTH CARE PROVIDERS WITHIN THE STATE OF NORTH DAKOTA

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

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

Benefit payments will be made directly to the Provider for Covered Services received from a Non-Participating Health Care Provider. Sanford Health Plan may designate a Health Care Provider as Non-Payable.

3.7.8 NON-PARTICIPATING HEALTH CARE PROVIDERS OUTSIDE THE STATE OF NORTH DAKOTA

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

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

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

3.7.9 NON-PARTICIPATING PROVIDERS OUTSIDE THE SANFORD HEALTH PLAN SERVICE AREA

When Covered Services are provided outside of Sanford Health Plan's Service Area by health care providers who have not entered into a "participating agreement" with Sanford Health Plan (Non-Participating Health Care Providers), the amount the Member pays for such services will generally be based on either Sanford Health Plan's Non-Participating Health Care Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

In certain situations, Sanford Health Plan may use other payment bases, such as the payment Sanford Health Plan would make if the Covered Services had been obtained within the Sanford Health Plan Service Area, or a special negotiated payment, as permitted, to determine the amount Sanford Health Plan will pay for Covered Services provided by Non-Participating Health Care Providers. In these situations, a Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

3.7.10 HEALTH CARE PROVIDERS OUTSIDE THE UNITED STATES

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

Sanford Health Plan will reimburse Prescription Medications purchased outside the United States by Members who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Members are traveling and new medication therapy is initiated for acute conditions

or where emergency replacement of medications originally prescribed and purchased in the United States is necessary. The reimbursable supply of medications in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

3.7.11 NON-PAYABLE HEALTH CARE PROVIDERS

If Sanford Health Plan designates a Health Care Provider as *Non-Payable*, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the *Non-Payable Health Care Provider*. Notice of designation as a Non-Payable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Non-Payable Health Care Provider.

As of the date of termination, all charges incurred by a Member for services received from the Non-Payable Health Care Provider will be the Subscriber's responsibility.

3.7.12 MEDICARE PRIVATE CONTRACTS

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services, and indicate that 1) neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider; and 2) the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge.

Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and Sanford Health Plan will limit its payment to the amount Sanford Health Plan would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by Sanford Health Plan.

3.7.13 COST SHARING AMOUNTS – DETAILS

A Cost Sharing Amount is the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Applicable Cost Sharing Amounts are identified in Section 2 and the Member's Summary of Benefits and Coverage. See the schedule above in *Overview of Cost Sharing Amounts and how they accumulate* for the specific Cost Sharing Amounts that apply to this Benefit Plan.

3.7.14 COINSURANCE

Sanford Health Plan shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the Sanford Health Plan contracted provider network on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

If Covered Services are obtained by a Member out of the Sanford Health Plan contracted provider network, the coinsurance calculation may be based on the Health Care Provider's billed charges. This may result in a

significantly higher Coinsurance Amount for certain services a Member incurs out of the Sanford Health Plan contracted provider network. It is not possible to provide specific information for each Health Care Provider outside of Sanford Health Plan's Service Area because of the many different arrangements between Health Care Providers. However, if a Member contacts Sanford Health Plan prior to receiving services from a Health Care Provider outside of Sanford Health Plan's Service Area, Sanford Health Plan may be able to provide information regarding specific Health Care Providers.

3.7.15 COINSURANCE AND COPAY MAXIMUM AMOUNTS

The cumulative Coinsurance and Copay Amount that is a Member's responsibility during a Benefit Period. The Coinsurance and Copay Maximum Amounts renew on January 1 of each consecutive Benefit Period.

3.7.16 DEDUCTIBLES

The Deductible Amounts renew on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward the Deductible Amount.

NOTE: The deductible amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Deductible Amount.

3.7.17 MEDICAL OUT-OF-POCKET MAXIMUM AMOUNTS

When the Out-of-Pocket Maximum Amounts are met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services. The Out-of-Pocket Maximum Amounts renew on January 1 of each consecutive Benefit Period. The Medical Out-of-Pocket Maximum Amounts accumulate separately from the Prescription Drug Out-of-Pocket Maximum Amount.

NOTE: The Out-of-Pocket Maximum Amounts for Covered Services received under the PPO Plan, or under the Basic Plan, cross accumulate jointly to the PPO Out-of-Pocket Maximum Amount.

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

3.7.18 PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM AMOUNT

When the Prescription Drug Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications. The Medical Out-of-Pocket Maximum Amounts accumulate separately from the Prescription Drug Out-of-Pocket Maximum Amount.

NOTE: Prescription Medication Coinsurance accumulate toward a Member's Prescription Drug Out-of-Pocket Maximum Prescription Medication Copay Amounts accumulate toward a Member's Medical Out-of-Pocket Maximum. The Out-of-Pocket Maximum Amounts renew on January 1 of each consecutive Benefit Period.

3.7.19 INFERTILITY SERVICES COINSURANCE/DEDUCTIBLE

Neither the Infertility Services Lifetime Deductible Amount nor any Member-paid Copays or Coinsurance for infertility services apply toward the Medical Deductible or Out-of-Pocket Maximum Amounts. Infertility services are limited to a lifetime benefit maximum, per Member, of $20,000.

3.8 OUTLINE OF COVERED SERVICES

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Inpatient Hospital and Medical Services		
• **Inpatient Hospital Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Medical Care Visits**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Consultations**	80% of Allowed Charge.	75% of Allowed Charge.
• **Concurrent Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Initial Newborn Care**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
Inpatient and Outpatient Surgical Services		
• **Professional Health Care Provider Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Assistant Surgeon Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ambulatory Surgical Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospital Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Anesthesia Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Outpatient Sterilization Procedures for Females**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Transplant Services		
• **Inpatient and Outpatient Hospital and Medical Services**	80% of Allowed Charge *when Preauthorization/Prior Approval is received from Sanford Health Plan.*	75% of Allowed Charge *when Preauthorization/Prior Approval is received from Sanford Health Plan.*
• **Transportation Services**	80% of Allowed Charge. *Maximum Benefit Allowance of $1,000 per transplant procedure.*	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Dental Services		
• **Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are subject to a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.	
• **Dental Services Related to Accidental Injury**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dental Anesthesia and Hospitalization**	80% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*	75% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*
Outpatient Hospital and Medical Services		
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Emergency Services**	$60 Copayment Amount, then deductible and 80% of coinsurance applies for emergency room facility fee billed by a Hospital.	$60 Copayment Amount, then deductible and 80% of coinsurance applies for emergency room facility fee billed by a Hospital.
	The Copayment Amount for the emergency room facility fee is waived when a Member is admitted directly as an Inpatient to a Hospital.	
	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. (*Deductible Amount is waived)*	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. (*Deductible Amount is waived*
	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Ambulance Services**	80% of Allowed Charge.	80% of Allowed Charge.
• **Radiation Therapy and Chemotherapy**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dialysis Treatment**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Infusion Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Visual Training for Members 17 and under**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are subject to an Annual Maximum of 16 visits per Member.	
• **Allergy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Phenylketonuria (PKU)** - *Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)*	80% of Allowed Charge.	75% of Allowed Charge.
Wellness 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.	
• **Well Child Care to the Member's 18th birthday**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *Pediatric services based on guidelines supported by the HRSA, including recommendations by the American Academy of Pediatrics Bright Future pediatric schedule, and newborn metabolic screenings;* • *Pediatric services based on evidence-informed preventive care and screening guidelines supported by the HRSA;* • *Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Immunizations**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
	Immunizations are provided and covered as recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) and by the Health Resources and Services Administration (HRSA), with respect to the Member involved.	
Preventive Screening Services for Members ages 18 and older		
• **Routine Preventive Wellness (Physical) Examination** *Preauthorization is not required when using a participating provider. Your annual preventive services do not need to be scheduled 12 months apart. For example, if your services were done July last year, it is okay to schedule them before July this year.*	100% of Allowed Charge. *Deductible Amount is waived.* *Office visit exam includes health advice and counseling on blood pressure, counseling and interventions on tobacco use, screening and counseling for alcohol use, sun exposure, screening for depression, obesity screening with referral for behavioral interventions for patients with a body mass index of 30 or higher and referrals to intensive behavioral counseling to promote a healthful diet and physical activity to decrease cardiovascular risk in adults that are overweight or obese and with cardiovascular disease risk factors. During the visit, you may receive immunizations/screenings based on your practitioner's recommendation.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Routine Diagnostic Screenings**	100% of Allowed Charge. *Deductible Amount is waived.* *Screenings include, but are not limited to the following:* • *Abdominal Aortic Aneurysm Screening; Lifetime Maximum Benefit Allowance of one (1) ultrasound screening per male Member ages 65 through 75 with a history of smoking* • *Anemia screening – Hemoglobin or Hematocrit (one or the other); one (1) per Member per year.* • *Basic Metabolic Panel; one (1) per Member per year.* • *Cholesterol Screening; coverage for frequency of Lipid Profile is dependent on Member age. Additional tests, such as comprehensive metabolic panels will be applied to your deductible/coinsurance.* • *Diabetes Screening; benefit allowance of one (1) per Member per year.* • *Hepatitis B Virus infection screening.* • *Hepatitis C Virus (HCV) infection screening; Lifetime Maximum Benefit Allowance of either: one (1) screening for Members born between 1945-1965; or one (1) screening for Members at risk.* • *Lung Cancer Screening; benefit allowance of one (1) per Member ages 55 through 80 who: 1) have a 30 pack-year smoking history; 2) currently smoke; or 3) have quit smoking within the past 15 years.* • *Osteoporosis Screening for female Members ages 65 and older, or younger if at increased risk.* • *Sexually Transmitted Disease (STD) Screening; one (1) per Member per year.* • *Genetic counseling and evaluation for BRCA Testing and BRCA lab screening for female members with a family history (breast, ovarian, tubal, or peritoneal cancer) associated with increased risk for harmful mutation in BRC or BRC. Lifetime Maximum Benefit Allowance of one (1) screening per Member.* *For a complete listing, see the Preventive Health Guidelines for Members by signing into your account at sanfordhealthplan.com/memberlogin or call (800) 499-3416 to request a copy. As these recommendations change, your coverage may also change.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Mammography Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	• *One (1) service for Members between the ages of 35 and 40.* • *One (1) service per year for Members age 40 and older.* • *Additional mammograms will be covered if recommended by a physician per N.D.C.C. §26.1-36-09.1.*	
• **Cervical Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period. Includes Office Visit.	
• **Colorectal Cancer Screening for Members ages 45 and older**	***Note:*** *Expenses incurred for tissue samples taken during a screening and sent for evaluation or colonoscopies due to a medical condition will be applied to your deductible/coinsurance.*	
➢ Fecal Occult Blood Test; *or*	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Maximum Benefit Allowance of one (1) test per Member per year.	
➢ Colonoscopy; *or*	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Maximum Benefit Allowance of one (1) test per Member every 10 years.	
➢ Sigmoidoscopy	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Maximum Benefit Allowance of one (1) test per Member every 5 years.	
• **Prostate Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of African American descent; and a male age 40 with a family history of prostate cancer. Includes Office Visit.	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Nutritional Counseling**	100% of Allowed Charge. *Deductible Amount is waived.* • *Hyperlipidemia – Maximum of four (4) visits per Member per year.* • *Gestational Diabetes – Maximum of four (4) visits per Member per year.* • *Diabetes Mellitus – Maximum of four (4) visits per Member per year.* • *Hypertension – Maximum of two (2) visits per Member per year.* • *Obesity – Maximum of four (4) visits per Member per year.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Aspirin to prevent cardiovascular disease**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefit is available for Male Members ages 45 through 79, and female Members ages 55 through 79 at risk for developing cardiovascular disease.*	100% of Allowed Charge. *Deductible Amount is waived.*
The preventive care benefits listed above provide a brief overview. For a detailed list of covered services, view the Plan's Preventive Health Guidelines by signing into your account at sanfordhealthplan.com/memberlogin.		
• **Outpatient Nutritional Care Services**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions:* • *Chronic Renal Failure – Four (4) Office Visits per Member per year.* • *Anorexia Nervosa – Four (4) Office Visits per Member per year.* • *Bulimia – Four (4) Office Visits per Member per year.* • *PKU – Four (4) Office Visits per Member per year.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Diabetes Education Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Dilated Eye Examination** *(for diabetes related diagnosis)*	$30 Copayment Amount, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount, then 75% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Tobacco Cessation Services**	*Tobacco Cessation services include screening for tobacco use and at least two (2) tobacco cessation attempts per year (for Members who use tobacco products).* *Covering a cessation attempt is defined to include coverage for:* • *Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without Preauthorization/Prior Approval; 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 without Preauthorization/Prior Approval.*	
Outpatient Therapy Services Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.		
• **Physical Therapy**	$30 Copayment Amount per Office Visit/Evaluation or $25 Copayment Amount Per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit/Evaluation or $30 Copayment Amount Per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	$25 Copayment Amount per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	$25 Copayment Amount per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Respiratory Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Cardiac Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions:* • *Myocardial Infarction* • *Coronary Artery Bypass Surgery* • *Coronary Angioplasty and Stenting* • *Heart Valve Surgery* • *Heart Transplant Surgery* *Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Pulmonary Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Physical Therapy for Members age 65 and older at risk for falls**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	——————Benefit subject to Medical Necessity——————	
Chiropractic Services	Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.	
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Therapy and Manipulations**	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
Maternity Services	The Deductible Amount is waived for delivery services received from a PPO Health Care Provider when the Member is enrolled in the *Healthy Pregnancy* Program.	
• **Inpatient Hospital and Medical Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Routine Prenatal and Postnatal Care**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **One (1) Prenatal Nutritional Counseling visit per pregnancy**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Lactation Counseling**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	Basic Plan After Deductible Amount
Infertility Services		
• **Diagnostics, Treatment, Office Visits, and Other Services**	80% of Allowed Charge. *Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.*	80% of Allowed Charge.
Contraceptive Services		
• **Diagnostics, Treatment, Office Visits, and Other Services**	100% of Allowed Charge. *Deductible Amount is waived.* *Prescription contraceptive services, obtainable with a Prescription Order, are paid under the Prescription Drug benefit. See Section 3.5.*	100% of Allowed Charge. *Deductible Amount is waived.*
Mental Health and Substance Use Disorder Treatment Services		
• **Mental Health Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of the Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*
Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge.	80% of Allowed Charge.
	Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.	*Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*
Other Services Not Previously Listed Above		
• **Skilled Nursing Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Health Care Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospice Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Private Duty Nursing Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Medical Supplies and Equipment**	80% of Allowed Charge.	75% of Allowed Charge.
- Home Medical Equipment - Prosthetic Appliances and Limbs - Orthotic Devices - Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Prescription Drug Benefit – See Section 3.5 - Oxygen Equipment and Supplies - Ostomy Supplies - External Hearing aids	*Limited to one hearing aid, per ear, per Member every 3 years in alignment with Medical Necessity and Sanford Health Plan guidelines..*	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Breast Pumps**	100% of Allowed Charge. *Deductible Amount is waived. Benefits are available for the rental or purchase of 1 breast pump per pregnancy. Supplies also covered; see Section 3.*	100% of Allowed Charge. *Deductible Amount is waived. Benefits are available for the rental or purchase of 1 breast pump per pregnancy. Supplies also covered; see Section 3.*
• **Eyeglasses or Contact Lenses** *(following a covered cataract surgery)*	80% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.*	75% of Allowed Charge.

Prescription Drug and Diabetes Supplies Benefits

Retail and Mail Order

Insulin and medical supplies for insulin dosing and administration

➢ **Insulin and Glucagon** Formulary or Non-Formulary		
1-30 day supply	$25 copayment	$25 copayment
31-60 day supply	$50 copayment	$50 copayment
61-100 day supply	$75 copayment	$75 copayment
➢ **Testing Supplies** Formulary		
1-30 day supply	25% coinsurance with maximum of $25	25% coinsurance with maximum of $25
31-60 day supply	25% coinsurance with maximum of $50	25% coinsurance with maximum of $50
61-100 day supply	25% coinsurance with maximum of $75	25% coinsurance with maximum of $75
➢ **Testing Supplies** Non-Formulary		
1-30 day supply	50% coinsurance with maximum of $25	50% coinsurance with maximum of $25
31-60 day supply	50% coinsurance with maximum of $50	50% coinsurance with maximum of $50
61-100 day supply	50% coinsurance with maximum of $75	50% coinsurance with maximum of $75
➢ **Insulin pen needles and syringes** Formulary or Non-Formulary		
1-30 day supply	12% coinsurance with maximum of $25	12% coinsurance with maximum of $25
31-60 day supply	12% coinsurance with maximum of $50	12% coinsurance with maximum of $50
61-100 day supply	12% coinsurance with maximum of $75	12% coinsurance with maximum of $75

Formulary Prescription Medication

➢ Generic	$7.50 Copayment Amount, then 88% of Allowed Charge. Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*
➢ Brand Name	$25 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
Non-Formulary Prescription Medication		
	\$30 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*	

Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount for Formulary Medications is:

————————————\$1,200 per Member per Benefit Period ————————————

Copayment Amount Application

- One Copayment Amount per Prescription Order or refill for a 1 - 34-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 35 - 100-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 2- or 3-month supply of Non-Formulary contraceptives.

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 do not apply. *Deductible Amount is waived.*

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.

If a Generic Prescription Medication is the therapeutic equivalent for a Brand Name Prescription Medication, and is authorized by a Member's Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent, the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication and applicable Cost Sharing Amounts. For details, see Section 3.5

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

Cost Sharing Amounts are waived for generic federal legend prenatal vitamins when the member is enrolled in the Healthy Pregnancy program. Member will be responsible for copayment plus co-insurance for all brand name federal legend prenatal vitamins and generic federal legend vitamins, if not enrolled in the Healthy Pregnancy Program. For details, see Section 3.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.* For details, see Section 3.

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.* For details, see Section 3.

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.* For details, see Section 3.

SECTION 4
LIMITED AND NON-COVERED SERVICES

This section describes services that are subject to limitations or NOT covered under this Contract. The Plan is not responsible for payment of non-covered or excluded benefits.

4.1 GENERAL MEDICAL EXCLUSIONS

1. Acupuncture
2. Additional refractive procedure (including lens) after coverage of initial lens at time of cataract correction.)
3. Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider
4. Adult vision exams (routine)
5. Air conditioners, air filters, or other products to eradicate dust mites
6. All other hearing related supplies, purchases, examinations, testing or fittings not covered under this policy
7. Alternative treatment therapies including, but not limited to: acupressure, massage therapy unless covered per plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
8. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination
9. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Certificate of Insurance
10. Any expenses related to surrogate parenting, except if Surrogate is a covered Member under this Certificate of Insurance and seeking otherwise Covered Services
11. Any form of allergy testing and immunotherapy that is considered experimental or not FDA approved
12. Any fraudulently billed charges or services received under fraudulent circumstances
13. Any other equipment and/or supplies which the Plan determines not eligible for coverage
14. Any services or supplies for the treatment of obesity that do not meet Sanford Health Plan's coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling); nutritional supplements or food supplements; and weight loss or exercise programs
15. Appetite suppressants and supplies of a similar nature
16. Appointment scheduling
17. Artificial organs, any transplant or transplant services not listed above
18. Autopsies, unless the autopsy is at the request of The Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense.
19. Blood and blood derivatives replaced by the Member
20. Bifocal contact lenses
21. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by the Plan.
22. Charges for professional sign language and foreign language interpreter services unless required by state or federal law
23. Charges for sales tax, mailing, interest and delivery

24. Charges for services determined to be duplicate services
25. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations, unless otherwise stated in this Certificate of Insurance
26. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers
27. Chemical peel for acne
28. Chiropractic manipulations for allergies
29. Clarification of simple instructions
30. Cleaning and polishing of prosthetic eye(s)
31. Clinical ecology, orthomolecular therapy, vitamins (unless listed as covered elsewhere in this COI) or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.
32. Commodes and/or similar convenience items
33. Complications resulting from non-covered or denied Health Care Services.
34. Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
35. Consultative message exchanges with an individual who is seen in the provider's office following a video visit for the same condition, per Sanford Health Plan guidelines
36. Convalescent care
37. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services, body contouring procedures, and body lift procedures, with the exception of WHCRA for coverage related to breast cancer
38. Costs related to locating organ donors
39. Coverage beyond one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
40. Cryogenic or other preservation techniques used in such or similar procedures;
41. Custodial care
42. Custodial or convalescent care
43. Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (except as stated above and in Section 3 "Diabetes supplies, equipment, and education")
44. Daycare, Attendant, or Homemaker Services
45. Deluxe equipment
46. Dental appliances of any sort, including but not limited to those related to Sleep Apnea, bridges, braces, and retainers that are for cosmetic reasons and/or medically unnecessary
47. Dental care and treatment (routine or non-routine) for Members ages nineteen (19) and older including but not limited to:
    a. natural Teeth replacements including crowns, bridges, braces or implants;
    b. extraction of wisdom teeth;
    c. hospitalization for extraction of teeth;
    d. dental x-rays or dental appliances;
    e. shortening of the mandible or maxillae for cosmetic purposes;
    f. services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty; and

g. dental appliances of any sort, including but not limited to bridges, braces, and retainers, other than for treatment of TMJ/TMD
h. Osseointegrated implant surgery (dental implants)

48. Dental services not specifically listed as Covered by the Policy
49. Dental x-rays
50. Diet therapy (specialty foods) for allergies
51. Dietary desserts and snack items
52. Dietary surveillance and counseling
53. Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
54. Domiciliary care or Long-Term Residential Care
55. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of embryos, sperm, or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing
56. Donor expenses for complications of transplants that occur after sixty (60) days from the date the an organ is removed, regardless if the donor is covered as a Member under this Plan or not
57. Duplicate or similar items
58. Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests
59. Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)
60. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to,
    a. Education on self-care or home management
    b. Educational or non-medical services for learning disabilities
    c. Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services as provided under the Individuals with Disabilities Education Act (IDEA)
    d. Educational or non-medical services for learning disabilities or behavioral problems
61. Elective abortion services
62. Elective health services received outside of the United States
63. Expenses incurred by a Member as a donor, unless the recipient is also a Member
64. Experimental and Investigational Services not part of an Approved Clinical Trial unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
65. Extra care costs related to taking part in an Approved Clinical Trial such as additional tests that a Member may need as part of the trial, but not Routine Patient Costs.
66. Extraction of wisdom teeth
67. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as Covered elsewhere in this Certificate of Insurance
68. Fees associated with Room and Board, unless Prior Authorization is received pursuant to Medical Necessity guidelines
69. First aid or precautionary equipment such as standby portable oxygen units
70. Food items for medical nutrition therapy
71. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Insurance).
72. Formula and supplements available Over the Counter

73. Genetic counseling or testing except for services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; Preauthorization/Prior Approval is required)
74. Hair transplants or hair plugs
75. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires primary coverage for the same
76. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition
77. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition
78. Health Care Services ordered by a court or as a condition of parole or probation, unless applicable law requires the Plan to provide coverage for the same
79. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only In-Network Participating Practitioner and/or Provider in the area, the Member may be treated by that Provider provided they are acting within the scope of their practice. The Member may also go to a Non-Participating Provider and receive In-Network coverage (Section 2). If the immediate family member is not the only In-Network Participating Practitioner and/or Provider in the area, the Member must go to another In-Network Participating Practitioner and/or Provider in order to receive coverage at the In-Network level.
80. Health Care Services prohibited state or federal rule, law, or regulation
81. Health Care Services provided either before the effective date of the Member's coverage or after the Member's coverage is terminated.
82. Health Care Services received from a Non-Participating Provider, unless otherwise specified in this Contract.
83. Health Care Services required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation
84. Health Care Services that are the responsibility of a Third-Party Payor
85. Health Care Services that we determine are not Medically Necessary
86. Health services received outside of the United States that are not Medically Necessary emergency or urgent care services.
87. Home birth settings, related equipment and fees
88. Home delivered meals or laundry services
89. Home modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
90. Home Traction Units
91. Homeopathic treatment of allergies
92. Hospitalization for extraction of teeth that is not Medically Necessary
93. Hot/cold pack therapy including polar ice therapy and water circulating devices
94. Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
95. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
96. Hypnotism

97. Iatrogenic condition illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to Iatrogenic illness or injury are not the responsibility of the Member.
98. Independent nursing, homemaker services, respite care
99. Inpatient services provided at a Residential Treatment Facility if treatment is not provided at an acute level of care with 24-hour registered nursing care under the supervision of a Chief Medical Officer.
100. Installation or maintenance of any telecommunication devices or systems
101. Intermediate level or domiciliary care
102. Items which are primarily non-medical and educational in nature or for vocation, comfort, convenience or recreation
103. LASIK eye surgery
104. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics
105. Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)
106. Long-Term Residential Care
107. Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
108. Maintenance and service fee for capped-rental items
109. Maintenance Care that is typically long-term and by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or initiated by Members without symptoms in order to promote health and to prevent further problems, unless specifically stated as covered elsewhere in this Certificate of Insurance
110. Maintenance Therapy
111. Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling
112. Maternity classes and/or education programs
113. Meals, custodial care or housekeeping
114. Methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.
115. Milieu therapy
116. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events.
117. Newborn delivery and nursery charges for adopted Dependents prior to the adoption-bonding period (See Section 1.8 “When Dependent Coverage Begins.”)
118. Non-licensed birthing assistance, such as doulas
119. Non-surgical treatments that do not meet the Plan’s Medically Necessary guidelines (available upon request)
120. Nursing care requested by, or for the convenience of the Member or the Member’s family (rest cures)
121. Nutritional or food supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding, except when it’s the sole means of nutrition)
122. Online assessment and management service provided by a qualified no physician health care professional, internet or electronic communications.
123. Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances
124. Panniculectomy that does not meet Plan guidelines
125. Personal comfort items (telephone, television, guest meals and guest beds)

126. PKU dietary desserts and snack items
127. Pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)
128. Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere
129. Provider-initiated e-mail
130. Provocative food testing
131. Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error
132. Refractive errors of the eye
133. Refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses
134. Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other Health Care Services
135. Reminders of scheduled office visits
136. Remote control devices as optional accessories
137. Removal of skin tags
138. Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; Member desire for change of implant; Member fear of possible negative health effects; or removal of ruptured saline implants that do not meet Medical Necessity criteria. Fees for room and board unless Prior Authorized
139. Replacement of lost, stolen, broken, or damaged lenses or glasses
140. Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
141. Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness; or if lost or stolen
142. Reproductive Health Care Services prohibited by the laws of This State
143. Requests for a referral
144. Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; Sanford Health Plan does not cover these costs.
145. Rest cures
146. Restorative replacements including crowns, bridges, braces or implants
147. Reversal of voluntary sterilization
148. Reversals of prior sterilization procedures
149. Revision of durable medical equipment, except when made necessary by normal wear or use
150. Revision/replacement of prosthetics (except as noted per Plan policy)
151. Routine cleaning of Scleral Shells
152. Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
153. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
154. Sensitivity training
155. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction)
156. Service call charges and charges for repair estimates
157. Services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty
158. Services and/or travel expenses relating to a Non-Emergency Medical Condition

159. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home that are not Medically Necessary
160. Services determined to be cosmetic by the Plan
161. Services for excluded benefits
162. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
163. Services not medically appropriate or necessary
164. Services not medically appropriate to do via telehealth.
165. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate
166. Services or supplies determined by the Plan to be special or unusual, including orthoptics, and vision aids
167. Services provided in the Member's home for convenience
168. Services related to environmental change
169. Services that are not Health Care Services
170. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
171. Services that can be provided safely and effectively by a non-clinically trained person
172. Services that involve payment of family members or nonprofessional care givers for services performed for the member
173. Service(s) that would similarly not be charged for in regular office visit
174. Services to assist in activities of daily living
175. Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies drugs and aftercare for or related to artificial or non-human organ transplants
176. Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee
177. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Center of Excellence
178. Shortening of the mandible or maxillae for cosmetic purposes
179. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered
180. Special lens coating or lens treatments for prosthetic eyewear
181. Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)
182. Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use
183. Sublingual allergy desensitization
184. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
185. Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)
186. Take-home drugs (Prescription medications provided to a Member at discharge are paid under the Prescription Drug benefit. See Sections 3.5, 3.7, and 3.8 for benefit details.)
187. Telecommunication Devices
188. Telephone assessment and management services
189. Tests considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: allergy testing, celiac antibody testing, hair analysis, testing for mitochondrial disorders, and micronutrient testing.
190. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer

or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.

191. Therabands and cervical pillows
192. Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, and hyperbaric oxygen therapy.
193. Therapy and service animals, including those used for emotional or anxiety support
194. Thermograms or thermography
195. Tinnitus Maskers
196. Transfers performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider
197. Transmission fees
198. Transplant evaluations with no end organ complications
199. Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria
200. Transportation costs for non-emergency services and/or travel
201. Treatment of weak, strained, or flat feet
202. Treatment received outside of the United States
203. Upgrades of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.
204. Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
205. Vitamins and minerals (unless otherwise specified as covered in this Policy)
206. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
207. Wearable artificial kidney, each
208. Weight loss or exercise programs that do not meet the Plan's Medical Necessity coverage guidelines

4.2 GENERL PHARMACY EXLCUSIONS

1. Any medication equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider
2. B-12 injection (except for pernicious anemia)
3. Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine
4. Compound medications with no legend (prescription) medication
5. Drug Efficacy Study Implementation ("DESI") drugs
6. Experimental or Investigational medications or medication usage pursuant to the Plan's medical coverage policies
7. Excluded medications from coverage that provide little or no evidence of therapeutic advantage over other products available.
8. Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances
9. Medical Cannabis and/or its equivalents

10. Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of Medical Necessity)
11. Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
12. Medications not listed in the Plans Formulary
13. Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;
14. Medications that are obtained without Prior Authorization or a Formulary exception from the Plan
15. Medications that may be received without charge under a government program, unless coverage is required for the medication
16. Medications that provide little or no evidence of therapeutic advantage over other products available
17. Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Member's medical benefit;
18. Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document, food supplements and baby formula (except to treat PKU or otherwise required to sustain life or amino acid-based elemental oral formulas), nutritional and electrolyte substances
19. Over-the-counter (OTC) medications vitamins and/or supplements, equipment or supplies (except for Plan B and its generic equivalents; insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets, or aspirin to prevent cardiovascular disease when prescribed by a Healthcare Practitioner and/or Provider) that by Federal or State law do not require a prescription order
20. Outpatient medications dispensed in a Provider's office or non-retail pharmacy location
21. Refills of any prescription older than one (1) year
22. Repackaged medications
23. Replacement of a prescription medication due to loss, damage, or theft
24. Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
25. Unit dose packaging
26. Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia

4.3 SPECIAL SITUATIONS AFFECTING COVERAGE

Neither Sanford Health, nor any Participating Provider, shall have any liability or obligation because of a delay or a Participating Provider's inability to provide services as a result of the following circumstances:

- Complete or partial destruction of the Provider's facilities;
- Declared or undeclared acts of War or Terrorism;
- Riot;
- Civil insurrection;
- Major disaster;
- Disability of a significant portion of the Participating Providers;
- Epidemic; or
- A labor dispute not involving Participating Providers, we will use our best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services is delayed due to a labor dispute involving Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

Additionally, non-Emergency care may be deferred until after resolution of the above circumstances.

4.4 SERVICES COVERED BY OTHER PAYORS

The following are excluded from coverage:

- Health Care Services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by Worker's compensation, no-fault auto insurance, medical payments coverage or similar legislation.
- The Plan is not issued in lieu of nor does it affect any requirements for coverage by Worker's Compensation. This Plan contains a limitation, which states that health services for injuries or sickness, which are job, employment or work, related for which benefits are paid under any Worker's Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid under the Plan, and it is determined that Member is eligible to receive Worker's Compensation for the same incident; Sanford Health Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse Sanford Health Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Worker's Compensation Division Hearing. Sanford Health Plan reserves its right to recover against Member even though:
    - The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise; or
    - No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
    - The amount of Worker's Compensation for medical or health care is not agreed upon or defined by Member or the Worker's Compensation carrier; or
    - The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.
- Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Worker's Compensation insurer, without the express written agreement of Sanford Health Plan.
- Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or Group.
- Health Care Services for injury or sickness for which there is other non-Group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
- Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.
- Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and TRICARE, unless applicable law requires the Plan to provide primary coverage for the same.

4.5 SERVICES AND PAYMENTS THAT ARE THE RESPONSIBILITY OF MEMBER

- Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Benefits and Coverage and Summary of Pharmacy Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;
- Finance charges, late fees, charges for missed appointments and other administrative charges; and
- Services for which a Member is neither legally, nor as customary practice, is required to pay in the absence of a group health plan or other coverage arrangement.

SECTION 5
HOW SERVICES ARE PAID FOR UNDER THE CERTIFICATE OF INSURANCE

5.1 REIMBURSEMENT OF CHARGES BY PARTICIPATING PROVIDERS

- When you see Participating Practitioner and/or Providers, receive services at Participating Practitioner and/or Provider Providers and facilities, or obtain your prescription drugs at Network Pharmacies, you will not have to file claims. You must present your current identification card and pay your Copay.
- When a Member receives Covered Services from a Participating Practitioner and/or Provider, Sanford Health Plan will pay the Participating Practitioner and/or Provider directly, and the Member will not have to submit claims for payment. The Member's only payment responsibility, in this case, is to pay the Participating Practitioner and/or Provider, at the time of service, any Copay, Deductible, or Coinsurance amount that is required for that service. Participating Practitioner and/or Providers agree to accept either Sanford Health Plan's payment arrangements or the negotiated contract amounts.

Time Limits. Participating Practitioner and/or Providers must file claims to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If the Member fails to show his/her ID card at the time of service, then the Member may be responsible for payment of claim after Practitioner and/or Provider's timely filing period of one hundred eighty (180) days has expired.

In any event, the claim must be submitted to Sanford Health Plan no later than one hundred eighty (180) days after the date that the cost was incurred, unless the claimant was legally incapacitated.

5.2 REIMBURSEMENT OF CHARGES BY NON-PARTICIPATING PROVIDERS

Sanford Health Plan does not have contractual relationships with Non-Participating Providers and they may not accept the Sanford Health Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount that is required for that service, Members are responsible for any difference between the amount charges and Sanford Health Plan's payment for Covered Services. Non-Participating Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

- the amount charged for a Covered Service or supply; or
- inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
- outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    - Fees typically reimbursed to providers for same or similar professionals; or
    - Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Providers. Sometimes these Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to Sanford Health Plan within one-hundred-eighty (180) days after the date that the cost was incurred.

If you, or the Non-Participating Provider, does not file the claim within 180 days after the date that the cost was incurred you will be responsible for payment of the claim.

If you need to file the claim, here is the process:

The Member must give Sanford Health Plan written notice of the costs to be reimbursed. Claim forms are available from the Customer Service Department to aid in this process. Bills and receipts should be itemized and show:

- Covered Member's name and ID number;
- Name and address of the Physician or Facility that provided the service or supply;
- Dates Member received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Time Limits: Claims must be submitted to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If you, or the Non-Participating Provider, file the claim after the one-hundred-eighty (180) timely filing limit has expired, you will be responsible for payment of the claim.

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

5.3 PAYMENTS FOR AIR AMBULANCE CHARGES

As a safeguard for Members, the reimbursement rate for Out-of-Network air ambulance services is equal to the average of Sanford Health Plan's In-Network rates for air ambulance providers licensed by the North Dakota Department of Health.

A claim made by the Member for Out-of-Network air ambulance services provided by an air ambulance provider licensed by the North Dakota Health Department will be paid in accordance with Sanford Health Plan's above mentioned policy. A payment made in accordance with this policy is the same as an In-Network payment for services.

If you have questions, please call our Customer Service Department.

5.4 BALANCE BILLING FROM NON-PARTICIPATING PROVIDERS

Balance billing, sometimes referred to as surprised billing, is the practice of a medical provider charging a patient for the difference between the total cost of services being billed and the amount the insurance pays. When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, the Member is protected from balance billing because the provider cannot attempt to collect charges above what Sanford Health Plan reimburses. When Sanford Health Plan does not have a contractual relationship in place and the provider is a Non-Participating Provider, they may not accept Sanford Health Plan's payment arrangements and members may be balanced billed for services received.

Members may be balance billed in emergency situations even when Sanford Health Plan covers all of the charges at an In-Network Level if the provider is a Non-Participating Provider who will not accept our

payment as full and final. In such circumstances, the Non-Participating Provider must satisfy the Notice and Consent Process and Requirements before sending surprise bills. Out-of-Network facilities and providers are prohibited from sending surprise bills for out-of-network cost sharing without signed consent from the Member. Please check the Sanford Health Plan provider directory before receiving services to make sure you are seeing an In-Network Participating Practitioner and/or Provider.

If you think you've been wrongly billed, contact the No Surprises Help Desk (NSHD) at 1-800-985-3059 or visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law. For Minnesota residents, you may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 for more information about your rights under Minnesota law.

5.5 HEALTH CARE SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

Deductible and applicable cost-share will apply for Medically Necessary emergency and urgent care services received in a foreign country. There is no coverage for elective or preventive Health Care Services if a Member or their dependent(s) travels to another country for the purpose of seeking medical treatment outside the United States. There is no coverage for any non-emergent Health Care Services if a Member or their dependent(s) resides in another country.

5.6 TIMEFRAME FOR PAYMENT OF CLAIMS

- The payment for reimbursement of the Member's costs will be made within *fifteen (15)* days of when Sanford Health Plan receives a complete written claim with all required supporting information.
- When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to our guidelines, Sanford Health Plan will arrange for direct payment to either the Non-Participating Provider or the Member. If the Provider refuses direct payment, the Member will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of This Contract. The Member will be responsible for any expenses that exceed Maximum Allowed Amount, as well as any Copay, Deductible, or Coinsurance required for the Covered Service.

5.7 WHEN WE NEED ADDITIONAL INFORMATION

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond

5.8 MEMBER BILL AUDIT PROGRAM

Upon receiving notice of a claims payment, or Explanation of Benefits (EOB), from Sanford Health Plan, Members are encouraged to audit their medical bills and notify the Plan of any services which are improperly billed or of services that the Member did not receive.

If, upon audit of a bill, an error of $40 or more is found, the Member will receive a minimum payment of $20 or 50% of the resulting savings for paid Covered Services up to a maximum payment of $500.

To obtain payment through the Member Bill Audit Program, the Member must complete a *Member Bill Audit Refund Request Form*. To obtain a form, sign into your account at sanfordhealthplan.com/memberlogin or call Sanford Health Plan Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* and request a form be mailed to you.

NOTE: This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim. For more information on claims with more than one payor, see Section 6, *Coordination of Benefits*.

SECTION 6
COORDINATION OF BENEFITS

NOTE: Sanford Health Plan follows North Dakota Administrative Code §45-08-01.2-03 regarding Coordination of Benefits (COB). The COB provision applies when a person has health care coverage under more than one "plan" as defined for COB purposes.

If a Member is covered by another health plan, insurance, or other coverage arrangement, the plans and/or insurance companies will share or allocate the costs of the Member's health care by a process called "Coordination of Benefits" so that the same care is not paid for twice.

The Member has two obligations concerning Coordination of Benefits ("COB"):

- The Member must tell Sanford Health Plan about any other plans or insurance that cover health care for the Member, and
- The Member must cooperate with Sanford Health Plan by providing any information requested by Sanford Health Plan.

The rest of the provisions under this section explain how COB works.

6.1 APPLICABILITY

This Coordination of Benefits (COB) provision applies to Sanford Health Plan when a Member has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan.

The benefits of this Plan:

- shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section below entitled: *"Effect of COB on the Benefits of this Plan."*

6.2 DEFINITIONS (FOR COB PURPOSES ONLY)

"**Plan**" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a) Group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of Group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in Group, Group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts; and Medicare or any other federal governmental plan, as permitted by law.

b) "Plan" may include coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title MX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time). Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"**This Plan**" refers to this certificate, which provides benefits for health care expenses and means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

"**Primary Plan/Secondary Plan**": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

a) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
b) When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
c) When there are more than two (2) plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"**Allowable Expense**" means a necessary, reasonable and customary health care service or expense including Deductibles, Coinsurance, or Copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:

a) The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the Member's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
b) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that compute the benefit payments on the basis of reasonable costs, any amount in excess of the highest of the reasonable costs for a specified benefit is not an allowable expense;
c) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;
d) If a person is covered by one plan that calculates its benefits or services on the basis of reasonable costs and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be allowable expense for all plans; or

e) When benefits are reduced under a Primary Plan because a Member does not comply with The Plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, Certification of admissions or because the person has a lower benefit because the person did not use a preferred Practitioner and/or Provider.

"**Claim**" means a request that benefits of a plan be provided or paid in the form of services (including supplies), payment for all or portion of the expenses incurred, or an indemnification.

"**Claim Determination Period**" means a Calendar Year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if over-insurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or similar provision takes effect.

"**Closed Panel Plan**" is a plan that provides health benefits to Members primarily in the form of services through a panel of Practitioner and/or Providers that have contracted with or are employed by The Plan, and that limits or excludes benefits for services provided by other Practitioner and/or Providers, except in cases of emergency or Plan authorized referral by an In-Network Participating Practitioner and/or Provider.

"**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

6.3 ORDER OF BENEFIT DETERMINATION RULES

General. When two or more plans pay benefits, the rules for determining the order of payment is as follows:

a) The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan;
c) If multiple contracts providing coordinated coverage are treated as a single plan under North Dakota State law, inclusive, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this law;
d) If a person is covered by more than one secondary plan, this order of benefit determination provisions decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of any primary plan and the benefits of any other plan, which has its benefits determined before those of that secondary plan;
e) Except as provided in subdivision (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with North Dakota State law, inclusive, is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary;
f) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The plan which covers the person as a Group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:

- secondary to the Plan covering the person as a Dependent; and
- primary to the Plan covering the person as other than a Dependent, for example a retired Group Member; then the order of benefits between the two plans is reversed so that the plan covering the person as a Group Member, Member, or Subscriber is secondary and the other plan is primary.

Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
- The parents are not separated (whether or not they even have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after The Plan is given notice of the court decree.

If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the Spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the Spouse of the noncustodial parent.

Active/Inactive Group Member. The benefit of a plan, which covers a person as a Group Member who is neither laid off nor retired (or as that Group Member's Dependent), is primary. If the other plan does not have this rule, and if as a result the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule ***"Child Covered Under More Than One Plan"*** **first bullet point** above.

Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

- primary, the benefits of a plan covering the person as a Group Member, Member or Subscriber (or as that person's Dependent);
- secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered a Group Member, Member or Subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

6.4 EFFECT OF COB ON THE BENEFITS OF THIS PLAN

When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules," section above, this Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph "b(ii)" immediately below.

Reduction in this Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than 100% of those Allowable Expenses.

If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a Non-Participating Provider, benefits are not payable by one closed panel plan, COB shall not apply between this plan and any other closed panel plans.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Plan's Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.5 CALCULATION OF BENEFITS, SECONDARY PLAN

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should The Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under The Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

6.6 COORDINATION OF BENEFITS WITH GOVERNMENT PLANS AND BENEFITS

After Sanford Health Plan, Medicare (if applicable), and/or any Medicare Supplementary Insurance (Medigap) have paid claims, then Medicaid and/or TRICARE pay last. Sanford Health Plan will pay primary to TRICARE and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is **NOT** a Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance. This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

6.7 COORDINATION OF BENEFITS WITH MEDICARE

The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:

- determining whether these individuals are eligible to participate in the Plan; or
- providing benefits under the Plan.

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, Sanford Health Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. Sanford Health Plan

reserves the right to coordinate benefits with respect to Medicare Part D. Sanford Health Plan will make this determination based on the information available through CMS.

When MSP Rules Apply to COB

Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Insurance and is enrolled for insurance under Medicare, Parts A and B. This provision applies before any other Coordination of Benefits Provision of this Certificate of Insurance.

Coordination with Medicare Part D

This Certificate of Insurance shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage.

The following provisions apply to Sanford Health Plan's COB with Medicare:

When Medicare is the primary payer for a Member's claims:

- If you're 65, or older, and have group health plan coverage based on your or your spouse's current employment
- If you have retiree insurance (insurance from former employment)

NOTE: The hospital or doctor will first file claims with Medicare. Once Medicare processes the claim, an Explanation Of Medicare Benefits (EOMB) form will be mailed to the Member explaining what charges were covered by Medicare. Then the health care professional will generally file the claim with us. If a professional does not do so, the Member may file the claim by sending a copy of the EOMB, together with his or her member identification number, to the address shown on his or her member ID card.

When Medicare is primary despite the MSP rules:

- A Medicare-entitled person refuses coverage under the Plan;*
- Medical services or supplies are covered by Medicare but are excluded under the group health plan;
- A Medicare-entitled person has exhausted his or her benefits under the group health plan;
- A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
- A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

*** NOTE:** *Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual's Medicare benefits.*

When this Certificate of Insurance is the primary payer for a Member's claims:

- If you're under 65 and disabled, and have coverage based on your or a family member's current employment
- When coverage is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- The Member (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
- A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Member/Employee.

NOTE: The Member's claim is filed with us by Practitioner or Provider. After the claim is processed, we send the Member an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the Practitioner or Provider of the covered charges. If there are remaining charges covered by Medicare, the Practitioner or Provider may file a claim with Medicare. If the Practitioner or Provider will not do so, the Member can file the claim with Medicare. Members may contact their local Social Security office to find out where and how to file claims with the appropriate "Medicare intermediary" (a private insurance company that processes Medicare claims).

If a Practitioner and/or Provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Sanford Health Plan's allowable expense is the Medicare allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.

6.8 MEMBERS WITH END STAGE RENAL DISEASE (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD. Benefits covered by Medicare, because of ESRD, are for all Covered Services, not only those related to the kidney failure condition.

Sanford Health Plan does not differentiate in the benefits it provides to individuals who have ESRD, e.g. terminating coverage, imposing benefit limitations, or charging higher premiums.

How Primary vs. Secondary is Determined:

The Plan will pay first for thirty (30) months after the Member becomes eligible to join Medicare, starting with the first dialysis month or transplant month. This applies regardless of employment status and includes COBRA or retirement plan coverage. After the 30-month coordination period where the Member should enroll in Medicare, Medicare is the primary payer for a Member's claims under ESRD.

When Medicare is the primary payer for a Member's claims under ESRD:

- If the Member is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

6.9 COORDINATION OF BENEFITS WITH MEDICAID

- A Covered Individual's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the applicable State's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state's Medicaid program; and Sanford Health Plan will honor any subrogation rights the State may have with respect to benefits that are payable under this Certificate of Insurance.
- When an individual covered by Medicaid also has coverage under this Certificate of Insurance, Medicaid is the payer of last resort. If also covered under Medicare, Sanford Health Plan pays primary, then Medicare, and Medicaid is tertiary.

See provisions below on Coordination of Benefits with TRICARE, if a Member is covered by both Medicaid and TRICARE.

6.10 COORDINATION OF BENEFITS WITH TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent that the service provided is also covered under the other plan.

- Sanford Health Plan pays first if an individual is covered by both TRICARE and Sanford Health Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
- TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
- When a TRICARE beneficiary is covered under Sanford Health Plan, and also entitled to either Medicare or Medicaid, Sanford Health Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).
- TRICARE-eligible employees and beneficiaries receive primary coverage under this Certificate of Insurance in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

The Plan does not:

- Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
- Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this health benefit plan.

SECTION 7
SUBROGATION AND RIGHT OF REIMBURSEMENT

Sanford Health Plan will provide Health Care Services to the Member for the illness or injury, just as it would in any other case. However, if the Member accepts the services from Sanford Health Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

Subrogation Defined

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, Sanford Health Plan may be able to "step into the shoes" of the Member to recover health care costs from the party responsible for the injury or illness. This is called "Subrogation."

Reimbursement Defined

Sanford Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Member. This is called "Reimbursement."

Covered Individuals

Each and every Covered Individual hereby authorizes Sanford Health Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 6 and 7.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges. This Plan may give or obtain needed information from another insurer or any other organization or person.

7.1 SANFORD HEALTH PLAN'S RIGHTS OF SUBROGATION

In the event of any payments for benefits provided to a Member under this Plan, Sanford Health Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, Member's parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and Workers' Compensation insurance or substitute coverage.

Sanford Health Plan shall be entitled to receive from any such recovery an amount up to the Maximum Allowed Amount for the services provided by Sanford Health Plan. In providing benefits to a Member, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the reasonable costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under this Certificate of Insurance for an illness or injury, Sanford Health Plan is subrogated to the Member's right to recover the reasonable costs of the benefits it provides on account of such illness or injury, even if those reasonable costs exceed the amount paid by Sanford Health Plan.

Sanford Health Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. Sanford Health Plan's first priority right applies whether or not the Member has been made whole by any recovery. Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for any past, present, or future

Health Care Services provided to the Member. Sanford Health Plan may give notice of that lien to any party who may have contributed to the loss.

If Sanford Health Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits provided or to be provided under this Plan. This includes Sanford Health Plan's right to bring suit against the third party in the Member's name.

7.2 SANFORD HEALTH PLAN'S RIGHT TO REDUCTION AND REIMBURSEMENT

Sanford Health Plan shall have the right to reduce or deny benefits otherwise payable by Sanford Health Plan, or to recover benefits previously paid by Sanford Health Plan, to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

To the extent that federal or state statutes or courts, eliminate or restrict any such right of reduction or reimbursement provided to Sanford Health Plan under this Policy; such rights shall thus either be limited or no longer apply, or be limited by the extent of federal and state actions.

Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount for the Health Care Services provided to the Member.

7.3 ERRONEOUS PAYMENTS

To the extent payments made by Sanford Health Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of this Certificate of Insurance, Sanford Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which Sanford Health Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

7.4 MEMBER'S RESPONSIBILITIES

The Member, Member's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as Sanford Health Plan requires to facilitate enforcement of its rights under this Certificate of Insurance .The Member shall take no action prejudicing the rights and interests of Sanford Health Plan under this provision.

Neither a Member nor Member's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of Sanford Health Plan, to negotiate or compromise Sanford Health Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without Sanford Health Plan's express written consent.

Any Member who fails to cooperate in Sanford Health Plan's administration of this Part shall be responsible for the reasonable cost for services subject to this section and any legal costs incurred by Sanford Health Plan to enforce its rights under this section. Sanford Health Plan shall have no obligation whatsoever to pay medical

benefits to a Covered Individual if a Covered Individual refuses to cooperate with Sanford Health Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as Sanford Health Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, Sanford Health Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness caused by a third-party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of Sanford Health Plan's 100%, first-dollar Subrogation and refund rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by Sanford Health Plan. Failure to comply will entitle Sanford Health Plan to withhold benefits, services, payments, or credits due under Sanford Health Plan.

7.5 SEPARATION OF FUNDS

Benefits paid by Sanford Health Plan, funds recovered by the Covered Individual(s), and funds held in trust over which Sanford Health Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect Sanford Health Plan's equitable lien, the funds over which Sanford Health Plan has a lien, or Sanford Health Plan's right to subrogation and reimbursement.

7.6 PAYMENT IN ERROR

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

SECTION 8
HOW COVERAGE ENDS

8.1 TERMINATION BY THE SUBSCRIBER

Upon a qualifying event, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. Sanford Health Plan must receive a written request from the Group to end coverage. The Subscriber will be responsible for any Service Charges through the date of termination or the end of the calendar month in which termination occurs, whichever is later.

8.2 TERMINATION, NONRENEWAL, OR MODIFICATION OF MEMBER COVERAGE

A Member or Dependent's coverage will automatically terminate at the earliest of the following events below. Such action by Sanford Health Plan is called "Termination" of the Member.

- **Failure to Pay Service Charge Payments**. Failure to make any required Service Charge payments when due. A grace period of thirty-one (31) days, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period.
- **Termination of Employment**. The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s).
- **Termination of this Contract**. In the event this Contract terminates, the last day of the month for which Service Charge Payments were made is the date benefits will cease for the Member(s).
- **Loss of Eligibility**. The last day of the month in which the Member is no longer an Eligible Group Member is the date benefits will cease for the Member(s).
- **Movement Outside the Service Area**. The last day of the month in which the Member no longer resides in the Service Area is the date benefits will cease for the Member(s).
- **Death.** The date the Member dies is the date benefits will cease for the Member(s).
- **Fraudulent Information**. An act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, may be used to rescind this application or Certificate of Insurance, terminate coverage and deny claims. The date identified on the notice of termination is the date benefits will cease for the Member(s).
- **Use of ID Card by Another.** The use of a Member's ID Card by someone other than the Member is considered fraud. The date a Member allows another individual to use his or her ID card to obtain services is the date benefits will cease for the Member(s).
- **Product Discontinuance.** Sanford Health Plan discontinues a particular product provided that Sanford Health Plan provides the Group and all Group Members with written notice at least 90 days before the date the product will be discontinued, Sanford Health Plan offers the Group and all Group Members the option to purchase any other coverage currently being offered by Sanford Health Plan to group health plans, and Sanford Health Plan acts uniformly without regard to claims experience of the Group or any health status-related factor relating to particular Group Members covered or who may be eligible for

coverage. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s)

- **Discontinuance of All Coverage in Group Market or All Markets.** Sanford Health Plan discontinues offering all coverage in the group market or in all markets in Minnesota provided that Sanford Health Plan provides the Group and all Group Members and the Minnesota Department of Insurance with written notice of the discontinuance at least 180 calendar days prior to the date the coverage will be discontinued and all coverage issued or delivered by Sanford Health Plan in the group market in Minnesota are discontinued and not renewed. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s).
- **Any other reason permitted by State or federal law**.

Notification

Sanford Health Plan must notify all covered persons of the termination at least 30 days before the effective termination date for the termination to be effective

Uniform Modification of Coverage

Sanford Health Plan may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with State law and is effective uniformly for all persons who have coverage under this type of contract.

8.3 MEMBER APPEAL OF TERMINATION

A Member may Appeal Sanford Health Plan's decision to terminate, cancel, or refuse to renew the Member's coverage. The Appeal will be considered a Member Grievance and the Sanford Health Plan's Policy on Member Grievances and Appeals will govern the process.

Pending the Appeal decision, coverage will terminate on the date that was set by Sanford Health Plan. However, the Member may continue coverage, if entitled to do so, by complying with the "Continuation of Coverage" provisions in Section 9. If the Appeal is decided in favor of the Member, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

NOTE: A Member may not be terminated due to the status of the Member's health or because the Member has exercised his or her rights to file a complaint or appeal.

8.4 TERMINATION OF MEMBER COVERAGE

For the purposes of this Benefit Plan, upon termination of Member Coverage, the following provisions control:

1. **Determining Ineligibility.** Eligibility for benefits subsequent to retirement or termination will be determined pursuant to N.D.C.C. §54-52.1-03.
2. **Continuation of health, dental, vision, or prescription drug coverage after termination.** An employee who terminates employment and is not receiving a monthly retirement benefit from one of the eligible retirement systems, and applies for continued coverage with the health, dental, vision, or prescription drug plan may continue such coverage for a maximum of eighteen (18) months by remitting timely payments to the Board. The employee desiring coverage shall notify the Board within sixty (60) days of the termination.

Coverage will become effective on the first day of the month following the last day of coverage by the employing agency, if an application is submitted within sixty (60) days. An individual who fails to timely notify the board is not eligible for coverage. [N.D.A.C. §71-03-03-06]

3. **Continuation of health, dental, vision, or prescription drug coverage for dependents.** Dependents of employees with family coverage may continue coverage with the group after their eligibility would ordinarily cease. This provision includes divorced or widowed spouses and children when they are no longer dependent on the employee. Coverage is contingent on the prompt payment of the premium, and in no case will coverage continue for more than thirty-six (36) months. Dependents desiring coverage shall notify the board within sixty (60) days of the qualifying event and must submit an application in a timely manner. An individual who fails to notify the Board within the sixty (60) days, and who desires subsequent coverage, will not be eligible for coverage. [N.D.A.C. §71-03-03-07]
4. **Leave without pay.** An employee on an approved leave without pay may elect to continue coverage for the periods specified in the plans for life insurance, health, dental, vision, or prescription drug coverages by paying the full premium to the agency. An eligible employee electing not to continue coverage during a leave of absence is entitled to renew coverage for the first of the month following the month that the employee has returned to work if the employee submits an application for coverage within the first thirty-one (31) days of returning to work. An eligible employee failing to submit an application for coverage within the first thirty-one (31) days of returning to work or eligibility for a special enrollment period, may enroll during the annual open enrollment. Upon a showing of good cause, the executive director may waive the thirty-one day application requirement. [N.D.A.C. §71-03-03-09]
    a. In the event an enrolled eligible employee is not entitled to receive salary, wages, or other compensation for a particular calendar month, that employee may make direct payment of the required premium to the board to continue the employee's coverage, and the employing department, board, or agency shall provide for the giving of a timely notice to the employee of that person's right to make such payment at the time the right arises. [N.D.C.C. §54-52.1-06]

NOTE: A Member's coverage may not be terminated due to the status of the Member's health, or because the Member has exercised his or her rights, under the Plan's policy on member complaints, or the policy on appeal procedures for medical review determinations.

8.5 CONTINUATION

1. If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet NDPERS requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:
    a. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion, the Plan Administrator through which the Subscriber is eligible has terminated coverage with Sanford Health Plan, and the Plan Administrator has enrolled with another insurance carrier.
    b. The Plan Administrator no longer meets Sanford Health Plan's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.
    c. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.
    d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under the group (NDPERS). The Subscriber may elect conversion (individual) coverage on a nongroup basis, subject to

premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for nongroup coverage within 31 days after the termination date of the previous group health plan coverage.

If a Member becomes otherwise ineligible for group membership under this Benefit Plan, Sanford Health Plan must at least offer the Subscriber its conversion (individual) benefit plan, if the Member lives in the Sanford Health Plan Service Area. There may be other coverage options for the Subscriber and/or Eligible Dependents through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

8.6 EXTENSION OF BENEFITS FOR TOTAL DISABILITY

An extension of benefits is provided Covered Members/Subscribers who become totally disabled while enrolled under this Benefit Plan and whom continue to be totally disabled at the date of termination of this Certificate. Upon payment applicable premium charges at the current Group rate, coverage will remain in full force and effect until the first of the following occurs:

- The end of a period of twelve (12) months starting with the date of termination of the Group contract;
- The date the Member is no longer totally disabled; or
- The date a succeeding plan provides replacement coverage to that Member without limitation as to the disabling condition.

Upon termination of the extension of benefits, the Member/Subscriber will have continuation and conversion rights as stated in Sections 9 and 10.

8.7 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

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

8.8 NOTICE OF CREDITABLE COVERAGE

You may request a Certificate of Creditable Coverage for you and your covered family Members upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling Customer Service.

8.9 NOTICE OF GROUP TERMINATION OF COVERAGE

- **Termination due to Non-Renewal**

The Group will give thirty (30) days written notice of the termination to the Members. For purposes of This Contract, "give written notice" means to present the notice to the Member or mail it to the Member's last known address.

This notice will set forth at least the following:

- The effective date and hour of termination or of the decision to not renew coverage;
- The reason(s) for the termination or nonrenewal; and
- The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
    - the availability of Continuation of Coverage, if any; and
    - the fact that the Member may have rights under federal COBRA provisions, independent from any provisions of This Contract, and should contact the Group for information on the COBRA provisions.
- **Termination due to Non-Payment of Premiums**

If an employer fails to submit Premium payment to Sanford Health Plan resulting in loss of coverage to the Members, switches plans or cancels the coverage, The Group is required to give written notice of the termination to the Members as soon as reasonably possible but no later than ten (10) days after the date of termination.

SECTION 9
OPTIONS AFTER COVERAGE ENDS

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

Notice of Continuation Coverage Rights Under COBRA for employer groups with twenty (20) or more employees

Introduction

You are getting this notice because you recently gained coverage under an employer sponsored group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when employer sponsored group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Plan Document (Policy) or contact the Plan Administrator (your Employer).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept "Late Entrants".

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If the Plan is subject to COBRA, your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring coverage under the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The employer is responsible for the timely mailing of applicable COBRA notices to Members (the "COBRA Notification Letter"). The employer must notify Sanford Health Plan when qualifying events occur. Sanford Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after being notified by the employer that a qualifying event has occurred. The employer must notify the Plan of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to:

North Dakota Public Employees Retirement System
PO Box 1657
Bismarck, ND 58502
(701) 328-3900

How is COBRA Coverage Provided?

Upon notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

- If you or a covered Dependent is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your covered Dependents may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

- If you or your covered Dependents experience another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if your employer is properly notified about the second qualifying event.
- This extension may be available to your Spouse and any Dependent Children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to offer employees and their Spouse and/or Dependent Children the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where the employee leaves the position of employment due to service in the military. The Member or the Member's Authorized Representative may elect to continue the employee's coverage by making an election of a form provided by Sanford Health Plan. The Member has sixty (60) days to elect continuation coverage measured from the later of (1) the date the employee left the position of employment, or (2) the date notice of election rights is received. If continuation coverage is elected within this period, the coverage will be retroactive to the date the employee left the position of employment.

The Member may elect continuation coverage on behalf of a covered Dependent; however, there is no independent right of each covered Dependent to elect continuation of coverage. If the Member does not elect coverage, there is no USERRA continuation available for the Spouse or Dependent Children. In addition, even if the Member does not elect USERRA coverage or continuation coverage, the Member has the right to have coverage reinstated upon reemployment. Continuation coverage continues for up to twenty-four (24) months.

This section is to inform covered individuals, in summary fashion, of their rights and obligations under the continuation of coverage provisions of USERRA. It is intended that no greater rights be provided than those required by federal law.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit healthcare.gov

Keep Sanford Health Plan Informed of Address Changes

To protect your family's rights, let Sanford Health Plan know about any changes in the addresses of covered Dependents. You should also keep a copy, for your records, of any notices you send to Sanford Health Plan.

Plan Contact Information

Mail:	Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.
Phone:	(877) 305-5463 (toll-free) | TTY/TDD: 711 (toll-free) For free help in a language other than English: (800) 752-5863 (toll-free)
Fax:	(605) 328-6812
Online:	www.sanfordhealthplan.com/memberlogin

Or contact your employer.

SECTION 10
PROBLEM RESOLUTION

10.1 MEMBER APPEAL PROCEDURES - OVERVIEW

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Benefits under this Certificate of Insurance will be paid only if Sanford Health Plan decides, at Sanford Health Plan's discretion, that the applicant is entitled to them.

Claims for benefits under this Certificate of Insurance can be post-service, pre-service, or concurrent. This Section of your Summary Plan Description explains how you can file a complaint regarding services provided by Sanford Health Plan; or appeal a partial or complete denial of a claim. The appeal procedures outlined below are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For information on medication/drug Formulary exception requests, see Section 2, *Pharmaceutical Review Requests and Exception to the Formulary Process*.

The following parties may request a review of any Adverse Determination by Sanford Health Plan: the Member and/or legal guardian; a health care Practitioner and/or Provider with knowledge of the Member's medical condition; an Authorized Representative of the Member; and/or an attorney representing the Member or the Member's estate.

NOTE: The Member or his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. In cases where the Member wishes to exercise this right, a written designation of representation from the Member should accompany a Member's complaint or request to Appeal an Adverse Determination. See *Designating an Authorized Representative* below for further details. For urgent (expedited) appeals, written designation of an Authorized Representative is not required.

Special Communication and Language Access Services

For Members who request language services, Sanford Health Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Members submit a complaint or appeal, and Sanford Health Plan will communicate with Members free of charge about their complaint or appeal in the Member's preferred language, upon request. To get help in a language other than English, call (800) 752-5863.

For Members who are deaf, hard of hearing, or speech-impaired

To contact Sanford Health Plan, a TTY/TDD line is available free of charge by calling toll-free 711. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

Help to understand this policy and your rights is free.
If you would like it in a different format (for example, in a larger font size),
please call us at (800) 499-3416 (toll-free).
If you are deaf, hard of hearing, or speech-impaired,
reach us at TTY/TDD: 711(toll-free).

Help in a language other than English is also free.
Please call (800) 752-5863 (toll-free) to connect with us using free translation services.

Maximum Appeal Timelines			
Type of Notice	**Emergency**	**Pre-Service**	**Post-Service**
Initial Determinations	72 Hours	15 days	30 Days
Extension for Initial Plan Determinations	NONE	15 days	15 Days
Additional Information Request (Plan)	24 Hours	15 days	15 Days
Response to Request For Additional Information (Member)	48 Hours	45 Days	45 Days
Request for Internal Appeal (Member)	180 Days	180 Days	180 Days
Internal Appeal Determinations	72 Hours	30 Days	60 Days
Request for External Appeal (Member)	N/A	4 months	4 Months
External Appeal Determinations	72 Hours	45 Days	45 Days

10.2 DESIGNATING AN AUTHORIZED REPRESENTATIVE

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service toll-free at (800) 499-3416; or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your provider is your Authorized Representative unless you tell us otherwise, in writing.

10.3 AUDIT TRAILS

Audit trails for Complaints, Adverse Determinations and Appeals are provided by Sanford Health Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal.
The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If Sanford Health Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

10.4 DEFINITIONS

Adverse Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) based on:

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

Appeal: A request to change a previous Adverse Determination made by Sanford Health Plan.

Inquiry: A telephone call regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address Member and Practitioner and/or Provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written Complaint.

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with Sanford Health Plan, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or non-renewals of coverage; administrative operations; discrimination based on race, color, national origin, sex, age, or disability; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a Complaint. The Member and his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the Complaint.

External Review: An External Review is a request for an Independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

Urgent Care Situation: A degree of illness or injury that is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. An Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

- Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
- In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is "Urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson as defined in Section 8. A Practitioner, with knowledge of the Member's medical condition, who

determines a request to be "Urgent," as defined in Section 8, shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

10.5 COMPLAINT (GRIEVANCE) PROCEDURES

A Member has the right to file a Complaint either by telephone or in writing to The Appeals and Grievances Department. The Appeals and Grievances Department will make every effort to investigate and resolve all Complaints. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

10.6 ORAL COMPLAINTS

A complainant may orally submit a Complaint to Customer Service. If the oral Complaint is not resolved to the complainant's satisfaction within ten (10) business days of receipt of the Complaint, Sanford Health Plan will provide a Complaint form to the complainant, which must be completed and returned to the Appeals and Grievances Department for further consideration. Upon request, Customer Service will provide assistance in submitting the Complaint form.

10.7 WRITTEN COMPLAINTS

A complainant can seek further review of a Complaint not resolved by phone by submitting a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

Complaints based on discrimination must be sent to the attention of the Civil Rights Coordinator.

The Appeals and Grievances Department will notify the complainant within *ten* (10) business days upon receipt of the Complaint form, unless the Complaint has been resolved to the complainant's satisfaction within those ***ten* (10) business days**.

Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.

10.8 COMPLAINT INVESTIGATIONS

The Appeals and Grievances Department will investigate and review the Complaint and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:

- A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within *thirty* (30) calendar days from the date Sanford Health Plan receives your request.

- In certain circumstances, the time period may be extended by up to *fourteen* (14) days upon agreement. In such cases, Sanford Health Plan will notify the complainant in advance, of the reasons for the extension.

Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within *twenty-four* (24) hours.

If the complaint is not resolved to the Member's satisfaction, the Member, or his/her Authorized Representative, has the right to Appeal any Adverse Determination made by Sanford Health Plan. Appeal Rights may be requested by calling the Appeals and Grievances Department.

Sanford Health Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in the complaint or appeals process.

All notifications described above will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in your written response.

10.9 APPEAL PROCEDURES

Types of Appeals
Types of appeals include:

- **A Pre-service Appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- **A Post-service Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
- An **Expedited Appeal** for Urgent Care is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of urgent, their review will generally be conducted within 24 hours.

10.10 CONTINUED COVERAGE FOR CONCURRENT CARE

A Member is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to Appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within twenty-four (24) hours.

10.11 INTERNAL APPEALS OF ADVERSE DETERMINATION (DENIAL)

Appeals can be made for up to 180 days from notification of the Adverse Determination.

Within one-hundred-eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. To Appeal, the Member may sign into their account at sanfordhealthplan.com/memberlogin and

complete the "Appeal Filing Form" under the *Forms* tab. The Member or their Authorized Representative may also contact the Plan by sending a written Appeal to the Plan.

If the Member, Authorized Representative, Practitioner/Provider, and/or attorney, has questions, they are encouraged to contact the Plan. Customer Service is available to help with understanding information and processes. Alternate formats are also available and translation is available free of charge for written materials and Member communication with the Plan.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Customer Service Department.

10.12 APPEAL RIGHTS AND PROCEDURES

If the Member or their Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

- The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members do not have the right to attend or have a representative attend the review.
- The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
- Confirm with the Member whether additional information will be provided for appeal review. Sanford Health Plan will document if additional information is provided or no new information is provided for appeal review.
- Before Sanford Health Plan can issue a final Adverse Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date. Members shall have the right to review all evidence and present evidence and testimony.
- The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
- The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the Appeals and Grievances Department.
- Sanford Health Plan will document the substance of the Appeal, including but not limited to, the Member's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. Sanford Health Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
- The review shall not afford deference to the initial Adverse Determination and shall be conducted by a Sanford Health Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.

- In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, Sanford Health Plan shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Sanford Health Plan shall identify the medical or vocational experts whose advice was obtained on behalf of Sanford Health Plan in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
- In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
- The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) working days of receipt of the Appeal.
- Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

10.13 APPEAL NOTIFICATION TIMELINES

For Prospective (Pre-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **thirty (30) calendar days** of receipt of the Appeal.

For Retrospective (Post-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **sixty (60) calendar days** of receipt of the Appeal.

For Appeals Based on Discrimination: Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing within **thirty (30) calendar days** of receipt of the Appeal.

If the Member does not receive the decision within the time periods stated above, the Member may be entitled to file a request for External Review.

10.14 EXPEDITED INTERNAL APPEAL PROCEDURE

An Expedited Appeal procedure is used when the Member's condition is emergent or urgent in nature, as defined in this Certificate. An Expedited Appeal of a Prior Authorization (Pre-service) Denial must be utilized if the Practitioner acting on behalf of the Member believes that the request is warranted. This can be done by oral or written notification to Sanford Health Plan. We will accept all necessary information (electronic or by telephone) for review from the Practitioner of care. A designated Physician advisor will conduct the review and will be

available to discuss the case with the attending Practitioner on request. For Medical Necessity reviews only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

If the Expedited Review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member or the Representative has been notified of the determination.

NOTE: For procedures, rights, and notification timelines related to an Appeal of Adverse Determination regarding pharmacy services, certification of a non-covered medication, or Formulary design issues, see External Procedures for Adverse Determinations of Pharmaceutical Exception Requests in this Section.

10.15 WRITTEN NOTIFICATION PROCESS FOR INTERNAL APPEALS

The written decision for the Appeal reviews will contain the following information:

- The results and date of the Appeal Determination;
- The specific reason for the Adverse Determination in easily understandable language;
- The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
- Reference to the evidence, benefit provision, guideline, protocol and/or other similar criterion on which the determination was based and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, protocols and other similar criterion free of charge;
- Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
- Statement of the reviewer's understanding of the Member's Appeal;
- The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
- Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate specialist to discuss the determination;
- If the Adverse Determination is based on Medical Necessity or Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Certificate of Insurance to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
- If applicable, instructions for requesting:
    a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination; or
    b. The written statement of the scientific or clinical rationale for the determination;
- For Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review a statement indicating:

1. The written procedures governing the standard internal review, including any required timeframe for the review; and
2. The Member's right to bring a civil action in a court of competent jurisdiction;
3. Notice of the Member's right to contact the Division of Insurance for assistance at any time.
4. Notice of the right to initiate the External Review process for Adverse Determinations based on Medical Necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Determination letters will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights.
5. If the Adverse Determination is completely overturned, the decision notice will state the decision and the date.

10.16 EXTERNAL PROCEDURES FOR ADVERSE DETERMINATIONS OF PHARMACEUTICAL EXCEPTION REQUESTS

Sanford Health Plan follows all requirements for denials and appeals as it relates to any Adverse Determination when there has been a Medical Necessity determination based on pharmacy service, certification of non-covered medication or Formulary design issue. This applies to requests for coverage of non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols.

External Exception Review (Appeal) of a Standard Exception Request:

- If we deny a request for a Standard Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- The Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following the Plan's receipt of the request if the original request was a Standard Exception Request.
- If the Plan grants an External Exception Review of a Standard Exception Request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription.

External Exception Review (Appeal) of an Expedited (Urgent) Exception Request:

- If Sanford Health Plan denies a request for an Expedited Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- Sanford Health Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following our receipt of the request if the original request as an expedited exception.
- If Sanford Health Plan grants an External Exception Review of an Expedited Exception Request, we will provide coverage of the non- Formulary drug for the duration of the exigency.

10.17 STANDARD EXTERNAL REVIEW REQUEST PROCESSES & PROCEDURES

1. The Plan will follow the procedure for providing independent, external review of final determinations as outlined by federal ERISA regulations and rules governing the Plan in the Patient Protection and Affordable Care Act. Accordingly, an Independent External Review is not available for a Benefit Denial

when it does not involve medical judgment.

NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding.

External Appeal Review Program – OVERVIEW

Members may file a request for External Review with Sanford Health Plan or with the North Dakota Insurance Commissioner. Refer to the Introduction section at the beginning of this document for contact information.

An expedited Appeal procedure is used when the condition is an Urgent Care Situation, as defined previously in this Certificate of Insurance.

An expedited review involving Urgent Care Requests for Adverse Determinations of Pre-service or Concurrent claims must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believe that an expedited determination is warranted. All of the procedures of a standard review described apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via oral notification by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than twenty-four (24) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within three (3) calendar days of the oral notification. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-urgent Pre-service or a Non-urgent post-service appeal, depending upon the circumstances.

If the expedited review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

10.18 EXTERNAL APPEAL REVIEW PROGRAM PROCEDURES

For independent, External Review of a final Adverse Determination, Sanford Health Plan will provide:

- Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
    - The Member is Appealing an Adverse Determination that is based on Medical Necessity (benefits Adverse Determinations are not eligible);
    - Sanford Health Plan has completed the internal Appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the available internal level of Appeal with the Member's permission;

    - The request for independent, External Review is filed within four (4) months of the date that Sanford Health Plan's Adverse Determination was made.

- Notification to Members about the independent, External Review program and decision are as follows:
    - General communications to Members, at least annually, to announce the availability of the right to independent, External Review.
    - Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, External Appeal rights, directions on how to use the process, contact information for the independent, External Review organization, and a statement that the Member does not bear any costs of the independent, External Review organization, unless otherwise required by state law.

- The External Review organization will communicate its decision in clear terms in writing to the Member and Sanford Health Plan. The decision will include:

    - a general description of the reason for the request for external review;
    - the date the independent review organization received the assignment from Sanford Health Plan to conduct the external review;
    - the date the external review was conducted;
    - the date of its decision;
    - the principal reason(s) for the decision, including any, Medical Necessity rationale or evidence-based standards that were a basis for its decision; and
    - the list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision.
    - The External Review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.

- Conduct of the External Appeal Review program as follows:

    - A Member will contact Sanford Health Plan with an external review request.
    - Within five (5) business days following the date of receipt of the external review request, Sanford Health Plan shall complete a preliminary review of the request to determine whether:
    - The Member is or was a covered person at the time the health care service was requested or, in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
    - The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
    - The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust Sanford Health Plan's internal Appeal process as defined above; and
    - The Member has provided all the information and forms required to process an external review.

- Within one (1) business day after completion of the preliminary review, Sanford Health Plan shall notify the Member and, if applicable, the Member's Authorized Representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include in the notice what information or materials are needed to make the request complete; or if the request is not eligible for external review, the NDID shall inform the

Member and, if applicable, the Member's Authorized Representative in writing and include the reasons for its ineligibility. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

- If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an independent review organization and notify in writing the Member, and, if applicable, the Member's Authorized Representative of the request's eligibility and acceptance for external review. The Member may submit in writing to the assigned Independent Review Organization within five (5) business days following the date of receipt of the notice provided by the NDID any additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.

- Within five (5) business days after the date the NDID determines the request is eligible for external review, of receipt, the NDID shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final Adverse Determination.

- The North Dakota Insurance Department contracts with the independent, external review organization that:
    - is accredited by a nationally recognized private accrediting entity;
    - conducts a thorough review, in which it considers all previously determined facts; allows the introduction of new information; considers and assesses sound medical evidence; and makes a decision that is not bound by the decisions or conclusions of Sanford Health Plan or determinations made in any prior appeal.
    - completes their review and issues a written final decision for non-urgent appeals within forty-five (45) calendar days of the request. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Member's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. Within forty-eight (48) hours after the date of providing the oral notification, the assigned independent review organization will provide written confirmation of the decision to the Member, or if applicable, the Member's Authorized Representative, and their treating Practitioner and/or Provider.
    - has no material professional, familial or financial conflict of interest with Sanford Health Plan.

- With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

- Sanford Health Plan will provide the Independent Review Organization with all relevant medical records as permitted by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including Sanford Health Plan's decision, criteria used and clinical reasons, utilization management criteria, communication from the Member to Sanford Health Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.

- The Member is not required to bear costs of the Independent Review Organization's review, including any filing fees. However, Sanford Health Plan is not responsible for costs associated with an attorney, physician or other expert, or the costs of travel to an independent, External Review hearing.

- The Member or his/her legal guardian may designate in writing a representative to act on his/her behalf. A Practitioner and/or Provider may not file an Appeal without explicit, written designation by the Member.

- The Independent Review Organization's decision is final and binding to Sanford Health Plan and Sanford Health Plan implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Member, because the Member has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Member may not file a subsequent request for external review involving the same Adverse Determination for which the Member has already received an external review decision.

- Sanford Health Plan maintains and tracks data on each appeal case, including descriptions of the denied item(s), reasons for denial, Independent, External Review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its Medical Necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

NOTE: ALL NOTIFICATIONS AND PROCEDURES DESCRIBED IN THIS SECTION, IN ADDITION TO THOSE RELATED TO BOTH BENEFIT AND MEDICAL CARE DETERMINATIONS IN SECTION 2, WILL COMPLY WITH APPLICABLE LAW. SHOULD A CONFLICT EXIST BETWEEN PLAN PROCEDURES AND FEDERAL REGULATIONS, FEDERAL REGULATIONS SHALL CONTROL.

A COMPLETE DESCRIPTION OF YOUR COMPLAINT (GRIEVANCE) AND APPEAL RIGHTS AND THE APPEAL PROCESS WILL BE INCLUDED IN DETERMINATION RESPONSES AND DECISIONS MADE BY SANFORD HEALTH PLAN. ADDITIONALLY, AN OVERVIEW OF YOUR COMPLAINT (GRIEVANCE) AND APPEAL RIGHTS, ALONG WITH AN APPEAL FILING FORM, IS INCLUDED IN ALL EXPLANATION OF BENEFITS (EOBS) GENERATED BY SANFORD HEALTH PLAN.

10.19 EXPEDITED EXTERNAL REVIEW REQUESTS

- A Member or the Member's Authorized Representative may request an expedited external review of an Adverse Determination if the Adverse Determination involves an Urgent Care requests for Prospective (pre-service) or Concurrent Review request for which
    - the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Member; or would jeopardize the Member's ability to regain maximum function; or
    - in the case of a request for Experimental or Investigational Services, the treating Provider certifies, in writing, that the requested Health Care Services or treatment would be significantly less effective if not promptly initiated.

- The Member has the right to contact the North Dakota Insurance Commissioner for assistance at any time.

- Immediately upon receipt of the request from the Member or the Member's Representative, the NDID shall determine whether the request is eligible for Expedited External Review. If the request is ineligible for an Expedited External Review as described in (1) above, the NDID will give notification to the Member or the Member's Representative that they may appeal to the state insurance department.

- Upon determination that the Expedited External Review request meets the reviewability requirements, the NDID shall assign a contracted, independent review organization to conduct the expedited external review. The assigned independent review organization is not bound by any decisions or conclusions reached during Sanford Health Plan's utilization review or internal appeal process.
- Sanford Health Plan will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.
- The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Member, and, if applicable, the Member's Authorized Representative, and the treating Practitioners and/or Providers as expeditiously as the Member's medical condition or circumstances requires but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within forty-eight (48) hours of the oral notification.
- At the same time a Member, or the Member's Authorized Representative, files a request for an internal Expedited Review of an Appeal involving an Adverse Determination, the Member, or the Member's Authorized Representative, may also file a request for an external Expedited External Review if the Member has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Member or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is an Experimental or Investigational Service and the Member's treating Practitioner and/or Provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated.
- Upon Sanford Health Plan's receipt of the independent review organization's decision to reverse the Adverse Determination, Sanford Health Plan shall immediately approve the coverage that was the subject of the Adverse Determination

SECTION 11
DEFINITIONS OF TERMS WE USE IN THIS CERTIFICATE OF INSURANCE

Adverse Determination	Any of the following determinations: The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination of a Member's eligibility to participate in the Plan; Any prospective review or retrospective Utilization Review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage determination.
Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
Admission	Entry into a facility as an Inpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Member is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by Sanford Health Plan.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: 1. Has an organized staff of Practitioners; 2. Has permanent facilities that are equipped and operated mostly for performing surgery; 3. Has continuous Practitioner services and Nursing Services when a patient is in the Facility; and 4. Does not have services for an overnight stay.
Annual Enrollment	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
Approved Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: 1. A federally funded or approved trial; 2. A clinical trial conducted under an FDA investigational new medication application; or A medication trial that is exempt from the requirement of an FDA investigational new medication application.

Authorized Representative	A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Members for services related to Avoidable Hospital Conditions.
Basic Plan	The Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level. Health Care Providers accessed at the Basic Plan level are also Participating Providers.

Benefit Period	A specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a Calendar Year (January 1st through December 31st) Benefit Period.
Benefit Plan	The agreement with Sanford Health Plan, including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
[The] Board	Means the North Dakota Public Employees Retirement System (NDPERS) board.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Certification	Certification is a determination by Sanford Health Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness.
Claims Administrator or Claims Payor	Sanford Health Plan
Class of Coverage	The type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage under this Benefit Plan are Single Coverage and Family Coverage.
Coinsurance Amount	A percentage of the Allowed Charge for Covered Services that is a Member's responsibility.
Coinsurance Maximum Amount	The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital inpatient care including care received at a Residential Treatment Facility and ongoing outpatient services, including ongoing ambulatory care.
[This] Contract or [The] Contract	This Certificate of Insurance, which is a statement of the essential features and services given to the Subscriber by the Plan, including all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.
Copayment (Copay)	A specified dollar amount payable by the Member for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.

Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Cost Sharing	The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes coinsurance, copayments, or similar charges, but it doesn't include premiums, balance-billing amounts for non-network providers, or the cost of non-covered services.
Covered Services	Those Health Care Services to which a Member is entitled under the terms of This Contract.
Creditable Coverage	Benefits or coverage provided under: 1. A group health benefit plan (as such term is defined under North Dakota law); 2. A health benefit plan (as such term is defined under North Dakota law); 3. Medicare; 4. Medicaid; 5. Civilian health and medical program for uniformed services; 6. A health plan offered under 5 U.S.C. 89; 7. A medical care program of the Indian Health Service or of a tribal organization; 8. A state health benefits risk pool, including coverage issued under N.D.C.C. Chapter 26.1-08; 9. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; 10. A health benefit plan under Section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and 11. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
Custodial Care	Care designed to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.
Deductible Amount	A specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period.
Dependent	The Spouse and any Dependent Child of a Subscriber.
Dependent Child	The definition of a Dependent Child of a Subscriber includes a child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and 3. The Dependent Child must be chiefly dependent on the Subscriber for support [N.D.C.C. §26.1-36-22 (3)(4)] .
Domiciliary Care	Domiciliary Care consists of a protected situation in a community or Facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require a 24-hour Facility or nursing care.
Eligible Dependent	An Eligible Dependent includes: (1) The Spouse of the Subscriber; (2) A Dependent child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility; and (3) a Dependent of Dependent (a) Is the natural child of the Subscriber's Dependent child, a child placed with the Subscriber's Dependent child for adoption, a legally adopted child by the Subscriber's Dependent child, a child for whom the Subscriber's Dependent child has legal guardianship, a stepchild of the Subscriber's Dependent child, or foster child of the Subscriber's Dependent child. These same definitions apply to dependents of the Dependent child(ren) of the Subscriber's living, covered Spouse; and (b) the Subscriber's
Eligible Dependent (CONTINUED)	Dependent child must be a Covered Dependent under this Certificate of Coverage for the dependent of the Dependent child to be eligible; and (c) The Dependent Child must be chiefly dependent on the Subscriber for support. [N.D.C.C. §26.1-36-22 (3)(4)].
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of NDPERS.

Emergency Care Services	Emergency Care Services means: (1) Within the Service Area: covered health care services rendered by Participating or Non-Participating Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Service Area include covered health care services from Non-Participating Providers only when delay in receiving care from Participating Providers could reasonably be expected to cause severe jeopardy to the Member's condition or (2) Outside the Service Area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the Plan's Service Area.
Emergency Medical Condition	A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.
Enrollee	An individual who is covered by this Plan.
ESRD	The federal End Stage Renal Disease program.
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews must be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: 1. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or 2. requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Family Coverage	The Class Of Coverage identifying that the Subscriber and Eligible Dependents are enrolled to received benefits for Covered Services under this Plan.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.
Gestational Carrier	An adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.

Grievance	A written complaint submitted in accordance with the Plan's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Member.
[The] Group or [This] Group	NDPERS has signed an agreement with Sanford Health Plan to provide health care benefits for its eligible employees, retirees, and Eligible Dependents.
Group Contract Holder	The individual to whom a Group Contract has been issued.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Practitioner and/or Provider's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities.

Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes an overnight stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
Iatrogenic Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
Infertility Services Deductible Amount	A specified dollar amount payable by the Member during their lifetime for infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.
In-Network Benefit Level	The PPO Plan level of benefits when a Member seeks services from a Participating Practitioner and/or Provider.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.
Intermediate Care	Intermediate Care means care in a Facility, corporation or association licensed or regulated by the State for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day.
Late Enrollee	An individual who enrolls in a group health plan on a date other than either the earliest date on which coverage can begin under the plan terms or on a special enrollment date.
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. *Exception: periodic reassessments are not considered Maintenance Care.*
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of (a) the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. Costs for facilities providing the same or similar services, plus a margin factor.
Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and A. help restore or maintain the Members health; or B. prevent deterioration of the Member's condition; or C. prevent the reasonably likely onset of a health problem or detect an incipient problem; or D. not considered Experimental or Investigative

Medical Out-of-Pocket Maximum Amount	The total Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility during a Benefit Period. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Medical Copay amounts apply toward the Medical Out-of-Pocket Maximum Amount. Prescription Medication Copay and Coinsurance Amounts apply toward the Prescription Drug Out-of-Pocket Maximum Amount.
Member	The Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents
Mental Health and/or Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
NDPERS	the North Dakota Public Employees Retirement System.
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill the Plan or Members for services related to Never Events.
Non-Covered Services	Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of This Contract.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by the Plan. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Non-Payable Health Care Provider.
Nursing Services	Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family.
Open Enrollment or Open Enrollment Period	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan
Out-of-Network Benefit Level	The Basic Plan level of benefits provided when a Member seeks services from a Non-Participating Practitioner and/or Provider. This is most often referred to as benefits received under the Basic Plan level but may include services received from Practitioners and/or Providers that have not signed a contract with the Plan.

Partial Hospitalization	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment.
Participating [Health Care] Provider	A Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan. A Participating Provider includes Providers at either the Basic or PPO Plan level.
Physician	An individual licensed to practice medicine or osteopathy.
[The] Plan or [This] Plan	Sanford Health Plan.
Plan Administrator	North Dakota Public Employees Retirement System (NDPERS)
PPO (Preferred Provider Organization) Plan	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. Health Care Providers accessed at the PPO level are also Participating Providers.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization	The process of the Member or the Member's representative notifying Sanford Health Plan to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Sections 2, 4 and 5. Preauthorization does not guarantee payment of benefits.
Prescription Drug Out-of-Pocket Maximum Amount	The total Formulary Coinsurance Amount for Prescription Medications that is a Member's responsibility during a Benefit Period. When this Prescription Drug Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications. This Prescription Drug Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Medical Copay amounts apply toward the Medical Out-of-Pocket Maximum Amount. Prescription Medication Copay and Coinsurance Amounts apply toward the Prescription Drug Out-of-Pocket Maximum Amount
Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care Practitioner and/or Provider (PCP)	A Participating Practitioner and/or Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist, who is a Participating Practitioner, and who has been chosen to be designated as a Primary Care Practitioner and/or Provider as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.

Prior Approval	The process of the Member or Member's representative providing information to Sanford Health Plan substantiating the medical appropriateness of specified services in order to receive benefits for such service. This information must be submitted in writing from the Member's Health Care Provider. Sanford Health Plan reserves the right to deny benefits if Preauthorization/Prior Approval is not obtained.
Prospective (Pre-service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a Health Care Service or a course of treatment.
[Health Care] Provider	An individual, institution or organization that provides services for Plan Members. Examples of Providers include but are not limited to Hospitals, Physicians, Practitioners and/or Providers, and home health agencies.
Prudent Layperson	A person who is without medical training and who possess an average knowledge of health and medicine and who draws on his/her practical experience when making a decision regarding the need to seek Emergency medical treatment.
Qualifying Event	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby) and gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
Qualified Mental Health Professional	A licensed Physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service providers in psychology; a licensed certified social worker who is a board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Provider without certification or prior-authorization when certification/prior-authorization is required.
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Retrospective (Post-service) Review	Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.

Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Members or the Plan for services related to Serious Reportable Events.
[NDPERS] Service Agreement and/or [Group] Contract	The Service Agreement between NDPERS and Sanford Health Plan that is a contract for Health Care Services, which by its terms limits eligibility to enrollees of a specified group. The Group Contract may include coverage for Dependents.
Service Area	The geographic Service Area approved by the State's Insurance Department.
Single Coverage	The Class Of Coverage identifying that only the Subscriber is enrolled to received benefits for Covered Services under this Plan.
Skilled Nursing Facility	A Facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly-licensed Physician.
Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
[This] State	The State of North Dakota.
Subscriber	An Eligible Group Member who is enrolled in the Plan whose employment or other status (except family dependency) is the basis for eligibility for enrollment in the Plan. A Subscriber is also a Member and Enrollee.
Surrogate	An adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.
Summary of Benefits and Coverage or SBC	Attachment I of this Contract that sets forth important information on coverage and Cost Sharing.
Urgent Care Request	Means a request for a Health Care Service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination which: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24)* hours, such as stitches for a cut finger. Urgent care means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Us/We/Our	Refers to Sanford Health Plan
Utilization Review	A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Preauthorization/Prior Approval, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
You	Refers to the Subscriber or Member, as applicable.

ATTACHMENT I. SUMMARY OF BENEFITS AND COVERAGE

This page is intentionally left blank. Your Summary of Benefits and Coverage is an attachment to this Certificate of Coverage.

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

HP-3203 6-19

SANFORD HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

North Dakota Public Employees Retirement System Non-Grandfathered Plan — Coverage Period: 07/01/2025-06/30/2027

Coverage for: Individual + Family | **Plan Type:** PPO | Non-Grandfathered

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://ndpers.nd.gov/image/cache/shp-coi-ngf.pdf or by calling 1-800-499-3416 *(toll free)* | TTY/TDD: 711 *(toll-free)*. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-499-3416 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO Providers: $500 individual / $1,500 family. Basic Providers: $500 individual / $1,500 family. Copays do not apply to deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $500 for infertility services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	PPO Providers: $1,500 individual / $3,500 family. Basic Providers: $2,000 individual / $4,500 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.com or call 1-800-499-3416 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit	$35 copay / visit	Deductible is waived.
	Specialist visit	$30 copay / visit	$35 copay / visit	
	Preventive care/screening/ Immunization	No charge	No charge	You may have to pay for services that aren't part of the preventive health guidelines. Ask your provider if these services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	25% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/pharmacy	Generic Formulary Drugs 0-34 days 35-100 days	$7.50 copay / prescription $15 copay / prescription Then 12% coinsurance	$7.50 copay / prescription $15 copay / prescription Then 12% coinsurance	Covers up to a 34-day supply. Two copays for a 35-100 day supply. Specialty medications are limited to a 30-day supply. Insulin and medical supplies for insulin dosing and administration maximum $25 cost-share per 30-day supply. The Prescription Drug coinsurance maximum amount for Formulary medications is $1,200 per person per benefit period. Cost-share for non-formulary drugs do not accumulate toward any Out-of-Pocket Maximums. Refer to your Formulary to determine which benefit applies to your medication.
	Brand Name Formulary Drugs 0-34 days 35-100 days	$25 copay / prescription $50 copay Then 25% coinsurance	$25 copay / prescription $50 copay Then 25% coinsurance	
	Non-Formulary Drugs 0-34 days 35-100 days	$30 copay / prescription $60 copay / prescription Then 50% coinsurance	$30 copay / prescription $60 copay / prescription Then 50% coinsurance	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	25% coinsurance after deductible	Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com.
	Physician/surgeon fees	20% coinsurance after deductible	25% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$60 copay / visit, then subject to deductible and then 20% coinsurance	$60 copay / visit, then subject to deductible and then 20% coinsurance	Emergency room copay waived if directly admitted. Additional services done during an Urgent care visit may be subject to deductible / coinsurance.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	$30 copay / visit	$30 copay / visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	25% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services Office visit: Other outpatient services:	 $30 copay / visit 20% coinsurance after deductible	 $35 copay / visit 20% coinsurance after deductible	For outpatient services, the first 5 visits of any calendar year will be covered at 100% (no charge). For full details, please refer to your plan document.
	Inpatient services	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
If you are pregnant	Office visits	No charge	No charge	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Deductible is waived. Deductible is waived on delivery services from a PPO healthcare provider when enrolled in the Healthy Pregnancy Program.
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	

If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Rehabilitation services Therapy visit: Other outpatient services:	 $25 copay / visit 20% coinsurance after deductible	 $30 copay / visit 25% coinsurance after deductible	For full details, please refer to your plan document.
	Habilitation services Therapy visit: Other outpatient services:	 $25 copay / visit 20% coinsurance after deductible	 $30 copay / visit 25% coinsurance after deductible	For full details, please refer to your plan document.
	Skilled nursing care	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.

If you need help recovering or have other special health needs	Durable medical equipment	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization may be required.
	Hospice services	20% coinsurance after deductible	25% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery	• Dental care (Adult) • Long-term care	• Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic Care	• Coverage provided outside the United States. For full details, refer to your plan document. • Hearing aids • Infertility treatment. $20,000 lifetime maximum	• Private-duty nursing • Routine foot care (for diabetics only) • Telehealth / e-visits / video visits

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: North Dakota Insurance Department at 1-800-247-0560. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Grievances at 1-800-499-3416 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-752-5863 (*toll-free).*
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-5863 (*toll-free).*
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-752-5863 (*toll-free).*
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-5863 (*toll-free).*

————To see examples of how this plan might cover costs for a sample medical situation, see the next section. ————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,560

Cost Sharing	
Deductibles	$100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,120

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

The plan would be responsible for the other costs of these EXAMPLE covered services.

North Dakota Public Employees Retirement System (NDPERS)

2025-2027 Certificate of Insurance

Non-Grandfathered High Deductible Health Plan

Help understanding this document is free.

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: 711*(toll-free)*.

Help in a language other than English is also free.

Please call (800) 752-5863 *(toll-free)* | TTY/TDD: 711*(toll-free)* to connect with us using free translation services.

SANFORD HEALTH PLAN

Table of Contents

FREE HELP IN OTHER LANGUAGES

This Policy replaces any prior policies you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it.

If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us toll-free at the number below.

For help in a language other than English, please call us toll-free at (800) 752-5863. Both oral and written translation services are available for free in at least 150 languages.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-752-5863 (رقم هاتف الصم والبكم: 711).

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-752-5863 (መስማት ለተሳናቸው: 711).

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-752-5863 (TTY: 711）。

Cushite (Oromo) - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-752-5863 (TTY: 711).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-752-5863 (TTY: 711).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-752-5863 (TTY: 711).

Karen - ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 800-752-5863 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-752-5863 (TTY: 711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-752-5863 (ATS: 711).

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-752-5863 (телетайп: 711).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-752-5863 (TTY: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-752-5863 (TTY: 711).

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-752-5863 (TTY: 711).

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-752-5863 (TTY: 711).

Notice

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description/Certificate of Insurance (COI) is provided to you in accordance with the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information.

This COI and the NDPERS Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance/Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

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

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

Plan Name

North Dakota Public Employees Retirement System Dakota Plan

Name and Address of Employer (Plan Sponsor)

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503

Plan Sponsor's IRS Employer Identification Number

45-0282090

Plan Number Assigned By the Plan Sponsor

N/A

Type of Welfare Plan

Health

Type of Administration

This employee welfare benefit plan is fully insured by Sanford Health Plan and issued by Sanford Health Plan. Sanford Health Plan is the Claims Administrator for this employee welfare benefit plan.

Name and Address of Sanford Health Plan

Sanford Health Plan
4800 W 57th St.
Sioux Falls, SD 57108
(877) 305-5463 *(toll-free)*
TTY/TDD: 711 *(toll-free)*

Plan Administrator's Name, Business Address and Business Telephone Number

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503
(701) 328-3900

Name and Address of Agent for Service of Legal Process

Plan Administrator	Sanford Health Plan
North Dakota Public Employees Retirement System 1600 E. Century Avenue, Suite 2 PO Box 1657 Bismarck, ND 58503	Sanford Health Plan ATTN: President 4800 W 57th St. PO Box 91110 Sioux Falls, SD 57109-1110

Title of Employees Authorized To Receive Protected Health Information

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

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business.

These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

Statement of Eligibility to Receive Benefits
As provided in N.D.C.C. §54-52.1-01(4) and §54-52.1-18, individuals eligible to receive benefits are every permanent employee who is employed by the state, and political subdivisions which elect the HDHP option, whose services are not limited in duration, who is filling an approved and regularly funded position in the state, and political subdivisions which elect the HDHP option, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment.

An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state boards, commissions, or associations, or political subdivision boards, commissions, or associations which elect the HDHP option, full-time employees of political subdivisions which elect the HDHP

option, elective state officers as defined by N.D.C.C. §54-06-01(2), disabled permanent state employees and disabled employees of political subdivisions which elect the HDHP option, who are receiving compensation from the North Dakota workforce safety and insurance.

A temporary employee of a political subdivision which elects the HDHP option, who is 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 if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015.

In order for a temporary employee of a political subdivision which elect the HDHP option, who is employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015.

To be eligible to participate in the uniform group insurance program, a temporary employee of a political subdivision which elects the HDHP option, who is first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)]. Temporary employees employed by the state of North Dakota are not eligible to participate in this Benefit Plan.

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

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

Description of Benefits

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

Sources of Premium Contributions to the Plan and the Method by Which the Amount of Contribution Is Calculated

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

End of the Year Date for Purposes of Maintaining the Plan's Fiscal Records

June 30

Clerical Error
Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and NDPERS retain contractual rights to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

Recovery of Benefit Payments
Pursuant to N.D.A.C. §71-03-05-06, whenever benefits are paid in noncompliance with the Contract, NDPERS, which is the Plan Administrator, or an agent of the Plan Administrator, retains the right to recover the payments from the party responsible.

If Sanford Health Plan, which is the Claims Administrator and Payor, or an agent of Sanford Health Plan, is at fault, the amount of overpayment will be withheld from the administrative fees paid by NDPERS.

If overpayments are made because of false or misleading information provided by a Member, Sanford Health Plan, or an agent of Sanford Health Plan, shall attempt to recover the amount. Any moneys recovered shall be credited to NDPERS.

If an overpayment is made because of a mistake or deliberate act by a Health Care Provider, Sanford Health Plan shall collect the money from the Provider and credit that amount to NDPERS.

If fraud is suspected, Sanford Health Plan shall inform NDPERS and NDPERS may turn the evidence over to the North Dakota State's Attorney or Attorney General's office for possible prosecution.

Amending and Terminating this Benefit Plan
As Plan Administrator, NDPERS has delegated responsibility for determinations regarding covered benefits, and the amount and manner of the payment of benefits, including the appeal of denied claims, to Sanford Health Plan, the insurer of the plan.

NDPERS reserves the right to terminate the plan, or amend or eliminate benefits under the North Dakota Public Employees Retirement System Dakota Plan, as insured and issued by Sanford Health Plan, at any time and at its discretion, upon mutual agreement between NDPERS and Sanford Health Plan. Should this Benefit Plan be amended or terminated, such action shall be by a written instrument duly adopted by both NDPERS and Sanford Health Plan, or the aforementioned entities' designees

Fiduciary Definitions

Claims Administrator Is a Fiduciary

Except for direct member appeals regarding an infertility services deductible, the North Dakota Public Employees Retirement Board has delegated to the Claims Administrator, herein known as Sanford Health Plan, benefit claims and appeals. Sanford Health Plan is a Plan fiduciary for these benefit claims and appeals only. As such, the Claims Administrator has the final and discretionary authority to determine these claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the Claims

Administrator on review is final and binding, subject to your right to file a lawsuit under other applicable laws. This decision making authority is limited only by the duties imposed. Any determination by the Claims Administrator is intended to be given deference by courts to the maximum extent allowed under applicable laws.

Summary Notice and Important Phone Numbers

This COI describes in detail your Employer's health care benefit Plan and governs the Plan's coverage. This COI, any amendments, and related documents comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this COI carefully. If you have any questions about the benefits, please contact Sanford Health Plan's Customer Service.

This COI describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan including Align powered by Sanford Health Plan and Great Plains Medicare Advantage. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD 711.
This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Member under a policy or contract, or a prospective Member, obtained by Sanford Health Plan from that person or from a health care Provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive**: We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services**: We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Practitioner and/or Provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the Premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family**: We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- **Disaster Relief**: We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law**: We will share information about you if State or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law.
- **For public health and safety**: We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.

- **Organ and tissue donation**: We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director**: We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation and other government requests**: We can share information to employers for workers' compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement**: We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **Lawsuits and legal actions**: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research**: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

We may contact you in the following situations:
- **Treatment options**: To provide information about treatment alternatives or other health related benefits or Sanford Health Plan services that may be of interest to you.
- **Fundraising**: We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION
When it comes to your health information, you have certain rights.
- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within thirty (30) calendar days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.
  Contact Information:
  Sanford Health Plan
  Customer Service
  PO Box 91110
  Sioux Falls, SD 57109-1110
  (800) 752-5863 *(toll-free)* | TTY/TDD 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and online at www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective February 1, 2022.

INTRODUCTION

HOW TO CONTACT SANFORD HEALTH PLAN [THE "PLAN"]

Method	Sanford Health Plan Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
TRANSLATION SERVICES	(800) 752-5863
WRITE	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
PHYSICAL ADDRESS	Sanford Health Plan 4800 W 57th St. Sioux Falls, SD 57108

How to contact Customer Service

For assistance with claim inquiries/status, eligibility and enrollment, provider access, and order ID cards, please call or write to Customer Service. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Customer Service Contact Information
CALL	(800) 499-3416 *calls to this number are free*
TTY	711
FAX	(605) 328-6812
HOURS	7:30 a.m. to 5:00 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
WRITE	Sanford Health Plan Customer Service PO Box 91110 Sioux Falls, SD 57109-1110

How to contact us with questions about Certification (prior authorization)

Some of the services listed in this document are covered only if your doctor or other network provider gets approval in advance (called Certification or prior authorization) from us. The Utilization Management department handles all certification requests. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Utilization Management Contact Information
CALL	(800) 805-7938 *calls to this number are free*
TTY	711
FAX	(605) 328-6813
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Utilization Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Pharmacy Management

For assistance with pharmacy benefit questions, formularies, or drug pre-authorization, please call or write to Pharmacy Management.

Method	Pharmacy Management Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
FAX	(701) 234-4568
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Pharmacy Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Appeals and Grievances

For assistance with Complaints (grievances) and appeal rights, contact the Appeals and Grievances department. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Appeals and Grievances Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Appeals and Grievances Department PO Box 91110 Sioux Falls, SD 57109-1110

How do I request an external review

Members may file a request for Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review with Sanford Health Plan or with the Division of Insurance. Refer to Section 10 PROBLEM RESOLUTION for more information.

Members have the right to contact the North Dakota Insurance Department at any time.

Method	North Dakota Insurance Department Contact Information
CALL	(800) 247-0560 (toll-free)
TTY	(800) 366-6888 (toll-free)
WRITE	North Dakota Insurance Department 600 E. Boulevard Ave. Bismarck, ND 58505-0320
EMAIL	insurance@nd.gov

MEMBER RIGHTS

Sanford Health Plan is committed to treating Members in a manner that respects their rights. In this regard, Sanford Health Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) has the right to the following:

- Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; color; gender; gender identity; age; sex; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.
- Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
- Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
- Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
- Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable North Dakota law.
- Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
- Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or Medically Necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.
- Members have the right to give informed consent before the start of any procedure or treatment.
- When Members do not speak or understand the predominant language of the community, Sanford Health Plan will make its best efforts to access an interpreter. Sanford Health Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
- Members have the right to receive printed materials that describe important information about Sanford Health Plan in a format that is easy to understand and easy to read.
- Members have the right to a clear Grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
- Members have the right to Appeal any decision regarding Medical Necessity made by Sanford Health Plan.
- Members have the right to terminate coverage, in accordance with Employer and/or Plan guidelines.

- Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
- Members have the right to receive information about Sanford Health Plan, its services, its Practitioners and Providers, and Members' rights and responsibilities.

MEMBER RESPONSIBILITIES

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

- Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- Members are responsible for following all access and availability procedures.
- Members are responsible for seeking emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that the Member must use the nearest emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
- Members are responsible for notifying Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
- Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
- Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
- Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- Members are responsible for notifying NDPERS within *thirty-one (31)* days of name, address, or telephone number changes.
- Members are responsible for notifying NDPERS of any changes of eligibility that may affect their membership or access to services. The Plan Sponsor is responsible for notifying Sanford Health Plan.

GRANDFATHERED VERSUS NON-GRANDFATHERED PLANS

A "Grandfathered" health plan is a health plan that was in place prior to March 23, 2010. Grandfathered plans are able to make routine changes to policies but are exempt from some of the Affordable Care Act's (ACA) health insurance reforms.

A "Non-Grandfathered" health plan is a health plan that must comply with all the Patient Protection and Affordable Care Act's health insurance reforms.

Please refer to your Summary of Benefits and Coverage (SBC) to find out if you have a grandfathered or non-grandfathered health plan.

SERVICE AREA

The Service Area for **SOUTH DAKOTA** and **NORTH DAKOTA** includes all counties in the state.

The Service Area for **IOWA** includes the following counties:

Clay	Emmet	Lyon	Osceola	Plymouth
Dickinson	Ida	O'Brien	Sioux	Woodbury

The Service Area for **MINNESOTA** includes the following counties:

Becker	Clearwater	Kittson	Martin	Otter Tail	Redwood	Stevens
Beltrami	Cottonwood	Lac Qui Parle	McLeod	Pennington	Renville	Swift
Big Stone	Douglas	Lake of the Woods	Meeker	Pipestone	Rock	Traverse
Blue Earth	Grant	Lincoln	Murray	Polk	Roseau	Wilkin
Brown	Hubbard	Lyon	Nicollet	Pope	Sibley	Watonwan
Chippewa	Jackson	Mahnomen	Nobles	Red Lake	Stearns	Yellow Medicine
Clay	Kandiyohi	Marshall	Norman			

MEDICAL TERMINOLOGY

All medical terminology referenced in this Certificate of Insurance follows the industry standard definitions of the American Medical Association.

DEFINITIONS

Capitalized terms are defined in Section 11 of this Policy.

CONFORMITY WITH STATE AND FEDERAL STATUTES

Any provision in this Policy not in conformity with North Dakota laws or rules may not be rendered invalid but must be construed and applied as if it were in full compliance with any applicable State and Federal statutes. If, on the effective date of this policy, any provision of this policy is in conflict with federal statutes, or the statutes of the State of North Dakota, then this Policy shall be considered amended to conform to the minimum requirements of such laws and regulations.

GOVERNING LAW

To the extent not superseded by the laws of the United States, this Policy will be construed in accordance with and governed by the laws and rules of the United States of America and the state of North Dakota. Any action brought because of a claim under this Policy will be litigated in state or federal courts located in the state of North Dakota and in no other.

SPECIAL COMMUNICATION NEEDS

Please call the Plan if you need help understanding written information at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services. Anyone with any disability, who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at (701) 328-3900.

TRANSLATION SERVICES

The Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. for help and to access translation services.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 752-5863 *(toll-free)*.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 752-5863 *(toll-free)*.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 752-5863 *(toll-free)*.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 752-5863 *(toll-free)*.

SERVICES FOR THE DEAF, HEARING IMPAIRED, and/or VISUALLY IMPAIRED

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: 711*(toll-free)*. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

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

NOTICE REGARDING HIGH DEDUCTIBLE HEALTH PLAN (HDHP) AND A HEALTH SAVINGS ACCOUNT (HSA)

This Benefit Plan is a high deductible health plan designed to comply with §223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account (HSA).

Sanford Health Plan does not, and is not authorized to, provide legal or tax advice to Members. Sanford Health Plan expressly disclaims responsibility for, and makes no representation or warranty regarding: (1) the eligibility of any Member to establish or contribute to an HSA; or (2) the suitability of this product in all circumstances for use with HSAs.

HEALTH SAVINGS ACCOUNT (HSA) ELIGIBILITY

This Benefit Plan is intended to be compatible with Health Savings Accounts (HSAs) as described in §223 of the U.S. Internal Revenue Code, which means the Benefit Plan is designed to comply with federal law requirements regarding Deductible Amounts and Out-of-Pocket Maximum Amounts.

If a Member desires to establish an HSA, the Member must enter into a separate written agreement with an HSA trustee or custodian. An HSA will be established for permanent employees of the State by NDPERS pursuant to the requirements and restrictions of N.D.C.C. §54-52.1-18.

Since HSAs are personal health care savings vehicles, Sanford Health Plan is unable to provide legal or tax advice as to whether Members are eligible to establish or contribute to an HSA in any tax year. In addition, although a Member must be covered by a High Deductible Health Plan in order to contribute to an HSA, additional rules apply:

a. Members may not contribute to an HSA, for example, if:
    1. the Member can be claimed as a dependent on someone else's tax return (this is different from an Eligible Dependent for purposes of insurance coverage under the Plan); or
    2. the Member has other health coverage (other than high deductible coverage), including Medicare, coverage through a spouse, or coverage under a cafeteria plan that provides reimbursement of medical expenses.
b. Members are solely responsible for determining the legal and tax implications of:
    1. establishing an HSA;
    2. eligibility for an HSA;
    3. the amount of contributions made to an HSA;
    4. the deductibility of contributions made to an HSA; and
    5. withdrawals from an HSA and related taxation.

Sanford Health Plan encourages Members to consult with an accountant, lawyer, or other qualified tax adviser about how HSA and HDHP rules apply to their own individual situations.

FRAUD

Fraud is a crime that can be prosecuted. Any Member who willfully and knowingly engages in an activity intended to defraud Sanford Health Plan is guilty of fraud.
As a Member, you must:

- File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
- Review the Explanation of Benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are uncertain or concerned about any information or charge that appears on a bill, form, or Explanation of Benefits; or if you know of, or suspect, any illegal activity, call Sanford Health Plan at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. All calls are strictly confidential. In the absence of fraud, all statements made by applicants, the Group or a Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall avoid such coverage or reduce benefits unless contained

in a written instrument signed by the Group or Member, a copy of which has been furnished to such Group or Member or the Member's representative.

PHYSICAL EXAMINATION

We may have, at our own expense, a physician examine you when, and as often as we may reasonably require, during the pendency of a claim under this Policy.

CLERICAL ERROR

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and NDPERS retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

VALUE-ADDED PROGRAM

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may receive rewards, access discounted rates from certain vendors for products and services available to the general public, or other incentives to engage in a healthy lifestyle or to adopt healthy habits. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

SUMMARY OF THIS PLAN DESCRIPTION

- This Certificate of Insurance serves as your health benefits policy and describes in detail your Employer's health care benefit plan and governs the coverage. The Certificate of Insurance, and any amendments and/or riders, comprise the entire contract between the Employer and Sanford Health Plan.
- A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate of Insurance carefully. If you have any questions about the benefits as presented in the Certificate of Insurance, please contact your Employer or Sanford Health Plan Customer Service.
- This Certificate of Insurance describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF NON-DISCRIMINATION

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Insurance, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.
Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Sanford Health Plan at (800) 752-5863.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Section 504 Coordinator.

Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57104
Phone: (877) 473-0911 | TTY: 711
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax, phone, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you.

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

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

SECTION 1.
ENROLLMENT

1.1 ELIGIBILITY AND WHEN TO ENROLL

As provided in N.D.C.C. §54-52.1-01(4) and §54-52.1-18, individuals eligible to receive benefits are every permanent employee who is employed by the state, and political subdivisions which elect the HDHP option, whose services are not limited in duration, who is filling an approved and regularly funded position in the state, and political subdivisions which elect the HDHP option, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment.

An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state boards, commissions, or associations, or political subdivision boards, commissions, or associations which elect the HDHP option, full-time employees of political subdivisions which elect the HDHP option, elective state officers as defined by N.D.C.C. §54-06-01(2), disabled permanent state employees and disabled employees of political subdivisions which elect the HDHP option, who are receiving compensation from the North Dakota workforce safety and insurance.

A temporary employee of a political subdivision which elects the HDHP option, who is 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 if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015.

In order for a temporary employee of a political subdivision which elect the HDHP option, who is employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee of a political subdivision which elects the HDHP option, who is first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

Temporary employees employed by the state of North Dakota are not eligible to participate in this Benefit Plan.

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

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

A "Late Enrollee" is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. A Late Enrollee can only enroll during the next scheduled Annual Enrollment Period. A Member is not a "Late Enrollee" if any "special enrollment right(s)" apply, as described later in this section.

1.2 HOW TO ENROLL

Both the Group and Eligible Group Member are involved in the enrollment process.

The Eligible Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

The Group must:

- Provide all information needed by Sanford Health Plan to determine eligibility; and
- Agree to pay the required premium payments on behalf of the Eligible Group Member.

1.3 WHEN COVERAGE BEGINS

Coverage generally becomes effective on the first day of the month that follows the date of hire, as designated by NDPERS.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, we will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this Certificate. Payment of benefits is subject to any obligations under a previous plan or coverage arrangement in accordance with state law and applicable regulations.

For more information, see Section 8, "*Extension of Benefits for Total Disability*".

1.4 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

The following Dependents are eligible for coverage ("Dependent coverage"):
Spouse - The Subscriber's spouse under a legally existing marriage. A Spouse is eligible for coverage, subject to eligibility requirements as designated by NDPERS.

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

1) Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2) Be one of the following:

- under twenty-six (26) years old; or
- incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within *thirty-one (31)* days of the Plan's request. Such a request may be no more than annually following the two year period of the disabled dependent child's attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]; If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent Child - To be eligible for coverage, a Dependent of the Dependent Child must be the Subscriber's grandchild or the grandchild of the Subscriber's living, covered Spouse if (1) the parent of the grandchild is a Member and (2) both the parent of the grandchild and the grandchild are primarily dependent on the Subscriber for financial support. The term grandchild means any of the following:

- natural child of a Dependent Child;
- child placed with a Dependent Child for adoption;
- child legally adopted by a Dependent Child;
- child for whom a Dependent Child has legal guardianship;
- stepchild of a Dependent Child; or
- foster child of a Dependent Child.

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

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

1.5 NONCUSTODIAL SUBSCRIBERS

Whenever a Dependent Child receives coverage through the noncustodial parent who is the Subscriber, Sanford Health Plan shall do all of the following:

- Provide necessary information to the custodial parent in order for the Dependent Child to receive benefits under this Contract;
- Allow the custodial parent or Provider, with the custodial parent's approval, to submit claims for Covered Services without approval from the noncustodial parent; and
- Make payment on the submitted claims directly to the custodial parent or Provider.

1.6 STATUS OF MEMBER ELIGIBILITY

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

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

A Member making a statement (including the omission of information) on the membership application or in relation to any of the terms of this Benefit Plan constituting fraud or an intentional misrepresentation of a material fact will result in the rescission of this Benefit Plan by Sanford Health Plan. A rescission is a cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding this Benefit Plan or any benefits paid under the terms of this Benefit Plan.

1.7 WHEN AND HOW TO ENROLL DEPENDENTS

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "Coverage from Birth" and "*Adoption or Children Placed for Adoption*" section below. There is also an exception for Spouses; see "*New Spouses*" section below.

How to Enroll Dependents

The Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

1.8 WHEN DEPENDENT COVERAGE BEGINS

A. **General**

If a Dependent is enrolled at the same time the Subscriber enrolls for coverage through NDPERS, the Dependent's effective date of coverage will be the same as the Subscriber's effective date as described in Section *"When Coverage Begins"* above.

B. **Delayed Effective Date of Dependent Coverage**

Except for newborns (see "*Coverage from Birth*" section below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits under any prior coverage exists, the Plan coordinates benefits. For more details on Coordination of Benefits, see Section 6.

C. **Coverage from Birth**

If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth. Depending on the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

a. Subscribers with Single Coverage: Newborns are covered under a Single Coverage Plan through the date of mother's discharge from the hospital in which the child was born. For coverage to extend after the mother's hospital discharge, Subscribers must submit application to NDPERS within thirty-one (31) days of the newborn's date of birth. Coverage will then be applied retroactively back to the date of birth.

b. Subscribers with Family Coverage: Newborn children will be added to the Certificate automatically if the Subscriber is enrolled in Family Coverage.

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

An Eligible Group Member who failed to enroll during a previous enrollment period shall be covered under this Contract from the date of the child's birth, provided that coverage is applied for through NDPERS within *thirty-one (31)* days of the birth. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse. The Spouse may be added if application is made within thirty-one (31) days of a child's birth if otherwise eligible for coverage under the Plan, provided that coverage is applied through NDPERS for the Spouse and, if applicable, the Group Member.

D. **Adoption or Children Placed for Adoption**

If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as an Eligible Dependent as of the date specified within a court order or other legal adoption papers. Regardless of the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

a. **Subscribers with either Single or Family Coverage:** For coverage to continue beyond thirty-one (31) days of the date specified within the court order or other legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage, the Subscriber must submit an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or other legal adoption papers that granted initial eligibility.

An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, who failed to enroll during a previous enrollment period, shall be covered as of the date specified within a court order or other legal adoption papers, if the Eligible Group Member, and any other Eligible Dependents, submits an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that an application for coverage is submitted to NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

Coverage at the time of placement for adoption includes the necessary care and treatment of medical conditions existing prior to the date of placement.

E. **New Spouses and Dependent Children**

If a Subscriber gets married, his or her Spouse, and any of the Spouse's Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for with NDPERS for the Spouse and/or Eligible Dependents within thirty-one (31) days of the date of marriage. If the Subscriber does not submit an application for coverage to NDPERS for the Spouse and/or any Eligible Dependent(s) within thirty-one (31) days of the date of marriage, then Late Enrollee provisions apply and the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st. This includes marriages for which coverage was effective on or after June 26, 2015, regardless of the Spouses' gender/sex.

If an Eligible Group Member, who is an Employee eligible to enroll in the Plan, but who did not do so during a previous enrollment period, gets married, the employee becomes an eligible Subscriber under the following conditions:

a. The Subscriber, his or her Spouse, and any Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty-one (31) days of the date of marriage or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.
b. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

** **NOTE:** Per Federal laws, guidance, and regulations, the sexual orientation and sex/gender of Spouses, married in a jurisdiction with legal authority to authorize their marriage, is not a factor in the issuance of coverage or benefit determinations. Sanford Health Plan, in compliance with federal guidance for all states, offers coverage to all legally married Spouses, and any Eligible Dependents as a result of marriage, regardless of the jurisdiction in which the marriage occurred. The provisions in this contract regarding Spousal eligibility and Late Enrollees continue to apply, regardless of Spouses' sex/gender.

1.9 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROVISION

A QMCSO is an order that creates the right of a Subscriber's Dependent Child to be enrolled in coverage under this Contract. If a QMCSO is issued, Sanford Health Plan will provide benefits to the Dependent Child(ren) of a Subscriber regardless of whether the Dependent Child(ren) reside with the Subscriber. In the event that a QMCSO is issued, each named Dependent Child(ren) will be covered by this Certificate of Insurance in the same manner as any other Dependent Child(ren).

When Sanford Health Plan is in receipt of a medical child support order, Sanford Health Plan will notify the Subscriber and each Dependent Child named in the order, whether or not it is a QMCSO. A QMCSO must contain the following information:

1. Name and last known address of the Subscriber and the Dependent Child(ren) to be covered by the Plan.
2. A description of the type of coverage to be provided to each Dependent Child.
3. The applicable period determined by the order.
4. The plan determined by the order.

In order for the Dependent Child's coverage to become effective as of the date of the court order issued, the Subscriber must apply for coverage as defined previously in this section. Each named Dependent Child may

designate another person, such as a custodial guardian, to receive copies of explanation of benefits, checks, and other materials.

Exceptions
If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements under *Dependent Child* need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Certificate of Insurance. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be terminated unless Sanford Health Plan is provided satisfactory written evidence of any of the following:

1. The court or administrative order is no longer in effect;
2. The Dependent Child(ren) currently receive(s) or will be enrolled in comparable health coverage through a health insurance issuer which will take effect not later than the effective date of the termination; or
3. The Group has eliminated family coverage for all of its Eligible Group Members.

1.10 SPECIAL ENROLLMENT PROCEDURES AND RIGHTS

A Special Enrollment Period may apply when an individual becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption or when an Eligible Group Member or an Eligible Dependent involuntarily loses other health coverage.

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within thirty-one (31) days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within thirty-one (31) days of the change or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.
   1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

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

   2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan due to legal separation, divorce, annulment, or death, coverage for the Subscriber's Spouse and/or Dependents under Family Coverage will cease, effective the first of the month immediately following timely notice of the event causing ineligibility.

      If living in the Sanford Health Plan Service Area (see *Service Area* in Introduction Section), a Member has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

      There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special

enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and Sanford Health Plan of any change in family status within thirty-one (31) days of the change. The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement, or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

   The following provisions will apply:

   1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within thirty-one (31) days of the date of birth for coverage to continue beyond the first thirty (30) days beginning with the child's birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
   2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to NDPERS within thirty-one (31) days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
   3. Children who have been placed under the care Subscriber, or the Subscriber's living, covered spouse due to the Subscriber, or the Subscriber's living, covered spouse being appointed legal guardian, may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
   4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
   5. If any of the Subscriber's children, or those of the Subscriber's living, covered spouse, who are Eligible Dependents under the Plan, beyond the age of 26, incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance, shall have coverage remain in effect as long as such disabled child remains dependent upon the Certificate holder/Subscriber or the Subscriber's spouse for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.
   6. If a child is no longer an Eligible Dependent under this Benefit Plan, and the child is living in the Sanford Health Plan Service Area (see *Service Area* in the above Introduction Section), the Dependent has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*. There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

7. At the time of birth or adoption, other Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to NDPERS within thirty-one (31 days) of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date. Pursuant to N.D.A.C. §71-03-03-01, an Employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:
   1. During the initial enrollment period the employee or dependent states, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
   2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
      a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special enrollment under the Benefit Plan but again choosing not to enroll, or employer contributions toward such coverage were terminated; or
      b. was under COBRA and the coverage was exhausted.
   3. The employee requests such enrollment within thirty-one (31) days after the exhaustion or termination of coverage.

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

   If the membership application is not received in accordance with this provision, and the Employee or Dependent is a Late Enrollee, the Late Enrollee's effective date of coverage will be the Group's anniversary date.

E. Employees and/or Dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:
   1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and the employee's or dependent's coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within sixty (60) days of the date of termination of coverage; or
   2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within sixty (60) days of the date the employee or dependent is determined to be eligible for premium assistance.

      The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

F. In accordance with the decision of the Supreme Court of the United States on June 26, 2015, in *Obergefell v. Hodges*, 576 U.S. (2015), regarding same-sex marriage:

1. **Same-sex marriages that occurred prior to June 26, 2015:** NDPERS will have a special enrollment period from July 1, 2015 through September 30, 2015. Coverage will be effective retroactive to July 1, 2015. If the Subscriber does not enroll during this eligibility period, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.
2. **Same-sex marriages that occur on or after June 26, 2015:** The Subscriber must submit an application for coverage within the first thirty-one (31) days of the event. If the Subscriber does not enroll when initially eligible, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.

Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent is enrolled.

* *Loss of coverage due to failure to make premium payment and/or allowable rescissions of coverage does not qualify for a Special Enrollment Period.*

* *Voluntarily terminating/dropping COBRA coverage before it runs out outside Annual Enrollment does not qualify for a Special Enrollment Period.*

COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment.

1.11 CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 grants special enrollment rights to employees and Dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

In order to qualify for special enrollment, an eligible employee or dependent must request coverage within *sixty (60) days* of either being terminated from Medicaid or CHIP coverage, or being determined to be eligible for federal premium assistance. In either situation, the Plan will also require the eligible employee to enroll in Plan coverage. Special enrollment rights extend to all benefit packages available under the Plan. If you have questions about enrolling in your employer plan under CHIPRA special enrollment rights, contact the U.S. Department of Labor at www.askebsa.dol.gov or call (866) 444-3272 *(toll-free)*.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

1.12 MICHELLE'S LAW

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance Certificate prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a written and signed certification from the Dependent Child's treating Practitioner and/or Provider stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary and the effective date of the leave.

SECTION 2
HOW YOU GET CARE

2.1 IDENTIFICATION CARDS

Sanford Health Plan will send you an identification (ID) card when you enroll. Each Subscriber will receive their own Member ID card after enrollment, which should be used when you receive care. You must show it whenever you receive services from a Provider, a health care Facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive Health Care Services or prescription medications, you will be responsible for payment of the claim after the Participating Practitioner and/or Provider's timely filing period of *one-hundred-eighty* (180) calendar days has expired. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

If you do not receive your ID card within *thirty* (30) calendar days after the effective date of your enrollment, you need a temporary card or replacement cards, please call us at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* or write to us at Sanford Health Plan, ATTN: NDPERS, PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards by signing into your account at sanfordhealthplan.com/memberlogin. Information on creating an account is available at sanfordhealthplan.com/ndpers.

2.2 CONDITIONS FOR COVERAGE

Members are entitled to coverage for the Health Care Services (listed in the "Covered Services," in Section 3)that are:

- Medically Necessary and/or Preventive;
- Received from or provided under the orders or direction of a Participating Provider;
- Approved by the Plan, including Preauthorization/Prior Approval where required; and
  Within the scope of health care benefits covered by the Plan

However, this specific condition does not apply to Emergency Medical Conditions or urgent care in and out of the Service Area. In such cases, the services will be covered if they are provided by a Non-Participating or Out-of-Network Provider.

If during an emergency or Urgent care situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest Participating Practitioner and/or Provider.

Members are not required, but strongly encouraged, to select a Primary Care Physician and use that Physician to coordinate their Health Care Services.

In addition, all Health Care Services are subject to:

- The exclusions and limitations described in Sections 3 and 4; and
- Any applicable Deductible and Coinsurance amount as stated in this COI, your Summary of Benefits and Coverage (SBC), and Pharmacy Handbook.

2.3 IN-NETWORK COVERAGE

In-Network coverage is provided under two (2) plan levels. For more information, see *Selecting a Health Care Provider* in Section 3.7 In-Network benefit payments pay according to coverage under:

1. Basic Plan; or
2. PPO Plan

Note: If you travel out of the Plan's Service Area for the purpose of seeking medical treatment outside the Plan's Service Area, as defined in this COI, without Preauthorization/Prior Approval for a service that requires such authorization/approval, your claims will be paid according to the Basic Plan benefits and stipulations set forth in Section 3.7.
Additionally, the Member will receive Basic Plan benefits if: 1) a PPO Health Care Provider is not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO).
For *Appropriate Access* standards, see below.

In the following circumstances, Medically Necessary Health Care Services received from Non-Participating Providers may be Covered Services subject to In Network Cost Sharing, although Members may be responsible for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services.

1. **Ancillary Health Care Services**. Health Care Services received from a Non-Participating Provider that are ancillary to a Covered Service being provided by In-Network Participating Practitioner and/or Provider, such as anesthesiology or radiology, if rendered in an In-Network Facility. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.
2. **Termination of a Participating Provider.** Health Care Services received from a Participating Provider by a Member who is under an Active Course of Treatment and we terminate the Participating Provider's status as a Participating Provider without cause. The Member or the terminated Participating Provider must request and receive written approval from us. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will not count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.

2.4 APPROPRIATE ACCESS

Primary Care Physicians and Hospital Providers

Appropriate access for Participating Practitioner and/or Providers who provide primary care services and Hospital Provider sites is within *fifty* (50) miles of a Member's city of legal residence

Specialty Practitioners and Providers

For other Participating Practitioner and/or Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within *fifty* (50) miles of a Member's city of legal residence. If you are traveling within the Service Area where other Participating Practitioner and/or Providers are available, then you must use Participating Practitioner and/or Providers.

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Practitioners and Providers as indicated in the Plan's Provider Directory. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If a Member chooses to go to a Non-Participating Practitioner or Provider when appropriate access (within *fifty (50)* miles of a Member's city of legal residence) is available, claims will be processed at the Basic Plan (Out-of-Network) level.

Transplant Services

Transplant Services must be performed at designated participating facilities and are not subject to the appropriate access standards outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations and terms of Sanford Health Plan's transplant policy.

2.5 CASE MANAGEMENT

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

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

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

Sanford Health Plan's case management process allows professional case managers to assist Members with certain complex and/or chronic health issues by coordinating treatment and/or other types of patient care plans.

In consultation with case managers, Sanford Health Plan may approve coverage that extends beyond the limited time period and/or scope of treatment initially approved. This consultation also includes utilization management processes as described below.

All decisions made through case management are based on the individual circumstances of a Member's case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) of the Member.

NOTE: For certain transplant procedures, case management services will be provided by the Plan's transplant vendor, *not* Sanford Health Plan. For benefit details on transplant services, see Section 3.2.

2.6 BENEFIT DETERMINATION REVIEW PROCESS

Sanford Health Plan Appeals and Grievances Department reviews all non-medical benefit determinations through review of Certificate of Insurance language, contractual terms, administrative policies related to benefits

as defined by this Policy, and benefits requests. All benefit determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

The date of receipt for non-urgent (standard) requests received outside of normal business hours will be the next business day.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances department.

2.7 ROUTINE (NON-URGENT) PRE-SERVICE BENEFIT REQUESTS

All pre-service benefit determination (approval) requests will be determined within fifteen (15) business days of receipt of the request. When a preauthorization (pre-approval) request is received before a service occurs, the date of receipt for non-urgent (standard) requests is the date the Plan receives the Member's request. If the request is made outside of business hours, the date or receipt will be next business day. If Sanford Health Plan denies a benefit (an Adverse Benefit Determination) the Plan will contact the Member via mail.

2.8 ROUTINE POST-SERVICE BENEFIT REQUESTS

Retrospective (post-service) requests occur when a Member has already utilized healthcare services and did not inquire about coverage pre-service. Post-service requests are not related documentation, coding or reimbursement from the Plan. Sanford Health Plan will review and approve or deny the service based on Medical Necessity within thirty (30) calendar days of receipt of the request. A letter will be sent to the Member within those 30 calendar days with the Plan's determination.

2.9 UTILIZATION MANAGEMENT REVIEW PROCESS

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Utilization Management department.

The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it is during normal business hours.

All Utilization Review Adverse Determinations will be made by the Sanford Health Plan Chief Medical Officer or appropriate Practitioner.

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This part of Section 2 explains how we process different types of claims.

Designating an Authorized Representative

You may act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. An Authorized Representative is someone you designate in writing to act on your behalf. We have developed a form that you must complete if you wish to designate an Authorized Representative. You can get the form by calling Customer Service. You can also log into your account at www.sanfordhealthplan.com/memberlogin and download a copy of the form. If a person is not properly

designated as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your Provider is your Authorized Representative unless you tell us otherwise in writing.

Your Right to Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as Medical Necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 business days of a request. We will not charge you for any information that you request regarding our decision.

Your Complaint (Grievance) & Appeal Rights

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write the Appeals and Grievances Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received; or
- You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 10 for more information on the Appeals Process.

The Plan's claims procedures are designed to comply with the requirements of ERISA., We will process your claim according to ERISA standards. In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), criteria for Medical Necessity determinations is available upon request to any current or potential Member, beneficiary, or contracting provider. For details on the complaint and appeals process, see Section 10.

NOTE: If you receive an Adverse Determination, you have the right to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not (and is not) considered a request for an Internal Appeal and/or External Review.

2.10 PROSPECTIVE (PRE-SERVICE) REVIEW OF SERVICES (CERTIFICATION PRIOR AUTHORIZATION)

Prior Authorization (also referred to as Certification) is a decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary and appropriate. Preauthorization is required for services as defined above, except in urgent or emergent situations. Although the Plan may authorize a health care service as medically necessary, it is not a guarantee the Plan will cover the cost.

Determination of the appropriateness of care is based on standard review criteria and assessment of the following factors:

- The Member's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
- Consultation with the treating Practitioner and/or Provider, as appropriate.
- Availability of resources and alternate modes of treatment. For admissions to Facilities, other than Hospitals, additional information may include but is not limited to history of present illness, patient treatment plan and goals, prognosis, staff qualifications and *twenty-four* (24) hour availability of qualified medical staff.
- Sanford Health Plan does not compensate Practitioners, Providers or other individuals conducting Utilization Review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Review decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

Prior authorization is required for all inpatient admissions.

This requirement applies, but is not limited to, the following:

1. Acute care Hospitalizations (including medical, surgical, and non-emergency mental health or substance use disorder inpatient admissions);
2. Residential Treatment Facility admissions; and
3. Rehabilitation center admissions.

Admission before the day of non-Emergency surgery will not be authorized unless the early admission is Medically Necessary and specifically approved by Sanford Health Plan. Coverage for Hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

Referrals to Recommended Providers
Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

Prior Authorization is the responsibility of your Practitioner and/or Provider. For an up to date list or more information on all things that require prior authorization, please visit:
https://www.sanfordhealthplan.com/members/prior-authorization.

2.11 PHARMACY PRE-APPROVAL (CERTIFICATION) REQUESTS

Certain specialty drugs, or those which require frequent dosing adjustments, close monitoring, special training, compliance assistance, or need special handling and/or administration, require preauthorization by the Pharmacy Management Department.

To acquire preauthorization for a medication, ask the prescribing Practitioner and/or Provider to contact us by phone, complete the Formulary Exception Form found online at sanfordhealthplan.com, or provide a letter of Medically Necessity. This applies to any request of:

1) A non-covered medication or drug; or
2) A medication, or drug not currently listed in the Formulary.

Sanford Health Plan will use appropriate practitioners to consider requests and grant an exceptions to the Formulary when the prescribing Practitioner and/or Provider of the drug attests the Formulary drug causes an adverse reaction, is considered contraindicated, or must be dispensed as written to provide maximum medical benefit to the Member.

The Pharmacy Management department will review the request and make a decision based on:

1. Medical records showing trial and failure of a formulary drug or reasons why a formulary drug trial should be avoided;
2. Clinical information (such as diagnosis, disease progression and/or medication history); and
3. Medical Necessity.

If the reason for the exception is not clear, the reviewing clinician will contact the prescribing Practitioner and/or Provider to discuss the request. Additionally, if necessary, a clinical consultant of the appropriate specialty may be consulted for review.

If a Formulary exception is granted, the Pharmacy Management Department will provide authorization to the Plan's Pharmacy Benefit Manager so the Member is able to obtain the requested medication immediately. Additionally, coverage of the non-Formulary drug will be provided for the duration of the prescription, including refills.

For more information on drugs that may require prior authorization including oral medications, step therapy and injectable medications, refer to the formulary and Section 3.5 of this document.

Routine/Standard Pharmacy Pre-Approval Requests

Routine/Standard (non-urgent) pharmacy pre-approval requests will be reviewed within **fifteen (15) days after receipt of the request.** If the request is made outside of business hours, the date or receipt will be next business day.

Urgent Pharmacy Pre-Approval Requests

Urgent pharmacy pre-approval requests be reviewed as soon as possible and no later than **twenty-four (24) hours** of receipt of the request. Sanford Health Plan in alignment with the Standard and Expedited Exception Request requirements. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision.

How to Request Pre-Approval for a Drug

You or your authorized representative can request a medication pre-approval by:

- Contacting Pharmacy Management
- Complete Formulary Exception Form found online at sanfordhealthplan.com
- Ask the prescribing Practitioner and/or Provider for a letter of medical necessity
- Ask the prescribing Practitioner and/or Provider to contact the Plan by phone

What to Include with the Request

Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision.

2.12 ADDITIONAL INFORMATION REGARDING FORMULARY EXCEPTION REQUESTS

1. For contraceptives not in the Formulary, if the prescribing Practitioner and/or Provider determines that a drug/device is Medically Necessary and an exception to the formulary is granted, the contraceptive drug/device will be covered at 100% (no charge).
2. If the decision is to approve a standard (routine) Formulary exception request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription, including refills. If a request is granted based on an emergent circumstance, Sanford Health Plan will provide coverage of for the duration of the incident.
3. In the event that an exception request is granted, Sanford Health Plan will treat the excepted drug(s) as an essential health benefit, including, if applicable per the Member's Policy, counting any cost-sharing towards the Member's annual limitation on cost-sharing and when calculating the actuarial value.

In determining whether to grant an exception, Sanford Health Plan adheres to, procedures, as outlined above, allowing Members to request and gain access to clinically appropriate drugs not covered under the Plan's Formulary.

2.13 Medical Pre-Approval (Certification) Requests

All requests for Prior Authorization (Certification) are to be made by the Member or Physician/Practitioner's office at least *three (3)* business days prior to the scheduled admission or requested service. The Utilization Management Department will review the Member's medical request against standard criteria.

Determination of the appropriateness of an admission is based on standard review criteria and assessment of:

1. Member medical information including:
    a. diagnosis;
    b. medical history;
    c. presence of complications and/or co-morbidities;
2. Consultation with the treating Practitioner, as appropriate;
3. Availability of resources and alternate modes of treatment; and
4. For admissions to Facilities other than acute general Hospitals, additional information may include but is not limited to the following:
    a. history of present illness;
    b. patient treatment plan and goals;
    c. prognosis;

d. staff qualifications; and
e. twenty-*four (24)* hour availability of qualified medical staff.

Routine Pre-Service Pre-Approval Requests

Routine/Standard (non-urgent) pre-service requests for services that require pre-approval from the Plan will be made within **fifteen (15) calendar days from the date** the Plan receives the request. If the request is made outside of business hours, the date or receipt will be next business day. If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **five (5) calendar days** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Urgent Pre-Service Pre-Approval Requests

Urgent pre-service requests for services that require pre-approval from the Plan will be reviewed as soon as possible and no later than **seventy-two (72) hours** after receipt of the request. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision. If the request does not meet the definition of urgent, or is for a service that has already occurred, (post-service/retrospective) the request will be processed as a routine/standard request.

If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **twenty-four (24) hours** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Emergent Medical Conditions

Pre-approval is not required if a prudent layperson that possesses an average knowledge of health and medicine determines urgent or emergent care is necessary in a particular situation. Members should notify Sanford Health Plan as soon as reasonably possible and no later than **forty-eight (48) hours** after physically or mentally able to do so. A Member's Authorized Representative may also notify the Plan on the Member's behalf.

How to Request Pre-Approval for a Medical Item or Health Care Service
Refer to the Introduction section at the beginning of this document for instructions on contacting the Utilization Management department to request a medical pre-approval request.

What to Include with a Pre-Approval Request

Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary medical information, we will notify the Member, their Authorized Representative (if applicable) and their Practitioner and/or Provider regarding what information is necessary to approve the request. If request was received from a Practitioner and/or Provider, the Plan will communicate solely with the requesting Practitioner and/or Provider regarding information needed to approve the request. The Plan will notify the appropriate party(ies) regarding the information needed to make a decision within:

- **Twenty-four (24) hours** of the receipt of the request if the request meets the definition of Urgent. The Plan will provide **forty-eight (48) hours** to supply the requested information. If not received by the end of the 48-hour extension, the request will be denied.
- **Fifteen (15) calendar days** of receipt of a routine/standard request. The Plan will provide forty-five (45) calendar days to supply the requested information. If not received by the end of the forty-five day extension, the request will be denied.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision:

- By phone no later than **forty-eight (48) hours** after the decision is made for Urgent requests. The Plan will also provide electronic or written notification of the decision as soon as possible, but no later than within **three (3) calendar days** of the phone notification if the request is deemed urgent.
- By mail within the **fifteen (15) calendar days** after receipt of the request.

Routine/Standard (Non-Urgent) Post-Service Pre-Approval Request

If a claim is denied for a service that has already occurred or item that has already been received (post-service or retrospective), the Member may file an appeal as outlined in Section 10 as the denied claim serves as the initial adverse determination.

2.14 ONGOING (CONCURRENT) PREAUTHORIZATION REQUESTS (CERTIFICATION) OF HEALTH CARE SERVICES

Concurrent Review is utilized when a request for an extension of an approved ongoing course of treatment for medical care, including care for behavioral, mental health, and/or substance use disorders, over a period of time or number of treatments, is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.

Determinations by us to Limit or Reduce Previously Approved Care

If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow the rules we establish for the filing of your appeal, such as the time limits within which the appeal must be filed (See Section 10 for more information on the

Appeals Process). Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow you to appeal and obtain a review determination before the benefit is reduced or terminated. In addition, individuals in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

Prior Authorization (Certification) of inpatient care stays will terminate on the date the Member is to be discharged from the Hospital or other Facility (as ordered by the attending Physician), or when the Member's coverage is terminated, whichever occurs first. Hospital/Facility days accumulated beyond ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioner and/or Providers associated with these non-certified days are non-covered.

The health care service or treatment that is the subject of the Adverse Determination shall be continued without liability to the Member until the Member or the Member's Authorized Representative has been notified of the determination with respect to the internal review request made pursuant to the Appeal Procedures.

Any reduction or termination during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination.

Requests to Extend Previously Approved Care

A Provider who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request Prior Authorization from Sanford Health Plan at least *twenty-four (24) hours* in advance of the termination of such continuing services. Your Provider may make this request in writing or orally directly to us. To request a concurrent review determination, call Utilization Management. Refer to the Introduction section for Utilization Management contact information.

If Utilization Management denies the extension of treatment, it will advise the Member and Practitioners and/or Providers within twenty-four (24) hours of receiving the request. If the Member decides to appeal this denial, the health care services or treatment subject to the Adverse Determination shall be continued without cost to the Member while the determination is under review as specified by the Appeal procedures outlined in Section 10.

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Member may pursue the appeal rights described in Section 10.

Any reduction or termination by the Plan during the course of treatment before the end of the period or number of treatments shall constitute an Adverse Determination.

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, Sanford Health Plan shall make a determination and orally notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service, of the determination as soon as possible, taking into account the Member's medical condition, but in no event more than seventy-two (72) hours after the date of Sanford Health Plan's receipt of the request.

Sanford Health Plan will provide electronic or written notification of an authorization to the Member, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the oral notification.

We shall provide written or electronic notification of the Adverse Determination to the Member and those Providers involved in the provision of the service sufficiently in advance (but no later than within three (3) calendar days of the telephone notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file a Grievance request to review of the Adverse Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. Sanford Health Plan will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination unless the decision has the potential to adversely affect the Member, in terms of coverage or financially, whether immediate or in the future.

Non-Urgent (Standard) Concurrent Reviews

If your request is non-urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service timeframes as outlined in this Section.

Urgent (Expedited) Concurrent Reviews

If your request for additional care is urgent, and if your Provider submits it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, Sanford Health Plan will make the decision as soon as possible (taking into account the medical exigencies) but no later than seventy-two (72) hours after receiving the request]. For authorizations and denials, we will give telephone notification of the decision to Members, Practitioners and those Providers involved in the provision of the service within seventy-two (72) hours of receipt of the request. We will give oral, written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within three (3) calendar days of the oral notification.

If your Provider attempt to file an urgent concurrent review but fails to follow our procedures for doing so, we will notify you and your Provider of the failure within twenty-four (24) hours. Our notification may be oral, unless asked for in writing.

Adverse Determinations

If the determination is an Adverse Determination, we shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedures outlined below. At this point, the Member can request an appeal of Adverse Determinations. Refer to the "Appeal Procedures" in Section 10 for details.

Lack of Necessary Information

If we need more information, we will let you know within twenty (24) hours of your claim. Sanford Health Plan will tell you what further information is needed. You will then have forty-eight (48) hours to provide us with the additional information. Sanford Health Plan will notify you of our decision within forty-eight (48) hours after we receive all requested information.

Our notification may be oral; if it is, we will follow it up in writing within three (3) days. If we do not receive the information, your claim will be considered denied at the expiration of the forty-eight (48) hours we gave you for furnishing the information to us.

2.15 WRITTEN NOTIFICATION PROCESS FOR ADVERSE DETERMINATIONS

The written notifications for Adverse Determinations will include the following:

1. The specific reason for the Adverse Determination in easily understandable language;

2. Reference to the specific provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual provisions, guidelines, and protocols free of charge upon request. Reasons for any denial or reimbursement or payment for services with respect to benefits under the plan will be provided within 30 business days of a request;

3. Notice of an Adverse Determination will include information sufficient to identify the claim involved, including the date of service the Provider, the claim amount (if applicable) and a statement notifying members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review;

4. If the Adverse Determination is based in whole or in part upon the Member failing to submit necessary information, the notice shall include a description of any additional material or information, which the Member failed to provide to support the request, including an explanation of why the material is necessary;

5. If the Adverse Determination is based on Medical Necessity or an Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the coverage to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;

6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Determinations, if information on any Medical Necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 business days of a Member/Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the plan, in compliance with MHPAEA;

7. If the Adverse Determination is based on Medical Necessity, a written statement of clinical rationale, including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision;

8. A description of appeal procedures, including how to obtain an expedited review if necessary (and any time limits applicable to those procedures) including:

    - a Member's right to bring civil action under §502(a) of ERISA
    - the right to submit written comments, documents or other information relevant to the appeal;
    - an explanation of the Appeal process including the right to Member representation;
    - notification that Expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and
    - the timeframe the Member has to make an appeal and the amount of time the Plan has to decide it

(including the different timeframes for Expedited Appeals);

9. If the Adverse Determination is based on Medical Necessity, notification and instructions on how the Practitioner can contact the Practitioner to discuss the determination;

10. You have the right to contact the North Dakota Insurance Commissioner at any time. (Refer to the Introduction section at the beginning of this document for contact information.)

SECTION 3
COVERED SERVICES – OVERVIEW

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides coverage for the following Covered Services. Payment for Covered Services is limited by or subject to any applicable Coinsurance or Deductible set forth in this Contract including the Summary of Benefits and Coverage. To receive maximum coverage for Covered Services, the terms of this Contract must be followed, including receipt of care from In-Network Participating Practitioner and/or Providers as well as obtaining any required Certification. You are responsible for all expenses incurred for Non-Covered Services. Health Care Services received from Non-Participating Providers or Out-of-Network Participating Providers are Non-Covered Services unless otherwise indicated in this Contract.

3.1 HEALTH CARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

Here are some important things you should keep in mind about these benefits:

- *All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.*
- *Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Your Practitioner and/or Provider must get Certification of some services in this Section. The benefit description will say "Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits. (See Services Requiring Certification in Section 2.)"*

3.1.1 ARTIFICIAL NUTRITION

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.)*. Coverage is subject to Sanford Health Plan Guidelines.

- Parenteral nutrition formula and supplies
- Enteral nutrition formula and supplies

3.1.2 ALLERGY CARE BENEFITS

- Testing and treatment
- Allergy injections
- Allergy serum

3.1.3 CHIROPRACTIC SERVICES

Covered when provided on an inpatient or outpatient basis when Medically Necessary as determined by Sanford Health Plan and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician.

Benefits are not available for Maintenance Care.

3.1.4 CLINICAL TRIALS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.
- Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.
    - The Health Care Service that is the subject of the Approved Clinical Trial.
    - Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
    - Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
    - An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
    - Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
    - A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
    - A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

3.1.5 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits.

Item	Information
Blood glucose test strips, glucagon, glucometers, glucose agents, lancets and lancet devices, prescribed oral agents for controlling blood sugars, syringes, urine testing strips	**Must be obtained at:** Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit; deductible/coinsurance may apply
Custom diabetic shoes and inserts; Limited to one (1) pair of depth-inlay shoes and three (3) pairs of inserts; or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts	**Must be obtained at:** Durable Medical Provider **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply
Continuous Glucose Monitor (CGM)	**Prior Authorization may be required** **Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit (must be on formulary and available through a pharmacy) or Medical Benefit (if obtained through a Durable Medical Provider); deductible/coinsurance may apply
Insulin Pump	**Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply

Coverage for the treatment of diabetes includes:

- Routine foot care, including toenail trimming is covered.
- Diabetes self-management training and education shall only be covered if:
  - the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner and/or Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator; and
  - the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the North Dakota Department on Health.

3.1.6 DIAGNOSTIC AND TREATMENT SERVICES

Professional services from Practitioners, Providers, Physicians, nurse practitioners, and Physician's assistants are covered when provided in Practitioner and/or Provider's offices and urgent care centers. Medical office consultations and second surgical opinions are also covered per Medical Necessity.

3.1.7 DIALYSIS BENEFIT

- Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under the End Stage Renal Disease (ESRD) program.
- Services include equipment, training, and medical supplies required for effective dialysis care. See Outpatient Nutrition Care Services in this Section for additional Chronic Renal Failure benefits. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 6.

3.1.8 DURABLE MEDICAL EQUIPMENT (DME) BENEFITS

- Coverage is available for DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Sanford Health Plan policy guidelines apply.
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan policy.
- Prior Approval is required for certain items. For updated information refer to: https://www.sanfordhealthplan.com/members/prior-authorization

3.1.9 EYE CARE/VISION SERVICES

Eye Care services are as follows:

Exams and Services	**Child** (age 0-18)	**Adult** (age 19+)
Routine eye exam	Not covered	Not covered
Dilated eye examination for diabetes-related diagnosis	Covered with a limit of one exam per Member per year	Covered with a limit of one exam per Member per year
Vision therapy	Covered for Members 17 and under; limited to 16 visits per Member per calendar year	Not covered
Services required because of injury, accident or cancer that damages the eye	Covered if the Member was covered under this Contract during the time of the injury or illness causing the damage	Covered if the Member was covered under this Contract during the time of the injury or illness causing the damage
Cataract surgery	Covered	Covered

Eye Wear (frames, lenses, contacts)	**Child** (age 0-18)	**Adult** (age 19+)
Aphakia patients: Eyeglasses or contact lenses or soft contact lenses	Up to $200 for eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Member per calendar year	Up to $200 for eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Member per calendar year
Scleral shells intended for the use in the treatment of a disease or injury	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime
Prescribed lenses and frames, unless otherwise listed the plan documents	Not covered	Not covered

3.1.10 FAMILY PLANNING BENEFITS

Family Planning Services include consultations, and pre-pregnancy planning. The following medications, services and devices are covered:

- Barrier methods: diaphragm and cervical cap fitting and purchase.
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years if obtained with a written prescription order, per Plan guidelines.
- Generic contraceptives are covered at 100% (no cost). If no generic equivalent exists for a formulary brand-name contraceptive, then that contraceptive is covered at 100% (no cost) per the Affordable Care Act. (See your Pharmacy Handbook/Formulary)
- Other contraceptives including injectable medroxyprogesterone acetate and emergency contraception with a written prescription (generic Plan B) are also covered at 100% (no cost).
- We cover implantable devices; including Mirena and ParaGard intrauterine devices. Placement and removal is covered once every five (5) years or as medically necessary.
- We cover sterilizations, including voluntary tubal ligations and vasectomies:
    - Medical – Occlusion of the fallopian tubes by use of permanent implants (e.g. Essure).
    - Surgical – Tubal ligation covered at 100% of allowed only when performed as the primary procedure. When performed as part of a maternity delivery or for any other medical reason, it will be covered as a medical benefit with the applicable cost-share applied.

NOTE: For Members enrolled in a High Deductible Health Plan, prescription drugs are subject to Deductible and Coinsurance amounts, unless the medication or drug dispensed is covered by the Contract at 100% (no charge).

3.1.11 FOOT CARE SERVICES

Routine foot care covered for Members with diabetes only.

- Non-routine diagnostic testing and treatment of the foot due to illness or injury

NOTE: See Section on Orthotic and prosthetic devices for information on podiatric shoe inserts

3.1.12 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Coverage is limited to diagnostic testing and treatment related to illness or injury only.

Hearing service coverage is as follows:

Exams and Services	**Child**	**Adult**
Routine care	Covered for ages 0-21 as outlined in Sanford Health Plan Preventive Health Guidelines	Not covered
Emergency and acute hearing services	Covered	Covered
Diagnosis and treatment of sudden sensorineural hearing loss (SSNHL)	Covered	Covered
Hearing Devices	**Child** (age 0-18)	**Adult** (age 19+)
Cochlear implants and bone-anchored (hearing-aid) implants	Certification required	Certification required
External Hearing Aids or devices	Hearing aids, communication aids or devices for Members 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Sanford Health Plan policy guidelines apply.	External hearing aids when medically necessary for conditions including, but not limited to: sudden sensorineural hearing loss (SSNHL), accident, injury or related illness.*
Hearing aid limits	Benefit is limited to one hearing aid, per ear, per Member under 19, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines	Benefit is limited to one hearing aid, per ear, per Adult Member, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines. This is a DME that requires prior approval (Certification).

* The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:

- provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by Sanford Health Plan; or
- help maintain or prevent deterioration in physical, cognitive, or behavioral function.

Note: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. *(See Services requiring Certification in Section 2.)*

3.1.13 HOME HEALTH SERVICES

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.).*

Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lieu of Hospital or Skilled Nursing Facility:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only
- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
- medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized

3.1.14 IMPLANTS/STIMULATORS

- Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per medical appropriate guidelines apply (available upon request).
- The following Implants/Stimulators may be covered with prior approval *(certification*);
  - Bone Growth (external)
  - Cochlear Implant (Device and Procedure)
  - Deep Brain Stimulation
  - Insertion, Removal, and Revisions of all Implants
  - Gastric Stimulator
  - Spinal Cord Stimulator (Device and Procedure)
  - Vagus Nerve Stimulator

3.1.15 INFERTILITY BENEFITS

Benefits are available for services, supplies and medications related to artificial insemination (AI) and assisted reproductive technology (ART), includes gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) or in vitro fertilization (IVF). Preauthorization/Prior Approval *is required.*

NOTE: Benefits are subject to a $20,000 Lifetime Benefit Maximum Amount per Member. Any Member-paid coinsurance for infertility services does not apply toward the Out-of-Pocket Maximum Amount.

3.1.16 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

Coverage includes, but is not limited to, the following

- High End Imaging services
  - CT Scans/MRI
  - PET Scans
- Blood tests
- DEXA Scans
- Electrocardiogram (EKG)
- Electroencephalography (EEG)Urinalysis

- Non-routine mammograms
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- Ultrasound
- Urinalysis

NOTE: Some of these services fall under High End Imaging and may require Certification. Failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

3.1.17 ONCOLOGY TREATMENT BENEFITS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Radiation Therapy.
- Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage.
  - The same cost-sharing amounts apply for intravenously administered or injected cancer chemotherapy agents as for prescribed, orally-administered, anticancer medications used to kill or slow the growth of cancerous cells

3.1.18 NEWBORN CARE BENEFITS

A newborn is eligible to be covered from birth. Members must complete NDPERS designated enrollment for the newborn within *thirty-one (31)* days of the infant's birth if enrolled in Single Coverage.

If the Subscriber is already enrolled in Family Coverage, the newborn will automatically be added to the Certificate if the Plan was aware of the pregnancy. The Subscriber should confirm enrollment of the new child with the Plan. For further details, see Section 2.

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3.2 for coverage information on correcting congenital defects).

3.1.19 ORTHOTIC AND PROSTHETIC DEVICES

Note: Select items may require prior approval *(certification*). For up to date information, please refer to https://www.sanfordhealthplan.com/members/prior-authorization

- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Member's condition or to improve the function are eligible for coverage and do not require Prior Authorization.
- Cranial Prosthesis, including wigs up to $200 (limited to one per benefit period). .
- Devices permanently implanted that are not Experimental or Investigational Services such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. *This is a DME that requires Certification*

- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *four (*4) bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year. These do not require prior authorization.
- Prosthetic limbs, sockets and supplies, and prosthetic eyes. *This is a DME that requires Certification*
- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 3.2 for payment information. Insertion of the device is paid under the surgery benefit.

3.1.20 OTHER TREATMENT THERAPIES NOT SPECIFIED ELSEWHERE

- Inhalation Therapy
- Non-Surgical, medically necessary treatment, of Gender Dysphoria (Gender Identity Disorder), including hormone therapy, mental/behavioral services, and laboratory testing to monitor the safety of continuous hormone therapy, per Plan guidelines (available upon request).
- Pheresis Therapy

3.1.21 OUTPATIENT NUTRITIONAL CARE SERVICES

Benefits are available for the following medical conditions:

- **Anorexia Nervosa** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Bulimia** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Chronic Renal Failure** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **PKU** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.

3.1.22 PEDIATRIC (CHILD) HEARING SERVICES

Refer to HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

3.1.23 PEDIATRIC (CHILD) VISION SERVICES

Refer to EYE CARE/VISION SERVICES

3.1.24 PHENYLKETONURIA (PKU) AND AMINO ACID-BASED ELEMENTAL ORAL FORMULAS COVERAGE BENEFITS

Phenylketonuria (PKU) Coverage is as follows:

- Testing, diagnosis and treatment of Phenylketonuria including dietary management, formulas, Case Management, intake and screening, assessment, comprehensive care planning and service referral.

Amino acid-based elemental oral formula coverage is as follows:

- 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 of amino acid or organic acid.

3.1.25 PHYSICAL, CARDIAC SPEECH AND OCCUPATIONAL THERAPIES

Coverage is as follows for outpatient rehabilitative and habilitative therapy services, which include the management of limitations and disabilities, and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function:

- **Physical Therapy:** Benefits are subject to medical necessity and performed by or under the direct supervision of a licensed Physical Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
    - Physical therapy and Vitamin D supplements with a prescription order are covered at 100% (no cost) for Members ages 65 and older who are at increased risk for falls. Benefits are subject to medical necessity.

- **Occupational Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Speech Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Respiratory/Pulmonary Therapy:** Available when services are performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of Members with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.

- **Cardiac Rehabilitation Services:** Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital. Twelve (12) visits per Member per episode, limited to the following diagnosed medical conditions:
    - Myocardial Infarction
    - Coronary Artery Bypass Surgery
    - Coronary Angioplasty and Stenting
    - Heart Valve Surgery
    - Heart Transplant Surgery

3.1.26 PRENATAL AND MATERNITY SERVICES

NOTE: Due to the inability to predict admission, you or your Practitioner and/or Provider are encouraged to notify us of your expected due date when the pregnancy is confirmed. You are also encouraged to notify us of the date of scheduled C-sections when it is confirmed. The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of 48 hours for a vaginal delivery or of up to 96 hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner and/or Provider, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Practitioners and/or Providers competent in postpartum care and newborn assessments.

All pre or post-natal care falling outside the routine care limits below will be covered per applicable cost sharing based on a Member's Plan. Routine prenatal care (as outlined below) will be covered at 100%:

- Anemia screening
- Bacteruria (bacteria in urine) screening
- Genetic counseling or testing that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. *This is considered an Outpatient Service that requires Preauthorization/Prior Approval.*
- Hepatitis B screening
- Outpatient Nutrition Care Services available for gestational diabetes and diabetes mellitus. See *Wellness Nutritional Counseling* in this Section.
- Preeclampsia prevention
  Prenatal vitamins without Cost Sharing if prescribed by a Practitioner
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Screening for gestational diabetes mellitus during pregnancy
- Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.

Maternity care includes prenatal through postnatal maternity care and delivery and care for complication of pregnancy of mother. We cover up to four (4) routine ultrasounds per pregnancy to determine fetal age, size, and development, per plan guidelines.

Breastfeeding support, supplies and counseling are covered in the following manner:

- Sanford Health Plan will allow one breast pump (electric or manual, non-Hospital grade) per pregnancy.
- Breast pump replacement supplies, including tubing, adapters, locking rings, breast shields, splash protectors, and breast pump bottles and caps, are covered.
- Breast milk storage bags are covered.
- Bottles which are not specific to breast pump operation and all associated supplies are NOT covered.
- Pumps and supplies are covered only when obtained from a Sanford Health Plan Participating durable medical equipment Provider. This does NOT include drugstores or department stores.

In addition to pumps, consultation with a lactation (breastfeeding) specialist is also covered.

Healthy Pregnancy Program-Details

The *Healthy Pregnancy Program* is designed to provide you with the tools and support you need to give your baby the healthiest start possible. Participation in the *Healthy Pregnancy Program* is voluntary and free to all Plan Members.

As a program participant, you will receive

- Educational information on pregnancy, childbirth and postpartum
- Access to Text4baby, a tool to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more
- Deductible waiver*
- Free prenatal vitamins
- Access to RN case manager to answer questions

After your first prenatal visit, Members may enroll in Sanford Health Plan's Healthy Pregnancy program starting their 8th week of pregnancy, but no later than the 34th week at sanfordhealthplan.com/ndpers/healthy-pregnancy-program. Members will need their Member number, health care provider name, and expected due date. If you have questions, please contact our care management team Monday through Friday from 8 a.m. to 5 p.m. CST at (888) 315-0884 (TTY: 711).

***Note:** When a Member is enrolled under the Healthy Pregnancy Program, the deductible Amount is waived for delivery services received from a PPO Health Care Provider. High Deductible Health Plan members may enroll in the program but will not receive the deductible waiver benefit.

Newborns' and Mothers' Health Protection Act Disclosure

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours for a vaginal delivery to a minimum of ninety-six (96) hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by a Participating Practitioner and/or Providers competent in postpartum care and newborn assessments within forty-eight (48) hours after discharge to verify the condition of the mother and newborn. If such an inpatient stay lasts longer than the minimum required hours, Sanford Health Plan will not set the level of benefits or out-of-pocket costs so that the later portion of the stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

3.1.27 PREVENTIVE CARE, ADULTS & CHILDREN

The following preventive services, received from In-Network Participating Practitioner and/or Provider are covered without payment of any deductible or coinsurance requirement that would otherwise apply:

- 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 (USPSTF); except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009. Which includes;
    - One baseline mammogram for women who are at least thirty-five (35) years of age but less than forty (40) years of age, and one mammogram every year, or more frequently if ordered by a physician, for women who are at least forty (40) years of age;
    - One prostate screening for asymptomatic men aged fifty (50) and over, African American men aged forty (40) and over, and men aged forty (40) and over with a family history of prostate cancer.

- Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
- With respect to covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to covered persons who are women, such additional preventive care and screenings not described in paragraph (1) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. You do not need prior authorization from Sanford Health Plan or any other person in order to obtain access to obstetrical and/or gynecological care through an In-Network Participating Practitioner and/or Provider.

The above is an overview of preventive services covered by Sanford Health Plan. As recommendations change, your coverage may also change. To view Sanford Health Plan's Preventive Health Guidelines, visit www.sanfordhealthplan.com/memberlogin. You may also request a copy by calling Customer Service.

3.1.28 PRIVATE DUTY NURSING

Note: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

Private duty nursing is nursing care that is provided to a Member on a one-on-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled service are already being provided.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a home health agency on a per visit basis for a specific purpose.
- The service is provided to a covered person by an independent nurse who is hired directly by the covered person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

3.1.29 TELEHEALTH SERVICES (VIRTUAL VISITS)

Services for telehealth are covered when the following conditions are met:

- The encounter involves a qualifying CPT (Current Procedural Terminology) code that the Health Plan has approved to be conducted by telehealth.
- The services are medically necessary and meet the definition of Covered Health Services as described in this Plan document.
- The technology platform used for the encounter is HIPAA (Health Insurance Portability and Accountability Act) compliant.
- The technology platform used for the encounter allows for fully synchronous, real-time, audio-video connection between the patient and the provider for the duration of the encounter.
- If the patient is physically present with one provider (host location) and is being connected to a remote (distant) provider, charges by the host provider as an originating site to facilitate the connection with the distant provider performing the service are also eligible for coverage, as well as the qualifying

charges from the distant provider for conducting the telehealth encounter.

These services shall be available only when services are provided by Participating Providers. Cost share may be subject to applicable Deductible and/or Cost Sharing Amounts and vary based on platform used to complete the visit. For more information, please refer to the Virtual Care Policy at sanfordhealthplan.com.

3.1.30 TOBACCO CESSATION TREATMENT BENEFITS

Tobacco cessation treatment coverage is as follows:

- 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 an In-Network provider are covered without payment of any Deductible or Coinsurance requirement that would otherwise apply.
- Tobacco cessation treatment includes:
    - Screening for tobacco use; and
    - At least two (2) tobacco cessation attempts per year (for Members who use tobacco products).
        - Covering a cessation attempt is defined to include coverage for:
            - Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and
            - One ninety (90) day treatment regimen of 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 without prior authorization.

3.1.31 WELLNESS NUTRITIONAL COUNSELING SERVICES

Wellness nutritional counseling services coverage is as follows:

Benefits are available for the following medical conditions:

- **Diabetes Mellitus** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Gestational Diabetes** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Hyperlipidemia** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Hypertension** – Maximum Benefit Allowance of two (2) Office Visits per Member per Benefit Period.
- **Obesity** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period

3.2 SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

Here are some important things you should keep in mind about these benefits:

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Policy and are payable only when we determine they are Medically Necessary.*
- *In-Network Participating Practitioner and/or Providers must provide or arrange your care and you must be hospitalized in a Network Facility.*
- *Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3.4).*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES.*

3.2.1 ADMISSIONS

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits.

The following Hospital Services are covered:

- Room and board
- Critical care services
- Use of the operating room and related facilities
- General Nursing Services, including special duty Nursing Services if approved by the Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the United States Pharmacopoeia.
- Special diets during Hospitalization, when specifically ordered
- Other services, supplies, biologicals, drugs and medicines prescribed by a Practitioner and/or Provider during Hospitalization

NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital up to 48 hours after the procedure.

3.2.2 ANESTHESIA

SHP covers services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized/approved procedure or treatment.

3.2.3 HOSPICE CARE

- A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, when the following circumstances apply:
    - The Member has been diagnosed with a terminal disease and has a life expectancy of six (6) months or less;

- The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);and
- The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Chief Medical Officer over the course of hospice care.

- The following Hospice Services are Covered Services:
  - Admission to a hospice Facility, Hospital, or Skilled Nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
  - In-home hospice care per Plan guidelines (available upon request)
  - Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for Member care up to eight (8) hours per day
  - Social services under the direction of an In-Network Participating Practitioner and/or Provider
  - Psychological and dietary counseling
  - Physical or occupational therapy, as described under Section 3.1
  - Consultation and Case Management services by an In-Network Participating Practitioner and/or Provider
  - Medical supplies, DME and drugs prescribed by an In-Network Participating Practitioner and/or Provider Expenses for In-Network Participating Practitioner and/or Providers for consultant or Case Management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of coverage for these services as listed in Section 3.1, but only where the hospice retains responsibility for the care of the Member

3.2.4 ORAL AND MAXILLOFACIAL SURGERY

NOTE: Some services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*.
  1. Care must be received within *twelve* (12) months of the occurrence
  2. Associated radiology services are included
  3. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
  4. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Orthognathic Surgery per Sanford Health Plan guidelines. *This is an Outpatient Surgery that requires Certification*
  1. Associated radiology services are included
  2. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
  3. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  1. Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  2. Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  3. TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
     - Splint limited to one (1) per Member per benefit period.
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity

defined by Sanford Health Plan's Medical coverage guidelines

- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    1. is a child age nine (9) or older- *(Certification is not required for children under 9)*; or
    2. is severely disabled or otherwise suffers from a developmental disability; or
    3. has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

    Note: For more information on Dental Services, see Section 3.

3.2.5 OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)
Health Care Services furnished in connection with a surgical procedure performed at an In-Network Participating Surgical Center include:

- Outpatient Hospital surgical center
- Outpatient Hospital services such as diagnostic tests
- Ambulatory Surgical Center (same day surgery)

3.2.6 RECONSTRUCTIVE SURGERY

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Surgery to restore bodily function or correct a deformity caused by illness or injury
- If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Coverage for mastectomy related benefits will be provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. **For single mastectomy:** coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see *Orthotic and Prosthetic devices* in this Section). Deductible and Coinsurance applies as outlined in your Summary of Benefits and Coverage.

3.2.7 SKILLED NURSING CARE FACILITY BENEFITS

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- Skilled Nursing Facility Services are covered if approved by the Plan in lieu of continued or anticipated Hospitalization. The following Skilled Nursing Facility Services are covered when provided through a state-licensed nursing Facility or program:
    1. Skilled nursing care, whether provided in an inpatient skilled nursing unit, a Skilled Nursing Facility, or a subacute (swing bed) Facility
    2. Room and board in a skilled nursing Facility
    3. Special diets in a Skilled Nursing Facility, if specifically ordered

Skilled nursing care in a Hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or Facility within a thirty-mile (30) radius of the Hospital.

3.2.8 TRANSPLANT SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

To be eligible for coverage, Transplants must meet United Network for Organ Sharing (UNOS) criteria and/or Sanford Health Plan Medical Criteria. Transplants must be performed at contracted Centers of Excellence or otherwise identified and accepted by Sanford Health Plan as qualified facilities.

Coverage is provided for transplants according to our medical coverage guidelines (available upon request) for the following services:

- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Drugs (including immunosuppressive drugs)
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan or other coverage arrangement
- Organ acquisition costs including:
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
- Post-transplant care and treatment
- Pre-operative care
- Psychological testing

- Second Opinions
    - SHP will notify the Member if a second opinion is required at any time during the determination of benefits period. If a Member is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second transplant facility for evaluation. If the second facility determines, for any reason, that the Member is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Member for the procedure.
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Supplies (must be Prior Authorized)
- Transplant procedure, Facility and professional fees

3.3 EMERGENCY SERVICES/ACCIDENTS

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.

3.3.1 BENEFIT DESCRIPTION

What is an Emergency Medical Condition?
An Emergency Medical Condition is the sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

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

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

If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to an urgent care or after-hours clinic.

We cover worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

3.3.2 EMERGENCY WITHIN OUR SERVICE AREA

Emergency services from Basic Plan-level Providers will be covered at the same benefit and Cost Sharing level as services provided by PPO-level Providers both within and outside of the Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. If the Plan determines the condition did not meet Prudent Layperson definition of an emergency, then the Basic Plan-level cost-sharing amounts will apply and the Member is responsible for charges above the Maximum Allowed Amount.

If an Emergency Condition arises, Members should proceed to the nearest emergency Facility that is an In-Network Participating Practitioner and/or Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency Facility, then the Member should seek care at the nearest emergency Facility. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

The Practitioner and/or Provider must notify the Plan and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.

3.3.3 PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize Members without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.4 NON- PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize a Member and may not require Prospective (Pre-Service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Emergency, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

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

3.3.5 EMERGENCY OUTSIDE OUR SERVICE AREA

If an Emergency occurs when traveling outside of the Service Area, Members should go to the nearest emergency Facility to receive care. The Member or a designated relative or friend must notify us and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.
Coverage will be provided for Emergency Medical Conditions outside of the Service Area unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

3.3.6 URGENT CARE SITUATION

Treatment provided in Urgent Care Situations from Basic Plan-level Providers will be covered at the same benefit and cost sharing level as services provided by PPO-level Providers both within and outside of the

Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the condition did not meet Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, and the Member is responsible for charges above the Maximum Allowed Amount.

If an **Urgent Care Situation** occurs, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Member should contact the Plan and follow the Plan's instructions. A Member may always go directly to a participating urgent care or after-hours clinic. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

3.3.7 PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.8 NON- PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval requirements if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Urgent Care Situation, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

3.3.9 AMBULANCE AND TRANSPORTATION SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

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

1. Medically Necessary; and
2. To the nearest In-Network Participating Practitioner and/or Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Here are some important things to keep in mind about these benefits:

- *All benefits are subject to the definitions, limitations, and exclusions in this Certificate of* Insurance *and are payable only when we determine they are Medically Necessary.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES. See the benefits description below.*

3.4.1 MENTAL HEALTH BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to Sanford Health Plan's mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate cost sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

Coverage is provided for mental health conditions which current prevailing medical consensus affirms substantially impairs perception, cognitive function, judgment, and/or emotional stability, and limits the life activities of the person with the condition(s). This includes but is not limited to the following conditions: schizophrenia; schizoaffective disorders; bipolar disorder; major depressive disorders (single episode or recurrent); obsessive-compulsive disorders; attention-deficit/hyperactivity disorder; autism spectrum disorders; post-traumatic stress disorders (acute, chronic, or with delayed onset); and anxiety disorders that cause significant impairment of function.

Mental health benefits are covered with the same Cost Sharing and restrictions as other medical/surgical benefits under the Contract. Coverage for mental health conditions includes:

- Diagnostic tests
- Electroconvulsive therapy (ECT)
- Inpatient services, including Hospitalizations
- Intensive Outpatient Programs
- Medication management
- Outpatient Professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health professionals
- Partial Hospitalization

If you are having difficulty obtaining an appointment with a mental health practitioner and/or Provider, or for mental health needs or assessment services by phone, call the Sanford USD Medical Center Triage Line toll-free at (888) 996-4673.

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Applied Behavior Analysis (ABA) is a covered service for the treatment of Members diagnosed with Autism Spectrum Disorder.

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits.

- Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
- ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
- ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
- Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
- Limits are subject to the Plan's medical management policies and determinations of Medical Necessity.

3.4.3 SUBSTANCE USE DISORDER BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate Cost Sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD).

Substance use disorder benefits are covered with the same Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for substance use disorders includes:

1. Addiction treatment, including for alcohol, drug-dependence, and gambling issues
2. Inpatient services, including Hospitalization
3. Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, Licensed Chemical Dependency Counselors, or other qualified mental health and substance use disorder treatment professionals
4. Partial Hospitalization
5. Intensive Outpatient Programs

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.com/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

Here are some important things to keep in mind about these benefits:

- *Always refer to your Summary of Benefits (SBC), Formulary and other plan documents for specific details on your coverage.*
- *SHP covers prescribed drugs and medications, as described in this Section and in your Summary of Benefits/Formulary documents.*
- *All benefits are subject to definitions, limitations and exclusions listed in this document and are only payable when considered Medically Necessary.*
- *You must receive prior approval (authorization) for some medications. See the Summary of Benefits and Formulary for information.*

Refer to the Introduction section at the beginning of this document for instructions on how to contact Pharmacy Management.

3.5.1 BENEFIT DESCRIPTION

You must fill the prescription at a Plan Participating pharmacy for Cost Sharing amounts to apply. A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims from a Participating Pharmacy must be submitted by the Participating Pharmacy. A listing of the Plan's Participating pharmacies is available by contacting the Plan or online at sanfordhealthplan.com/ndpers. Specialty pharmacy options include any in network pharmacy, there is no specialty pharmacy requirement. If a Member receives Prescription Medications from a Non-Participating Pharmacy, the Member is responsible for submitting a Claim for Benefits. Charges in excess of the Allowed Charge are the Member's responsibility.

- To fill a prescription, you must present your ID card to your pharmacy, if you do not, you will be responsible for all (100%) of the costs of the prescription to the pharmacy. Additionally, if you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.

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

- Sanford Health Plan uses a formulary: a list of prescription drug products, which are covered by the Plan for dispensing to Members when appropriate. The formulary will be reviewed regularly, and medications may be added or removed from the Formulary throughout the year. The Plan will notify you of the changes as they occur. For a copy of the Plan Formulary, contact Pharmacy Management or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- Sanford Health Plan reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per Plan medical necessity and limitation guidelines. Payment for excluded medications will be the Member's responsibility in full. Members may request an appeal

(review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this Certificate of Insurance.

- Sanford Health Plan will use appropriate Pharmacists and Practitioner and/or Providers to review formulary exception requests and promptly grant an exception to the formulary for a Member when that the prescriber indicates:
  - the Formulary drug causes an adverse reaction in the Member;
  - the Formulary drug is contraindicated for the Member; or
  - the prescription drug must be dispensed as written to provide maximum medical benefit to the Member.
- **NOTE**: To request a Formulary exception, please call Pharmacy Management or send a request by logging into the provider portal at www.sanfordhealthplan.com/memberlogin.
  - Members must first try formulary medications before an exception to the formulary will be made unless the prescriber and the plan determine that use of the formulary drug may cause an adverse reaction or be contraindicated for the Member. If an exception is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.
- With certain medications, the Plan requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization (pre-approval) Review. Request Prior Authorization by contacting Pharmacy Management. Refer to the Formulary for a complete list of medications that require step therapy.
- To be covered by the Plan, certain medications require prior authorization (pre-approval) to ensure medical necessity. This can be in the form of written or verbal certification by a prescriber. To request certification, contact Pharmacy Management. Refer to the formulary for a complete list of medications that require Prior Authorization.
- Certain medications have a quantity limit to ensure the medication is being used as prescribed and the member is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your formulary for a complete list of medications with quantity limits.

There are dispensing limitations.

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

- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.
- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic equivalent or biosimilar alternative, in addition to applicable cost sharing (deductible and coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.

- Specialty medications can be filled up to a 30-day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan.
- For participants enrolled in a High Deductible Health Plan, the prescription drug benefit is subject to your deductible and coinsurance amounts.

3.5.2 COVERED MEDICATIONS AND SUPPLIES

To be covered by the Plan, prescriptions must be:

a. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
b. Listed in the Plan Formulary, unless certification (authorization) is given by the Plan;
c. Provided by an In-Network Participating Pharmacy except in the event of urgent or emergent medical situations (if a prescription is filled at a Non-Participating and/or Out-of-Network Pharmacy in non-urgent or emergent medication situations, the Member will be responsible for the cost of the prescription medication in full.);
d. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

3.5.3 COVERED TYPES OF PRESCRIPTIONS

1. Federal Legend Drugs. Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to applicable laws and regulations.
2. Self-Administered medications- medications such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a Network Pharmacy
3. Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations
4. Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
5. Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, continuous glucose monitor receiver, diabetic needles and syringes are covered when medically necessary. (See section 3.1 for Diabetic supplies, equipment, and self-management training benefits.)
6. Generic oral contraceptives, injections and/or devices will be covered by the Plan at 100% (no charge)
7. The following preventive medications/supplies are covered at 100% (no charge) with a written prescription order:
    - Folic Acid Supplements for women planning to become pregnant or in their childbearing years
    - Vitamin D Supplements for Members ages 65 and older at risk for falls
    - Formulary breast cancer preventive medications for women at increased risk for breast cancer

3.6 DENTAL BENEFITS

Here are some important things to keep in mind about these benefits:

1. *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of* Insurance *and are payable only when we determine they are Medically Necessary.*
2. *We cover Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the Member. See Section 3.2 for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.*
3. *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
4. *YOU MUST GET CERTIFICATION OF THESE SERVICES.*

3.6.1 BENEFIT DESCRIPTION

NOTE: The following benefits are Outpatient Surgeries, Services, or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. See Prospective (Pre-Services) Review of Services (Certification Prior Authorization) in Section 2.

1. Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
   - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
   - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
   - Associated radiology services are included

   "Injury" does not include injuries to Natural Teeth caused by biting or chewing
2. Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
   a. Services for the Treatment and Diagnosis of TMJ/TMD subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
   b. Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers and is Medically Necessary pursuant to Sanford Health Plan's medical coverage guidelines.
   c. TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
      - Splint limited to one (1) per Member per benefit period.
3. Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
4. Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service that requires Certification.*
   - is a child under age nine (9); or
   - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or
   - has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

Coverage applies regardless of whether the services are provided in a Hospital or a dental office

Coverage applies to stabilization related to accident or injury only and not restoration.

3.6.2 PEDIATRIC (CHILD) DENTAL CARE

Not covered

3.7 SCHEDULE OF BENEFITS

3.7.1 GENERAL

This section outlines the payment provisions for Covered Services described in Sections 3 and 5, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

3.7.2 OVERVIEW OF COST SHARING AMOUNTS AND HOW THEY ACCUMULATE

Cost Sharing Amounts include Coinsurance, Deductibles, Prescription Drug Coinsurance Maximum, Infertility Services Deductible and Out-of-Pocket Maximum Amounts. See *Cost Sharing Amounts – Details & Definitions* later in this Section for more information.

NOTE:

- A Member must meet the annual Deductible Amount before Coinsurance Amounts apply to the cost of Covered Services, unless otherwise specified in this Certificate of Insurance and/or the Member's Summary of Benefits and Coverage (SBC).
- The Deductible Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, accumulate jointly up to the PPO Deductible Amount.
- The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, accumulate jointly up to the PPO Out-of-Pocket Maximum Amount.
- When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge
- Covered Services sought on a Basic Plan basis will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.
- Prescription Medication/Coinsurance costs accumulate toward a Member's cumulative annual Out-of-Pocket Maximum.

A Member is responsible for Cost Sharing Amounts. All Members in the family contribute to Deductible and Coinsurance Amounts. Health Care Providers may bill you directly or request payment of Coinsurance, and Deductible Amounts at the time services are provided. For the specific benefits and limitations that apply to this Plan, please see Section 3.8, *Outline of Covered Services*; Section 3, *Covered Services*; Section 4, *Limited and Non-Covered Services*; and your Summary of Benefits and Coverage.

If Sanford Health Plan pays amounts to the Health Care Provider that are the Member's responsibility, such as Deductibles or Coinsurance Amounts, Sanford Health Plan may collect such amounts directly from the Member. The Member agrees that Sanford Health Plan has the right to collect such amounts from the Member.

3.7.3 BENEFIT SCHEDULE

Benefit Schedule	PPO Plan	Basic Plan
Under this Benefit Plan the Medical Deductible Amounts are:		
Single Coverage	$2,000 per Benefit Period	$2,000 per Benefit Period
Family Coverage	$4,000 per Benefit Period	$4,000 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$1,500 per Benefit Period	$2,000 per Benefit Period
Family Coverage	$3,000 per Benefit Period	$4,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$3,500 per Benefit Period	$4,000 per Benefit Period
Family Coverage	$7,000 per Benefit Period	$8,000 per Benefit Period

The benefit payment available under this Benefit Plan differs depending on the Subscriber's choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with Sanford Health Plan. Providers that are contracted with Sanford Health Plan, and participate in the Plan's Network, will be paid at either the PPO Plan or Basic Plan level.

Members should refer to the Sanford Health Plan website (sanfordhealthplan.com/ndpers) for the Provider Directory, which lists Participating Health Care Providers. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Health Care Providers. Members may also call Customer Service to request a provider directory.

3.7.4 HOW PPO VS. BASIC PLAN DETERMINES BENEFIT PAYMENT

PPO Plan

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

Note: Benefits for Covered Services received by Eligible Dependents, as outlined in Section 2, *Eligibility Requirements for Dependents*, who are residing out of the state of North Dakota will be paid at the Basic Plan level. If the Subscriber, or the Subscriber's spouse, is required by court order to provide health coverage for that Eligible Dependent, you may be asked to provide a copy of the court order to the Plan.

Basic Plan

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

3.7.5 PARTICIPATING HEALTH CARE PROVIDERS

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

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

Participating Health Care Providers have also agreed to perform managed benefits requirements on behalf of the Member. If the Health Care Provider is a Participating Health Care Provider (either at the PPO or Basic Plan level by contracted "participation agreement" with Sanford Health Plan), the benefit payment will be as indicated in the Outline of Covered Services and the Member's Summary of Benefits and Coverage (SBC).

3.7.6 NON-PARTICIPATING HEALTH CARE PROVIDERS

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

3.7.7 NON-PARTICIPATING HEALTH CARE PROVIDERS WITHIN THE STATE OF NORTH DAKOTA

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

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

Benefit payments will be made directly to the Provider for Covered Services received from a Non-Participating Health Care Provider. Sanford Health Plan may designate a Health Care Provider as Non-Payable.

3.7.8 NON-PARTICIPATING HEALTH CARE PROVIDERS OUTSIDE THE STATE OF NORTH DAKOTA

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

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

If a Member receives Covered Services from a Health Care Provider in a county contiguous to North Dakota,

the benefit payment will be provided on the same basis as a Health Care Provider located in the state of North Dakota. If the Health Care Provider is a Participating Health Care Provider, the benefit payment will be as indicated in the Outline of Covered Services and SBC. If the Health Care Provider is not a Participating Health Care Provider, benefits will be available at the same level as Non-Participating Health Care Providers within the state of North Dakota. Sanford Health Plan may designate a Health Care Provider as Non-Payable.

3.7.9 NON-PARTICIPATING PROVIDERS OUTSIDE THE SANFORD HEALTH PLAN SERVICE AREA

When Covered Services are provided outside of Sanford Health Plan's Service Area by health care providers who have not entered into a "participating agreement" with Sanford Health Plan (Non-Participating Health Care Providers), the amount the Member pays for such services will generally be based on either Sanford Health Plan's Non-Participating Health Care Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

In certain situations, Sanford Health Plan may use other payment bases, such as the payment Sanford Health Plan would make if the Covered Services had been obtained within the Sanford Health Plan Service Area, or a special negotiated payment, as permitted, to determine the amount Sanford Health Plan will pay for Covered Services provided by Non-Participating Health Care Providers. In these situations, a Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

3.7.10 HEALTH CARE PROVIDERS OUTSIDE THE UNITED STATES

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

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

3.7.11 NON-PAYABLE HEALTH CARE PROVIDERS

If Sanford Health Plan designates a Health Care Provider as *Non-Payable*, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the *Non-Payable Health Care Provider*. Notice of designation as a Non-Payable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Non-Payable Health Care Provider.

As of the date of termination, all charges incurred by a Member for services received from the Non-Payable Health Care Provider will be the Subscriber's responsibility.

3.7.12 MEDICARE PRIVATE CONTRACTS

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services, and indicate that 1) neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider; and 2) the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge.

Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and Sanford Health Plan will limit its payment to the amount Sanford Health Plan would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by Sanford Health Plan.

3.7.13 COST SHARING AMOUNTS-DETAILS

A Cost Sharing Amount is the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance and Deductible Amounts. Applicable Cost Sharing Amounts are identified in Section 2 and the Member's Summary of Benefits and Coverage. See the schedule above in *Overview of Cost Sharing Amounts and how they accumulate* for the specific Cost Sharing Amounts that apply to this Benefit Plan.

3.7.14 COINSURANCE

Sanford Health Plan shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the Sanford Health Plan contracted provider network on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

If Covered Services are obtained by a Member out of the Sanford Health Plan contracted provider network, the coinsurance calculation may be based on the Health Care Provider's billed charges. This may result in a significantly higher Coinsurance Amount for certain services a Member incurs out of the Sanford Health Plan contracted provider network. It is not possible to provide specific information for each Health Care Provider outside of Sanford Health Plan's Service Area because of the many different arrangements between Health Care Providers. However, if a Member contacts Sanford Health Plan prior to receiving services from a Health

Care Provider outside of Sanford Health Plan's Service Area, Sanford Health Plan may be able to provide information regarding specific Health Care Providers.

3.7.15 COINSURANCE MAXIMUM AMOUNTS

The cumulative Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amounts renew on January 1 of each consecutive Benefit Period.

3.7.16 DEDUCTIBLES

The Deductible Amounts renew on January 1 of each consecutive Benefit Period. A Member must meet the annual Deductible Amount before Coinsurance Amounts apply to the cost of Covered Services, unless otherwise specified in this Certificate of Insurance.

NOTE: The deductible amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Deductible Amount.

3.7.17 OUT OF POCKET MAXIMUM AMOUNTS

When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services. The Out-of-Pocket Maximum Amounts renew on January 1 of each consecutive Benefit Period.

NOTE: The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider, or under the Basic Plan, cross accumulate jointly to the PPO Out-of-Pocket Maximum Amount.

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

3.7.18 PRESCRIPTION MEDICATIONS AND COINSURANCE

A Member must meet the Annual Deductible before Coinsurance Amounts will apply to prescription medications. When the Out-of-Pocket Maximum Amount that is a Member's responsibility during a Benefit Period is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications. This Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.

NOTE: Prescription Medication Coinsurance Amounts accumulate toward a Member's cumulative annual Out-of-Pocket Maximum. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.

3.7.19 INFERTILITY SERVICES COINSURANCE/DEDUCTIBLE

Any Member-paid coinsurance costs for infertility services do not apply toward annual Out-of-Pocket Maximum Amounts. Infertility services are limited to a lifetime benefit maximum, per Member, of $20,000.

3.8 OUTLINE OF COVERED SERVICES

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Inpatient Hospital and Medical Services		
• **Inpatient Hospital Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Medical Care Visits**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Consultations**	80% of Allowed Charge.	75% of Allowed Charge.
• **Concurrent Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Initial Newborn Care**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
Inpatient and Outpatient Surgical Services		
• **Professional Health Care Provider Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Assistant Surgeon Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ambulatory Surgical Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospital Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Anesthesia Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Outpatient Sterilization Procedures for Females**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Transplant Services		
• **Inpatient and Outpatient Hospital and Medical Services**	80% of Allowed Charge *when Preauthorization/Prior Approval is received from Sanford Health Plan.*	75% of Allowed Charge *when Preauthorization/Prior Approval is received from Sanford Health Plan.*
• **Transportation Services**	80% of Allowed Charge.	75% of Allowed Charge.
	Maximum Benefit Allowance of $1,000 per transplant procedure.	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Dental Services		
• **Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment**	80% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.*	75% of Allowed Charge.
• **Dental Services Related to Accidental Injury**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dental Anesthesia and Hospitalization**	80% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*	75% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*
Outpatient Hospital and Medical Services		
• **Home and Office Visits**	80% of Allowed Charge.	75% of Allowed Charge.
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Emergency Services**	80% coinsurance applies for emergency room facility fee billed by a Hospital. 80% coinsurance applies for office or emergency room visit billed by a Professional Health Care Provider. 80% coinsurance applies for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% coinsurance applies for emergency room facility fee billed by a Hospital. 80% coinsurance applies for office or emergency room visit billed by a Professional Health Care Provider. 80% coinsurance applies for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.
• **Ambulance Services**	80% of Allowed Charge.	80% of Allowed Charge.
• **Radiation Therapy and Chemotherapy**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dialysis Treatment**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Infusion Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Allergy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Phenylketonuria (PKU)** - *Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)*	80% of Allowed Charge.	75% of Allowed Charge.
Wellness 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.	
• **Well Child Care to the Member's 18th birthday**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *Pediatric services based on guidelines supported by the HRSA, including recommendations by the American Academy of Pediatrics Bright Future pediatric schedule, and newborn metabolic screenings;* • *Pediatric services based on evidence-informed preventive care and screening guidelines supported by the HRSA;* • *Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Immunizations**	100% of Allowed Charge. *Deductible Amount is waived.* *Immunizations are provided and covered as recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) and by the Health Resources and Services Administration (HRSA), with respect to the Member involved.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Preventive Screening Services for Members ages 18 and older		
• **Routine Preventive Wellness (Physical) Examination** *Preauthorization is not required when using a participating provider. Your annual preventive services do not need to be scheduled 12 months apart You may have your preventive services one time per calendar year. For example, if your services were done July last year, it is okay to schedule them before July this year.*	100% of Allowed Charge. *Deductible Amount is waived.* *Office visit exam includes health advice and counseling on blood pressure, counseling and interventions on tobacco use, screening and counseling for alcohol use, sun exposure, screening for depression, obesity screening with referral for behavioral interventions for patients with a body mass index of 30 or higher and referrals to intensive behavioral counseling to promote a healthful diet and physical activity to decrease cardiovascular risk in adults that are overweight or obese and with cardiovascular disease risk factors. During the visit, you may receive immunizations and screenings based on your practitioner's recommendation.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Routine Diagnostic Screenings**	100% of Allowed Charge. *Deductible Amount is waived.* *Screenings include, but are not limited to the following:* • *Abdominal Aortic Aneurysm Screening; Lifetime Maximum Benefit Allowance of one (1) ultrasound screening per male Member ages 65 through 75 with a history of smoking* • *Anemia screening – Hemoglobin or Hematocrit (one or the other); one (1) per Member per year.* • *Basic Metabolic Panel; one (1) per Member per year.* • *Cholesterol Screening; coverage for frequency of Lipid Profile is dependent on Member age. Additional tests, such as comprehensive metabolic panels will be applied to your deductible/coinsurance.* • *Diabetes Screening; benefit allowance of one (1) per Member per year.* • *Hepatitis B Virus infection screening.* • *Hepatitis C Virus (HCV) infection screening; Lifetime Maximum Benefit Allowance of either: one (1) screening for Members born between 1945-1965; or one (1) screening for Members at risk.* • *Lung Cancer Screening; benefit allowance of one (1) per Member ages 55 through 80 who: 1) have a 30 pack-year smoking history; 2) currently smoke; or 3) have quit smoking within the past 15 years.* • *Osteoporosis Screening for female Members ages 65 and older, or younger if at increased risk.* • *Sexually Transmitted Disease (STD) Screening; one (1) per Member per year.* • *Genetic counseling and evaluation for BRCA Testing and BRCA lab screening for female members with a family history (breast, ovarian, tubal, or peritoneal cancer) associated with increased risk for harmful mutation in BRC or BRC. Lifetime Maximum Benefit Allowance of one (1) screening per Member.* *For a complete listing, see the Preventive Health Guidelines for Members by signing into your account at sanfordhealthplan.com/memberlogin or call (800) 499-3416 to request a copy. As these recommendations change, your coverage may also change.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Mammography Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	• *One (1) service for Members between the ages of 35 and 40.* • *One (1) service per year for Members age 40 and older.* • *Additional mammograms will be covered if recommended by a physician per N.D.C.C. §26.1-36-09.1.*	
• **Cervical Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period. Includes Office Visit.	
• **Colorectal Cancer Screening for Members ages 45 and older**	***Note:*** *Expenses incurred for tissue samples taken during a screening and sent for evaluation or colonoscopies due to a medical condition will be applied to your deductible/coinsurance.*	
➢ Fecal Occult Blood Test; *or*	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Maximum Benefit Allowance of one (1) test per Member per year.	
➢ Colonoscopy; *or*	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Maximum Benefit Allowance of one (1) test per Member every 10 years.	
➢ Sigmoidoscopy	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Maximum Benefit Allowance of one (1) test per Member every 5 years.	
• **Prostate Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of African American descent; and a male age 40 with a family history of prostate cancer. Includes Office Visit.	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Nutritional Counseling**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	• *Hyperlipidemia – Maximum of four (4) visits per Member per year.* • *Gestational Diabetes – Maximum of four (4) visits per Member per year.* • *Diabetes Mellitus – Maximum of four (4) visits per Member per year.* • *Hypertension – Maximum of two (2) visits per Member per year.* • *Obesity – Maximum of four (4) visits per Member per year.*	
• **Aspirin to prevent cardiovascular disease**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Benefit is available for Male Members ages 45 through 79, and female Members ages 55 through 79 at risk for developing cardiovascular disease.	
The preventive care benefits listed above provide a brief overview. For a detailed list of covered services, view the Plan's Preventive Health Guidelines by signing into your account at sanfordhealthplan.com/memberlogin.		
• **Outpatient Nutritional Care Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions: • *Chronic Renal Failure – Four (4) Office Visits per Member per year.* • *Anorexia Nervosa – Four (4) Office Visits per Member per year.* • *Bulimia – Four (4) Office Visits per Member per year.* • *PKU – Four (4) Office Visits per Member per year.*	
• **Diabetes Education Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Dilated Eye Examination** *(for diabetes related diagnosis)*	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Tobacco Cessation Services**	*Tobacco Cessation services include screening for tobacco use and at least two (2) tobacco cessation attempts per year (for Members who use tobacco products).* *Covering a cessation attempt is defined to include coverage for:* • *Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without Preauthorization/Prior Approval; 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 without Preauthorization/Prior Approval.*	
Outpatient Therapy Services Only the Office Visit Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.		
• **Physical Therapy**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Respiratory Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Cardiac Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions:* • *Myocardial Infarction* • *Coronary Artery Bypass Surgery* • *Coronary Angioplasty and Stenting* • *Heart Valve Surgery* • *Heart Transplant Surgery* *Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Pulmonary Rehabilitation Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Physical Therapy for Members age 65 and older at risk for falls**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefit subject to Medical Necessity*	100% of Allowed Charge. *Deductible Amount is waived.*
Chiropractic Services	Only the Office Visit Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.	
• **Home and Office Visits**	80% of Allowed Charge.	75% of Allowed Charge.
• **Therapy and Manipulations**	80% of Allowed Charge.	75% of Allowed Charge.
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
Maternity Services	The Deductible Amount is waived for delivery services received from a PPO Health Care Provider when the Member is enrolled in the *Healthy Pregnancy* Program.	
• **Inpatient Hospital and Medical Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Routine Prenatal and Postnatal Care**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **One (1) Prenatal Nutritional Counseling visit per pregnancy**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Lactation Counseling**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Infertility Services		
• **Diagnostics, Treatment, Office Visits, and Other Services**	80% of Allowed Charge. *Benefits are subject to a $20,000 Lifetime Benefit Maximum Amount per Member. Any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.*	80% of Allowed Charge.
Contraceptive Services		
• **Diagnostics, Treatment, Office Visits, and Other Services**	100% of Allowed Charge. *Deductible Amount is waived.* *Prescription contraceptive services, obtainable with a Prescription Order, are paid under the Prescription Drug benefit. See Section 3.5.*	100% of Allowed Charge. *Deductible Amount is waived.*
Mental Health and Substance Use Disorder Treatment Services		
• **Mental Health Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of the Allowed Charge (includes Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period. Coverage of the first five (5) hours will not apply when you elect an HSA.*	
Office Visits	80% of Allowed Charge.	75% of Allowed Charge.
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge.	80% of Allowed Charge.
Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of the Allowed Charge (includes Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period. Coverage of the first five (5) hours will not apply when you elect an HSA.*	
Office Visits	80% of Allowed Charge.	75% of Allowed Charge.
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge.	80% of Allowed Charge.
Other Services Not Previously Listed Above		
• **Skilled Nursing Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Health Care Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospice Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Private Duty Nursing Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Medical Supplies and Equipment** - Home Medical Equipment - Prosthetic Appliances and Limbs - Orthotic Devices - Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Prescription Drug Benefit (See Section 3.5) - Oxygen Equipment and Supplies - Ostomy Supplies - External Hearing aids	80% of Allowed Charge. *Limited to one hearing aid, per ear, per Member every 3 years in alignment with Medical Necessity and Sanford Health Plan guidelines..*	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Breast Pumps**	100% of Allowed Charge. *Deductible Amount is waived. Benefits are available for the rental or purchase of 1 breast pump per pregnancy. Supplies also covered; see Section 3.*	100% of Allowed Charge. *Deductible Amount is waived. Benefits are available for the rental or purchase of 1 breast pump per pregnancy. Supplies also covered; see Section 3.*
• **Eyeglasses or Contact Lenses** *(following a covered cataract surgery)*	80% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.*	75% of Allowed Charge.
Prescription Drug and Diabetes Supplies Benefits		
Retail and Mail Order		
Insulin and medical supplies for insulin dosing and administration		
• **Insulin** Formulary and Non-Formulary	*Insulin only: Deductible amount is waived*	
1-30 day supply	$25 copayment	$25 copayment
31-60 day supply	$50 copayment	$50 copayment
61-100 day supply	$75 copayment	$75 copayment
• **Testing Supplies, Pen Needles and Syringes** Formulary and Non-Formulary		
1-30 day supply	Deductible then 20% coinsurance with maximum of $25	Deductible then 20% coinsurance with maximum of $25
31-60 day supply	Deductible then 20% coinsurance with maximum of $50	Deductible then 20% coinsurance with maximum of $50
61-100 day supply	Deductible then 20% coinsurance with maximum of $75	Deductible then 20% coinsurance with maximum of $75
Formulary Prescription Medication	80% of Allowed Charge	80% of Allowed Charge
Non-Formulary Prescription Medication	50% of Allowed Charge	50% of Allowed Charge

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
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.* If a Generic Prescription Medication is the therapeutic equivalent for a Brand Name Prescription Medication, and is authorized by a Member's Professional Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent, the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication and applicable Cost Sharing Amounts. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply. Cost Sharing Amounts are waived for generic federal legend prenatal vitamins when the member is enrolled in the Healthy Pregnancy program. Member will be responsible for copayment plus co-insurance for all brand name federal legend prenatal vitamins and generic federal legend vitamins, if not enrolled in the Healthy Pregnancy Program. For details, see Section 3. 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.* For details, see Section 3. 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.* For details, see Section 3. 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*. For details, see Section 3.		

SECTION 4
LIMITED AND NON-COVERED SERVICES

This section describes services that are subject to limitations or NOT covered under this Contract. The Plan is not responsible for payment of non-covered or excluded benefits.

4.1 GENERAL MEDICAL EXCLUSIONS

1. Acupuncture
2. Additional refractive procedure (including lens) after coverage of initial lens at time of cataract correction.)
3. Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider
4. Adult vision exams (routine)
5. Air conditioners, air filters, or other products to eradicate dust mites
6. All other hearing related supplies, purchases, examinations, testing or fittings not covered under this policy
7. Alternative treatment therapies including, but not limited to: acupressure, massage therapy unless covered per plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
8. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination
9. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Certificate of Insurance
10. Any expenses related to surrogate parenting, except if Surrogate is a covered Member under this Certificate of Insurance and seeking otherwise Covered Services
11. Any form of allergy testing and immunotherapy that is considered experimental or not FDA approved
12. Any fraudulently billed charges or services received under fraudulent circumstances
13. Any other equipment and/or supplies which the Plan determines not eligible for coverage
14. Any services or supplies for the treatment of obesity that do not meet Sanford Health Plan's coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling); nutritional supplements or food supplements; and weight loss or exercise programs
15. Appetite suppressants and supplies of a similar nature
16. Appointment scheduling
17. Artificial organs, any transplant or transplant services not listed above
18. Autopsies, unless the autopsy is at the request of The Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense.
19. Blood and blood derivatives replaced by the Member
20. Bifocal contact lenses
21. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by the Plan.
22. Charges for professional sign language and foreign language interpreter services unless required by state or federal law
23. Charges for sales tax, mailing, interest and delivery

24. Charges for services determined to be duplicate services
25. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations, unless otherwise stated in this Certificate of Insurance
26. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers
27. Chemical peel for acne
28. Chiropractic manipulations for allergies
29. Clarification of simple instructions
30. Cleaning and polishing of prosthetic eye(s)
31. Clinical ecology, orthomolecular therapy, vitamins (unless listed as covered elsewhere in this COI) or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.
32. Commodes and/or similar convenience items
33. Complications resulting from non-covered or denied Health Care Services.
34. Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
35. Consultative message exchanges with an individual who is seen in the provider's office following a video visit for the same condition, per Sanford Health Plan guidelines
36. Convalescent care
37. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services, body contouring procedures, and body lift procedures, with the exception of WHCRA for coverage related to breast cancer
38. Costs related to locating organ donors
39. Coverage beyond one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
40. Cryogenic or other preservation techniques used in such or similar procedures;
41. Custodial care
42. Custodial or convalescent care
43. Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (except as stated above and in Section 3 "Diabetes supplies, equipment, and education")
44. Daycare, Attendant, or Homemaker Services
45. Deluxe equipment
46. Dental appliances of any sort, including but not limited to those related to Sleep Apnea, bridges, braces, and retainers that are for cosmetic reasons and/or medically unnecessary
47. Dental care and treatment (routine or non-routine) for Members ages nineteen (19) and older including but not limited to:
    a. natural Teeth replacements including crowns, bridges, braces or implants;
    b. extraction of wisdom teeth;
    c. hospitalization for extraction of teeth;
    d. dental x-rays or dental appliances;
    e. shortening of the mandible or maxillae for cosmetic purposes;
    f. services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty; and

g. dental appliances of any sort, including but not limited to bridges, braces, and retainers, other than for treatment of TMJ/TMD
h. Osseointegrated implant surgery (dental implants)

48. Dental services not specifically listed as Covered by the Policy
49. Dental x-rays
50. Diet therapy (specialty foods) for allergies
51. Dietary desserts and snack items
52. Dietary surveillance and counseling
53. Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
54. Domiciliary care or Long-Term Residential Care
55. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of embryos, sperm, or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing
56. Donor expenses for complications of transplants that occur after sixty (60) days from the date the an organ is removed, regardless if the donor is covered as a Member under this Plan or not
57. Duplicate or similar items
58. Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests
59. Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)
60. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to,
    a. Education on self-care or home management
    b. Educational or non-medical services for learning disabilities
    c. Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services as provided under the Individuals with Disabilities Education Act (IDEA)
    d. Educational or non-medical services for learning disabilities or behavioral problems
61. Elective abortion services
62. Elective health services received outside of the United States
63. Expenses incurred by a Member as a donor, unless the recipient is also a Member
64. Experimental and Investigational Services not part of an Approved Clinical Trial unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
65. Extra care costs related to taking part in an Approved Clinical Trial such as additional tests that a Member may need as part of the trial, but not Routine Patient Costs.
66. Extraction of wisdom teeth
67. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as Covered elsewhere in this Certificate of Insurance
68. Fees associated with Room and Board, unless Prior Authorization is received pursuant to Medical Necessity guidelines
69. First aid or precautionary equipment such as standby portable oxygen units
70. Food items for medical nutrition therapy
71. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Insurance).
72. Formula and supplements available Over the Counter

73. Genetic counseling or testing except for services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; Preauthorization/Prior Approval is required)
74. Hair transplants or hair plugs
75. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires primary coverage for the same
76. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition
77. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition
78. Health Care Services ordered by a court or as a condition of parole or probation, unless applicable law requires the Plan to provide coverage for the same
79. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only In-Network Participating Practitioner and/or Provider in the area, the Member may be treated by that Provider provided they are acting within the scope of their practice. The Member may also go to a Non-Participating Provider and receive In-Network coverage (Section 2). If the immediate family member is not the only In-Network Participating Practitioner and/or Provider in the area, the Member must go to another In-Network Participating Practitioner and/or Provider in order to receive coverage at the In-Network level.
80. Health Care Services prohibited state or federal rule, law, or regulation
81. Health Care Services provided either before the effective date of the Member's coverage or after the Member's coverage is terminated.
82. Health Care Services received from a Non-Participating Provider, unless otherwise specified in this Contract.
83. Health Care Services required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation
84. Health Care Services that are the responsibility of a Third-Party Payor
85. Health Care Services that we determine are not Medically Necessary
86. Health services received outside of the United States that are not Medically Necessary emergency or urgent care services.
87. Home birth settings, related equipment and fees
88. Home delivered meals or laundry services
89. Home modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
90. Home Traction Units
91. Homeopathic treatment of allergies
92. Hospitalization for extraction of teeth that is not Medically Necessary
93. Hot/cold pack therapy including polar ice therapy and water circulating devices
94. Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
95. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
96. Hypnotism

97. Iatrogenic condition illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to Iatrogenic illness or injury are not the responsibility of the Member.
98. Independent nursing, homemaker services, respite care
99. Inpatient services provided at a Residential Treatment Facility if treatment is not provided at an acute level of care with 24-hour registered nursing care under the supervision of a Chief Medical Officer.
100. Installation or maintenance of any telecommunication devices or systems
101. Intermediate level or domiciliary care
102. Items which are primarily non-medical and educational in nature or for vocation, comfort, convenience or recreation
103. LASIK eye surgery
104. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics
105. Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)
106. Long-Term Residential Care
107. Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
108. Maintenance and service fee for capped-rental items
109. Maintenance Care that is typically long-term and by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or initiated by Members without symptoms in order to promote health and to prevent further problems, unless specifically stated as covered elsewhere in this Certificate of Insurance
110. Maintenance Therapy
111. Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling
112. Maternity classes and/or education programs
113. Meals, custodial care or housekeeping
114. Methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.
115. Milieu therapy
116. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events.
117. Newborn delivery and nursery charges for adopted Dependents prior to the adoption-bonding period (See Section 1.8 “When Dependent Coverage Begins.”)
118. Non-licensed birthing assistance, such as doulas
119. Non-surgical treatments that do not meet the Plan’s Medically Necessary guidelines (available upon request)
120. Nursing care requested by, or for the convenience of the Member or the Member’s family (rest cures)
121. Nutritional or food supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding, except when it’s the sole means of nutrition)
122. Online assessment and management service provided by a qualified non-physician health care professional, internet or electronic communications.
123. Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances
124. Panniculectomy that does not meet Plan guidelines
125. Personal comfort items (telephone, television, guest meals and guest beds)

126. PKU dietary desserts and snack items
127. Pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)
128. Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere
129. Provider-initiated e-mail
130. Provocative food testing
131. Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error
132. Refractive errors of the eye
133. Refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses
134. Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other Health Care Services
135. Reminders of scheduled office visits
136. Remote control devices as optional accessories
137. Removal of skin tags
138. Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; Member desire for change of implant; Member fear of possible negative health effects; or removal of ruptured saline implants that do not meet Medical Necessity criteria. Fees for room and board unless Prior Authorized
139. Replacement of lost, stolen, broken, or damaged lenses or glasses
140. Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
141. Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness; or if lost or stolen
142. Reproductive Health Care Services prohibited by the laws of This State
143. Requests for a referral
144. Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; Sanford Health Plan does not cover these costs.
145. Rest cures
146. Restorative replacements including crowns, bridges, braces or implants
147. Reversal of voluntary sterilization
148. Reversals of prior sterilization procedures
149. Revision of durable medical equipment, except when made necessary by normal wear or use
150. Revision/replacement of prosthetics (except as noted per Plan policy)
151. Routine cleaning of Scleral Shells
152. Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
153. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
154. Sensitivity training
155. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction)
156. Service call charges and charges for repair estimates
157. Services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty
158. Services and/or travel expenses relating to a Non-Emergency Medical Condition

159. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home that are not Medically Necessary
160. Services determined to be cosmetic by the Plan
161. Services for excluded benefits
162. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
163. Services not medically appropriate or necessary
164. Services not medically appropriate to do via telehealth
165. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate
166. Services or supplies determined by the Plan to be special or unusual, including orthoptics, and vision aids
167. Services provided in the Member's home for convenience
168. Services related to environmental change
169. Services that are not Health Care Services
170. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
171. Services that can be provided safely and effectively by a non-clinically trained person
172. Services that involve payment of family members or nonprofessional care givers for services performed for the member
173. Service(s) that would similarly not be charged for in regular office visit
174. Services to assist in activities of daily living
175. Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies drugs and aftercare for or related to artificial or non-human organ transplants
176. Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee
177. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Center of Excellence
178. Shortening of the mandible or maxillae for cosmetic purposes
179. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered
180. Special lens coating or lens treatments for prosthetic eyewear
181. Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)
182. Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use
183. Sublingual allergy desensitization
184. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
185. Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)
186. Take-home drugs (Prescription medications provided to a Member at discharge are paid under the Prescription Drug benefit. See Sections 3.5, 3.7, and 3.8 for benefit details.)
187. Telecommunication Devices
188. Telephone assessment and management services
189. Tests considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: allergy testing, celiac antibody testing, hair analysis, testing for mitochondrial disorders, and micronutrient testing.
190. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer

or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.

191. Therabands and cervical pillows
192. Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, and hyperbaric oxygen therapy.
193. Therapy and service animals, including those used for emotional or anxiety support
194. Thermograms or thermography
195. Tinnitus Maskers
196. Transfers performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider
197. Transmission fees
198. Transplant evaluations with no end organ complications
199. Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria
200. Transportation costs for non-emergency services and/or travel
201. Treatment of weak, strained, or flat feet
202. Treatment received outside of the United States
203. Upgrades of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.
204. Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
205. Vitamins and minerals (unless otherwise specified as covered in this Policy)
206. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
207. Wearable artificial kidney, each
208. Weight loss or exercise programs that do not meet the Plan's Medical Necessity coverage guidelines

4.2 GENERAL PHARMACY EXCLUSIONS

1. Any medication equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider
2. B-12 injection (except for pernicious anemia)
3. Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine
4. Compound medications with no legend (prescription) medication
5. Drug Efficacy Study Implementation ("DESI") drugs
6. Experimental or Investigational medications or medication usage pursuant to the Plan's medical coverage policies
7. Excluded medications from coverage that provide little or no evidence of therapeutic advantage over other products available.
8. Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances
9. Medical Cannabis and/or its equivalents
10. Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of Medical Necessity)

11. Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
12. Medications not listed in the Plans Formulary
13. Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;
14. Medications that are obtained without Prior Authorization or a Formulary exception from the Plan
15. Medications that may be received without charge under a government program, unless coverage is required for the medication
16. Medications that provide little or no evidence of therapeutic advantage over other products available
17. Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Member's medical benefit;
18. Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document, food supplements and baby formula (except to treat PKU or otherwise required to sustain life or amino acid-based elemental oral formulas), nutritional and electrolyte substances
19. Over-the-counter (OTC) medications vitamins and/or supplements, equipment or supplies (except for Plan B and its generic equivalents; insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets, or aspirin to prevent cardiovascular disease when prescribed by a Healthcare Practitioner and/or Provider) that by Federal or State law do not require a prescription order
20. Outpatient medications dispensed in a Provider's office or non-retail pharmacy location
21. Refills of any prescription older than one (1) year
22. Repackaged medications
23. Replacement of a prescription medication due to loss, damage, or theft
24. Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
25. Unit dose packaging
26. Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia

4.3 SPECIAL SITUATIONS AFFECTING COVERAGE

Neither Sanford Health, nor any Participating Provider, shall have any liability or obligation because of a delay or a Participating Provider's inability to provide services as a result of the following circumstances:

- Complete or partial destruction of the Provider's facilities;
- Declared or undeclared acts of War or Terrorism;
- Riot;
- Civil insurrection;
- Major disaster;
- Disability of a significant portion of the Participating Providers;
- Epidemic; or
- A labor dispute not involving Participating Providers, we will use our best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services is delayed due to a labor dispute involving Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

Additionally, non-Emergency care may be deferred until after resolution of the above circumstances.

4.4 SERVICES COVERED BY OTHER PAYORS

The following are excluded from coverage:

- Health Care Services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by Worker's compensation, no-fault auto insurance, medical payments coverage or similar legislation.
- The Plan is not issued in lieu of nor does it affect any requirements for coverage by Worker's Compensation. This Plan contains a limitation, which states that health services for injuries or sickness, which are job, employment or work, related for which benefits are paid under any Worker's Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid under the Plan, and it is determined that Member is eligible to receive Worker's Compensation for the same incident; Sanford Health Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse Sanford Health Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Worker's Compensation Division Hearing. Sanford Health Plan reserves its right to recover against Member even though:
    - The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise; or
    - No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
    - The amount of Worker's Compensation for medical or health care is not agreed upon or defined by Member or the Worker's Compensation carrier; or
    - The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.
- Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Worker's Compensation insurer, without the express written agreement of Sanford Health Plan.
- Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or Group.
- Health Care Services for injury or sickness for which there is other non-Group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
- Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.
- Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and TRICARE, unless applicable law requires the Plan to provide primary coverage for the same.

4.5 SERVICES AND PAYMENTS THAT ARE THE RESPONSIBILITY OF MEMBER

- Out-of-pocket costs, including Deductibles and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Benefits and Coverage and Summary of Pharmacy Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;
- Finance charges, late fees, charges for missed appointments and other administrative charges; and
- Services for which a Member is neither legally, nor as customary practice, is required to pay in the absence of a group health plan or other coverage arrangement.

SECTION 5
HOW SERVICES ARE PAID FOR UNDER THE CERTIFICATE OF INSURANCE

5.1 REIMBURSEMENT OF CHARGES BY PARTICIPATING PROVIDERS

- When you see Participating Practitioner and/or Providers, receive services at Participating Practitioner and/or Provider Providers and facilities, or obtain your prescription drugs at Network Pharmacies, you will not have to file claims. You must present your current identification card and pay any deductible/coinsurance amount due.
- When a Member receives Covered Services from a Participating Practitioner and/or Provider, Sanford Health Plan will pay the Participating Practitioner and/or Provider directly, and the Member will not have to submit claims for payment. The Member's only payment responsibility, in this case, is to pay the Participating Practitioner and/or Provider, at the time of service, any Deductible or Coinsurance amount that is required for that service. Participating Practitioner and/or Providers agree to accept either Sanford Health Plan's payment arrangements or the negotiated contract amounts.

Time Limits. Participating Practitioner and/or Providers must file claims to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If the Member fails to show his/her ID card at the time of service, then the Member may be responsible for payment of claim after Practitioner and/or Provider's timely filing period of one hundred eighty (180) days has expired.

In any event, the claim must be submitted to Sanford Health Plan no later than one hundred eighty (180) days after the date that the cost was incurred, unless the claimant was legally incapacitated.

5.2 REIMBURSEMENT OF CHARGES BY NON-PARTICIPATING PROVIDERS

Sanford Health Plan does not have contractual relationships with Non-Participating Providers and they may not accept the Sanford Health Plan's payment arrangements. In addition to any Deductible or Coinsurance amount that is required for that service, Members are responsible for any difference between the amount charges and Sanford Health Plan's payment for Covered Services. Non-Participating Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

- the amount charged for a Covered Service or supply; or
- inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
- outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    - Fees typically reimbursed to providers for same or similar professionals; or
    - Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Providers. Sometimes these Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to Sanford Health Plan within one-hundred-eighty (180) days after the date that the cost was incurred.

If you, or the Non-Participating Provider, does not file the claim within 180 days after the date that the cost was incurred you will be responsible for payment of the claim.

If you need to file the claim, here is the process:

The Member must give Sanford Health Plan written notice of the costs to be reimbursed. Claim forms are available from the Customer Service Department to aid in this process. Bills and receipts should be itemized and show:

- Covered Member's name and ID number;
- Name and address of the Physician or Facility that provided the service or supply;
- Dates Member received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Time Limits: Claims must be submitted to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If you, or the Non-Participating Provider, file the claim after the one-hundred-eighty (180) timely filing limit has expired, you will be responsible for payment of the claim.

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

5.3 PAYMENTS FOR AIR AMBULANCE CHARGES

As a safeguard for Members, the reimbursement rate for Out-of-Network air ambulance services is equal to the average of Sanford Health Plan's In-Network rates for air ambulance providers licensed by the North Dakota Department of Health.

A claim made by the Member for Out-of-Network air ambulance services provided by an air ambulance provider licensed by the North Dakota Health Department will be paid in accordance with Sanford Health Plan's above mentioned policy. A payment made in accordance with this policy is the same as an In-Network payment for services.

If you have questions, please call our Customer Service Department.

5.4 BALANCE BILLING FROM NON-PARTICIPATING PROVIDERS

Balance billing, sometimes referred to as surprised billing, is the practice of a medical provider charging a patient for the difference between the total cost of services being billed and the amount the insurance pays. When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, the Member is protected from balance billing because the provider cannot attempt to collect charges above what Sanford Health Plan reimburses. When Sanford Health Plan does not have a contractual relationship in place and the provider is a Non-Participating Provider, they may not accept Sanford Health Plan's payment arrangements and members may be balanced billed for services received.

Members may be balance billed in emergency situations even when Sanford Health Plan covers all of the charges at an In-Network Level if the provider is a Non-Participating Provider who will not accept our payment as full and final. In such circumstances, the Non-Participating Provider must satisfy the Notice and Consent Process and Requirements before sending surprise bills. Out-of-Network facilities and providers are prohibited from sending surprise bills for out-of-network cost sharing without signed consent from the Member. Please check the Sanford Health Plan provider directory before receiving services to make sure you are seeing an In-Network Participating Practitioner and/or Provider.

If you think you've been wrongly billed, contact the No Surprises Help Desk (NSHD) at 1-800-985-3059 or visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law. For Minnesota residents, you may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 for more information about your rights under Minnesota law.

5.5 HEALTH CARE SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

Deductible and applicable cost-share will apply for Medically Necessary emergency and urgent care services received in a foreign country. There is no coverage for elective or preventive Health Care Services if a Member or their dependent(s) travels to another country for the purpose of seeking medical treatment outside the United States. There is no coverage for any non-emergent Health Care Services if a Member or their dependent(s) resides in another country.

5.6 TIMEFRAME FOR PAYMENT OF CLAIMS

- The payment for reimbursement of the Member's costs will be made within *fifteen (15)* days of when Sanford Health Plan receives a complete written claim with all required supporting information.
- When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to our guidelines, Sanford Health Plan will arrange for direct payment to either the Non-Participating Provider or the Member. If the Provider refuses direct payment, the Member will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of This Contract. The Member will be responsible for any expenses that exceed Maximum Allowed Amount, as well as any Deductible or Coinsurance required for the Covered Service.

5.7 WHEN WE NEED ADDITIONAL INFORMATION

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond

5.8 MEMBER BILL AUDIT PROGRAM

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

To obtain payment through the Member Bill Audit Program, the Member must complete a *Member Bill Audit Refund Request Form*. To obtain a form, sign into your account at www.sanfordhealthplan.com/memberlogin or call Sanford Health Plan Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* and request a form be mailed to you.

Note: This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim. For more information on claims with more than one payor, see Section 6, *Coordination of Benefits*.

SECTION 6
COORDINATION OF BENEFITS

NOTE: Sanford Health Plan follows North Dakota Administrative Code §45-08-01.2-03 regarding Coordination of Benefits (COB). The COB provision applies when a person has health care coverage under more than one "plan" as defined for COB purposes.

If a Member is covered by another health plan, insurance, or other coverage arrangement, the plans and/or insurance companies will share or allocate the costs of the Member's health care by a process called "Coordination of Benefits" so that the same care is not paid for twice.

The Member has two obligations concerning Coordination of Benefits ("COB"):

- The Member must tell Sanford Health Plan about any other plans or insurance that cover health care for the Member, and
- The Member must cooperate with Sanford Health Plan by providing any information requested by Sanford Health Plan.

The rest of the provisions under this section explain how COB works.

6.1 APPLICABILITY

This Coordination of Benefits (COB) provision applies to Sanford Health Plan when a Member has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan.

The benefits of this Plan:

- shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section below entitled: *"Effect of COB on the Benefits of this Plan."*

6.2 DEFINITIONS (FOR COB PURPOSES ONLY)

"**Plan**" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a) Group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of Group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in Group, Group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts; and Medicare or any other federal governmental plan, as permitted by law.

b) "Plan" may include coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title MX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time). Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"**This Plan**" refers to this certificate, which provides benefits for health care expenses and means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

"**Primary Plan/Secondary Plan**": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

a) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
b) When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
c) When there are more than two (2) plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"**Allowable Expense**" means a necessary, reasonable and customary health care service or expense including Deductibles, Coinsurance that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:

a) The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the Member's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
b) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that compute the benefit payments on the basis of reasonable costs, any amount in excess of the highest of the reasonable costs for a specified benefit is not an allowable expense;
c) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;
d) If a person is covered by one plan that calculates its benefits or services on the basis of reasonable costs and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be allowable expense for all plans; or

e) When benefits are reduced under a Primary Plan because a Member does not comply with The Plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, Certification of admissions or because the person has a lower benefit because the person did not use a preferred Practitioner and/or Provider.

"**Claim**" means a request that benefits of a plan be provided or paid in the form of services (including supplies), payment for all or portion of the expenses incurred, or an indemnification.

"**Claim Determination Period**" means a Calendar Year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if over-insurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or similar provision takes effect.

"**Closed Panel Plan**" is a plan that provides health benefits to Members primarily in the form of services through a panel of Practitioner and/or Providers that have contracted with or are employed by The Plan, and that limits or excludes benefits for services provided by other Practitioner and/or Providers, except in cases of emergency or Plan authorized referral by an In-Network Participating Practitioner and/or Provider.

"**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

6.3 ORDER OF BENEFIT DETERMINATION RULES

General. When two or more plans pay benefits, the rules for determining the order of payment is as follows:

a) The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan;
c) If multiple contracts providing coordinated coverage are treated as a single plan under North Dakota State law, inclusive, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this law;
d) If a person is covered by more than one secondary plan, this order of benefit determination provisions decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of any primary plan and the benefits of any other plan, which has its benefits determined before those of that secondary plan;
e) Except as provided in subdivision (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with North Dakota State law, inclusive, is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary;
f) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The plan which covers the person as a Group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:

- secondary to the Plan covering the person as a Dependent; and
- primary to the Plan covering the person as other than a Dependent, for example a retired Group Member; then the order of benefits between the two plans is reversed so that the plan covering the person as a Group Member, Member, or Subscriber is secondary and the other plan is primary.

Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
- The parents are not separated (whether or not they even have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after The Plan is given notice of the court decree.

If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the Spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the Spouse of the noncustodial parent.

Active/Inactive Group Member. The benefit of a plan, which covers a person as a Group Member who is neither laid off nor retired (or as that Group Member's Dependent), is primary. If the other plan does not have this rule, and if as a result the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule *"**Child Covered Under More Than One Plan"*** above.

Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

- primary, the benefits of a plan covering the person as a Group Member, Member or Subscriber (or as that person's Dependent);
- secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered a Group Member, Member or Subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

6.4 EFFECT OF COB ON THE BENEFITS OF THIS PLAN

When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules," section above, this Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph "b(ii)" immediately below.

Reduction in this Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than 100% of those Allowable Expenses.

If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a Non-Participating Provider, benefits are not payable by one closed panel plan, COB shall not apply between this plan and any other closed panel plans.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Plan's Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.5 CALCULATION OF BENEFITS, SECONDARY PLAN

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should The Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under The Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

6.6 COORDINATION OF BENEFITS WITH GOVERNMENT PLANS AND BENEFITS

After Sanford Health Plan, Medicare (if applicable), and/or any Medicare Supplementary Insurance (Medigap) have paid claims, then Medicaid and/or TRICARE pay last. Sanford Health Plan will pay primary to TRICARE and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is **NOT** a Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance. This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

6.7 COORDINATION OF BENEFITS WITH MEDICARE

The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:

- determining whether these individuals are eligible to participate in the Plan; or
- providing benefits under the Plan.

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, Sanford Health Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. Sanford Health Plan

reserves the right to coordinate benefits with respect to Medicare Part D. Sanford Health Plan will make this determination based on the information available through CMS.

When MSP Rules Apply to COB

Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Insurance and is enrolled for insurance under Medicare, Parts A and B. This provision applies before any other Coordination of Benefits Provision of this Certificate of Insurance.

Coordination with Medicare Part D

This Certificate of Insurance shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage.

The following provisions apply to Sanford Health Plan's COB with Medicare:

When Medicare is the primary payer for a Member's claims:

- If you're 65, or older, and have group health plan coverage based on your or your spouse's current employment
- If you have retiree insurance (insurance from former employment)

NOTE: The hospital or doctor will first file claims with Medicare. Once Medicare processes the claim, an Explanation Of Medicare Benefits (EOMB) form will be mailed to the Member explaining what charges were covered by Medicare. Then the health care professional will generally file the claim with us. If a professional does not do so, the Member may file the claim by sending a copy of the EOMB, together with his or her member identification number, to the address shown on his or her member ID card.

When Medicare is primary despite the MSP rules:

- A Medicare-entitled person refuses coverage under the Plan;*
- Medical services or supplies are covered by Medicare but are excluded under the group health plan;
- A Medicare-entitled person has exhausted his or her benefits under the group health plan;
- A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
- A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

  *** NOTE:** *Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual's Medicare benefits.*

When this Certificate of Insurance is the primary payer for a Member's claims:

- If you're under 65 and disabled, and have coverage based on your or a family member's current employment
- When coverage is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- The Member (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
- A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Member/Employee.

NOTE: The Member's claim is filed with us by Practitioner or Provider. After the claim is processed, we send the Member an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the Practitioner or Provider of the covered charges. If there are remaining charges covered by Medicare, the Practitioner or Provider may file a claim with Medicare. If the Practitioner or Provider will not do so, the Member can file the claim with Medicare. Members may contact their local Social Security office to find out where and how to file claims with the appropriate "Medicare intermediary" (a private insurance company that processes Medicare claims).

If a Practitioner and/or Provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Sanford Health Plan's allowable expense is the Medicare allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.

6.8 MEMBERS WITH END STAGE RENAL DISEASE (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD. Benefits covered by Medicare, because of ESRD, are for all Covered Services, not only those related to the kidney failure condition.

Sanford Health Plan does not differentiate in the benefits it provides to individuals who have ESRD, e.g. terminating coverage, imposing benefit limitations, or charging higher premiums.

How Primary vs. Secondary is Determined:

The Plan will pay first for thirty (30) months after the Member becomes eligible to join Medicare, starting with the first dialysis month or transplant month. This applies regardless of employment status and includes COBRA or retirement plan coverage. After the 30-month coordination period where the Member should enroll in Medicare, Medicare is the primary payer for a Member's claims under ESRD.

When Medicare is the primary payer for a Member's claims under ESRD:

- If the Member is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

6.9 COORDINATION OF BENEFITS WITH MEDICAID

- A Covered Individual's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the applicable State's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state's Medicaid program; and Sanford Health Plan will honor any subrogation rights the State may have with respect to benefits that are payable under this Certificate of Insurance.
- When an individual covered by Medicaid also has coverage under this Certificate of Insurance, Medicaid is the payer of last resort. If also covered under Medicare, Sanford Health Plan pays primary, then Medicare, and Medicaid is tertiary.

See provisions below on Coordination of Benefits with TRICARE, if a Member is covered by both Medicaid and TRICARE.

6.10 COORDINATION OF BENEFITS WITH TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent that the service provided is also covered under the other plan.

- Sanford Health Plan pays first if an individual is covered by both TRICARE and Sanford Health Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
- TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
- When a TRICARE beneficiary is covered under Sanford Health Plan, and also entitled to either Medicare or Medicaid, Sanford Health Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).
- TRICARE-eligible employees and beneficiaries receive primary coverage under this Certificate of Insurance in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

The Plan does not:

- Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
- Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this health benefit plan.

SECTION 7
SUBROGATION AND RIGHT OF REIMBURSEMENT

Sanford Health Plan will provide Health Care Services to the Member for the illness or injury, just as it would in any other case. However, if the Member accepts the services from Sanford Health Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

Subrogation Defined

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, Sanford Health Plan may be able to "step into the shoes" of the Member to recover health care costs from the party responsible for the injury or illness. This is called "Subrogation."

Reimbursement Defined

Sanford Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Member. This is called "Reimbursement."

Covered Individuals

Each and every Covered Individual hereby authorizes Sanford Health Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 6 and 7.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges. This Plan may give or obtain needed information from another insurer or any other organization or person.

7.1 SANFORD HEALTH PLAN'S RIGHTS OF SUBROGATION

In the event of any payments for benefits provided to a Member under this Plan, Sanford Health Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, Member's parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and Workers' Compensation insurance or substitute coverage.

Sanford Health Plan shall be entitled to receive from any such recovery an amount up to the Maximum Allowed Amount for the services provided by Sanford Health Plan. In providing benefits to a Member, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the reasonable costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under this Certificate of Insurance for an illness or injury, Sanford Health Plan is subrogated to the Member's right to recover the reasonable costs of the benefits it provides on account of such illness or injury, even if those reasonable costs exceed the amount paid by Sanford Health Plan.

Sanford Health Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. Sanford Health Plan's first priority right applies whether or not the Member has been made whole by any recovery. Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for any past, present, or future

Health Care Services provided to the Member. Sanford Health Plan may give notice of that lien to any party who may have contributed to the loss.

If Sanford Health Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits provided or to be provided under this Plan. This includes Sanford Health Plan's right to bring suit against the third party in the Member's name.

7.2 SANFORD HEALTH PLAN'S RIGHT TO REDUCTION AND REIMBURSEMENT

Sanford Health Plan shall have the right to reduce or deny benefits otherwise payable by Sanford Health Plan, or to recover benefits previously paid by Sanford Health Plan, to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

To the extent that federal or state statutes or courts, eliminate or restrict any such right of reduction or reimbursement provided to Sanford Health Plan under this Policy; such rights shall thus either be limited or no longer apply, or be limited by the extent of federal and state actions.

Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount for the Health Care Services provided to the Member.

7.3 ERRONEOUS PAYMENTS

To the extent payments made by Sanford Health Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of this Certificate of Insurance, Sanford Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which Sanford Health Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

7.4 MEMBER'S RESPONSIBILITIES

The Member, Member's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as Sanford Health Plan requires to facilitate enforcement of its rights under this Certificate of Insurance. The Member shall take no action prejudicing the rights and interests of Sanford Health Plan under this provision.

Neither a Member nor Member's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of Sanford Health Plan, to negotiate or compromise Sanford Health Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without Sanford Health Plan's express written consent.

Any Member who fails to cooperate in Sanford Health Plan's administration of this Part shall be responsible for the reasonable cost for services subject to this section and any legal costs incurred by Sanford Health Plan to enforce its rights under this section. Sanford Health Plan shall have no obligation whatsoever to pay medical

benefits to a Covered Individual if a Covered Individual refuses to cooperate with Sanford Health Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as Sanford Health Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, Sanford Health Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness caused by a third-party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of Sanford Health Plan's 100%, first-dollar Subrogation and refund rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by Sanford Health Plan. Failure to comply will entitle Sanford Health Plan to withhold benefits, services, payments, or credits due under Sanford Health Plan.

7.5 SEPARATION OF FUNDS

Benefits paid by Sanford Health Plan, funds recovered by the Covered Individual(s), and funds held in trust over which Sanford Health Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect Sanford Health Plan's equitable lien, the funds over which Sanford Health Plan has a lien, or Sanford Health Plan's right to subrogation and reimbursement.

7.6 PAYMENT IN ERROR

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

SECTION 8
HOW COVERAGE ENDS

8.1 TERMINATION BY THE SUBSCRIBER

Upon a qualifying event, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. Sanford Health Plan must receive a written request from the Group to end coverage. The Subscriber will be responsible for any Service Charges through the date of termination or the end of the calendar month in which termination occurs, whichever is later.

8.2 TERMINATION, NONRENEWAL, OR MODIFICATION OF MEMBER COVERAGE

A Member or Dependent's coverage will automatically terminate at the earliest of the following events below. Such action by Sanford Health Plan is called "Termination" of the Member.

- **Failure to Pay Service Charge Payments**. Failure to make any required Service Charge payments when due. A grace period of thirty-one (31) days, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period.
- **Termination of Employment**. The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s).
- **Termination of this Contract**. In the event this Contract terminates, the last day of the month for which Service Charge Payments were made is the date benefits will cease for the Member(s).
- **Loss of Eligibility**. The last day of the month in which the Member is no longer an Eligible Group Member is the date benefits will cease for the Member(s).
- **Movement Outside the Service Area**. The last day of the month in which the Member no longer resides in the Service Area is the date benefits will cease for the Member(s).
- **Death.** The date the Member dies is the date benefits will cease for the Member(s).
- **Fraudulent Information**. An act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, may be used to rescind this application or Certificate of Insurance, terminate coverage and deny claims. The date identified on the notice of termination is the date benefits will cease for the Member(s).
- **Use of ID Card by Another.** The use of a Member's ID Card by someone other than the Member is considered fraud. The date a Member allows another individual to use his or her ID card to obtain services is the date benefits will cease for the Member(s).
- **Product Discontinuance.** Sanford Health Plan discontinues a particular product provided that Sanford Health Plan provides the Group and all Group Members with written notice at least 90 days before the date the product will be discontinued, Sanford Health Plan offers the Group and all Group Members the option to purchase any other coverage currently being offered by Sanford Health Plan to group health plans, and Sanford Health Plan acts uniformly without regard to claims experience of the Group or any health status-related factor relating to particular Group Members covered or who may be eligible for

coverage. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s)

- **Discontinuance of All Coverage in Group Market or All Markets.** Sanford Health Plan discontinues offering all coverage in the group market or in all markets in Minnesota provided that Sanford Health Plan provides the Group and all Group Members and the Minnesota Department of Insurance with written notice of the discontinuance at least 180 calendar days prior to the date the coverage will be discontinued and all coverage issued or delivered by Sanford Health Plan in the group market in Minnesota are discontinued and not renewed. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s).
- **Any other reason permitted by State or federal law**.

Notification

Sanford Health Plan must notify all covered persons of the termination at least 30 days before the effective termination date for the termination to be effective

Uniform Modification of Coverage

Sanford Health Plan may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with State law and is effective uniformly for all persons who have coverage under this type of contract.

8.3 MEMBER APPEAL OF TERMINATION

A Member may Appeal Sanford Health Plan's decision to terminate, cancel, or refuse to renew the Member's coverage. The Appeal will be considered a Member Grievance and the Sanford Health Plan's Policy on Member Grievances and Appeals will govern the process.

Pending the Appeal decision, coverage will terminate on the date that was set by Sanford Health Plan. However, the Member may continue coverage, if entitled to do so, by complying with the "Continuation of Coverage" provisions in Section 9. If the Appeal is decided in favor of the Member, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

NOTE: A Member may not be terminated due to the status of the Member's health or because the Member has exercised his or her rights to file a complaint or appeal.

8.4 TERMINATION OF MEMBER COVERAGE

For the purposes of this Benefit Plan, upon termination of Member Coverage, the following provisions control:

1. **Determining Ineligibility.** Eligibility for benefits subsequent to retirement or termination will be determined pursuant to N.D.C.C. §54-52.1-03.
2. **Continuation of health, dental, vision, or prescription drug coverage after termination.** An employee who terminates employment and is not receiving a monthly retirement benefit from one of the eligible retirement systems, and applies for continued coverage with the health, dental, vision, or prescription drug plan may continue such coverage for a maximum of eighteen (18) months by remitting timely payments to the Board. The employee desiring coverage shall notify the Board within sixty (60) days of the termination.

Coverage will become effective on the first day of the month following the last day of coverage by the employing agency, if an application is submitted within sixty (60) days. An individual who fails to timely notify the board is not eligible for coverage. [N.D.A.C. §71-03-03-06]

3. **Continuation of health, dental, vision, or prescription drug coverage for dependents.** Dependents of employees with family coverage may continue coverage with the group after their eligibility would ordinarily cease. This provision includes divorced or widowed spouses and children when they are no longer dependent on the employee. Coverage is contingent on the prompt payment of the premium, and in no case will coverage continue for more than thirty-six (36) months. Dependents desiring coverage shall notify the board within sixty (60) days of the qualifying event and must submit an application in a timely manner. An individual who fails to notify the Board within the sixty (60) days, and who desires subsequent coverage, will not be eligible for coverage. [N.D.A.C. §71-03-03-07]
4. **Leave without pay.** An employee on an approved leave without pay may elect to continue coverage for the periods specified in the plans for life insurance, health, dental, vision, or prescription drug coverages by paying the full premium to the agency. An eligible employee electing not to continue coverage during a leave of absence is entitled to renew coverage for the first of the month following the month that the employee has returned to work if the employee submits an application for coverage within the first thirty-one (31) days of returning to work. An eligible employee failing to submit an application for coverage within the first thirty-one (31) days of returning to work or eligibility for a special enrollment period, may enroll during the annual open enrollment. Upon a showing of good cause, the executive director may waive the thirty-one day application requirement. [N.D.A.C. §71-03-03-09]
    a. In the event an enrolled eligible employee is not entitled to receive salary, wages, or other compensation for a particular calendar month, that employee may make direct payment of the required premium to the board to continue the employee's coverage, and the employing department, board, or agency shall provide for the giving of a timely notice to the employee of that person's right to make such payment at the time the right arises. [N.D.C.C. §54-52.1-06]

NOTE: A Member's coverage may not be terminated due to the status of the Member's health, or because the Member has exercised his or her rights, under the Plan's policy on member complaints, or the policy on appeal procedures for medical review determinations.

8.5 CONTINUATION

1. If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet NDPERS requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:
    a. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion, the Plan Administrator through which the Subscriber is eligible has terminated coverage with Sanford Health Plan, and the Plan Administrator has enrolled with another insurance carrier.
    b. The Plan Administrator no longer meets Sanford Health Plan's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.
    c. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.
    d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under the group (NDPERS). The Subscriber may elect conversion (individual) coverage on a nongroup basis, subject to

premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for nongroup coverage within 31 days after the termination date of the previous group health plan coverage.

If a Member becomes otherwise ineligible for group membership under this Benefit Plan, Sanford Health Plan must at least offer the Subscriber its conversion (individual) benefit plan, if the Member lives in the Sanford Health Plan Service Area. There may be other coverage options for the Subscriber and/or Eligible Dependents through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

8.6 Extension of Benefits for Total Disability

An extension of benefits is provided Covered Members/Subscribers who become totally disabled while enrolled under this Benefit Plan and whom continue to be totally disabled at the date of termination of this Certificate. Upon payment applicable premium charges at the current Group rate, coverage will remain in full force and effect until the first of the following occurs:

- The end of a period of twelve (12) months starting with the date of termination of the Group contract;
- The date the Member is no longer totally disabled; or
- The date a succeeding plan provides replacement coverage to that Member without limitation as to the disabling condition.

Upon termination of the extension of benefits, the Member/Subscriber will have continuation and conversion rights as stated in Sections 9 and 10.

8.7 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

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

8.8 NOTICE OF CREDITABLE COVERAGE

You may request a Certificate of Creditable Coverage for you and your covered family Members upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling Customer Service.

8.9 NOTICE OF GROUP TERMINATION OF COVERAGE

- **Termination due to Non-Renewal**

The Group will give thirty (30) days written notice of the termination to the Members. For purposes of This Contract, "give written notice" means to present the notice to the Member or mail it to the Member's last known address.

This notice will set forth at least the following:

- The effective date and hour of termination or of the decision to not renew coverage;
- The reason(s) for the termination or nonrenewal; and
- The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
    - the availability of Continuation of Coverage, if any; and
    - the fact that the Member may have rights under federal COBRA provisions, independent from any provisions of This Contract, and should contact the Group for information on the COBRA provisions.
- **Termination due to Non-Payment of Premiums**

If an employer fails to submit Premium payment to Sanford Health Plan resulting in loss of coverage to the Members, switches plans or cancels the coverage, The Group is required to give written notice of the termination to the Members as soon as reasonably possible but no later than ten (10) days after the date of termination.

SECTION 9
OPTIONS AFTER COVERAGE ENDS

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

Notice of Continuation Coverage Rights Under COBRA for employer groups with twenty (20) or more employees

Introduction

You are getting this notice because you recently gained coverage under an employer sponsored group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when employer sponsored group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Plan Document (Policy) or contact the Plan Administrator (your Employer).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept "Late Entrants".

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If the Plan is subject to COBRA, your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring coverage under the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The employer is responsible for the timely mailing of applicable COBRA notices to Members (the "COBRA Notification Letter"). The employer must notify Sanford Health Plan when qualifying events occur. Sanford Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after being notified by the employer that a qualifying event has occurred. The employer must notify the Plan of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to:

North Dakota Public Employees Retirement System
PO Box 1657
Bismarck, ND 58502
(701) 328-3900

How is COBRA Coverage Provided?

Upon notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

- If you or a covered Dependent is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your covered Dependents may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

- If you or your covered Dependents experience another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if your employer is properly notified about the second qualifying event.
- This extension may be available to your Spouse and any Dependent Children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to offer employees and their Spouse and/or Dependent Children the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where the employee leaves the position of employment due to service in the military. The Member or the Member's Authorized Representative may elect to continue the employee's coverage by making an election of a form provided by Sanford Health Plan. The Member has sixty (60) days to elect continuation coverage measured from the later of (1) the date the employee left the position of employment, or (2) the date notice of election rights is received. If continuation coverage is elected within this period, the coverage will be retroactive to the date the employee left the position of employment.

The Member may elect continuation coverage on behalf of a covered Dependent; however, there is no independent right of each covered Dependent to elect continuation of coverage. If the Member does not elect coverage, there is no USERRA continuation available for the Spouse or Dependent Children. In addition, even if the Member does not elect USERRA coverage or continuation coverage, the Member has the right to have coverage reinstated upon reemployment. Continuation coverage continues for up to twenty-four (24) months.

This section is to inform covered individuals, in summary fashion, of their rights and obligations under the continuation of coverage provisions of USERRA. It is intended that no greater rights be provided than those required by federal law.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit healthcare.gov.

Keep Sanford Health Plan Informed of Address Changes

To protect your family's rights, let Sanford Health Plan know about any changes in the addresses of covered Dependents. You should also keep a copy, for your records, of any notices you send to Sanford Health Plan.

Plan Contact Information

Mail:	Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.
Phone:	(800) 752-5863 (toll-free) | TTY/TDD: 711 (toll-free)
	For free help in a language other than English: (800) 752-5863 (toll-free)
Fax:	(605) 328-6812
Online:	www.sanfordhealthplan.com/memberlogin

Or contact your employer.

SECTION 10
PROBLEM RESOLUTION

10.1 MEMBER APPEAL PROCEDURES - OVERVIEW

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Benefits under this Certificate of Insurance will be paid only if Sanford Health Plan decides, at Sanford Health Plan's discretion, that the applicant is entitled to them.

Claims for benefits under this Certificate of Insurance can be post-service, pre-service, or concurrent. This Section of your Summary Plan Description explains how you can file a complaint regarding services provided by Sanford Health Plan; or appeal a partial or complete denial of a claim. The appeal procedures outlined below are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For information on medication/drug Formulary exception requests, see Section 2, *Pharmaceutical Review Requests and Exception to the Formulary Process*.

The following parties may request a review of any Adverse Determination by Sanford Health Plan: the Member and/or legal guardian; a health care Practitioner and/or Provider with knowledge of the Member's medical condition; an Authorized Representative of the Member; and/or an attorney representing the Member or the Member's estate.

NOTE: The Member or his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. In cases where the Member wishes to exercise this right, a written designation of representation from the Member should accompany a Member's complaint or request to Appeal an Adverse Determination. See *Designating an Authorized Representative* below for further details. For urgent (expedited) appeals, written designation of an Authorized Representative is not required.

Special Communication and Language Access Services

For Members who request language services, Sanford Health Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Members submit a complaint or appeal, and Sanford Health Plan will communicate with Members free of charge about their complaint or appeal in the Member's preferred language, upon request. To get help in a language other than English, call (800) 892-0625.

For Members who are deaf, hard of hearing, or speech-impaired

To contact Sanford Health Plan, a TTY/TDD line is available free of charge by calling toll-free 711. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

Help to understand this policy and your rights is free.
If you would like it in a different format (for example, in a larger font size),
please call us at (800) 499-3416 (toll-free).
If you are deaf, hard of hearing, or speech-impaired,
reach us at TTY/TDD: 711(toll-free).

Help in a language other than English is also free.
Please call (800) 752-5863 (toll-free) to connect with us using free translation services.

Maximum Appeal Timelines			
Type of Notice	**Emergency**	**Pre-Service**	**Post-Service**
Initial Determinations	72 Hours	15 days	30 Days
Extension for Initial Plan Determinations	NONE	15 days	15 Days
Additional Information Request (Plan)	24 Hours	15 days	15 Days
Response to Request For Additional Information (Member)	48 Hours	45 Days	45 Days
Request for Internal Appeal (Member)	180 Days	180 Days	180 Days
Internal Appeal Determinations	72 Hours	30 Days	60 Days
Request for External Appeal (Member)	N/A	4 months	4 Months
External Appeal Determinations	72 Hours	45 Days	45 Days

10.2 DESIGNATING AN AUTHORIZED REPRESENTATIVE

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service toll-free at (800) 499-3416; or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your provider is your Authorized Representative unless you tell us otherwise, in writing.

10.3 AUDIT TRAILS

Audit trails for Complaints, Adverse Determinations and Appeals are provided by Sanford Health Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal.
The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If Sanford Health Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

10.4 DEFINITIONS

Adverse Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) based on:

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

Appeal: A request to change a previous Adverse Determination made by Sanford Health Plan.

Inquiry: A telephone call regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address Member and Practitioner and/or Provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written Complaint.

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with Sanford Health Plan, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or non-renewals of coverage; administrative operations; discrimination based on race, color, national origin, sex, age, or disability; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a Complaint. The Member and his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the Complaint.

External Review: An External Review is a request for an Independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

Urgent Care Situation: A degree of illness or injury that is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. An Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

- Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
- In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is "Urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson as defined in Section 8. A Practitioner, with knowledge of the Member's medical condition, who

determines a request to be "Urgent," as defined in Section 8, shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

10.5 COMPLAINT (GRIEVANCE) PROCEDURES

A Member has the right to file a Complaint either by telephone or in writing to The Appeals and Grievances Department. The Appeals and Grievances Department will make every effort to investigate and resolve all Complaints. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

10.6 ORAL COMPLAINTS

A complainant may orally submit a Complaint to Customer Service. If the oral Complaint is not resolved to the complainant's satisfaction within ten (10) business days of receipt of the Complaint, Sanford Health Plan will provide a Complaint form to the complainant, which must be completed and returned to the Appeals and Grievances Department for further consideration. Upon request, Customer Service will provide assistance in submitting the Complaint form.

10.7 WRITTEN COMPLAINTS

A complainant can seek further review of a Complaint not resolved by phone by submitting a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

Complaints based on discrimination must be sent to the attention of the Civil Rights Coordinator.

The Appeals and Grievances Department will notify the complainant within *ten* (10) business days upon receipt of the Complaint form, unless the Complaint has been resolved to the complainant's satisfaction within those ***ten* (10) business days**.

Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.

10.8 COMPLAINT INVESTIGATIONS

The Appeals and Grievances Department will investigate and review the Complaint and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:

- A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within *thirty* (30) calendar days from the date Sanford Health Plan receives your request.
- In certain circumstances, the time period may be extended by up to *fourteen* (14) days upon agreement. In such cases, Sanford Health Plan will notify the complainant in advance, of the reasons for the extension.

Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within *twenty-four* (24) hours.

If the complaint is not resolved to the Member's satisfaction, the Member, or his/her Authorized Representative, has the right to Appeal any Adverse Determination made by Sanford Health Plan. Appeal Rights may be requested by calling the Appeals and Grievances Department.

Sanford Health Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in the complaint or appeals process.

All notifications described above will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in your written response.

10.9 APPEAL PROCEDURES

Types of Appeals
Types of appeals include:

- **A Pre-service Appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- **A Post-service Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
- An **Expedited Appeal** for Urgent Care is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of urgent, their review will generally be conducted within 24 hours.

10.10 CONTINUED COVERAGE FOR CONCURRENT CARE

A Member is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to Appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within twenty-four (24) hours.

10.11 INTERNAL APPEALS OF ADVERSE DETERMINATION (DENIAL)

Appeals can be made for up to 180 days from notification of the Adverse Determination.

Within one-hundred-eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. To Appeal, the Member may sign into their account at sanfordhealthplan.com/memberlogin and complete the "Appeal Filing Form" under the *Forms* tab. The Member or their Authorized Representative may also contact the Plan by sending a written Appeal to the Plan.

If the Member, Authorized Representative, Practitioner/Provider, and/or attorney, has questions, they are encouraged to contact the Plan. Customer Service is available to help with understanding information and processes. Alternate formats are also available and translation is available free of charge for written materials and Member communication with the Plan.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Customer Service Department.

10.12 APPEAL RIGHTS AND PROCEDURES

If the Member or their Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

- The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members do not have the right to attend or have a representative attend the review.
- The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
- Confirm with the Member whether additional information will be provided for appeal review. Sanford Health Plan will document if additional information is provided or no new information is provided for appeal review.
- Before Sanford Health Plan can issue a final Adverse Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date. Members shall have the right to review all evidence and present evidence and testimony.
- The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
- The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the Appeals and Grievances Department.
- Sanford Health Plan will document the substance of the Appeal, including but not limited to, the Member's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. Sanford Health Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
- The review shall not afford deference to the initial Adverse Determination and shall be conducted by a Sanford Health Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, Sanford Health Plan shall consult with a health

care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.

- Sanford Health Plan shall identify the medical or vocational experts whose advice was obtained on behalf of Sanford Health Plan in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
- In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
- The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) working days of receipt of the Appeal.
- Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

10.13 APPEAL NOTIFICATION TIMELINES

For Prospective (Pre-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **thirty (30) calendar days** of receipt of the Appeal.

For Retrospective (Post-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **sixty (60) calendar days** of receipt of the Appeal.

For Appeals Based on Discrimination: Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing within **thirty (30) calendar days** of receipt of the Appeal.

If the Member does not receive the decision within the time periods stated above, the Member may be entitled to file a request for External Review.

10.14 EXPEDITED INTERNAL APPEAL PROCEDURE

An Expedited Appeal procedure is used when the Member's condition is emergent or urgent in nature, as defined in this Certificate. An Expedited Appeal of a Prior Authorization (Pre-service) Denial must be utilized if the Practitioner acting on behalf of the Member believes that the request is warranted. This can be done by oral or written notification to Sanford Health Plan. We will accept all necessary information (electronic or by telephone) for review from the Practitioner of care. A designated Physician advisor will conduct the review and will be available to discuss the case with the attending Practitioner on request. For Medical Necessity reviews only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

If the Expedited Review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member or the Representative has been notified of the determination.

NOTE: For procedures, rights, and notification timelines related to an Appeal of Adverse Determination regarding pharmacy services, certification of a non-covered medication, or Formulary design issues, see External Procedures for Adverse Determinations of Pharmaceutical Exception Requests in this Section.

10.15 WRITTEN NOTIFICATION PROCESS FOR INTERNAL APPEALS

The written decision for the Appeal reviews will contain the following information:

- The results and date of the Appeal Determination;
- The specific reason for the Adverse Determination in easily understandable language;
- The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
- Reference to the evidence, benefit provision, guideline, protocol and/or other similar criterion on which the determination was based and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, protocols and other similar criterion free of charge;
- Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
- Statement of the reviewer's understanding of the Member's Appeal;
- The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
- Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate specialist to discuss the determination;
- If the Adverse Determination is based on Medical Necessity or Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Certificate of Insurance to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
- If applicable, instructions for requesting:
    a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination; or
    b. The written statement of the scientific or clinical rationale for the determination;
- For Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review a statement indicating:
    1. The written procedures governing the standard internal review, including any required timeframe for the review; and
    2. The Member's right to bring a civil action in a court of competent jurisdiction;
    3. Notice of the Member's right to contact the Division of Insurance for assistance at any time.

4. Notice of the right to initiate the External Review process for Adverse Determinations based on Medical Necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Determination letters will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights.
5. If the Adverse Determination is completely overturned, the decision notice will state the decision and the date.

10.16 EXTERNAL PROCEDURES FOR ADVERSE DETERMINATIONS OF PHARMACEUTICAL EXCEPTION REQUESTS

Sanford Health Plan follows all requirements for denials and appeals as it relates to any Adverse Determination when there has been a Medical Necessity determination based on pharmacy service, certification of non-covered medication or Formulary design issue. This applies to requests for coverage of non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols.

External Exception Review (Appeal) of a Standard Exception Request:

- If we deny a request for a Standard Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- The Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following the Plan's receipt of the request if the original request was a Standard Exception Request.
- If the Plan grants an External Exception Review of a Standard Exception Request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription.

External Exception Review (Appeal) of an Expedited (Urgent) Exception Request:

- If Sanford Health Plan denies a request for an Expedited Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- Sanford Health Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following our receipt of the request if the original request as an expedited exception.
- If Sanford Health Plan grants an External Exception Review of an Expedited Exception Request, we will provide coverage of the non- Formulary drug for the duration of the exigency.

10.17 STANDARD EXTERNAL REVIEW REQUEST PROCESSES & PROCEDURES

1. The Plan will follow the procedure for providing independent, external review of final determinations as outlined by federal ERISA regulations and rules governing the Plan in the Patient Protection and Affordable Care Act. Accordingly, an Independent External Review is not available for a Benefit Denial when it does not involve medical judgment.

NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding.

External Appeal Review Program – OVERVIEW

Members may file a request for External Review with Sanford Health Plan or with the North Dakota Insurance Commissioner. Refer to the Introduction section at the beginning of this document for contact information.

An expedited Appeal procedure is used when the condition is an Urgent Care Situation, as defined previously in this Certificate of Insurance.

An expedited review involving Urgent Care Requests for Adverse Determinations of Pre-service or Concurrent claims must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believe that an expedited determination is warranted. All of the procedures of a standard review described apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via oral notification by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than twenty-four (24) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within three (3) calendar days of the oral notification. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-urgent Pre-service or a Non-urgent post-service appeal, depending upon the circumstances.

If the expedited review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

10.18 EXTERNAL APPEAL REVIEW PROGRAM PROCEDURES

For independent, External Review of a final Adverse Determination, Sanford Health Plan will provide:

- Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
    - The Member is Appealing an Adverse Determination that is based on Medical Necessity (benefits Adverse Determinations are not eligible);
    - Sanford Health Plan has completed the internal Appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the available internal level of Appeal with the Member's permission;
    - The request for independent, External Review is filed within four (4) months of the date that Sanford Health Plan's Adverse Determination was made.
- Notification to Members about the independent, External Review program and decision are as follows:
    - General communications to Members, at least annually, to announce the availability of the right to

independent, External Review.
    - Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, External Appeal rights, directions on how to use the process, contact information for the independent, External Review organization, and a statement that the Member does not bear any costs of the independent, External Review organization, unless otherwise required by state law.

- The External Review organization will communicate its decision in clear terms in writing to the Member and Sanford Health Plan. The decision will include:

    - a general description of the reason for the request for external review;
    - the date the independent review organization received the assignment from Sanford Health Plan to conduct the external review;
    - the date the external review was conducted;
    - the date of its decision;
    - the principal reason(s) for the decision, including any, Medical Necessity rationale or evidence-based standards that were a basis for its decision; and
    - the list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision.
    - The External Review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.

- Conduct of the External Appeal Review program as follows:

    - A Member will contact Sanford Health Plan with an external review request.
    - Within five (5) business days following the date of receipt of the external review request, Sanford Health Plan shall complete a preliminary review of the request to determine whether:
    - The Member is or was a covered person at the time the health care service was requested or, in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
    - The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
    - The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust Sanford Health Plan's internal Appeal process as defined above; and
    - The Member has provided all the information and forms required to process an external review.

- Within one (1) business day after completion of the preliminary review, Sanford Health Plan shall notify the Member and, if applicable, the Member's authorized representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include in the notice what information or materials are needed to make the request complete; or if the request is not eligible for external review, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include the reasons for its ineligibility. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

- If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an independent review organization and notify in writing the Member, and, if applicable, the Member's Authorized Representative of the request's eligibility and acceptance for external review. The Member may submit in writing to the assigned Independent Review Organization within five (5) business days following the date of receipt of the notice provided by the NDID any additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.

- Within five (5) business days after the date the NDID determines the request is eligible for external review, of receipt, the NDID shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final Adverse Determination.

- The North Dakota Insurance Department contracts with the independent, external review organization that:
    - is accredited by a nationally recognized private accrediting entity;
    - conducts a thorough review, in which it considers all previously determined facts; allows the introduction of new information; considers and assesses sound medical evidence; and makes a decision that is not bound by the decisions or conclusions of Sanford Health Plan or determinations made in any prior appeal.
    - completes their review and issues a written final decision for non-urgent appeals within forty-five (45) calendar days of the request. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Member's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. Within forty-eight (48) hours after the date of providing the oral notification, the assigned independent review organization will provide written confirmation of the decision to the Member, or if applicable, the Member's Authorized Representative, and their treating Practitioner and/or Provider.
    - has no material professional, familial or financial conflict of interest with Sanford Health Plan.

- With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

- Sanford Health Plan will provide the Independent Review Organization with all relevant medical records as permitted by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including Sanford Health Plan's decision, criteria used and clinical reasons, utilization management criteria, communication from the Member to Sanford Health Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.

- The Member is not required to bear costs of the Independent Review Organization's review, including any filing fees. However, Sanford Health Plan is not responsible for costs associated with an attorney, physician or other expert, or the costs of travel to an independent, External Review hearing.

- The Member or his/her legal guardian may designate in writing a representative to act on his/her behalf. A Practitioner and/or Provider may not file an Appeal without explicit, written designation by the Member.

- The Independent Review Organization's decision is final and binding to Sanford Health Plan and Sanford Health Plan implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Member, because the Member has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a

Member may not file a subsequent request for external review involving the same Adverse Determination for which the Member has already received an external review decision.

- Sanford Health Plan maintains and tracks data on each appeal case, including descriptions of the denied item(s), reasons for denial, Independent, External Review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its Medical Necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

NOTE: ALL NOTIFICATIONS AND PROCEDURES DESCRIBED IN THIS SECTION, IN ADDITION TO THOSE RELATED TO BOTH BENEFIT AND MEDICAL CARE DETERMINATIONS IN SECTION 2, WILL COMPLY WITH APPLICABLE LAW. SHOULD A CONFLICT EXIST BETWEEN PLAN PROCEDURES AND FEDERAL REGULATIONS, FEDERAL REGULATIONS SHALL CONTROL.

A COMPLETE DESCRIPTION OF YOUR COMPLAINT (GRIEVANCE) AND APPEAL RIGHTS AND THE APPEAL PROCESS WILL BE INCLUDED IN DETERMINATION RESPONSES AND DECISIONS MADE BY SANFORD HEALTH PLAN. ADDITIONALLY, AN OVERVIEW OF YOUR COMPLAINT (GRIEVANCE) AND APPEAL RIGHTS, ALONG WITH AN APPEAL FILING FORM, IS INCLUDED IN ALL EXPLANATION OF BENEFITS (EOBS) GENERATED BY SANFORD HEALTH PLAN.

10.19 EXPEDITED EXTERNAL REVIEW REQUESTS

- A Member or the Member's Authorized Representative may request an expedited external review of an Adverse Determination if the Adverse Determination involves an Urgent Care requests for Prospective (pre-service) or Concurrent Review request for which
    - the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Member; or would jeopardize the Member's ability to regain maximum function; or
    - in the case of a request for Experimental or Investigational Services, the treating Provider certifies, in writing, that the requested Health Care Services or treatment would be significantly less effective if not promptly initiated.
- The Member has the right to contact the North Dakota Insurance Commissioner for assistance at any time.

- Immediately upon receipt of the request from the Member or the Member's Representative, the NDID shall determine whether the request is eligible for Expedited External Review. If the request is ineligible for an Expedited External Review as described in (1) above, the NDID will give notification to the Member or the Member's Representative that they may appeal to the state insurance department.

- Upon determination that the Expedited External Review request meets the reviewability requirements, the NDID shall assign a contracted, independent review organization to conduct the expedited external review. The assigned independent review organization is not bound by any decisions or conclusions reached during Sanford Health Plan's utilization review or internal appeal process.

- Sanford Health Plan will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.
- The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Member, and, if applicable, the Member's Authorized Representative, and the treating Practitioners and/or Providers as expeditiously as the Member's medical condition or circumstances requires but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within forty-eight (48) hours of the oral notification.
- At the same time a Member, or the Member's Authorized Representative, files a request for an internal Expedited Review of an Appeal involving an Adverse Determination, the Member, or the Member's Authorized Representative, may also file a request for an external Expedited External Review if the Member has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Member or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is an Experimental or Investigational Service and the Member's treating Practitioner and/or Provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated.
- Upon Sanford Health Plan's receipt of the independent review organization's decision to reverse the Adverse Determination, Sanford Health Plan shall immediately approve the coverage that was the subject of the Adverse Determination

SECTION 11
DEFINITIONS OF TERMS WE USE IN THIS CERTIFICATE OF INSURANCE

Adverse Determination	Any of the following determinations: The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination of a Member's eligibility to participate in the Plan; Any prospective review or retrospective Utilization Review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage determination.
Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
Admission	Entry into a facility as an Inpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Member is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by Sanford Health Plan.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: 1. Has an organized staff of Practitioners; 2. Has permanent facilities that are equipped and operated mostly for performing surgery; 3. Has continuous Practitioner services and Nursing Services when a patient is in the Facility; and Does not have services for an overnight stay.
Annual Enrollment	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
Approved Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: 1. A federally funded or approved trial; 2. A clinical trial conducted under an FDA investigational new medication application; or A medication trial that is exempt from the requirement of an FDA investigational new medication application.

Authorized Representative	A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Members for services related to Avoidable Hospital Conditions.
Basic Plan	The Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level. Health Care Providers accessed at the Basic Plan level are also Participating Providers.

Benefit Period	A specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a Calendar Year (January 1st through December 31st) Benefit Period.
Benefit Plan	The agreement with Sanford Health Plan, including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
[The] Board	Means the North Dakota Public Employees Retirement System (NDPERS) board.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Certification	Certification is a determination by Sanford Health Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness.
Claims Administrator or Claims Payor	Sanford Health Plan
Class of Coverage	The type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage under this Benefit Plan are Single Coverage and Family Coverage.
Coinsurance Amount	A percentage of the Allowed Charge for Covered Services that is a Member's responsibility.
Coinsurance Maximum Amount	The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital inpatient care including care received at a Residential Treatment Facility and ongoing outpatient services, including ongoing ambulatory care.
[This] Contract or [The] Contract	This Certificate of Insurance, which is a statement of the essential features and services given to the Subscriber by the Plan, including all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.

Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Cost Sharing	The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes coinsurance, copayments, or similar charges, but it doesn't include premiums, balance-billing amounts for non-network providers, or the cost of non-covered services.
Covered Services	Those Health Care Services to which a Member is entitled under the terms of This Contract.
Creditable Coverage	Benefits or coverage provided under: 1. A group health benefit plan (as such term is defined under North Dakota law); 2. A health benefit plan (as such term is defined under North Dakota law); 3. Medicare; 4. Medicaid; 5. Civilian health and medical program for uniformed services; 6. A health plan offered under 5 U.S.C. 89; 7. A medical care program of the Indian Health Service or of a tribal organization; 8. A state health benefits risk pool, including coverage issued under N.D.C.C. Chapter 26.1-08; 9. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; 10. A health benefit plan under Section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and 11. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
Custodial Care	Care designed to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.
Deductible Amount	A specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period.
Dependent	The Spouse and any Dependent Child of a Subscriber.
Dependent Child	The definition of a Dependent Child of a Subscriber includes a child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and The Dependent Child must be chiefly dependent on the Subscriber for support [N.D.C.C. §26.1-36-22 (3)(4)] .
Domiciliary Care	Domiciliary Care consists of a protected situation in a community or Facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require a 24-hour Facility or nursing care.
Eligible Dependent	An Eligible Dependent includes: (1) The Spouse of the Subscriber; (2) A Dependent child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility; and (3) a Dependent of Dependent (a) Is the natural child of the Subscriber's Dependent child, a child placed with the Subscriber's Dependent child for adoption, a legally adopted child by the Subscriber's Dependent child, a child for whom the Subscriber's Dependent child has legal guardianship, a stepchild of the Subscriber's Dependent child, or foster child of the Subscriber's Dependent child. These same definitions apply to dependents of the Dependent child(ren) of the Subscriber's living, covered Spouse; and (b) the Subscriber's
Eligible Dependent (CONTINUED)	Dependent child must be a Covered Dependent under this Certificate of Coverage for the dependent of the Dependent child to be eligible; and (c) The Dependent Child must be chiefly dependent on the Subscriber for support. [N.D.C.C. §26.1-36-22 (3)(4)].
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of NDPERS.

Emergency Care Services	Emergency Care Services means: (1) Within the Service Area: covered health care services rendered by Participating or Non-Participating Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Service Area include covered health care services from Non-Participating Providers only when delay in receiving care from Participating Providers could reasonably be expected to cause severe jeopardy to the Member's condition or (2) Outside the Service Area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the Plan's Service Area.
Emergency Medical Condition	A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.
Enrollee	An individual who is covered by this Plan.
ESRD	The federal End Stage Renal Disease program.
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews must be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: 1. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or 2. requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Family Coverage	The Class Of Coverage identifying that the Subscriber and Eligible Dependents are enrolled to received benefits for Covered Services under this Plan.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.
Gestational Carrier	An adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.

Grievance	A written complaint submitted in accordance with the Plan's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Member.
[The] Group or [This] Group	NDPERS has signed an agreement with Sanford Health Plan to provide health care benefits for its eligible employees, retirees, and Eligible Dependents.
Group Contract Holder	The individual to whom a Group Contract has been issued.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.
Health Savings Account (HSA)	A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses, and roll over year to year, if you don't spend them.
High Deductible Health Plan (HDHP)	A plan that features higher deductibles than traditional insurance plans. High Deductible Health Plans can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Practitioner and/or Provider's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities.

Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes an overnight stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
Iatrogenic Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
Infertility Services Deductible Amount	A specified dollar amount payable by the Member during their lifetime for infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.
In-Network Benefit Level	The PPO Plan level of benefits when a Member seeks services from a Participating Practitioner and/or Provider.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.
Intermediate Care	Intermediate Care means care in a Facility, corporation or association licensed or regulated by the State for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day.
Late Enrollee	An individual who enrolls in a group health plan on a date other than either the earliest date on which coverage can begin under the plan terms or on a special enrollment date.
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. *Exception: periodic reassessments are not considered Maintenance Care.*
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of (a)the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or Costs for facilities providing the same or similar services, plus a margin factor.

Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and A. help restore or maintain the Members health; or B. prevent deterioration of the Member's condition; or C. prevent the reasonably likely onset of a health problem or detect an incipient problem; or D. not considered Experimental or Investigative
Member	The Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents
Mental Health and/or Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
NDPERS	The North Dakota Public Employees Retirement System.
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill the Plan or Members for services related to Never Events.
Non-Covered Services	Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of This Contract.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by the Plan. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Non-Payable Health Care Provider.
Nursing Services	Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family.
Open Enrollment or Open Enrollment Period	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan

Out-of-Network Benefit Level	The Basic Plan level of benefits provided when a Member seeks services from a Non-Participating Practitioner and/or Provider. This is most often referred to as benefits received under the Basic Plan level but may include services received from Practitioners and/or Providers that have not signed a contract with the Plan.
Out-of-Pocket Maximum Amount	The total Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility during a Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.
Partial Hospitalization	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment.
Participating [Health Care] Provider	A Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan. A Participating Provider includes Providers at either the Basic or PPO Plan level.
Physician	An individual licensed to practice medicine or osteopathy.
[The] Plan or [This] Plan	Sanford Health Plan.
Plan Administrator	North Dakota Public Employees Retirement System (NDPERS)
PPO (Preferred Provider Organization) Plan	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. Health Care Providers accessed at the PPO level are also Participating Providers.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization	The process of the Member or the Member's representative notifying Sanford Health Plan to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Sections 2, 4 and 5. Preauthorization does not guarantee payment of benefits.
Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care Practitioner and/or Provider (PCP)	A Participating Practitioner and/or Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist, who is a Participating Practitioner, and who has been chosen to be designated as a Primary Care Practitioner and/or Provider as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.

Prior Approval	The process of the Member or Member's representative providing information to Sanford Health Plan substantiating the medical appropriateness of specified services in order to receive benefits for such service. This information must be submitted in writing from the Member's Health Care Provider. Sanford Health Plan reserves the right to deny benefits if Preauthorization/Prior Approval is not obtained.
Prospective (Pre-service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a Health Care Service or a course of treatment.
[Health Care] Provider	An individual, institution or organization that provides services for Plan Members. Examples of Providers include but are not limited to Hospitals, Physicians, Practitioners and/or Providers, and home health agencies.
Prudent Layperson	A person who is without medical training and who possess an average knowledge of health and medicine and who draws on his/her practical experience when making a decision regarding the need to seek Emergency medical treatment.
Qualifying Event	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby) and gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
Qualified Mental Health Professional	A licensed Physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service providers in psychology; a licensed certified social worker who is a board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Provider without certification or prior-authorization when certification/prior-authorization is required.
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Retrospective (Post-service) Review	Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.

Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Members or the Plan for services related to Serious Reportable Events.
[NDPERS] Service Agreement and/or [Group] Contract	The Service Agreement between NDPERS and Sanford Health Plan that is a contract for Health Care Services, which by its terms limits eligibility to enrollees of a specified group. The Group Contract may include coverage for Dependents.
Service Area	The geographic Service Area approved by the State's Insurance Department.
Single Coverage	The Class Of Coverage identifying that only the Subscriber is enrolled to received benefits for Covered Services under this Plan.
Skilled Nursing Facility	A Facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly-licensed Physician.
Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
[This] State	The State of North Dakota.
Subscriber	An Eligible Group Member who is enrolled in the Plan whose employment or other status (except family dependency) is the basis for eligibility for enrollment in the Plan. A Subscriber is also a Member and Enrollee.
Surrogate	An adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.
Summary of Benefits and Coverage or SBC	Attachment I of this Contract that sets forth important information on coverage and Cost Sharing.
Urgent Care Request	Means a request for a Health Care Service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination which: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24)* hours, such as stitches for a cut finger. Urgent care means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Us/We/Our	Refers to Sanford Health Plan
Utilization Review	A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Preauthorization/Prior Approval, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
You	Refers to the Subscriber or Member, as applicable.

ATTACHMENT I. SUMMARY OF BENEFITS AND COVERAGE

This page is intentionally left blank. Your Summary of Benefits and Coverage is an attachment to this Certificate of Coverage.

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

HP-3203 6-19

SANFORD HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

North Dakota Public Employees Retirement System High Deductible Non-Grandfathered Health Plan HSA Qualified

Coverage Period: 07/01/2025-06/30/2027

Coverage for: Individual + Family | Plan Type: PPO | Non-Grandfathered

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://ndpers.nd.gov/image/cache/shp-coi-hdhp.pdf or by calling 1-800-499-3416 *(toll free)* | TTY/TDD: 711 *(toll-free)*. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-499-3416 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO Providers: $2,000 individual / $4,000 family. Basic Providers: $2,000 individual / $4,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	PPO Providers: $3,500 individual / $7,000 family. Basic Providers: $4,000 individual / $8,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.com or call 1-800-499-3416 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	25% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	25% coinsurance after deductible	None
	Preventive care/screening/ Immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if these services you need are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	25% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/ pharmacy	Formulary Drugs	20% coinsurance after deductible	20% coinsurance after deductible	Prescription Medications or Drugs and nonprescription diabetes supplies are subject to a dispensing limit of 100-day supply. Specialty medications are limited to a 30-day supply. Insulin and medical supplies for insulin dosing and administration maximum $25 cost-share per 30-day supply. Deductible amount is waived for insulin only. Refer to your Formulary to determine which benefit applies to your medication. Certain contraceptive drugs covered at 100%.
	Non-Formulary Drugs	50% coinsurance after deductible	50% coinsurance after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	25% coinsurance after deductible	These services may require preauthorization / prior approval by the Health Plan.

	Physician/surgeon fees	20% coinsurance after deductible	25% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	None
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	25% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	20% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
If you are pregnant	Office visits	No charge	No charge	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Deductible is waived.
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.
	Rehabilitation services	20% coinsurance after deductible	25% coinsurance after deductible	For full details, please refer to your plan document.

	Habilitation services	20% coinsurance after deductible	25% coinsurance after deductible	For full details, please refer to your plan document.
	Skilled nursing care	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you need help recovering or have other special health needs	Durable medical equipment	20% coinsurance after deductible	25% coinsurance after deductible	Prior authorization may be required.
	Hospice services	20% coinsurance after deductible	25% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Coverage provided outside the United States. For full details, refer to your plan document.	• Private-duty nursing
• Chiropractic Care	• Hearing aids	• Routine foot care (for diabetics only)
	• Infertility treatment. $20,000 lifetime maximum	• Telehealth / e-visits / video visits

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: North Dakota Insurance Department at 1-800-247-0560. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Grievances at 1-800-499-3416 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-752-5863 (*toll-free).*
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-5863 (*toll-free).*
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-752-5863 (*toll-free).*
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-5863 (*toll-free).*

————To see examples of how this plan might cover costs for a sample medical situation, see the next section. ————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,360

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,200

The plan would be responsible for the other costs of these EXAMPLE covered services

Attachment 3

EXHIBIT B

Health Plan Performance Guarantees
2025-2027

	Performance Guarantee	Requirement	Measurement	Value of Forfeiture
1	**Plan Performance Review**	Within ten (10) calendar days following delivery of performance reviews to NDPERS, vendor shall develop and submit a corrective action plan (CAP) of issues identified for approval by NDPERS, and implement such plan within the time prescribed in the approved CAP.	Measurement methodology shall be measured from date of delivery of the plan performance review in calendar days	$1,000 per calendar day beyond the due date
2	**Customer Satisfaction Surveys**	Member satisfaction surveys will be designed by the vendor and approved by NDPERS. Vendor will invite a random sample of members to participate in the survey to collect a statistically significant number of completed surveys. Using a 1-5 scale of Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. SHP will meet or exceed a 90% satisfaction rate across all survey questions.	Vendor will provide annual survey results to confirm compliance with performance standard	***Biannually (every 2 years)*** 8 of 10 @ 90% = 5,000 7 of 10 @ 90% = 10,000 <6 of 10@ 90% = 25,000
3	**Team Meetings**	NDPERS requires monthly team meetings to address all planning / implementation, business, financial, clinical / formulary (including new drug review) and operational needs.	Compliance to be monitored and assessed by NDPERS	$5,000 for each meeting missed
4	**NDPERS board meetings**	Vendor will participate in quarterly performance reviews to examine operational and financial performance.	Compliance to be monitored and assessed by NDPERS	$5,000 for each quarter missed
5	**Electronic Eligibility**	Eligibility files will be uploaded within eight (8) hours when received before 1:00 PM CST. All transactions within the file will be completed by SHP within eighteen (18) business hours from the time the NDPERS file has been received, excluding errors requiring corrective action taken by NDPERS before the data can be uploaded and completed. Files received after 1:00 PM CST will be considered off-schedule and completed within 24 hours of receipt.	Vendor will provide annual reports to confirm compliance with performance standard	$500 for each missed file deadline

	Performance Guarantee	Requirement	Measurement	Value of Forfeiture
6	**Manual Eligibility**	Manual eligibility will be loaded within eight (8) hours upon receipt or notification and must be applied and active in the vendor's system within one (1) business day, excluding transactions requiring information or corrective action to be taken by NDPERS to complete eligibility.	Vendor will provide audit results quarterly to confirm compliance with performance standard	$500 for each missed file deadline
7	**Fatal Error Reports**	The fatal error report identifying critical errors will be completed by SHP within eighteen (18) business hours from the time the NDPERS file received before 1:00 PM CST. Files received after 1:00 PM CST will be considered off-schedule and completed within 24 hours of receipt.	Vendor will notify NDPERS within eighteen (18) business hours from the time the fatal error report is received.	$500 for each missed file deadline
8	**Data Files**	Monthly data files (membership, medical, pharmacy) will be available by the 15th of the following month.	Will be available to NDPERS upon request	$1,000 for each month not met
9	**Health Risk Assessment**	By June 30, 2027, at least 18% of eligible NDPERS members will have completed a Health Risk Assessment.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	17.99%-15% = $2,500 14.99%-12.01% = $5,000 12% or less= $10,000 For the biennium
10	**Worksite Interventions**	By June 30, 2027, at least 75% of participating employer-based wellness program agencies will have implemented a worksite intervention (i.e., wellness consultation, fruit program, , wellness training, screening & prevention event, walking program, etc.).	Compliance to be monitored and assessed by NDPERS	$5,000 if not achieved for the biennium
11	**Diabetes Management**	By December 31 of each calendar year, SHP will have engaged at least 5% of diagnosed pre-diabetic and/or diabetic population of members in an intervention program that may include, but is not limited to: DPP, Livongo, Exercise is Medicine, Positively Me, Daily Habits, or Better Choices Better Health.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$5,000 for each calendar year of the biennium
12	**Fitness Center Reimbursement**	By Dec. 31st of each calendar year, at least 5% of eligible members will receive the fitness center reimbursement in at least one month during the 2025 calendar year or will have tracked at least 150 minutes of exercise per week for three weeks in the wellness portal. By Dec. 31st of each calendar year, at least 5% of eligible members will receive the fitness center reimbursement in at least one month during the 2026 calendar year or will have tracked at least 150 minutes of exercise per week for three weeks in the wellness portal.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	4.9-4% = $2,500 3.9-3% = $5,000 2.9 or less = $10,000 For each calendar year of the biennium

	Performance Guarantee	Requirement	Measurement	Value of Forfeiture
13	**Wellness Redemption Center (online and worksite activity only)**	By Dec. 31st of each calendar year, $850,000 will be paid out in the wellness redemption center for the 2025 calendar year. By Dec. 31st of each calendar year, 9% of eligible members will have processed a redemption for wellness activity during the 2025 calendar year. By Dec. 31st of each calendar year, $850,000 will be paid out in the wellness redemption center for the 2026 calendar year. By Dec. 31st of each calendar year, 9% of eligible members will have processed a redemption for wellness activity during the 2026 calendar year.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$849,999-700,000 = $2,500 $699,999-600,000 = $5,000 $599,000 or less= $7,500 For each year of the biennium
14	**Healthy Pregnancy Program & High-Risk Obstetric Case Management**	a) At least 33% of eligible pregnant NDPERS members will be enrolled in the Health Pregnancy Program between July 1, 2025-June 30, 2027. b) At least 25% of eligible high risk pregnant NDPERS members will be enrolled in the High-Risk Obstetric Case Management Program between July 1, 2025- June 30, 2027.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$7,500 for each goal (a & b) for each year of the biennium with a $15,000 max for each year of the biennium Note: PG for each metric will be calculated by SHP using the n of enrolled by the total eligible for each year of the biennium
15	**HEDIS-like measures**	Breast cancer screening rates will be at least 80%	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$15,000 for the 2-year biennium
16	**HEDIS-like measures**	Cervical cancer screening rates will be at least 85%	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$15,000 for the 2-year biennium
17	**HEDIS-like measures**	Colorectal cancer screening rates will be at least 60%	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$15,000 for the 2-year biennium
18	**NDPERS PPO network**	Vendor shall maintain ninety-two (92%) percent or more of hospitals, practicing MD's and DOs of the proposed network.	Vendor will provide a quarterly Executive Summary report to	$75,000 for the 2-year biennium

	Performance Guarantee	Requirement	Measurement	Value of Forfeiture
			confirm compliance with performance standard	
19	**Claims Financial Accuracy**	Claims Financial Accuracy will be 99% or greater, each year of the biennium. Measured as the absolute value of financial errors divided by the total paid value of audited dollars paid based on quarterly internal audit of statistically valid sample.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$12,500 for each year of the biennium
20	**Claims Payment Accuracy**	Claims Payment incidence Accuracy will be 98% or greater, each year of the biennium. Measured as the percent of Claims processed without financial payment error.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$12,500 for each year of the biennium
21	**Claims Processing Accuracy**	Claims Procedural Accuracy will be 95% or greater, each year of the biennium. Measured as the percent of Claims processed without non-financial error.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$12,500 for each year of the biennium
22	**Claim Timeliness**	Clean claims processing within 14 calendar days will be 95% or greater, each year of the biennium. Measured from the date the claim is received to the date the claim is processed.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$12,500 for each year of the biennium
23	**Average Speed of Answer**	Average Speed of Answer will be 30 seconds or less, each year of the biennium. Vendor will have an established measurement process that shall be reviewed with NDPERS. SHP shall be at risk of $1,000 per month for not meeting the 30 second average speed of answer guarantee.	Vendor will provide a quarterly Executive Summary report to confirm compliance with the performance standard.	$12,000 maximum for each year of the biennium $1,000 per month if the average speed of answer is greater than 30 seconds.
24	**Call Abandonment**	Call Abandonment rate will be 5% or less, each year of the biennium.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$10,000 for each year of the biennium
25	**Accuracy and Timelines/ First Call Resolution Written Inquiry Response Time**	a.) 95% of inquiries must be resolved during the initial call, excluding appeals, billing errors, and escalations. b.) 95% of written inquiries must be responded to within 24 business hours of date stamp of receipt, excluding appeals, billing errors and escalations.	Vendor must evaluate a statistically valid sample of inquiries with reports provided.	$6,250 for each goal (a & b) for each year with a $12,500 maximum for each year of the biennium.

	Performance Guarantee	Requirement	Measurement	Value of Forfeiture
26	**Over payment Recovery**	One hundred percent (100%) of all confirmed overpayments identified from Sanford HealthPlan participating providers shall be recovered/requested within 90 days when the overpayment can be deducted from the payment cycle. Refunds from nonparticipating providers will be deducted from future payments. A refund request will be submitted for nonpayment after 90 days.	Vendor will provide annual reports to confirm compliance with performance standard	$12,500 for each year of the biennium
27	**Access Rate to Primary Care Physicians**	Sanford Health Plan shall meet NDCC, 26.1-47-03 which defines appropriate access and availability for primary care providers as 50 miles for primary care physicians if eligible providers exist within 50 miles of the home ZIP Code.	Vendor will provide annual reports to confirm compliance with performance standard	$5,000 for each full % below for each of the biennium.
28	**Access Rate to Pediatricians**	Sanford Health Plan shall meet NDCC, 26.1-47-03 which defines appropriate access and availability for primary care providers as 50 miles for Pediatricians if eligible providers exist within 50 miles of the home ZIP Code.	Vendor will provide annual reports to confirm compliance with performance standard	$5,000 for each full % below for each of the biennium.
29	**Access Rate to Specialists and OB/GYNs**	Sanford Health Plan shall meet NDCC, 26.1-47-03 which defines appropriate access and availability for Specialists and OBGYNs if eligible providers exist within 50 miles of the home ZIP Code.	Vendor will provide annual reports to confirm compliance with performance standard	$5,000 for each full % below for each of the biennium.
30	**Access Rate to Hospitals**	Sanford Health Plan shall meet NDCC, 26.1-47-03, which defines appropriate access and availability for hospital if eligible providers exist within 50 miles of the home ZIP Code.	Vendor will provide annual reports to confirm compliance with performance standard	$5,000 for each full % below for each of the biennium.
31	**Payment to NDPSC for the About the Patient Program**	Payments will be made within 5 business days of approval to NDPSC for the About the Patient program.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$10,000 per year
32	**Interest rate on funds held by vendor under the fully insured contract**	Rate as determined by NDPERS and vendor.	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$5,000 per occurrence

	Performance Guarantee	Requirement	Measurement	Value of Forfeiture
33	**Prescription drug turnaround time – clean prescriptions**	98% within two (2) business days if no intervention required.	Vendor will provide quarterly reports to confirm compliance with performance standard	$1,000 for each point below standard for each year of the biennium
34	**Prescription drug mail dispensing accuracy**	99.9% Mail service dispensing accuracy rate. Fields measured include member name, drug strength, directions, quantity, and prescriber name.	Vendor will provide annual reports to confirm compliance with performance standard	$12,500 for each year of the biennium
35	**Prescription drug home delivery pharmacy intervention prescription turnaround.**	At least 95 percent of non-routine prescription orders will be shipped within five business days. • Measured in whole business days from the date a prescription order is received by Administrator (either by mail, phone, fax, or Internet) to the date the prescription order is shipped. • Calculated by taking the number of intervention prescription orders shipped within five business days divided by the total number of intervention prescription orders.	Vendor will provide annual reports to confirm compliance with performance standard	$12,500 for each year of the biennium
36	**Prescription drug specialty pharmacy delivery**	PBM Specialty Pharmacies guarantee on time delivery of Specialty Drugs by the Member “needs by” date at least ninety eight percent (98%) of the time.	Vendor will provide annual reports to confirm compliance with performance standard	$12,500 for each year of the biennium
37	**Network Pharmacy Access**	Pharmacy network composition will not be reduced by more than 5% in North Dakota compared to the network submitted in the RFP.	Vendor will provide annual reports to confirm compliance with performance standard	$12,500 for each year of the biennium
38	**Medical Network Discount**	Vendor will guarantee a minimum provider discount from in-network providers of at least 30% be calculated as (1- (Allowed/Billed Charge)).	Vendor will provide a quarterly Executive Summary report to confirm compliance with performance standard	$500,000 for the 2-year biennium

Forfeiture values are calculated on a calendar year basis. Any forfeiture that occurs during or at the end of a calendar year will be paid within 30 days of the run-out period required to calculate the Performance Guarantee criteria.

Attachment 4

EXHIBIT C
Premium Rate Structure Table
2025-2027

JULY 2025 NDPERS Health Rates

Rate Structure A

For Anyone Enrolled Prior to July 1, 2025

Rates for July 1, 2025 - June 30, 2027

Code	Struct	Description	Total Health Premiums	Medicare Part D Premiums	Total Premiums	Less NDPERS Retention	Total Prem Paid to SHP	Total Prem Paid to Humana	Total Paid to SHP	NDPERS Retention	**NDPERS Billing Rate**
Medicare Retiree											
41	11	1 Medicare only	$234.76	$60.74	$295.50	$2.80	$231.96	$60.74	$231.96	$2.80	**$295.50**
42	11	2 Medicare only	$466.42	$121.48	$587.90	$2.80	$463.62	$121.48	$463.62	$2.80	**$587.90**
50	11	3 Medicare only	$697.78	$182.22	$880.00	$2.80	$694.98	$182.22	$694.98	$2.80	**$880.00**
51	11	4 Medicare only	$929.46	$242.96	$1,172.42	$2.80	$926.66	$242.96	$926.66	$2.80	**$1,172.42**
43	11	1 Medicare+Others	$894.56	$60.74	$955.30	$2.80	$891.76	$60.74	$891.76	$2.80	**$955.30**
49	11	2 Medicare+Others	$1,126.22	$121.48	$1,247.70	$2.80	$1,123.42	$121.48	$1,123.42	$2.80	**$1,247.70**
55	11	3 Medicare+Others	$1,357.58	$182.22	$1,539.80	$2.80	$1,354.78	$182.22	$1,354.78	$2.80	**$1,539.80**
58	11	4 Medicare+Others	$1,589.26	$242.96	$1,832.22	$2.80	$1,586.46	$242.96	$1,586.46	$2.80	**$1,832.22**
44	11	Part A Single	$589.72	$60.74	$650.46	$2.80	$586.92	$60.74	$586.92	$2.80	**$650.46**
Grandfathered Rates											
42	14	2 Medicare only	$466.08	$121.48	$587.56	$2.80	$463.28	$121.48	$463.28	$2.80	**$587.56**
50	14	3 Medicare only	$494.54	$182.22	$676.76	$2.80	$491.74	$182.22	$491.74	$2.80	**$676.76**
51	14	4 Medicare only	$302.44	$242.96	$545.40	$2.80	$299.64	$242.96	$299.64	$2.80	**$545.40**
Medicare Retirees COBRA (for Non-Medicare dependents of Medicare Retirees)											
30	11	Single	$662.60		$662.60	$2.80	$659.80		$659.80	$13.18	**$672.98**
31	11	Family	$935.11		$935.11	$2.80	$932.31		$932.31	$18.41	**$950.72**

JULY 2025 NDPERS Health Rates

Rate Structure A

For Anyone Enrolled Prior to July 1, 2025

Rates for July 1, 2025 - June 30, 2027

Non-Medicare Retiree

21	11	Single	$1,366.90	$2.80	$1,364.10	$1,364.10	$2.80	**$1,366.90**
22	11	Family	$2,733.80	$2.80	$2,731.00	$2,731.00	$2.80	**$2,733.80**
23	11	Family (3+)	$3,417.26	$2.80	$3,414.46	$3,414.46	$2.80	**$3,417.26**
COBRA								
24	11	Single	$1,366.90	$2.80	$1,364.10	$1,364.10	$30.14	**$1,394.24**
25	11	Family	$2,733.80	$2.80	$2,731.00	$2,731.00	$57.48	**$2,788.48**
26	11	Family (3+)	$3,417.26	$2.80	$3,414.46	$3,414.46	$71.16	**$3,485.62**

State Contracts with Wellness Program

Active			(Flat Single/Family Rate)					
1-3	2	S/F/Dual	$1,893.30	$2.80	$1,890.50	$1,890.50	$2.80	**$1,893.30**
COBRA								
4	2	Single	$911.26	$2.80	$908.46	$908.46	$21.00	**$929.46**
5	2	Family	$2,197.56	$2.80	$2,194.76	$2,194.76	$46.74	**$2,241.50**
Part-Time/Temporary/LOA								
6	2	Single	$911.26	$2.80	$908.46	$908.46	$2.80	**$911.26**
7	2	Family	$2,197.56	$2.80	$2,194.76	$2,194.76	$2.80	**$2,197.56**
Active HDHP								
1-3	17	S/F/Dual	$1,652.80	$2.80	$1,650.00	$1,650.00	$243.30	**$1,893.30**
COBRA HDHP								
4	17	Single	$791.64	$2.80	$788.84	$788.84	$18.64	**$807.48**
5	17	Family	$1,908.20	$2.80	$1,905.40	$1,905.40	$40.92	**$1,946.32**
LOA HDHP								
6	17	Single	$791.64	$2.80	$788.84	$788.84	$2.80	**$791.64**
7	17	Family	$1,908.20	$2.80	$1,905.40	$1,905.40	$2.80	**$1,908.20**

JULY 2025 NDPERS Health Rates

Rate Structure A

For Anyone Enrolled Prior to July 1, 2025

Rates for July 1, 2025 - June 30, 2027

State Contracts w/o Wellness Program

			(Flat Single/Family Rate)					
Active								
1-3	1	S/F/Dual	$1,893.30	$2.80	$1,890.50	$1,890.50	$21.72	**$1,912.22**
COBRA								
4	1	Single	$911.26	$2.80	$908.46	$908.46	$21.00	**$929.46**
5	1	Family	$2,197.56	$2.80	$2,194.76	$2,194.76	$46.74	**$2,241.50**
Part-Time/Temporary/LOA								
6	1	Single	$911.26	$2.80	$908.46	$908.46	$11.92	**$920.38**
7	1	Family	$2,197.56	$2.80	$2,194.76	$2,194.76	$24.76	**$2,219.52**
Active HDHP								
1-3	16	S/F/Dual	$1,652.80	$2.80	$1,650.00	$1,650.00	$262.22	**$1,912.22**
COBRA HDHP								
4	16	Single	$791.64	$2.80	$788.84	$788.84	$18.64	**$807.48**
5	16	Family	$1,908.20	$2.80	$1,905.40	$1,905.40	$40.92	**$1,946.32**
LOA HDHP								
6	16	Single	$791.64	$2.80	$788.84	$788.84	$10.72	**$799.56**
7	16	Family	$1,908.20	$2.80	$1,905.40	$1,905.40	$21.86	**$1,927.26**

Political Subdivision Rates with Wellness Program

Active								
1	4	Single	$973.64	$2.80	$970.84	$970.84	$2.80	**$973.64**
2	4	Family	$2,353.58	$2.80	$2,350.78	$2,350.78	$2.80	**$2,353.58**
COBRA								
4	4	Single	$973.64	$2.80	$970.84	$970.84	$22.22	**$993.06**
5	4	Family	$2,353.58	$2.80	$2,350.78	$2,350.78	$49.84	**$2,400.62**
Temps								
6	4	Single	$973.64	$2.80	$970.84	$970.84	$2.80	**$973.64**
7	4	Family	$2,353.58	$2.80	$2,350.78	$2,350.78	$2.80	**$2,353.58**

JULY 2025 NDPERS Health Rates

Rate Structure A

For Anyone Enrolled Prior to July 1, 2025

Rates for July 1, 2025 - June 30, 2027

Political Subdivision Rates w/o Wellness Program

Active								
1	3	Single	$973.64	$2.80	$970.84	$970.84	$12.52	**$983.36**
2	3	Family	$2,353.58	$2.80	$2,350.78	$2,350.78	$26.32	**$2,377.10**
COBRA								
4	3	Single	$973.64	$2.80	$970.84	$970.84	$22.22	**$993.06**
5	3	Family	$2,353.58	$2.80	$2,350.78	$2,350.78	$49.84	**$2,400.62**
Temps								
6	3	Single	$973.64	$2.80	$970.84	$970.84	$12.52	**$983.36**
7	3	Family	$2,353.58	$2.80	$2,350.78	$2,350.78	$26.32	**$2,377.10**

NGF Political Subdivision Rates with Wellness Program

Active								
1	24	Single	$985.46	$2.80	$982.66	$982.66	$2.80	**$985.46**
2	24	Family	$2,382.24	$2.80	$2,379.44	$2,379.44	$2.80	**$2,382.24**
COBRA								
4	24	Single	$985.46	$2.80	$982.66	$982.66	$22.50	**$1,005.16**
5	24	Family	$2,382.24	$2.80	$2,379.44	$2,379.44	$50.44	**$2,429.88**
Temps								
6	24	Single	$985.46	$2.80	$982.66	$982.66	$2.80	**$985.46**
7	24	Family	$2,382.24	$2.80	$2,379.44	$2,379.44	$2.80	**$2,382.24**
Active HDHP								
1	26	Single	$869.80	$2.80	$867.00	$867.00	$2.80	**$869.80**
2	26	Family	$2,102.78	$2.80	$2,099.98	$2,099.98	$2.80	**$2,102.78**
COBRA HDHP								
4	26	Single	$869.80	$2.80	$867.00	$867.00	$20.18	**$887.18**
5	26	Family	$2,102.78	$2.80	$ 2,099.98	$2,099.98	$44.84	**$2,144.82**
Temps HDHP								
6	26	Single	$869.80	$2.80	$867.00	$867.00	$2.80	**$869.80**
7	26	Family	$2,102.78	$2.80	$ 2,099.98	$2,099.98	$2.80	**$2,102.78**

JULY 2025 NDPERS Health Rates
Rate Structure A
For Anyone Enrolled Prior to July 1, 2025
Rates for July 1, 2025 - June 30, 2027

NGF Political Subdivision Rates w/o Wellness Program

Active								
1	23	Single	$985.46	$2.80	$982.66	$982.66	$12.62	**$995.28**
2	23	Family	$2,382.24	$2.80	$2,379.44	$2,379.44	$26.60	**$2,406.04**
COBRA								
4	23	Single	$985.46	$2.80	$982.66	$982.66	$22.50	**$1,005.16**
5	23	Family	$2,382.24	$2.80	$2,379.44	$2,379.44	$50.44	**$2,429.88**
Temps								
6	23	Single	$985.46	$2.80	$982.66	$982.66	$12.62	**$995.28**
7	23	Family	$2,382.24	$2.80	$2,379.44	$2,379.44	$26.60	**$2,406.04**
Active HDHP								
1	25	Single	$869.80	$2.80	$867.00	$867.00	$11.50	**$878.50**
2	25	Family	$ 2,102.78	$2.80	$ 2,099.98	$2,099.98	$23.86	**$2,123.84**
COBRA HDHP								
4	25	Single	$869.80	$2.80	$867.00	$867.00	$20.18	**$887.18**
5	25	Family	$2,102.78	$2.80	$ 2,099.98	$ 2,099.98	$44.84	**$2,144.82**
Temps HDHP								
6	25	Single	$869.80	$2.80	$867.00	$867.00	$11.50	**$878.50**
7	25	Family	$2,102.78	$2.80	$2,099.98	$ 2,099.98	$23.86	**$2,123.84**

Health, RX & HMO Insurance Plans:

Medicare Retiree (NonMedicare Split Rate)			
98	11	Single NM Dependents with GF Status	**$659.80**
99	11	Family NM Dependents with GF Status	**$659.80**
Pre-Medicare			
98	14	Single NM Dependents with GF Status	**$282.14**
99	14	Family NM Dependents with GF Status	**$282.14**

JULY 2025 NDPERS Health Rates

Rate Structure A

For Anyone Enrolled Prior to July 1, 2025

Rates for July 1, 2025 - June 30, 2027

GAP Coverage

61	11	GAP Single			$1,365.02	$2.80	$1,362.22		$1,362.22	$2.80	**$1,365.02**
62	11	GAP Family			$2,726.32	$2.80	$2,723.52		$2,723.52	$2.80	**$2,726.32**
63	11	GAP Family (3+)			$3,406.96	$2.80	$3,404.16		$3,404.16	$2.80	**$3,406.96**
64	11	GAP 1 Medicare + Others	$894.56	$60.74	$955.30	$2.80	$891.76	$60.74	$891.76	$2.80	**$955.30**
65	11	GAP 2 Medicare + Others	$1,126.22	$121.48	$1,247.70	$2.80	$1,123.42	$121.48	$1,123.42	$2.80	**$1,247.70**
66	11	GAP 3 Medicare + Others	$1,357.58	$182.22	$1,539.80	$2.80	$1,354.78	$182.22	$1,354.78	$2.80	**$1,539.80**
67	11	GAP 4 Medicare + Others	$1,589.26	$242.96	$1,832.22	$2.80	$1,586.46	$242.96	$1,586.46	$2.80	**$1,832.22**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2025 - June 30, 2026

Code	Struct	Description	Total Health Premiums	Medicare Part D Premiums	Total Premiums	Less NDPERS Retention	Total Prem Paid to SHP In Struct A	Total Prem Paid to Humana	Change From Sturcture A	Total Paid to SHP	NDPERS Retention	**NDPERS Billing Rate**
Medicare Retiree												
41	12	1 Medicare only	$231.74	$60.74	$292.48	$2.80	$231.96	$60.74	($3.02)	$228.94	$2.80	**$292.48**
42	12	2 Medicare only	$460.40	$121.48	$581.88	$2.80	$463.62	$121.48	($6.02)	$457.60	$2.80	**$581.88**
50	12	3 Medicare only	$688.76	$182.22	$870.98	$2.80	$694.98	$182.22	($9.02)	$685.96	$2.80	**$870.98**
51	12	4 Medicare only	$917.42	$242.96	$1,160.38	$2.80	$926.66	$242.96	($12.04)	$914.62	$2.80	**$1,160.38**
43	12	1 Medicare+Others	$874.40	$60.74	$935.14	$2.80	$891.76	$60.74	($20.16)	$871.60	$2.80	**$935.14**
49	12	2 Medicare+Others	$1,103.06	$121.48	$1,224.54	$2.80	$1,123.42	$121.48	($23.16)	$1,100.26	$2.80	**$1,224.54**
55	12	3 Medicare+Others	$1,331.42	$182.22	$1,513.64	$2.80	$1,354.78	$182.22	($26.16)	$1,328.62	$2.80	**$1,513.64**
58	12	4 Medicare+Others	$1,560.08	$242.96	$1,803.04	$2.80	$1,586.46	$242.96	($29.18)	$1,557.28	$2.80	**$1,803.04**
Medicare Retirees COBRA (for Non-Medicare dependents of Medicare Retirees)												
30	12	Single			$645.46	$2.80	$659.80		($17.14)	$642.66	$13.18	**$655.84**
31	12	Family			$910.89	$2.80	$932.31		($24.22)	$908.09	$18.41	**$926.50**
21	12	Single			$1,366.90	$2.80	$1,364.10			$1,364.10	$2.80	**$1,366.90**
22	12	Family			$2,733.80	$2.80	$2,731.00			$2,731.00	$2.80	**$2,733.80**
23	12	Family (3+)			$3,417.26	$2.80	$3,414.46			$3,414.46	$2.80	**$3,417.26**
COBRA												
24	12	Single			$1,366.90	$2.80	$1,364.10			$1,364.10	$30.14	**$1,394.24**
25	12	Family			$2,733.80	$2.80	$2,731.00			$2,731.00	$57.48	**$2,788.48**
26	12	Family (3+)			$3,417.26	$2.80	$3,414.46			$3,414.46	$71.16	**$3,485.62**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2025 - June 30, 2026

Political Subdivision Rates with Wellness Program

Active									
1	8	Single	$948.42	$2.80	$970.84	($25.22)	$945.62	$2.80	**$948.42**
2	8	Family	$2,292.48	$2.80	$2,350.78	($61.10)	$2,289.68	$2.80	**$2,292.48**
COBRA									
4	8	Single	$948.42	$2.80	$970.84	($25.22)	$945.62	$21.72	**$967.34**
5	8	Family	$2,292.48	$2.80	$2,350.78	($61.10)	$2,289.68	$48.66	**$2,338.34**
Temps									
6	8	Single	$948.42	$2.80	$970.84	($25.22)	$945.62	$2.80	**$948.42**
7	8	Family	$2,292.48	$2.80	$2,350.78	($61.10)	$2,289.68	$2.80	**$2,292.48**

Political Subdivision Rates w/o Wellness Program

Active									
1	7	Single	$948.42	$2.80	$970.84	($25.22)	$945.62	$12.28	**$957.90**
2	7	Family	$2,292.48	$2.80	$2,350.78	($61.10)	$2,289.68	$25.74	**$2,315.42**
COBRA									
4	7	Single	$948.42	$2.80	$970.84	($25.22)	$945.62	$21.72	**$967.34**
5	7	Family	$2,292.48	$2.80	$2,350.78	($61.10)	$2,289.68	$48.66	**$2,338.34**
Temps									
6	7	Single	$948.42	$2.80	$970.84	($25.22)	$945.62	$12.28	**$957.90**
7	7	Family	$2,292.48	$2.80	$2,350.78	($61.10)	$2,289.68	$25.74	**$2,315.42**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2025 - June 30, 2026

NGF Political Subdivision Rates with Wellness Program

Active									
1	28	Single	$959.92	$2.80	$982.66	($25.54)	$957.12	$2.80	**$959.92**
2	28	Family	$2,320.38	$2.80	$2,379.44	($61.86)	$2,317.58	$2.80	**$2,320.38**
COBRA									
4	28	Single	$959.92	$2.80	$982.66	($25.54)	$957.12	$21.98	**$979.10**
5	28	Family	$2,320.38	$2.80	$2,379.44	($61.86)	$2,317.58	$49.22	**$2,366.80**
Temps									
6	28	Single	$959.92	$2.80	$982.66	($25.54)	$957.12	$2.80	**$959.92**
7	28	Family	$2,320.38	$2.80	$2,379.44	($61.86)	$2,317.58	$2.80	**$2,320.38**
Active HDHP									
1	30	Single	$847.28	$2.80	$867.00	($22.52)	$844.48	$2.80	**$847.28**
2	30	Family	$2,048.24	$2.80	$2,099.98	($54.54)	$2,045.44	$2.80	**$2,048.24**
COBRA HDHP									
4	30	Single	$847.28	$2.80	$867.00	($22.52)	$844.48	$19.74	**$864.22**
5	30	Family	$2,048.24	$2.80	$2,099.98	($54.54)	$2,045.44	$43.74	**$2,089.18**
Temps HDHP									
6	30	Single	$847.28	$2.80	$867.00	($22.52)	$844.48	$2.80	**$847.28**
7	30	Family	$2,048.24	$2.80	$2,099.98	($54.54)	$2,045.44	$2.80	**$2,048.24**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2025 - June 30, 2026

NGF Political Subdivision Rates w/o Wellness Program

Active									
1	27	Single	$959.92	$2.80	$982.66	($25.54)	$957.12	$12.40	**$969.52**
2	27	Family	$2,320.38	$2.80	$2,379.44	($61.86)	$2,317.58	$25.98	**$2,343.56**
COBRA									
4	27	Single	$959.92	$2.80	$982.66	($25.54)	$957.12	$21.98	**$979.10**
5	27	Family	$2,320.38	$2.80	$2,379.44	($61.86)	$2,317.58	$49.22	**$2,366.80**
Temps									
6	27	Single	$959.92	$2.80	$982.66	($25.54)	$957.12	$12.40	**$969.52**
7	27	Family	$2,320.38	$2.80	$2,379.44	($61.86)	$2,317.58	$25.98	**$2,343.56**
Active HDHP									
1	29	Single	$847.28	$2.80	$867.00	($22.52)	$844.48	$11.26	**$855.74**
2	29	Family	$2,048.24	$2.80	$2,099.98	($54.54)	$2,045.44	$23.26	**$2,068.70**
COBRA HDHP									
4	29	Single	$847.28	$2.80	$867.00	($22.52)	$844.48	$19.74	**$864.22**
5	29	Family	$2,048.24	$2.80	$2,099.98	($54.54)	$2,045.44	$43.74	**$2,089.18**
Temps HDHP									
6	29	Single	$847.28	$2.80	$867.00	($22.52)	$844.48	$11.26	**$855.74**
7	29	Family	$2,048.24	$2.80	$2,099.98	($54.54)	$2,045.44	$23.26	**$2,068.70**

Medicare Retiree (NonMedicare Split Rate)

98	12	Single NM Dependents with GF Status	**$642.66**
99	12	Family NM Dependents with GF Status	**$642.66**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2025 - June 30, 2026

GAP Coverage

61	12	GAP Single			$1,329.66	$2.80	$1,362.22		($35.36)	$1,326.86	$2.80	**$1,329.66**
62	12	GAP Family			$2,655.52	$2.80	$2,723.52		($70.80)	$2,652.72	$2.80	**$2,655.52**
63	12	GAP Family (3+)			$3,318.48	$2.80	$3,404.16		($88.48)	$3,315.68	$2.80	**$3,318.48**
64	12	GAP 1 Medicare + Others	$874.40	$60.74	$935.14	$2.80	$891.76	$60.74	($20.16)	$871.60	$2.80	**$935.14**
65	12	GAP 2 Medicare + Others	$1,103.06	$121.48	$1,224.54	$2.80	$1,123.42	$121.48	($23.16)	$1,100.26	$2.80	**$1,224.54**
66	12	GAP 3 Medicare + Others	$1,331.42	$182.22	$1,513.64	$2.80	$1,354.78	$182.22	($26.16)	$1,328.62	$2.80	**$1,513.64**
67	12	GAP 4 Medicare + Others	$1,560.08	$242.96	$1,803.04	$2.80	$1,586.46	$242.96	($29.18)	$1,557.28	$2.80	**$1,803.04**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2026 - June 30, 2027

Code	Struct	Description	Total Health Premiums	Medicare Part D Premiums	Total Premiums	Less NDPERS Retention	Total Prem Paid to SHP In Struct A	Total Prem Paid to Humana	Change From Sturcture A	Total Paid to SHP	NDPERS Retention	**NDPERS Billing Rate**
Medicare Retiree												
41	12	1 Medicare only	$237.78	$60.74	$298.52	$2.80	$231.96	$60.74	$3.02	$234.98	$2.80	**$298.52**
42	12	2 Medicare only	$472.44	$121.48	$593.92	$2.80	$463.62	$121.48	$6.02	$469.64	$2.80	**$593.92**
50	12	3 Medicare only	$706.80	$182.22	$889.02	$2.80	$694.98	$182.22	$9.02	$704.00	$2.80	**$889.02**
51	12	4 Medicare only	$941.50	$242.96	$1,184.46	$2.80	$926.66	$242.96	$12.04	$938.70	$2.80	**$1,184.46**
43	12	1 Medicare+Others	$914.72	$60.74	$975.46	$2.80	$891.76	$60.74	$20.16	$911.92	$2.80	**$975.46**
49	12	2 Medicare+Others	$1,149.38	$121.48	$1,270.86	$2.80	$1,123.42	$121.48	$23.16	$1,146.58	$2.80	**$1,270.86**
55	12	3 Medicare+Others	$1,383.74	$182.22	$1,565.96	$2.80	$1,354.78	$182.22	$26.16	$1,380.94	$2.80	**$1,565.96**
58	12	4 Medicare+Others	$1,618.44	$242.96	$1,861.40	$2.80	$1,586.46	$242.96	$29.18	$1,615.64	$2.80	**$1,861.40**
Medicare Retirees COBRA (for Non-Medicare dependents of Medicare Retirees)												
30	12	Single			$679.74	$2.80	$659.80		$17.14	$676.94	$13.18	**$690.12**
31	12	Family			$959.33	$2.80	$932.31		$24.22	$956.53	$18.41	**$974.94**
21	12	Single			$1,366.90	$2.80	$1,364.10			$1,364.10	$2.80	**$1,366.90**
22	12	Family			$2,733.80	$2.80	$2,731.00			$2,731.00	$2.80	**$2,733.80**
23	12	Family (3+)			$3,417.26	$2.80	$3,414.46			$3,414.46	$2.80	**$3,417.26**
COBRA												
24	12	Single			$1,366.90	$2.80	$1,364.10			$1,364.10	$30.14	**$1,394.24**
25	12	Family			$2,733.80	$2.80	$2,731.00			$2,731.00	$57.48	**$2,788.48**
26	12	Family (3+)			$3,417.26	$2.80	$3,414.46			$3,414.46	$71.16	**$3,485.62**

JULY 2025 NDPERS Health Rates
Rate Structure B
New Subscribers or Groups as of July 1, 2025 and After
Rates for July 1, 2026 - June 30, 2027

Political Subdivision Rates with Wellness Program

Active									
1	8	Single	$998.86	$2.80	$970.84	$25.22	$996.06	$2.80	**$998.86**
2	8	Family	$2,414.68	$2.80	$2,350.78	$61.10	$2,411.88	$2.80	**$2,414.68**
COBRA									
4	8	Single	$998.86	$2.80	$970.84	$25.22	$996.06	$22.72	**$1,018.78**
5	8	Family	$2,414.68	$2.80	$2,350.78	$61.10	$2,411.88	$51.06	**$2,462.94**
Temps									
6	8	Single	$998.86	$2.80	$970.84	$25.22	$996.06	$2.80	**$998.86**
7	8	Family	$2,414.68	$2.80	$2,350.78	$61.10	$2,411.88	$2.80	**$2,414.68**

Political Subdivision Rates w/o Wellness Program

Active									
1	7	Single	$998.86	$2.80	$970.84	$25.22	$996.06	$12.74	**$1,008.80**
2	7	Family	$2,414.68	$2.80	$2,350.78	$61.10	$2,411.88	$26.92	**$2,438.80**
COBRA									
4	7	Single	$998.86	$2.80	$970.84	$25.22	$996.06	$22.72	**$1,018.78**
5	7	Family	$2,414.68	$2.80	$2,350.78	$61.10	$2,411.88	$51.06	**$2,462.94**
Temps									
6	7	Single	$998.86	$2.80	$970.84	$25.22	$996.06	$12.74	**$1,008.80**
7	7	Family	$2,414.68	$2.80	$2,350.78	$61.10	$2,411.88	$26.92	**$2,438.80**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2026 - June 30, 2027

NGF Political Subdivision Rates with Wellness Program

Active									
1	28	Single	$1,011.00	$2.80	$982.66	$25.54	$1,008.20	$2.80	**$1,011.00**
2	28	Family	$2,444.10	$2.80	$2,379.44	$61.86	$2,441.30	$2.80	**$2,444.10**
COBRA									
4	28	Single	$1,011.00	$2.80	$982.66	$25.54	$1,008.20	$23.02	**$1,031.22**
5	28	Family	$2,444.10	$2.80	$2,379.44	$61.86	$2,441.30	$51.66	**$2,492.96**
Temps									
6	28	Single	$1,011.00	$2.80	$982.66	$25.54	$1,008.20	$2.80	**$1,011.00**
7	28	Family	$2,444.10	$2.80	$2,379.44	$61.86	$2,441.30	$2.80	**$2,444.10**
Active HDHP									
1	30	Single	$892.32	$2.80	$867.00	$22.52	$889.52	$2.80	**$892.32**
2	30	Family	$2,157.32	$2.80	$2,099.98	$54.54	$2,154.52	$2.80	**$2,157.32**
COBRA HDHP									
4	30	Single	$892.32	$2.80	$867.00	$22.52	$889.52	$20.66	**$910.18**
5	30	Family	$2,157.32	$2.80	$2,099.98	$54.54	$2,154.52	$45.94	**$2,200.46**
Temps HDHP									
6	30	Single	$892.32	$2.80	$867.00	$22.52	$889.52	$2.80	**$892.32**
7	30	Family	$2,157.32	$2.80	$2,099.98	$54.54	$2,154.52	$2.80	**$2,157.32**

JULY 2025 NDPERS Health Rates
Rate Structure B
New Subscribers or Groups as of July 1, 2025 and After
Rates for July 1, 2026 - June 30, 2027

NGF Political Subdivision Rates w/o Wellness Program

Active									
1	27	Single	$1,011.00	$2.80	$982.66	$25.54	$1,008.20	$12.86	**$1,021.06**
2	27	Family	$2,444.10	$2.80	$2,379.44	$61.86	$2,441.30	$27.22	**$2,468.52**
COBRA									
4	27	Single	$1,011.00	$2.80	$982.66	$25.54	$1,008.20	$23.02	**$1,031.22**
5	27	Family	$2,444.10	$2.80	$2,379.44	$61.86	$2,441.30	$51.66	**$2,492.96**
Temps									
6	27	Single	$1,011.00	$2.80	$982.66	$25.54	$1,008.20	$12.86	**$1,021.06**
7	27	Family	$2,444.10	$2.80	$2,379.44	$61.86	$2,441.30	$27.22	**$2,468.52**
Active HDHP									
1	29	Single	$892.32	$2.80	$867.00	$22.52	$889.52	$11.72	**$901.24**
2	29	Family	$2,157.32	$2.80	$2,099.98	$54.54	$2,154.52	$24.40	**$2,178.92**
COBRA HDHP									
4	29	Single	$892.32	$2.80	$867.00	$22.52	$889.52	$20.66	**$910.18**
5	29	Family	$2,157.32	$2.80	$2,099.98	$54.54	$2,154.52	$45.96	**$2,200.48**
Temps HDHP									
6	29	Single	$892.32	$2.80	$867.00	$22.52	$889.52	$11.72	**$901.24**
7	29	Family	$2,157.32	$2.80	$2,099.98	$54.54	$2,154.52	$24.40	**$2,178.92**

Medicare Retiree (NonMedicare Split Rate)

98	12	Single NM Dependents with GF Status	**$676.94**
99	12	Family NM Dependents with GF Status	**$676.94**

JULY 2025 NDPERS Health Rates

Rate Structure B

New Subscribers or Groups as of July 1, 2025 and After

Rates for July 1, 2026 - June 30, 2027

GAP Coverage

61	12	GAP Single			$1,400.38	$2.80	$1,362.22		$35.36	$1,397.58	$2.80	**$1,400.38**
62	12	GAP Family			$2,797.12	$2.80	$2,723.52		$70.80	$2,794.32	$2.80	**$2,797.12**
63	12	GAP Family (3+)			$3,495.44	$2.80	$3,404.16		$88.48	$3,492.64	$2.80	**$3,495.44**
64	12	GAP 1 Medicare + Others	$914.72	$60.74	$975.46	$2.80	$891.76	$60.74	$20.16	$911.92	$2.80	**$975.46**
65	12	GAP 2 Medicare + Others	$1,149.38	$121.48	$1,270.86	$2.80	$1,123.42	$121.48	$23.16	$1,146.58	$2.80	**$1,270.86**
66	12	GAP 3 Medicare + Others	$1,383.74	$182.22	$1,565.96	$2.80	$1,354.78	$182.22	$26.16	$1,380.94	$2.80	**$1,565.96**
67	12	GAP 4 Medicare + Others	$1,618.44	$242.96	$1,861.40	$2.80	$1,586.46	$242.96	$29.18	$1,615.64	$2.80	**$1,861.40**

Sanford Health Plan reserves the right to amend these rates effective 1/1/2026 due to the passage of House Bill 1216 (Out-of-pocket expenses- Prescription drugs) and House Bill 1322 (Out of Network Ground Ambulance).

Attachment 5

EXHIBIT D

Illustration of the NDPERS Settlement Process 2025-2027

Exhibit D
Illustration of the NDPERS Settlement Process

Key	NDPERS Settlement Illustration - No Settlement	Section 7.2 Initial Settlement	Section 7.3 Final Settlement
	First Period of Biennium	7/1/25-6/30/26	7/1/25-6/30/26
	Second Period of Biennium	7/1/26-6/30/27	7/1/26-6/30/27
	Paid Through Date	6/30/2028	6/30/2029
	Initial Settlement	8/31/2028	7/31/2029
	Average Contracts	25,586	25,586
	Average Medicare Contracts	6,740	6,740
	Average Non-Medicare Contracts	18,846	18,846
A	Earned Biennium Premium (which is net of NDPERS Admin Fee)	$ 378,582,971	$ 378,582,971
B	Plus interest on Surplus	$ 750,000	$ 750,000
C	Less Claims Incurred for Biennium Paid through 6/30/26 (Claims include Value Based Provider Payments/Receivables)	$ 368,453,739	$ 373,453,739
D	Less Estimated Unpaid claims	$ 5,000,000	$ 250,000
E	Less Direct Claims Reduction Expenses	$ 3,500,000	$ 3,500,000
F	Less Admin Expense $99.04 per Non-Medicare Contract $20.57 per Medicare Contract	$ 24,061,796	$ 24,061,796
G = A+B -(C:F)	Subtotal	$ (21,682,564)	$ (21,932,564)
H = G-I	Initial Settlement Amount Due to NDPERS 8/31/28	-	N/A
H = G-I	Final Settlement Amount Due to NDPERS 7/31/29	N/A	-
I = Unlimited downside	Net Carrier Retained	$ (21,682,564)	$ (21,932,564)

Key	NDPERS Settlement Illustration - With Settlement	Section 7.2 Initial Settlement	Section 7.3 Final Settlement
	First Period of Biennium	7/1/25-6/30/26	7/1/25-6/30/26
	Second Period of Biennium	7/1/26-6/30/27	7/1/26-6/30/27
	Paid Through Date	6/30/2028	6/30/2029
	Initial Settlement	8/31/2028	7/31/2029
	Average Contracts	25,586	25,586
	Average Medicare Contracts	6,740	6,740
	Average Non-Medicare Contracts	18,846	18,846
A	Earned Biennium Premium (which is net of NDPERS Admin Fee)	$ 378,582,971	$ 378,582,971
B	Plus interest on Surplus	$ 750,000	$ 750,000
C	Less Claims Incurred for Biennium Paid through 6/30/26 (Claims include Value Based Provider Payments/Receivables)	$ 331,608,365	$ 336,108,365
D	Less Estimated Unpaid claims	$ 5,000,000	$ 250,000
E	Less Direct Claims Reduction Expenses	$ 3,500,000	$ 3,500,000
F	Less Admin Expense $99.04 per Non-Medicare Contract $20.57 per Medicare Contract	$ 24,061,796	$ 24,061,796
G = A+B -(C:F)	Subtotal	$ 15,162,810	$ 15,412,810
H = G-I	Initial Settlement Amount Due to NDPERS 8/31/28	$ 15,162,810	N/A
H = G-I	Final Settlement Amount Due to NDPERS 7/31/29	N/A	$ 15,412,810
I = Unlimited downside	Net Carrier Retained	$ -	$ -

In both examples, for illustrative purposes, so one can follow the key - each settlement year is calculated in total.
Any final settlement, if necessary, will be a true up from the initial settlement.

Attachment 6

EXHIBIT E

Pharmacy Disease Management Program Obligations
2025-2027

PHARMACY DISEASE MANAGEMENT PROGRAM TERMS

WHEREAS, during the 2007 North Dakota legislative session, House Bill 1433 was passed and enacted into law. House Bill 1433 allows pharmacists and other qualified North Dakota health care providers to provide “disease state management” (DSM) to North Dakota public employees that suffer from chronic diseases and specifically have diabetes; and

WHEREAS, The North Dakota Pharmacy Service Corporation wants to offer a disease state management program of diabetes through delivery of services and support to individual North Dakota public employees (NDPERS Members) that have a chronic disease identified as diabetes (Type 1 or Type 2). To this end, the North Dakota Pharmacy Service Corporation desires to implement a program to increase access to health care, redefine how services are delivered, increase the participants’ knowledgebase regarding their disease, increase the quality of life for participants, improve overall health status and medication adherence for their participants, and reduce health care costs on multiple levels for numerous interest groups; and

WHEREAS, the North Dakota Pharmacy Service Corporation in collaboration with the North Dakota Pharmacists Association, the North Dakota Society of Health-System Pharmacists, and North Dakota State University College of Pharmacy, Nursing and Allied Sciences, proposed an acting model to extend such disease management program to NDPERS Members; and

WHEREAS, NDPERS is interested in offering the services proposed by the acting model to NDPERS Members and reimbursing the North Dakota Pharmacy Service Corporation for the costs of administering this program out of the NDPERS Programs Cash Reserve Account currently held in trust by SHP; and

WHEREAS, as it relates to this acting model diabetes disease management program, NDPERS is desirous of entering into The terms hereof to sponsor and extend the disease management program with SHP to administer certain facets of the program on behalf of NDPERS, including certain reporting requirements, program promotion, and cost reconciliation for the administration of the program based on the responsibilities of SHP in relation to its management of the NDPERS group health plan and the program objectives for monitoring and containing health care; and

WHEREAS, because SHP is contracted with NDPERS to provide health care benefits to NDPERS Members, NDPERS has determined that SHP is best positioned to act as its agent in the administration of the diabetes disease management program.

NOW, WHEREFORE, in recognition of the mutual promises herein contained and for other good and valuable consideration hereby acknowledged by the parties hereto, NDPERS and SHP agree to the following.

I. RECOGNIZING THE PHARMACY DISEASE MANAGEMENT PROGRAM.

SHP acknowledges and agrees that it has reviewed the diabetes disease management program established through the enactment of House Bill 1433 and that the program as outlined provides services consistent with the wellness initiative reflected in the Administrative Services Agreement between SHP and NDPERS. SHP agrees that this program should remain in force through the next biennium.

II. TERMS.

The terms relating to the program shall begin on July 1, 2025, and shall extend to June 30, 2027.

III. SCOPE OF PROGRAM.

The duties and responsibilities of SHP in furtherance of the diabetes disease management program as outlined herein shall be limited in nature as specifically set forth herein.

IV. REPORTING.

SHP agrees to provide the following:

A. Covered Drug List. A covered drug list with established criteria related to drugs by class with each renewal period.

B. NDPERS Member Eligibility List. A database to identify those NDPERS Members who appear to be eligible for the diabetes disease management program based on criteria developed and provided by NDPERS and/or its vendor, each trimester to track those NDPERS Members eligible for the diabetes disease management program during The terms hereof.

C. Co-Pay Report. A triannual co-pay report that NDPERS and/or its vendor can use to reconcile appropriate co-pays incurred by eligible NDPERS Members to facilitate incentive payments under the diabetes disease management program, including coinsurance for diabetic testing supplies. SHP agrees to work with NDPERS to develop a reporting format that can be used by NDPERS and/or its vendor in administering the diabetes disease management program.

V. PROMOTION.

Upon request and subject to approval by the NDPERS Board of Directors, SHP will provide promotional support for the diabetes disease management program services which may include but not be limited to agency notes, paycheck stuffers, e-mail notices, posters, and notices to home addresses to be distributed at periodic intervals throughout the Term. SHP shall be reimbursed its costs for these promotional activities and materials.

VI. PAYMENT RECONCILIATION.

Program costs such as provider payments, copay/coinsurance reimbursements and promotional charges are funded through the NDPERS Programs Cash Reserve Account maintained by SHP after authorization from NDPERS.

Attachment 7

EXHIBIT G

Wellness Benefit Program Obligations
2025-2027

WELLNESS BENEFIT PROGRAM TERMS

WHEREAS, the state of North Dakota, acting through NDPERS, and SHP, in an effort to create healthier lifestyles for NDPERS Members and to help contain health care costs, desire to promote, support and sponsor health and wellness initiatives; and

WHEREAS, NDPERS and SHP have agreed to administer a Wellness Benefit Program related to health and wellness promotion for NDPERS Members; and

WHEREAS, the Wellness Benefit Program anticipates there will be costs and fees associated with supporting such health and wellness programs provided to NDPERS Members and to be administered through this agreement with SHP.

NOW, WHEREFORE, in recognition of the mutual promises herein contained and for other good and valuable consideration hereby acknowledged by the parties hereto, NDPERS and SHP agree to the following.

I. TERM.

The terms relating to the program shall begin on July 1, 2025, and shall extend to June 30, 2027.

II. FUNDING.

The parties acknowledge, understand and agree that funding for the benefits and services of the program shall be taken from the NDPERS Programs Cash Reserve Account maintained by SHP.

NDPERS agrees to pay costs associated with the benefits and services extended hereunder to SHP.
Program related activities will be reimbursed based on the following schedule:

Calculation 1: 100% of the first $500 or actual program expenses, whichever is less, plus 75% of actual expenses in excess of $500 to a maximum benefit of $1,000,

OR

Calculation 2: $2.00 multiplied by the number of health contracts.

The Wellness Committee will use the calculation that provides the best benefit to the state agency or political subdivision based on actual program expenses. The state agency or political subdivision will be responsible for expenses that exceed the maximum benefit allowed under either calculation method.

The parties acknowledge, understand, and agree that the fees and charges provisions of the foregoing Administrative Services Agreement, including fees set forth for various wellness programs as approved and funded, are subject to specific funding provisions as set forth in Sections 7.2 and 7.3.

III. OTHER TERMS AND CONDITIONS.

Applications for approval of benefits and services under the Wellness Benefit Program shall be submitted to the Bismarck NDPERS office to the attention of the Chief Benefits Officer by each agency interested in establishing such a program.

A Wellness Committee shall be established to review any such applications submitted. The Wellness Committee shall be comprised of: one (1) NDPERS staff member, and one (1) SHP staff member. Upon appointment, the Wellness Committee shall establish criteria to ensure a uniform basis upon which it may grant or deny each agency application. Wellness benefits or healthy lifestyle programs, such as smoking cessation, nutrition, exercise, stress management, weight control, wellness education and the number of people affected by each program will be taken into consideration and shall be part of the criteria established by the Wellness Committee.

The applying agency will be notified by the Wellness Committee of the approval or denial of the proposed program.

Funds may either be distributed directly to the applying agency or, preferably, paid directly to the vendor providing said service or facilitating said Wellness Benefit Program.

All funds distributed shall be for Wellness Benefit Programs completed within the current 2025-2027 biennium budget.

Funds are available for agency group activities only and will not be available to specific individuals or to fund specific individual memberships in diet programs or health, athletic or fitness clubs.

Applying agencies that receive funds for a Wellness Benefit Program are required to submit to the Wellness Committee an evaluation of the sponsored program after its completion.

Attachment 8

Business Associate Agreement

This Business Associate Agreement is entered into by and between, the North Dakota Public Employees Retirement System ("NDPERS") and the **Sanford Health Plan, 4800 W 67th St., Sioux Falls, South Dakota, 57108**, each individually a "Party" and collectively the "Parties." This Agreement is hereby incorporated into the underlying Contract, **AGREEMENT FOR SERVICES BETWEEN SANFORD HEALTH PLAN AND NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM**, between the parties dated July 1, 2025, (hereinafter both the Agreement and underlying Contract shall collectively be referred to as the "Agreement").

1. DEFINITIONS

Terms used, but not otherwise defined, in this Agreement have the same meaning as those terms in the HIPAA Rules.

Catch-all definitions:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

a. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the party to this Agreement, shall mean Sanford Health Plan.

b. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this Agreement, shall mean NDPERS.

c. Electronic Protected Health Information. "Electronic Protected Health Information" (ePHI) shall generally have the same meaning as the term "electronic protected health information" at 45 CFR § 160.103.

d. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

e. Protected Health Information. "Protected Health Information" (PHI) shall generally have the same meaning as the term "protected health information" at 45 CFR § 160.103 that Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity.

2. OBLIGATIONS OF BUSINESS ASSOCIATE

The Business Associate agrees to:

a. Not use or disclose PHI other than as permitted or required by this Agreement or as required by law, or as otherwise authorized in writing by Covered Entity;

b. Use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;

c. Not request, use, or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. § 164 if done by Covered Entity, except that Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate.

d. Not request, use, or disclose more than the minimum amount of PHI necessary to accomplish the purpose of the use, disclosure, or request in accordance with 45 C.F.R. § 164.502(b).

e. Not share, use, or disclose PHI in any form via any medium with any individual beyond the boundaries and jurisdiction of the United States of America without express written authorization from Covered Entity.

f. Ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI, in accordance with 45 CFR § 164.502(e)(1) and § 164.308(b).

g. Within twenty (20) business days of receiving written notice from Covered Entity, make any amendments to PHI in a Designated Record Set, as directed or agreed to by Covered Entity pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy the Covered Entity's obligations under 45 CFR § 164.526.

h. PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate.

i. Report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 C.F.R. § 164.410, and any security incident of which it becomes aware;

j. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Covered Entity as required by the HIPAA Rules.

k. To make available to the Secretary the Business Associate's internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI and ePHI received from, or created or received by Business Associate on behalf of Covered Entity, for the purpose of determining the Covered Entity's compliance with the HIPAA Rules, subject to any applicable legal privileges.

l. Provide to Covered Entity within fifteen (15) days of a written notice from Covered Entity, information necessary to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

m. To provide, within ten (10) days of receiving a written request, information necessary for the Covered Entity to respond to an Individual's request for access to PHI about himself or herself under 45 C.F.R. § 164.524, in the event that PHI in the Business Associate's possession constitutes a Designated Record Set.

3. REPORTING OF A VIOLATION TO COVERED ENTITY BY BUSINESS ASSOCIATE

Business Associate shall report to Covered Entity's Breach Investigation Team (BIT) via email at ndpers-info@nd.gov any use or disclosure of PHI or ePHI not provided for by this Agreement, of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR § 164.410, and any Security Incident of which it becomes aware, immediately, and in no case later than ten (10) business days after the use or disclosure.

a. Security Incident. "Security Incident" means (as defined by 45 CFR § 164.304), the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. For purposes of clarification of this Section, Security Incident includes use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which Business Associate becomes aware. Business Associate shall track all Security Incidents and shall report such Security Incidents in summary fashion as may be requested by the Covered Entity.

    i. Unsuccessful Security Incidents. Business Associate and Covered Entity agree that this Agreement constitutes notice from Business Associate of such Unsuccessful Security Incidents. By way of example, Covered Entity and Business Associate consider the following to be illustrative of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of PHI or interference with an information system:

        1. Pings on Business Associate's firewall;

        2. Port Scans, which are attempts to log on to a system or enter a database with an invalid password or username;

3. Denial-of-service attacks that do not result in a server being taken off-line; and

4. Malware (e.g., worms, viruses).

b. Discovery of a Violation. If the use or disclosure amounts to a breach of Unsecured PHI or ePHI, Business Associate shall ensure its report is made to Covered Entity's Breach Investigation Team (BIT) via email at ndpers-info@nd.gov immediately upon becoming aware of the Breach, and in no case later than ten (10) business days after discovery. The Violation shall be treated as "discovered" on the first day which the Violation is known to the Business Associate or, by exercising reasonable diligence would have been known to the Business Associate. For purposes of clarification of this Section, Business Associate must notify Covered Entity of an incident involving the acquisition, access, use, or disclosure of PHI or ePHI in a manner not permitted under 45 C.F.R. Part E within ten (10) business days after an incident even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA Rules.

c. Investigation of Breach. Business Associate shall immediately investigate the Violation and report in writing within ten (10) business days to Covered Entity with the following information:

i. Each Individual whose PHI has been or is reasonably believed to have been accessed, acquired, or disclosed during the Incident;

ii. A description of the types of PHI that were involved in the Violation (such as full name, social security number, date of birth, home address, account number);

iii. A description of unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

iv. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

v. A description of probable causes of the improper use or disclosure;

vi. A brief description of what Business Associate is doing to investigate the Incident, to mitigate losses, and to protect against further Violations;

vii. The actions Business Associate has undertaken or will undertake to mitigate any harmful effect of the occurrence; and

viii. A Corrective Action Plan that includes the steps Business Associate has taken or shall take to prevent future similar Violations.

d. Breach Notification.

i. Business Associate shall cooperate and coordinate with Covered Entity in the preparation of any reports or notices to the Individual, required to be made under the HIPAA Rules or any other Federal or State laws, rules or regulations, provided that any such reports or notices shall be subject to the prior written approval of Covered Entity.

ii. Covered Entity shall make the final determination whether the Breach requires notices to affected Individuals and whether the notices shall be made by Covered Entity or Business Associate.

iii. For any notice regarding a Breach of Unsecured PHI caused by Business Associate that Covered Entity is required to provide pursuant to 45 C.F.R. §§ 164.404 – 164.408, Business Associate shall reimburse Covered Entity for all costs associated with Covered Entity's obligation of notifying affected Individuals, the Secretary, and the media.

e. Mitigation. Business Associate shall mitigate to the extent practicable, and at its sole expense, any harmful effects known to the Business Associate of a use, disclosure, or loss of PHI by Business Associate in violation of the requirements of this Agreement, including, without limitation, any Security Incident or Breach of Unsecured PHI. Business Associate shall reasonably cooperate with the Covered Entity's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual Breach, or to recover its PHI, including complying with a reasonable Corrective Action Plan.

4. Permitted Uses and Disclosures by Business Associate

a. General Use and Disclosure Provisions. Business Associate may only use or disclose the minimum PHI and ePHI to perform functions, activities, or services for, or on behalf of, Covered Entity, specifically, as necessary to perform the services set forth in the Agreement. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except for the specific uses and disclosures set forth in subsection b below.

b. Specific Use and Disclosure Provisions. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI and ePHI:

i. As required by law.

ii. To make uses, disclosures, and requests for PHI consistent with Covered Entity's minimum necessary policies and procedures.

iii. For the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

iv. To report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §§ 164.304 and 164.502(j)(1).

5. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of:

i. Any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that any such limitation may affect Business Associate's use or disclosure of PHI.

ii. Any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that any such changes may affect Business Associate's use or disclosure of PHI.

Any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that any such restriction may affect Business Associate's use or disclosure of PHI.

b. Covered Entity agrees that it:

i. Has included, and will include, in Covered Entity's Notice of Privacy Practices required by the Privacy Rule that Covered Entity may disclose PHI for Health Care Operations purposes.

ii. Has obtained, and will obtain, from Individuals any consents, authorizations and other permissions necessary or required by laws applicable to Covered Entity for Business Associate and Covered Entity to fulfill their obligations under the underlying Agreement and this Agreement.

iii. Will promptly notify Business Associate in writing of any restrictions on the use and disclosure of PHI about Individuals that Covered Entity has agreed to that may affect Business Associate's ability to perform its obligations under the underlying Agreement or this Agreement.

iv. Will promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to use or disclose PHI, if the change or revocation may affect Business Associate's ability to perform its obligations under the underlying Agreement or this Agreement.

6. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Subpart E of 45 CFR Part 164 if done by Covered Entity, except that the Business Associate may use or disclose PHI and ePHI for management and administration and legal responsibilities of Business Associate.

7. Term and Termination

a. Term. The Term of this Agreement shall be effective as of July 1, 2025, and shall terminate when all of the PHI and ePHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to

Covered Entity, or, if it is infeasible to return or destroy PHI and ePHI, protections are extended to any such information, in accordance with the termination provisions in this Section.

b. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Agreement or expiration of the services provided.

c. Termination for Cause. Business Associate agrees that if in good faith Covered Entity determines that Business Associate has materially breached any of its obligations under this Agreement, Covered Entity may:

    1. Exercise any of its rights to reports, access, and inspection under this Agreement;

    2. Require the Business Associate to cure the breach or end the violation within the time specified by Covered Entity;

    3. Terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity

    4. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

    5. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

    6. Before exercising either (c)(2) or (c)(3), Covered Entity shall provide written notice of preliminary determination to Business Associate describing the violation and the action Covered Entity intends to take.

d. Effect of Termination

    1. Upon termination, cancellation, expiration, or other conclusion of this Agreement, Business Associate shall:

        1) Return to Covered Entity or, if return is not feasible, destroy all PHI, ePHI, and any compilation of PHI in any media or form. Business Associate agrees to ensure that this provision also applies to PHI and ePHI in possession of subcontractors and agents of Business Associate. Business Associate agrees that any original record or copy of PHI and ePHI in any media is included in and covered by this provision, as well as all originals or copies of PHI or ePHI provided to subcontractors or agents of Business Associate. Business Associate agrees to complete the return or destruction as promptly as possible, but not more than thirty (30) business days after the conclusion of this Agreement. Business Associate will provide written documentation evidencing that return or destruction of all PHI and ePHI has been completed.

2) If Business Associate destroys PHI and ePHI, it shall be done with the use of technology or methodology that renders the PHI or ePHI unusable, unreadable, or undecipherable to unauthorized individuals as specified by the Secretary. Acceptable methods for destroying PHI or ePHI include:

   i. For paper, film, or other hard copy media: shredding or destroying in order that PHI cannot be read or reconstructed; and

   ii. For electronic media: clearing, purging, or destroying consistent with the standards of the National Institute of Standards and Technology (NIST).

Redaction is specifically excluded as a method of destruction of PHI and ePHI.

3) If Business Associate believes that the return or destruction of PHI or ePHI is not feasible, Business Associate shall provide written notification of the conditions that make return or destruction not feasible. If Business Associate determines that return or destruction of PHI or ePHI is not feasible, Business Associate shall extend the protections of this Agreement to the PHI or ePHI and prohibit further uses or disclosures of the PHI and ePHI without the express written authorization of Covered Entity. Subsequent use or disclosure of any PHI and ePHI subject to this provision will be limited to the use or disclosure that makes return or destruction not feasible.

8. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Rules and any other applicable laws or regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

c. Survival. The respective rights and obligations of Business Associate under Section 7(d), related to "Effect of Termination," of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity and Business Associate to comply with the HIPAA Rules.

e. Headings. Paragraph Headings used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of this Agreement.

f. Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

g. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything this Agreement confer, upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

h. Applicable Law and Venue. This Business Associate Agreement is governed by and construed in accordance with the laws of the State of North Dakota. Any action commenced to enforce this Contract must be brought in the state District Court of Burleigh County, North Dakota.

i. Contact Persons. Business Associate shall identify "key contact persons" in Attachment A for all matters relating to this Agreement and shall notify Covered Entity of any change in these key contacts during the term of this Agreement in writing within ten (10) business days.

j. Business Associate agrees to comply with all the requirements imposed on a business associate under Title XIII of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health (HI-TECH) Act, and, at the request of NDPERS, to agree to any reasonable modification of this Agreement required to conform the Agreement to any Model Business Associate Agreement published by the Department of Health and Human Services.

9. Entire Agreement

This Agreement and the underlying Agreement contains all of the agreements and understandings between the parties with respect to the subject matter of this Agreement. No agreement or other understanding in any way modifying the terms of this Agreement will be binding unless made in writing as a modification or amendment to this Agreement and executed by both parties.

IN WITNESS OF THIS, **NDPERS** ["Covered Entity"] and **SANFORD HEALTH PLAN** ["Business Associate"] agree to and intend to be legally bound by all terms and conditions set forth above and hereby execute this Agreement as of the effective date set forth above.

For Covered Entity:

Mike Seminary, Board Chairman
ND Public Employees Retirement System

Date

For Business Associate:

Courtney Meyer
Signature

Courtney Meyer
Printed Name

Chief Growth Officer
Title

5/30/25
Date

ATTACHMENT "A"
BUSINESS ASSOCIATE KEY CONTACT PERSONS

When applicable, Business Associate shall notify Covered Entity of any change in key contacts during the term of this Agreement in writing within ten business days.

Website URL (if applicable):	

FIRST POINT OF CONTACT	
Name:	David Hill
Title:	Director, Chief Privacy Offier
Address:	2301 E 60th St N, Sioux Falls, SD 57104
Phone Number:	(605)312-6658
Fax Number:	
Email Address:	David.Hill@SanfordHealth.org

SECOND POINT OF CONTACT	
Name:	Courtney Meyer
Title:	Chief Growth Officer
Address:	4800 W 57th St, Sioux Falls, SD 57108
Phone Number:	(605)312-2613
Fax Number:	
Email Address:	Courtney.Meyer@SanfordHealth.org

Business Associate

(Signature): Courtney Meyer

(Print Name): Courtney Meyer

(Title): Chief Growth Officer

(Date): 5/30/25

Attachment 9

EXHIBIT I

ADMINISTRATION AGREEMENT FOR HEALTH SAVINGS ACCOUNTS 2025-2027

ADMINISTRATION AGREEMENT FOR HEALTH SAVINGS ACCOUNTS

This Administration Agreement for Health Savings Accounts ("HSA Agreement") is entered into between the State of North Dakota, acting through its Public Employees Retirement System ("the Plan Sponsor"); the North Dakota Public Employees Retirement System ("NDPERS") ("the Plan Administrator"); and Sanford Health Plan, a South Dakota non-profit corporation ("SHP") (referred collectively to as "Parties")

WHEREAS, NDPERS has established and maintains certain benefit plans and programs (the "Plans") some or all of which must comply with the Internal Revenue Code of 1986 (the "Code"); and

WHEREAS, the Plans are not employee welfare benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") because they are governmental plans or church plans;

WHEREAS, the Parties desire that SHP furnish certain services described in this Exhibit I for Health Savings Accounts ("HSA");

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and the exhibits and Addenda, if any, attached hereto, the Parties hereby agree as follows:

I. Definitions

The following definitions shall apply to this HSA Agreement:

Participant: NDPERS Subscriber enrolled in a High Deductible Health Plan as defined by the Internal Revenue Service.

HSA Trustee / Custodian: A third-party selected by SHP to administer the NDPERS HSA accounts / program. HSA Trustee / Custodian shall provide account management services, eligibility questions and determinations, contribution requirements, general administrative services to assist Participants with general information about HSA Accounts, and answer questions concerning coverage status, claims status, compliant administration, and other inquiries.

HSA Account. A tax-exempt trust or custodial account set up with a qualified HSA trustee that qualifies as such under Section 223 of the Internal Revenue Code.

High Deductible Health Plan: A plan that qualifies as a High Deductible Health Plan as defined by the Internal Revenue Service.

II. SHP Responsibilities

a. Payment of Fees. SHP shall pay the HSA Trustee / Custodian the following fees associated with the administration of the HSA accounts / program for Participants:

Service	2025 Fee Structure
Monthly Admin Fee	$3.00 Per Employee Per Month
Reimbursement Check	$2.00 for paper check. No fee for electronic funds transfer.
Reimbursement Card	$5.00 for additional cards beyond three (3).
Return deposited item	$20.00 per item.
Stop payment request	$20.00 per item.
Excess Contribution	$20.00 per request.
Paper statement	$1.00 per monthly statement
Investment fee	.03% on average monthly balance of investment amounts

b. Enrollment File: The Plan Sponsor shall submit to SHP an 834 enrollment file as the source of eligible Participants for an HSA Account. SHP shall submit the 834 file to the HSA Trustee / Custodian.

c. Distributions. SHP shall have no responsibilities with respect to distributions from HSA accounts. HSA distributions are made by the HSA Trustee / Custodian. SHP shall have no responsibility for any reporting or notifications for HSA Accounts, such as, but not limited to, tax returns, or local, state or federal filings.

III. Plan Sponsor / Plan Administrator Responsibilities

a. Plan Sponsor / Plan Administrator shall assist eligible Participants with establishing HSAs with the HSA Trustee / Custodian. Participants shall be responsible for signing all appropriate contracts and documents and submitting documentation to and with the HSA Trustee / Custodian.

b. HSA Contributions. Plan Sponsor / Plan Administrator shall be responsible for transferring HSA contributions (including contributions made via salary reduction through Participant's cafeteria plan) to the HSA Trustee / Custodian.

c. Eligibility. Plan Sponsor / Plan Administrator shall make determinations regarding a Participants eligibility for an HSA Account and provide eligible Participants with necessary enrollment material and information regarding the HSA Accounts.

IV. Miscellaneous

a. HIPAA. The Parties acknowledge that the Business Associate Agreement, Exhibit H, applies to this HSA Agreement.

b. Guarantee of Benefits. In performing its obligations under this HSA Agreement, SHP neither assumes liability for nor otherwise agrees to underwrite the benefits provided by a third party. Except as otherwise provided herein, SHP shall have no duty or obligation to defend any legal action or proceeding brought to recover, directly or indirectly, a claim for benefits.

c. Unless otherwise specified in this HSA Agreement, this HSA Agreement shall follow the provisions as outlined in the Administrative Services Agreement.

d. Third Party Beneficiaries. The obligation of the Parties to this HSA Agreement shall be solely to the benefit of the other Party(ies). Except as expressly provided in the HSA Agreement, no person or entity is intended to be or shall be construed or deemed to be a third-party beneficiary of this HSA Agreement.

e. Eligible Participants. Eligible participant shall be ultimately responsible to determine whether he or she is eligible for HSA contributions, applicable tax reporting and withholding responsibilities resulting from excess contributions, and eligible participants maintain responsibility for ensuring his or her contributions comply with the comparable contributions rules, if applicable.

IN WITNESS WHEREOF, the parties have executed this HSA Agreement to be effective as of July 1, 2025, through June 30, 2027.

Plan Sponsor / Administrator

By:_____
Authorized Representative of North Dakota Public Employee Retirement System

Its:_____

Sanford Health Plan

By:_____
Authorized Representative of Sanford Health Plan

Its: Chief Growth Officer, Sanford Health Plan

Attachment 10

EXHIBIT J

Fitness Center & Virtual Wellness Access for
NDPERS Dakota Retiree Plan
(Medicare Supplement)
2025-2027

FITNESS CENTER & VIRTUAL WELLNESS TERMS

WHEREAS, the state of North Dakota, acting through NDPERS, and SHP, in an effort to create healthier lifestyles for NDPERS Medicare Supplement Members and to help contain health care costs, desire to promote, support and sponsor health and wellness initiatives; and

WHEREAS, NDPERS and SHP have agreed to provide Fitness Center and/or Virtual Wellness Access for NDPERS Medicare Supplement Members. Fitness Center and/or Virtual Wellness Access will be administrated by a vendor chosen by SHP, and Eligible Members will have access to the Basic Fitness Centers and/or Virtual Wellness options (e.g.: "Standard Network") at no cost. Eligible Members may have the option to purchase upgraded fitness services from the chosen vendor.

Fitness and Virtual Wellness Access refers to a provision of services that may include access to participating fitness facilities, gyms, and digital wellness offerings. Digital offerings may encompass, but are not limited to, virtual fitness classes, workout content, wellness coaching, and related online tools or resources designed to support physical activity and overall well-being. Access is subject to the terms, conditions, and availability of participating providers.

Fitness Center and/or Virtual Wellness will herein be referred to as "The Program".

NOW, WHEREFORE, in recognition of the mutual promises herein contained and for other goods and valuable consideration hereby acknowledged by the parties hereto, NDPERS and SHP agree to the following.

I. TERM.

The terms relating to The Program shall begin on July 1, 2025, and shall extend to June 30, 2027.

II. SHP Responsibilities.

a) Contract with a vendor to administer The Program for Medicare Supplement Members.

b) Payment of Fees. SHP shall pay the chosen vendor for Eligible Members who enroll in a Basic Fitness Center and/or access Virtual Wellness membership.

c) Eligibility: SHP shall determine eligible Participants for The Program and send weekly eligibility files to the chosen vendor.

III. NDPERS Responsibilities.

a) Enrollment: NDPERS shall submit to SHP a weekly 834 enrollment file as the source of Eligible Members enrolled in the Medicare Supplement Plan

IV. MISCELLANEOUS

a) HIPAA. The Parties acknowledge that the BAA, Exhibit B, applies to this Exhibit J.

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1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: June 10, 2025

SUBJECT: Vision Insurance Plan Contract Amendment

At the April 2025 meeting, the Board approved the contract renewal for the NDPERS group vision insurance plan with Superior Vision Services by MetLife (Superior Vision). The renewal was approved for the January 1, 2026, through December 31, 2027, contract period. Attached is the contract amendment drafted by NDPERS legal staff and approved by representatives from Superior Vision.

BOARD ACTION REQUESTED:

Approve the contract amendment for the NDPERS group vision insurance plan for the January 1, 2026, through December 31, 2027, contract period.

Attachment

AGREEMENT FOR SERVICES
BETWEEN
SUPERIOR VISION SERVICES, INC.
AND
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
("AGREEMENT FOR SERVICES")
AMENDMENT NUMBER: 1

This Amendment No. 1 is made to the Agreement for Services between the State of North Dakota, acting through its North Dakota Public Employees Retirement System ("NDPERS"), and Superior Vision Services, Inc. ("CONTRACTOR" or "Superior Vision") (collectively "the Parties").

WHEREAS NDPERS and CONTRACTOR entered into the two-year Agreement for Services (Agreement), effective January 1, 2024.

WHEREAS in its Vision Insurance Plan Renewal proposal ("Proposal") to NDPERS dated March 24, 2025, incorporated into this Amendment as Exhibit 1, CONTRACTOR offered to renew vision benefits with no rate increase for the period of January 1, 2026, through December 31, 2027.

WHEREAS, pursuant to North Dakota Century Code (N.D.C.C.) § 54-52.1-05(2), the NDPERS Board reviewed the Proposal, considered the matter, and motioned to renew the Agreement for Services because:

1. CONTRACTOR's performance under the existing Agreement for Services meets the Board's expectations;
2. The Proposal does not exceed the Board's pricing expectations; and
3. Renewal of the Agreement for Services best serves the interests of the state and the State's eligible employees.

NOW THEREFORE, the Parties agree to amend the Agreement for Services as follows:

AGREEMENT

1. **SECTION 2) <u>TERM</u>** is amended to read:

The term of this Agreement shall commence on January 1, 2026, and ends on December 31, 2027. NDPERS may renew this Agreement as authorized by N.D.C.C. § 54-52.1-05.

2. **SECTION 17) <u>NOTICE</u>** is amended to read:

All notices or other communications required under this contract must be given by registered or certified mail and are complete on the date mailed when addressed to the parties at the following addresses:

NDPERS:
Board Chairperson
ND Public Employees Retirement System
1600 East Century Avenue, Suite 2
P.O. Box 1657
Bismarck, ND 58502-1657

CONTRACTOR:
Superior Vision Services, Inc. c/o
Versant Health, Inc.
Attn: General Counsel
500 Jordan Road
Troy, New York 12180

Notice provided under this provision does not meet the notice requirements for monetary claims against the State found at N.D.C.C. § 32-12.2-04.

3. Except as specifically set forth in this Amendment, all terms and conditions of the Contract remain in force and govern the relationship between NDPERS and CONTRACTOR.

This Amendment No. 1 to Agreement for Services is effective as of the date the last party signs.

Superior Vision Services, Inc.

Signature: Signed by: Alan Hirschberg 145D27F28FFB447...

Printed: Alan Hirschberg

Title: Executive Vice President

Date: 5/20/2025 | 5:23 PM EDT

State of North Dakota through its Public Employees Retirement System

Signature: _____

Printed: _____

Title: _____

Date: _____

Form approved by Legal DS

Amy Lashmet

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
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Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: June 10, 2025

SUBJECT: Employee Assistance Program (EAP) Update

The NDPERS Board approved contracts for four EAP vendors as agency choices for the 2025-2027 biennium at the May 2025 Board meeting. These providers were CHI St. Alexius, The Village, Bree Health (eni NexGen), and ComPsych.

The following seven agencies switched EAP providers during our open enrollment:

Towner County Public Health
Public Finance Authority
Office of Management & Budget
ND Information Technology
Lake Region District Health Unit
Lake Region State College
ND Vision Services

This item is informational and does not require any action by the Board.

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Memorandum

TO: NDPERS Board

FROM: Rebecca Fricke

DATE: June 10, 2025

SUBJECT: 2024 Health Insurance Plan Claims Review

Each year, NDPERS performs a review of a sample of the Sanford Health Plan medical and pharmacy claims, as well as claims for the Humana Medicare Part D plan. This review is conducted by the NDPERS Internal Audit Division, led by Shawna Piatz as Chief Audit Officer.

Attached are the results of this audit for calendar year 2024, referred to as observations. In addition, the attached provides both responses from management and Sanford Health Plan to the observations, along with a list of the types of claims that were reviewed through the audit. The audit report has been shared with the Audit Committee at their May 2025 meeting. Any outstanding issues are being tracked by both Internal Audit and management to ensure resolution.

This item is informational only. Shawna and I will be available at the meeting should the Board have any questions.

PURPOSE: Each year we conduct an audit to verify the accuracy of the health plan claims processing to the current Certificate of Insurance (COI) documents.

PROCEDURES: In April 2025, the Internal Auditors met virtually with Sanford Health Plan (SHP) and Humana staff to review a sample of NDPERS claims. A list of the claim specifications reviewed is provided in Attachment A. Internal Audit requested to review 132 claims and made a few adjustments as noted during the review. A random sample of claims from 2024 within each of the categories noted was reviewed. Sanford had pre-built queries to pull the total claims for 2024 for each of the categories, the queries were run during the virtual meetings and NDPERS Internal Audit pulled the random claim sample from the query population.

RESULTS:

Observation #1: Professional Dilated Eye Exam for Diabetes Related Diagnosis Claims – During the 2022 claims review, it was discovered that there was an error in the configuration of a formula for this claim type in the SHP system and the co-insurance was not being applied as expected. The formula had been fixed, an impact query run and all known errors were reprocessed at that time. During the 2023 review, the same error was discovered and it was determined that the query had only been run for dates in 2022 and not for the time from January 2023 through when the formula had been fixed. SHP ran the query for 2023 and found an additional 191 claims that have been reprocessed.

During the 2024 review, the same issue was found in the Non Grandfathered plan and it appears that the formula was not corrected in this plan.

Recommendation: NDPERS management should direct SHP to review system programing in the Non Grandfathered and High Deductible Health Plans to ensure all plans are correctly programmed to apply applicable cost shares, specifically coinsurance. An impact analysis should be provided for any 2023 and 2024 claims that will need to be reprocessed. Claims in this category should be reviewed again in the 2025 claims audit to ensure they are processing as expected.

Management Response:
Management agrees with the recommendation and will ask SHP to review system programming in the NGF PPO/Basic & HDHP. SHP will be asked to do an impact analysis and reprocess claims.

Sanford Health Plan Response:
Agree with Observation.
Sanford Action: *Sanford will make updates to claims build to ensure NG plans and HDHP are taking 80% coinsurance. Sanford will pull an impact report and reprocess claims for those members that did not have coinsurance applied.*

Observation #2: Professional Mammogram Claims – Mammography screening services are paid at one screening for members between the ages of 35 and 40 and one screening per year for members ages 40 and older. Mammograms are also considered a wellness service and can be paid for with the member's $200 non-diagnostic screening service benefit allowance.

During the review a mammography claim was reviewed that had cost shares applied with a portion of the claim needing to be paid by the member. This was the second mammography for a member in the 35 to 40 age range so would not be covered under that benefit however the member still had a portion of their $200 non-diagnostic screening service benefit allowance available. This allowance should have covered the amount due from them however it did not.

Recommendation: NDPERS management should direct SHP to review this claim to determine why the non-diagnostic screening service benefit allowance was not applied to this claim and should determine if system programing is necessary under all plans to ensure mammogram claims are processed first under both the mammogram screening services and second under the non-diagnostic screening service benefit allowance. An impact analysis should be provided for any 2024 claims that will need to be reprocessed under all plans. Claims in this category should be reviewed again in the 2025 claims audit to ensure they are processing as expected.

Management Response:
Management agrees with the recommendation and will ask SHP to review the claim and perform an impact analysis to determine if other individuals were impacted so that claims can be reprocessed.

Sanford Health Plan Response:
Agree with Observation.
Sanford Action: *It was determined after further internal review that members 34 years and younger were having the $200 benefit applied due to no other benefits available for this age group. The member between 35-39 received her 1 covered mammogram then her yearly mammograms after that went to cost shares. After further discussion with NDPERS team, they would like Sanford to pull an analysis of members wellness benefits and the utilization in 2024. If there is no cost impact, NDPERS would like Sanford to start applying $200 benefit to all mammograms before requiring cost shares.*

Observation #3: Out of Country Care – An out of country claim was reviewed which included an amount for co-insurance. The co-insurance had to be manually calculated and was correct, however the co-insurance was not included in the co-insurance accumulator. At the time of the review, the affected member had not yet met their max co-insurance however the amount calculated from this claim plus all other amounts exceeds the maximum allowed and the member was therefore overcharged.

Recommendation: NDPERS management should direct SHP to review and reprocess this member's claims as necessary. SHP should also review any other manually processed claims to ensure they were allocated to all respective accumulators.

Management Response:
Management agrees and will direct SHP to review this claim and reprocess as necessary. SHP will also be asked to review any other manually processed claims to ensure they are appropriately allocated to accumulators.

Sanford Health Plan Response:
Agree with Observation and recommendation.
Sanford Action: *Reprocess claim to ensure member receives $844 in the coinsurance accumulator. Review out of country workflow and claims to ensure this was a singular incident.*

Observation #4: Prescription Drug Claims – During the review, a claim was found in which deductible was not applied for a High Deductible Health plan member in which the maximum deductible required had not yet been met. Co-insurance for this claim was calculated and applied correctly.

Recommendation: NDPERS Management should request SHP to review for any other similar issues.

Management Response:
Management agrees with this recommendation and will request SHP to review for any other similar issues.

Sanford Health Plan Response:
Agree with Observation and recommendation.

Sanford Action: *Sanford is working with OptumRx to identify the issue and determine if there was impact on all members or if this was a singular incident.*

Observation #5: Outpatient Sterilization – Surgical procedures, including vasectomies, that can be done in a Practitioner office setting, are not covered under the health plans. During the review, a claim for a vasectomy that should have been denied was sent to the SHP review team who allowed the claim to be paid at 80%. At the time of the review, SHP was unable to determine why the claim was allowed.

Recommendation: NDPERS management should request SHP to provide support for why the claim was paid at 80% to ensure it was processed correctly. If a medically necessary reason cannot be provided, NDPERS management should direct SHP to reprocess the claim accordingly.

Management Response:
Management agrees with this recommendation and will request SHP to provide support for why the claim was paid as it was. If medical necessity cannot be provided, SHP should reprocess the claim accordingly.

Sanford Health Plan Response:
Agree with Observation and recommendation. During additional internal review, it was determined that this claim was paid in error during manual processing by a claims examiner.
Sanford Action: *Sanford Health Plan will review sterilization workflow and claims to ensure this was a singular incident. Education is provided to the individual claims examiner.*

Attachment A

NDPERS Audit of 2024 Sanford Health Plan Claims

1. Institutional COB (2 claims)
2. Institutional COB (2 with Medicare Member age 65+)
3. Institutional COB (2 with Medicare Member age <65)
4. Institutional COB (3 with Workers Compensation)
5. Professional COB (2 claims Other Insurance Plan)
6. Professional COB (2 with Medicare)
7. Professional COB (2 with Workers Compensation)
8. Institutional Psych (3 claims)
9. Professional Psych (3 claims)
10. Institutional Chemical Dependency (3 claims)
11. Professional Chemical Dependency (2 claims)
12. Professional Dilated Eye Exam for diabetes related diagnosis (5 claims) (No COB)
13. Professional Mammograms (3 claims) (No COB) – actually reviewed 7
14. Professional A1C Screening (2 claims) (No COB)
15. Adult Routine Diagnosis Physical Office Visit with Screenings (2 claims) – actually reviewed 3
16. Prosthetic limb (2 claims) – No claims to review
17. Skilled nursing care (3 claims)
18. Outpatient Sterilization (2 vasectomies and 2 tubal ligations)
19. Tobacco Cessation Services (2 claims)
20. Lasik eye surgery (2 claim) – Only 1 claim to review
21. Well Child visits (2 PPO & 2 HDHP)
22. Institutional 'Denied Experimental' (2 claims)
23. Hearing aids (3 claims)
24. Claims for Durable Medical Equipment (2 claims)
25. Professional from HDHP member (3 claims)
26. Institutional from HDHP member (3 claims)
27. Institutional Delivery Claim on Healthy Pregnancy Program (2 claims)
28. Infertility Benefits - (3 claims – review the member and the spouse) – actually reviewed 4
29. Emergency room visit with admittance into inpatient stay (3 claims GF or NGF only)
30. Out-Of-State Out-Of-Network Professional Claims (4 claims)
31. Out of country care (3 claims)
32. In Country claims paid directly to subscriber (2 in state and 2 out of state)
33. Claims pulled by IA during Financial ICR Audit (8 claims) – No claims to review
34. Prescription Drug Diabetic supplies (3 GF and 2 HDHP)
35. Prescription Drug Formulary (3 claims)
36. Prescription Drug Non-Formulary (3 claims)
37. Prescription Drug Contraception (2 claims PPO & 3 claims HDHP)
38. Prescription Drug for Flu Vaccine (2 claims) (No COB)
39. Prescription Drug for COVID-19 Vaccine (3 claims) (No COB)
40. Prescription Drug for Diabetic medications (3 GF and 2 HDHP) – actually reviewed 7
41. Prescription Drug 2024 history for HDHP member (2 members)
42. Prescription Drug Medicare Part-D claims (9 claims) - Humana
    - Two claims from each Tier and three additional claims from Tier 4

Total 123 Claims from Sanford
Total 9 Claims from Humana

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Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: HB 1113 457 Deferred Compensation Plan Administrative Fees

Over the past few weeks, NDPERS staff and Callan have been collaborating to develop recommendations on how best to implement the assessment of these fees.

Three primary considerations have emerged for discussion:

1. **Frequency of Fee Collection** – The frequency of assessing administrative fees is ultimately at the discretion of the Board. Common industry practices generally align around monthly or quarterly assessments.

   From a transparency and consistency standpoint, aligning the NDPERS administrative fee assessment with Empower's current fee schedule (which is quarterly) may be the most straightforward and understandable approach for participants. This alignment would reduce confusion and ensure a uniform experience in how fees are communicated and applied.

   The Investment Subcommittee recommendation is to collect the NDPERS admin fees quarterly to align with Empower's current fee schedule.

2. **Methodology of Fee Collection** – The methodology for calculating and collecting administrative fees from participant accounts can significantly impact both fairness and administrative efficiency. The three primary approaches considered are:

A) **Asset-Based Percentage:**
While commonly used, this method introduces variability and potential imbalance in collections. It carries point-in-time risk, as fees are based on market values that fluctuate, which could result in over- or under-collection. This would likely require more frequent monitoring and adjustments to remain accurate and sufficient.

B) **Tiered Structure**:
A tiered fee model—charging different rates based on account size—could be seen as more equitable but may introduce complexity and confusion for participants. It also complicates administration and participant communication.

C) **Flat Rate**:
A flat fee ensures predictable and stable revenue to cover administrative costs. While participants with lower account balances would pay a higher percentage relative to their balance, this approach is the most transparent, easy to communicate, and administratively straightforward.

The Investment Subcommittee recommends implementing a flat rate structure. This model ensures adequate funding for the NDPERS office while remaining simple to administer and explain to participants. This approach also aligns with Empower's current fee schedule.

3. **Accounts to be Charged –** Historically, NDPERS has not assessed administrative fees on participant accounts with balances under $1,000. This practice has been rooted in a philosophy of supporting new or lower-balance participants, allowing them time to grow their accounts before incurring fees.

   The average annual contribution into a participant's Deferred Compensation account is just over $1,100. As a result, this approach effectively provides the average participant with approximately one year of recordkeeping services at no cost, which can serve as an incentive for enrollment and continued participation.

   The investment subcommittee recommends not assessing participant accounts under $1,000.

Board Action Requested:

Approve a methodology on how to assess NDPERS administrative fees for the 457 Deferred Compensation Plan.

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Memorandum

TO: NDPERS Board

FROM: Marcy Aldinger and MaryJo Anderson

DATE: June 10, 2025

SUBJECT: Retirement Employer Participation Agreements

Legislation passed in House Bill (HB) 1146 and HB 1419 that will require updates to the retirement employer participation agreements used for enrolling new employer groups into the NDPERS retirement plans. Both bills are effective August 1, 2025.

HB 1146

This bill allows new political subdivision employer groups that are not currently participating in NDPERS retirement to join the Defined Contribution Plan.

Based upon guidance from Ice Miller, if the new political subdivision employer joins the NDPERS retirement plan and previously offered another retirement plan (excluding a 457 Deferred Compensation Plan), the new group may not be eligible to join the NDPERS plan given the pre-tax contributions elected by their employees in their previous retirement plan must exactly match the contribution levels within the NDPERS retirement plan. This is due to the same Cash or Deferred Arrangement (CODA) provisions under federal law that we have discussed recently with the Board.

Therefore, as NDPERS is contacted by an interested political subdivision, staff will discuss these provisions with the group to determine if they are eligible to join and offer the plan to their employees. In addition, staff will be preparing new administrative rules to address employer group eligibility as mentioned above.

To implement HB 1146, the Retirement Employer Participation Agreement (Attachment 1) was updated to include provisions of the Defined Contribution Plan. Legal counsel has reviewed the agreement and confirmed the necessary changes to it.

HB 1419

This bill revises the correctional officer definition and expands eligibility in the Public Safety Plan to include dispatchers and emergency medical services personnel. Given this expanded eligibility, the Law Enforcement Retirement Employer Participation Agreement (Attachment 2) was amended. Legal counsel has reviewed the agreement and confirmed the necessary changes to it.

Board Action Requested:

Approve the retirement employer participation agreements to allow:

1) A new political subdivision to join the Defined Contribution Plan due to the provisions of HB 1146 (Attachment 1).

2) A political subdivision that elects to offer the Law Enforcement Retirement Plan to include dispatchers and emergency medical services personnel in the eligible class of employees for the plan due to the provisions of HB 1419 (Attachment 2).

Attachment 1

EMPLOYER PARTICIPATION AGREEMENT
IN THE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
RETIREMENT PROGRAM

This Agreement is entered into pursuant to Section 54-52-02.1 of the North Dakota Century Code (N.D.C.C.) by and between ORG NAME, CITY, North Dakota, as authorized by the resolution hereto attached and the state of North Dakota, by and through its NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM (NDPERS) as authorized by the Retirement Board through its chairman and executive director, and shall be effective on _____ 1, 2025.

Whereas, a referendum of the eligible employees of ORG NAME, CITY, North Dakota, has been held pursuant to N.D.C.C. § 54-52-02.2, and a majority of such eligible employees voted in favor of participation in NDPERS and ORG NAME has determined that this Agreement should be entered into; and

Whereas, the Retirement Board agrees to extend the benefits of the NDPERS to eligible employees of ORG NAME;

Now, therefore, it is agreed and understood that:

1. All of the provisions of N.D.C.C. chs. 54-52 and 54-52.6 and the current or later amended rules of the Retirement Board shall apply with regard to benefits, contributions and administration of the system.

2. The employee contribution rate has been actuarially determined to be percentage of "wages" and "salaries" as defined in N.D.C.C. §§ 54-52-01 and 54-52.6-01 for those eligible employees employed as of the date of this Agreement and for those eligible employees whose date of employment is after the effective date.

3. The employer contribution rate shall be a percentage of "wages" and "salaries" for all eligible employees as defined in N.D.C.C. §§ 54-52-01 and 54-52.6-01, which specific percentage shall be determined by the Retirement Board. See N.D.C.C. §§ 54-52-06, 54-52.1-03.2, and 54-52.6-09.

4. Eligible employees who are employed by ORG NAME at the time this Agreement is entered into have the option of not participating in the NDPERS. Eligible employees who waive participation in the NDPERS may not have their pay increased as a result of that waiver, which determination shall be made by the Retirement Board in its sole discretion, and any violation of this requirement will constitute a breach of this Agreement.

5. All eligible employees hired by ORG NAME on or after _____ , 2025, must participate in the NDPERS.

6. Should ORG NAME wish to terminate membership with the NDPERS, it shall do so only after:

   (a) Submitting a request in writing to the Retirement Board at least sixty (60) days prior to the requested date of withdrawal; and

(b) Complying with N.D.C.C. § 54-52-02.1 and the administrative rules of the Retirement Board regarding withdrawal from the system.

7. This Agreement may be amended in writing by mutual agreement of both parties.

8. If the ORG NAME fails to perform according to its statutory participation requirements, the Retirement Board may terminate the ORG NAME's enrollment in NDPERS. The termination shall be performed pursuant to the withdrawal procedures outlined in N.D.C.C. chs. 54-52 and 54-52.6.

Executed at_____, North Dakota, this ____ day of _____, 20____.

ORG NAME

By _____

By _____

Executed at Bismarck, North Dakota, this ____ day of _____, 20____.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

By _____
Executive Director Date

Attachment 2

EMPLOYER PARTICIPATION AGREEMENT
IN THE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
PUBLIC SAFETY RETIREMENT PLAN

This Agreement is entered into pursuant to Section 54-52-02.1 of the North Dakota Century Code (N.D.C.C.) by and between (ORG), North Dakota, as authorized by the resolution hereto attached and the state of North Dakota, by and through its NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM (NDPERS) as authorized by the Retirement Board through its chairman and executive director and shall be effective on _____ 1, 2025.

Whereas, a referendum of the eligible peace officers, correctional officers, firefighters, dispatchers, and emergency medical services personnel of ORG, North Dakota, has been held pursuant to N.D.C.C. §54-52-02.2, and a majority of such eligible employees voted in favor of participation in NDPERS and ORG has determined that this Agreement should be entered into; and

Whereas, the Retirement Board agrees to extend the benefits of NDPERS to eligible employees of ORG;

Now, therefore, it is agreed and understood that:

1. All of the provisions of N.D.C.C. ch. 54-52 and the current or later amended rules of the Retirement Board shall apply with regard to benefits, contributions and administration of the system.

2. The employee contribution rate has been actuarially determined to be as percentage of "wages" and "salaries" as defined in N.D.C.C. §54-52-01 for those eligible employees employed as of the date of this Agreement and for those eligible employees whose date of employment is after the effective date.

3. The employer contribution rate shall be a percentage of "wages" and "salaries" for all eligible employees as defined in N.D.C.C. §54-52-01, which specific percentage shall be determined by the Retirement Board. See N.D.C.C. §§54-52-06 and 54-52.1-03.2.)

4. Eligible employees who are employed by ORG at the time this Agreement is entered into have the option of not participating in NDPERS. Eligible employees who waive participation in NDPERS may not have their pay increased as a result of that waiver, which determination shall be made by the Retirement Board in its sole discretion, and any violation of this requirement will constitute a breach of this Agreement.

5. All eligible employees hired by ORG on or after _____ 1, 2025, must participate in NDPERS.

6. Should ORG wish to terminate membership with NDPERS, it shall do so only after:

   (a) Submitting a request in writing to the Retirement Board at least sixty (60) days prior to the requested date of withdrawal; and

   (b) Complying with N.D.C.C. §54-52-02.1 and administrative rules of the Retirement Board regarding withdrawal from the system.

7. This Agreement may be amended in writing by mutual agreement of both parties.

8. If the ORG fails to perform according to its statutory participation requirements and the terms of this Agreement, the Retirement Board may terminate the ORG's enrollment in NDPERS. The termination shall be performed pursuant to the withdrawal procedures outlined in N.D.C.C. ch. 54-52.

Executed at _____, North Dakota, this ___ day of _____, 20____.

ORG

By _____

By _____

Executed at Bismarck, North Dakota, this ____ day of _____, 20____.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

By _____
Executive Director

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

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Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: June 10, 2025

SUBJECT: Proposed Administrative Rules

Based upon Board action taken at the May Board meeting to establish two Board policies related to elected county officials and their participation in the NDPERS retirement plan, and the Board's direction that staff begin preparing administrative rules regarding these policies, legal counsel and staff are providing the attached. Both representatives of the Attorney General's Office and Ice Miller have reviewed and provided their input on the proposed administrative rules.

Board Action Requested: Approve moving forward with the rulemaking process with the attached proposed administrative rules, specifically seeking approval for emergency rule promulgation.

Attachment

Title 71
Retirement Board

Article

ARTICLE 71-02
PUBLIC EMPLOYEES RETIREMENT SYSTEM

Chapter

CHAPTER 71-02-02
MEMBERSHIP

71-02-02-01. Membership - General rule.

When an eligible employee becomes a member of the public employees retirement system, the following requirements apply:

1. A temporary employee must submit a completed participation agreement within six months of the date of hire as a temporary employee or within six months of a change in status from a permanent to temporary position. If no application is made and filed with the office, an irrevocable waiver of participation will occur for as long as the employee is in temporary status.

2. Delinquent payments of over thirty days, for reasons other than leave of absence or seasonal employment, will result in termination of eligibility to participate as a temporary member.

3. Upon taking a refund, future participation as a temporary member is waived.

4. A member may not contribute concurrently to the plan within any given month as both a permanent and a temporary member. Permanent employment has precedence.

~~5. Elected officials of participating counties and elected state officials, at their individual option, must enroll or waive participation in writing within six months of taking office or beginning a new term. If no application is made and filed with the office, an irrevocable waiver of participation will occur until the official makes application within six months from the start of a new term.~~

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1992; June 1, 1996; July 1, 1998; May 1, 2004; July 1, 2006; April 1, 2016; July 1, 2018; April 1, 2022; _____, 2025.
General Authority: NDCC 54-52-04, 54-52-23
Law Implemented: NDCC 54-52-01, 54-52-02.9, 54-52-05, 54-52-23

71-02-02-02. Nonstate Elected Officials – Membership and Return to Service

1. **Purpose.** North Dakota Century Code sections 54-52-02.11 and 54-52.6-02.1(3) conflict with Internal Revenue Code sections 401(a)(36) and 401(k)(4)(B)(ii) and related regulations and relevant guidance.

   Pursuant to the authority granted to the board under North Dakota Century Code section 54-52-23, the purpose of this section is to ensure compliance with federal statutes and rules until the conflict between North Dakota Century Code section 54-52-02.11 and federal law is addressed by the legislative assembly.

2. **Membership.**

   a. As used in this subsection, "eligible elected official" means a county elected official who is a permanent employee, peace officer, firefighter, or correctional officer and who is eighteen years or more of age.

   b. Effective May 13, 2025, an eligible elected official of a participating county, from and after the date that individual takes office, must participate in the defined contribution retirement plan established under North Dakota Century Code chapter 54-52.6, unless at the time of taking office the individual is:

      1) eligible to participate in the law enforcement plan, in which case the eligible elected official must participate in the law enforcement plan under North Dakota Century Code chapter 54-52; or

      2) a participating or deferred member under North Dakota Century

Code chapter 54-52, in which case the eligible elected official must participate in the defined benefit plan under North Dakota Century Code chapter 54-52.

c. Effective May 13, 2025, a county elected official who is not an eligible elected official shall have the same participation options as a temporary employee.

3. **Return to Service.**

a. As used in this subsection, "impacted member" means a participating member who has reached their normal retirement date, returned to service or continued employment as an elected official of the same participating county with which the member was employed at the time the member retired, and is not contributing to the law enforcement plan, the defined benefit plan, or the defined contribution retirement plan.

b. Before August 1, 2027, a request by an impacted member to receive in-service benefit distributions while the impacted member is an elected official of the county of prior employment shall be approved.

c. Retroactive Effective Date. This subsection is retroactive to July 1, 2007.

4. **Sunset provision.** This section shall terminate on the effective date of any measure enacted by the legislative assembly providing the necessary amendments to the North Dakota Century Code to ensure compliance with the federal statutes or rules.

History: Effective XXX, 2025.
General Authority: NDCC 54-52-04, 54-52-23
Law Implemented: NDCC 54-52-02.15, 54-52-05

CHAPTER 71-02-07
RETURN TO SERVICE

71-02-07-02. Return to service - Retired member.

The benefits of a retired member who returns to permanent employment shall be suspended without interest accruing on the suspended account, except as provided in subsection 1 of North Dakota Century Code section 54-52-05 and section 71-02-02-02. Upon subsequent termination and retirement, the member is required to select the same benefit option as the option selected at initial retirement. The member's total benefit upon subsequent retirement must equal the original benefit plus the calculated benefit for the return to work period. The member's benefit attributable to any return to work period shall be based upon service and earnings attributable to the return to

work period only and be calculated as follows:

1. The member's calculated benefit shall be based on the benefit provisions in effect at subsequent retirement and shall include the member's and spouse's ages, salary earned during the period of reemployment, total service credits earned after reemployment, and actuarial factors in effect at subsequent retirement.

2. If a member dies during subsequent employment, the member's initial retirement benefit option election will apply and the date of death will be considered the subsequent retirement date.

3. If a member's spouse dies during the subsequent employment of the member, section 71-02-04-04 applies to the member's initial and subsequent retirement benefit calculation.

History: Amended effective November 1, 1990; July 1, 1998; May 1, 2004; July 1, 2006; July 1, 2010; July 1, 2018; _____, 2025.
General Authority: NDCC 54-52-04, 54-52-17, 54-52-23
Law Implemented: NDCC 54-52-17, 54-52-02.15, 54-52-05

ARTICLE 71-08
DEFINED CONTRIBUTION RETIREMENT PLAN

CHAPTER 71-08-02
MEMBERSHIP IN DEFINED CONTRIBUTION RETIREMENT PLAN

71-08-02-03. Nonstate Elected Officials – Membership and Return to Service

1. **Purpose.** North Dakota Century Code sections 54-52-02.11 and 54-52.6-02.1(3) conflict with Internal Revenue Code sections 401(a)(36) and 401(k)(4)(B)(ii) and related regulations and relevant guidance.

   Pursuant to the authority granted to the board under North Dakota Century

Code sections 54-52-23 and 54-52.6-23, the purpose of this section is to ensure compliance with federal statutes and rules until the conflict between North Dakota Century Code sections 54-52-02.11 and 54-52.6-02.1(3) and federal law is addressed by the legislative assembly.

2. **Membership.** A county elected official shall participate in the defined contribution retirement plan as provided under section 71-02-02-02.

3. **Return to Service.**

   a. Before August 1, 2027, a request by a county elected official to receive in-service benefit distributions shall be approved as provided under section 71-02-02-02.

   b. Retroactive Effective Date. This subsection is retroactive to July 1, 2007.

4. **Sunset provision.** This section shall terminate on the effective date of any measure enacted by the legislative assembly providing the necessary amendments to the North Dakota Century Code to ensure compliance with the federal statutes or rules.

History: Effective XXX, 2025.
General Authority: NDCC 54-52-04, 54-52.6-23
Law Implemented: NDCC 54-52-02.15, 54-52.6-02

CHAPTER 71-08-09
RETURN TO SERVICE – RETIRED MEMBER

71-08-09-01. Return to service - Retired member.

The benefits of a retired member of the defined contribution plan who returns to permanent employment shall be suspended except as provided in North Dakota Century Code section 54-52.6-02 and section 71-08-02-03.

History: Amended ~~E~~effective July 1, 2006, XXX, 2025.
General Authority: NDCC 54-52-04, 54-52.6, 54-52.6-23
Law Implemented: NDCC 54-52.6-01~~.~~(7), 54-52.6-02~~.~~(7), 54-52-02.15, 54-52.6-02

CHAPTER 71-08-10
PERMANENT EMPLOYEE PARTICIPATION

71-08-10-01. Permanent employee participation.

1. Under this chapter "eligible employee" means a permanent employee who:

   a. Meets all the eligibility requirements set by North Dakota Century Code chapter 54-52;

b. Is at least eighteen years of age;

c. Becomes a participating member after December 31, 2024; and

d. Is not eligible to participate in the law enforcement plan, judges' plan, highway patrol plan, teachers' fund for retirement plan, or alternative retirement program established under subsection 6 of North Dakota Century Code chapter 15-10-17 for employees of the board of higher education or state institutions under the jurisdiction of the board of higher education.

2. Effective January 1, 2025, the public employees retirement system defined benefit main plan maintained for employees is closed to new eligible employees. However, an employee who first becomes a participating or deferred member under North Dakota Century Code chapter 54-52 before January 1, 2025, remains in the defined benefit retirement plan under North Dakota Century Code chapter 54-52, regardless of being rehired after December 31, 2024.

3. Except as otherwise provided under this section and section 71-08-02-03, effective January 1, 2025, an eligible employee who begins employment with an employer as defined under subsection 6 of North Dakota Century Code chapter 54-52-01 shall participate in the defined contribution retirement plan under North Dakota Century Code chapter 54-52.6 as provided under North Dakota Century Code chapter 54-52.6-02.1.

4. This section does not impact an employee to the extent the employee is a participating member in one or more of the following enumerated plans: law enforcement plan, judges' plan, highway patrol plan, teachers' fund for retirement plan, or alternative retirement program established under subsection 6 of North Dakota Century Code chapter 15-10-17 for employees of the board of higher education or state institutions under the jurisdiction of the board of higher education.

   a. A participating or deferred member in the defined contribution retirement plan under North Dakota Century Code chapter 54-52.6 who becomes eligible to participate in a plan enumerated under subsection 4 shall cease participation in the defined contribution retirement plan under North Dakota Century Code chapter 54-52.6 and commence participation in the retirement plan enumerated under subsection 4.

   b. Unless subsection 2 applies, a participating member of a retirement plan enumerated under subsection 4 who ceases participation in that plan and becomes an eligible employee under the defined contribution retirement plan under North Dakota Century Code chapter 54-52.6 shall participate in the defined contribution retirement plan under North Dakota Century Code chapter 54-52.6.

5. An eligible employee must be enrolled in the plan within the first thirty days of

employment.

History: Amended ~~E~~effective January 1, 2025, XXX, 2025.
General Authority: NDCC 54-52-04, 54-52-02.15
Law Implemented: NDCC 54-52-02.15, 54-52.6-09, 54-52-02.15, 54-52.6-02

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Memorandum

TO: NDPERS Board

FROM: Shawna Piatz

DATE: June 10, 2025

SUBJECT: Audit Committee Memo

Attachment 1 are the approved minutes from the February 6, 2025 Audit Committee meeting. The minutes may also be viewed on the NDPERS website at www.ndpers.nd.gov.

In an attempt to provide information more timely to the Board, I have also attached the agenda (Attachment 2) from the meeting on May 12, 2025 and want to note the items below which were discussed at this meeting.

- 2024 Sanford Health Plan Claims Audit – Each year, ND PERS performs a review of a sample of medical and pharmacy claims from the Sanford health plan and the Humana Medicare Part-D prescription drug plan. A sample of 132 claims from 2024 were selected for review. Internal Audit met virtually in April with Sanford and Humana staff to review the selections. There were initially seven observations which were discussed in more detail in an attached report. Since the Audit Committee meeting, further information has been provided on two of the observations which supported that both are no longer issues and therefore have been removed from the report. This report will be discussed in more detail under a separate Board agenda item.

- Retirement Benefit Payment Status Report – Information was provided to the Audit Committee, which summarizes the accuracy percentages of the new monthly retirement benefit and refund payments.

  As of April 1, 2025, 297 of the 915 new retirees or $1,332,568.55 of the $3,550,565.42 total gross benefits issued have been audited. The fiscal year-to-date internal calculation accuracy rate is 98.65% for FY 2025. The fiscal year-to-date

compliance/other accuracy rate is 96.63% resulting in an overall accuracy rate of 95.29% for FY 2025.

As of April 1, 2025, 151 of the 1,779 or $4,904,512.88 of the $18,445,656.52 total gross refunds issued for FY 2025 were audited. The fiscal year-to-date internal calculation accuracy rate is 97.35% for FY 2025. The fiscal year-to-date compliance/other accuracy rate is 99.34% resulting in an overall accuracy rate of 96.69% for FY 2025.

- Outstanding Issues Status Report – The Outstanding Issues Status report reflects new and outstanding issues as of April 30, 2025. Updates were provided on the 33 existing recommendations and 5 new recommendations were added to the report. Of the 38 total outstanding issues, 15 were closed out and 23 issues remain outstanding. The new and outstanding issues were reviewed and discussed.

- 2024 CAO Annual Performance Review – The 2024 CAO Annual Performance evaluation, including the CAO's self-evaluation and scores by the Executive Director, and each of the Audit Committee members who chose to respond, was reviewed, discussed and approved by the committee.

The next regular audit committee meeting is scheduled virtually and in person for August 18, 2025 at 3:00 pm. This is for your information.

Attachments

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MEMORANDUM

Attachment 1

TO: Audit Committee
Adam Miller
Senator Dick Dever
Tyler Erickson
Nina Sand
Rebecca Fricke
Derrick Hohbein
Mary Kae Kelsch
Shannon Ennen

FROM: Shawna Piatz, Chief Audit Officer

DATE: Thursday February 6, 2025

SUBJECT: **February 6, 2025 Audit Committee Meeting**

In Attendance:
Senator Dick Dever
Adam Miller
Tyler Erickson
Nina Sand
Shawna Piatz
Shannon Ennen

The meeting was called to order at 3:02 p.m. by Mr. Erickson

I. Conflict of Interest Disclosure

A. Conflict of interest disclosures concerning any of the agenda topics were considered. No conflicts of interest were disclosed.

II. Approval of prior Audit Committee Minutes

A. The Audit Committee minutes from the prior Audit Committee meeting held on November 25, 2024 were examined. Mr. Miller moved approval of the minutes. The motion was seconded by Mr. Erickson This was followed and approved by voice vote.

III. Internal Audit Reports

A. Quarterly Audit Plan Status Report – Information was provided on the past quarter's activity November 1, 2024 through January 31, 2025 and progress made on the 2024-2025 Audit Plan. Internal Audit spent 28.26% of their time on audit activities and 26.97% on consulting services. The remaining 44.77% of their time was spent on administrative items which included coordinating the Risk Assessment reviews and working on the HB 1040 Special Election window.

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B. 2024 Risk Assessment Summary and Audit Plan Report - The Audit Plan is updated each biennium with an update provided every year. The Audit Plan for calendar years 2024 – 2025 was presented to and approved by the Audit Committee in February 2024. Internal Audit coordinated the completion of the annual risk assessment updates with management over the previous quarter, reviewed the results and does not believe any updates are needed to the approved Audit Plan that is in effect until December 31, 2025. Incorporating the new plan Tiers created by HB 1040 will be included in the on-going new retiree audit.

The 2025 Risk Assessment Summary and 2024 - 2025 Audit Plan were reviewed. Mr. Erickson moved approval of the confirmation that the 2024-2025 Audit Plan to remain unchanged. The motion was seconded by Mr. Miller. This was followed and approved by voice vote.

C. Retirement Benefit Payment Status Report – Information was provided to the Audit Committee, which summarizes the accuracy percentages of the new monthly retirement benefit and refund payments. The report shows the number of new retirees or refunds each month, the total number of new retirees or refunds audited and whether issues identified were procedural, system or compliance issues.

As of February 1, 2025, 248 of the 750 new retirees or $1,044,442.73 of the $2,805,389.30 total gross benefits issued have been audited. The fiscal year-to-date internal calculation accuracy rate is 98.39% for FY 2025. The fiscal year-to-date compliance/other accuracy rate is 96.77% resulting in an overall accuracy rate of 95.16% for FY 2025.

As of February 1, 2025, 123 of the 1,415 or $3,908,873.91 of the $14,147,723.90 total gross refunds issued for FY 2025 were audited. The fiscal year-to-date internal calculation accuracy rate is 96.75% for FY 2025. The fiscal year-to-date compliance/other accuracy rate is 100% resulting in an overall accuracy rate of 96.75% for FY 2025.

D. Benefit/Premium Adjustments Report – The quarterly benefit adjustment report was provided to the Audit Committee. The report is in several sections, each representing the type of correction made. The dollar amount and the number of errors has decreased over the last quarter and there 13 new issues that were reviewed and discussed.

E. Outstanding Issues Status Report – The Outstanding Issues Status report has been updated to reflect new and outstanding issues as of January 31, 2025. There were 31 existing recommendations and 4 new recommendations added to this report. The new and outstanding issues were reviewed and discussed.

V. Administrative

A. Audit Committee Charter Matrix Review - Per the Audit Committee charter, the Audit Committee is to "Confirm annually all responsibilities outlined in this charter have been carried out. Review and assess periodically the adequacy of the Committee charter, request Board approval for proposed changes, and ensure appropriate disclosure as

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may be required by law or regulation."

To meet this responsibility a matrix was developed to review against current activities to ensure that the audit committee is meeting its responsibilities. A summary of the progress made and activities completed through January 2025 was reviewed. The Audit Committee Charter was distributed for signatures to confirm that all responsibilities outlined in the charter have been carried out. Each Audit Committee Member needs to sign the document and return it to the CAO.

B. Internal Audit Charter Matrix Review – In order to confirm all responsibilities outlined in the Audit Committee Charter are carried out annually, a matrix was developed to review each objective quarterly and ensure that Internal Audit is meeting its responsibilities. The matrix was reviewed and discussed for progress and activities completed through January 31, 2025.

C. 2024 CAO Annual Performance Review – The CAO Annual Performance evaluation, including the CAO's self-evaluation and scores by the Executive Director, was provided to each Audit Committee member. Each member will need to complete and return the evaluation to the Executive Director before the next Audit Committee meeting. Next quarter the Audit Committee will vote on final evaluation scores.

D. Report on Consultant Fees – According to the Audit Committee Charter, the Audit Committee should "Periodically review a report of all costs of and payments to the external financial statement auditor. The listing should separately disclose the costs of the financial statement audit, other attest projects, agreed-upon procedures and any non-audit services provided." To accomplish this objective, a summary of the consulting, investment and administrative fees paid as of January 31, 2025 was provided and reviewed by the Committee.

E. Travel Expenditures – The Audit Committee reviews the out-of-state travel expenditures incurred by the Executive Director or Board each quarter. There were no out-of-state travel expenditures for the Executive Director or the Board for the period November 1, 2024 through January 31, 2025.

F. CPE, Training and Webinars – A report on the training and education, including continuing professional education (CPE) webinars and seminars, Internal Audit participated in for the period November 1, 2024 through January 31, 2025 was provided to the committee for their review. There were no training, webinars or seminars to report during this time.

The meeting adjourned at 4:15 p.m. by Mr. Erickson.

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Attachment 2

Audit Committee Agenda

Location: NDPERS Conference Room, 1600 East Century Avenue, Bismarck ND
By phone: 701.328.0950 Conference ID: 943 165 247#
Date: **Monday May 12, 2025**
Time: 3:00 P.M. Join the meeting now

I. CONFLICT OF INTEREST DISCLOSURE CONSIDERATION

A. Conflict of Interest Disclosure Consideration

II. AUDIT COMMITTEE MINUTES

A. February 6, 2025 Audit Committee Minutes **(Committee Action)**

III. INTERNAL AUDIT REPORTS

A. 2024 Sanford Health Plan Claims Audit
B. Quarterly Audit Plan Status Report
C. Retirement Benefit Payment Status Report
D. Benefit / Premium Adjustments Report
E. Outstanding Issues Status Report

IV. ADMINISTRATIVE

A. Audit Committee Charter Matrix
B. Internal Audit Charter Matrix
C. 2024 CAO Annual Performance Review **(Committee Action)**
D. Report on Consultant Fees
E. Travel Expenditures
F. CPE, Training and Webinars

*Next Audit Committee meeting: August 18, 2025

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Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: Sagitec Maintenance Contract

Attached is the agreement with Sagitec Solutions, LLC for licensing fees and application development services for the 2025-27 biennium. Legal has reviewed the agreement, and the addendum reflects the amounts that were included in our budget request.

Please note this agreement also includes one-time additional funding for two additional developers our agency was appropriated, as well as a project manager to help us manage the large IT projects currently in process.

The table below shows a comparison of the fees for the current biennium and the upcoming biennium.

	2023 – 2025 Biennium	**2025 – 2027 Biennium**
Licensing	$ 375,000.00	$ 398,471.00
Development & Consulting	1,489,495.20	2,423,551.00
Total	1,864,495.20	2,822,022.00

Board Action Requested:

Approve the maintenance and support agreement with Sagitec Solutions LLC for the 2025-27 biennium, and authorize Rebecca to sign the agreement.

Attachment

2025–2027 Addendum to the Maintenance and Support Agreement

This document is an addendum ("Addendum") to the Maintenance and Support Agreement between Sagitec Solutions, LLC ("Sagitec") and the State of North Dakota, through its Public Employees Retirement System ("NDPERS"), dated July 1, 2019 ("Agreement").

1. The parties wish to revise Exhibit A and Exhibit B to the Agreement.

2. In view of the above, Exhibit A and Exhibit B to this Addendum replace Exhibit A and Exhibit B of the Agreement and all previous Addendums replacing Exhibit A and Exhibit B of the Agreement. This revision to Exhibit A and Exhibit B will be effective from July 1, 2025, through June 30, 2027.

3. In the event of a conflict between the terms of this Addendum and the terms of the Agreement, the terms of this Addendum will prevail.

4. Except as amended, the terms and conditions contained in the Agreement shall remain in full force and effect in accordance with its terms.

SAGITEC SOLUTIONS, LLC	NDPERS
By 	By _____
Name Subodh Murthi	Name _____
Title Managing Director - Pension	Title _____
Date 06/06/2025	Date _____

Exhibit A

PRODUCT RELEASE SERVICES FEE

Fixed fee for Product Release Services as described in Exhibit B of this document for the period July 1, 2025, through June 30, 2027, is $398,471.00. This amount corresponds to a fixed annual fee amount of $199,235.50 per contract year ("Fixed Annual Fee Amount"). Each contract year begins on July 1 and ends on June 30.

The Product Release Services fee shall be divided into twenty-four (24) equal monthly installments of $16,602.96. This fee will be due and payable within thirty (30) calendar days after the date of Sagitec's invoice.

This fee is effective starting on July 1, 2025, and shall continue through June 30, 2027, unless terminated earlier. If NDPERS terminates this Agreement without cause during a contract year, NDPERS shall pay Sagitec the balance of the Fixed Annual Fee Amount minus any credits, within thirty (30) calendar days after termination becomes effective. If Sagitec terminates this Agreement without cause, NDPERS shall pay Sagitec within thirty (30) calendar days after termination becomes effective the monthly installments incurred through the termination date, minus any credits, with the final installment adjusted pro-rata if termination occurs before the end of the month. Sagitec may increase the fee upon the renewal process with NDPERS. Sagitec shall notify NDPERS of any proposed annual increase no later than 90 days prior to the renewal of this Agreement for the following year.

PRODUCT CONSULTING SERVICES FEE

Fixed fee for Product Consulting Services as described in Exhibit B of this document for the period July 1, 2025, through June 30, 2027, is $1,211,775.50.

The Product Consulting Services fee shall be divided into twenty-four (24) equal monthly installments of $50,490.64. This fee will be due and payable within thirty (30) calendar days after the date of Sagitec's invoice.

This fee is effective starting on July 1, 2025, and shall continue through June 30, 2027, unless terminated earlier. If this agreement is terminated without cause, NDPERS shall pay Sagitec the monthly installments incurred through the termination date, minus any credits, with the final installment adjusted pro-rata if termination occurs before the end of the month. Payment shall be due within thirty (30) calendar days after termination becomes effective. Sagitec may increase the fee upon the renewal process with NDPERS. Sagitec shall notify NDPERS of any proposed annual increase no later than 90 days prior to the renewal of this agreement for the following year.

APPLICATION DEVELOPMENT OUTSOURCING FEE

NDPERS will pay Sagitec the fixed amount of $1,211,775.50 for Application Development Services, as described in Exhibit B of this document, for the period July 1, 2025, through June 30, 2027.

The ADO fee shall be divided into twenty-four (24) equal monthly installments of $50,490.64. ADO fees will be due and payable within thirty (30) days after the date of Sagitec's invoice.

Should NDPERS decide to purchase additional ADO services the following hourly rates apply:

	2025	2026	2027
On Site Resources	$300	$310	$320
Off Site Resources	$200	$210	$220

Sagitec will provide discounted rates for blocks of ADO hours over 1,000. Hourly rates do not include travel expenses and are subject to change depending on prevailing market conditions.

This fee is effective starting on July 1, 2025, and shall continue through June 30, 2027, unless terminated earlier. If this agreement is terminated without cause, NDPERS shall pay Sagitec the monthly installments incurred through the termination date, minus any credits, with the final installment adjusted pro-rata if termination occurs before the end of the month. Payment shall be due within thirty (30) calendar days after termination becomes effective. Sagitec may increase the fee upon the renewal process with NDPERS. Sagitec shall notify NDPERS of any proposed annual increase no later than 90 days prior to the renewal of this agreement for the following year.

Exhibit B

PRODUCT RELEASE SERVICES

NDPERS shall receive services as follows:

- Access to all major and minor Product releases
- Enrollment as Beneficiary to Standard Escrow Agreement

PRODUCT CONSULTING SERVICES and APPLICATION DEVELOPMENT OUTSOURCING (ADO) SERVICES

Sagitec shall provide two (2) onshore resources for up to 3,600 hours per year (1800 hours per FTE), and five (5) offsite resources for up to 9,000 hours per year (1800 hours per FTE) for product consulting and ADO services.

PRODUCT CONSULTING SERVICES

- Product installation and configuration services
- A technical and business overview of the new features of the Product and Product Extensions and implementation pre-requisites prior to the implementation of the Product.
- Enterprise licenses to Product Extensions
- Product Service Desk (e.g., Help Desk) –Non-dispatched service assistance or resolution delivered via phone, e-mail, and/or on-line communication.
- Dedicated service desk and account manager

APPLICATION DEVELOPMENT OUTSOURCING (ADO) SERVICES

Corrective, adaptive, preventative, and perfective support activities, to be directed by NDPERS.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: Presort Contract

Attached is the agreement with Presort Plus, LLC for courier and mail services for the 2025-27 biennium. Legal has reviewed the agreement, and the addendum reflects an amount that falls within the parameters that were included in our budget request.

Presort Plus, LLC does a number of things for our office including:

- Picking up mail from our PO Box and delivering it to our office daily
- Picking up mail from the Capitol and delivering it to our office daily
- Picking up inside mail and checks from our office and delivering them to the Capitol
- Picking up mail from our building and delivering it to the Post Office daily
- Pick up retirement checks and ad hoc checks from Central Duplicating on a weekly basis
- Pick up payroll checks from the Treasurer's Office and deliver to our office twice a month
- Performs the following periodic tasks
    - Meter and bar code NDPERS mail
    - Special pickups or drop offs at other agencies
    - Pick up supplies, printing, and delivery of items to and from the Capitol

The pricing for this contract remains the same as the current biennium at $28.95 a day.

BOARD ACTION:

Consider the courier and mail services agreement with Presort Plus, LLC for the 2025-27 biennium, and authorize Rebecca to sign the agreement.

AGREEMENT FOR SERVICES BETWEEN PRESORT PLUS, LLC AND NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

1. PARTIES

The parties to this contract (Contract) are the state of North Dakota, acting through its ***North Dakota Public Employees Retirement System*** (STATE), and ***Presort Plus, LLC*** having its principal place of business at ***2355 Vermont Ave, Bismarck, ND 58504*** (CONTRACTOR);

2. SCOPE OF WORK

CONTRACTOR in exchange for the compensation paid by STATE under this Contract, shall provide the following courier and mailing services during the business week, Monday through Friday, except on holidays recognized by STATE.

MORNING:

1. Pick up NDPERS mail at the U.S. Post Office location (P.O. Box 1657) and deliver to NDPERS, 1600 E Century Ave, Suite 2, Bismarck, by approximately 8:30 a.m.
2. Pick up the following at the Capitol and deliver to NDPERS by approximately 9:30 a.m.:
    a. Inside mail – Mailroom (Ground Floor, Capitol)
    b. Checks – Treasurer's Office (3rd Floor, Capitol)
3. Pick up NDPERS mail, including State Treasurer deposit, and deliver to the Capitol before 10:00 a.m. to meet the 12:00 p.m. deadline for deposits to the Treasurer's Office.

AFTERNOON:

1. Pick up NDPERS inside mail after 12:30 p.m.
2. Deliver NDPERS inside mail to the Capitol mailroom.
3. Pickup NDPERS outgoing mail by 3:15 p.m. daily.

MONTHLY:

1. Pick up retirement checks and ad hoc checks from Central Duplicating then deliver to NDPERS (usually the last week of each month).
2. If necessary, on the 1st and 10th working day, pick up payroll checks from the Treasurer's office and deliver to NDPERS before noon.

MISCELLANEOUS:

1. CONTACTOR will meter and bar code NDPERS mail.
2. Periodically, upon request, do special pick-ups or drop-offs at other agencies inside and outside of the Capitol. If a special pick-up becomes a regular request, the parties will further negotiate terms for such pickups.
3. Pick up of supplies and printing and delivery of items to and from the Capitol, as requested, as part of the normal run. Special trips will be billed on a courier rate basis.
4. CONTRACTOR must notify NDPERS prior to any delays or if unable to meet mailing deadlines.

QUALITY CONTROL MEASURES TO BE PROVIDED TO STATE:

1. CONTRACTOR will maintain equipment to ensure secure mail processing (sealed mail).
2. CONTRACTOR will have in place rigorous quality control measures to make sure that all processed outgoing mail is sealed and includes postage. Refer to Section 13, Confidentiality.

3. COMPENSATION

a. Contractual Amount

STATE shall pay for the accepted services provided by CONTRACTOR under this Contract an amount not to exceed $28.95 per day that services are provided plus the actual postage cost of metered NDPERS mail.

The Contractual Amount is firm for the duration of this Contract and constitutes the entire compensation due CONTRACTOR for performance of its obligations under this Contract regardless of the difficulty, materials or equipment required, including fees, licenses, overhead, profit and all other direct and indirect costs incurred by CONTRACTOR, except as provided by an amendment to this Contract.

b. Payment

1) Payment made in accordance with this Compensation section shall constitute payment in full for the services and work performed and the deliverables and work(s) provided under this Contract and CONTRACTOR shall not receive any additional compensation hereunder.

2) CONTRACTOR shall invoice STATE monthly. STATE shall make payment under this Contract within forty-five (45) calendar days after receipt of an approved invoice.

3) Payment of an invoice by STATE will not prejudice STATE's right to object to or question that or any other invoice or matter in relation thereto. CONTRACTOR's invoice will be subject to reduction for amounts included in any invoice or payment made which are determined by STATE, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute allowable costs. At STATE's sole discretion, all payments shall be subject to reduction for amounts equal to prior overpayments to CONTRACTOR.

4) For any amounts that are or will become due and payable to STATE by CONTRACTOR, STATE reserves the right to deduct the amount owed from payments that are or will become due and payable to CONTRACTOR under this Contract.

c. Travel

CONTRACTOR acknowledges travel costs are covered by the Contractual Amount and shall not invoice STATE for travel costs.

d. Prepayment

STATE will not make any advance payments before performance or delivery by CONTRACTOR under this Contract.

e. Payment of Taxes by STATE

STATE is not responsible for and will not pay local, state, or federal taxes. STATE sales tax exemption number is E-2001. STATE will furnish certificates of exemption upon request by the CONTRACTOR.

f. Taxpayer ID

CONTRACTOR'S federal employer ID number is: 45-0455733.

g. PURCHASING CARD

STATE may make payment using a government credit card. CONTRACTOR will accept a government credit card without passing the processing fees for the government credit card back to STATE.

4. TERM OF CONTRACT

This Contract term begins on ***July 1, 2025,*** and ends on ***June 30, 2027***.

a. No Automatic Renewal

This Contract will not automatically renew.

5. TIME IS OF THE ESSENCE

CONTRACTOR hereby acknowledges that time is of the essence for performance under this Contract unless otherwise agreed to in writing by the Parties.

6. TERMINATION

a. Termination by Mutual Agreement

This Contract may be terminated by mutual consent of both Parties executed in writing.

b. Termination for Convenience

This Contract may be terminated by STATE upon thirty (30) days' written notice to CONTRACTOR. This Contract may be terminated by mutual consent of both Parties executed in writing.

c. Early Termination in the Public Interest

STATE is entering this Contract for the purpose of carrying out the public policy of the State of North Dakota, as determined by its Governor, Legislative Assembly, Agencies and Courts. If this Contract ceases to further the public policy of the State of North Dakota, STATE, in its sole discretion, by written notice to CONTRACTOR, may terminate this Contract in whole or in part.

d. Termination for Lack of Funding or Authority

STATE by written notice to CONTRACTOR, may terminate the whole or any part of this Contract under any of the following conditions:

1) If funding from federal, state, or other sources is not obtained or continued at levels sufficient to allow for purchase of the services or goods in the indicated quantities or term.

2) If federal or state laws or rules are modified or interpreted in a way that the services or goods are no longer allowable or appropriate for purchase under this Contract or are no longer eligible for the funding proposed for payments authorized by this Contract.

3) If any license, permit, or certificate required by law or rule, or by the terms of this Contract, is for any reason denied, revoked, suspended, or not renewed.

Termination of this Contract under this subsection is without prejudice to any obligations or liabilities of either Party already accrued prior to termination.

e. Termination for Cause.

STATE may terminate this Contract effective upon delivery of written notice to CONTRACTOR, or any later date stated in the notice:

1) If CONTRACTOR fails to provide services or goods required by this Contract within the time specified or any extension agreed to in writing by STATE; or

2) If CONTRACTOR fails to perform any of the other provisions of this Contract, or so fails to pursue the work as to endanger performance of this Contract in accordance with its terms.

The rights and remedies of STATE provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

7. FORCE MAJEURE

Neither Party shall be held responsible for delay or default caused by fire, riot, terrorism, pandemic (excluding COVID-19), acts of God, or war if the event was not foreseeable through the exercise of reasonable diligence by the affected Party, the event is beyond the Party's reasonable control, and the affected Party gives notice to the other Party promptly upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default. If CONTRACTOR is the affected Party and does not resume performance within fifteen (15) days or another period agreed between the Parties, then STATE may seek all available remedies, up to and including termination of this Contract pursuant to its Termination Section, and STATE shall be entitled to a pro-rata refund of any amounts paid for which the full value has not been realized, including amounts paid toward software subscriptions, maintenance, or licenses.

8. INDEMNIFICATION

Contractor agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. The legal defense provided by Contractor to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. Contractor also agrees to reimburse the State for all costs, expenses and attorneys' fees incurred if the State prevails in an action against Contractor in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this agreement.

9. INSURANCE

Contractor shall secure and keep in force during the term of this agreement and Contractor shall require all subcontractors, prior to commencement of an agreement between Contractor and the subcontractor, to secure and keep in force during the term of this agreement, from insurance companies, government self-insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $2,000,000 per occurrence.

2) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 per occurrence. [If

Applicable]

3) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.

4) Employer's liability or "stop gap" insurance of not less than $2,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of the Contractor. Optional Provision: The amount of any deductible or self-retention is subject to approval by the State.

2) This insurance may be in policy or policies of insurance, primary and excess, including the so called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.

3) The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.

4) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy on a primary and noncontributory basis, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this agreement or by the contractual indemnity obligations of the Contractor.

5) A "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State.

6) The Contractor shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this agreement. All endorsements shall be provided as soon as practicable.

7) Failure to provide insurance as required in this agreement is a material breach of contract entitling the State to terminate this agreement immediately.

8) Contractor shall provide at least 30-day notice of any cancellation or material change to the policies or endorsements. Contractor shall provide on an ongoing basis, current certificates of insurance during the term of the contract. A renewal certificate will be provided 10 days prior to coverage expiration. Optional Provision: An updated, current certificate of insurance shall be provided in the event of any change to a policy

10. NOTICE

All notices or other communications required under this Contract must be given by registered or certified mail and are complete on the date postmarked when addressed to the Parties at the following addresses:

STATE	CONTRACTOR
Name: Rebecca Fricke	Name: Kyle Nordmeyer
Title: Executive Director	Title: General Manager
Address: 1600 East Century Ave, Suite 2 PO Box 1657	Address: 2355 Vermont Ave PO Box 1555
City, State, Zip: Bismarck, ND 58502-1657	City, State, Zip: Bismarck, ND 58504

Notice provided under this provision does not meet the notice requirements for monetary claims against the State found at N.D.C.C. § 32-12.2-04.

11. CONFIDENTIALITY

CONTRACTOR shall not use or disclose any information it receives from STATE under this Contract that STATE has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this Contract or as authorized in advance by STATE. STATE shall not disclose any information it receives from CONTRACTOR that CONTRACTOR has previously identified as confidential and that STATE determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota public records law, N.D.C.C. ch. 44-04. The duty of STATE and CONTRACTOR to maintain confidentiality of information under this section continues beyond the Term of this Contract.

12. COMPLIANCE WITH PUBLIC RECORDS LAWS

Under the North Dakota public records law and subject to the Confidentiality clause of this Contract, certain records may be open to the public upon request.

Public records may include: (a) records STATE receives from CONTRACTOR under this Contract, (b) records obtained by either Party under this Contract, and (c) records generated by either Party under this Contract.

CONTRACTOR agrees to contact STATE immediately upon receiving a request for information under the public records law and to comply with STATE's instructions on how to respond to such request.

13. INDEPENDENT ENTITY

CONTRACTOR is an independent entity under this Contract and is not a STATE employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. CONTRACTOR retains sole and

absolute discretion in the manner and means of carrying out CONTRACTOR's activities and responsibilities under this Contract, except to the extent specified in this Contract.

14. ASSIGNMENT AND SUBCONTRACTS

CONTRACTOR may not assign or otherwise transfer or delegate any right or duty without STATE's express written consent, provided, however, that CONTRACTOR may assign its rights and obligations hereunder in the event of a change of control or sale of all or substantially all of its assets related to this Contract, whether by merger, reorganization, operation of law, or otherwise. Should Assignee be a business or entity with whom STATE is prohibited from conducting business, STATE shall have the right to terminate in accordance with the Termination for Cause section of this Contract.

CONTRACTOR may enter subcontracts provided that any subcontract acknowledges the binding nature of this Contract and incorporates this Contract, including any attachments. CONTRACTOR is solely responsible for the performance of any subcontractor with whom CONTRACTOR contracts. CONTRACTOR does not have authority to contract for or incur obligations on behalf of STATE.

15. SPOLIATION (NOTICE OF POTENTIAL CLAIMS)

CONTRACTOR shall promptly notify STATE of all potential claims that arise or result from this Contract. CONTRACTOR shall also take all reasonable steps to preserve all physical evidence and information that may be relevant to the circumstances surrounding a potential claim, while maintaining public safety, and grants to STATE the opportunity to review and inspect such evidence, including the scene of an accident.

16. MERGER AND MODIFICATION – CONFLICT IN DOCUMENTS

This Contract constitutes the entire agreement between the Parties. There are no understandings, agreements, or representations, oral or written, not specified within this Contract. This Contract may not be modified, supplemented, or amended, in any manner, except by written agreement signed by both Parties.

17. SEVERABILITY

If any term of this Contract is declared to be illegal or unenforceable by a court having competent jurisdiction, the validity of the remaining terms is unaffected and, if possible, the rights and obligations of the Parties are to be construed and enforced as if this Contract did not contain that term.

18. APPLICABLE LAW AND VENUE

This Contract is governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this Contract must be adjudicated exclusively in the state District

Court of Burleigh County, North Dakota. Each Party consents to the exclusive jurisdiction of such court and waives any claim of lack of jurisdiction or *forum non conveniens*.

19. ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

By entering this Contract, STATE does not agree to binding arbitration, mediation, or any other form of mandatory Alternative Dispute Resolution. The Parties may enforce the rights and remedies in judicial proceedings. STATE does not waive any right to a jury trial.

20. ATTORNEY FEES

In the event a lawsuit is instituted by STATE to obtain performance due under this Contract, and STATE is the prevailing Party, CONTRACTOR shall, except when prohibited by N.D.C.C. § 28-26-04, pay STATE's reasonable attorney fees and costs in connection with the lawsuit.

21. NONDISCRIMINATION AND COMPLIANCE WITH LAWS

CONTRACTOR agrees to comply with all applicable federal and state laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. (*See* N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women.)

CONTRACTOR agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.

CONTRACTOR shall have and keep current all licenses and permits required by law during the Term of this Contract all licenses and permits required by law.

CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE to terminate in accordance with the Termination for Cause section of this Contract.

CONTRATOR is prohibited from boycotting Israel for the duration of this Contract. (*See* N.D.C.C § 54-44.4-15.) CONTRACTOR represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If STATE receives evidence that CONTRACTOR boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if CONTRACTOR has fewer than ten full-time employees.

CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE to terminate in accordance with the Termination for Cause section of this Contract.

22. STATE AUDIT

Pursuant to N.D.C.C. § 54-10-19, all records, regardless of physical form, and the accounting practices and procedures of CONTRACTOR relevant to this Contract are subject to examination by the North Dakota State Auditor, the Auditor's designee, or Federal auditors, if required. CONTRACTOR shall maintain these records for at least three (3) years following completion of this Contract and be able to provide them upon reasonable notice. STATE, State Auditor, or Auditor's designee shall provide reasonable notice to CONTRACTOR prior to conducting examination.

23. COUNTERPARTS

This Contract may be executed in multiple, identical counterparts, each of which is to be deemed an original, and all of which taken together shall constitute one and the same contract.

24. EFFECTIVENESS OF CONTRACT

This Contract is not effective until fully executed by both Parties. If no start date is specified in the Term of Contract, the most recent date of the signatures of the Parties shall be deemed the Effective Date.

CONTRACTOR	**STATE OF NORTH DAKOTA**
Presort Plus, LLC	Acting through its **NDPERS**
BY: *[Signature]*	
[Printed Name] Kyle Nordmeyer	Rebecca Fricke
[Title] GM	NDPERS Executive Director
Date: 6-4-25	Date:

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: Office Lease

Attached is the proposed office lease agreement to extend our existing office space through June 30, 2027. This proposal matches the request that was used to project our budget, and is a $1 per square foot increase over the current biennium. Our attorney has reviewed the agreement and does not have any concerns with the attached.

BOARD ACTION:

Approve the proposed lease, and authorize for Rebecca to sign the agreement.

Attachment

LEASE AMENDMENT

LEASE NAME AND NUMBER: ND Public Employees Retirement System

AMENDMENT NUMBER: 3

This amendment is made to the ND Public Employees Retirement System Lease dated December 29, 2020 (Lease) between the State of North Dakota, acting through its ND Public Employees Retirement System (STATE), and its Workforce Safety & Insurance (LANDLORD).

The parties agree to the following terms and conditions and expressly agree that if any of the following terms and conditions conflict with any of the terms and conditions of the Lease, then, notwithstanding any term in the Lease, the following terms and conditions govern and control the rights and obligations of the parties.

The parties agree to amend the Lease as follows:

RENTAL PAYMENTS

Pursuant to the Term of the Lease, the rental rate must be negotiated prior to the renewal of each lease period and prior to the renewal of the Lease. The RENTAL PAYMENTS section is hereby amended as follows:

> STATE will pay rent for the premises, consisting of 6,003 square feet of office space suite #2, at $17.00 per square foot per annum, or $102,051 per annum and 759 square feet of storage space in storage room #147 at $5.00 per square foot per annum, or $3,795 per annum, for a total lease cost of $105,846 per annum.
>
> Rent will be paid in advance by the 10th day of each month in a monthly amount of $8,820.50, which is 1/12 of the annual amount, commencing on July 1, 2025, and continuing monthly thereafter for the term of the Lease. Rent shall be payable at the residence of the LANDLORD, which is 1600 East Century Ave., Suite #1, Bismarck, ND 58506, unless STATE is notified otherwise in writing by the LANDLORD.

TERM OF LEASE

The parties have agreed to renew or extend the Lease for an additional 24 months, and amend the TERM OF LEASE language as follows:

> The original term of this Lease (Term) is for a period of 24 months, and the parties are executing a second renewal of the Lease for a period of 24 months, commencing on July 1, 2025, and terminating on June 30, 2027. The term of this Lease will automatically renew at the end of each lease period for an additional 24 month period, unless either party provides notice of intent to non-renew the Lease as indicated below.
>
> At least 60 days before the end of the lease period, Landlord will notify State if the rental rate will be adjusted for the new lease period.
>
> Either party may provide a notice of intent to non-renew the lease, in writing, at least ninety (90) days prior to the end of any lease period. All other terms and conditions of the Lease will remain in effect and in force during the lease period.

The parties agree that the terms and conditions of the Contract and this Amendment govern and control the rights and obligations of the parties.

This change is authorized under the TERM OF LEASE, RENTAL PAYMENT, and MERGER AND MODIFICATION sections of the Lease**.**

All other terms of the Lease remain in effect. This Lease Amendment is not effective until fully executed by all parties.

EXECUTION

LANDLORD	**STATE OF NORTH DAKOTA**
Workforce Safety & Insurance	Acting through its ND Public Employees Retirement System
BY:	BY:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

APPROVED AS TO FORM: WSI	**APPROVED BY OMB FACILITY MANAGEMENT**
BY:	BY:
Printed:	Printed: Brandon Solberg
Title:	Title: Director, Facilities Management
Date:	Date:

APPROVED AS TO FORM: NDPERS	
BY:	
Printed:	
Title:	
Date:	

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: June 10, 2025

SUBJECT: External Audit Contract

The State Auditor's Office has completed the RFP process for our external audit for Fiscal Years 2025-2027. They have selected UHY LLP to conduct the audit of both RIO and PERS.

UHY LLP has significant pension experience, and both the Partner and the Manager with oversight on the audit both came from CliftonLarsonAllen, and both were previously assigned to the RIO/PERS audits in the past. UHY also was the external audit firm that oversaw the 2024 fiscal year audit.

Our legal counsel has reviewed the contract, provided input, and does not have any legal concerns with the document.

Board Action Requested:
Review and consider approval of the contract for UHY LLP, and authorize Executive Director to sign.

Attachment

CONTRACT

1. PARTIES

The parties to this contract (Contract) are the State of North Dakota, acting through its **Public Employees Retirement System** ("PERS"), and State of North Dakota, acting through its **Office of the State Auditor** ("STATE") and **UHY LLP** (Maryland CPA Limited Liability Partnership), having its principal place of business at 8601 Robert Fulton Dr, STE 210, Columbia, MD 21046 (CONTRACTOR).

2. SCOPE OF WORK

CONTRACTOR, in exchange for the compensation paid by PERS under this Contract, shall provide the following:

To fulfill the scope of work for PERS for State of North Dakota fiscal years 2025, 2026, and 2027 as described in RFP #117-25-04 issued on March 19, 2025.The State of North Dakota fiscal year is July 1 through June 30.

Final Report Date to PERS and STATE: November 22nd of each fiscal year.

3. COMPENSATION-PAYMENTS

a. Contractual Amount

PERS shall pay for the accepted services provided by CONTRACTOR under this Contract an amount not to exceed the following (PERS Contractual Amount):

FY	2025	2026	2027	Total
PERS	$109,400	$114,600	$119,800	$343,800

The Contractual Amount is firm for the duration of this Contract and constitutes the entire compensation due CONTRACTOR for performance of its obligations under this Contract regardless of the difficulty, materials or equipment required, including fees, licenses, overhead, profit and all other direct and indirect costs incurred by CONTRACTOR, except as provided by an amendment to this Contract.

b. Payment

1) Payment made in accordance with this Compensation section shall constitute payment in full for the services and work performed and the deliverables and work(s) provided under this Contract and CONTRACTOR shall not receive any additional compensation hereunder.

2) Progress billings may be submitted for up to 80% of the total fee. A final billing of the remaining contract fee will be accepted and paid after the reports have been approved in writing by PERS.

3) PERS shall make payment under this Contract within forty-five (45) calendar days after receipt of a correct invoice.

4) Payment of an invoice by PERS will not prejudice its right to object to or question that or any other invoice or matter in relation thereto. CONTRACTOR's invoice will be subject to a reduction for amounts included in any invoice or payment made which are determined by PERS, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute allowable costs. At PERS' sole discretion, all payments shall be subject to reduction for amounts equal to prior overpayments to CONTRACTOR.

5) For any amounts that are or will become due and payable to PERS by CONTRACTOR, PERS reserves the right to deduct the amount owed from payments that are or will become due and payable to CONTRACTOR under this Contract.

c. Travel

CONTRACTOR acknowledges travel costs are covered by the Contractual Amount and shall not invoice PERS for travel costs.

d. Prepayment

PERS will not make any advance payments before performance or delivery by CONTRACTOR under this Contract.

e. Payment of Taxes by STATE

PERS is not responsible for and will not pay local, state, or federal taxes. PERS sales tax exemption number is E-2001. PERS will furnish certificates of exemption upon request by the CONTRACTOR.

f. Taxpayer ID

CONTRACTOR'S federal employer ID number is: 20-0694403.

4. TERM OF CONTRACT

This Contract term (Term or Initial Term) begins when signed by all parties and continues until performance of the scope of work is fulfilled.

a. No Automatic Renewal

This Contract will not automatically renew.

5. TIME IS OF THE ESSENCE

CONTRACTOR hereby acknowledges that time is of the essence for performance under this Contract unless otherwise agreed to in writing by the Parties.

6. TERMINATION

a. Termination for Convenience or by Mutual Agreement

This Contract may be terminated by STATE or PERS upon thirty (30) days' written notice to CONTRACTOR and the non-noticing state agency Party. This Contract may be terminated by mutual consent of all Parties executed in writing.

b. Early Termination in the Public Interest

STATE and PERS are entering this Contract for the purpose of carrying out the public policy of the State of North Dakota, as determined by its Governor, Legislative Assembly, Agencies and Courts. If this Contract ceases to further the public policy of the State of North Dakota, STATE and PERS, in their sole discretion, by written notice to CONTRACTOR, may terminate this Contract in whole or in part.

c. Termination for Lack of Funding or Authority

STATE or PERS by written notice to CONTRACTOR and the non-noticing state agency Party, may terminate the whole or any part of this Contract under any of the following conditions:

1) If funding from federal, state, or other sources is not obtained or continued at levels sufficient to allow for purchase of the services or goods in the indicated quantities or term.

2) If federal or state laws or rules are modified or interpreted in a way that the services or goods are no longer allowable or appropriate for purchase under this Contract or are no longer eligible for the funding proposed for payments authorized by this Contract.

3) If any license, permit, or certificate required by law or rule, or by the terms of this Contract, is for any reason denied, revoked, suspended, or not renewed.

Termination of this Contract under this subsection is without prejudice to any obligations or liabilities of any Party already accrued prior to termination.

d. Termination for Cause

STATE or PERS may terminate this Contract effective upon delivery of written notice to CONTRACTOR and the non-noticing state agency Party, or any later date stated in the notice:

1) If CONTRACTOR fails to provide services or goods required by this Contract within the time specified or any extension agreed to in writing by STATE, or

2) If CONTRACTOR fails to perform any of the other provisions of this Contract, or so fails to pursue the work as to endanger performance of this Contract in accordance with its terms.

The rights and remedies of STATE and PERS provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

7. FORCE MAJEURE

No Party shall be held responsible for delay or default caused by fire, riot, terrorism, pandemic (excluding COVID-19), acts of God, or war if the event was not foreseeable through the exercise of reasonable diligence by the affected Party, the event is beyond the Party's reasonable control, and the affected Party gives notice to the other Party promptly upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default. If CONTRACTOR is the affected Party and does not resume performance within fifteen (15) days or another period agreed between the Parties, then STATE or PERS may seek all available remedies, up to and including termination of this Contract pursuant to its Termination Section, and STATE or PERS shall be entitled to a pro-rata refund of any amounts paid for which the full value has not been realized, including amounts paid toward software subscriptions, maintenance, or licenses.

8. INDEMNIFICATION

CONTRACTOR agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers, and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or

contributory negligence or fault, sole negligence, or intentional misconduct. This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions. The legal defense provided by CONTRACTOR or to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. CONTRACTOR also agrees to reimburse the State for all costs, expenses and attorneys' fees incurred if the State prevails in an action against CONTRACTOR in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this Contract.

9. INSURANCE

CONTRACTOR shall secure and keep in force during the term of this Contract, from insurance companies, government self-insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages, with minimum liability limits of $2,000,000 per occurrence.

2) Professional errors and omissions with minimum limits of $1,000,000 per claim and in the aggregate, CONTRACTOR shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, CONTRACTOR shall purchase an extended reporting period to meet the time periods required in this section.

3) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 per occurrence.

4) Workers compensation coverage meeting all statutory requirements.

The insurance coverages listed must meet the following additional requirements:

1) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be place with insurers rate “A-” or better by A.M. Best Company, Inc. provided any excess policy follows form for coverage. Less than an “A-” rating must be approved by STATE and PERS. The policies shall be in form and terms approved by STATE and PERS.
2) The duty to defend, indemnify, and hold harmless the State under this Contract shall not be limited by the insurance required in this Contract.
3) CONTRACTOR shall furnish a certificate of insurance to the undersigned STATE representative prior to commencement of this Contract.
4) Failure to provide the insurance as required in this Contract is a material breach of contract entitling STATE or PERS to terminate this Contract immediately.
5) CONTRACTOR shall provide at least 30-day notice of any cancellation or material change to the policies or endorsements. An updated, current certificate of insurance shall be provided in the event of any change to a policy. CONTRACTOR shall provide certificate of insurance and any endorsements to STATE electronically to:

Name: James Carroll
Email Address: jpcarroll@nd.gov
Email Subject Line: Certificate of Insurance – 117-25-04 PERS

STATE shall provide a copy of the Certificate of Insurance to PERS.

10. WORKS FOR HIRE

CONTRACTOR acknowledges that all work(s) under this Contract is "work(s) for hire" within the meaning of the United States Copyright Act (Title 17 United States Code) and hereby assigns to STATE and PERS all rights and interests CONTRACTOR may have in the work(s) it prepares under this Contract, including any right to derivative use of the work(s). All software and related materials developed by CONTRACTOR in performance of this Contract for STATE and PERS shall be the sole property of STATE and PERS, and CONTRACTOR hereby assigns and transfers all its right, title, and interest therein to STATE and PERS. CONTRACTOR shall execute all necessary documents to enable STATE and PERS to protect STATE and PERS's intellectual property rights under this section.

11. WORK PRODUCT

All deliverables created for PERS and STATE or purchased by PERS under this Contract belong to STATE and PERS and must be immediately delivered to STATE and PERS at their request upon termination of this Contract. STATE shall have access to CONTRACTOR's working papers for twenty-four (24) months following the completion of the Contract.

12. NOTICE

All notices or other communications required under this Contract must be given by email, registered or certified mail and are complete on the date postmarked when addressed to the Parties at the following addresses:

STATE	**CONTRACTOR**
James Carroll, CPA	Thomas R. Rey, Jr., CPA
Procurement Officer	Partner
600 E Boulevard Ave, Dept 117	8601 Robert Fulton Dr, STE 210
Bismarck, ND 58505	Columbia, MD 21046
jpcarroll@nd.gov	trey@uhy-us.com

PERS
Derrick Hohbein, CPA
Chief Operating/ Financial Officer
1600 East Century Ave., Suite 2 P.O. Box 1657
Bismarck, ND 58502-1657
dhohbein@nd.gov

Notice provided under this provision does not meet the notice requirements for monetary claims against the State found at N.D.C.C. § 32-12.2-04.

13. CONFIDENTIALITY

CONTRACTOR shall not use or disclose any information it receives from STATE or PERS under this Contract that STATE or PERS has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this Contract, as authorized in advance by STATE or PERS. STATE or PERS shall not disclose any information it receives from CONTRACTOR that CONTRACTOR has previously identified as confidential and that STATE or PERS determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota public records law, N.D.C.C. ch. 44-04. The duty of STATE, PERS, and CONTRACTOR to maintain confidentiality of information under this section continues beyond the Term of this Contract.

14. COMPLIANCE WITH PUBLIC RECORDS LAWS

Under the North Dakota public records law and subject to Section 13 of this Contract, certain records may be open to the public upon request.

Public records may include: (a) records STATE or PERS receives from CONTRACTOR under this Contract, (b) records obtained by any Party under this Contract, and (c) records generated by any Party under this Contract.

CONTRACTOR agrees to contact PERS and STATE immediately upon receiving a request for information under the public records law and to comply with their instructions on how to respond to such request.

15. INDEPENDENT ENTITY

CONTRACTOR is an independent entity under this Contract and is not a PERS or STATE employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. CONTRACTOR retains sole and absolute discretion in the manner and means of carrying out CONTRACTOR's activities and responsibilities under this Contract, except to the extent specified in this Contract.

16. ASSIGNMENT AND SUBCONTRACTS

CONTRACTOR may not assign or otherwise transfer or delegate any right or duty without STATE's and PERS' express written consent, provided, however, that CONTRACTOR may assign its rights and obligations hereunder in the event of a change of control or sale of all or substantially all of its assets related to this Contract, whether by merger, reorganization, operation of law, or otherwise. Should Assignee be a business or entity with whom PERS or STATE is prohibited from conducting business, PERS or STATE shall have the right to terminate in accordance with the Termination for Cause section of this Contract.

CONTRACTOR may enter subcontracts provided that any subcontract acknowledges the binding nature of this Contract and incorporates this Contract, including any attachments. CONTRACTOR is solely responsible for the performance of any subcontractor with whom CONTRACTOR contracts. CONTRACTOR does not have authority to contract for or incur obligations on behalf of PERS or STATE.

17. SPOLIATION – PRESERVATION OF EVIDENCE

CONTRACTOR shall promptly notify PERS and STATE of all potential claims that arise or result from this Contract. CONTRACTOR shall also take all reasonable steps to preserve all physical evidence and information that may be relevant to the circumstances surrounding a potential claim, while maintaining

public safety, and grants to PERS and STATE the opportunity to review and inspect such evidence, including the scene of an accident.

18. MERGER AND MODIFICATION, CONFLICT IN DOCUMENTS

This Contract, including the following documents, constitutes the entire agreement between the Parties. There are no understandings, agreements, or representations, oral or written, not specified within this Contract. This Contract may not be modified, supplemented or amended, in any manner, except by written agreement signed by all Parties.

Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Contract, the documents must control in this order of precedence:

The terms of this Contract as may be amended;

b. STATE's Solicitation Amendment #1 to Request for Proposal ("RFP") number 117-25-04 dated April 4, 2025;
c. STATE's Request for Proposal ("RFP") number 117-25-04, dated March 19, 2025;
d. CONTRACTOR's proposal dated April 23, 2025, in response to RFP number 117-25-04.
e. All terms and conditions contained in any automated end-user agreements (e.g., click-throughs, shrink wrap, or browse wrap) are specifically excluded and null and void, and shall not alter the terms of this Contract.

19. SEVERABILITY

If any term of this Contract is declared to be illegal or unenforceable by a court having competent jurisdiction, the validity of the remaining terms is unaffected and, if possible, the rights and obligations of the Parties are to be construed and enforced as if this Contract did not contain that term.

20. APPLICABLE LAW AND VENUE

This Contract is governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this Contract must be adjudicated exclusively in the state District Court of Burleigh County, North Dakota. Each Party consents to the exclusive jurisdiction of such court and waives any claim of lack of jurisdiction or *forum non conveniens*.

21. ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

By entering this Contract, STATE and PERS do not agree to binding arbitration, mediation, or any other form of mandatory Alternative Dispute Resolution. The Parties may enforce the rights and remedies in judicial proceedings. STATE and PERS do not waive any right to a jury trial.

22. ATTORNEY FEES

In the event a lawsuit is instituted by PERS or STATE to obtain performance due under this Contract, and PERS or STATE is the prevailing Party, CONTRACTOR shall, except when prohibited by N.D.C.C. § 28-26-04, pay PERS' and STATE's reasonable attorney fees and costs in connection with the lawsuit.

23. NONDISCRIMINATION AND COMPLIANCE WITH LAWS

CONTRACTOR agrees to comply with all applicable federal and state laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. (See N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women.)

CONTRACTOR agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.

CONTRACTOR shall have and keep current and in good standing all licenses and permits required by law during the Term of this Contract.

CONTRACTOR is prohibited from boycotting Israel for the duration of this Contract. (See N.D.C.C § 54-44.4-15.) CONTRACTOR represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If PERS or STATE receives evidence that CONTRACTOR boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if CONTRACTOR has fewer than ten (10) full-time employees.

CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE or PERS to terminate in accordance with the Termination for Cause section of this Contract.

24. STATE AUDIT

Pursuant to N.D.C.C. § 54-10-19, all records, regardless of physical form, and the accounting practices and procedures of CONTRACTOR relevant to this Contract are subject to examination by the North Dakota State Auditor, the Auditor's designee, or Federal auditors, if required. CONTRACTOR shall maintain these records for at least three (3) years following completion of this Contract and be able to provide them upon reasonable notice. STATE, State Auditor, or Auditor's designee shall provide reasonable notice to CONTRACTOR prior to conducting examination.

25. BACKGROUND CHECK

If STATE or PERS have the necessary authority under N.D.C.C. § 12-60-24, they may require personnel that CONTRACTOR assigns to perform work under this Contract, including employees, contracted staff, subcontractors, or other individuals, to submit to a criminal history record check. STATE or PERS shall have the right to reject any individual CONTRACTOR assigns to perform work under this Contract if, in their sole discretion, they determine that the results of the criminal history record check make the individual unacceptable. CONTRACTOR agrees to be responsible for all costs associated with criminal history record checks carried out pursuant to this paragraph.

26. COUNTERPARTS

This Contract may be executed in multiple, identical counterparts, each of which is be deemed an original, and all of which taken together shall constitute one and the same contract.

27. EFFECTIVENESS OF CONTRACT

This Contract is not effective until fully executed by both Parties. If no start date is specified in the Term of Contract, the most recent date of the signatures of the Parties shall be deemed the Effective Date.

CONTRACTOR	STATE OF NORTH DAKOTA
UHY LLP	Acting through its Office of the State Auditor
BY:	BY:
Printed Name: Thomas R. Rey, Jr.	Printed Name: Joshua C. Gallion
Title: Partner	Title: State Auditor
Date: 6.5.25	Date:

STATE OF NORTH DAKOTA
Acting through its Public Employees Retirement System
BY:
Printed Name:
Title:
Date:

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: June 10, 2025

SUBJECT: Contracts under $10,000

Attached is a document that shows the contracts under $10,000 that have been signed since the last update. Please let me know if you have any questions on any of these contracts.

This topic is informational only.

Attachment

All Contracts Signed During 2025:

Vendor	Amount	Notes
Empower	$ -	457 Plan Catch-up Opt Out Forms
Inter Office	$ 1,176.16	Office Chair
Rolette County Soil Conservation D	$ -	Joined Deferred Compensation Plan 1/1/25
UHY	$ -	GASB 68 & 74 Management Rep. Letters
Great Plains Housing Authority	$ -	Joined Deferred Compensation Plan 7/1/25
Richland School District	$ -	Joined Deferred Compensation Plan 2/1/25
Ellendale Public School	$ -	Joined Deferred Compensation Plan 1/1/25
Inter Office	$ 824.76	Rising Desk
Rolette Public School	$ -	Joined Deferred Compensation Plan 3/1/25
Inter Office	$ 1,171.66	Office Chair
Souris Valley Special Education	$ -	Joined Deferred Compensation Plan 5/1/25
Inter Office	$ 824.76	Rising Desk
City of Cavalier	$ -	Joined Deferred Compensation Plan 6/1/25
McHenry County	$ -	Joined Public Safety Plan 5/1/2025
Inter Office	$ 840.17	Risking Desk

Contracts Signed Since Last Reported:

City of Walhalla	$ -	Joined Deferred Compensation Plan 5/1/25
City of Stanley	$ -	Joined Public Safety Plan 6/1/25