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: 402 440 737#
Date: **Tuesday, September 13, 2022**
Time: 8:30 A.M.

I. MINUTES

A. August 16, 2022

II. PRESENTATIONS

A. Open Records and Meetings – Dean DePountis
B. Actuarial Primer – Scott

III. GROUP INSURANCE

A. Health Insurance Renewal – Scott (Board Action) ***EXECUTIVE SESSION**
B. Health Plan Request For Proposal Draft – Derrick (Board Action)

IV. DEFERRED COMPENSATION / FLEXCOMP

A. FlexComp Voluntary Insurance Products – Rebecca (Board Action)
B. FlexComp Plan Document – Rebecca (Board Action)
C. 457 Deferred Compensation Provider Processes – Scott (Board Action)
   ****EXECUTIVE SESSION** (attorney-client consultation)
   1. Waddell & Reed/ Fiduciary Trust Company of New Hampshire (FTC)
   2. Lincoln Financial Group

V. RETIREMENT

A. Job Service Plan Asset Allocation – Derrick (Board Action)
B. Investment Report Quarter 2 – Derrick (Information)
C. Investment Options Summary Book – Derrick (Information)

VI. MISCELLANEOUS

A. Audit Committee Report – Shawna (Information)
B. Budget Status – Derrick (Information)
C. Special Board Election – Scott (Information)
D. Legislative Relations/Update – Scott (Information)
E. Contracts Under $10,000 – Scott (Information)
F. Board Self-evaluation – Scott (Information)

*Executive Session pursuant to N.D.C.C. § 44-04-19.1(9) and § 44-04-19.2 to discuss negotiating strategy or provide negotiating instructions to its attorney or other negotiator.

**Executive Session pursuant to N.D.C.C. §44-04-19.1(2) & (5), 44-04-19.1(9) and §44-04-19.2 for Attorney Consultation.

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: Open Meetings and Records Presentation

Dean DePountis will provide a presentation on open meetings and records for the Board's education.

Attachment

Open Records and Open Meetings (NDPERS 2022)

Dean DePountis
Assistant Attorney General

What is subject to open record laws?

- All **records**
- In the possession of a **public entity**
- Regarding **public business**

N.D.C.C. § 44-04-17.1(16)

What is a Record?

- **Recorded information** of any kind, regardless of the physical form or characteristic by which the information is stored, recorded, or reproduced . . .

N.D.C.C. § 44-04-17.1(16)

What is Public Business?

- **All matters** that relate or may foreseeably relate in any way to . . . the performance of the public entity's governmental functions, including any matter over which the public entity has supervision, control, jurisdiction, or advisory power; or…the public entity's use of public funds.

N.D.C.C. § 44-04-17.1(12)

What is protected?

- All public business records are open unless a law specifically provides the record is protected.
- Protected means the record is "not subject to Article XI of the North Dakota Constitution," "not an open record," "**exempt**," or "**confidential**."

Exempt

- May be released.
- Public entity has discretion – needs entity action.
- May be called a “closed” record.
- Not against the law to release an exempt record.

Confidential

- Cannot be released.
- Public entity has no discretion.
- Can only be released pursuant to a statute.
- Class C felony to knowingly release confidential records.

N.D.C.C. § 44-04-17.1(5) and N.D.C.C. § 44-04-17.1(3)

Exempt

Public employee personal information, including:

- Month/Day of Birth;
- Home Address;
- Personal Phone Numbers;
- Photograph;
- DMV and Employee ID Numbers;
- Payroll Deduction Information;
- Dependent/emergency contact information;
- Any credit, debit, or electronic fund transfer card number;
- Any account number at a bank or other financial institution; and
- Type of leave taken, and leave applied for but not yet taken.

Confidential

- Social Security Numbers;
- Computer Passwords;
- Employee use of Employee Assistance Programs; and
- BCI background checks.

2021 Open Record Legislative Changes

- Medical records, or a record containing medical information, in possession of a public entity are exempt. (N.D.C.C. § 44-04-18.32)
- Applications (N.D.C.C. § 44-04-18.27)
  - *Applications and any records related to the applications which contain information that could reasonably be used to identify an applicant are exempt. Finalists' information remains open.*
- Active litigation records (N.D.C.C. § 44-04-19.1(12))
  - *Records obtained, compiled, or prepared by a public entity or the attorney representing a public entity for the purpose of litigation, unless the records already have been filed publicly or the litigation is completed, are exempt.*

N.D.C.C. 54-52-26. Confidentiality of records

- All records relating to the retirement benefits of a member or a beneficiary under this chapter, chapter 54-52.2, and chapter 54-52.6 are confidential and are not public records.

N.D.C.C. 54-52-26 - Information and records may be disclosed, under rules adopted by the board, only to:

- 1. A person to whom the member has given written consent to have the information disclosed.
- 2. A person legally representing the member, upon proper proof of representation, and unless the member specifically withholds consent.
- 3. A person authorized by a court order.
- 4. A member's participating employer, limited to information concerning the member's years of service credit and years of age. The board may share other types of information as needed by the employer to validate the employer's compliance with existing state or federal laws. Any information provided to the member's participating employer under this subsection must remain confidential except as provided in subsection 6.

N.D.C.C. 54-52-26 - Information and records may be disclosed, under rules adopted by the board, only to:

- 5. The administrative staff of the retirement and investment office for purposes relating to membership and benefits determination.
- 6. State or federal agencies for purposes of reporting on a service provider's provision of services or when the employer must supply information to an agency to validate the employer's compliance with existing state or federal laws.
- 7. Member interest groups approved by the board on a third-party blind list basis, limited to information concerning the member's participation, name, and address.
- 8. The member's spouse or former spouse, that individual's legal representative, and the judge presiding over the member's dissolution proceeding for purposes of aiding the parties in drafting a qualified domestic relations order under section 54-52-17.6. The information disclosed under this subsection must be limited to information necessary for drafting the order.

N.D.C.C. 54-52-26 - Information and records may be disclosed, under rules adopted by the board, only to:

- 9. Beneficiaries designated by a participating member or a former participating member to receive benefits after the member's death, but only after the member's death. Information relating to beneficiaries may be disclosed to other beneficiaries of the same member.
- 10. The general public, but only after the board has been unable to locate the member for a period in excess of one year and limited to the member's name and the fact that the board has been unable to locate the member.
- 11. Any person if the board determines disclosure is necessary for treatment, operational, or payment purposes, including the completion of necessary documents.
- 12. A government child support enforcement agency for purposes of establishing paternity or establishing, modifying, or enforcing a child support obligation of the member.
- 13. A person if the information relates to an employer service purchase, but the information must be limited to the member's name and employer, the retirement program in which the member participates, the amount of service credit purchased by the employer, and the total amount expended by the employer for that service credit purchase, and that information may only be obtained from the member's employer.

N.D.C.C. 54-52.1-04.15. Health insurance benefits coverage - Prescription drug coverage -Transparency - Audits - Confidentiality.

3. Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts.

N.D.C.C. 54-52.1-04.16. Prescription drug coverage - Performance audits.

2. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board. The board's auditor, the insurance department, and the employee benefits programs committee may access any information the board may access under this section. All information accessed by the board, board's auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This subsection does not limit the information required to be disclosed to the board under subsection 1.

N.D.C.C. 54-52.1-11. Confidentiality of employee records.

In addition to the confidentiality requirements in section 26.1-36-12.4, information pertaining to an eligible employee's group medical records for claims, employee premium payments made, salary reduction amounts taken, history of any available insurance coverage purchased, and amounts and types of insurance applied for under the supplemental life insurance coverage under this chapter is confidential and is not a public record.

N.D.C.C. 54-52.1-11. Confidentiality of employee records.

The information and records may be disclosed, under rules adopted by the board, only to:

1. A person to which the eligible employee has given written authorization to have the information disclosed.

2. A person legally representing the eligible employee, upon proper proof of representation, and unless the eligible employee specifically withholds authorization.

3. A person authorized by a court order.

4. A person to which the board is required to disclose information pursuant to federal or state statutes or regulations.

5. Any person if the purpose of the disclosure is for treatment, payment, or health care operations.

N.D.C.C. 54-52.1-12. Ownership and confidentiality of the uniform group health insurance medical records of employees, retirees, and dependents.

The medical records and related data of the employees, retirees, and dependents, obtained as the result of enrollment in the uniform group insurance program, are the property of the public employees retirement system. The records and data are confidential and are not public records. However, the board may allow administrators of administrative services only contracts or third-party administrators contracts access to the records and data where it is required in the performance of the administrator's duties pursuant to the contract. No administrator may be held liable for furnishing to the board information with respect to any patient, or any physician, hospital, or other health care provider.

N.D.C.C. 54-52.3-05. Confidentiality of program records.

Any records and information pertaining to a public employee's medical and dependent care reimbursement under the pretax benefits program are confidential and are not public records subject to section 44-04-18 and section 6 of article XI of the Constitution of North Dakota.

N.D.C.C. 54-52.3-05. Confidentiality of program records.

The records and information may be disclosed, under rules adopted by the board, only to:

1. A person to whom the employee has given written authorization to have the information disclosed.

2. A person legally representing the employee, upon proper proof of representation.

3. A person authorized by a court order.

4. A person or entity to which the board is required to disclose information pursuant tofederal or state statutes or regulations.

5. Any person or entity if the purpose of the disclosure is for health care treatment, payment, or operations.

44-04-18.4. Confidentiality of trade secret, proprietary, commercial, financial, and research information

Trade secret, proprietary, commercial, and financial information is confidential if it is of a privileged nature, and it has not been previously publicly disclosed.

"Commercial information"

...means information pertaining to buying or selling of goods and services that has not been previously publicly disclosed and that if the information were to be disclosed would impair the public entity's future ability to obtain necessary information or would cause substantial competitive injury to the person from which the information was obtained.

"Financial information"

...means information pertaining to monetary resources of a person that has not been previously publicly disclosed and that if the information were to be disclosed would impair the public entity's future ability to obtain necessary information or would cause substantial competitive injury to the person from which the information was obtained.

"Proprietary information"

(2) Information received from a private business that has entered or is negotiating an agreement with a public entity to conduct research or manufacture or create a product for potential commercialization.

(5) Technical, financial, or marketing records that are received by a public entity, which are owned or controlled by the submitting person, are intended to be and are treated by the submitting person as private, and the disclosure of which would cause harm to the submitting person's business.

"Trade secret"

...means information, including a formula, pattern, compilation, program, device, method, technique, technical know-how, or process, that:

(1) Derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons that can obtain economic value from its disclosure or use; and

(2) Is the subject of efforts that are reasonable under the circumstances to maintain the secrecy of the information.

Analysis

1) Does the requested record contain:

a. A trade secret;
b. Commercial information;
c. Financial information; or
d. Proprietary information.

If not, it is not confidential and must be released. If yes, proceed to step 2.

2) Was the information previously publicly disclosed?

If yes, it is not confidential and must be released. If not, proceed to step 3.

3) Is the information privileged(impair state's ability to obtain information or substantial harm to competitive position of provider of information)?

If not, it is not confidential and must be released. If yes, the record must be redacted as appropriate.

What is a Meeting?

- A **quorum** of
- A **governing body**
- Of a **public entity**
- Discussing **public business**

N.D.C.C. § 44-04-17.1(9)

What is a Quorum?

- **One-half or more of the members** of the governing body, or any smaller number if sufficient for a governing body to transact business on behalf of the public entity.

N.D.C.C. § 44-04-17.1(15)

Committees

- Committee: **Two or more people** acting collectively pursuant to authority delegated to that group by the governing body.
  - *Includes delegation of <u>any</u> public business, including information gathering.*
  - *Applies even if the public business being discussed was not delegated to the committee by the governing body, so long as it relates to the business of the public entity.*

Key questions:

- Did the governing body delegate any sort of authority?
- Is the committee doing something the governing body could do itself?

Committees

It does not matter...

- If the committee does not have final authority;
- If the committee is just "brainstorming" or "fact-finding;"
- If the committee is only intended to recommend something to the governing body;
- If the subject being discussed is not a subject within the authority delegated to the committee.

...a quorum of a committee is still a meeting.

A Meeting can happen...

- By conference call;
- On very short notice;
- Over video conference; or
- At a restaurant

Anywhere a quorum is present.

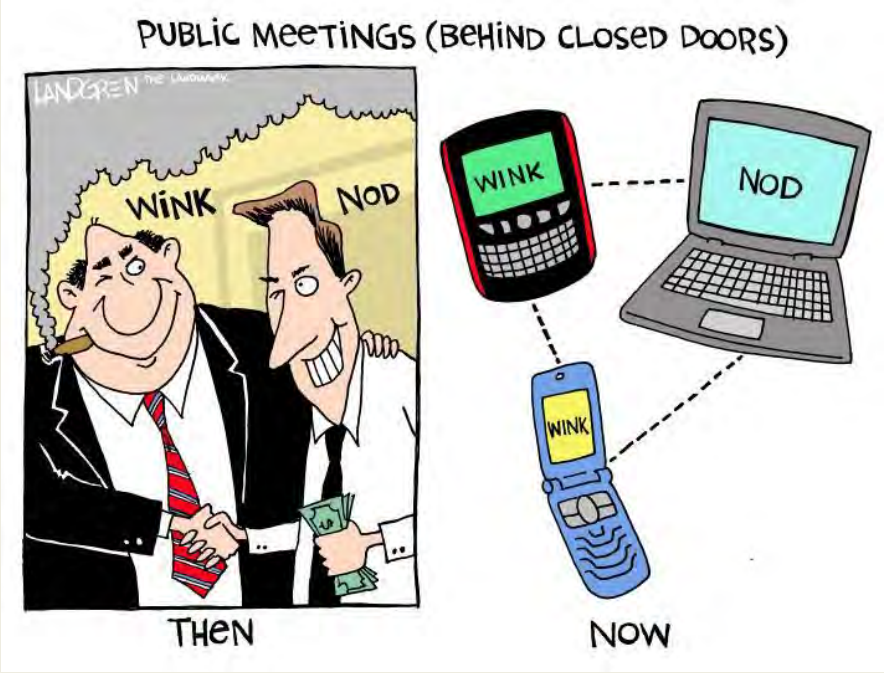
Open Meeting Exceptions

- Chance or social gatherings where no public business is considered or discussed.
- Emergency operations during a disaster or emergency declared under section 37-17.1-10 or an equivalent ordinance if a quorum of the members of the governing body are present but are not discussing public business as the full governing body or as a task force or working group.
- Attendance at meetings of national, regional, or state associations.
- Training seminars where no public business is discussed.

N.D.C.C. § 44-04-17.1(9)(b)

Common Violations

- Using technology to circumvent open meetings laws.



Common Violations

Using emails or other communication methods where a quorum is involved to discuss public business.

- Permissible
  - *To provide information for members to review before a meeting;*
  - *To set a meeting date.*
- Violation
  - *A member sharing thoughts, ideas, or opinions to a quorum of a public entity or a committee, even if no one responds.*
  - *Hitting "reply all" to a permissible communication to hold a discussion or provide an opinion.*

Common Violations

- Telephone straw polling (no matter who does the polling).
- Serial meetings - a series of smaller gatherings which collectively constitute a quorum - and public business is discussed.

2021 Open Meetings Legislative Change

Access to Public Meetings

- If a meeting is held in-person, the meeting room must be accessible to, and the size of the room must accommodate, the number of persons reasonably expected to attend the meeting.
- If the meeting is held by electronic means, the electronic capacity must accommodate the number of persons reasonably expected to attend the meeting remotely.

N.D.C.C. § 44-04-19(2)

Executive Session

Must be legally authorized:

- Most common: exempt/confidential records, attorney consultation, and negotiation strategy.
- Most common violation: closing meeting to discuss personnel matters.

Executive Session

Attorney consultation – 2 Ways

1. Advice regarding and in anticipation of reasonably predictable or pending litigation or adversarial administrative proceedings **OR**
2. To receive attorney's advice and guidance on the legal risks, strengths, and weaknesses of an action of a public entity, which, if held in public, **would have an adverse fiscal effect**.

- Remember: Just because attorney is sitting in does not automatically make it an attorney consultation.

N.D.C.C. § 44-04-19.1(5)

Executive Session

Negotiation strategy

- Must relate to strategy or provide instructions to an attorney or other negotiator,
- Regarding a pending claim, litigation, adversarial administrative proceedings, or contracts,
- Which is currently being negotiated or for which negotiation is reasonably likely to occur in the immediate future,
- **AND** must have adverse fiscal effect if the discussion would be held in public.

N.D.C.C. § 44-04-19.1(9)

Executive Session Procedure

- Convene in open meeting;
- Announce in open meeting the topics to be discussed and legal authority;
  - *Note: To discuss confidential information – no motion necessary. To discuss exempt/closed information - motion to enter executive session.*
- Record the session (keep for 6 months);
- Note time of executive session and who attended in minutes;
- Only discuss topics in announcement;
- (usually) Final action in open meeting.

N.D.C.C. § 44-04-19.2

Resources

Attorney General's website: www.attorneygeneral.nd.gov.

- Open Records & Meetings Laws
  - *Manuals & Guides*
    - Open Records Guide ("One pager")
    - Template for Responding to Records Requests
    - Open Meetings Guide ("One pager")
    - Sample Form for Closing Executive Session
    - Sample Meeting Notice
    - Notice Checklist

Thank you!

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: Actuarial Primer

GRS, the Board's actuarial firm, will present the actuarial valuation for the various retirement plans during the October Board meeting. The Board previously agreed that having a primer on actuarial theories and language before receiving the valuation would be helpful for it to understand the upcoming valuations. To aid in doing so, I have provided some information for your use. Below are several screenshots out of the 2020 Main PERS Plan's valuation. Those screenshots contain some of the important information from within the valuation. We will go through that information to help clarify your understanding of the actuarial issues discussed.

The reason I'm using 2020's valuation data is to show what happens with the "single discount rate". In 2021, that data was no different than the other data in the valuation. However, when the plan is having difficulties, the single discount rate data can show what the GASB reporting will look like for the next set of financial statements. Because we suffered an investment loss for FY 2021-22 and we reduced the assumed rate of return, I anticipate we will be in that situation for the 7/1/22 valuation.

	Main System	%
Total Actuarial Accrued Liability	$ 4,557,679,020	
Actuarial Value of Assets (AVA)	3,112,920,033	
Unfunded Actuarial Accrued Liability (UAAL)	1,444,758,987	
Funded Ratio (Actuarial Value of Assets)	68.3%	
Total Annual Gross Normal Cost	132,492,248	11.33%
Employee Contribution	81,838,631	7.00%
Annual Employer Normal Cost	50,653,617	4.33%
Amortization of Unfunded Liability [1]	100,626,735	8.61%
Actuarial Contribution	$ 151,280,352	12.94%
Statutory Employer Contribution	83,709,228	7.16%
Statutory Contribution Deficit/(Surplus)	67,571,124	5.78%
Employer UAAL Contribution from Statutory Rate	33,055,611	2.83%
Amortization Period from Statutory Rate (Years)	100+	
Market Value of Assets (MVA)	$ 3,011,499,294	
Unfunded Actuarial Accrued Liability (UAAL)	1,546,179,726	
Funded Ratio (Market Value of Assets)	66.1%	
Actuarial Contribution		13.54%
Amortization Period from Statutory Rate (Years)	100+	

Single Discount Rate

Projected benefit payments are required to be discounted to their actuarial present values using a Single Discount Rate that reflects (1) a long-term expected rate of return on pension plan investments (to the extent that the plan's fiduciary net position is projected to be sufficient to pay benefits) and (2) a tax-exempt municipal bond rate based on an index of 20-year mixed maturity general obligation bonds with an average Standard & Poor's Corp.'s AA credit rating (which is published by Fidelity) as of the measurement date (to the extent that the contributions for use with the long-term expected rate of return are not met).

For the purpose of this actuarial valuation, the expected rate of return on pension plan investments is 7.00%; the municipal bond rate is 2.45% (based on the most recent date available on or before the measurement date of the "20-year Municipal GO Index" from Fidelity); and the resulting Single Discount Rate is 4.64%.

Net Pension Liability

Total Pension Liability	$ 6,157,520,698
Plan Fiduciary Net Position	3,011,499,294
Net Pension Liability	$ 3,146,021,404

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: Health Insurance Renewal

Representatives from the Sanford Health Plan (SHP) presented SHP's proposed premium increases at the August Board meeting. After discussing the proposal with Deloitte and the Board negotiating strategy in closed session, the Board directed staff to continue working with SHP on the proposal numbers.

We had a good discussion with SHP, their actuary Milliman, and Deloitte. SHP provided additional information regarding what was behind their numbers, which staff discussed with Deloitte. I also have had conversations directly with John Snyder. John provided the attached revision of the proposed premium numbers. Given the short timeframe we have for an RFP process, I have asked John whether this is their best and final offer. I will provide the Board with an update at the meeting. We do have this noticed for a closed session to discuss negotiation strategy with staff and Deloitte.

Board Action Requested: Determine whether to renew the health plan with SHP.

Attachment 1

From: Snyder,John
To: Miller, Scott A.
Subject: SHP revised rates
Date: Thursday, September 1, 2022 3:08:31 PM
Attachments: image001.jpg

Hi Scott,

Please see below – SHP's revised rate increase proposals for Biennium 5.

While Milliman remains comfortable that our initial numbers represent their best estimate, we have worked to see where we can make differing assumptions.

Commercial – 17% increase (Down from the 20.6% Milliman best estimate)

Some of the key changes we made include

- Admin flat at a percentage level - 4.1% for entire book of business
- RX rebates – reduced expected rebates received to 21% of the RX claims for biennium 5. This is consistent with what we are seeing in early 2022.
- Combined Trend – bought down to approximately 5.41%

Medicare Supplement – 1% increase (Down from the Milliman 4.4% best estimate)

Some of the key changes we made include

- Admin flat at a percentage level - 4.1% for entire book of business
- Trend bought down to the 1-2% range.

As always, thank you for your partnership. I look forward to further discussion and next steps towards a final agreement.

John

John Snyder
President, Sanford Health Plan
Phone (605) 312-2750 **Route** 5485
Email John.Snyder@sanfordhealth.org
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Attachment 2

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: August 16, 2022

SUBJECT: Health Insurance Renewal

The memo I provided at the February, 2022 meeting (attached) provides the statutory requirements regarding the health insurance renewal process. To summarize:

1) The Board must have its consultant independently prepare a renewal estimate for the Board to use in determining the reasonableness of the proposed premium;
2) The Board must review the carrier's relevant performance measures and use them to determine the Board's satisfaction with the carrier's performance;
3) The Board must consider other relevant information, including:
   a. The economy to be effected.
   b. The ease of administration.
   c. The adequacy of the coverages.
   d. The financial position of the carrier, with special emphasis on the solvency of the carrier.
   e. The reputation of the carrier and any other information available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

Deloitte has prepared a renewal estimate, which we will review with the Board in closed session after Sanford's presentation. Sanford has presented its member survey results, and during this agenda topic will makes its renewal presentation incorporating additional considerations for the Board and the proposed renewal premium.

As we have in the past, we have obtained Sanford Health's assurance that it financially backs Sanford Health Plan and its provision of health insurance to NDPERS' participants. We have also reached out to the Insurance Department for any information they have regarding SHP's performance and financial position, and they report that they have no solvency concerns with SHP.

Next month we will bring the renewal topic back for a final review of any additional information the Board needs. The Board will make a decision in September on whether to renew with SHP or issue an RFP for the health plan.

Board Action Requested: Provide staff with guidance (in closed session) regarding negotiation strategy with SHP for a possible renewal.

Attachment 3

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: February 8, 2022

SUBJECT: Health Insurance Renewal

As you will recall, our health plan contract with Sanford Health Plan (SHP) runs for two years (biennium), with two additional possible two-year renewals. The current contract, the first two years of the possible six years, runs through June of 2023. Because an RFP in the event we do not renew takes so much time, we need to begin the process to determine if the Board would like to renew with SHP for another two years.

The timeframe for this process is as follows:

- July/August – obtain renewal estimate from Deloitte
- August – receive and consider the proposed renewal and other required information
- September – determine whether to renew or issue an RFP

If the Board decides to issue an RFP, the timeframe for that is as follows:

- September – issue RFP
- November/December – receive RFPs
- February – award the plan for the 2023-2025 biennium

To expedite the RFP process in the event the Board goes that direction, staff will be reviewing/editing the previous RFP over the next couple of months, and will bring the final product to the Board for it's approval prior to the September issue date.

The statutory requirements for renewal are found in NDCC section 54-52.1-05(2):

> 2. The initial term or the renewal term of a uniform group insurance contract through a contract for insurance, health maintenance

organization, or self-insurance health plan for hospital benefits coverage, medical benefits coverage, or prescription drug benefits coverage may not exceed two years.

a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations, the proposed premium renewal amount does not exceed the board's expectations, and renewal best serves the interests of the state and the state's eligible employees.
b. In making a determination under this subsection, the board shall:
   (1) Use the services of a consultant to concurrently and independently prepare a renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.
   (2) Review the carrier's performance measures, including payment accuracy, claim processing time, member service center metrics, wellness or other special program participation levels, and any other measures the board determines relevant to making the determination and shall consider these measures in determining the board's satisfaction with the carrier's performance.
   (3) Consider any additional information the board determines relevant to making the determination.
c. The board may determine the carrier's performance under the existing contract does not meet the board's expectations, the proposed premium renewal amount exceeds the board's expectations, or renewal does not best serve the interests of the state or the state's eligible employees and the board therefore may decide to solicit a bid under section 54-52.1-04.

The proposed premium renewal amount has historically been the sticking point in the renewal process. Four years ago the initial renewal numbers from Deloitte and SHP were quite different, and the Board came very close to doing an RFP rather than renewing. We were eventually able to agree on a renewal premium after the continued sharing of information and several negotiation meetings.

As we have in the past, we will have Deloitte prepare a renewal estimate for the Board’s use in the negotiation process, as required by subsection 2(b)(1). SHP will also perform its usual customer survey, which it will present to the Board in March, which satisfies some of the requirements in subsection 2(b)(2).

In 2016 and 2018, SHP obtained an outside audit of the performance measures required in subsection 2(b)(2) and provided that information for the Board’s consideration. We do not believe that was requested of BCBS in the past. Further, that audit is not required by the statutes – the performance metrics SHP presents to the Board seem to be all that is required. We presume we asked SHP for that additional level of assurance due to the political issues early in our relationship.

Given that those audits showed equal or better performance than SHP initially reported, we question whether we need that additional information going forward. Further, Bryan Reinhardt and Shawna Piatz go to SHP every year to perform an audit of SHP claims processing, which typically goes very well (they will share the most recent results with the Board in March). Thus, the Board should consider whether this additional effort, and the corresponding cost, is something it wants to continue to request.

The "additional information" the Board has typically reviewed to comply with subsection 2(b)(3) includes the information required by NDCC section 54-52.1-04(1) for an RFP:

a. The economy to be effected.
b. The ease of administration.
c. The adequacy of the coverages.
d. The financial position of the carrier, with special emphasis on the solvency of the carrier.
e. The reputation of the carrier and any other information available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

Little has changed since the 2020 RFP process regarding subsections 1(a), 1(b) and 1(c). As such, we may not need additional information on these. SHP's performance measures and the customer survey should satisfy subsection 1(e). To satisfy subsection 1(d), the financial position of the carrier, in the past we have requested a letter from the President of Sanford Health, the overarching legal entity, confirming the financial stability of Sanford Health and its willingness to financially support SHP if needed. We will also reach out to the Insurance Department to see what information they have.

We have typically asked for the following additional information from SHP, and staff would recommend it for this renewal, as well:

- the effect on the rates of losing our Grandfathered status
- a schedule from Sanford Health Plan of the effect of plan design changes (deductibles, co-insurance, etc.)
- the cost of coverage changes (ACA benefits, coverage for birth control without cost sharing, additional wellness incentives such as smoking deterrents and re-starting the tobacco cessation program, etc.)
- information on the PERS special programs including wellness, About the Patient, and the Healthy Pregnancy Program

Board Action Requested:

1. Confirm the Board wishes to follow the process described above
2. Determine whether to ask SHP to obtain an audit of its performance measurements
3. Confirm requesting the additional information described above

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

Scott A. Miller
Executive Director
(701) 328-3900
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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: September 13, 2022

SUBJECT: NDPERS Health Plan Draft RFP

Attached is an updated Health Plan request for proposals (RFP) in the event the Board decides not to renew with Sanford Health Plan. The RFP document and some of the Appendices (including question documents) are attached for your review.

Here is the proposed timeline:

Activity	Date/Time
NDPERS publishes Request for Proposal (RFP)*	September 14, 2022
Bidder Conference**	September 16, 2022 (9am – 11am CST)
Bidder questions (in writing) due	September 19, 2022 (5pm CST)
Proposals due	**November 15, 2022 (5 pm CST)**
Finalist presentations (if requested)	December 2022
NDPERS notifies finalist of intent to negotiate	January/February 2023
Bidder and NDPERS begin implementation	March 2023
Bidder begins providing services	July 1, 2023

Board Action Requested:
Determine whether to approve the RFP to be published for the Health Plan.

Attachment A

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Request for Proposal

Group Medical and Prescription Drug Coverage

Release Date: September 14, 2022

Proposals Due:
By 5:00 p.m. CST
November 15, 2022

Key Information

Objective

North Dakota Public Employees Retirement System (“NDPERS”) is soliciting proposals for the insurance and/or administration of its employee/retiree medical and prescription drug insurance plan. Proposals will be accepted from administrative/insurance companies (“Bidders”) that are capable of offering a statewide provider network, utilization management, disease management, wellness program and pharmacy benefit manager services along with other related services. The contract to be awarded is a multi-year arrangement beginning July 1, 2023 and ending June 30, 2025.

This RFP is requesting proposals for both fully-insured and self-insured arrangements. The NDPERS Board will determine which funding approach it will implement based on the results of the RFP (See Section II of this RFP for further detail). See also Appendix C1 (Fully-Insured Questionnaire), Appendix C2 (Self-Insured Questionnaire Medical), and Appendix C3 (Self Insured Questionnaire Prescription Drug).

Background

NDPERS is responsible for the administration of the State of North Dakota’s Retirement, Health, Life, Deferred Compensation, FlexComp, Employee Assistance Program (EAP), Retiree Health Insurance Credit, voluntary Dental and voluntary Vision programs. In addition, cities, counties, schools and other political subdivisions of the state may participate at their option. Approximately 23,000 active employees and 11,000 retirees are eligible to participate in these plans.

NDPERS reserves the right to select the health plan proposals that best fit its needs and the needs of its eligible employees/retirees. NDPERS has retained Deloitte Consulting LLP (“Deloitte Consulting”) to assist with the RFP process.

Sanford Health Plan (SHP) currently insures the medical and prescription drug plan under a fully-insured arrangement. OptumRx is Sanford’s pharmacy benefits manager (PBM) partner.

In determining which bid, if any, will best serve the interests of eligible employees/retirees and the state, the NDPERS and its Board will assess the following factors:

1. The economy to be effected.
2. The ease of administration.
3. The adequacy of the coverages.
4. The financial position and experience of the carrier, with special emphasis as to its solvency.
5. The reputation of the carrier and any other information that is available to show past experience with the carrier in matters of claim settlement, underwriting, and services.
6. Multi-year guaranteed premium/fees.
7. The value proposition of different insurance arrangements including self-insurance to determine if it is in the best interest of the State and the State’s eligible employees.

The successful bidder of this RFP for fully-insured coverage is eligible to have the initial term of this contract extended for two two-year periods (2025-2027 and 2027-2029) at the option of the NDPERS Board (see Section III in this RFP for renewal conditions).

A self-insured contract (bundled or unbundled with PBM for pharmacy benefits administration) may be awarded for two years with a renewal option for two additional two-year periods at the option of the NDPERS Board.

Proposed Timetable

The timeline is provided below for informational purposes. NDPERS reserves the right to change the dates. Every effort will be made to notify Bidders of changes to the proposed timeline.

Activity	Date/Time
NDPERS publishes Request for Proposal (RFP)*	September 14, 2022
Bidder Conference**	September 16, 2022 (9am – 11am CST)
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Bidder and NDPERS begin implementation	March 2023
Bidder begins providing services	July 1, 2023

RFP Coordinator Contact

Drew Rasmussen
Deloitte Consulting LLP
773-661-8327
drasmussen@deloitte.com

Note:

From the date of issuance until the announcement of the finalist(s), Bidders may contact only the RFP Coordinator. All correspondence and questions must be submitted in writing via e-mail to the RFP Coordinator in accordance with the timeline set forth in this RFP. NDPERS personnel are not authorized to discuss this RFP with Bidders; doing so may result in disqualification. Bidders may continue to communicate with NDPERS staff regarding other relevant business matters.

*Password to access protected files may be requested from the RFP Coordinator via email.

**A Bidders' conference call will be held on September 16, 2022 from 9:00am – 11:00am or until all questions have been submitted. Bidders may call in to 701-328-0950 Conference ID: 60520397# the day of the conference. The phone number will be activated at 8:55 am CST. Anyone calling in must identify themselves for everyone on the call. Any expenses incurred by bidders to participate in the bidders' conference are the responsibility of the bidder and will, under no circumstances, be reimbursed by NDPERS. Those who elect to participate must understand that no accommodation will be made in the event of lost connectivity or poor audio quality, etc. Other than publishing questions and final answers, no follow-up meeting or broadcast will be made to accommodate or rectify any shortcomings in the teleconference format.

Table of Contents

I. Overview of the NDPERS Program

NDPERS

The North Dakota Public Employees Retirement System (NDPERS) is a separate agency created under North Dakota state statute, and, while subject to state budgetary controls and procedures, as are all state agencies, is not a state agency subject to direct executive control. NDPERS is managed by a Board comprised of nine members:

- Chairman – appointed by the Governor
- Member – appointed by the Attorney General
- Member – elected by retirees
- Members (3) – elected by active employees
- Legislators (2) – appointed by Legislative management
- State Health Officer or Designee

Dakota Plan

NDPERS contracts with Sanford Health Plan ("Sanford" or "SHP") to provide fully-insured health care coverage with a risk sharing agreement. The plans provided pursuant to this fully funded arrangement are:

- PPO/Basic – Grandfathered plan
- PPO/Basic – Non-grandfathered plan
- HDHP/HSA Plan – Non-grandfathered
- Dakota Retiree Plan

PPO

NDPERS offers a Preferred Provider Organization ("PPO") through Sanford. The PPO offers broad access to members with in and out-of-network benefits.

Basic Plan

If a PPO health care provider is not available in the member's area, or if the member chooses or is referred to a health care provider not participating in the Preferred Provider Organization, the member will receive the Basic Plan benefits.

High Deductible Health Plan (HDHP)

In addition to the PPO and Basic Plans, NDPERS offers state employees the option to enroll in a High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA). The HDHP/HSA option has a higher annual deductible and coinsurance costs for medical services. However, the higher out-of-pocket costs are partially offset by an employer contribution to the HSA. For the 7/1/21-6/30/23 contract period the NDPERS monthly HSA contributions are: $88.46 for single coverage and $214.06 for family coverage.

The NDPERS Board has approved the option for large political subdivisions to offer the HDHP and for the plan to be the only choice for their employees. However, NDPERS does not administer a HSA on behalf of the political subdivisions. The election to participate must be made by November 15 prior to the January 1 effective date and must be for the full calendar year. As of the date of RFP issuance, there are currently not any large political

subdivisions participating in the HDHP.

Value-Based Health Care Overlay

NDPERS started a value-based health care arrangement with several large health care providers in North Dakota. See Exhibit 27 for more information on the program.

Coverage Rules: When Coverage Begins & Eligibility

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. Each eligible employee may elect to enroll his/her eligible dependents.

Eligible employees include:

- State employees or employees of participating political subdivisions first employed prior to August 1, 2013 who are at least 18 years of age and whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employed at least 17.5 hours per week and at least five months each year;

- State employees or employees of participating political subdivisions first employed after August 1, 2013, who are employed at least 20 hours per week and at least 20 weeks each year of employment are eligible to receive benefits; and

- 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 section 4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An Eligible Dependent includes:

- The Spouse of the Subscriber;
- 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 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 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

- 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)].

- Survivors of a first responder who died in the line of duty on or after January 1, 2010 will receive the option to enroll in the NDPERS health insurance without having to pay premium towards the coverage.

Detailed information regarding current eligibility for dependents for the Dakota Plan can be found in the 2019-2021 Certificate of Insurance at: https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-health/shp-coi-gf.pdf

Pre-Medicare Retiree Eligibility

Prior to July 1, 2015, retirees or surviving spouses who are under age 65 and are receiving a retirement allowance from the Public Employees Retirement System, the Highway Patrol Retirement System, the Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA), the Job Service Retirement Plan, the Teachers' Fund for Retirement (TFFR), or retirees who have accepted a retirement allowance from a participating political subdivision's retirement plan were eligible for benefits. In addition, former legislators are also eligible for this coverage.

Effective July 1, 2015, all new pre-Medicare retirees after that date are eligible for COBRA coverage as long as the retiree was participating in the health plan as an active employee prior to retirement. The pre-Medicare plan is no longer available to retirees who received their first retirement payment on or after July 1, 2015. Pre-Medicare retirees who retired before that date will continue to be eligible and may participate. Former legislators continue to remain eligible.

The pre-Medicare retiree single rate is 150% of the active member single rate; the rate for a pre-Medicare retiree plus one is twice the pre-Medicare single rate, and the rate for a pre-Medicare retiree plus two or more dependents is two and one-half times the pre-Medicare retiree single rate.

The NDPERS Board can elect to open the Pre-Medicare Retiree eligibility to retirees after July 1, 2015. However, ND law requires that the premium to be charged must be based on the experience of the population and not based on the rates outlined above. At this time, the Board has opted not to re-open the Pre-Medicare Retiree plan.

Dakota Retiree Plan

The Dakota Retiree Plan provides health care coverage as a secondary payer to Medicare. Coverage for Medicare retirees is different than the coverage for Pre-Medicare retirees. The NDPERS Medicare retiree plan mirrors Medicare supplement Plan F. Each eligible retiree may elect to enroll his/her eligible dependents as described in the *Eligibility* section above. The prescription drug benefit for retirees is provided through a group Prescription Drug Plan (PDP/EGWP) on a calendar year basis and is not part of this RFP.

Detailed information regarding current eligibility for dependents for the Dakota Plan can be found in the Certificate of Insurance at:
https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-health/shp-coi-retiree.pdf

Employer Eligibility Criteria

According to North Dakota Century Code (NDCC) 54-52.1-03.1, political subdivisions may offer the benefits of the NDPERS group health plan to its eligible employees subject to the criteria provided in the Employer Participation Agreement. However, according to the Affordable Care Act (ACA), small employers, defined as 50 employees or less, will not be eligible to participate in the NDPERS group health plan because the plan does not meet the ACA requirements. For employers eligible to join NDPERS, it requires 60-90 days to enroll a new group. Political subdivisions joining the NDPERS health plan at this time will be offered the choice of joining the NDPERS Non-Grandfathered PPO/Basic Plan or the High Deductible Health Plan (HDHP). However, the employer may only select one plan and all eligible employees that elect to participate will be members of that one plan.

Please review the eligibility and coverage information carefully as it explains the rights and responsibilities of both the employer and employee.

https://ndpers.nd.gov/employers/join-ndpers-plans/health-plan/

Participating political subdivisions may elect to terminate their participation in the NDPERS group health plan by providing written notice at least 60 days prior to the date of termination and per the provisions of NDCC 654-52.1-03.1 and NDAC 71-03-07-07.

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

If eligible under federal law, a political subdivision may extend the benefits of the uniform group insurance program under this chapter to its permanent employees, subject to minimum requirements established by the board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation in the uniform group insurance program, before completing sixty months of participation, unless federal or state laws or rules are modified or interpreted in a way that makes participation by the political subdivision in the uniform group insurance program no longer allowable or appropriate, the political subdivision shall make payment to the board in an amount equal to any expenses incurred in the uniform group insurance program that exceed income received on behalf of the political subdivision's employees as determined under rules adopted by the board. The Garrison Diversion Conservancy District, and district health units required to participate in the public employees retirement system under section 54-52-02, shall participate in the uniform group insurance

program under the same terms and conditions as state agencies. A retiree who has accepted a retirement allowance from a participating political subdivision's retirement plan may elect to participate in the uniform group under this chapter without meeting minimum requirements at age sixty-five, when the employee's spouse reaches age sixty-five, upon the receipt of a benefit, when the political subdivision joins the uniform group insurance plan if the retiree was a member of the former plan, or when the spouse terminates employment. If a retiree or surviving spouse does not elect to participate at the times specified in this section, the retiree or surviving spouse must meet the minimum requirements established by the board. Each retiree or surviving spouse shall pay directly to the board the premiums in effect for the coverage then being provided. The board may require documentation that the retiree has accepted a retirement allowance from an eligible retirement plan other than the public employees retirement system.

71-03-07-07. Minimum requirements for political subdivisions.
An enrolled political subdivision must extend the benefits of the group insurance program to its eligible employees and paid members of its board, commission, or association subject to minimum requirements established by the retirement board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation before completing sixty months of participation, unless federal or state laws or rules are modified or interpreted in a way that makes participation by the political subdivision in the uniform group insurance program no longer allowable or appropriate, the political subdivision must make payment to the retirement board equal to the expenses incurred on behalf of that political subdivision's employees which exceed the income received by the retirement board on behalf of that political subdivision's employees during the time of participation. For purposes of this section:

1. "Expenses incurred" means:
    a. Claims incurred by the political subdivision during the enrolled period and paid during or within three months after the enrolled period and includes capitated payments to providers;
    b. Reasonable administrative expenses as incurred by the public employees retirement system and the claims administrator as set forth in the master contract; and
    c. The cost of any premium buydown provided.
2. "Income received" means all premiums paid by the political subdivision to the retirement board.

Full payment is due within three months after receipt of notice from the executive director, unless an alternative payment schedule has been approved by the retirement board. A late payment charge must be assessed on all money due on an account at a rate of one and three-fourths percent per month.

Pharmacy Benefit Manager

The prescription drug plan coverage for active and pre-Medicare retirees is bundled with the medical plan provided by Sanford Health Plan. In responding to this RFP, PBM services may be offered as a bundled proposal with the medical insurance for fully-insured or self-insured, or it may be offered as an unbundled (“carve-out”), fully-insured or self-insured option directly by the PBM.

Data Warehouse

NDPERS maintains a health care data warehouse. The medical records and related data of the employees, retirees, and dependents, obtained as the result of enrollment in the uniform group insurance program, are the property of NDPERS (North Dakota Century Code § 54-52.1-12). Currently, the health plan provides raw data, including detailed claims and enrollment data sets, based on a mutually agreed upon format no less than monthly for the data warehouse repository. All vendors are required to submit claims and enrollment data in an agreed upon format.

Reporting Requirements

All monthly reports should be prepared for each plan offered (e.g., Grandfathered PPO, Non-Grandfathered PPO, HDHP, etc.) and should also roll up to quarterly and annual aggregate reports. The selected vendor must provide NDPERS with data by secure download or other agreed upon medium in an acceptable format to NDPERS and subject to all federal and state laws on confidentiality and open records. NDPERS requires vendors to provide reporting which includes, but is not limited to, the following:

1. Monthly experience report by plan including enrollment, paid claims, administration fees, etc.
2. Quarterly and annual reporting to include financial/trend analysis, membership and health utilization summary, high dollar claims, prescription drug spending and payment trend, health management and wellness program key indicators, performance standards and guarantee measures and accounting of completed and other ongoing activities such as smoking cessation, the about the patient program, and healthy pregnancy program.
3. Annual policy accounting statement including claim reserves.
4. Provide biennial close-out report.
5. Annual ACA-required reporting.

In addition to the above plan-wide reporting, the successful Bidder will provide plan-specific reporting as requested for the following:

- PPO/Basic – Grandfathered plan
- PPO/Basic – Non-grandfathered plan
- HDHP/HSA Plan – Non-grandfathered
- Dakota Retiree Plan

- Also please note NDCC § 54-52.1-12, which applies to all information the successful Bidder acquires relating to NDPERS.

Funding/ Risk Sharing

Currently NDPERS contracts with Sanford Health Plan to provide its health care coverage on a fully-insured basis with a risk sharing arrangement. Sanford Health Plan maintains full liability for incurred claims in excess of paid premium (no deficit carryover). If incurred claims plus expenses are less than premiums paid plus interest, NDPERS and the carrier share 50/50 in the

first $3 million in gains and thereafter all gains are returned to NDPERS. All funds in the account get interest paid each month equal to the rate based on US Treasury Notes quoted by the Wall Street Journal. NDPERS recognizes that different funding arrangements will be necessary to implement a self-insured program.

Performance Standards and Guarantees

The current health plan administrator adheres to agreed-upon performance standards and guarantees with a financial incentive/forfeiture component that is negotiated each biennium as part of the renewal process. The settlement/payment for such incentive/forfeiture is included in the annual settlement process. See Appendix H for performance standards and guarantees. NDPERS is interested in replicating or enhancing these standards in a future contract. It is a priority for the Board to have a comprehensive set of standards and guarantees relating to this plan.

Current Annual Settlement and Reconciliation

Within 31 days of 12 months after the end of the biennium, NDPERS requires an accounting summary which will result in an initial settlement of the biennium agreement. Within 31 days of 24 months after the end of the biennium a final accounting summary is required, which will result in a final settlement of the biennium agreement. NDPERS recognizes that different settlement arrangements will be necessary to implement a self-insured program.

Current and Desired Plan Designs

In addition to matching the current coverage provisions, as noted below, the successful Bidder shall include adding any federally required coverage provisions on or after July 1, 2023. The successful Bidder will also need to carry over all accumulator totals from January 1 through June 30 (if applicable). For additional details, refer to the following:

Dakota Plan:

- PPO/Basic – Grandfathered plan PPO/Basic Grandfathered | NDPERS
- PPO/Basic – Non-grandfathered plan PPO/Basic Non-Grandfathered | NDPERS
- HDHP/HSA – Non-grandfathered plan High Deductible Health Plan (HDHP) | NDPERS

Please note NDPERS is requesting that the proposer also provide a HSA product as part of this proposal for the HDHP product.

Dakota Retiree Plan: Dakota Retiree Plan (Medicare) | NDPERS

Member Access

PPO benefits are currently available with a PPO-participating provider within North Dakota or its contiguous counties. If a PPO health care provider is not available in the member's area, or if the member chooses or is referred to a health care provider not participating in the PPO, the member will receive the Basic Plan benefits. The copayments, annual deductibles and coinsurance amounts vary between the PPO Plan and Basic Plan.

Directory

The current provider directory is available through the Sanford Health Plan website at: https://www3.viiad.com/shp/public/. Bidders must be able to provide a comparable network to the existing provider networks to provide appropriate access on a statewide basis.

Disease and Other Health Management Programs

Sanford Health Plan provides disease management and health improvement programs for eligible members. The list below includes examples of programs currently offered:

- Coronary Heart Disease
- Diabetes
- Hypertension
- Immunizations
- ADHD
- Colorectal Cancer
- Asthma

Bidders are expected to offer comprehensive, high quality case/disease management programs, including rare and chronic diseases, for the plans offered to both actives and retirees.

Wellness Programs

NDPERS offers a variety of wellness programs for eligible members and employers. The list below provides more details on some of the programs currently offered:

Wellness Program Employee Incentives:

- Covered employees and/or spouses are each eligible to receive up to $250 in incentives per year through participation. All covered retirees and/or spouses are also eligible for this incentive. Each participant must complete an annual health risk assessment through the vendor's online wellness tool. Two programs are currently available to achieve the $250 benefit (See Exhibit 17). The programs are:

  1) Online Wellness Tool (Platform used by current vendor is StayWell) – participants utilize the online wellness tool to take steps towards better health goals, including tracking activity and performing challenges to receive points for their participation. The points are then redeemed towards various gift cards or fitness related prizes - see Exhibit 1.

  2) Fitness Center Reimbursement – participants who utilize a health club facility 12 days per month will be reimbursed $20 per month towards their membership fee - see Exhibit 2.

- The successful Bidder will be required to carry-over wellness incentive balances (if applicable).

Employer Based Wellness Program:

- The employer-based wellness program provides that employers who do not have an onsite wellness program pay premiums to NDPERS that are 1% higher. These funds are retained by NDPERS for administration. The program is given its authority in NDCC § 54-52.1-14. The goals for the program are to:

  - ✓ have 100% of participating employers supporting a wellness message at their worksite
  - ✓ help NDPERS members gain a greater understanding of wellness

- ✓ create a better quality of life for NDPERS membership
- ✓ contain health care costs

- Employers that participate in the NDPERS Group Health Insurance Plan have the opportunity to enroll in the employer-based wellness program on an annual basis. For the wellness year July 1, 2021 to June 30, 2022, there are 177 of 223 employers participating. The wellness plan year is from July 1 to June 30. See the following for more details:

https://ndpers.nd.gov/employers/employer-resources/employer-based-wellness/

Employer Based Wellness Benefit Funding Program:

The NDPERS Wellness Benefit Funding Program is available to employer groups that participate in the NDPERS group health plan and have been approved for the Employer Based Wellness Discount Program. The Wellness Funding Program, in conjunction with the Wellness Discount Program, encourages employers to commit to promoting wellness planning and programming at their work sites. The funding program provides funding assistance to employers that develop and sponsor onsite wellness programs for their employees. Benefits are available to eligible employers once each fiscal year of the biennium. For details, visit https://ndpers.nd.gov/employers/employer-resources/employer-based-wellness/ The successful Bidder will administer the reimbursement program to employers. NDPERS will deposit with the vendor necessary funds for paying such reimbursements as approved by NDPERS. In addition, one member of the vendor's wellness team will serve on the funding program committee that reviews employer applications for funding and determines their approval/denial based upon Board approved provisions.

Additional Wellness Related Services & Programs:

- **Wellness Consultants** – the successful Bidder must provide a dedicated staff member(s) to assist employees and employers with their wellness initiatives. Examples of services provided include:

  To members:

  - ✓ Assist with online wellness tool issues and questions.
  - ✓ Assist with Fitness Center Reimbursement issues.
  - ✓ Develop various challenges for participants to do through online wellness tool.
  - ✓ Monthly wellness newsletter.
  - ✓ Health coaching.
  - ✓ Offer supplemental programs as available (current programs include "Exercise is Medicine" and "Center for Lifestyle Medicine")
  - ✓ Annual notice to retirees regarding amount of taxable benefits.

  To employers:

- ✓ Conduct monthly coordinator calls/webinars with employer wellness coordinators. – see Exhibit 15
- ✓ Prepare and distribute a monthly wellness newsletter for coordinators. – see Exhibit 14
- ✓ Prepare monthly wellness newsletter for employees –See Exhibit 13
- ✓ Conduct coordinator workshops each summer across state for wellness coordinators to attend. – see Exhibit 19
- ✓ Coordinate the awarding of up to 12,000 points (towards $250 maximum) on the online tool for an employee's participation in the employer sponsored wellness program activities. – see Exhibit 11
- ✓ Coordinate and promote Walk at Work Day – see Exhibit 12
- ✓ Report monthly on employee wellness redemptions for tax reporting purposes.

Member Education Presentations on Wellness Topics – The current vendor provides 2 to 3 member education consultants that travel statewide to worksites and conduct presentations for employees on various wellness related topics. In addition, an additional wellness consultant is available to assist with member and/or employer issues related to the online wellness tool and employer funding request evaluations. There are currently 16 different topics provided. See Exhibit 16 for an example.

Other Added Value Programs:

- Healthy Pregnancy Program – a program designed to provide support to pregnant members. See https://www.sanfordhealthplan.org/ndpers/healthy-pregnancy-program for details.
- Diabetes Management – The About the Patient diabetes program is offered to covered members that are diabetic to support drug adherence. The program is coordinated with the ND Pharmacy Association. See https://www.aboutthepatient.net/patients/diabetes-info/ndpers-program-info/ for details.
- Diabetes Prevention Program (DPP) – The DPP started as a pilot program and has been expanded to Bismarck, Fargo, Grand Forks, Dickinson, Jamestown and Minot. The purpose of the program is to encourage healthy lifestyles for members at risk of developing diabetes. The DPP is also offered online through Sanford Health Plan to allow members to participate remotely.

The successful Bidder will also need to perform the following administrative services in support of these added value programs:

- Healthy Pregnancy Program
  - ✓ Enrollment services (telephonic and online options)
  - ✓ Host website with details of the program
  - ✓ Provider member communications
  - ✓ Administer a deductible waiver for participants
  - ✓ Administer free prenatal vitamins for participants
  - ✓ Provide RN Case Managers for periodic calls to participants

- ✓ RN Case Manager to administer risk assessment upon initial enrollment
- ✓ Send pregnancy information/tips to participants via text
- ✓ Provide pregnancy and childbirth information online
- ✓ Integrate the program with the broader Dakota Wellness Benefit program
- ✓ Send a welcome "gift" to each participant (e.g. baby book, bib)
- ✓ Provide quarterly participation reporting to NDPERS

- Diabetes Management – The About the Patient diabetes program
  - ✓ Provide a monthly file to PERS of members with diabetes related claims.
  - ✓ Intake a file of members with reimbursable claims on a regular basis.
  - ✓ Work with Pharmacy Association to coordinate payments to members.
  - ✓ Provide guidance to PERS on allowable reimbursements/eligible expenses

- Make payments for the NDPERS Wellness Funding Program. – see https://ndpers.nd.gov/employers/employer-resources/employer-based-wellness/wellness-benefit-funding-program/ for details.

Program Enhancements in 2021-2023

The Board approved the following changes to the health benefits in for the 2021-2023 biennium. These programs will be continued with the successful Bidder.

- All contraceptives requiring a Prescription Order or dispensed by a Healthcare Provider are covered, subject to Member's Cost Share

Infertility Benefit

NDPERS provides infertility benefits with a $500 deductible and a $20,000 lifetime maximum. The successful Bidder will be required to accept transition files for members who have accumulated benefits towards the deductible and lifetime maximum to carryover the benefits without interruption or restarting the lifetime maximum.

Employee Assistance Program (EAP)

The mission of the Employee Assistance Program (EAP) is to provide confidential, accessible counseling and referral services to individual employees in order to restore and strengthen the health and productivity of employees and the workplace. The EAP is available to employees and their immediate family members. For more information regarding the current EAP, refer to the website: https://www.ndpers.nd.gov/active-members/insurance-plans/ndpers-employee-assistance-program-eap

The successful Bidder is expected to cooperate as needed and as requested by NDPERS. NDPERS is not seeking proposals for this service as part of this RFP.

Enrollment/Premium Administration

NDPERS will submit enrollments, billing and/or premium remittance via a centralized electronic system. NDPERS will collect enrollment/eligibility information which will be provided to the successful Bidder on a data file that follows the HIPAA 834 file specifications. The indicative data provided on the 834 enrollment/eligibility file is to be loaded onto the successful Bidder's data base and used for ID cards and all transactions/communications related to the member's participation in the plan. Premium payment information will be provided on a data file that

follows the HIPAA 820 file specifications. Files will be transmitted using a secure file transmission process. The successful Bidder must be able to receive this data in that format and media.

COBRA Administration

NDPERS provides COBRA continuation for terminated/retired employees in compliance with federal regulations. NDPERS administers this program. The successful Bidder is expected to cooperate as needed to ensure seamless administration and member service. NDPERS is not seeking proposals for this service as part of this RFP.

Workers' Compensation Program

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

COBRA Notification

Upon enrollment under the NDPERS Benefit Plan, the successful Bidder will provide written notice to covered employees and their covered spouses of their applicable continuation rights pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA") or under State law pursuant to NDCC §26.1-36-23, if applicable.

Out-of-Area Coverage

If a member receives care from a non-participating health care provider within the state of North Dakota, benefit payments are reduced by a certain percentage and the member is responsible for the payment reduction. If a member receives care 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 the vendor if the plan is fully insured. If the plan is self-insured the allowance for covered services will be an amount determined by the board. The benefits available under the Dakota Plan and Dakota Retiree Plan are also available to members traveling or living outside of the United States (subject to certain requirements such as preauthorization and prior approval). Detailed information regarding eligibility and out of area benefit levels can be found in the 2021-2023 Summary of Benefits at https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-health/shp-coi-gf.pdf

Annual Enrollment

Dakota Plan annual open enrollment typically takes place in October/November of each year. Employees may enroll in coverage or make changes in coverage during this period. Annual open enrollment is not applicable to pre-Medicare or Medicare retirees.

Current and Historical Monthly Rates and Employee Contributions

The contributions for single or family coverage for state employees are currently paid at 100% by the State, although this practice may change in the future. Please note that for the state, a single composite rate is used instead of the single/family rate. The contributions for employees of participating political subdivisions are at the discretion of the subdivision and subject to the

minimum contribution requirements of NDPERS. The contributions for temporary employees are either at their own expense or their employer may pay any portion of the premium subject to its budget authority.

In the case of a temporary employee who is an applicable taxpayer as defined in section 36B(c)(1)(A) of the Internal Revenue Code [26 U.S.C. 36B(c)(1)(A)], the temporary employee's required contribution for medical and hospital benefits self-only coverage may not exceed the maximum employee required contribution specified under section 36B(c)(2)(C) of the Internal Revenue Code [26 U.S.C. 36B(c)(2)(C)], and the employer shall pay any difference between the maximum employee required contribution for medical and hospital benefits for self-only coverage and the cost of the premiums in effect for this coverage.

The chart in Exhibit E20 shows the current total monthly rates for NDPERS members.

II. RFP Objectives and Bidder Responsibilities

RFP Objectives

North Dakota Public Employees Retirement System ("NDPERS") is soliciting proposals for the insurance and/or administration of its employee/retiree medical and prescription drug insurance plan. Proposals will be accepted from administrative/insurance companies ("Bidders") that are capable of offering a statewide provider network, utilization management, disease management, wellness program and pharmacy benefit manager services along with other related services. The contract to be awarded is a multi-year arrangement beginning July 1, 2023 and ending June 30, 2025.

The board may establish a self-insured plan only if it is determined to be in the best interest of the state and the state's eligible employees.

Successful Bidder Responsibilities

The successful Bidder must demonstrate the ability to develop and manage a health care provider network, provide claims processing services, utilization management, medical management, disease management, wellness program, dedicated account service and support, dedicated member/customer service, data/management reporting, billing, appeals process and other administrative services. The successful Bidder should also adjudicate and resolve Medicare Secondary Payer demands (see Exhibit E8).

In addition, the successful Bidder is expected to conduct ongoing performance review meetings with NDPERS regarding plan financial performance, provider contracting issues, progress related to network goals and new network development, patient satisfaction, new or emerging legal issues, and other relevant and timely operational issues that may affect the plan.

Additional details regarding expected health plan administrator duties can be found in Appendix G. Bidders must review these sections carefully to confirm the ability to replicate the current contract benefits. A redlined contract must be included with the proposal (see Appendix A1, A2, and A3). Specific responses are needed for the analysis of "equivalent contract benefits".

The proposed effective date of the program is July 1, 2023. Bidders will have the opportunity to demonstrate capabilities in these areas by responding to the questionnaires provided in this RFP and potentially with additional finalist questions and presentations.

Request for Proposal (RFP) Requested Scope

This RFP includes seven (7) options to respond:

1. Fully-insured medical and pharmacy proposal
2. Self-insured medical and pharmacy proposal
3. Fully-insured medical proposal only
4. Self-insured medical proposal only
5. Fully-insured pharmacy proposal only
6. Self-insured pharmacy proposal only
7. Stop loss insurance for all self-insured options

Bidders may choose the option(s) they will submit proposals for.

Special Self-Insurance Requirements for a Self-Insured Plan

The following provisions relate to oversight of the North Dakota Insurance Commissioner over PERS and its vendors under a self-insured arrangement:

> ***26.1-36.6-03. Self-insurance health plans - Requirements.***
> *The following policy provisions apply to a self-insurance health plan or to the administrative services only or third-party administrator, and are subject to the jurisdiction of the commissioner: 26.1-36-03, 26.1-36 -03.1, 26.1-3 -05, 26.1- 36-10, 26.1-36 12, 26.1-36-12.4, 26.1-36-12.6, 26.1-13, 26.1-36-14, 26.1-36-17, 26.1-36-18, 26.1-36-19, 26.1-36-23, 26.1-36 -29, 26.1-36-37.1, 26.1-36-38, 26.1- 36-39, 26.1-36-41, 26.1-36 44, and 26.1- 36 -46*

All self-insured arrangements must comply with the above and other applicable direction from the North Dakota Insurance Commissioner.

Pharmacy Benefit Manager (PBM) Requirement

North Dakota Century Code chapter 54-52.1 includes specific provisions for pharmacy benefits disclosures. Proposals are expected to comply with the law.

If you are unable to comply with the provisions described in North Dakota Century Code chapter 54-52.1, you may still submit a proposal that specifies which provisions you are unable to comply with, why you are unable to comply, additional costs associated with compliance, and a recommended approach to meeting the intent of the law.

The requirements are:

54-52.1-04.16. Prescription drug coverage - Performance audits.

1. *Except for Medicare part D, prescription drug coverage, the board may not enter or renew a contract for prescription drug coverage unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services. The contract must provide:*

a. The board must have full access to data regarding: (1) The total dollars paid to the pharmacy benefits manager by the carrier and the board; (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier which were not subsequently paid to a licensed pharmacy in the state; and (3) Payments made to all pharmacy providers.

b. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated.

c. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated.

e. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. The contract must provide that all drug rebates, financial incentives, fees, and discounts must be disclosed to the board.

2. *The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board. The board's auditor, the insurance department, and the employee benefits programs committee may access any information the board may access under this section. All information accessed by the board, board's auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This subsection does not limit the information required to be disclosed to the board under subsection 1.*

3. *Except for Medicare part D, if the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.*

4. *Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to.*

PBM Transparency Preference

North Dakota statutes provide a preference for proposals with PBM efforts that meet the following requirements:

54-52.1-04.15. Health insurance benefits coverage – Prescription drug coverage - Transparency - Audits - Confidentiality.

1. *If the prescription drug coverage component of a health insurance benefits coverage contract received in response to a request for bids under section 54-52.1-04 utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, in addition to the factors set forth under section 54-52.1-04 the board shall consider and give preference to an insurer's contract that:*
    a. *Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefits management company which controls the prescriptions drug coverage offered as part of the health insurance benefits coverage, and if the contract is revised or a new contract is entered, requires the insurer to provide the board with the revision or new contract within thirty days of the change.*
    b. *Provides the board with monthly claims data and information on all programs being implemented or modified, including prior authorization, step therapy, mandatory use of generic drugs, or quantity limits.*
    c. *Describes the extent to which the board may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are covered; the formulary; and the member programs implemented.*
    d. *Describes the audit rights of the board.*
2. *The board may conduct annual audits to the extent permitted under the contract terms agreed to under subsection 1. The audits must include:*
    a. *A review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.*
    b. *A review of a list of all programs that have been implemented or modified during the audit period under subsection 1, and in connection with each program the auditor shall report on the cost, the cost savings or avoidance, member disruption, the process for and number of overrides or approvals and disapprovals, and clinical outcomes.*
    c. *Recommendations for proposed changes to the prescription drug benefit programs to decrease costs and improve plan beneficiaries' health care treatment. 3. Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts. 4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager; a pharmaceutical manufacturer representative; or any retail, mail, or specialty drug pharmacy representative or vendor.*

III. Proposal Content

Proposal Contents

By submission of a proposal, Bidder warrants that the information provided is true, correct and reliable for purposes of evaluation for potential contract award. The submission of inaccurate or misleading information may be grounds for disqualification from the award. The contents of the proposal and any subsequent clarifications submitted by the successful proposers will become part of the contractual obligation and incorporated by reference into the ensuing contract.

By submitting your proposal, you agree:

- Proposals submitted in response to this request will be considered the only submission; revised proposals will not be allowed after the proposal return date and time unless requested by NDPERS or approved by the NDPERS Board.
- All proposals answer all applicable questions fully in the attached questionnaire(s).
- All proposals become the property of NDPERS and will not be returned to the offering Bidder. Also, all information provided is a public record under North Dakota law unless specifically exempted by law.
- You are prepared to make finalist presentations and allow site visits.

Term of Contract

The North Dakota Public Employees Retirement System is governed by North Dakota State statutes, which includes a requirement to solicit bids for medical benefits coverage for a specified term for a fully-insured arrangement and every other biennium for an Administrative Services arrangement. NDPERS has determined that the specified term for providing such hospital and medical/prescription drug benefits under a self-insured arrangement shall be for a two-year period with the option to renew for an additional two two-year periods.

For the fully-insured bid it is the intent of NDPERS to contract for a two-year period with the option to renew for an additional two two-year periods.

Pursuant to North Dakota law a renewal of a self-insured or fully insured contract(s) will be subject to the following:

a. *The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations and the proposed premium renewal amount does not exceed the board's expectations.*
b. *In making a determination under this subsection, the board shall:*
    (1) *Use the services of a consultant to concurrently and independently prepare a renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.*

(2) *Review the carrier's performance measures, including payment accuracy, claim processing time, member service center metrics, wellness or other special program participation levels, and any other measures the board determines relevant to making the determination and shall consider these measures in determining the board's satisfaction with the carrier's performance.*
(3) *Consider any additional information the board determines relevant to making the determination.*

c. *If the board determines the carrier's performance under the existing contract does not meet the board's expectations or the proposed premium renewal amount exceeds the board's expectations and the board determines to solicit a bid under section 54-52.1-04, the board shall specify its reasons for the determination to solicit a bid.*

If the plan is awarded as a self-insured or fully-insured plan pursuant to this RFP, NDPERS and the successful Bidder may renegotiate the existing contract during the interim biennium without resorting to a formal bidding process. If NDPERS and the successful Bidder are unable to reach an agreement during renegotiations, a formal bidding process will be initiated. Negotiations will begin in June and end in September in the year before the end of the biennium

Minimum Requirements

Minimum requirements are in the response template in Appendix B; please review and respond as part of your submission.

Response Check List

This RFP allows 7 ways to offer services which include:

1. Fully-insured medical and pharmacy proposal
2. Self-insured medical and pharmacy proposal
3. Fully-insured medical proposal
4. Self-insured medical proposal
5. Fully-insured pharmacy proposal
6. Self-insured pharmacy proposal
7. Stop loss insurance for all self-insured options

The following table indicates the submission requirements based on the proposal type.

Required Proposal Content:	Proposed Services:						
	1. Fully Insured Medical & Rx	**2. Self-insured Medical & Rx**	**3. Fully-Insured Medical Only**	**4. Self-insured Medical Only**	**5. Fully-Insured Rx**	**6. Self-Insured Rx**	**7. Stop Loss**
Transmittal Letter	x	x	x	x	x	x	x
Executive Summary	x	x	x	x	x	x	
Appendix A1 – Model Fully-Insured Contract	x		x				
Appendix A2 – Model Self-Insured Prescription Drug Contract		x			x	x	
Appendix A3 – Model Self-Insured Medical Contract		x		x			
B-Response Template	x	x	x	x	x	x	x
C1 – Fully-Insured Questionnaire	x		x		x		
C2 - Self-insured Questionnaire (Medical)		x		x			
C3 – Self-insured Questionnaire (Pharmacy)		x				x	
D1 - Fully-Insured Cost Proposal	x		x		x		
D2 - Self-insured Medical Cost Proposal		x		x			
D3 – Self-Insured Pharmacy Cost Proposal		x				x	
D4 – Stop Loss Cost Proposal							x
D5 – Cost Proposal – Plan Design Changes	x	x	x	x			
E1 – Medical Network Access	x	x	x	x			
E2 – Prescription Drug Network & Formulary Match	x	x			x	x	
F - Deviations	x	x	x	x	x	x	x
G - Services to be performed	x	x	x	x	x	x	
H – Performance Guarantees	x	x	x	x	x	x	
I - Suggested changes (optional)	x	x	x	x	x	x	
J - Confidential Information	x	x	x	x	x	x	x

Submission Instructions for Multiple Proposal Options

Bidders electing to submit multiple proposal options are only required to submit one copy of the completed proposal forms and are not required to duplicate submissions under each proposal option.

Please note that the self-insured questionnaires are not identical to the fully-insured questionnaires. Completing only a fully-insured questionnaire or only a self-insured questionnaire is insufficient to be considered for both options.

IV. Proposal Review and Evaluation

Rights of NDPERS

This RFP does not obligate NDPERS to complete the proposed project. NDPERS reserves the right to cancel the solicitation if it is considered to be in its best interest. Costs incurred for developing a proposal are the sole responsibility of the Bidder. NDPERS also reserves the right to:

1. Reject any and all proposals received in response to this RFP.
2. Amend and re-issue this RFP.
3. Select proposals for contract award or for negotiations other than those with the lowest cost.
4. Select proposals for contract award or for negotiations with more than one Bidder.
5. Consider a late modification of a proposal if the proposal itself was submitted on time, if the modifications were requested by the State, and if the modifications make the terms of the proposal more favorable to the State.
6. Determine that a deficiency is not substantive and waive the deficiency as immaterial. However, waiver of the deficiency shall in no way modify the RFP documents or relieve the Bidder from full compliance with the terms of the contract if the Bidder is awarded the contract.
7. Negotiate any aspect of the proposal with any Bidder and negotiate with more than one Bidder at the same time.
8. Use any or all ideas presented in any proposal received in response to this RFP, unless the Bidder presents a positive statement of objection in the proposal. Objections will be considered as valid only relative to proprietary information of the Bidder and so designated in the proposal. Exceptions to this are ideas that were known to NDPERS before submission of such proposal or properly became known to NDPERS thereafter through other sources or through acceptance of the proposal.

Selection Advisory Team

A review team made up of NDPERS staff and its consultant(s) will evaluate all proposals. The NDPERS Board will make the final decision on the award. NDPERS reserves the right to alter the composition of this selection team and its responsibilities.

Proposal Review and Evaluation Criteria

Proposals will initially be reviewed and evaluated by the selection team. The cost proposal will be reviewed independently to ensure that it is complete and submitted in the format requested. In reviewing the proposals, the requirements in NDCC § 54-52.1-04 will be considered.

Phase I – Preliminary Review Criteria

Proposals will initially be evaluated to determine if they comply with the following review criteria:

- Completeness of proposal, including minimum Bidder requirements, as outlined in Appendix B, Proposal Content, and submitted in the format designated in the RFP.
- Completeness and quality of responses to questionnaire(s) provided.
- Extensive statewide provider networks which offers access to key population areas within the State.

Phase II – Evaluation Criteria

Proposals that have met the review criteria listed above will then be reviewed based on the following factors.

- **Overall Cost**

  NDPERS intends to continue to provide its employees and retirees with comprehensive health care that is affordable and competitive. NDPERS is focused on stabilizing and controlling costs and increases to both the employer and employees. To accomplish this, NDPERS is interested in competitive premium arrangements, administrative and program fees, and competitive provider reimbursement arrangements for the duration of the biennium contract.

- **Full Disclosure of Prescription Drug Financials**

  Bidders are expected to comply with North Dakota Century Code statutes that define disclosures and audit rights. Proposals that do not comply with the statutes may be considered by the Board based upon the measures and actions described by the Bidder to comply as fully as practicable.

- **Plan Design**

  NDPERS is interested in maintaining the existing plan design. Any plan design parameters that cannot be duplicated must be clearly noted in your proposal in Appendix F – Deviations.

- **Comparable Statewide Provider Network/PPO Network and out-of-state network.**

  NDPERS is interested in the following:

  - A network of in- and out-of-state providers for the Basic and PPO plans that is commensurate with the existing network.
  - Broad network in terms of the number, breadth, quality and location of network providers, with the goal of matching as closely as possible the current provider networks and geographic access. If a new Bidder is selected they must at a minimum maintain the existing network for the first year of the contract and utilize that time to negotiate with any provider outside the network.

- Limited doctor/patient disruption – NDPERS is interested in limiting the disruption employees may experience in the event of a change in vendors. (see Appendix E1 & E2)

- Access to preferred providers outside the local geographic service area (national).

- Ability of the Bidder to negotiate NDPERS-specific contracts.

- The ability to match or exceed existing discount levels

- Commitment to pay for performance and other cost and quality initiatives.

- The ability to provide a value-based purchasing program similar or comparable to the existing program

- **Disease and Other Care Management Programs**

  NDPERS will continue to offer disease management, care management and care support programs as part of the overall health care program, and is interested in exploring innovative, positive incentives for participation in these programs. Bidders must demonstrate their ability to report and provide meaningful, interpretive data to better support the disease and other care management programs.

- **Health Improvement, Education and Wellness Programs**

  NDPERS is interested in partnering with the successful Bidder to offer the same or similar program that is already a part of NDPERS. The existing program also links to the NDPERS employer-based wellness program and this functionality will continue to be required. NDPERS also wishes to maintain a dedicated wellness staff member with the successful Bidder who will work with our worksite wellness coordinators. The successful Bidder must provide this resource.

- **Retiree Medicare Coverage**

  Match the existing coverage and arrangement and the ability to provide new coverage levels as determined by the NDPERS Board.

Phase III. Board Evaluation and Decision

1. The Board will consider the Selection Advisory Team evaluation of proposals.
2. The Board may elect to interview the proposers.
3. The Board may also consider additional information.
4. The Board will review the fully-insured and self-insured proposals as demonstrated below and make an award to the Bidder that best serves the interest of the state and it eligible employees.

V. Proposal Submission

Instructions

All proposals should be submitted simply and economically providing a direct, concise delineation of the Bidder's proposal and qualifications adhering to the proposal format guidelines outlined below. Bidders should also refer to Appendix B for a list of minimum requirements and general requirements.

- Proposals should be typed or printed on 8.5" x 11" paper.
- All proposals must include a transmittal letter/statement which includes the following:
  - An acknowledgement of receipt of the group health RFP specifications and any addenda and a statement that the proposal conforms to the RFP minimum requirements. This letter must include the title and signature of a Duly Authorized Officer of the company.
  - Any deviations from the specifications must be clearly identified in Appendix F. Failure to note deviations may exclude the proposal from further consideration. If you do not identify and explain deviations, your proposal will be deemed a certification that you will comply in every respect with the requirements and contractual language set forth in this RFP.
- All proposals must include a table of contents and follow the required content listed below:
- All pages of proposals must have consecutive page numbers.
- Proposals must respond to RFP minimum requirements (Appendix B).
- Responses to questions must include a restatement of the question (number and text as identified in the RFP) with the response immediately following.
- Appendices and other supplemental information provided with your proposal must be clearly identified.
- Cost proposal must be submitted in a separate, sealed envelope and clearly marked, "Cost Proposal". Insured rates and/or Administrative fees and/or pharmacy rates and/or stop loss premiums quoted must be all-inclusive. NDPERS will not be billed any additional amounts for services, including commissions or brokerage fees.
- NDCC § 54-52.1-10 (Exemption From State Premium Tax) provides that "All premiums, consideration for annuities, policy fees, and membership fees collected under this chapter are exempt from the tax payable pursuant to section 26.1-03-17". Thus, Offeror's responses should not reflect any amounts for premium taxes.

Proposal Submission and Contact Information

Proposals should be submitted in two parts, with the cost proposal separately from the qualitative proposal (cost proposal includes Appendices D1-D5).

All electronic and hard copy proposals must be received no later than Tuesday, November 15, 2022 at 5 pm CST. Late proposals will not be considered unless approved by the Board. Proposals will be sent to two parties, as described below:

Bidders should submit one proposal including all proposed coverage/administration options. Bidders are required to submit one (1) original and ten (10) paper copies of the qualitative proposals along with one (1) unredacted electronic copy (on a flash drive) as well as one (1) electronic, editable, PDF redacted copy of the qualitative proposal on a separate flash drive (note that the electronic redacted copies may not be a picture) to:

North Dakota PERS
1600 East Century Ave, Suite 2
PO Box 1657
Bismarck, ND 58503

A full electronic copy of the qualitative proposal and cost proposal must be emailed to Deloitte Consulting. All appendices submitted with the RFP must be provided in Word or Excel format. Supplemental material may be included in PDF format.

Drew Rasmussen
Deloitte Consulting LLP
773-661-8327
drasmussen@deloitte.com

***PLEASE NOTE*:** As indicated above, cost proposals should only be submitted to Deloitte Consulting. Cost proposals should follow the Confidential/Proprietary Information instructions in Appendix J. Any provisions of the Bidder's proposal that are desired to be confidential must be identified specifically on each page of the proposal and included in the table provided in Appendix J.

From the date of issuance until the announcement of the finalist, Bidders should only contact the Deloitte RFP coordinator, Drew Rasmussen. All correspondence and questions must be submitted in writing via e-mail to Deloitte Consulting in accordance with the timeline set forth in this RFP. NDPERS personnel are not authorized to discuss this RFP with Bidder; doing so may result in disqualification. Bidders may continue to communicate with NDPERS staff regarding other relevant business matters.

Appendix C1. Fully-Insured Medical or Fully-Insured Medical & Prescription Drug Questionnaire

This questionnaire must be completed if your organization is proposing fully-insured medical with or without pharmacy coverage for NDPERS.

To be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. Include both the question and the answer in your proposal response. An electronic copy of this questionnaire has been provided to facilitate your response.

Reference should not be made to a prior response unless the question involved specifically provides such an option. Proposers should refer to the earlier sections of this RFP before responding to any of the questions, to ensure that you have a complete understanding of the requirements with respect to your organization's proposal.

Bidders may include additional information that you consider relevant or useful to NDPERS. If you elect to provide additional information on services you can provide in response to the question, please specifically indicate that it is not included in the covered services offered in your proposal. If not so indicated, those services will be considered to be a part of your proposed fees. However, responses to all of the questions set forth below must be provided.

If this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated and executed, any controversy arising over such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal. Bidders are reminded that **any and all deviations must be clearly identified and described in the RFP and the deviations worksheet provided in Appendix F.**

This questionnaire is divided into the following categories:

General and Medical

- Organizational Background, Strength, and Experience
- References
- Implementation and Account Management
- Communications and Website
- Plan Administration
- Eligibility
- Customer/Member Service
- Claims Administration
- Medical Information Technology
- Reporting
- Case/Utilization Management
- Health Risk Management Programs
- Network Accessibility and Disruption
- Cost, Quality, and Pay for Performance
- Credentialing and Contracting
- Reimbursement and Discounts
- Performance Standards and Guarantees
- HDHP/HSA
- Economy to be Affected
- Fiduciary Responsibility
- Appeals Process
- Actuarial Services

Pharmacy Benefit Management

- Compliance with North Dakota Statutory Requirements
- Pharmacy Benefit Management Organization General Information
- Pharmacy Benefit Clinical Management
- Specialty Pharmacy
- Formulary
- Data Analytics & Management Reporting
- Customer Service
- Retail Pharmacy Network
- Mail Service
- Eligibility
- Regulatory and Compliance
- Implementation

General and Medical

Organizational Background, Strength, and Experience

1000. Provide a brief description of your organization, including your company history, organizational structure, services provided, location of headquarters, and length of time you have been in business. Describe any significant historical or future organizational developments (acquisitions, mergers, change in subcontracted vendors, etc.)

1001. Bidders responding to this RFP must be able to substantiate their financial stability. Provide a copy of your audited financial statement or other financial information. Include, at a minimum, a Balance Sheet and a Profit and Loss Statement, together with the name and address of the bank(s) with which you conduct business and the public accounting firm(s) that audit your financial statements. Other sufficient information may include a written statement from a financial institution confirming the creditworthiness and financial stability of the Bidder.

1002. Provide a copy of any State or Federal regulatory audit performed within the last two years.

1003. Confirm that your organization agrees to be accountable for everything stated in and submitted as part of your proposal, even if not specifically addressed in the Minimum Contract Provisions in Appendix B.

1004. Indicate if your organization has been a party to litigation regarding a medical benefit plan contract or data security breach over the prior five years or at present. If so, provide details of the litigation or action. Failure to disclose this may constitute grounds for rejection of any proposal or termination of any contract.

1005. State whether the Bidder, its officers, agents or employees, who are expected to perform services under the NDPERS contract, have been disciplined, admonished, warned, or had a license, registration, charter, certification, or any similar authorization to do business suspended or revoked for any reason.

1006. Include a description of your organization's major short-term strategic initiatives and your long term strategic business plan. Specifically address cost containment efforts, providing specific examples of how you have made changes that resulted in savings for your clients.

1007. Describe how your organization differentiates itself from your competitors. Specifically, what makes your organization the best partner for NDPERS?

1008. Identify all services that are currently outsourced or subcontracted, the name of the vendor/partner, and length of the relationship and the nature of the long-term partnership (e.g.: are the contracts expected to expire during the course of this contract?). Describe how you ensure quality customer service and timely and effective issue resolution.

1009. What ratings have you received from the following third-party rating companies and organizations?

Rating Organization	Rating	Date of Last Accreditation / Rating
A.M. Best		
Standard & Poor's		
Moody's		

1010. Are any of the services you are proposing to provide to NDPERS contracted outside the U.S.A? Describe any business you do outside the U.S.A. and the financial impact, if any, of requiring those services to be provided within the U.S.A.

1011. Confirm that your proposal includes any and all deviations to the Sample Contract/ASA and other RFP requirements (via submission of Appendix F).

1012. Confirm that you will conform to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 as applicable to NDPERS.

1013. Has your company been involved in any mergers or acquisitions in the prior 24 months? If so, how will those events impact NDPERS?

References

1014. Provide the following information on a maximum of three (3) of your largest plan clients for whom you provide services similar to those proposed in this proposal. References of similar size and scope to NDPERS are preferred; one must be your largest public sector client and one must be your largest North Dakota-based client.

a. Name of employer sponsoring plan and location
b. Type of services provided to plan sponsor
c. Plan inception date
d. Length of time as client
e. Number of contracts and members participating in the plan
f. Contact information (name, title, phone number, email address)

1015. Provide the following information for two (2) of your largest clients that have terminated services during the preceding 3-year period. References of similar size and scope to NDPERS are preferred.

a. Name of employer sponsoring plan and location
b. Type of services provided to plan sponsor
c. Plan inception date
d. Length of time as client
e. Number of contracts and members participating in the plan
f. Reason for termination
g. Contact information (name, title, phone number, email address)

Implementation and Account Management

1016. Bidders must outline in detail the specific activities and tasks necessary to implement the NDPERS program. Be specific with regard to the following:

a. Amount of total time needed to effectively implement the program
b. Activities/tasks and corresponding timing (Detailed Timeline)
c. Responsible parties and amount of time dedicated to implementation, broken out by Bidder and NDPERS staff
d. Any transition activities required with incumbent carriers, including data transfers and providing members adequate notice regarding current care or treatment plans at least 60 days prior to a change
e. Length of time implementation team lead and members will be available to NDPERS

1017. Provide an overview of how the NDPERS relationship will be managed, both strategically and on a day-to-day basis. Include an organizational chart. Designate the names, titles, location, telephone numbers, and email addresses for the representatives listed below. For the account service individuals listed (b, c, d, and e below), provide brief biographical information, such as years of service with your company, experience as it relates to this proposal, and the number of clients for which they perform similar services.

a. The key individual representing your company during the proposal process;
b. The key individuals on your proposed implementation team;
c. The key individual assigned to overall contract management;
d. The key dedicated individual or team members responsible for day-to-day account management and service;
e. The key individual responsible for provider contracting; and
f. The key individual responsible for provider relations if different than letter e. above.
g. Medical and/or pharmacy director assigned to NDPERS (as applicable)

1018. Please provide the requested information for the functions that will be servicing NDPERS in the table below:

Area	Geographical Location(s) and Organization Name (if out-sourced)	Hours of Operation (Specify PST/CST/EST)	Is this service Outsourced? Yes or No? *If Yes, provide name of company to which the function is outsourced*
Member Service			❑ Yes *Specify Company Name:* _____ ❑ No
Claims Processing			❑ Yes *Specify Company Name:* _____ ❑ No
Enrollment and Eligibility			❑ Yes *Specify Company Name:* _____ ❑ No
Disease Management			❑ Yes *Specify Company Name:* _____ ❑ No
Case and Utilization Management			❑ Yes *Specify Company Name:* _____ ❑ No
Health, Education and Wellness Programs/Services (including dedicated wellness support staff)			❑ Yes *Specify Company Name:* _____ ❑ No
HSA			❑ Yes *Specify Company Name:* _____ ❑ No
Pharmacy Benefits Management			❑ Yes *Specify Company Name:* _____ ❑ No
Other (Specify functional area)			❑ Yes *Specify Company Name:* _____ ❑ No

Communications and Website

1019. Are you willing to provide communication and marketing resources to work with NDPERS in the development of NDPERS-specific member communication materials (educational, open enrollment, benefit plan related, ongoing communications)? Describe the resources, sample communications, and your proposed approach and strategy/plan.

1020. How much lead time is necessary for you to guarantee that ID cards will be received by members prior to the plan year effective date of July 1, 2023?

1021. Describe how you handle communications for the post-65 programs that you will offer to NDPERS retirees.

1022. To what reading grade level are your written and website communications written? Are other languages available? What customization is allowed related to member communications?

1023. Does your website provide NDPERS specific plan information?

1024. Does your website offer a provider locator?

1025. What additional information does your site provide?

1026. Describe any additional web-based capabilities that could benefit NDPERS and our members.

Plan Administration

1027. Confirm that you will communicate legislative changes related to the operations of the plan in a timely manner, and describe the support staff and process. Provide examples of materials you have used in the past to educate your clients on legislative changes/updates.

1028. What support will your organization provide NDPERS to comply with the obligations of the CAA, Transparency in Coverage rules, and Mental Health Parity rules? Provide responses to the following questions and include information regarding additional compliance items required by these rules and regulations not specifically listed.

a. Are your claim systems and operational processes able to comply with the No Surprises Act effective as of January 1, 2022? Please describe how your organization will prevent Surprise Balance Billing.

b. Are you able to comply with provider directory accuracy requirements (if there is a network directory error and a plan participant uses an out-of-network provider they believe to be in-network, the cost-share cannot be more than in-network amount)?

c. Are you able to comply with member ID card requirements that include deductibles and out-of-pocket maximums for in-network and out-of-network coverage?

d. Will your organization, on behalf of NDPERS, create and provide machine readable files of in-network reimbursement rates and out-of-network allowed amounts and billed charges?

e. Will your organization have the ability to host the machine-readable files on a public website?

f. Does your organization have an internet-based price comparison tool for plan participants? If so, please describe. If not, will you have a tool by January 1, 2023?

g. Are you able to comply with the annual reporting requirements about health care and prescription drug spending?

h. Mental Health Parity: Will your organization provide a full non-quantitative treatment limitations (NQTL) analysis and document a comparative analysis of the design and application of NQTLs for NDPERS' plans?

i. If there are additional costs for any of the services your organization will provide to assist NDPERS in complying with these regulations they must be listed as “other” fees in the cost template submitted with your proposal. Confirm your understanding of this requirement.

1029. Confirm your ability to conduct annual employer ACA contribution testing to ensure compliance with ACA and that a working paper of testing results will be prepared and shared with NDPERS, and this testing is included in the cost proposal (see Exhibit E22)

1030. Describe your proposed transition plan. At a minimum, the transition plan must address:

a. Conditions or type of care that is typically transitioned;
b. Individuals who are in a course of treatment or have prior authorizations or preapproval with the current vendor;
c. Transition process of current medical treatment;
d. Transition of individuals in disease management programs;
e. Communication of transition issues to all plan members.
f. Member cost sharing and accumulators.
g. Member secondary payer and Coordination Of Benefits information
h. Member Wellness incentive redemptions
i. Identify any costs associated with the transition plan that are not included in the cost proposal

1031. Describe your process for Medicare Secondary Payer administration.

1032. What is your total commercial and Medicare health plan enrollment? Complete the table below.

Dates	Commercial	Medicare
As of January 2019		
As of January 2020		
As of January 2021		

1033. NDPERS is considering offering a Part G look-alike plan in the future. Please provide comment on considerations in making this decision including recommendations on closing the Part F look-alike and migrating participants or continuing to offer the Part G and allowing participants of Part F to elect participation in the Part G. Also provide commentary on allowing new enrollees to enroll in Part F or Part G plan if both remain available.

Eligibility

1034. Are ID paper/electronic cards the sole means of determining member eligibility? If not, please describe.

1035. If desired, can NDPERS update and maintain eligibility and check employee claim status online? Are there any special charges for access to and use of these tools? Please provide a sample ID and link to your site so NDPERS can review your system.

1036. NDPERS will submit enrollments, billing and/or premium remittance via a centralized electronic system. NDPERS will collect enrollment/eligibility information which will be provided to the successful Bidder on a data file that follows the HIPAA 834 file specifications. The indicative data provided on the 834 enrollment/eligibility file is to be loaded onto the successful Bidder’s database and used for ID cards and all transactions/communications related to the member’s participation in the plan. Premium payment information will be provided on a data file that follows the HIPAA 820 file specifications. Files will be transmitted using a secure file transmission process. The successful Bidder must be able to receive this data in that format

and media. Please confirm you agree to allow this and outline any specific requirements you have related to submission of enrollment.

1037. Please describe how you handle manual eligibility updates and the turn-around/timing of such updates.

Customer/Member Service

1038. Confirm if you will provide and maintain customer service staff acceptable to NDPERS. This unit will provide dedicated local and toll-free telephone numbers and shall respond directly to member inquiries regarding benefits, claim status, selecting participating providers, and provide general assistance with navigating on-line and other resources available through the health plan and NDPERS websites. Describe the structure and organization and provide an organizational chart of the unit you are proposing.

1039. Provide information on the operational metrics given to the client related to customer services and how often these are provided.

1040. Confirm the hours/days your customer/member service team is open for operations. How are calls handled that are received after hours (e.g. can member leave a voicemail?)

1041. Does your organization have online support, where a member can chat online with a customer service representative, or email a question to your organization?

1042. Will your organization identify a dedicated customer service/call center for the NDPERS account? If customer service/call center representatives are shared with other clients, on average, how many clients does one team service? What is the average length of service of the representatives?

1043. Does your customer service inquiry system allow representatives to record comments so other customer service representatives can view previous notes to assist members?

1044. What is the location of your call center(s)? What call center(s) would be responsible for servicing NDPERS members?

1045. Describe how you manage spikes in call volume.

1046. How do you ensure that your representatives are providing timely and accurate information?

1047. Provide your customer service goals and actual performance rates for your book of business for 2021 calendar years for the following:

- Abandonment – What was the rate? How is this measured and confirmed? What was the average abandonment time?
- Busy rate – What percent of calls received a busy signal? How is this measured and confirmed?
- Time to answer – What was the average time to answer a call? What percent of calls took longer than 15 seconds to answer? What percent took longer than one minute? On average, what was the maximum wait time to speak with a representative?
- First call resolution –What percent of calls were resolved at first point of contact? How is this measured and confirmed? What percent of calls were resolved with a return call within three days after the initial call?
- Member survey – Provide a copy of member survey responses.

1048. Discuss your online services available to members, including details regarding information available through the portal.

1049. Do you have a mobile app and/or mobile ID card available to your members? Please describe the capabilities.

1050. Could you provide a call center in North Dakota? If so, what would be the additional cost?

Claims Administration

1051. Provide the following information regarding the claims administration unit that will handle the NDPERS account. If there is more than one claims processing location, provide information for each.

	Claims Processing Unit
Address/Location	
Phone Numbers	
Days and Hours of Operation	
Number of Members Serviced	
Number of Employer Groups Serviced	
Ratio of Claims Unit Staff to Members Serviced	
Volume of Claims Processed Daily	

1052. Will your organization identify a dedicated team of claims processors for the NDPERS account? If processors are shared with other clients, on average, how many clients does one team service? What is the average length of service of the claim processors?

1053. Confirm that you are able to administer the NDPERS designs Dakota Plan (Grandfathered and Non-Grandfathered) and Dakota Retiree Plan, HDHP/HSA and benefit levels without manual intervention. If you are unable to administer the plan, you must specify any plan design deviations proposed as specified in the RFP.

1054. Describe your claims processing system/platform and claims administration process. Are you expecting to have any system upgrades over the course of this contract?

1055. How do you determine reasonable and customary ("R&C") charge allowances? What methodology is used (e.g. FAIR, Medicare)? What percentile is used? How often are R&C schedules updated?

1056. Are EOBs provided to each dependent for their services and mailed to the subscriber's address on file unless a request has been made by the dependent for an alternative mailing address?

1057. Are your EOBs customizable for the NDPERS plan?

1058. What is your frequency and method of distribution of EOBs?

1059. Provide information on the operational metrics given to the client related to claims processing and how often these are provided.

Medical Information Technology

1060. Describe your options for external system connectivity and data transfer including web-enabled services/technology.

1061. Describe your privacy protection and data security standards (e.g., HIPAA, PHI). Describe certifications and other external audits. Describe the test criteria used to ensure the standards are met. Can you supply the results? Have you completed external ethical hacking tests?

1062. Are there any major system enhancements or conversions planned or being considered within the next 36 months? How are regulatory items managed in the release process? For packaged applications, what is the process and duration to upgrade a vendor release to the released version? What is the process used to maintain operating systems? What is the potential impact on NDPERS implementation?

1063. Describe your business continuity and disaster recovery plans for internet, eligibility, claims process and information management (data warehouse) systems. As part of the response, highlight any adjustments in the plan according to the magnitude and duration of the disaster (e.g., outages of one day, vs. a week, month, etc.).

1064. Have you had any security breaches involving electronic protected health information or personal financial information? If so, what was the scope of the breach? Were disclosures made to affected individuals? What operations changes, if any, were implemented after the breach? Describe your capabilities to support management of PHI data. Do you have insurance to cover a breach?

1065. Describe your levels of security utilized in the proposed system and how each addresses HIPAA security rules/regulations.

Reporting

1066. Confirm your ability to provide the reports described in the RFP and provide samples.

1067. Describe your online reporting capabilities. Please describe the data/information and types of reports that can be accessed and downloaded from your online system.

1068. Explain your ability to comply with the NDPERS current data warehouse arrangement by providing medical and pharmacy claims and enrollment data to NDPERS in a format agreed upon between you and NDPERS no less than monthly and within 3 months of award of contract.

1069. Please confirm that you will provide a monthly medical file feed, at no cost, to a PERS specified vendor to integrate with pharmacy claims and laboratory data.

1070. If requested, please confirm you will provide complete medical claims data to other authorized third-parties at no cost.

1071. Is your organization able to share information regarding wellness and disease management activities to be used in the data warehouse? If yes, what type of information is available?

1072. Do you participate in the ND Health Information Network (NDHIN) reporting?

Case/Utilization Management

1073. Provide a brief overview of your utilization management programs, including pre-authorization, prior approval, concurrent review, discharge planning, and large case management.

1074. Does your organization offer an advocacy program that members can utilize to help with coordinating/managing a newly diagnosed disease for themselves or another covered member?

1075. What is the source of the criteria used for the following:

a. Determining surgical necessity and whether a second opinion is required.
b. Determining approved length of stay.
c. What percentile of the data is used?
d. Approximately what percentages of review cases are referred to a physician because the initial review and attending physician cannot reach agreement on the proposed level of care?
e. Does this percentage vary between medical/surgical and psychiatric/substance abuse cases? If so, provide variances.

1076. What is the process for identifying members for large case management and how are claims transferred to case managers?

a. What are the automatic and manual triggers to identify cases for large case management?

b. How do you ensure that large cases are appropriately managed?

c. How do you calculate case management savings?

d. How do you work with medical group and hospital staff in the case management function?

Health Risk Management Programs

1077. Indicate in the table below if you currently provide the care or disease management program listed, the number of members from ND-based employers currently enrolled, the cost per participant, and its accreditation status.

	Program	Number of Members Enrolled (ND)	Is Cost Included in Proposal? (Y/N)	Cost if Not Included (PMPM)	Accredited? If so, indicate accrediting organization.
☐	Arthritis				
☐	Asthma				
☐	Cancer				
☐	Congestive Heart Failure				
☐	COPD				
☐	Depression				
☐	Diabetes				
☐	Low Back Pain				
☐	Stress				
☐	High Risk Pregnancy/ Prenatal Support				
☐	Hypercholesterolemia				
☐	Pain Management				
☐	Renal Failure				
☐	Tobacco Cessation				
☐	Weight Management				
☐	Other, please indicate:				

1078. Briefly describe each of the programs currently offered, if it is included in your cost proposal, and, if not, the cost of adding each program not included. Do you currently track and report specific clinical outcome measurements for each of the conditions for which care/disease management is offered? Please list them.

1079. Are you willing to customize your care management/DM programs and services for NDPERS? If so, please explain and provide an example of a program you developed and utilized with another client. Include any ROI or outcome data that was measured on the effectiveness of the program

1080. Describe how you coordinate members involved in more than one program, for example members with diabetes and chronic heart failure.

1081. Describe the programs offered to patients with rare and chronic diseases. Is this program outsourced? Who is the current vendor?

1082. What is your organization doing to identify and reduce health outcome disparities by race, ethnicity, or other social determinants of health?

1083. Describe in detail your ability to provide online wellness programs. Compare it to the existing program presently in the NDPERS program (see Exhibit 1). Specifically identify any deviations from the existing program. Include any future enhancements that are planned, including planned date for roll-out of the new feature.Describe Wellness incentives you offer. Compare and contrast that with the existing incentives. (see Exhibits 1 & 2).

1084. Describe your ability to support NDPERS Wellness initiatives by providing the administrative services for:

a. Tobacco Cessation program
b. NDPERS Diabetes Program (About the Patient Program coordinated with the ND Pharmacy Assoc.)
c. Dedicated Wellness Program Consultant and Educators
d. Healthy Pregnancy program
e. New programs or mandates
f. Diabetes Prevention Program
g. $250 Wellness Incentive with required tax reporting to employers

1085. Describe your ability to support the employer-based wellness program and the wellness benefit funding program. https://ndpers.nd.gov/employers/employer-resources/employer-based-wellness/

Network Accessibility and Disruption

1086. We are requesting that Bidders provide a GeoAccess network accessibility and disruption analysis in Appendix E1. If you are proposing a combination of owned and leased networks, please provide your results separately by network. This GeoAccess analysis must be provided for your proposed NDPERS network(s).

1087. Provide a listing or provider directory and link to the web for the provider networks you are proposing for NDPERS. Identify and describe your national preferred provider organization.

1088. Does your network exclude any major health systems or provider practices in North Dakota?

1089. Describe how an employee or dependent that requires care while outside of North Dakota will be provided services. Example: a dependent who requires care over an extended period while away from home (e.g. student attending college). Do you have “guest” or “visitor” status programs for people who are temporarily domiciled outside of the service area?

1090. Confirm your willingness to negotiate and maintain NDPERS-specific provider contracts to allow for cost control mechanisms and alignment of contract and plan years. Also discuss how

you would maintain the existing PERS PPO program. Describe your process and approach for accomplishing this.

1091. Does your organization offer telehealth services beyond those required in North Dakota statute? If so, please describe the network available, how services are billed, and provide general overview of program.

1092. Does your organization offer any narrow or tiered networks? If so, please describe these network options including level of discount differences between the option and your traditional network.

1093. Do you anticipate any significant provider contract changes for 2023? Describe any expected changes.

1094. Complete the table below by type of behavior health specialist.

Behavioral Health Network	Mental Health Providers	Chemical Health Providers
A. Percent of NDPERS population within 30 minutes or 30 miles of a specialist		
B. Percent of providers accepting new patients		
C. Average wait time to secure an appointment		

1095. What strategies do you have in place to improve accessibility to licensed mental health providers?

1096. How many of your network providers specialize in working with first responders, law enforcement, and corrections staff?

1097. How many of your providers are self-identified as black, indigenous and people of color (BIPOC)?

1098. Please describe your telehealth services as it pertains to mental and chemical health?

a. Have your telehealth services expanded as a result of the pandemic? If so, will the changes be permanent?

b. Please describe how telehealth visits are reimbursed to providers, are reimbursements equal to regular office visits?

Cost, Quality, and Pay for Performance

1099. Describe the programs and methodologies currently in place to gather and measure meaningful provider quality and efficiency data that can be shared with members.

1100. Describe any online transparency tools you have available that members can access to view quality and/or cost information on your network providers. Provide access to this site. How updated is the information on the site?

1101. Describe in detail the performance standards you currently have in place with your contracted physicians, provider groups, hospitals, and other providers. Outline the types of measures

utilized, how you monitor and track these measures, how providers are held accountable, and how frequently the data is compiled and shared with the physicians and provider groups.

1102. Describe your participation in pay-for-performance initiatives. To what extent do these activities impact the health care costs of NDPERS or claims incurred by its covered population? What percentage of your contracts are pay-for-performance? How is this likely to change in the next 2-3 years?

Credentialing and Contracting

1103. Briefly describe the initial credentialing process. How often are physician, hospital and other contracts (labs, imaging facilities, DME, home health care) reviewed?

Reimbursement and Discounts

1104. Provide the reimbursement methodologies (by percentage) agreed to in your contractual arrangements to reimburse inpatient and outpatient hospital services (e.g., discount from charges, case rate, per diem, global DRG, fee schedule, etc.).

1105. Provide the reimbursement methodologies (by percentage) used to reimburse professional services (e.g., fee-for-service from billed charges, fee-for-service with discount, percent of RBRVS, capitation).

1106. How often are your R&C databases updated? What data version of UCR are you using?

1107. Do you negotiate discounts with non-network providers on a case-by-case basis? Please describe your negotiation process (including criteria used to determine when this will be done.) Do you charge for these special negotiations? If so, how is that charge assessed to NDPERS?

1108. If a network physician directs a member to a non-network lab for services, how is that lab service paid?

1109. If certain specialties (e.g. radiology or anesthesiology) or services (e.g. ambulance) are not represented in your network of providers, do you have the ability to pay these services as in-network if they were completed at an in-network facility?

1110. Provide your estimate of percent of charges that will be processed in North Dakota under your network.

1111. NDPERS presently has a value-based contract in place with certain providers in North Dakota. See Exhibit E27. Discuss your ability to offer the same or similar program. Identify if any additional cost would be required for such an option

1112. Provide details on any recent, upcoming or anticipated changes to the risk-based contracting profile of your network (e.g. ACOs, innovative contracts, changes to the level of provider risk, etc.)

Performance Standards and Guarantees

Health plan Bidders are required to comply with performance standards and guarantees that include a financial incentive/forfeiture which is negotiated as part of the renewal process. See Appendix H for a copy of these performance standards and guarantees. You are required to offer your performance standards and guarantees for the board's consideration using Appendix H. It is a priority for the Board to have a comprehensive set of standards and guarantees relating to this plan.

1113. Please confirm you have completed Appendix H and confirm your willingness to comply with the performance standards and guarantees or provide suitable alternatives. Identify your process for measurement and audit availability. Identify any additional standards and metrics your organization would be willing to include.

HDHP/HSA

1114. Describe how your organization will administer the HSA option. What details are provided to individuals that select this option, the enrollment process, claim reimbursement options, limit monitoring, ability to accept employee pre- & post-tax contributions, record-keeping, fees, reporting capabilities, the name of the service vendor and any other applicable information.

Economy to be Affected

1115. Please indicate if you will have an office in North Dakota and where most of the work on this contract will be done?

1116. Please identify the number of employees you will employ in North Dakota pursuant to this contract.

1117. Of your total administrative fee please estimate the amount that will be spent in North Dakota and the amount that will spent outside the state.

Fiduciary Responsibility

1118. Confirm your organization will assume full fiduciary responsibility for claim determination.

Appeals Process

1119. Please describe your internal and external appeals process for fully-insured plans.

Actuarial Services

1120. As part of the fully insured contract PERS is asking that the Bidders actuary will do certain actuarial work for the Board. Confirm your ability to provide these services and that they are included in the cost proposal:

a. Develop estimates of the cost of adding/deleting benefit provisions to the plan
b. Provide PERS estimates of potential premium cost for 2023-2025 in the first half of 2022
c. Provide PERS actuary with actuarial analyses of proposed legislation and plan design changes.
d. Actuarial services NDPERS may request.

Pharmacy Benefit Management

If you are proposing fully insured medical with prescription drug coverage, the following section of this questionnaire (below) must be completed. If you are submitting a fully insured medical only bid these questions do not need to be answered.

The responses of this questionnaire should be based on the organization or operations that will administer the pharmacy benefits for eligible NDPERS employees and dependents.

Compliance with North Dakota Statutory Requirements

1121. Indicate you will comply with all the requirements of North Dakota Century Code, including chapter 54-52.1

1122. Indicate if you could comply with the preference criteria in 54-52.1-04.15.

1123. Indicate if your proposal includes:

a. Compliance with 54-52.1-04.16
b. Does not include compliance 54-52.1-04.16
c. Includes both

1124. Indicate any areas of the North Dakota Century Code you cannot meet and why.

Pharmacy Benefit Management Organization General Information

1125. Please provide the legal name of the company that will be providing the pharmacy benefit management (PBM) services in this contract.

1126. Please describe the PBM's corporate governance structure.

1127. Where is the PBM headquartered?

1128. Does the PBM contract supporting the fully-insured contract expire during the course of the NDPERS biennium (2023 – 2025)?

1129. What unique and differentiated capabilities does the PBM offer to NDPERS?

Pharmacy Benefit Clinical Management

1130. Please describe your approach to clinical management in the pharmacy benefit.

1131. Please provide a list of your clinical programs with a short description of each, and associated cost for each program. At minimum, please include prior authorization, step therapy, quantity limits, drug utilization review, opioid management, diabetes management, compound management, and specialty drug management programs. If applicable, please include return-on-investment guarantees or measurement metrics for each program

1132. Based on the plan design currently in place, the drug utilization, and the demographics, what are three specific recommendations to reduce cost and/or improve the health of NDPERS members (without changing plan design elements like copays)?

1133. Please describe the accreditations you maintain (URAC, JCAHO, NCQA)

1134. Please describe your capabilities of combining pharmacy data with medical data for individual members to coordinate care, case management, and utilization oversight..

1135. Please describe your Pharmacy & Therapeutics Committee (P&T) and the formulary review process.

1136. Please describe your approach or solutions to manage compound medications. Please note if you have a dollar threshold for prior authorization, exclusion strategy, or another approach.

1137. Please describe your COVID testing and vaccine administration programs

1138. Please describe your capabilities to track and report on COVID testing and vaccine claims

1139. Please discuss how you measure adherence; do you track medication possession ratio (MPR) and/or proportion of days covered (PDC)? Are there other factors you evaluate for certain therapeutic classes?

1140. Do you align your performance measurement with national quality measures (e.g. HEDIS)?

1141. What tools and programs do you utilize to shift percent of membership toward formulary and preferred/generic drugs?

1142. Provide a description of your prior authorization process, including type of personnel involved in the process and average turnaround time.

1143. Do clients have access to your system to enter administrative prior authorization overrides?

a. How does the process work?

b. Is training provided?

c. Will your client be able to report on volume of overrides and outcomes determination?

1144. Describe your quality assurance measures for your prior authorization process. What reports and tools do you provide for clients to assess if state/federal/NCQA quality measures (e.g. timeliness, overturn rates, accreditation) are met?

1145. Explain your process around instances when your prior authorization team cannot immediately contact the provider (i.e., how often do you attempt to contact the provider, what methods do you use to contact the provider, what do you do when you get no response).

1146. Please describe how members are notified of denials and expiration of prior authorizations.

1147. Describe all programs related to identification and management of potential abuse by members, providers and pharmacies.

1148. Please provide a list of real-time utilization (concurrent) review elements at retail and mail. How are interventions managed? How are outcomes of interventions documented?

1149. Does your Retrospective Drug Utilization Review (RDUR) Program target physicians and members? How do you notify physicians and members?

1150. Please provide a list of RDUR edits. What is the timeframe for intervention? Is the intervention automated? Fax? Is there a survey collected to assess the usefulness of the intervention? Are responses charted to provide auditable savings results?

1151. Do you work with any electronic medical record (EMR) companies to provide prescription drug information to prescribers?

1152. Are you capable of receiving data and integrating it from an EMR?

1153. Do you have a preferred partner for electronic prior authorization and eligibility/formulary verification?

1154. What percentage of claims in your book-of-business are e-prescribed?

1155. Please provide sample reports that document savings of clinical programs (case management, disease management, utilization review, etc.) that NDPERS will be receiving monthly, quarterly, etc.

Specialty Pharmacy

1156. How many specialty pharmacies do you operate?

1157. Are your specialty pharmacies owned or subcontracted?

1158. Which specialty pharmacy would primarily service the NDPERS account?

1159. Is the proposed specialty network an open network (where members can use any specialty pharmacy) or closed network (members may only use Bidder's network)?

1160. Please describe your approach to specialty pharmacy. Please focus on the aspects that differentiate your services in the market.

1161. Are members contacted before each specialty fill? If so, is the outbound call made by a representative or an automated call?

1162. What is the average length of time spent with a member prior to the first fill of their specialty medication?

1163. Do you have pharmacists and technicians that are dedicated to serving members with certain disease states?

1164. Please describe any specialty patient assistance programs that are offered. Describe how you can maximize the value of these programs for the member and the plan.

1165. For any specialty patient assistance programs, describe if your programs are income based and/or rebate compliant?

1166. Please describe your strategy (formulary or more broadly), and how you engage your self-insured clients on coverage decisions related to high-cost therapies (e.g., CAR-T, Zolgensma)

1167. Please describe specialty site-of-care programs or initiatives or partnerships.

1168. Please describe solutions available to address rising costs of prescription drugs in the medical benefit?

1169. Please confirm that specialty products shipped in error, damaged in shipment, lost in transit, left by courier without confirmation of receipt and rendered unusable by NDPERS to due negligence or error in delivery process will not be the financial responsibility to NDPERS. How are these types of shipment error reported to NDPERS?

1170. Describe your specialty drug trend forecasting services. For example, how is the specialty drug pipeline monitored and what modeling tools are available to demonstrate the financial impact to the Client?

1171. What percentage of Limited Distribution Drugs commercially available do you have access to?

1172. What is the process for procuring any limited distribution drugs that you currently do not have access to?

1173. Do you have infusion services? Can you arrange for nurses or other assistance on behalf of the member?

Formulary

NDPERS formulary has three coverage tiers. Tier 1 includes formulary generic drugs, Tier 2 includes formulary brand drugs, and Tier 3 includes all non-formulary products. Please provide a quote based on your formulary that best aligns with NDPERS current structure.

1174. Please indicate which formulary is being proposed for NDPERS, and why?

1175. If your proposed formulary is exclusionary, how many products are excluded?

1176. How frequently is your proposed formulary updated?

1177. If desired, could you grandfather existing members for a select period of time (1-3 fills, 1 year, indefinitely)?

1178. Does the proposed formulary require compliance with formulary utilization management controls (prior authorization and/or step therapy and/or quantity limits) or are all formulary and clinical utilization management programs an "add on" after the formulary is selected

1179. Does your formulary include all generics in the lowest cost tier and all brands in the preferred or non-preferred tiers or does your proposed formulary tier brand and generic products according to different criteria?

1180. Please discuss your position regarding "lowest net cost" as it relates to your formulary strategy and your flexibility in facilitating a “lowest net cost” strategy for clients.

1181. Please provide a copy of your proposed Formulary including National Drug Code (NDC), drug name, and formulary tier in excel format

1182. Complete Appendix E2 – Network Access & Formulary Match

Data Analytics & Management Reporting

1183. Describe data analytic and reporting capabilities currently available.

1184. Is there an extra charge for data analytic services? If so, what are the charges?

1185. Describe or provide samples of standard reports around cost and utilization for the plan and its customers.

1186. Please confirm that you will provide a monthly prescription drug file feed, at no cost, to a PERS specified vendor to integrate with medical claims and laboratory data.

1187. If requested, please confirm you will provide complete pharmacy claims data to other authorized third-parties at no cost.

Customer Service

Please answer the following if the customer service operations are different than the customer service operations for the medical segment of the business, including, but not limited to.

1188. What is the location of the PBM call center(s)?

1189. What call center(s) would be responsible for servicing NDPERS members?

1190. Describe your use of Interactive Voice Response (IVR).

1191. Will the PBM have a dedicated phone number for NDPERS?

1192. Is the pharmacy call center available to members 24/7/365?

1193. Is a pharmacist available to members 24/7/365?

1194. Can a member leave a message at the member service line after hours? If so, what is the protocol for responding to this message?

1195. What is your first call resolution rate in the pharmacy call center?

1196. Do you have the capability to record 100% of the calls?

1197. Does your call monitoring application also provide for monitoring of screen navigation as well as call recording?

1198. Does your customer service inquiry system allow representatives to record comments so other customer service representatives can view previous notes to assist members?

1199. Describe in detail the training and qualifications of the customer service representatives. How will they be trained and educated on NDPERS specifics and new initiatives?

1200. How will you assist with notifying members when the formulary status of medication has changed?

1201. Do you track Net Promoter Score (NPS)? If so, please provide the most recent NPS and describe if it applies to specific business segments (e.g. customer service).

1202. How do you define / track member complaints and/or grievances?

1203. How do you report the complaints and grievances?

a. What are your turnaround times? Describe your workflow process.

b. How are complaints/grievances tracked by reason code?

c. Do you maintain a complaint log? Describe your complaint resolution process.

1204. Will the appeal process for pharmacy service be different than for medical services: If so describe the appeal process. Provide materials used for member, physician, and pharmacy notification and provide your workflow process including turnaround times. How do you manage the process differently for states with unique requirements?

1205. Describe how written inquiries are handled.

1206. Please describe your member website and member portal.

a. Can your website provide NDPERS specific plan information?

b. Does your website offer a pharmacy locator? Does the site offer information on retail stores that are open 24 hours/day?

c. Can members see their prescription drug claim history on the website?

d. Describe the web-enabled pricing comparison tools available to your members. Will the pricing tool account for NDPERS plan design?

e. Does your web-enabled pricing comparison tool provide pricing detail by pharmacy?

1207. Does your mobile app and/or mobile enabled website include the following:

a. Formulary information

b. Network pharmacy lookup

c. Plan design information

d. Member ID card

e. Claims history

f. Family claims history

g. Drug price lookup by pharmacy

Retail Pharmacy Network

1208. Please describe your retail pharmacy network strategy and how it is differentiated from competitors.

1209. List the name of your proposed network and the number of retail pharmacies that participate in North Dakota and nationally.

1210. Based on the member zip data in Exhibit E9, please submit a Geo-Access analysis.

1211. Please describe your credentialing process including the process for removing pharmacies from the network. How often is credentialing/re-credentialing undertaken?

1212. Describe your 90-day retail network (including % of ND pharmacies in-network) and potential cost savings to NDPERS.

Mail Service

1213. How many mail service pharmacies do you operate?

1214. Where are your mail pharmacies located? Which mail service pharmacy would primarily service the NDPERS account?

1215. Are your mail service pharmacies owned or subcontracted?

1216. Do you have a program at the mail facility to align and bundle shipment for members with more than one prescription?

1217. How do you assure patient consent to send an order prior to shipping?

1218. Are there any items/medications you do not ship (e.g. controlled substances)?

1219. What company or companies do you have shipping contracts with for the mail service?

1220. Can members track their mail order prescription?

1221. Can you deliver mail or specialty medications to the member's location of choice (e.g. home address, office, doctor's office, hospital, pharmacy, neighbor's address)?

1222. How long will you hold a prescription that requires an intervention before returning, filling, or calling members?

1223. Do you retain member credit cards? If so, what security measure do you employ to protect this information?

1224. Is payment required before orders are shipped? If not, what is the maximum outstanding balance owed before you hold orders?

1225. Do you provide Durable Medical Equipment items through the mail pharmacy?

1226. Are you willing to agree that medications shipped in error, damaged in shipment, lost in transit, left by courier without confirmation of receipt when requested, and rendered unusable by NDPERS due to negligence or error in delivery process will not be the financial burden to NDPERS or our patients? How are these types of shipping errors reported to NDPERS?

Eligibility

1227. Please describe any differences in eligibility management for the prescription drug benefit compared to the medical benefit.

Regulatory and Compliance

1228. Please detail your due diligence process used in retaining the proposed PBM. Including but not limited to: review of any outstanding disputes, that the PBM is fully licensed, complaints from providers and covered members, fines, integrity of data systems, any data breaches, lawsuits, etc.

1229. Please provide the latest SOC2 report for the PBM providing pharmacy services under this agreement.

Implementation

1230. Pharmacy related implementation detail should be included in the medical section of your response

Appendix C2. Self-Insured Medical Questionnaire

This questionnaire must be completed if your organization is proposing self-insured medical plan administration for NDPERS.

To be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. Include both the question and the answer in your proposal response. An electronic copy of this questionnaire has been provided to facilitate your response.

Reference should not be made to a prior response unless the question involved specifically provides such an option. Proposers should refer to the earlier sections of this RFP before responding to any of the questions, to ensure that you have a complete understanding of the requirements with respect to your organization's proposal. Proposers may include additional information that you consider relevant or useful to NDPERS. If you elect to provide additional information on services in response to a question please specifically indicate that it is not included in the covered services offered in your proposal. If not indicated those services will be considered to be a part of your proposed fees. However, responses to all of the questions set forth below must be provided.

If this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated and executed, any such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal. Vendors are reminded that **any and all deviations must be clearly identified and described in the RFP and the deviations worksheet provided in Appendix F.**

The questionnaire is broken down into the following categories:

General and Medical

- Organizational Background, Strength, and Experience
- References
- Implementation and Account Management
- Communications and Website
- Plan Administration
- Eligibility
- Customer/Member Service
- Claims Administration
- Medical Information Technology
- Reporting
- Case/Utilization Management
- Health Risk Management Programs
- Network Accessibility and Disruption
- Cost, Quality, and Pay for Performance
- Credentialing and Contracting
- Reimbursements and Discounts
- Performance Standards and Guarantees
- HDHP/HSA
- Economy to be affected
- Fiduciary Responsibility
- Appeals Process
- Regulatory / Compliance
- Confidentiality
- Lawsuits/Claims
- Related Party Issues
- Discussion of Information Used to Manage Business

- Controls / Compliance
- Risk Management and Insurance Information

Organizational Background, Strength, and Experience

2001. Provide a brief description of your organization, including your company history, organizational structure, services provided, location of headquarters, and length of time you have been in business. Describe any significant historical or future organizational developments (acquisitions, mergers, change in subcontracted vendors, etc.).

2002. Vendors responding to this RFP must be able to substantiate their financial stability. Provide a copy of your audited financial statement or other financial information. Include, at a minimum, a Balance Sheet and a Profit and Loss Statement, together with the name and address of the bank(s) with which you conduct business and the public accounting firm(s) that audit your financial statements. Other sufficient information may include a written statement from a financial institution confirming the creditworthiness and financial stability of the vendor.

2003. Provide a copy of any State or Federal regulatory audit performed within the last two years.

2004. Confirm that your organization agrees to be accountable for everything stated in and submitted as part of your proposal, even if not specifically addressed in the Minimum Contract Provisions in Appendix B

2005. Indicate if your organization has been a party to litigation regarding a medical benefit plan contract or data security breach over the prior five years or at present. If so, provide details of the litigation or action. Failure to disclose this may constitute grounds for rejection of any proposal or termination of any contract.

2006. State whether the vendor, its officers, agents or employees, who are expected to perform services under the NDPERS contract, have been disciplined, admonished, warned, or had a license, registration, charter, certification, or any similar authorization to do business suspended or revoked for any reason.

2007. Include a description of your organization's major short-term strategic initiatives and your long term strategic business plan. Specifically address cost containment efforts, providing specific examples of how you have made changes that resulted in savings for your clients.

2008. Describe how your organization differentiates itself from your competitors. Specifically, what makes your organization the best partner for NDPERS?

2009. Identify all services that are currently outsourced or subcontracted, the name of the vendor/partner, and length of the relationship and the nature of the long-term partnership (e.g.: are the contracts expected to expire during the course of this contract). Describe how you ensure quality customer service and timely and effective issue resolution.

2010. What ratings have you received from the following third-party rating companies and organizations?

Rating Organization	Rating	Date of Last Accreditation / Rating
A.M. Best		
Standard & Poor's		
Moody's		

2011. Are any of the services you are proposing to provide to NDPERS contracted outside the U.S.A? Describe any business you do outside the U.S.A. and the financial impact, if any, of requiring those services to be provided within the U.S.A.

2012. Confirm that your proposal includes any and all deviations to the Sample Contract/ASA and other RFP requirements (via submission of Appendix E3).

2013. Has your company been involved in any mergers or acquisitions in the prior 24 months? If so, how will those events impact NDPERS?

References

2014. Provide the following information on a maximum of three (3) of your largest plan clients for whom you provide services similar to those proposed in this proposal. References of similar size and scope to NDPERS are preferred; one must be your largest public sector client and one must be your largest North Dakota-based client.

a. Name of employer sponsoring plan and location
b. Type of services provided to plan sponsor
c. Plan inception date
d. Length of time as client
e. Number of contracts and members participating in the plan
f. Contact information (name, title, phone number, email address)

2015. Provide the following information for two (2) of your largest clients that have terminated services during the preceding 3-year period. References of similar size and scope to NDPERS are preferred.

a. Name of employer sponsoring plan and location
b. Type of services provided to plan sponsor
c. Plan inception date
d. Length of time as client
e. Number of contracts and members participating in the plan
f. Reason for termination
g. Contact information (name, title, phone number, email address)

Implementation and Account Management

2016. Vendors must outline in detail the specific activities and tasks necessary to implement the NDPERS program. Be specific with regard to the following:

a. Amount of total time needed to effectively implement the program
b. Activities/tasks and corresponding timing (Detailed Timeline)
c. Responsible parties and amount of time dedicated to implementation, broken out by vendor, current vendor and NDPERS staff
d. Any transition activities required with incumbent carriers, including data transfers and providing members adequate notice regarding current care or treatment plans at least 60 days prior to a change
e. Length of time implementation team lead and members will be available to NDPERS

2017. Provide an overview of how the NDPERS relationship will be managed, both strategically and on a day-to-day basis. Include an organizational chart. Designate the names, titles, location, telephone numbers, and email addresses for the representatives listed below. For the account service individuals listed (b, c, d, and e below), provide brief biographical information, such as years of service with your company, experience as it relates to this proposal, and the number of clients for which they perform similar services.

a. The key individual representing your company during the proposal process;
b. The key individuals on your proposed implementation team;
c. The key individual assigned to overall contract management;
d. The key dedicated individual or team members responsible for day-to-day account management and service;
e. The key individual responsible for provider contracting; and
f. The key individual responsible for provider relations if different than letter e. above.
g. Medical and/or pharmacy director assigned to NDPERS (as applicable)

2018. Please provide your most recent customer experience survey results.

2019. Please provide the requested information for the functions that will be servicing NDPERS in the table below:

Area	Geographical Location(s) and Organization Name (if out-sourced)	Hours of Operation (Specify PST/CST/EST)	Is this service Outsourced? Yes or No? *If Yes, provide name of company to which the function is outsourced*
Member Service			❑ Yes *Specify Company Name:* _____ ❑ No
Claims Processing			❑ Yes *Specify Company Name:* _____ ❑ No
Enrollment and Eligibility			❑ Yes *Specify Company Name:* _____ ❑ No
Disease Management			❑ Yes *Specify Company Name:* _____ ❑ No

Area	Geographical Location(s) and Organization Name (if out-sourced)	Hours of Operation (Specify PST/CST/EST)	Is this service Outsourced? Yes or No? *If Yes, provide name of company to which the function is outsourced*
Case and Utilization Management			❑ Yes *Specify Company Name:* _____ ❑ No
Health, Education and Wellness Programs/Services (including dedicated wellness support staff)			❑ Yes *Specify Company Name:* _____ ❑ No
HSA			❑ Yes *Specify Company Name:* _____ ❑ No
Pharmacy Benefits Management			❑ Yes *Specify Company Name:* _____ ❑ No
Other (Specify functional area)			❑ Yes *Specify Company Name:* _____ ❑ No

Communications and Website

2020. Are you willing to provide communication and marketing resources to work with NDPERS in the development of NDPERS-specific member communication materials (educational, open enrollment, benefit plan related, ongoing communications)? Describe the resources, sample communications, and your proposed approach and strategy/plan.

2021. How much lead time is necessary for you to guarantee that ID cards will be received by members prior to the plan year effective date of July 1, 2023?

2022. Describe how you handle communications for the post-65 programs that you will offer to NDPERS retirees.

2023. What reading grade level are your written and website communications written to? Are other languages available? What customization is allowed related to member communications?

2024. Does your website provide NDPERS specific plan information?

2025. Does your website offer a provider locator? What additional information does your site provide?

2026. Describe any additional web-based capabilities that could benefit NDPERS and our members.

Plan Administration

2027. Confirm that you will communicate legislative changes related to the operations of the plan in a timely manner, and describe the support staff and process. Provide examples of materials you have used in the past to educate your clients on legislative changes/updates.

2028. What support will your organization provide NDPERS to comply with the obligations of the CAA, Transparency in Coverage rules, and Mental Health Parity rules? Provide responses to the following questions and include information regarding additional compliance items required by these rules and regulations not specifically listed.

a. Are your claim systems and operational processes prepared to comply with the No Surprises Act effective as of January 1, 2022? Please describe how your organization will prevent Surprise Balance Billing.

b. Are you prepared to comply with provider directory accuracy requirements (if there is a network directory error and a plan participant uses an out-of-network provider they believe to be in-network, the cost-share cannot be more than in-network amount)?

c. Are you able to comply with member ID card requirements that include deductibles and out-of-pocket maximums for in-network and out-of-network coverage?

d. Will your organization, on behalf of NDPERS, create and provide machine readable files of in-network reimbursement rates and out-of-network allowed amounts and billed charges?

e. Will your organization have the ability to host the machine readable files on a public website?

f. Does your organization have an internet-based price comparison tool for plan participants? If so, please describe. If not, will you have a tool by January 1, 2023?

g. Are you able to comply with the annual reporting requirements about health care and prescription drug spending?

h. Mental Health Parity: Will your organization provide a full non-quantitative treatment limitations (NQTL) analysis and document a comparative analysis of the design and application of NQTLs for NDPERS' plans?

i. If there are additional costs for any of the services your organization will provide to assist NDPERS in complying with these regulations they must be listed as "other" fees in the cost template submitted with your proposal. Confirm your understanding of this requirement

2029. Confirm your ability to conduct annual employer ACA contribution testing to ensure compliance with ACA and that a working paper of testing results will be prepared and shared with NDPERS and this testing is included in the cost proposal (see Exhibit 22).

2030. Describe your proposed transition plan. At a minimum, the transition plan must address:

a. Conditions or type of care that is typically transitioned;
b. Individuals who are in a course of treatment or have prior authorizations or preapproval with the current vendor;
c. Transition process of current medical treatment;
d. Transition of individuals in disease management programs;
e. Communication of transition issues to all plan members.
f. Member cost sharing and accumulators.
g. Member secondary payer and Coordination Of Benefits information
h. Member Wellness incentive redemptions
i. Identify any costs associated with the transition plan that are not included in the cost proposal.

2031. Describe your process for Medicare Secondary Payer administration including but not limited to: Roles and responsibility of the vendor and PERS; identifying and recovering Medicare mistaken payments where PERS has primary responsibility, receiving payment and resolving outstanding issues, etc.

2032. What is your total commercial and Medicare health plan enrollment? Complete the table below.

Dates	Commercial	Medicare
As of January, 2019		
As of January, 2020		
As of January, 2021		

2033. Please describe your standard (or proposed) financial arrangements with NDPERS under a self-funded arrangement including but not limited to: account requirements and process for claim payment, frequency of reimbursement to the administrator for claims paid, methodology for funds transfers, required reserves in claim account, etc.

Eligibility

2034. Are ID paper/electronic cards the sole means of determining member eligibility? If not, please describe.

2035. If desired, can NDPERS update and maintain eligibility and check employee claim status online? Are there any special charges for access to and use of these tools? Please provide a sample ID and link to your site so NDPERS can review your system.

2036. NDPERS will submit enrollments via a centralized electronic system. NDPERS will collect enrollment/eligibility information which will be provided to the successful vendor on a data file that follows the HIPAA 834 file specifications. The indicative data provided on the 834 enrollment/eligibility file is to be loaded onto the successful vendor's data base and used for ID cards and all transactions/communications related to the member's participation in the plan. Files will be transmitted using a secure file transmission process. The successful vendor must be able to receive this data in that format and media. Please confirm you agree to allow this and outline any specific requirements you have related to submission of enrollment.

2037. Please describe how you handle manual eligibility updates and the turn-around/timing of such updates.

Customer/Member Service

2038. Confirm if you will provide and maintain customer service staff acceptable to NDPERS. This unit will provide dedicated local and toll-free telephone numbers and shall respond directly to member inquiries regarding benefits, claim status, selecting participating providers, and provide general assistance with navigating on-line and other resources available through the health plan and NDPERS websites. Describe the structure and organization and provide an organizational chart of the unit you are proposing.

2039. Provide information on the operational metrics given to the client related to customer services and how often these are provided.

2040. Confirm the hours/days your customer/member service team is open for operations. How are calls handled that are received after hours (e.g. can member leave a voicemail?)

2041. Does your organization have online support, where a member can chat online with a customer service representative, or email a question to your organization?

2042. Will your organization identify a dedicated customer service/call center for the NDPERS account? If customer service/call center representatives are shared with other clients, on average, how many clients does one team service? What is the average length of service of the representatives?

2043. Does your customer service inquiry system allow representatives to record comments so other customer service representatives can view previous notes to assist members?

2044. What is the location of your call center(s)? What call center(s) would be responsible for servicing NDPERS members? Could you provide a call center in ND? If so what would be the additional cost?

2045. Describe how you manage spikes in call volume.

2046. How do you ensure that your representatives are providing timely and accurate information?

2047. Provide your customer service goals and actual performance rates for your book of business for calendar year 2021,2020 and 2019 for the following:

- Abandonment – What was the rate? How is this measured and confirmed? What was the average abandonment time?
- Busy rate – What percent of calls received a busy signal? How is this measured and confirmed?
- Time to answer – What was the average time to answer a call? What percent of calls took longer than 15 seconds to answer? What percent took longer than one minute? On average, what was the maximum wait time to speak with a representative?
- First call resolution – How is this measured and confirmed? What percent of calls were resolved at first point of contact? What percent of calls were resolved with a return call within three days after the initial call?
- Member survey – Provide a copy of member survey responses.

2048. Discuss your online services available to members, including details regarding information available through the portal.

2049. Do you have a mobile app and/or mobile ID card available to your members? Please describe the capabilities.

2050. Could you provide a call center in North Dakota? If so, what would be the additional cost?

Claims Administration

2051. Provide the following information regarding the claims administration unit that will handle the NDPERS account. If there is more than one claims processing location, provide information for each.

	Claims Processing Unit
Address/Location	
Phone Numbers	
Days and Hours of Operation	
Number of Members Serviced	
Number of Employer Groups Serviced	
Ratio of Claims Unit Staff to Members Serviced	
Volume of Claims Processed Daily	

2052. Will your organization identify a dedicated team of claims processors for the NDPERS account? If processors are shared with other clients, on average, how many clients does one team service? What is the average length of service of the claim processors?

2053. Confirm that you are able to administer the NDPERS designs Dakota Plan (Grandfathered and Non-Grandfathered) and Dakota Retiree Plan, (HDHP/HSA) and benefit levels without manual intervention. If you are unable to administer the plan, you must specify any plan design deviations proposed as specified in the RFP.

2054. Describe your claims processing system/platform and claims administration process. Are you expecting to have any system upgrades over the course of this contract?

2055. How do you determine reasonable and customary ("R&C") charge allowances? What methodology is used (e.g. FAIR, Medicare)? What percentile is used? How often are R&C schedules updated?

2056. Are EOBs provided to each dependent for their services and mailed to the subscriber's address on file unless a request has been made by the dependent for an alternative mailing address?

2057. Are your EOBs customizable for the NDPERS plan?

2058. What is your frequency and method of distribution of EOBs?

2059. Provide information on the operational metrics given to the client related to claims processing and how often these are provided.

Medical Information Technology

2060. Describe your options for external system connectivity and data transfer including web enabled services/technology.

2061. Describe your privacy protection and data security standards (e.g., HIPAA, PHI). Describe certifications and other external audits. Describe the test criteria used to ensure the standards are met. Can you supply the results? Have you completed external ethical hacking tests?

2062. Are there any major system enhancements or conversions planned or being considered within the next 36 months? How are regulatory items managed in the release process? For packaged applications, what is the process and duration to upgrade a vendor release to the released version? What is the process used to maintain operating systems? What is the potential impact on NDPERS implementation?

2063. Describe your business continuity and disaster recovery plans for internet, eligibility, claims process and information management (data warehouse) systems. As part of the response, highlight any adjustments in the plan according to the magnitude and duration of the disaster (e.g., outages of one day, vs. a week, month, etc.).

2064. Have you had any security breaches involving electronic protected health information or personal financial information? If so, what was the scope of the breach? Were disclosures made to affected individuals? What operations changes, if any, were implemented after the breach? Describe your capabilities to support management of PHI data. Do you have insurance to cover a breach?

2065. Describe your levels of security utilized in the proposed system and how each addresses HIPAA security rules/regulations.

Reporting

2066. Confirm your ability to provide the reports described in the RFP and provide samples.

2067. Describe your online reporting capabilities. Please describe the data/information and types of reports that can be accessed and downloaded from your online system.

2068. Explain your ability to comply with the NDPERS current data warehouse arrangement by providing medical claims and enrollment data to NDPERS in a format agreed upon between you and NDPERS no less than monthly and within 3 months of award of contract.

2069. Please confirm that you will provide a monthly medical file feed, at no cost, to a PERS specified vendor to integrate with pharmacy claims and laboratory data.

2070. If requested, please confirm you will provide complete medical claims data to other authorized third-parties at no cost.

2071. Is your organization able to share information regarding wellness and disease management activities to be used in the data warehouse? If yes, what type of information is available?

2072. Do you participate in the ND Health Information Network (NDHIN) reporting?

Case/Utilization Management

2073. Provide a brief overview of your utilization management programs, including pre-authorization, prior approval, concurrent review, discharge planning, and large case management.

2074. Does your organization offer an advocacy program that members can utilize to help with coordinating/managing a newly diagnosed disease for themselves or another covered member?

2075. What is the source of the criteria used for the following:

a. Determining surgical necessity and whether a second opinion is required.
b. Determining approved length of stay.
c. What percentile of the data is used?
d. Approximately what percentages of review cases are referred to a physician because the initial review and attending physician cannot reach agreement on the proposed level of care?
e. Does this percentage vary between medical/surgical and psychiatric/substance abuse cases? If so, provide variances.

2076. What is the process for identifying members for large case management and how are claims transferred to case managers?

a. What are the automatic and manual triggers to identify cases for large case management?

b. How do you ensure that large cases are appropriately managed?

c. How do you calculate case management savings?

d. How do you work with medical group and hospital staff in the case management function?

Health Risk Management Programs

2077. Indicate in the table below if you currently provide the care or disease management program listed, the number of members from ND-based employers currently enrolled, the cost per participant, and its accreditation status.

	Program	Number of Members Enrolled (ND)	Is Cost Included in Proposal? (Y/N)	Cost if Not Included (PMPM)	Accredited? If so, indicate accrediting organization.
☐	Arthritis				
☐	Asthma				
☐	Cancer				
☐	Congestive Heart Failure				
☐	COPD				
☐	Depression				
☐	Diabetes				
☐	Low Back Pain				
☐	Stress				
☐	High Risk Pregnancy/ Prenatal Support				
☐	Hypercholesterolemia				
☐	Pain Management				
☐	Renal Failure				
☐	Tobacco Cessation				
☐	Weight Management				
☐	Other, please indicate:				

2078. Briefly discuss each of the programs currently offered, identify if it is included in your cost proposal and if not the cost to add each program. Do you currently track and report specific clinical outcome measurements for each of the conditions for which care/disease management is offered? Please list them.

2079. Are you willing to customize your care management/DM programs and services for NDPERS? If so, please explain and provide an example of a program you developed and utilized with another client. Include any ROI or outcome data that was measured on the effectiveness of the program.

2080. Describe how you coordinate members involved in more than one program, for example members with diabetes and chronic heart failure.

2081. Describe the programs offered to patients with rare and chronic diseases. Is this program outsourced? Who is the current vendor?

2001. What is your organization doing to identify and reduce health outcome disparities by race, ethnicity, or other social determinants of health?

2002. Describe in detail your ability to provide online wellness programs. Compare it to the existing program presently in the NDPERS program (see Exhibit 1). Specifically identify any deviations from the existing program. Include any future enhancements that are planned, including planned date for roll-out of the new feature.Describe Wellness incentives you offer. Compare and contrast that with the existing incentives. (see Exhibits 1 & 2).

2003. Describe your ability to support NDPERS Wellness initiatives by providing the administrative services for:

a. Tobacco Cessation program
b. NDPERS Diabetes Program (About the Patient Program coordinated with the ND Pharmacy Assoc.)
c. Dedicated Wellness Program Consultant and Educators
d. Healthy Pregnancy program
e. New programs or mandates
f. Diabetes Prevention Program
g. $250 Wellness Incentive with required tax reporting to employers

2004. Describe your ability to support the employer-based wellness program and the wellness benefit funding program. https://ndpers.nd.gov/employers/employer-resources/employer-based-wellness/

Network Accessibility and Disruption

2005. We are requesting that vendors provide a GeoAccess network accessibility and disruption analysis in Appendix E1. If you are proposing a combination of owned and leased networks, please provide your results separately by network. This GeoAccess analysis must be provided for your proposed NDPERS network(s).

2006. Provide a listing or provider directory and link to the web for the provider networks you are proposing for NDPERS.

2007. Identify and describe your national preferred provider organization.

2008. Does your network exclude any major health systems or provider practices in North Dakota?

2009. Describe how an employee or dependent that requires care while outside of North Dakota will be provided services. Example: a dependent who requires care over an extended period while away from home (e.g. student attending college). Do you have “guest” or “visitor” status programs for people who are temporarily domiciled outside of the service area?

2010. Confirm your willingness to negotiate and maintain NDPERS-specific provider contracts to allow for cost control mechanisms and alignment of contract and plan years. Also discuss how you maintain the existing PERS PPO program. Describe your process and approach for accomplishing this.

2011. Does your organization offer telehealth visits? If so, please describe the network available, how services are billed, and provide general overview of program.

2012. Does your organization offer any narrow or tiered networks? If so, please describe these network options including level of discount differences between the option and your traditional network.

2013. Do you anticipate any significant provider contract changes for 2023? Describe any expected changes.

2014. Complete the table below by type of behavior health specialist.

Behavioral Health Network	Mental Health Providers	Chemical Health Providers
A. Percent of NDPERS population within 30 minutes or 30 miles of a specialist		
B. Percent of providers accepting new patients		
C. Average wait time to secure an appointment		

2015. What strategies do you have in place to improve accessibility to licensed mental health providers?

2016. How many of your network providers specialize in working with first responders, law enforcement, and corrections staff?

2017. How many of your providers are self-identified as black, indigenous and people of color (BIPOC)?

2018. Please describe your telehealth services as it pertains to mental and chemical health?

a. Have your telehealth services expanded as a result of the pandemic? If so, will the changes be permanent?

b. Please describe how telehealth visits are reimbursed to providers, are reimbursements equal to regular office visits?

Cost, Quality, and Pay for Performance

2019. Describe the programs and methodologies currently in place to gather and measure meaningful provider quality and efficiency data that can be shared with members.

2020. Describe any online transparency tools you have available that members can access to view quality and/or cost information on your network providers. Provide access to this site. How updated is the information on the site?

2021. Describe in detail the performance standards you currently have in place with your contracted physicians, provider groups, hospitals, and other providers. Outline the types of measures utilized, how you monitor and track these measures, how providers are held accountable, and how frequently the data is compiled and shared with the physicians and provider groups.

2022. Describe your participation in pay-for-performance initiatives. To what extent do these activities impact the health care costs of NDPERS or claims incurred by its covered population? What percentage of your contracts are pay-for-performance? How is this likely to change in the next 2-3 years?

Credentialing and Contracting

2023. Briefly describe the initial credentialing process. How often are physician, hospital and other contracts (labs, imaging facilities, DME, home health care) reviewed?

Reimbursement and Discounts

2024. Please complete and submit Appendix D2.

2025. Provide the reimbursement methodologies (by percentage) agreed to in your contractual arrangements to reimburse inpatient and outpatient hospital services (e.g., discount from charges, case rate, per diem, global DRG, fee schedule, etc.).

2026. Provide the reimbursement methodologies (by percentage) used to reimburse professional services (e.g., fee-for-service from billed charges, fee-for-service with discount, percent of RBRVS, capitation).

2027. How often are your R&C databases updated? What data version of UCR are you using?

2028. Do you negotiate discounts with non-network providers on a case-by-case basis? Please describe your negotiation process (including criteria used to determine when this will be done.) Do you charge for these special negotiations? If so, how is that charge assessed to NDPERS?

2029. If a network physician directs a member to a non-network lab for services, how is that lab service paid?

2030. If certain specialties (e.g. radiology or anesthesiology) or services (e.g. ambulance) are not represented in your network of providers, do you have the ability to pay these services as in-network if they were completed at an in-network facility?

2031. Provide your estimate of percent of charges that will be processed in North Dakota under your network.

2032. NDPERS presently has a value-based contract in place with certain ND providers. See Exhibit E27. Discuss your ability to offer the same or similar program. Identify if any additional cost would be required for such an option

2033. Provide details on any recent, upcoming or anticipated changes to the risk-based contracting profile of your network (e.g. ACOs, innovative contracts, changes to the level of provider risk, etc.)

Performance Standards and Guarantees

As described in Section I. Overview, of this RFP, health plan vendors are required to comply with performance standards and guarantees that include a financial incentive/forfeiture which is negotiated as part of the renewal process. See Appendix H for a copy of these performance standards and guarantees. You are required to offer your performance standards and guarantees for the board's consideration using Appendix H. It is a priority for the board to have a comprehensive set of standards and guarantees relating the to this plan.

2034. Please confirm you have completed Appendix H and confirm your willingness to comply with the performance standards and guarantees or provide suitable alternatives. Identify your process for measurement and audit availability. Identify any additional standards and metrics your organization would be willing to include.

HDHP/HSA

2035. Describe how your organization will administer the HSA option. What details are provided to individuals that select this option, the enrollment process, claim reimbursement options, limit monitoring, ability to accept employee pre- & post-tax contributions, record-keeping, fees, the name of the service vendor and any other applicable information.

Economy to be affected

2036. Please indicate if you will have an office in North Dakota and where most of the work on this contract will be done?

2037. Please identify the number of employees you will employ in North Dakota pursuant to this contract.

2038. Of your total administrative fee please estimate the amount that will be spent in North Dakota and the amount that will spent outside the state.

Fiduciary Responsibility

2039. Confirm your organization will assume full fiduciary responsibility for claim determination.

Appeals Process

2040. Please describe your internal and external appeals process for self-insured plans.

a. What is the timeline to respond to appeals?

b. Is there a clinical protocol to distinguish medical necessity from administrative benefit denials?

c. Describe the medical standards of care utilized when reviewing an appeal.

d. How and when do you communicate to patients and providers?

e. Provide an overview of the staff involved in reviewing appeals, as well as their qualifications and experience. Do different staff review initial and secondary appeals?

f. Describe the process/approach utilized for cases where agreement cannot be reached between the patient and the health plan.

Regulatory Requirements

2041. Confirm that you will conform to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 as applicable to NDPERS.

2042. Do you have any disputes currently outstanding (or threatened) with any state or federal regulators related to any portion of your business? If so, what is the nature of these disputes?

2043. What is the relationship between you and state regulatory agencies including, but not limited to, state departments of insurance and health? What measures, if any, are being taken to maintain/ improve your regulatory relations?

2044. Provide a summary of any state department of insurance, state attorney general, U.S. Department of Labor and other state or Federal regulatory agency complaints filed against you, as well as information on complaints, grievances and appeals resulting from operations in the previous 5 years. Indicate what provider, member, plan sponsor or regulatory issue is involved, as well as, upheld/ overturned status and general nature of complaint or investigation. If the matter resulted in a corrective action plan (“CAP”), please provide a copy of the CAP.

2045. Have you been investigated or audited, directly or indirectly through an investigation or audit of a client/customer, by any state or Federal agency or other regulatory body (e.g., DOI, DOH, CMS, DOL, DEA, etc.) in the past three years? What were the findings and what steps are (were) being taken to address any deficiencies? Are you currently subject to or threatened with any state or Federal investigation or regulatory audit? Please provide copies of regulatory audit reports and your responses, if applicable.

2046. Have you been subjected to any fines or penalties, or been excluded/barred from any activities or programs as a result of regulatory or judicial action, within the past three years? If so, what was the nature of the underlying issue(s), and what was the penalty? What steps are being (were)

taken to prevent recurrences? Any pending or threatened proceedings that could result in such penalties?

2047. Is the process you use for late claim interest/penalties automated or manual? Please explain.

2048. Please provide a copy of your Compliance Plan including fraud, waste and abuse program (to the extent not provided in response to previous sections of the RFP). Have you had adverse findings in a Market Conduct exam within the last three years? If so, please provide details.

2049. Please provide a copy of your most recent SOC2 report

2050. Please provide the following:

a. Organizational and reporting charts for compliance operations (to the extent not provided in response to prior section of this RFP);

b. A review of compliance training requirements for employees and sub-contractors

c. Compliance monitoring and oversight policies and procedures;

d. Description of internal investigations and any self-disclosures.

Confidentiality

2051. Please provide a status report on your HIPAA and other privacy law compliance efforts. How are HIPAA and privacy compliance incorporated into your overall compliance activities?

2052. How frequently do you conduct audits for HIPAA compliance? Are you willing to share the results of those audits with us? Would you be willing to audit at a frequency required by NDPERS?

2053. Indicate your practice with respect to sharing members' medical and prescription information with providers, plan sponsors, pharmaceutical manufacturers or other commercial entities such as data aggregators.

2054. Identify your designated Privacy & Security Officers and describe their qualifications.\

2055. Please indicate if you can comply with NDCC 54-52.1-11 & 54-52.1-12.

Lawsuits/Claims

2056. What is the nature and extent (number of cases, potential financial or other exposure) of current litigation outstanding, or to the knowledge of management threatened, against you?

2057. Does any of this litigation involve: (i) multiple plaintiffs or a class of plaintiffs; (ii) any allegation of (A) criminal wrongdoing (including any RICO claim), (B) violation of securities, antitrust or environmental statuses; (C) direct or vicarious malpractice on your part or you employees; or (D) any action or matter excluded from coverage under your insurance policies; or (iii) claims for (A) punitive or exemplary damages, or (B) compensatory damages in excess of $500,000? If so, what are the details of the suit?

2058. Are any claims pending, or to your knowledge threatened, against you or your officers or directors before any regulatory body or agency in connection? What is the nature and status of the claim(s)?

2059. Are you a party to any pending arbitration or mediation proceeding? If so, what is the nature and status?

Related Party Issues

2060. Describe any equity, financial or other interests you hold in vendors, suppliers, consultants and other business with which you have a commercial relationship related to your operations.

Discussion of Information Used to Manage Business

2061. Describe the capabilities of your financial reporting systems.

2062. Describe what information is available and how timely the information becomes available with regard to revenues, medical costs, and overhead.

2063. Describe how your profitability is tracked by product segment, by market and by customer.

2064. Describe how often financial closing are performed and how long it takes to get final results.

Controls / Compliance

2065. Describe your internal accounting controls and how the internal controls are monitored.

2066. Describe the structure of your Internal Audit function.

2067. Indicate whether internal/external audits have revealed any significant internal control deficiencies or weaknesses or other issues in the past three years.

2068. Indicate what your compliance policies are and indicate whether there have been significant failures over the past three years, including regulatory violations, affecting the health operations.

Risk Management and Insurance Information

2069. Confirm proposal meets all regulatory requirements.

2070. Confirm proposal meets NDCC 26.1-36.6-03: 26.1-36.6-03. Self-insurance health plans - Requirements.

a. The following policy provisions apply to a self-insurance health plan or to the administrative services only or third-party administrator, and are subject to the jurisdiction of the commissioner: 26.1-36-03, 26.1-36-03.1, 26.1-36-05, 26.1-36-10, 26.1-36-12, 26.1-36-12.4, 26.1-36-12.6, 26.1-36-13, 26.1-36-14, 26.1-36-17, 26.1-36-18, 26.1-36-19, 26.1-36-23, 26.1-36-29, 26.1-36-37.1, 26.1-36-38, 26.1-36-39, 26.1-36-41, 26.1-36-44, and 26.1-36-46.

Appendix C3. Self-Insured ("Carve-Out") Pharmacy Questionnaire

This questionnaire must be completed if you are quoting self-insured prescription drug services.

To be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. Include both the question and the answer in your proposal response. An electronic copy of this questionnaire has been provided to facilitate your response.

Reference should not be made to a prior response unless the question involved specifically provides such an option. Proposers should review all sections of this RFP before responding to any of the questions here, to ensure that you have a complete understanding of the requirements with respect to your organization's proposal.

Bidders may include additional information that you consider relevant or useful to NDPERS. If you elect to provide additional information on services in response to a question please specifically indicate that it is not included in the covered services offered in your proposal. If not indicated those services will be a part of your proposed fees. However, responses to all of the questions set forth below must be provided.

If this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated and executed, any such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal. Bidders are reminded that **any and all deviations must be clearly identified and described in the RFP and the deviations worksheet provided in Appendix F.**

The questionnaire is broken down into the following categories:

Questionnaire:

- Compliance with North Dakota Statutory Requirements
- Bidder Overview
- Clinical Programs and Drug Utilization Review
- Specialty Pharmacy
- Formulary
- Account Management
- Data Analytics and Management Reporting
- Customer Service
- Retail Pharmacy Network
- Mail Service
- Implementation
- Eligibility
- Claims Processing/Adjudication
- Information Technology
- Financial
- Regulatory / Compliance
- Confidentiality
- Lawsuits/Claims
- Related Party Issues
- Discussion of Information Used to Manage Business
- Controls / Compliance
- Risk Management and Insurance Information

PHARMACY BACKGROUND

North Dakota Public Employees Retirement – Strategic Objectives

NDPERS is seeking a Bidder partner that:

- Manages prescription drug cost for members and NDPERS
- Delivers services at competitive prices commensurate with the total covered lives
- Provides exceptional service, from both a member and management experience
- Champions transparency (and other innovations) in contracting, operations and can fully meet the provisions in NDCC 54-52.1-04.16
- Brings innovation to the services provided to members and management
- Seamlessly integrates with NDPERS medical plans, and other partners

Partnership Considerations

NDPERS is interested in exploring the value creation from combining the respective strengths of NDPERS and a best-in-class pharmacy benefits partner. NDPERS goal is to explore a partner's role in managing the following functions:

- Overall financial and operational transparency
- Specialty drug management and contracting
- Formulary management
- Clinical programs administration
- Customer service (to both members and providers)
- Pharmacy claims processing
- Reporting and data analytics
- Pharmacy network management
- Rebate processing and contracting

This request for proposal is intended to provide NDPERS with the necessary information to assess your capabilities and strategic fit. To the extent that you see opportunities to add value that is not explicitly identified in the RFP, please provide additional information.

Compliance with North Dakota Statutory Requirements

3001. Indicate that you will comply with all the requirements of North Dakota Century Code including chapter 54-52.1

3002. Indicate if you could comply with the preference criteria in 54-52.1-04.15.

3003. Indicate if your proposal includes:

a. Compliance with 54-52.1-04.16
b. Does not include compliance 54-52.1-04.16
c. Includes both

3004. Indicate any areas of the North Dakota Century Code you cannot meet and why..

Bidder Overview

3005. Please provide the legal name of the company that will be providing the pharmacy benefit management services in this contract.

3006. Please describe your corporate governance structure.

3007. Where is your business headquartered?

3008. How many years have you operated as a pharmacy benefits manager?

3009. How many commercial plan sponsors do you serve?

3010. How many government (Federal, State, Local) plan sponsors do you serve?

3011. How many PBM member lives are in your book-of-business?

3012. How many PBM member lives do you serve in North Dakota?

3013. How many total lives are in your book-of-business (e.g. “all lives”, includes other health plans, rebate aggregation, etc.)?

3014. Do you outsource any of your operations or business functions? If so, which functions and through what organization(s)? Please provide a list of all locations/countries where your outsourced functions take place.

3015. Bidders responding to this RFP must be able to substantiate their financial stability. Provide a copy of your audited financial statement or other financial information. Include, at a minimum, a Balance Sheet and a Profit and Loss Statement, together with the name and address of the bank(s) with which you conduct business and the public accounting firm(s) that audit your financial statements. Other sufficient information may include a written statement from a financial institution confirming the creditworthiness and financial stability of the Bidder.

3016. What teaming arrangements, joint marketing arrangements and/or partnerships do you currently have in place with other organizations (heath plans, PBMs, Pharmacies, Others)? Please describe.

3017. What unique and differentiated capabilities can you offer to NDPERS?

3018. Do you have strategic advantages in North Dakota that make you a better choice for NDPERS than other Bidders?

3019. Provide the following information on a maximum of three (3) of your largest plan clients for whom you provide services similar to those proposed in this proposal. References of similar size and scope to NDPERS are preferred; one must be your largest public sector client and one must be your largest North Dakota-based client. Also provide the following for two former governmental clients similar to PERS or larger, if possible.

   a. Name of employer sponsoring plan and location

   b. Type of services provided to plan sponsor

   c. Plan inception date

   d. Length of time as client

   e. Number of contracts and members participating in the plan

   f. Contact information (name, title, phone number, email address)

Clinical Programs and Drug Utilization Review

3020. Please describe your approach to clinical management in the pharmacy benefit.

3021. Please provide a list of your clinical programs with a short description of each, and associated cost for each program. At minimum, please include prior authorization, step therapy, quantity limits, drug utilization review, opioid management, diabetes management, compound management, and specialty drug management programs. If applicable, please include return-on-investment guarantees or measurement metrics for each program.

3022. Based on the plan design currently in place, drug utilization, and demographics, what are specific recommendations to reduce cost and/or improve the health of NDPERS members (without changing plan design elements like copays)? Please limit your responses to no more than three recommendations or programs.

3023. Please describe the accreditations you maintain (URAC, JCAHO, NCQA)

3024. Please describe your capabilities of combining pharmacy data with medical data for individual members to coordinate care, case management, and utilization oversight.

3025. Please describe your Pharmacy & Therapeutics Committee (P&T) and the formulary review process.

3026. Please describe your approach or solutions to manage compound medications. Please note if you have a dollar threshold for prior authorization, exclusion strategy, or another approach.

3027. Please describe your COVID testing and vaccine administration programs

3028. Please describe your capabilities to track and report on COVID testing and vaccine claims

3029. Please discuss how you measure adherence; do you track medication possession ratio (MPR) and/or proportion of days covered (PDC)? Are there other factors you evaluate for certain therapeutic classes?

3030. Do you align your performance measurement with national quality measures (e.g. HEDIS)?

3031. What tools and programs do you utilize to shift percent of membership toward formulary and preferred/generic drugs?

3032. How do you measure the return on investment on clinical edits on an ongoing basis? What kind of reports and services do you provide to evaluate existing clinical edits and model return on investment for future clinical edits?

3033. Provide a description of your prior authorization process, including type of personnel involved in the process and average turnaround time.

3034. Do clients have access to your system to enter administrative prior authorization overrides?

    a. How does the process work?
    b. Is training provided?
    c. Will your client be able to report on volume of overrides and outcomes determination?

3035. Describe how you calculate return on investment of prior authorizations performed. What reports do you provide to your clients to assess ROI, denial rate, appropriateness of denials?

3036. Describe your quality assurance measures for your prior authorization process. What reports and tools do you provide for clients to assess if state/federal/NCQA quality measures (e.g. timeliness, overturn rates, accreditation) are met?

3037. Explain your process around instances when your prior authorization team cannot immediately contact the provider (i.e., how often do you attempt to contact the provider, what methods do you use to contact the provider, what do you do when you get no response).

3038. Please describe how members are notified of denials and expiration of prior authorizations.

3039. Describe all programs related to identification and management of potential abuse by members, providers and pharmacies.

3040. Please provide a list of real-time utilization (concurrent) review elements at retail and mail. How are interventions managed? How are outcomes of interventions documented?

3041. Does your Retrospective Drug Utilization Review (RDUR) Program target physicians and members? How do you notify physicians and members?

3042. Please provide a list of RDUR edits. What is the timeframe for intervention? Is the intervention automated? Fax? Is there a survey collected to assess the usefulness of the intervention? Are responses charted to provide auditable savings results?

3043. Do you work with any electronic medical record (EMR) companies to provide prescription drug information to prescribers?

3044. Are you capable of receiving data and integrating it from an EMR?

3045. Do you have a preferred partner for electronic prior authorization and eligibility/formulary verification?

3046. What percentage of claims in your book-of-business are e-prescribed?

3047. Please provide sample reports that document savings of clinical programs (case management, disease management, utilization review, etc.) that NDPERS will be receiving monthly, quarterly, etc.

Specialty Pharmacy

3048. How many specialty pharmacies do you operate?

3049. Are your specialty pharmacies owned or subcontracted?

3050. Which specialty pharmacy would primarily service the NDPERS account?

3051. Is the proposed specialty network an open network (where members can use any specialty pharmacy) or closed network (members may only use Bidder's network)?

3052. Please describe your approach to specialty pharmacy. Please focus on the aspects that differentiate your services in the market.

3053. Are members contacted before each specialty fill? If so, is the outbound call made by a representative or an automated call?

3054. What is the average length of time spent with a member prior to the first fill of their specialty medication?

3055. Do you have pharmacists and technicians that are dedicated to serving members with certain disease states?

3056. Please describe any specialty patient assistance programs that are offered. Describe how you can maximize the value of these programs for the member and the plan.

3057. For any specialty patient assistance programs, describe if your programs are income based and/or rebate compliant?

3058. Please describe your strategy (formulary or more broadly), and how you engage your self-insured clients on coverage decisions related to high-cost therapies (e.g., CAR-T, Zolgensma)

3059. Please describe specialty site-of-care programs or initiatives or partnerships.

3060. Please describe solutions available to address rising costs of prescription drugs in the medical benefit?

3061. Please confirm that specialty products shipped in error, damaged in shipment, lost in transit, left by courier without confirmation of receipt and rendered unusable by NDPERS to due negligence or error in delivery process will not be the financial responsibility to NDPERS. How are these types of shipment error reported to NDPERS?

3062. Describe your specialty drug trend forecasting services. For example, how is the specialty drug pipeline monitored and what modeling tools are available to demonstrate the financial impact to the Client?

3063. What percentage of Limited Distribution Drugs commercially available do you have access to?

3064. What is the process for procuring any limited distribution drugs that you currently do not have access to?

3065. Do you have infusion services? Can you arrange for nurses or other assistance on behalf of the member?

3066. Please provide a copy of your proposed specialty drug list including national drug code (NDC), drug name, and formulary tier in excel format. Please include on the specialty drug list, or provide as a separate list, indicators for limited distribution drugs and include a separate indicator if you are an authorized distributor for that product

Formulary

NDPERS formulary has three coverage tiers. Tier 1 includes formulary generic drugs, Tier 2 includes formulary brand drugs, and Tier 3 includes all non-formulary products. Please provide a quote based on your formulary that best aligns with NDPERS current structure.

3067. Please describe your formulary offerings.

3068. Please indicate which formulary is being proposed for NDPERS, and why.

3069. Please provide a copy of your proposed Formulary including NDC, drug name, and formulary tier in excel format

3070. How frequently in your proposed formulary updated?

3071. Does the proposed formulary require compliance with formulary utilization management controls (prior authorization and/or step therapy and/or quantity limits) or are all formulary and clinical utilization management programs an “add on” after the formulary is selected?

3072. Does your formulary include all generics in the lowest cost tier and all brands in the preferred or non-preferred tiers or does your proposed formulary tier brand and generic products according to different criteria?

3073. Please discuss your position regarding "lowest net cost" as it relates to your formulary strategy and your flexibility in facilitating a “lowest net cost” strategy for clients.

3074. Does your proposed formulary exclude drug products that are high-cost with low clinical value (e.g. combination products where the combined products could be bought separately for a fraction of the cost)?

3075. Do you have controls or procedures to manage drugs that rapidly increase in price? Please describe how you monitor drug price inflation and the options that plan sponsors may have to mitigate this risk.

3076. Will you agree to maintain one comprehensive Maximum Allowable Cost (MAC) list for NDPERS at retail and mail throughout the term of the contract?

3077. Will you agree to utilize the lowest price MAC list compared to any other PBM maintained MAC list for NDPERS?

3078. Please confirm you will provide a copy of the MAC list, including NDC and drug prices upon request.

3079. If desired, could you grandfather existing members for a select period of time (1-3 fills, 1 year, indefinitely)?

3080. Please describe any minimum formulary or plan design requirements for NDPERS to participate in rebate payments.

Account Management

3081. Do you propose a designated or dedicated account team for NDPERS?

3082. Provide an organizational chart for the NDPERS account management group and reporting structure to your management team.

3083. Will you agree to let NDPERS switch account team members if NDPERS is dissatisfied with service or fit?

3084. Describe the role of each proposed account team member and include a resume for each. Please include, at minimum, tenure at your company, years of experience, and office location.

3085. Will NDPERS have an executive sponsor? What role with the Executive Sponsor play during the contract term?

3086. What is your account team turnover rate (%)?

3087. What commitments will you make to ensure the consistency of the account team members you have proposed for NDPERS?

3088. Do you regularly survey your clients for their satisfaction with the quality of account management support provided by your firm? Please provide a copy of the assessment tool used.

3089. Please indicate your 2021 client retention rate

Data Analytics and Management Reporting

3090. Describe data analytic and reporting capabilities currently available.

3091. Is there an extra charge for data analytic services? If so, what are the charges?

3092. What are your market differentiators regarding analytic capabilities and outcomes?

3093. Please confirm that you will provide a monthly prescription drug file feed, at no cost, to a PERS specified vendor to integrate with medical claims and laboratory data.

3094. If requested, please confirm you will provide complete pharmacy claims data to other authorized third-parties at no cost.

3095. What data types can you currently take-in and integrate for analytic purposes (e.g., Rx claims, lab data, medical data, behavioral data)?

3096. How do you notify/advise clients of new drugs in the pipeline and potential budget impact as well as benefit design implications?

3097. Describe what applications used to deliver results (e.g., dash board web-based reporting)

3098. What is your ability to provide web-based reporting? Does the user have the ability to create custom queries, drill-downs, etc.?

3099. Do you provide on-line training for web-based reporting? Please describe.

3100. How do you communicate drug recalls and warning notifications?

3101. What is your ability to provide customized and/or ad-hoc reporting and associated fees, if any?

3102. What is your ability to generate prior authorization (PA) reports that define denied and approved PAs, percentage of total requests approved, turnaround times and costs by product, group, region?

3103. Describe or provide samples of standard reports around cost and utilization for the plan and its customers.

3104. Include sample copies of available reports.

Customer Service

3105. What is the location of your call center(s)?

3106. What call center(s) would be responsible for servicing NDPERS members?

3107. Describe your use of Interactive Voice Response (IVR).

3108. Will you have a dedicated phone number for NDPERS?

3109. Is your pharmacy call center available to members 24/7/365?

3110. Is a pharmacist available to members 24/7/365?

3111. Can a member leave a message at the member service line after hours? If so, what is the protocol for responding to this message?

3112. What is your first call resolution rate in the pharmacy call center?

3113. Do you have the capability to record 100% of the calls?

3114. Does your call monitoring application also provide for monitoring of screen navigation as well as call recording?

3115. Does your customer service inquiry system allow representatives to record comments so other customer service representatives can view previous notes to assist members?

3116. Describe in detail the training and qualifications of your customer service representatives (CSR). How will they be trained and educated on NDPERS specifics and new initiatives?

3117. Describe the system used to monitor the average speed of answer and abandonment rates. Describe in detail your time range standards. How often will this information be shared with NDPERS? Provide a sample report.

3118. Describe the level and frequency of customer service reporting you would provide NDPERS.

3119. How do you define / track member complaints and/or grievances?

3120. How do you report the complaints and grievances?

a. What are your turnaround times? Describe your workflow process.

b. How are complaints/grievances tracked by reason code?

c. Do you maintain a complaint log? Describe your complaint resolution process.

3121. Do you have an executive level complaint department? Describe the process from intake to resolution.

3122. Do you track Net Promoter Score (NPS)? If so, please provide the most recent NPS and describe if it applies to specific business segments (e.g. customer service).

3123. Describe your professional services departments for pharmacist inquiries.

a. Include company hours and days of operation, staffing and communications.

b. Where are these departments located?

c. Are these hours different than the retail pharmacy help desk? If so, what are the hours?

3124. Describe the qualifications and experience of the staff who handle Prior Authorization (PA) requests.

3125. Please describe your member website and member portal.

a. Can your website provide NDPERS specific plan information?

b. Does your website offer a pharmacy locator? Does the site offer information on retail stores that are open 24 hours/day?

c. Can members see their prescription drug claim history on the website?

d. Describe the web-enabled pricing comparison tools available to your members. Will the pricing tool account for NDPERS plan design?

e. Does your web-enabled pricing comparison tool provide pricing detail by pharmacy?

3126. Describe the staff and experience level of individuals who respond to member inquires received via email. What turnaround times and quality rates do you guarantee for email responses?

3127. How would you propose to handle email inquiries regarding pharmacy issues received via NDPERS's website?

3128. Does your mobile app and/or mobile enabled website include the following:

a. Formulary information

b. Network pharmacy lookup

c. Plan design information

d. Member ID card

e. Claims history

f. Family claims history

g. Drug price lookup by pharmacy

3129. Provide samples of communication material and welcome packets.

3130. What non-English language customer service staff or programs are available to assist NDPERS members?

3131. How will you assist with notifying members when the formulary status of medication has changed?

3132. Describe the appeal process. Provide materials used for member, physician, and pharmacy notification and provide your workflow process including turnaround times. How do you manage the process differently for states with unique requirements?

3133. Describe how written inquiries are handled.

Retail Pharmacy Network

3134. Please describe your retail pharmacy network strategy and how it is differentiated from other competitors.

3135. List the name of your proposed network and the number of retail pharmacies that participate in North Dakota and nationally.

3136. Based on the member zip data in Exhibit E9, please submit a Geo-Access analysis.

3137. Please describe your credentialing process including the process for removing pharmacies from the network. How often is credentialing/re-credentialing undertaken?

3138. Describe your 90-day retail network (including % of ND pharmacies in-network) and potential cost savings to NDPERS.

3139. Does your retail network contracting recognize some of the unique challenges of largely rural state? If so how?

Mail Service

3140. How many mail service pharmacies do you operate?

3141. Where are your mail pharmacies located? Which mail service pharmacy would primarily service the NDPERS account?

3142. Are your mail service pharmacies owned or subcontracted?

3143. Do you have a program at the mail facility to align and bundle shipment for members with more than one prescription?

3144. How do you assure patient consent to send an order prior to shipping?

3145. Are there any items/medications you do not ship (e.g. controlled substances)?

3146. What company or companies do you have shipping contracts with for the mail service?

3147. Can members track their mail order prescription?

3148. Can you deliver mail or specialty medications to the member's location of choice (e.g. home address, office, doctor's office, hospital, pharmacy, neighbor's address)?

3149. How long will you hold a prescription that requires an intervention before returning, filling, or calling members?

3150. Do you retain member credit cards? If so, what security measure do you employ to protect this information?

3151. Is payment required before orders are shipped? If no, what is the maximum outstanding balance owed before you hold orders?

3152. Do you provide Durable Medical Equipment (DME) items through the mail pharmacy?

3153. Are you willing to agree that medications shipped in error, damaged in shipment, lost in transit, left by courier without confirmation of receipt when requested, and rendered unusable by NDPERS due to negligence or error in delivery process will not be the financial burden to NDPERS or our patients? How are these types of shipping errors reported to NDPERS?

Implementation

3154. How long is the recommended timeline for a successful implementation? Please provide a proposed implementation plan – include resource requirement, tools, timelines, etc.

3155. Who will comprise your dedicated implementation team and what roles will they serve?

3156. Who has the ultimate responsibility for issues that occur during implementation?

3157. Does the account management team participate in the implementation?

3158. Please define in detail your expectations of NDPERS (deliverables, resource access, etc.) to support and facilitate the implementation process.

3159. Please describe your preferred banking arrangement and flexibility to accommodate alternative arrangements.

3160. If you are provided with prior pharmacy claims history, will you load open prior authorizations files, specialty pharmacy claims histories, open mail order refills, and accumulator files? If yes, explain the recommended process to follow and data specifications for transfer of data.

3161. Will you agree to provide 24 months of complete claims data, open prior authorization files, and open mail order refill files to NDPERS upon the termination of the agreement/ contract?

3162. Please describe how you manage the transition process from the incumbent for members on specialty medications to mitigate disruption?

3163. Please describe how prior authorizations, mail order prescriptions not yet delivered, would be managed when transitioning pharmacy vendors?

3164. Please describe the formulary and benefit design accuracy testing processes that occur during implementation? After implementation? How are issues found and handled?

3165. If an error occurs in coding of the plan design or clinical edits during implementation, what is your typical turnaround time to resolve the issue?

3166. What type of training will you provide during implementation on your systems and reporting tools? Will the training be provided on-site at NDPERS's location if desired?

3167. What is the typically the biggest implementation challenge facing you given the size and scope of our business?

Eligibility

3168. What is your process when a request is received for prescriptions from someone who is not eligible, or shown as terminated from the plan?

3169. Do you have any restrictions to the eligibility file layouts that you can support?

3170. What happens if a record on file is rejected via the load process? What is the process to reconcile a file load? How quickly is the report/reconciliation regarding the file load returned to the Plan?

3171. What system edits and processes do you have in place to ensure that an incorrectly submitted NDPERS file does not have a significant impact to eligibility? Please describe these processes and systemic edits with specific examples of what they prevent.

3172. Will NDPERS be able to make online eligibility changes real time? Describe the internal and external systems security measures in place. Describe any charges for this access.

3173. If members are added online, how does the eligibility file process against that member if the data is not the same?

3174. How much time is required to produce ID cards after receipt of clean eligibility data?

Claims Processing/Adjudication

3175. Describe your ability to integrate accumulators between medical and prescription drug either on an integrated or “carve-out” basis.

3176. How often can accumulators be exchanged/updated for members that elect the high-deductible health plan?

3177. How are member out-of-pocket accumulators reconciled to validate that the limits are not exceeded?

3178. If errors are identified in pricing or claims processing, how will NDPERS and its members be notified? How quickly will underpayments or overpayments be reconciled?

3179. What is your process for handling disputed claims?

3180. What is your system hierarchy (client, group, individual)?

3181. Do you measure claim financial accuracy and claim procedural accuracy separately? What are your standards for each?

3182. Please describe your procedures for paying delayed claim interest. Is the process entirely automated? If not, please describe any manual intervention. Also, please describe your procedures for keeping current regarding state delayed claim interest regulations and federal prompt pay legislation.

3183. Direct Member Reimbursements (DMR):

a. How do you handle receipt of a form that is incomplete or not in the required format?

b. What is your turnaround time for paying manual claims? Define how this is measured.

3184. Can you administer coordination of benefits at the point of sale? If client supplied indicators are required, please describe the requirements.

3185. What quality assurance measures are taken to ensure that the federal and/or state laws for member submitted claim turnaround times are adhered to? What is the frequency of validation that all laws are being adhered to?

3186. Audit services:

c. What audit functionality exists to ensure that claims are being paid accurately? Include both prospective and retrospective programs that focus on overpayments (inappropriately paid claims), fraud, waste and abuse.

d. How often do you audit the accuracy of plan pricing and overall adjudication accuracy? Please describe this process.

e. What is the average drug cost savings achieved as a result of an audit?

f. NDPERS requires an unrestricted right regarding the selection of an auditor (no Bidder input or sign-off) to perform its audit functions of the Bidder, pharmacy or downstream contractors. Please note any issues or concerns that the Bidder may have with this requirement.

g. Once claims are archived, what is the retrieval timeframe if needed for an audit?

3187. How long is claims data stored in the system before it is archived?

3188. Provide samples of your explanation of benefits (EOB) and claims forms.

3189. Provide a copy of your most recent SSAE 18 results.

Information Technology

3190. Describe your privacy protection and data security standards (e.g., HIPAA, PHI). Describe certifications and other external audits. Describe the test criteria used to ensure the standards are met.

3191. Are there any major system enhancements or conversions planned or being considered within the next 24 months? How are regulatory items managed in the release process? For packaged applications, what is the process and duration to upgrade a vendor release to the released version? What is the process used to maintain operating systems? What is the potential impact on NDPERS implementation?

3192. Describe your business continuity and disaster recovery plans for internet, eligibility, claims process and information management (data warehouse) systems. As part of the response, highlight any adjustments in the plan according to the magnitude and duration of the disaster (e.g., outages of one day, vs. a week, month, etc.).

3193. List the number of times and duration claims processing system experienced unscheduled down-time over the past twelve months. Have customer commitments been missed? Do Service Level Agreements (SLAs) exist and can you provide copies of the SLAs and recent results?

3194. What additional third-party systems does your system interface with (e.g., medical claims processing systems, phone systems, etc.)?

3195. Have you had any security breaches involving electronic protected health information or personal financial information? If so, what was the scope of the breach? Were disclosures made to affected individuals? What operations changes, if any, were implemented after the breach? Describe your capabilities to support management of PHI data.

3196. Describe your practices for prevention of identity theft and compliance with any applicable legal requirements, including FTC Red Flag Rules, to the extent applicable. Are customers / businesses notified if a breach occurs? What are the internal/external processes for managing a breach?

Financial

NOTE: Submit your pricing proposal separately from that of your technical proposal using Appendix D.

3197. Based on clients in your book-of-business that have had your proposed formulary in place, please provide the average drug trend in 2019, 2020, and 2021 gross and net of rebates?

3198. Please describe your ability to implement pricing terms based on National Average Drug Acquisition Cost (NADAC) or other alternatives to AWP. Please describe how other pricing benchmarks could be implemented by NDPERS.

3199. How will newly introduced specialty drugs be included in the specialty drug discount guarantee? Will new specialty products automatically default to a minimum discount in the therapeutic class?

3200. Based on your book-of-business, what percentage of prescriptions adjudicate at U&C price?

3201. Based on your book-of-business, what percentage of generic prescriptions adjudicate at MAC price?

3202. How often are MAC prices updated?

3203. Once a generic comes to market, how long does it take to add it to the MAC price list?

3204. Please describe if you own or participate in a Group Purchasing Organization (GPO) for rebates.

3205. Please describe your typical manufacturer revenue payment schedule (e.g. 90 days after the end of the quarter).

3206. How are rebates paid? Paid by crediting NDPERS account or payment is issued by check?

3207. Please describe your manufacturer revenue reconciliation process and timing against manufacturer contracts to confirm accurate payment to NDPERS.

3208. Under a pass-through contract, will you agree to a full pass-through for all manufacturer revenue derived by NDPERS specific utilization, with full audit rights to manufacturer contracts, rebate payments, and administrative fees?

3209. Please list any fees or payments that are paid to, or retained by, the rebate aggregator or GPO as compensation for collecting and remitting rebates.

3210. Under a pass-through contract, will you agree to quarterly reports that indicate the dollar volume of manufacturer revenue collected at the NDC level?

3211. How often are rebate contracts renegotiated?

3212. Do you have any inflation protection contracts in place today? If so, under a pass-through contract, do you agree to include any revenue resulting from inflation protection contracts back to NDPERS?

3213. Do you have any value-based rebate contracts in place today? If so, what mechanisms are in place to govern value-based payments?

3214. In a pass-through contract, please confirm that manufacturer revenue collected as a result of utilization from biosimilars or limited distribution drugs will be paid to NDPERS.

3215. Please confirm if you are willing to act as a fiduciary in the administration of this prescription drug plan.

3216. Please confirm your proposal is based on the plan design included with this RFP and the proposal parameters

3217. Please confirm your proposal does not require any plan design changes to qualify for the terms in your offer (e.g., specific differential between preferred and non-preferred brands to qualify for rebates, etc.)

3218. Please confirm you will use Medi-Span as the sole source of Average Wholesale Price (AWP) (excepting a change in the industry that would require a change)

3219. Please confirm that AWP will be defined as Medi-Span's unit price for the 11-digit national drug code (NDC) of the product dispensed on the date-of-service for the quantity dispensed.

3220. Please confirm "Generic Drug" will be defined according to Medi-Span classification (Medi-Span Multisource Code field is a "Y" indicator)

3221. Please confirm "Brand Drug" will be defined according to Medi-Span classification (Medi-Span Multisource Code field is a "M", "N", or "O" indicator)

3222. Please confirm Usual and customary (U&C) will be defined as: the retail price at a retail pharmacy on the date the drug is dispensed based on the NDC-11 dispensed

3223. Please confirm that once a drug product is defined as "Generic" or "Brand" at adjudication, it will remain classified as such for purposes of all financial measurements including AWP discounts, manufacturer revenue reporting and payment, management reporting and guarantee reconciliation.

3224. Please confirm that manufacturer derived revenue will be defined as all revenue received from pharmaceutical manufacturers, whether from the manufacturer directly, rebate aggregator, or other third party and will include all monies received as a result of the formulary utilization which includes but is not limited to rebates, manufacturer administration fees, inflation or price protection payments, and pro rata share of monies received for services provided to manufacturers that depends on the inclusion of NDPERS's claim utilization or data.

3225. Please confirm 100% of revenue earned from manufacturers will be passed through to NDPERS, which includes but is not limited to rebates, manufacturer administration fees, inflation or price protection payments, and pro rata share of monies received for services provided to manufacturers that depends on the inclusion of NDPERS' claim utilization or data.

3226. Please confirm member cost share will always be the lowest of the U&C, MAC, AWP discount, or member cost share.

3227. Please confirm that OTC exclusions (to the extent applicable) are not applicable to insulin or diabetic supplies (such as test strips)

3228. Please confirm that any coupons used by members will be excluded from ingredient cost calculation.

3229. Please confirm guarantees will include "Zero Balance Due" (100% member paid) claims at the ingredient cost prior to application of the member cost share and shall not be counted as AWP-100%.

3230. Please confirm that guarantees will exclude all claims that adjudicate at U&C.

3231. Please confirm there is no dispensing fee assessed for U&C claims.

3232. Please confirm that discount guarantees are not subject to aggregate day supply minimums and will be reconciled according to distribution channel.

3233. Please confirm that rebate guarantees are not subject to aggregate day supply minimums and will be reconciled according to distribution channel.

3234. Please confirm your proposal includes both a specialty drug list drug-by-drug discounts and an overall effective specialty discount guarantee.

3235. Please confirm that no DAW penalties will be included in discount reconciliation.

3236. Please confirm that your manufacturer derived revenue guarantees account for known patent expirations and the proposed guarantees will not be modified on the basis of patent expirations that can be reasonably known at the time of this proposal.

3237. Please confirm there are no minimum “claim floors” or amount due (at retail, mail, or specialty)

3238. Please confirm that postage increases will not be passed on to NDPERS.

3239. Please describe any requirements, terms, exclusions, or other caveats related to your manufacturer revenue guarantee.

3240. Please confirm manufacturer revenue will not include any funds collected through patient assistance programs.

3241. Please confirm generic discount guarantees are inclusive of MAC and Non-MAC discounts.

3242. Please confirm that New to Market drugs and/or Exclusive or Limited Distribution Drugs will be included in the specialty drug list with a specific discount guarantee within 30 days of becoming a covered product on the formulary and will not be excluded from pricing guarantees or restricted to a default discount for the duration of the contract.

3243. Please confirm that dispensing fees are assessed on paid claims only and not reversed or rejected claims.

3244. Please confirm that if changes are made to the safe harbor provision governing rebates is eliminated, or if other regulatory changes are implemented that impact the payment of manufacturer revenue to the plan sponsor, the contract resulting from this RFP may be re-opened.

3245. Please confirm the proposed discounts, dispensing fees, and manufacturer revenue are guaranteed by distinct component within the retail, mail, and specialty distribution channels such

that a guarantee surplus in one guarantee component is not offset by a shortfall in another guarantee component.

3246. Please confirm that any shortfall determined during guarantee reconciliation will be paid to NDPERS on a dollar-for-dollar basis with no maximum limit of liability

3247. Please confirm that pricing guarantee reconciliation will take place within 90 days of the close of the contract year (including discounts, dispensing fees, admin fees (as applicable)), as well as a preliminary analysis of manufacturer revenue paid compared to guarantees with a full reconciliation of manufacturer revenue after all manufacturer revenue has been collected and remitted from the manufacturers (no later than 270 days after the end of the contract year))

3248. Please provide a copy of your audit language.

Regulatory / Compliance

3249. Do you have any disputes currently outstanding (or threatened) with any state or federal regulators related to any portion of your business? If so, what is the nature of these disputes?

3250. What is the relationship between you and state regulatory agencies including, but not limited to, state departments of insurance and health? What measures, if any, are being taken to maintain/ improve your regulatory relations?

3251. Confirm you are fully-licensed or registered as a PBM, utilization review company or third party administrator in North Dakota. Please provide a copy of the procedures you used to assure compliance with Federal and North Dakota State regulatory, government contracting and quasi-regulatory (e.g., NCQA, URAC) requirements, including, but not limited to, pharmacy auditing, contracting and credentialing.

3252. Provide a summary of any state department of insurance, state attorney general, state pharmacy board, U.S. Department of Labor and other state or Federal regulatory agency complaints filed against you, as well as information on complaints, grievances and appeals resulting from PBM operations in the previous five years. Indicate what provider, member, plan sponsor or regulatory issue is involved, as well as, upheld/ overturned status and general nature of complaint or investigation. If the matter resulted in a corrective action plan (“CAP”), please provide a copy of the CAP.

3253. Have you been investigated or audited, directly or indirectly through an investigation or audit of a client/customer, by any state or Federal agency or other regulatory body (e.g., DOI, DOH, CMS, DOL, DEA, State Pharmacy Board, etc.) in the past three years? What were the findings and what steps are (were) being taken to address any deficiencies? Are you currently subject to or threatened with any state or Federal investigation or regulatory audit? Please provide copies of regulatory audit reports and your responses, if applicable.

3254. Have you been subjected to any fines or penalties, or been excluded/barred from any activities or programs as a result of regulatory or judicial action, within the past three years? If so, what was the nature of the underlying issue(s), and what was the penalty? What steps are being (were) taken to prevent recurrences? Any pending or threatened proceedings that could result in such penalties?

3255. How are you supporting IRSB-Notice requirements? Do you have the ability to perform back-up withholdings on flagged providers?

3256. Is the process you use for late claim interest/penalties automated or manual? Please explain.

3257. Please provide a copy of your Compliance Plan including fraud, waste and abuse program (to the extent not provided in response to previous sections of the RFP). Have you had adverse findings in a Market Conduct exam within the last three years? If so, please provide details.

3258. Please provide a copy of your most recent SOC2 report

3259. Describe any significant failures over the past three years in your compliance program effectiveness, including regulatory violations, affecting PBM related operations.

3260. Please provide the following:

a. Organizational and reporting charts for compliance operations (to the extent not provided in response to prior section of this RFP);

b. A review of compliance training requirements for employees and sub-contractors Compliance monitoring and oversight policies and procedures;

c. Description of internal investigations and any self-disclosures.

Confidentiality

3261. Please provide a status report on your HIPAA and other privacy law compliance efforts. How are HIPAA and privacy compliance incorporated into your overall compliance activities?

3262. How frequently do you conduct audits for HIPAA compliance? Are you willing to share the results of those audits with us? Would you be willing to audit at a frequency required by NDPERS?

3263. Indicate your practice with respect to sharing members' medical and prescription information with providers, plan sponsors, pharmaceutical manufacturers or other commercial entities such as data aggregators.

3264. Identify your designated Privacy & Security Officers and describe their qualifications.\

3265. Please confirm you will comply with NDCC 54-52.1-11 & 54-52.1-12.

Lawsuits/Claims

3266. What is the nature and extent (number of cases, potential financial or other exposure) of current litigation outstanding, or to the knowledge of management threatened, against you?

3267. Does any of this litigation involve: (i) multiple plaintiffs or a class of plaintiffs; (ii) any allegation of (A) criminal wrongdoing (including any RICO claim), (B) violation of securities, antitrust or environmental statuses; (C) direct or vicarious malpractice on your part or you employees; or (D) any action or matter excluded from coverage under your insurance policies; or (iii) claims for (A) punitive or exemplary damages, or (B) compensatory damages in excess of $500,000? If so, what are the details of the suit?

3268. Are any claims pending, or to your knowledge threatened, against you or your officers or directors before any regulatory body or agency in connection? What is the nature and status of the claim(s)?

3269. Are you a party to any pending arbitration or mediation proceeding? If so, what is the nature and status?

Related Party Issues

3270. Describe any equity, financial or other interests you hold in vendors, suppliers, consultants and other business with which you have a commercial relationship related to your pharmacy or PBM operations.

Discussion of Information Used to Manage Business

3271. Describe the capabilities of your financial reporting systems.

3272. Describe what information is available and how timely the information becomes available with regard to revenues, medical costs, and overhead.

3273. Describe how your profitability is tracked by product segment, by market and by customer.

3274. Describe how often financial closing are performed and how long it takes to get final results.

Controls / Compliance

3275. Describe your internal accounting controls and how the internal controls are monitored.

3276. Describe the structure of your Internal Audit function.

3277. Indicate whether internal/external audits have revealed any significant internal control deficiencies or weaknesses or other issues in the past three years.

3278. Indicate what your compliance policies are and indicate whether there have been significant failures over the past three years, including regulatory violations, affecting the health operations.

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Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: September 13, 2022

SUBJECT: **FlexComp – Voluntary Insurance Products**

We have conducted our annual review of the vendors for the voluntary insurance products approved for pretax premiums under our Section 125 FlexComp Plan. We sent all current vendors a request to confirm the products they offer, provide a brief product description, and verify whether it is eligible to be a pretax product. Following is a list of the respondents:

AFLAC
Central United
Colonial Life
Total Dental Administrators (TDA)
USABLE

All of the vendors have responded and confirmed the ongoing eligibility of their products for pretax treatment under our FlexComp plan. The attached outlines the vendor products available for payroll deduction, a brief description of the product, and certification by the vendor regarding which products are or are not eligible to be pre-taxed. No new products are being proposed by any of the participating companies.

Staff recommends that the vendors and their eligible products be approved for inclusion as pretax benefits under the FlexComp program for the 2023 plan year.

Board Action Requested

Approve the inclusion of the products eligible to be pre-taxed for the FlexComp 2023 plan year.

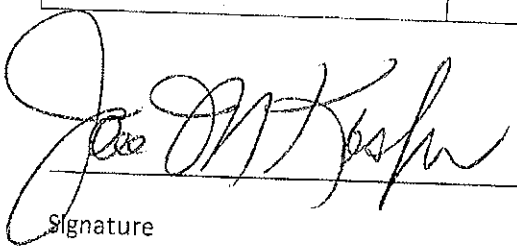
Attachment

AFLAC Product Name	Company Representative – Lynn Brokaw 400 E Broadway Ste 307 Bismarck ND 58501 701-258-6040 E-Mail: lynn_brokaw@us.aflac.com Product Description	Pretax Eligibility
Cancer	Cancer indemnity policies providing benefits for diagnosis of skin cancer, internal cancer as well as annual screening benefits.	Yes
Hospital Confinement	Indemnity benefits whether hospitalized days or weeks.	Yes
Hospital Intensive Care	Provides coverage in the event of a sickness or injury and is admitted to the ICU unit.	Yes
Accident	Accident indemnity policies providing benefits for accident/injury.	Yes
Lump Sum Critical Illness	Pays a lump sum benefit for code red major critical illness event. (Heart attack, stroke, coma, paralysis, major organ transplant, end stage renal failure. Riders available for cancer, sudden cardiac death.)	Yes
Personal Sickness Indemnity	Indemnity policy for sickness related hospital confinement, major diagnostic exams, in & out-patient surgeries.	No
Specified Health Event	Critical care, recovery indemnity policies for major critical illness.	Yes
Disability	All disability policies that are specific replacement of income benefits.	No
Dental	Voluntary dental. No networks, no deductibles, no pre-certifications.	No
Vision Now	Vision indemnity policy providing vision insurance, vision correction benefits.	No
Life	All life policies.	No

Lynn A Brokaw
Signature

07-25-2022
Date

Central United Product Name	Company Representative – James M Kasper C/O Asset Management Group Inc. PO Box 9016 Fargo ND 58103--9016 701-232-6250 E-Mail: jmkasper@amg-nd.com Product Description	Pretax Eligibility
Cancer Insurance	Provides cash benefits to covered persons for treatment of cancer.	Yes



Signature

Aug 1, 2022

Date

Colonial Life Product Name	Company Representative – John Guzman Famer's Union Insurance 4141 38th St S Ste C Fargo ND 58104 E-Mail: john.guzman@fumic.com Product Description	Pretax Eligibility
Accident	Composite rated, guaranteed renewable accident product with choice of plan levels and optional riders. It provides indemnity benefits for on and off the job accidents.	Yes
Cancer	Composite rated, guaranteed renewable specified disease product with choice of plan levels and optional riders. Provides benefits for expenses related to cancer.	Yes
Disability	Age banded, guaranteed renewable short-term disability income product.	No
Medical Bridge	Age banded, guaranteed renewable hospital confinement indemnity product. Choice of plans, levels. Includes confinement, rehab unit, surgical and diagnostic procedures.	Yes
Critical Illness	Specified disease product with a lump sum benefit upon diagnosis of a covered specified disease with a choice of plan options for reoccurrence, cancer, face amounts, and optional riders.	No
Life	All life insurance policies.	No

Signature

8/1/2022

Date

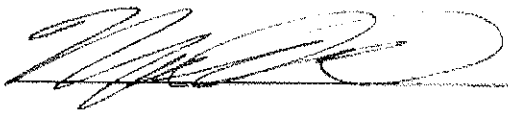
Total Dental Administrators Product Name	Company Representative – Logan Stucki 2800 N 44th Street Ste 500 Phoenix AZ 85008 [redacted] 801 - 270 - 2958 E-Mail: [redacted]dental.com lstucki@emihealth.com Product Description	Pretax Eligibility
Elite Choice	Fully insured dental program.	Yes

Signature

2022.08.01

Date

USABLE Product Name	Company Representative – Matthew Sullivan Azurance Group 4510 13 Ave S Fargo ND 58121 701-282-1243 E-Mail: Matthew.Sullivan@azurance.net Product Description	Pretax Eligibility
Accident Elite	Employees can get help prevent financial hardship due to medical/travel expenses caused from an accident. Payments direct to employee.	Yes
Cancer Care Elite	Payments direct to employee for new and experimental treatment, travel, lodging, out of pocket medical costs, deductibles, co-pay amounts.	Yes
Hospital Confinement Plan	Payment direct to employee for costs related to intensive care, hospitalization, birth of a child, accidents.	Yes



Signature

8/01/2022

Date

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

Scott A. Miller
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: September 13, 2022

SUBJECT: **FlexComp – Plan Document**

NDPERS staff have been tracking minor edits to the FlexComp Plan Document that have been suggested by the current vendor, ASIFlex, and reviewed with our federal consultant. Given 2023 is the final year that we can contract with ASIFlex for the current 6-year contracting cycle and we will be going out to bid for the product after that, staff felt it was an appropriate time to bring the edits forward for the Board's consideration and approval. The attached document has the suggested changes tracked for the Board's review. Upon approval, the Table of Contents and font will be updated as well.

Staff is requesting approval of the updates to the Plan Document effective with the new plan year, January 1, 2023.

Board Action Requested

Approve the updates to the NDPERS FlexComp Plan Document effective January 1, 2023.

Attachment

STATE OF NORTH DAKOTA

FLEXCOMP PLAN DOCUMENT

Effective January 1, ~~2018~~2023

ADOPTION RESOLUTION

Resolved, that effective January 1, 20~~18~~23, the State of North Dakota has adopted the attached amended and restated Section 125 FlexComp Plan. The Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code, as amended, and its associated regulations.

By: _____

Title: _____

Dated: _____

TABLE OF CONTENTS

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ARTICLE I. PURPOSE OF PLAN

The purpose of the State of North Dakota FlexComp Plan ("Plan") is to allow Employees to pay medical, dental, vision, group term life, disability and cancer insurance premiums and other medical and dependent care expenses using pre-tax dollars.

The Board (pursuant to North Dakota Century Code Section 54-52-04) has, therefore, adopted the Plan as set forth herein and as amended from time to time, effective January 1, 2023~~18~~ for the exclusive benefit of those Employees.

The Plan is intended to qualify as a cafeteria plan within the meaning of Code section 125 and shall be construed in a manner consistent with that section such that salary reduction elections will be eligible for exclusion from a Participant's taxable income. The Dependent Care FSA Plan is intended to qualify as a dependent care assistance program within the meaning of Code section 129, and the Health FSA Plan is intended to qualify as a self-insured medical reimbursement plan under Code section 105. The tax implications of this Plan, however, are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, neither the Board nor an Employer represents or warrants to any Participant that any particular tax consequence will result from participation in this Plan. By participating in the Plan, each Participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Board or an Employer.

This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited group under Code sections 105, 125, and 129. The Plan provisions shall apply uniformly to all Employees.

ARTICLE II. DEFINITIONS

The following words and phrases have the following meaning, unless a different meaning is plainly required by the text:

2.01 **Board.** "Board" means the North Dakota Public Employees Retirement System (PERS) board.

2.02 **Benefit Package Option.** "Benefit Package Option" means a qualified benefit under Code section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan

2.03 **Benefit Plan.** "Benefit Plan" means the life insurance, medical, dental, vision, cancer insurance and in some cases disability plans and any alternate medical coverage under a health maintenance organization approved by the Board.

2.04 **Code.** "Code" means the Internal Revenue Code of 1986, as amended.

2.05 **Dependent Care Center.** "Dependent Care Center" means any facility which:

a. complies with all applicable laws and regulations of the State of North Dakota and unit of local government in which it is located;

b. provides care for more than six (6) individuals (other than individuals who reside at the center); and

c. receives a fee, payment or grant for providing services for any such individuals (regardless of whether such facility is operated for profit).

2.06 **Dependent Care FSA Plan.** "Dependent Care FSA Plan" means the dependent care assistance plan under this Plan that permits Employees to receive reimbursements from Qualified Dependent Care Expense accounts.

2.07 **Dependent Child.** For purposes of payment of the Pre-Tax Premiums to a Benefit Plan, "Dependent Child" means a child who is the Participant's "qualifying child" or "qualifying relative" as those terms are defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rule in Code section 152(e) for divorced or separated parents or a child (within the meaning of Code section 152(f)(1)) who has not attained age 27 as of the end of the year. For purposes of the Qualified Health Care Expense accounts, "Dependent Child" means a child (within the meaning of Code section 152(f)(1)) who is either (1) a "qualifying child" as that term is defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rules in Code section 152(e) for divorced or separate parents or (2) a child (within the meaning of Code section 152(f)(1)) who has not attained age 27 as of the end of the year.

Notwithstanding the foregoing, a child named in a qualified medical child support order (QMCSO) as defined in section 609 of the Employee Retirement Security Income Act (ERISA) shall be a Dependent Child to the extent specified in the QMCSO. The

preceding sentence applies only to the Pre-Tax Premiums for a Benefit Plan and the Qualified Health Care Expense accounts under this Plan.

2.08 **Earned Income.** "Earned Income" means earned income as set forth in Code section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

2.09 **Employee.** "Employee" means employees of the State of North Dakota and district health units that are eligible to participate in the Plan. In addition, members of the Legislative Assembly are considered employees and eligible to participate in the Plan. Employees of higher education and political subdivisions are excluded from participation in the Plan.

Eligible employees who are eighteen (18) years of age, whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employed at least seventeen and one-half (17 ½) hours per week and at least five (5) months each year, or those first employed after August 1, 2003 who are employed at least twenty (20) hours per week and at least twenty (20) weeks each year, are eligible to participate in the Plan.

2.10 **Employer.** "Employer" means the State of North Dakota, excluding higher education, and any participating district health units as defined in Section 54-52.3-01 of the North Dakota Century Code.

2.11 **Grace Period.** "Grace Period" shall mean the period that begins immediately following the close of a Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year.

2.12 **Health Care Expense.** "Health Care Expense" means expenses incurred by a Participant for "medical care" within the meaning of Code section 213(d), incurred by a Participant, Spouse, or Dependent Child, but do not include premium payments for other medical plan coverage, including premiums paid for medical coverage under a plan maintained by the employer of a Spouse or Dependent Child or "qualified long-term care services," as described in Code section 213(d)(1)(C). For over-the-counter (OTC) drugs and medicines (other than insulin) which are for medical care as defined in Code section 213(d) will not be reimbursable as a Health Care Expense unless the Participant, Spouse or Dependent Child has a prescription for such drug or medicine. However, OTC products that are not considered drugs or medicines continue to be reimbursable if the product is for medical care as defined in Code section 213(d) and is not merely for good health or for cosmetic purposes.

2.13 **Health FSA Plan**. "Health FSA Plan" means the health flexible spending arrangement plan under this Plan that permits Employees to receive reimbursements from Qualified Health Care Expense accounts.

2.14 **Health Savings Account (HSA).** "Health Savings Account" or "HSA" means a health savings account established under Code section 223 as an individual trust or custodial account, each separately established and maintained by an Employee with a qualified trustee or custodian.

2.15 **Participant.** "Participant" means an Employee who is participating in the Plan.

2.16 **Plan.** "Plan" means the State of North Dakota FlexComp Plan, as set forth herein.

2.17 **Plan Administrator.** "Plan Administrator" means the North Dakota Public Employees Retirement System (PERS) with the authority and responsibility to manage and direct the operation and administration of the Plan. Plan Administrator includes any designated agent to which specified administrative functions under the Plan have been delegated, to the extent of such delegation.

2.18 **Plan Year.** "Plan Year" means a twelve (12) consecutive month period beginning January 1 and ending December 31.

2.19 **Pre-Tax Premium(s).** "Pre-Tax Premium(s)" means the cost of life, disability, medical, dental, vision and cancer insurance under the Benefit Plan which a Participant is required, as a condition for coverage, to defray. The amount of the Pre-Tax Premium(s) under the Benefit Plan shall be approved by the Board in accordance with the Board's policies that are applied to all Employees in a consistent manner.

2.20 **Qualified Beneficiary.** "Qualified Beneficiary" means an individual who, on the day before a Qualifying Event, is a Spouse or Dependent Child of a Participant in the Health FSA Plan. A person who becomes a new Spouse of an existing Qualified Beneficiary during a period of continuation coverage is not a Qualified Beneficiary.

In the case of a Qualifying Event that is termination of employment or reduction in hours, Qualified Beneficiary also includes an individual, who on the day before such Qualifying Event, is a Participant in the Health FSA Plan.

A newborn child or adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not a covered Employee will be entitled to the same continuation coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary. A newborn child or adopted child of a Qualified Beneficiary or child placed for adoption with a Qualified Beneficiary who was a covered Employee shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.

A Qualified Beneficiary must notify the Board within thirty (30) days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

2.21 **Qualified Dependent Care Expense.** "Qualified Dependent Care Expense" means any employment-related dependent care expense eligible for reimbursement under the Plan as determined under Code sections 129(e)(1) and 21(b)(2). Such expense includes amounts paid for household services and for the care of Qualifying Individuals enabling the Employee and his/her Spouse to be gainfully employed or if the Spouse is physically or mentally unable to care for self, or if the Spouse is a Student.

2.22 **Qualified Health Care Expense.** "Qualified Health Care Expense" means any Health Care Expense which is not otherwise reimbursable under a Benefit Plan or other plan or entity.

2.23 **Qualifying Event.** "Qualifying Event" means any of the following with respect to continued participation in the Health FSA Plan under Section 3.07, if it results in termination of coverage:

a. The death of a Participant.

b. The voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a Participant.

c. The divorce or legal separation of a Participant from his/her Spouse.

d. A Dependent Child ceasing to be a Dependent Child.

2.24 **Qualifying Individual.** "Qualifying Individual" means, for purposes of a Qualified Dependent Care Expense account, any individual who is:

a. The Participant's dependent child (as defined in Code section 152(a)(1) and who has not attained age thirteen (13); or

b. The Participant's dependent (as defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof)), who (i) is physically or mentally incapable of caring for himself or herself; and (ii) has the same principal place of abode as the Participant for more than one-half of the Plan Year; or

c. The Participant's Spouse if the Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of the Plan Year.

Notwithstanding the foregoing, in the case of divorced or separated parents (within the meaning of Code section 152(e) or parents that were never married, a Qualifying Individual who is a child shall, as provided in Code section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code section 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

Expenses incurred outside the Participant's household for a Qualifying Individual under (b) or (c) above shall constitute Qualified Dependent Care Expenses only if the Qualifying Individual regularly spends at least eight (8) hours each day in the Participant's household.

2.25 **Salary Reduction Agreement.** "Salary Reduction Agreement" means an agreement by a Participant to reduce his/her salary or wage to pay for applicable Pre-Tax Premiums, to allocate to a Qualified Health Care Expense account or Qualified Dependent Care Expense account, or to contribute to an HSA.

2.26 **Spouse.** "Spouse" means the spouse of a Participant but shall not include an individual legally separated from a Participant under a decree of divorce or of separate maintenance. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign

jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

2.27 **Student.** "Student" means an individual who, during each of five (5) calendar months during a taxable year is a full-time student at an educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.01 **Eligibility.** All Employees eligible to participate in a Benefit Plan are eligible to participate in the Plan for purposes of payment of Pre-Tax Premiums under section 4.01. All Employees are eligible to participate in the Plan for purposes of payment of eligible Qualified Health Care Expenses under Section 4.02, except that an Employee with any contributions to a Health Savings Account in a Plan Year cannot participate in the Qualified Health Care Expense Account portion of the Plan for such Plan Year. All Employees are eligible to participate in the Plan for purposes of payment of Qualified Dependent Care Expenses under Section 4.03.

An employee who becomes an eligible Employee during the Plan Year shall be allowed to participate the first day of the month following the date he or she becomes an Employee. An Employee shall also be allowed to participate if he or she experiences a change in participation status, as described in section 3.03.

3.02 **Participation.** Participation is established on a Plan Year to Plan Year basis. Each Employee shall be a Participant in the Plan for a Plan Year as follows:

a. For purposes of receiving Pre-Tax Premium benefits under Section 4.01 and HSA benefits under Section 4.04, participation will become effective when the appropriate Salary Reduction Agreement has been submitted as outlined in Article VI.

   For the purpose of receiving employee supplemental life insurance Pre-Tax Premium benefits for the first $50,000 in coverage, participation will be automatic unless an employee elects not to participate under this Plan for the Plan Year for the purpose of Pre-Tax Premium. An Employee who is eligible to participate may elect not to participate by completing and submitting the Premium Conversion declination submitting an appropriate declination form with the Employer within the election period established by the Board. An Employee who elects not to participate with regard to payment of Pre-tax Premiums for life insurance shall pay for such Pre-tax Premiums for life insurance under the Benefit Plan on an after–tax basis.

b. For purposes of receiving reimbursement for Qualified Health Care Expenses and/or Qualified Dependent Care Expenses, participation will begin when the appropriate Salary Reduction Agreement(s)have been submitted and become effective under Article VI.

A Participant's Salary Reduction Agreement shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year.

3.03 **Changes in Participation Status.** With respect to the Pre-Tax Premiums, Qualified Health Care Expense accounts, and Qualified Dependent Care Expense accounts, a Participant may revoke or amend participation in the Plan during a Plan Year only on account of and consistent with a change in status or other circumstances allowed under applicable law or regulation.

Unless otherwise specified, a revocation or amendment of participation must be made within thirty-one (31) days after the change in status occurs and will be effective for the balance of the Plan Year in which the election is made, beginning with the first appropriate pay period after the election is received.

A Participant reducing his/her election, based on a change in status, cannot reduce his/her Salary Reduction Agreement election to the point where his/her contributions to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for the Plan Year are less than the amount already reimbursed for that Plan Year.

With respect to the HSA, a Participant who makes an election to contribute an amount on a pre-tax salary reduction basis to his or her HSA may change such election on a prospective basis at any time during the Plan Year.

a. Change in Status Events. *(Applies to Pre-Tax Premiums, Qualified Health Care Expense accounts and Qualified Dependent Care Expense accounts.)*

1. Change in the Participant's legal marital status, including marriage, divorce, death of Spouse, legal separation, or annulment.

2. Change in number of the Participant's Dependent Children, including birth, adoption, placement for adoption, or death.

3. Change in the employment status of the Participant, Spouse, or Dependent Child, including the following:

(a) Termination or commencement of employment.

(b) A reduction or increase in hours of employment by the Employee, the Employee's Spouse or the Employee's Dependent Child, including a switch between part-time and full-time status or commencement of or return from an unpaid leave of absence.

(c) A change in employment status that results in the Participant, Spouse, or Dependent Child becoming or ceasing to be eligible for benefits under the individual's plan (such as switching from part-time to full-time or from full-time to part-time employment status).

(d) Any situation where the Employee, the Employee's Spouse or the Employee's Dependent Child has special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in Section 3.04.

4. Dependent Child satisfies (or ceases to satisfy) dependent eligibility requirements, such as attainment of age, Student status or any similar circumstances.

b. Change in Residence. *(Applies to Pre-Tax Premiums only.)* A change in residence of the Employee, Spouse, or Dependent Child is considered a status change event. An election change is permissible if the change in residence affects the Participant's eligibility for coverage.

c. Change in Cost. *(Applies to Pre-Tax Premiums and the Dependent Care Expense accounts.)* A Participant may make election changes as a result of changes in cost under the following circumstances:

1. If the cost of a qualified benefits plan increases (or decreases), the Plan may automatically make a prospective increase (or decrease) in Employee contributions for the Plan.

2. If the cost of a Benefit Package Option significantly increases or significantly decreases, a Participant may make a prospective increase or decrease in payments or revoke his/her election and, in lieu thereof, choose another Benefit Package Option providing similar coverage, prospectively. This paragraph only applies in the case of the dependent care expense accounts if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

   For purposes of the dependent care expense accounts, a change in provider is a significant change in coverage similar to a Benefit Package Option becoming available, and may permit an election change under this Section 3.03.

d. Change in Coverage. *(Applies to Pre-Tax Premiums)* A Participant may make election changes as a result of changes in coverage under the following circumstances:

1. If the coverage under the Benefit Plan is significantly curtailed without a loss of coverage, a Participant may revoke his/her election for that coverage. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Benefit Plan so as to constitute reduced coverage to Participants generally.

   If the coverage under the Benefit Plan is significantly curtailed and a loss of coverage occurs, a Participant may revoke his/her election. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage or to drop coverage if no similar Benefit Package Option is available. A loss of coverage means a complete loss of coverage under the Benefit Package Option, or other coverage option, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation.

2. If the Benefit Plan adds a new Benefit Package Option or improves a Benefit Package Option, or other coverage option (or eliminates an existing option) a Participant may elect the newly added option (or elect another option if an option has been eliminated) prospectively and may make corresponding election changes with respect to other Benefit Package Options providing similar coverage. The Plan may permit eligible Employees who have not

previously made an election to make an election on a prospective basis for coverage under a new or improved Benefit Package Option.

e. With the exception of Qualified Health Care Expense accounts, a Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan, including a plan of the same employer or of another employer, if:

1. The other plan permits the Participant to make an election change that would be permitted under federal regulations; or

2. The plan permits Participants to make an election for a period of coverage that is different from the period of coverage under this Plan.

f. A Participant may make an election change on a prospective basis to add coverage under a Benefit Plan for the Employee, Spouse or Dependent Child if the Employee, Spouse or Dependent Child loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

1. A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;

2. A medical care program of an Indian Tribal government (as defined in Code section 7701(a)(40)), the Indian Health Service, or a tribal organization;

3. A state health benefits risk pool; or

4. A foreign government group health plan.

g. Judgement, Decrees and Orders. *(Applies to Pre-Tax Premiums and Qualified Health Care Expense accounts.)* In the case of a Benefit Plan that provides health or accident coverage, and for Qualified Health Care Expense accounts, a Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

1. If a judgment, decree, or order (collectively, "Order") results from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO) defined in ERISA section 609) that requires accident or health coverage for an Employee's Dependent Child or for a foster child who is a dependent of the Employee; and

2. The Employee changes his/her election to provide coverage for the Dependent Child or foster child if the Order requires coverage under the Employee's plan; or

3. The Employee changes his/her election to revoke coverage for the Dependent Child or foster child if the Order requires the former spouse to provide coverage.

h. Entitlement to Medicare and Medicaid. *(Applies to Pre-Tax Premiums and Qualified Health Care Expense accounts.)* In the case of a Benefit Plan that provides health or accident coverage, a Participant's revocation or amendment of

participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

1. If the Employee, Spouse, or Dependent Child becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); and

2. If the Employee changes his/her election to revoke coverage for that Employee, Spouse or Dependent Child under the Benefit Plan or Qualified Health Care Expense account.

i. Consistency Rules Applicable to Change in Status Events. A Participant's mid-year election change under this Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects the Participant's, Spouse's or Dependent Child's eligibility or loss of eligibility for coverage under an employer's plan.

If the change in status event is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent Child, or a Dependent Child ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent Child, or the Dependent Child that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances fails to correspond with the change in status event.

If a Participant, Spouse or Dependent Child gains eligibility for coverage under a cafeteria plan or qualified benefits plan of the employer of the Spouse or Dependent Child as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other plan. The Plan may rely on the Participant's certification that such individual has obtained or will obtain coverage under the other plan unless the Plan has reason to believe that the Participant's certification is incorrect.

Notwithstanding the foregoing, for purposes of the Qualified Dependent Care Expense account, a Participant's mid-year election change under Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects expenses described in Code section 129 (including employment-related expenses as defined in Code section 21(b)(1) with respect to dependent care assistance.

The Plan Administrator, in its sole discretion, shall determine, based on the surrounding facts and circumstances and prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change in status event.

3.04 **HIPAA Special Enrollment Rights.** *(Applies to Pre-Tax Premiums only.)* A Participant may make a change to an annual election during the Plan Year if the change corresponds to a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Code section 9801(f), whether or not the change is permitted under any other section of this Plan, as follows:

a. Acquisition of a new Spouse or Dependent Child as a result of marriage, birth, adoption or placement for adoption.

b. Loss of eligibility under another group health plan or other health insurance by anyone who would otherwise be eligible under this Plan, including for (but not limited to) the following reasons:

1. Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation, cessation of dependent status, or

2. Loss of coverage through an HMO that does not provide benefits to individuals who do not reside, live or work in the service area, or

3. Termination of employer contributions toward that other coverage, or

4. If the other coverage was COBRA continuation coverage and the coverage was exhausted.

c. Loss of eligibility for coverage under Title XIX of the Social Security Act (Medicaid) or under Title XXI of the Social Security Act that is coverage under a state children's health insurance program (SCHIP) or becoming eligible for a premium assistance subsidy from Medicaid or SCHIP. A Participant has sixty (60) days after the date of the event to change his or her election.

d. For individuals losing other coverage, an Employee may revoke participation in a Benefit Plan and make a new election if the Employee is eligible, but not enrolled, for coverage under the terms of the Benefit Plan (or a Spouse or Dependent Child of such an Employee if the Spouse or Dependent Child is eligible, but not enrolled, for coverage); and

1. The Employee, Spouse or Dependent Child was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee.

2. The Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.

3. The Employee's, Spouse's or Dependent Child's coverage under a group health plan or health insurance was under a COBRA continuation provision and the coverage under such provision was exhausted, or not under a COBRA continuation provision and either the coverage was

terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or the Employer contributions towards such coverage were terminated.

Under this subsection d., a revocation or amendment of participation must be made within thirty-one (30 1) days after the date of exhaustion of coverage described in paragraph 1. or the termination of coverage or Employer contribution described in paragraph 3. and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made.

e. For acquisition of a Spouse or Dependent Child, an Employee may revoke participation in a Benefit Plan and make a new election if:

1. A person becomes a Spouse or a Dependent Child of the Participant through marriage, birth, or adoption or placement for adoption, and

2. The Participant elects to enroll himself/herself, the Spouse, and/or the Participant's Dependent Child or Children in the Plan, to the extent that the Spouse or Dependent Children are otherwise eligible for coverage.

Under this subsection e., a revocation or amendment of participation must be made within thirty-one (31) days after the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption and will be effective for the balance of the Plan Year in which the election is made, and in the case of marriage, beginning with the first appropriate pay period after the election is received; or in the case of a Dependent Child's birth, as of the date of such birth; or in the case of a Dependent Child's adoption or placement for adoption, the date of such adoption or placement for adoption.

f. An election change on account of birth, adoption or placement for adoption will be effective retroactive to the date of birth, adoption or placement for adoption, provided the request to change the annual election is made within thirty-one (31) days of the birth, adoption or placement for adoption. Except as otherwise provided for herein, election changes for other special enrollment events (e.g., marriage or loss of other health coverage) will be effective as soon as practicable once a request for such election changes has been received, provided the request to change the annual election is made within thirty-one (31) (or sixty (60) days, as applicable) of the event.

g. Retroactive coverage of a newly acquired Dependent Child on account of birth, adoption or placement for adoption applies to the Pre-Tax Premiums under section 4.01 and Qualified Health Care Expense accounts, but not to the Qualified Dependent Care Expense accounts. The effective date of coverage of a new Spouse or Dependent Child under the Qualified Dependent Care Expense account in accordance with Section 3.03 will be prospective for the balance of the Plan Year

beginning as soon as practicable after the date the new Salary Reduction Agreement is received by the Plan Administrator.

h. Payroll changes made in accordance with special enrollment under this Section 3.04 will be effective with the first pay period following approval of a request to change a salary reduction election amount even if the effective date of a Dependent Child's coverage is retroactive.

3.05 Additional Election Change Pursuant to IRS Notice 2014-55. *(Applies to Pre-Tax Premiums for accident and health coverage only.)* An Employee who is eligible to enroll in a government sponsored exchange (marketplace coverage) during a marketplace special enrollment or open enrollment period may drop Benefit Plan accident and health coverage midyear, but only if the change corresponds to the Employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in marketplace coverage that is effective no later than the day after the last day of the original coverage.

3.06 Termination of Participation.

a. Pre-Tax Premium(s). Participation with regard to Pre-Tax Premium(s) provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. The end of the month following the month of termination of employment;

2. The date the applicable Salary Reduction Agreement is revoked;

3. The date the Plan or applicable Benefit Plan is terminated; or

4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week.

b. Qualified Health Care Expenses. Participation with regard to Qualified Health Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. The last day of month in which a Participant ceases to be an Employee;

2. The date the applicable Salary Reduction Agreement is revoked;

3. The date the Plan or the Health FSA Plan is terminated; or

4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week.

c. Qualified Dependent Care Expenses. Participation with regard to Qualified Dependent Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. Upon exhaustion of the ~~account balance~~annual election once during the Plan Year in which the Employee ceases employment;

2. The date the applicable Salary Reduction Agreement is revoked;

3. The date the Plan or the Dependent Care FSA Plan is terminated; or

4. The date of a change in employment status from permanent to temporary or reduction in hours to less that twenty (20) hours per week.

Notwithstanding any provision of the Plan to the contrary, a former Participant shall be entitled to submit a request for reimbursement of Qualified Health Care Expenses, in accordance with Article VII, as if he/she were a Participant, provided such Qualified Health Care Expenses were incurred while the former Participant participated in the Plan.

If participation terminates because the Participant ceases to be an Employee and the individual returns to eligible employment with the Employer in the same Plan Year within thirty (30) days, and without any other intervening event that would permit a Participant to revoke or amend participation, then the Employee will be required to take the same benefit election for the remaining portion of the Plan Year as he/she had before he/she terminated. Participation shall be effective the first of the month following such election.

If the individual returns to employment, with the Employer, after more than thirty (30) days he/she will not be eligible to participate in the Pre-tax Premium benefit, the Qualified Health Care Expense account or the Qualified Dependent Care Expense account for the remainder of the Plan Year. Notwithstanding the foregoing, an individual who returns to employment with the Employer after more than thirty (30) days and within thirteen (13) weeks is eligible to participate in the Pre-tax Premium benefit with respect to group health plan and life insurance coverage only.

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Notwithstanding any provisions of the Plan to the contrary, a Qualified Beneficiary may elect to continue coverage for Qualified Health Care Expenses by electing continuation coverage as set forth in Section 3.07.

3.07 Continuation Coverage.

a. Eligibility. A Qualified Beneficiary may continue coverage under the Health FSA Plan under this Section 3.07 by making election to do so with the Employer and submitting the applicable continuation coverage contribution, subject to all conditions and limitations under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The amount of the monthly contribution will be established by the Plan Administrator and will be paid on an after-tax basis on a uniform and consistent basis. However, Qualified Beneficiaries who elect COBRA are permitted to pay the COBRA premiums on a pre-tax basis through the end of the current Plan Year from their final paychecks.

b. Maximum Self-Payment Period. A Qualified Beneficiary may elect continuation coverage because of a Qualifying Event described in Section 2.2~~1~~3 only for the remainder of the Plan Year in which the Qualifying Event occurs (plus the Grace Period).

c. Procedures to Elect Continuation Coverage.

1. In the case of a Qualifying Event described in Section 2.23, a. or b (death, termination of employment or reduction in hours) a Qualified Beneficiary will receive information concerning continuation coverage, including the rates, within forty-four (44) days of loss of coverage.

2. In the case of a Qualifying Event as described in Section 2.2~~1~~3, c. or ~~e~~d, (legal separation or divorce, or a child no longer qualifies as a Dependent Child) a Qualified Beneficiary must notify the Plan Administrator within sixty(60) days of the Qualifying Event. If notice is not received within sixty (60) days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage.

   Following receipt of timely notice of a Qualifying Event and within fourteen (14) days of receipt of such notice, the Plan Administrator will provide the Qualified Beneficiary with information concerning continuation coverage and rates.

3. After notification of continuation coverage, the Qualified Beneficiary will have sixty (60) days to elect continuation coverage, after the **later** of:

   (a) the date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or

   (b) the date that the Qualified Beneficiary is sent such the COBRA election notice.

   If a Qualified Beneficiary chooses to waive coverage, a waiver of continuation coverage will be effective on the date that the waiver is received by the Plan Administrator.

   A Qualified Beneficiary who, during the election period, waives continuation coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives continuation coverage later revokes the waiver, coverage will be effective on the date that the revocation of the waiver and election to continue is received by the Plan Administrator.

4. The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Plan Administrator within forty-five (45) days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is elected, and shall be considered timely if received within thirty (30) days of the date due.

5. If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Plan Administrator in accordance with paragraph 4. above.

6. The election must specify which Qualified Beneficiaries are electing COBRA continuation coverage. If it does not specify the Qualified Beneficiaries, the election shall be deemed to be an election on behalf of all Qualified Beneficiaries.

d. Termination of Continuation Coverage. Continuation coverage as provided under this section will terminate on the **earliest** of the following dates, as applicable:

1. The date after election of continuation coverage that the Qualified Beneficiary first becomes covered under any other group medical coverage as an employee or dependent.

2. The end of the period for which the last payment was made for coverage in a timely manner.

3. The end of the Plan Year in which the Qualifying Event occurs (plus the Grace Period).

4. The date the Qualified Beneficiary becomes entitled to Medicare.

5. Under any circumstance where a non-COBRA beneficiary would have benefits terminated for cause (e.g., fraud).

6. The date the Board or the applicable Employer ceases to provide any group health plan.

3.08 Death of a Participant. With respect to Qualified Dependent Care Expenses, if a Participant dies, his/her participation in the Plan shall cease. However, such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year or, if earlier, until the account balance is exhausted.

With respect to Qualified Health Care Expenses, if a Participant dies, his/her participation in the Plan shall cease on the last day of such month. However, there are two ways for a deceased Participant's family members to access the money in the Participant's Qualified Health Care Expense account. Such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year. In addition, a Qualified Beneficiary may be eligible to elect COBRA continuation coverage in accordance with Section 3.07 and obtain reimbursement for their own health care expenses incurred after the Participant's death through the end of the Plan Year and Grace Period. A copy of the death certificate may need to be provided to the Plan Administrator or designated agent.

ARTICLE IV. BENEFITS

4.01 **Pre-Tax Premium(s).** An Employee may elect to pay Pre-Tax Premium(s) for a Benefit Plan subject to the provisions of Section 5.01.

4.02 **Qualified Health Care Expenses.** The Plan Administrator or designated agent shall reimburse a Participant for Qualified Health Care Expenses incurred by the Participant or the Participant's Spouse or Dependent Child in accordance with the provisions of Section 5.02. Reimbursement for Qualified Health Care Expenses during a Plan Year is limited to the annualized amount elected by the Participant to the Qualified Health Care Expense account under a valid Salary Reduction Agreement. The annual amount elected by the Participant for a Qualified Health Care Expense account under a valid Salary Reduction Agreement (minus any reimbursed expenses for the Plan Year) shall be available at all times during the applicable period of coverage regardless of the actual amount deducted from the Participant's salary for the Plan Year. An Employee who is enrolled in a High Deductible Health Plan with contributions to a Health Savings Account cannot participate in the Qualified Health Care Expense account portion of this Plan.

4.03 **Qualified Dependent Care Expenses.** The Plan Administrator or designated agent shall reimburse a Participant for Qualified Dependent Care Expenses in accordance with the provisions of Section 5.03. Reimbursement for Qualified Dependent Care Expenses during a Plan Year is limited to the amount of expenses incurred, not to exceed the amount in the Participant's account at the time a claim is made.

4.04 **HSA.** An Employee may elect to contribute on a pre-tax basis to an HSA.

4.05 **Determination of Noncompliance.** It is the intent of this Plan to provide a benefits plan that is nondiscriminatory and provide benefits to a classification of Employees while not discriminating in favor of any group, as set forth in Code sections 125, 105, and 129. In the event that a determination is made that all or any part of the contributions to the Plan do not qualify as non-taxable contributions under Code sections 125, 105, and/or 129, the affected contributions made by any Participant shall be treated as taxable salary and, to the extent not yet expended, returned to such Participant. The Participant shall pay:

a. Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed thereon;

b. The Participant's share (as determined in good faith) of any applicable FICA contributions which would have been withheld from such amounts, had such amounts been treated as taxable salary and not as Qualifying Dependent Care Expenses or Qualified Health Care Expenses.

ARTICLE V. SALARY REDUCTIONS

5.01 **Pre-Tax Premium(s).** A Participant agrees to reduce the Participant's salary or wage each month by the amount of the Pre-Tax Premium(s) under the Benefit Plan under a Salary Reduction Agreement.

5.02 **Qualified Health Care Expense Account.**

a. Qualified Health Care Expenses shall be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement.

b. A Participant's salary or wage may be reduced under this Section 5.02 in an amount not to exceed ~~the $2,500~~the federally allowed maximum as adopted by the NDPERS Board, as adjusted in accordance with Code section 125(i) to the extent such adjustment is approved by the Board.

1. The salary reduction amount so elected shall be paid pro rata over the number of consecutive pay periods in the Plan Year. The salary reduction amount for any single pay period may not exceed the amount of the Participant's salary or wage for that period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period; however, the total amount of salary reduction must equal the annual election amount.

c. The Plan Administrator or designated agent shall establish individual Qualified Health Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.02. The Plan Administrator or designated agent shall reimburse Participants for Qualified Health Care Expenses in accordance with Article VII.

5.03 **Qualified Dependent Care Expense Account.**

a. Qualified Dependent Care Expenses may be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement, not to exceed the amount in the Participant's account at the time reimbursement is required.

b. A Participant's salary or wage may be reduced under this Section 5.03 each Plan Year in an amount not to exceed the lesser of (1) the earned income limitation described in Code section 129(b) or (2) $5,000 or$2,500 if the Participant is married, but filing separately. In the case of a married Participant who elected an amount in excess of $2,500, the Plan Administrator shall be entitled to rely on the Participant's election as constituting a certification by the Participant that he or she will file a joint tax return.

1. The salary reduction amount so elected shall be paid pro rata over the number of consecutive pay periods in the Plan Year. The salary reduction amount for any single pay period may not exceed the amount of the Participant's salary or wage for the pay period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period; however, the total amount of salary reduction must equal the annual election amount.

c. The Plan Administrator or designated agent shall establish individual Qualified Dependent Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts ~~elected~~ contributed under this Section 5.03. The Plan Administrator or designated agent shall reimburse Participants for Qualified Dependent Care Expenses in accordance with Article VII.

5.04 Funding of Health Savings Accounts.

Effective January 1, 2019. An Employee can elect to participate in the Health Savings Account portion of the Plan by electing to make pre-tax contributions to an HSA via a valid Salary Reduction Agreement. Such amounts will be contributed to a Health Savings Account established and maintained outside this Plan by a trustee or custodian. The benefits under the HSA portion of the Plan consist solely of an Employee's ability to make pre-tax contributions to a Health Savings Account. The terms and conditions of each applicable Participant's HSA is governed by the Health Savings Account trust and/or custodial agreement. An Employee's election under a Salary Reduction Agreement to contribute to a Health Savings Account can be increased, decreased or revoked prospectively at any time during the Plan Year. Contributions to an HSA cannot be elected with benefits under a Qualified Health Care Expense account.

A participant who has an election for Qualified Health Care Expenses that is in effect on the last day of a Plan Year cannot elect HSA contributions for any of the first three months following the close of that Plan Year, unless the Participant's Qualified Health Care Expense account balance is $0 as of the last day of that Plan Year.

In no event shall the amount contributed to a Participant's Health Savings Account, including pre-tax contributions under this Plan, any after-tax employee contributions, and any employer contributions, exceed the maximum amount under Code section 223(b), as prorated for the number of months the Participant is eligible to contribute to an HSA, in accordance with Code section 223(b).

5.05 Accounting. The Plan Administrator or designated agent shall maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of

Qualified Health Care Expenses or Qualified Dependent Care Expenses on behalf of any Participant for six (6) years.

ARTICLE VI. SALARY REDUCTION ELECTIONS

6.01 Election Period for Salary Reduction.

a. In order to contribute to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for a Plan Year, a Participant must submit to the Plan Administrator an appropriate Salary Reduction Agreement election form within the applicable election period.

b. An Employee who elects salary reduction for Pre-Tax Premium(s) must submit to the Plan Administrator an appropriate Salary Reduction Agreement within the applicable election period.

c. For the purpose of employee supplemental life insurance Pre-tax Premium benefits for the first $50,000 of coverage, an employee may elect not to participate by completing an appropriate Salary Reduction Agreement declination form within the applicable election period.

6.02 Termination, Revocation, or Amendment of Salary Reduction Elections.

a. A Participant's Salary Reduction Agreement for a Plan Year shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year. Failure to make such an election will result in waiving participation in the Plan for the Plan Year.

b. The employee supplemental life insurance Pre-tax benefits for the first $50,000 of coverage will be automatic unless an Employee declines this action.

c. Termination, revocation or amendment of salary reduction elections may only be made by a Participant in accordance with Article III.

6.03 Limitations on Exclusion from Gross Income for Dependent Care Expense Account.

a. Reimbursements under the Plan for Qualified Dependent Care Expenses shall be excluded from the gross income of a Participant during a Plan Year in accordance with Code section 129. An Employee's exclusion from gross income under the Plan in a calendar year shall not exceed the lesser of:

1. $5,000 if the Employee is married and filing a joint return or if the Employee is a single parent or $2,500 if the employee is married, but filing separately; or

2. In the case of an Employee who is not married at the close of such Plan Year, the Earned Income of such Employee for such Plan Year; or

3. In the case of an Employee who is married at the close of such Plan Year, the lesser of the Earned Income of such Employee or the Earned Income of the Spouse of such Employee for such Plan Year.

To the extent reimbursements exceed the maximum amount excludable from a Participant's gross income, the reimbursements shall be treated as taxable income to the Participant.

b. The amount excluded from the income of an Employee under the Plan for any Plan Year shall not include:

1. Payments made or incurred to an individual who can be claimed as a Dependent Child of the Employee or the Spouse of such Employee; or

2. Payments made or incurred to an individual who is a child, under the age of nineteen (19), of such Employee or the Spouse of such Employee.

6.04 Forfeiture of Salary Reduction Amounts.

a. If a Participant fails to claim any amounts in the Qualified Health Care Expense account or Qualified Dependent Care Expense account by the time allowed in Section 7.04, d., and Section 7.05, d., such amounts shall not be carried over to reimburse the Participant for expenses incurred during a subsequent Plan Year and rights to such amounts shall be forfeited by the Participant.

b. All forfeitures under this Plan shall be used first to offset any losses experienced by the Board during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the amounts paid by such Participant via salary reductions. Second, forfeitures shall be used to reduce the Board's cost of administering this Plan during the Plan Year.

6.05 Amendment of Salary Reduction Elections Due To Leave of Absence, Family and Medical Leave Act (FMLA) or Military Leave.

a. Pre-Tax Premiums and Qualified Health Care Expense Account.

1. *Leave with taxable compensation.* Pre-tax contributions during a leave will continue to be made if taxable compensation is due to the Participant while on leave of absence, FMLA leave, or military leave.

2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.

3. *FMLA.* A Participant commencing a qualifying leave under FMLA may, to the extent required by the FMLA, continue to maintain coverage under the Benefit Plan and Qualified Health Care Expense Account under the terms and conditions set forth hereafter.

4. With respect to a Benefit Plan, for unpaid leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in 6.05, a., 2., then the same election the

Participant had before the leave must be maintained for the remainder of the Plan Year upon return from the leave.

(a) *"Pre-pay option":* A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.

(b) *"Catch-up option":* Employer will continue coverage during the leave. A Participant must make pre-tax contributions after he or she returns from leave to make up missed contributions.

5. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis or by after tax contributions described in paragraph 4 above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed for Qualified Health Care Expenses as described in section 4.02 herein.

6. *USERRA.* If a Participant returns from a qualified military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2 above, or to elect not to participate for the remainder of the Plan Year.

7. For the Qualified Health Care Expense account, if a Participant revokes coverage upon commencement of the leave and elects to be reinstated upon return from the leave, the Participant has a choice between two options:

(a) *Full Coverage:* The Participant may maintain the same election the Participant had before the leave and reinstate the level of coverage in effect when the leave began, provided that the Participant makes contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account for the contributions that were missed during the leave.

(b) *Prorated Coverage:* The Participant may reinstate a level of coverage that is reduced by the amount of contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account that were missed during the leave.

b. Qualified Dependent Care Expense Account.

1. *Leave with taxable compensation.* Pre-tax contributions during a leave may be made if taxable compensation is due to the Participant while on leave of

absence, FMLA leave, or military leave and the employee has Qualified Dependent Care Expenses.

2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.

3. *FMLA.* A Participant commencing a qualifying leave under FMLA may continue to maintain coverage under the Qualified Dependent Care Expense Account under the terms and conditions set forth hereafter. For unpaid leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in paragraph 2 above, then the same election the Participant had before the leave must be maintained for the remainder of the calendar year upon return from the leave.

   (a) *"Pre-pay option":* A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.

   (b) *"Catch-up option":* Employer will continue coverage during the leave. A Participant must make pre-tax contributions after he or she returns from the leave to make up missed contributions.

4. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis described in paragraph 3 above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed as described in section 4.03 herein. Eligible expenses are only those expenses that enable the Employee or the Employee and the Employee's Spouse to be gainfully employed or the Spouse to be a Student. Any other expenses would not be reimbursable during the leave of absence period.

5. *USERRA.* If a Participant returns from a qualified military leave under USERRA and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2 above, or to elect not to participate for the remainder of the Plan Year.

ARTICLE VII. PAYMENT OF CLAIMS

7.01 **Determination of Status of Eligible Expenses**. After receiving an appropriately submitted claim and the information required under Section 7.04 or Section 7.05, the Plan Administrator shall determine whether such expenses are Qualified Health Care Expenses or Qualified Dependent Care Expenses. The Plan Administrator may delegate the authority to administer claims under the Plan to a designated agent.

7.02 **Payment of Claims**. The Plan Administrator will authorize payment of properly submitted claims for reimbursement at such intervals, as it may consider appropriate.

7.03 **Expenses**. All administrative expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan shall be paid as authorized by the Plan Administrator.

7.04 **Claims Reimbursement for Qualified Health Care Expenses**.

a. The Participant must submit a properly completed claim form to the Plan Administrator or the designated agent along with written evidence from an independent third party describing the Health Care Expense that has been incurred, the person on whose behalf such Health Care Expense has been incurred, the date such expense was incurred, the amount of such expense, and such other information as the Plan Administrator may find necessary.

b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Health Care Expenses.

c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Health Care Expenses.

d. All claims for reimbursement must be submitted no later than April 30 following the end of the Plan Year in which the expense was incurred.

e. Claims reimbursement for Qualified Health Care Expenses using a debit card shall be made in accordance with the terms of the debit card agreement and Proposed Treasury Regulations section 1.125-6 and other applicable IRS rulings.

7.05 **Claims Reimbursement for Qualified Dependent Care Expenses.**

a. To make a claim for reimbursement of Qualified Dependent Care Expenses, the Participant shall submit a statement to the Plan Administrator or the designated agent on an appropriate form adopted by the Plan Administrator which may contain the following information:

1. The Qualifying Individual(s) for whom the Qualified Dependent Care Expenses were incurred;

2. A statement to substantiate that the dependent or dependents are Qualifying Individuals, such as the age of the dependent or a statement as to the physical or mental capacity of the dependent;

3. The nature of the services which will generate the Qualified Dependent Care Expenses;

4. Written evidence from an independent third party stating the expenses have been incurred, the amount of such expense, the date of such expense, and such other information as the Plan Administrator in its sole discretion may request;

5. The name of the person, organization or entity to who the expense was paid, including the taxpayer identification number, and the relationship, if any, of the person performing the services to the Participant;

6. A statement as to where the services were performed;

7. If the services are to be performed in a Dependent Care Center, a statement verifying that each of the requirements for a Dependent Care Center specified in Section 2.05 of the Plan are met;

8. A statement indicating whether the services are necessary to enable the Participant to be gainfully employed;

9. If the Participant is married, a statement:

   (a) that the Spouse is employed; or

   (b) if the Spouse is not employed, a statement that he/she is incapacitated or that he/she is a Student within the meaning of Section 2.25 of the Plan.

   If an Employee's Spouse is not employed, not incapacitated, nor a Student as defined in Section 2.25 at the time the expense was incurred, the expense is not a Qualified Dependent Care Expense; and

10. A statement that the Qualified Dependent Care Expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.

b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator or designated agent certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Dependent Care Expenses.

c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Dependent Care Expenses.

d. All claims for reimbursement must be submitted not later than April 30 following the end of the Plan Year in which the expense was incurred.

7.06 Grace Period for Qualified Health Care Expenses. Amounts remaining in a Participant's Qualified Health Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Health Care Expenses that are incurred during Grace Period under the following conditions:

a. Applicability. In order for an individual to be reimbursed for Qualified Health Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Health Care Expense account at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) a Participant with Health Care Expense account coverage that is in effect on the last day of that Plan Year; or (2) a Qualified Beneficiary (as defined under COBRA) who has COBRA coverage under the Health Care Expense account component on the last day of that Plan Year.

b. No Cash-Out or Conversion. Prior Plan Year Qualified Health Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a prior Plan Year Health Care Expense account may not be used to reimburse Qualified Dependent Care Expenses.

c. Reimbursement of Grace Period Expenses. Qualified Health Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Health Care Expense account component will be reimbursed and charged first from any available prior Plan Year Qualified Health Care Expense account balance. If a current Plan Year Qualified Health Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Health Care Expense account component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.

d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Health Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from prior Plan Year Qualified Health Care Expense account amounts. Any prior Plan Year Qualified Health Care Expense account amounts that remain after all reimbursement have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in section 6.04 of the Plan.

e. Qualified Health Care Expense Account Balance, Grace Period and Health Savings Accounts. This Plan's Qualified Health Care Expense account operates with a Grace Period. Under IRS rules regarding a Qualified Health Care Expense Account's Grace Period, if a Participant's Qualified Health Care Expense Account is in effect with any balance in that account on the last day of a Plan Year, the

Participant (and their Spouse, if married), nor an Employer on behalf of the Participant, can contribute to a Health Savings Account during the first three (3) months following the close of the Plan Year.

f. Employee Participation in a Qualified Health Care Expenses Account Prevents Spouse or Dependent Child from Contributing to an HSA. Since this Plan's Qualified Health Care Expenses account is a general purpose account that permits reimbursement of qualifying medical expenses of Employees, Spouses and Dependent Children, under IRS rules, if the Spouse (or Dependent Child) of the Employee is enrolled in a High Deductible Health Plan with Health Savings Account, the Spouse (and Dependent Child) cannot contribute to an HSA while the Employee is enrolled in a general purpose Qualified Health Care Expenses account.

7.07 Grace Period for Qualified Dependent Care Expenses. Amounts remaining in a Participant's Qualified Dependent Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Dependent Care Expenses that are incurred during the Grace Period under the following conditions:

a. Applicability. In order for an individual to be reimbursed for Qualified Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Dependent Care Expense Account at the end of the Plan Year to which that Grace Period relates, he or she must be a Participant with Qualified Dependent Care Expense account coverage that is in effect on the last day of that Plan Year.

b. No Cash-Out or Conversion. Prior Plan Year Qualified Dependent Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a Prior Plan Year Qualified Dependent Care Expense account may not be used to reimburse Qualified Health Care Expenses.

c. Reimbursement of Grace Period Expenses. Qualified Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Dependent Care Expense account will be reimbursed and charged first from any available prior Plan Year Qualified Dependent Care Expense account. If a current Plan Year Qualified Dependent Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Dependent Care Expense account will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.

d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Dependent Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from a prior Plan Year Qualified Dependent Care Expense account balance. Any prior Plan Year Qualified Dependent Care Expense account balance that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in Section 6.04 of the Plan.

e. Grace Period Effect on Dependent Care Expense Account Exclusions. Grace Periods may have an adverse effect on the exclusions or credits that individuals report on their personal income tax return. There may be taxable income to an individual if the Qualified Dependent Care Expense account reimbursements exceed IRS permitted Qualified Dependent Care Expense Account exclusion amounts as a result of the Grace Period. For example, if as a result of the Grace Period, a participant receives Qualified Dependent Care Expense account reimbursements for services incurred in a year that exceed his or her maximum Qualified Dependent Care Expense account exclusion, the excess may be included in the Participant's taxable income. Individuals should be guided by the advice of their tax professional(s).

ARTICLE VIII. ADMINISTRATION

8.01 **Board Powers and Duties.** The Board shall interpret the Plan and decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Board with respect to any matter under the Plan shall be conclusive and binding on all persons. The Board shall:

a. Make and enforce administrative rules or policies.

b. Decide questions concerning the Plan.

c. Provide a review to any Participant whose claim for benefits has been denied in whole or in part.

8.02 **Plan Administrator Duties.** The Plan Administrator or designated agent shall manage and administer the Plan. The Plan Administrator shall:

a. Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.

b. Prescribe the use of administrative policies and procedures as it considers necessary for the efficient administration of the Plan.

c. Determine the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.

d. Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan.

8.03 **Additional Operating Rules.** A Participant's salary reduction amount will generally not be subject to federal income tax withholding or to applicable Social Security (FICA) tax withholding. Salary reduction amounts will generally not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

8.04 **Use and Disclosure of Protected Health Information.** The Health FSA Plan will use protected health information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). Specifically, the Health FSA Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Health FSA Plan rarely, if ever, uses or discloses PHI for treatment purposes. In addition, the Health FSA Plan does not use or disclose PHI that is genetic information (as defined in 45 CFR 160.103) for underwriting purposes, as set forth in 45 CFR 164.502(a)(5)(1)).

The Health FSA Plan may disclose PHI to a Benefit Plan for purposes related to administration of these plans, as permitted by law.

The Health FSA Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Employer, as Plan sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Health FSA Plan document or as required by law;

b. Ensure that any agents to whom the Health FSA Plan sponsor provides PHI received from the Health FSA Plan agree to the same restrictions and conditions that apply to the Health FSA Plan sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

d. Not use or discloses PHI in connection with any other benefit or employee benefit plan of the Health FSA Plan sponsor unless authorized by an individual;

e. Report to the Health FSA Plan any PHI use or disclosure that is inconsistent with the uses or disclosure provided for of which it becomes aware;

f. Make PHI available to an individual in accordance with HIPAA's access requirements;

g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

h. Make available the information required to provide an accounting of disclosures;

i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Health FSA Plan available to the HHS Secretary for the purposes of determining the Health FSA Plan's compliance with HIPAA;

j. If feasible, return or destroy all PHI received from the Health FSA Plan that the Plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

k. If a breach of unsecured protected health information (PHI) occurs, the Health FSA Plan will notify affected individuals in accordance with applicable federal law and regulations.

In accordance with HIPAA, only the Executive Director of the Public Employees Retirement System and staff designated by the Executive Director may be given access to PHI. Such persons may only have access to and use and disclose PHI for Health FSA Plan administration functions that the Plan sponsor performs for the Health FSA Plan. If such persons do not comply with this Section 8.04, the Health FSA Plan sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

In addition, the Health FSA Plan sponsor will comply with the following HIPAA security standards:

a. **Safeguards**. The plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Health FSA Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

b. **Agents**. The plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information

c. **Security Incidents**. The plans sponsor shall report to the Health FSA Plan any security incident under the HIPAA Security Standards of which it becomes aware.

d. **Adequate Separation**. The plan sponsor shall establish reasonable and appropriate security measures to ensure adequate separation between the Health FSA Plan and plan sponsor.

ARTICLE IX. APPEALS PROCEDURE

9.01 **Notice to Employee.** Any person who claims he/she has been denied a benefit under the Plan shall be entitled, upon written request to the Plan Administrator to receive, within sixty (60) days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefore, citing pertinent provisions of the Plan and a statement of the procedure to be followed in requesting a review of his/her claim.

9.02 **Late Claim Appeal.** Claims for the reimbursement of Qualified Health Care Expenses incurred in a Plan Year shall be paid as soon after a claim has been filed as is administratively practicable. If a Participant fails to submit a claim within the four (4) month period immediately following end of the Plan Year, those Health Care Expense claims shall not be considered for reimbursement by the Plan Administrator or designated agent; provided however, after four (4) months from the close of the Plan Year and before the end of three hundred sixty (360) days following the close of the Plan Year, a Participant may request the Board to authorize reimbursement of a Qualifying Health Care Expense incurred during the Plan Year by the Participant. The Participant must submit a written request to the Board specifying the request and the reason(s) why the Qualifying Health Care Expense was not submitted on or before the end of the 4th month following the close of the Plan Year. The Board may authorize payment for any reason constituting good cause not involving fault on the part of the Participant if such payment would be permitted under the Plan. Upon authorization of the Board, the Plan Administrator or designated agent shall reimburse the Participant for the amount not to exceed the Qualified Health Care Expense account balance for that Plan Year. The decision of the Board shall be final.

9.03 **Appeal of Denial of Benefit.** If the claimant wishes further consideration of his/her claim, he/she may request a review. The Plan Administrator shall schedule a review by the Board on the issue within sixty (60) days following receipt of the claimant's request for such review. The decision following such review shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Board as to all claims shall be final.

ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN

The Board reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modifications or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Board reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Board shall determine.

ARTICLE XI. GENERAL PROVISIONS

11.01 **No Right to be Retained in Employment.** Nothing contained in the Plan shall give any Employee the right to be retained in the employment of any Employer or affect the right of the Employer to dismiss any Employee.

11.02 **Alienation of Benefits.** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so is void.

11.03 **Use of Form Required.** All communications in connection with the Plan made by a Participant are effective only when submitted to the Plan Administrator or designated agent.

11.04 **Applicable Law.** The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of North Dakota.

11.05 **Statement of Benefits.** On or before January 31 of each year, the Board or a designated agent will furnish each Participant who received Qualified Dependent Care Expense account benefits under the Plan a written statement on appropriate forms required by the Internal Revenue Service, showing the amounts paid or incurred by the Plan in providing reimbursement under the Plan for Qualified Dependent Care Expenses with respect to the Participant for the prior Plan Year.

11.06 **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of a Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan shall, to the extent it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he/she is properly entitled under the Plan. Such actions by the Plan may include withholding any amounts due to the Plan or the Employer from compensation paid by the Employer.

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

Scott A. Miller
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(701) 328-3900
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Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: 457 Deferred Compensation Provider Processes

Waddell & Reed/FTC

At last month's Board meeting, I brought forward issues we've been having with Waddell & Reed/FTC. That memo and its attachment are attached. The issues have been:

1) Failure to provide a single point of contact for NDPERS;
2) Failure to provide accurate reports in a format we can use;
3) The unexplained split of our plan into 12-15 different plans;
4) Failure to timely process employee contributions.

Just prior to last month's Board meeting we had a phone conference with FTC representatives, who assured us these issues were either fixed or would be shortly. As of the time I am writing this memo, that is decidedly not the case. In fact, none of the issues have been corrected.

Given that more than 30 days have elapsed since I notified FTC of the issues, which have gone unresolved, it may be prudent to exercise the rights provided in NDAC section 71-04-06-11: "If the provider fails to deliver the required report within the thirty-day period, the provider is in violation of the administrative agreement and shall lose active provider status as described under subsection 1 of section 71-04-04-09." We will discuss at the meeting whether FTC's failures warrant termination of its provider status, as allowed by NDAC section 71-04-06-11:

> If the provider has not filed the report within ninety days after the end of the reporting period, the provider shall lose provider status as described under subsection 2 of section 71-04-04-09. Loss of provider status results in all current contributions of active participants being suspended effective in the

next payroll cycle. The board will notify all participants of the company's failure to deliver the required reports. Current participants will be required to either select a new provider for future contributions, or have their account go into a dormant status with the company losing provider status. The board will then terminate the agreement with the provider.

There are currently 89 members actively contributing to this provider, and 71 who are no longer actively contributing but still have funds in a provider account.

Lincoln Financial

Lincoln has also had it's share of problems in 2022, which is documented in the non-compliance letter I sent to them (attached). Initially, we do not have a direct contact with them, which makes working through these issues even more difficult. However, they did respond back to us and have stated they have been working to resolve our issues. We are still working through the problems with the 3/31/22 statement, although we have resolved our issues with the 6/30/22 statement. Hopefully we will have more information at the Board meeting.

This is a non-active provider (they did not sign the fiduciary amendment). As such, the 90-day termination of contract is the only recourse we have. They have nine members actively contributing and 45 inactive members.

Board Action Requested: Determine how to proceed with these providers.

Attachment

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: August 16, 2022

SUBJECT: Waddell & Reed Reporting

Waddell & Reed has been a deferred compensation provider since at least 1998. They were one of the few providers that agreed to signing our fiduciary amendment, and so they are an active provider.

Unfortunately, their recent acquisition by the Fiduciary Trust Company of New Hampshire (FTC) has not resulted in positive changes, at least from NDPERS' perspective. Attached you will find a letter we sent to FTC on August 1st advising them of the myriad of problems we have recently had. The letter constitutes our 30-day notice of breach of the agreement.

As of the time I wrote this memo, we have not been contacted by FTC. I will let you know at the Board meeting whether I hear from them, and whether they will virtually attend the meeting to explain how they intend to remedy the various problems we currently face with their provision of services.

Board Action Requested: Determine whether to terminate the agreement with Waddell & Reed/FTC.

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August 1, 2022

Fiduciary Trust Company of New Hampshire (FTC)
PO Box 219638
Kansas City. MO 64121-9638
Fax – 816-218-0421

Dear Sirs:

This is to notify you that NDPERS has repeatedly had issues with Waddell & Reed delivering accurate quarterly reports to NDPERS as required by Section II(C) of the signed Provider Administrative Agreement. Pursuant to section II(C) of the agreement, the provider is required to provide reports – accurately – within thirty days of the end of each reporting period. You are now in violation of that agreement.

Since Waddell & Reed transitioned to Fiduciary Trust Company of New Hampshire (FTC) in 2022, the quarterly statement reporting issues encountered previously have continued. The FTC statements also appear to have 12-15 different plans shown rather than being consolidated into one. In addition, FTC has failed at processing employee contributions timely. To our knowledge, participant contributions have not been deposited into accounts in over 10 weeks.

Given that you have failed to provide accurate reporting and timely posting of participant contributions, you are now in material breach of our agreement. The Retirement Board's remedy for your material breach is to inform the participants using your services of the breach and that the Board is commencing termination of its agreement with you as provided in Section II(C). This means you will no longer be eligible to supply services under the State of North Dakota Deferred Compensation Program and the participants will no longer be allowed to contribute to the program using you as their provider.

We will take this situation to the Board for its consideration at the August 16, 2022 Board meeting. If we do not have a designated point of contact for FTC (formerly Waddell & Reed) or you have otherwise failed to correct this situation by this meeting, I will recommend that the Board exercise its remedy and terminate this agreement. I suggest you make plans to attend this meeting, virtually or in person, to explain to the Board why you seem to have problems with basic reporting requirements and responding to our requests for information in a timely manner.

If you have any questions, please contact me.

Sincerely,

Scott Miller
Executive Director

Certified Mail: 7021 0350 0001 1030 5228

Attachment

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Public Employees Retirement System
1600 E Century Ave, Suite 2 • Box 1657
Bismarck, North Dakota 58502-1657

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August 22, 2022

Lincoln Financial Group / Plan ID : CR20540
P.O Box 2348
Fort Wayne, IN 46801-2348
Fax : 260-455-9427

Dear Sirs:

This is to notify you that NDPERS has had issues with Lincoln Financial delivering accurate quarterly reports to NDPERS as required by Section II(C) of the signed Provider Administrative Agreement. Pursuant to section II(C) of the agreement, the provider is required to provide reports – accurately – within thirty days of the end of each quarterly reporting period. You are also required to provide us with a direct contact and contact information, which we no longer have. Please provide that contact information within five business days.

The quarterly statement reporting issues encountered have continued throughout 2022. NDPERS continues to have unresolved issue pending. We have requested to receive a statement where the quarterly statements reflect a beginning balance that matches the ending balance of the prior period. In addition, we are still waiting on quarterly reports ending March 31, 2022 and ending June 30, 2022, which is not acceptable.

Lincoln's failure to provide us with accurate quarterly statements regarding participant contributions is a material breach of our agreement. Lincoln has thirty (30) days from the date of this letter to remedy that failure. Further, pursuant to ND Administrative Rule 71-04-06-11, if Lincoln does not provide those required reports within ninety (90) days of this letter, Lincoln will lose all provider status, all contributions will be suspended, and our affected members will be required to select a new provider or have their Lincoln accounts go dormant.

We will take this situation to the Board for its consideration at the September 13, 2022 Board meeting to provide the Board members with an update on Lincoln's problems. I suggest that you make plans to attend this meeting, virtually or in person, to explain to the Board why Lincoln cannot satisfy these basic reporting requirements.

If you have any questions, please contact me.

Sincerely,

Scott Miller
Executive Director

Certified Mail:

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

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: September 13, 2022

SUBJECT: Job Service Plan Asset Allocation

At the June Board meeting, an updated investment policy for the Job Service Plan Asset Allocation was approved. When the Retirement & Investment Office was reviewing the Board-approved policy, they presented some additional recommendations. The Investment Subcommittee heard those recommendations at their August meeting, and recommends the full NDPERS Board approve the revised updated policy for the Job Service plan.

Board Action Requested:

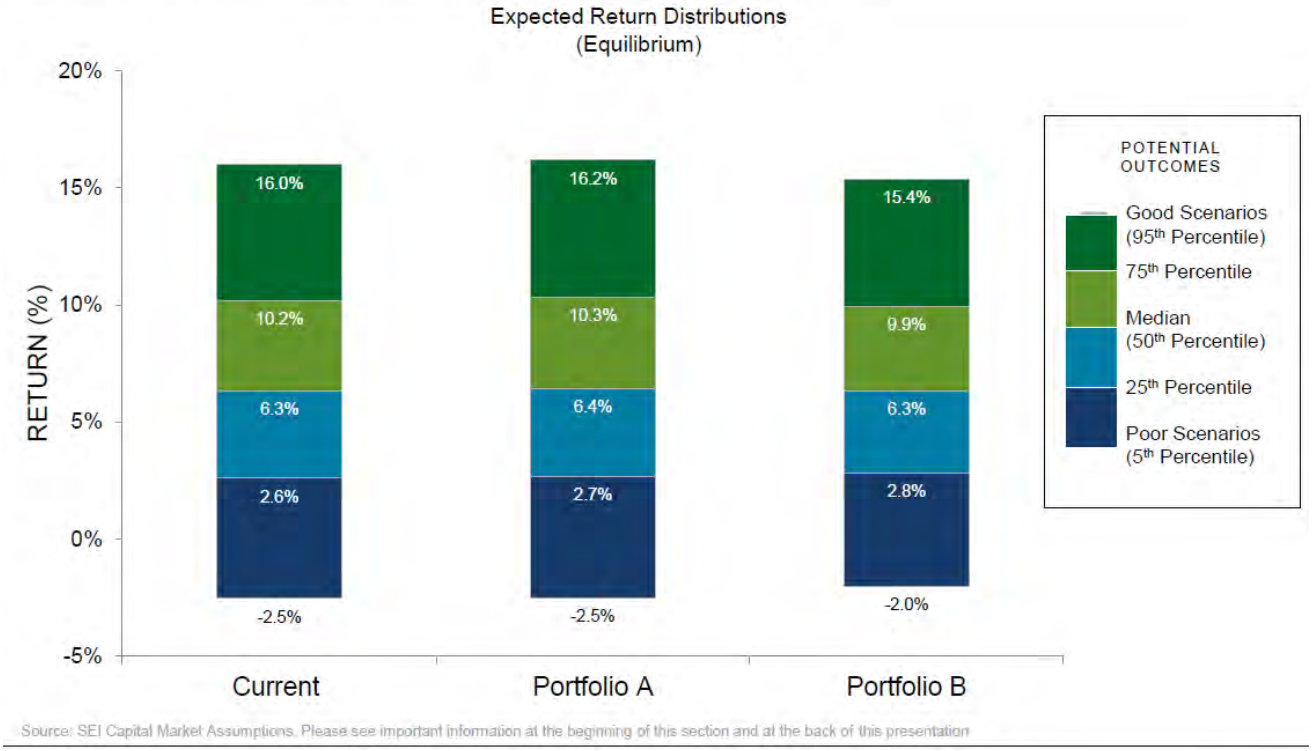
Approve the updated Job Service Investment Policy and give the authority for the Executive Director to sign.

North Dakota (Job Service): Modeled Portfolios

Asset Class	Current	Portfolio A	Portfolio B
US Low Beta Equities	2.0	2.0	-
Global Low Beta Equities	18.0	18.0	15.0
Total Return Enhancement Exposure	**20.0**	**20.0**	**15.0**
U.S. High Yield	3.0	3.0	2.0
Emerging Markets Debt	3.0	3.0	2.0
Core Fixed Income	34.0	38.0	45.0
Limited Duration Fixed Income	10.0	16.0	25.0
Diversified Short Term Fixed Income	5.0	5.0	4.0
Short Term Corporate Fixed Income	25.0	15.0	7.0
Total Risk Management	**80.0**	**80.0**	**85.0**
Portfolio Metrics (%) – Net of Fees			
Expected Return (Short-term)	2.8	2.8	2.6
Expected Return (Equilibrium)	6.3	6.4	6.3
Risk	5.6	5.7	5.3
Poor Scenario Return (Short-term)	-6.0	-6.1	-5.8
Fee Impact	-	-	-1 bps

Source: SEI Capital Market Assumptions. Please see important information at the beginning of this section and at the back of this presentation

Job Service: Expected Return Distributions



Source: SEI Capital Market Assumptions. Please see important information at the beginning of this section and at the back of this presentation

RETIREMENT PLAN FOR EMPLOYEES OF JOB SERVICE NORTH DAKOTA
INVESTMENT POLICY STATEMENT

1. PLAN CHARACTERISTICS AND FUND CONSTRAINTS

The Retirement Plan for the Employees of Job Service North Dakota (Plan) is a defined benefit retirement plan for the eligible employees hired before October 1, 1980. There have been no new entrants to the plan since October 1, 1980. The plan provides retirement benefits, disability benefits and survivor benefits consistent with the written Plan document. Until October 1, 1993, annuities were purchased from the Travelers for retirees, since that date retiree benefits are paid from Plan assets. Annual cost of living adjustments for all Plan pensioners including annuitants with the Travelers are paid from Plan assets. The NDPERS Board (the Board) is the Plan Administrator and administers the Plan in accord with Chapter 52-11 of the North Dakota Century Code.

Job Service North Dakota as the employer contributes 4% of the active participant's salary as a contribution 'on behalf of the employee' and the active participants pay 3% of their salary into Plan assets.

Each year the Plan has an actuarial valuation performed. The current actuarial assumed rate of return on assets is 3.75%.

2. RESPONSIBILITIES AND DISCRETION OF THE STATE INVESTMENT BOARD (SIB)

Aggregate plan contributions plus earnings, minus allowable expenses constitute the Fund. The Board is charged by NDCC chapters 54-52, 21-10-01, and 39-03.1 to establish policies for the investment goals and asset allocation of the Fund. The State Investment Board (SIB) is charged with implementing the asset allocation as promptly and prudently as possible in accordance with the Board's policies by investing the assets of the Fund in the manner provided in the prudent investor rule, which provides:

Fund fiduciaries shall exercise the judgment and care, under the circumstances then prevailing, that an institutional investor of ordinary prudence, discretion, and intelligence exercises in the management of large investments entrusted to it, not in regard to speculation but in regard to the permanent disposition of funds, considering probable safety of capital as well as probable income. The retirement funds belonging to the teachers' fund for retirement and the public employees retirement system must be invested exclusively for the benefit of their members and in accordance with the respective funds' investment goals and objectives. (NDCC 21-10-07)

The SIB may delegate investment responsibility of the Fund or any portion of the Fund to professional money managers. Where a money manager has been retained, the SIB's role in determining investment strategy is supervisory not advisory.

The SIB may at its discretion, pool the assets of the Fund with another fund or funds having similar investment objectives and time horizons in order to maximize returns and minimize costs. In pooling fund assets the SIB will establish asset class pools it deems necessary to achieve the specific quality, diversification, restrictions, and performance objectives subject to the prudent investor rule and the objectives of the funds participating in the pools.

The SIB is responsible for establishing the selection criteria, determining the performance measures, and retaining all fund money managers. SIB is also responsible for the selection and retention of any investment consultants that may be employed in the investment of the Fund assets.

3. DELEGATION OF AUTHORITY

Management responsibility for NDPERS funds not assigned to the North Dakota State Investment Board (SIB) in Chapter 21-10 of the North Dakota Century Code (NDCC) is hereby delegated to the SIB, which must establish written policies and procedures for the operation of the NDPERS funds, consistent with this investment policy.

Such procedures must provide for:

1. The definition and assignment of duties and responsibilities to advisory services and persons employed by the SIB pursuant to NDCC 21-10-02.1(1) (a).

2. Investment diversification, investment quality, qualification of money managers, and amounts to be invested by money managers pursuant to NDCC 21-10-02.1(1)(e). In developing these policies it is understood:

    a. Futures and options may be used to hedge or replicate underlying index exposure, but not for speculation.
    b. The use of derivatives will be monitored to ensure that undue risks are not taken by the money managers.
    c. All assets must be held in custody by the SIB's master custodian or such other custodians as are selected by the SIB.

3. Guidelines for the selection and redemption of investments will be in accordance with NDCC 21-10-02.1(1) (d).

4. The criteria for making decisions with respect to hiring, retention, and termination of money managers will be clearly defined. This also includes selecting performance measurement standards, consultants, report formats, and frequency of meetings with money managers.

All participants in the investment process must seek to act responsibly as custodians of the public trust.

4. INVESTMENT GOALS

The investment objectives of the Plan have been established by the Plan's Administrator upon consideration of its strategic objectives and a comprehensive review of current and projected financial requirements.

Objective #1: To maintain a level of surplus sufficient to eliminate the need for future contributions;

Objective #2: To achieve a rate of return which exceeds the rate of inflation, as measured by the Consumer Price index (CPI), by 3.0 or more percentage points per year (based on current actuarial assumptions of 3.75% return and 2.5% inflation), over a complete market cycle; and

Objective #3: As a secondary objective, to maximize the Plan's surplus to increase future benefit payments.

5. INVESTMENT PERFORMANCE OBJECTIVE

The NDPERS Board will seek to make investments that generate sufficient return to meet the goals outlined in this policy. The objectives established in this section are in accordance with the fiduciary requirement in federal and state law.

It is in the best interest of NDPERS and its beneficiaries that performance objectives be established for the total Fund. It is clearly understood these objectives are to be viewed over the long term and have been established after full consideration of all factors set forth in this Statement of Investment Goals, Objectives, and Policies.

a) The annual standard deviation of total returns for the Fund should not materially exceed 5.7%.

b) Over 5-year and longer periods the fund should match or exceed the expected rate of return projected in the most recent asset/liability study and the standard deviation of returns should not materially exceed 5.7%

c) The standard deviation of portfolio returns compared to the policy benchmark or tracking error should not materially exceed 1.25%.

6. ASSET ALLOCATION

The NDPERS Board as plan Administrator establishes the asset allocation of the Fund, with input from consultants and SIB staff. The current asset allocation is based upon the asset/liability study completed by SEI Consultants in 2017. That study provided an appraisal of current cash flow projections and estimates of the investment returns likely to be achieved by the various asset classes.

In recognition of the Plan's objectives, projected financial status, and capital market expectations, the following asset allocation options were deemed appropriate for the Fund:

US Low Beta Equities - 2%
Global Low Beta Equites 18%
U.S. High Yield Bonds - 3%
Emerging Markets Debt - 3%
Core Fixed Income - 38%
Limited Duration Fixed Income - 16% Diversified
Short Term Fixed Income - 5% Short Term
Corporate Fixed Income - 15%

Rebalancing of the Fund to this target allocation will be done in accordance with the SIB's rebalancing policy, but not less than annually.

7. RESTRICTIONS

While the SIB is responsible for establishing specific quality, diversification, restrictions, and performance objectives for the investment vehicles in which the Fund's assets will be invested, it is understood that:

a. Futures and options may be used to hedge or replicate underlying index exposure, but not for speculation.

b. Derivatives use will be monitored to ensure that undue risks are not taken by the money managers.

c. All assets will be held in custody by the SIB's master custodian or such other custodians as are acceptable to the SIB.

Social Investing is defined as *"The investment or commitment of public pension fund money for the purpose of obtaining an effect other than a maximized return to the intended beneficiaries."*

d. Social investing is prohibited unless it meets the Exclusive Benefit Rule and it can be substantiated that the investment must provide an equivalent or superior rate of return for a similar investment with a similar time horizon and similar risk.

Economically targeted investment is defined as an investment designed to produce a competitive rate of return commensurate with risk involved, as well as to create collateral economic benefits for a targeted geographic area, group of people, or sector of the economy.

e. Economically targeted investing is prohibited unless the investment meets the Exclusive Benefit Rule.

The Exclusive Benefit Rule is met if the following four conditions are satisfied:

(1) The cost does not exceed the fair market value at the time of investment.

(2) The investment provides the Fund with an equivalent or superior rate of return for a similar investment with a similar time horizon and similar risk.

(3) Sufficient liquidity is maintained in the Fund to permit distributions in accordance with the terms of the plan.

(4) The safeguards and diversity that a prudent investor would adhere to are present.

8. INTERNAL CONTROLS

The SIB must have a system of internal controls to prevent losses of public funds arising from fraud or employee error. The controls deemed most important are the separation of responsibilities for investment purchases from the recording of investment activity, custodial safekeeping, written confirmation of investment transactions, and established criteria for broker relationships. The annual financial audit must include a comprehensive review of the portfolio, accounting procedures for security transactions and compliance with the investment policy.

9. EVALUATION

Investment management of the Fund will be evaluated against the Fund's investment objectives and investment performance standards.

An annual performance report must be provided to the Board by the State Investment Officer at a regularly scheduled NDPERS Board meeting. The annual performance report must include asset returns and allocation data as well as information regarding all significant or material matters and changes pertaining to the investment of the Fund, including:

- Changes in asset class portfolio structures, tactical approaches and market values;
- All pertinent legal or legislative proceedings affecting the SIB.
- Compliance with these investment goals, objectives and policies.
- A general market overview and market expectations.
- A review of fund progress and its asset allocation strategy.

In addition, the State Investment Officer shall review with the Board the procedures and policies established by the SIB relating to this statement of investment goals, objectives, and policies.

Scott Miller
Plan Administrator and Trustee
Retirement Plan for Employees of
Job Service North Dakota

Date:_____

Approved by the PERS Board:

Janilyn Murtha
Executive Director
North Dakota Retirement and Investment Office

Date:_____

Approved by the SIB:

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

Scott A. Miller
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: September 13, 2022

SUBJECT: 457 Companion Plan & 401(a) Plan 2nd Quarter 2022 Report

Here is the 2nd quarter 2022 investment report for the 401(a) & 457 Companion Plans. The reports are available separately on the NDPERS website. The NDPERS Investment Sub-committee reviewed the 2nd quarter reports. The two plans have 9,588 participants with $184.1 million in assets.

Assets in the 401(a) plan decreased to $16.8 million on June 30, 2022. The number of active participants is at 92. The TIAA-CREF Target Date funds have 59% of the plan assets.

Assets in the 457 Companion Plan decreased to $167.3 million on June 30, 2022. The number of active participants slightly decreased and is now at 6,495. The TIAA-CREF Target Date funds have 69% of the plan assets.

Benchmarks:
Fund returns for the quarter were mostly negative for the funds in the core lineup. 2 core funds had positive returns for the quarter (34 negative). Core fund performance was mixed when compared to benchmarks. Fund performance in the 3-year & 5-year periods were mostly good. Note that index funds are expected to slightly underperform their benchmarks because of fund administration fees.

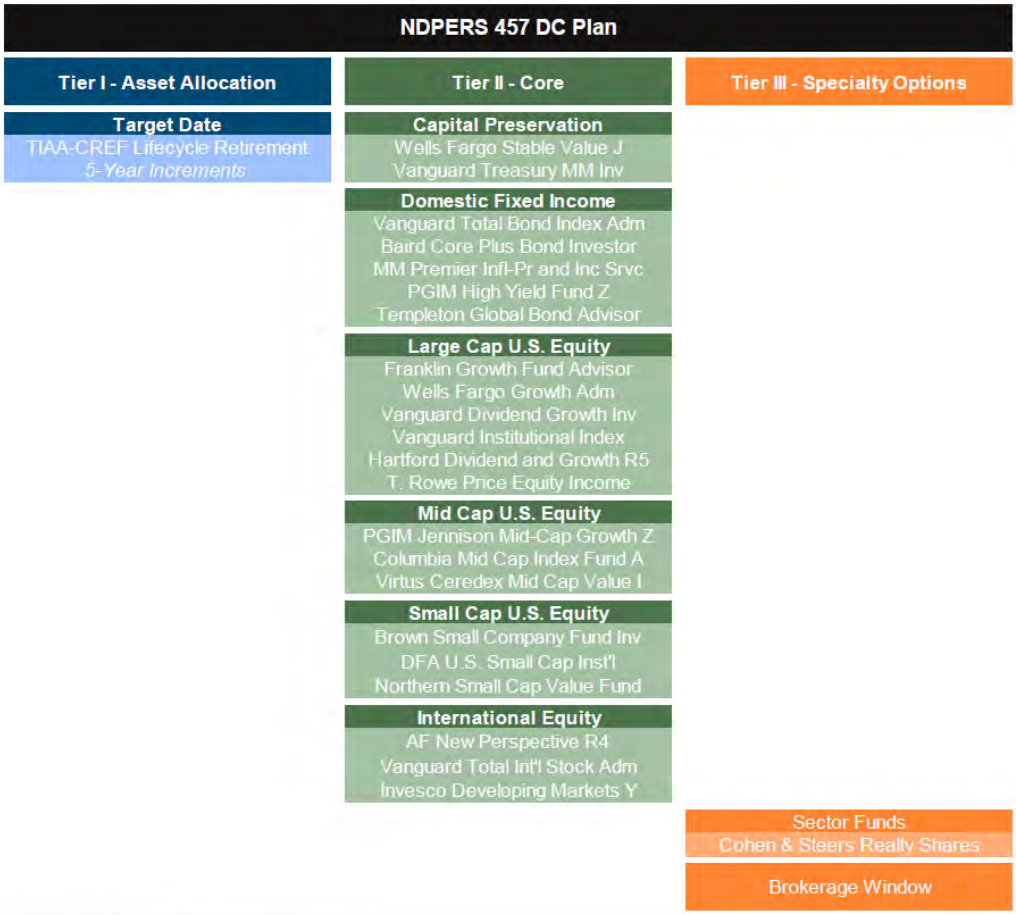
Fund / Investment News:
The NDPERS Investment Subcommittee reviewed the 2nd quarter 2022 plan review and field activity report with TIAA. Callan gave a market overview and investment performance report. The Subcommittee reviewed the two funds under formal fund review (Templeton Global Bond and Wells Fargo Growth). The investment subcommittee did not have any actionable concerns for the Board to consider. Callan reviewed the NDPERS core fund offerings and will continue presenting the Investment Subcommittee with recommendations for the equity (and possible annuity) lineup at the next meeting scheduled in November 2022.

Attachment

NDPERS
Quarterly Investment Report
2nd Quarter
4/1/2022 – 6/30/2022

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

457 & 401(a) Investment Structure



Plan Performance Monitoring

As of June 30, 2022

	Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 7 Years
Asset Allocation Funds					
TIAA-CREF Lifecycle Ret. Inc	(8.41%)	(11.37%)	2.51%	3.69%	4.01%
LifeCycle Ret Income CB	(8.72%)	(10.93%)	3.20%	4.31%	4.45%
Callan Tgt Dt Idx 2010	(8.32%)	(10.05%)	2.82%	4.01%	4.19%
TIAA-CREF Lifecycle Ret. 2010	(8.36%)	(11.39%)	2.51%	3.76%	4.11%
LifeCycle 2010 CB	(8.45%)	(10.69%)	3.24%	4.40%	4.58%
Callan Tgt Dt Idx 2010	(8.32%)	(10.05%)	2.82%	4.01%	4.19%
TIAA-CREF Lifecycle Ret. 2015	(8.85%)	(11.85%)	2.84%	4.07%	4.40%
LifeCycle 2015 Cust Bnch	(9.15%)	(11.28%)	3.54%	4.72%	4.90%
CAI Tgt Dt Idx 2015	(8.71%)	(10.33%)	3.06%	4.25%	4.43%
TIAA-CREF Lifecycle Ret. 2020	(9.42%)	(12.59%)	3.08%	4.36%	4.70%
LifeCycle 2020 Cust Bnchm	(9.81%)	(11.84%)	3.90%	5.10%	5.30%
CAI Tgt Dt Idx 2020	(9.23%)	(10.69%)	3.47%	4.68%	4.88%
TIAA-CREF Lifecycle Ret. 2025	(10.37%)	(13.53%)	3.54%	4.80%	5.12%
LifeCycle 2025 Cust Bnch	(10.68%)	(12.51%)	4.37%	5.58%	5.78%
CAI Tgt Dt Idx 2025	(10.18%)	(11.37%)	4.12%	5.29%	5.47%
TIAA-CREF Lifecycle Ret. 2030	(11.41%)	(14.60%)	4.00%	5.23%	5.52%
LifeCycle 2030 Cust Bnch	(11.67%)	(13.25%)	4.88%	6.09%	6.28%
CAI Tgt Dt Idx 2030	(11.28%)	(12.16%)	4.73%	5.86%	6.04%
TIAA-CREF Lifecycle Ret. 2035	(12.44%)	(15.58%)	4.42%	5.64%	5.90%
LifeCycle 2035 Cust Bnch	(12.66%)	(13.99%)	5.37%	6.57%	6.75%
CAI Tgt Dt Idx 2035	(12.40%)	(12.87%)	5.31%	6.37%	6.51%
TIAA-CREF Lifecycle Ret. 2040	(13.36%)	(16.41%)	4.92%	6.07%	6.27%
LifeCycle 2040 Cust Bnch	(13.57%)	(14.55%)	5.93%	7.07%	7.23%
CAI Tgt Dt Idx 2040	(13.33%)	(13.49%)	5.70%	6.71%	6.84%
TIAA-CREF Lifecycle Ret. 2045	(14.24%)	(17.18%)	5.47%	6.42%	6.61%
LifeCycle 2045 Cust Bnch	(14.45%)	(15.03%)	6.53%	7.51%	7.63%
CAI Tgt Dt Idx 2045	(13.96%)	(13.92%)	5.96%	6.92%	7.03%
TIAA-CREF Lifecycle Ret. 2050	(14.64%)	(17.46%)	5.50%	6.48%	6.68%
LifeCycle 2050 Cust Bnch	(14.86%)	(15.28%)	6.61%	7.59%	7.73%
CAI Tgt Dt Idx 2050	(14.30%)	(14.18%)	6.03%	6.98%	7.09%
TIAA-CREF Lifecycle Ret. 2055	(14.71%)	(17.52%)	5.57%	6.54%	6.75%
LifeCycle 2055 Cust Bnch	(14.99%)	(15.36%)	6.70%	7.67%	7.83%
CAI Tgt Dt Idx 2055	(14.43%)	(14.28%)	6.06%	7.01%	7.14%
TIAA-CREF Lifecycle Ret. 2060	(14.76%)	(17.58%)	5.70%	6.61%	6.84%
LifeCycle 2060 Cust Bnch	(15.13%)	(15.43%)	6.78%	7.75%	7.92%
Callan Tgt Dt Idx 2055	(14.43%)	(14.28%)	6.06%	7.01%	7.14%
T. Rowe Capital Appreciation Adv	(11.75%)	(7.85%)	8.09%	9.41%	9.36%
S&P 500 Index	(16.10%)	(10.62%)	10.60%	11.31%	11.14%

Plan Performance Monitoring

As of June 30, 2022

	Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 7 Years
Large Cap U.S. Equity					
Franklin Growth Fund Advisor	(18.42%)	(19.65%)	8.48%	11.00%	10.89%
S&P 500 Index	(16.10%)	(10.62%)	10.60%	11.31%	11.14%
Wells Fargo Growth Adm	(24.02%)	(34.93%)	3.87%	10.53%	9.48%
Russell 3000 Growth Index	(20.83%)	(19.78%)	11.84%	13.63%	12.85%
Vanguard Dividend Growth Inv	(9.17%)	(0.01%)	10.44%	12.13%	11.67%
S&P 500 Index	(16.10%)	(10.62%)	10.60%	11.31%	11.14%
Vanguard Institutional Index	(16.11%)	(10.65%)	10.58%	11.28%	11.11%
S&P 500 Index	(16.10%)	(10.62%)	10.60%	11.31%	11.14%
Hartford Dividend and Growth R5	(11.41%)	(1.64%)	11.42%	10.78%	10.57%
S&P 500 Index	(16.10%)	(10.62%)	10.60%	11.31%	11.14%
T. Rowe Price Equity Income	(10.69%)	(2.80%)	8.46%	8.07%	8.41%
Russell 1000 Value Index	(12.21%)	(6.82%)	6.87%	7.17%	7.69%
Mid Cap U.S. Equity					
PGIM Jennison Mid-Cap Growth Z	(21.03%)	(26.86%)	6.67%	9.40%	7.82%
Russell MidCap Growth Idx	(21.07%)	(29.57%)	4.25%	8.88%	8.35%
Columbia Mid Cap Index Fund A	(15.46%)	(14.96%)	6.37%	6.53%	7.26%
S&P Mid Cap 400 Index	(15.42%)	(14.64%)	6.87%	7.02%	7.76%
Virtus Ceredex Mid-Cap Value I	(14.06%)	(13.03%)	4.65%	5.70%	7.00%
Russell MidCap Value Idx	(14.68%)	(10.00%)	6.70%	6.27%	7.15%
Small Cap U.S. Equity					
Brown Small Company Fund Investor	(23.39%)	(35.46%)	(2.64%)	5.15%	7.59%
Russell 2000 Growth Index	(19.25%)	(33.43%)	1.40%	4.80%	4.96%
DFA U.S. Small Cap Inst'l	(13.71%)	(14.07%)	7.77%	6.40%	6.85%
Russell 2000 Index	(17.20%)	(25.20%)	4.21%	5.17%	5.91%
Northern Small Cap Value Fund	(13.04%)	(11.69%)	3.71%	3.23%	4.98%
Russell 2000 Value Index	(15.28%)	(16.28%)	6.18%	4.89%	6.40%
Non-U.S. Equity					
AF New Perspective R4	(19.04%)	(22.47%)	7.76%	9.04%	9.03%
MSCI ACWI	(15.66%)	(15.75%)	6.21%	7.00%	6.98%
Vanguard Total Int'l Stock Adm	(12.86%)	(18.94%)	2.00%	2.71%	3.21%
FTSE GI All Cap ex US Idx	(14.08%)	(19.27%)	1.91%	2.74%	3.22%
Invesco Developing Markets Y	(11.38%)	(34.95%)	(4.33%)	0.28%	1.59%
MSCI EM	(11.45%)	(25.28%)	0.57%	2.18%	2.79%

Plan Performance Monitoring

As of June 30, 2022

	Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 7 Years
Fixed Income					
Vanguard Total Bond Index Adm	(4.71%)	(10.40%)	(0.94%)	0.84%	1.40%
Blmbg:Aggregate Flt Adj	(4.73%)	(10.38%)	(0.91%)	0.90%	1.45%
Baird Core Plus Bond Investor	(5.32%)	(11.27%)	(0.75%)	1.02%	1.74%
Blmbg:Universal	(5.13%)	(10.89%)	(0.94%)	0.94%	1.62%
MM Premier Infl-Pr and Inc Srvc	(6.67%)	(6.35%)	2.78%	2.96%	2.68%
Blmbg:TIPS	(6.08%)	(5.14%)	3.04%	3.21%	2.82%
PGIM High Yield Fund Z	(9.25%)	(12.00%)	0.55%	2.62%	3.95%
Blmbg HY Corp 1% Iss Cap	(9.86%)	(12.82%)	0.01%	1.97%	3.38%
Templeton Global Bond Advisor	(7.96%)	(9.01%)	(5.85%)	(2.87%)	(1.28%)
FTSE WGBI	(8.91%)	(16.77%)	(4.27%)	(1.17%)	0.08%
Capital Preservation					
Wells Fargo Stable Value J	0.30%	1.19%	1.76%	1.61%	1.42%
3-month Treasury Bill	0.10%	0.17%	0.63%	1.11%	0.89%
Vanguard Treasury MM Inv	0.15%	0.17%	0.54%	1.01%	0.80%
3-month Treasury Bill	0.10%	0.17%	0.63%	1.11%	0.89%
Sector Funds					
Cohen & Steers Realty Shares	(13.53%)	(4.66%)	7.28%	8.10%	8.71%
FTSE NAREIT All Eq Index	(14.68%)	(5.89%)	5.34%	6.75%	8.03%

Active Manager Monitoring Summary

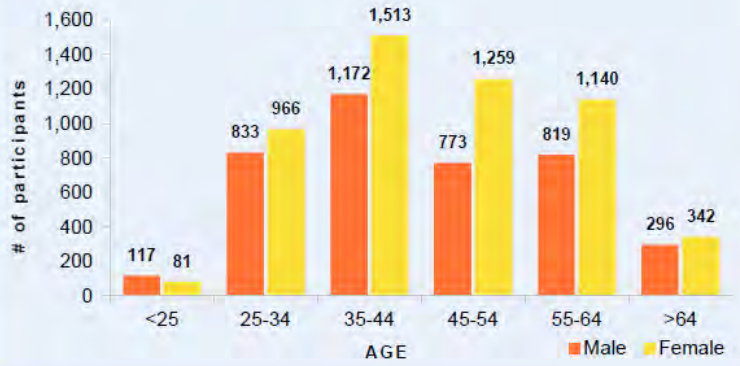
As of June 30, 2022

Manager	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	
Large U.S. Equity											
Franklin Growth Fund	Yes	No	No	No	No						Stable
Allspring Growth	Yes	No	No	No	No						On Watch
Vanguard Dividend Growth	Yes	No	Yes	Yes	Yes						Stable
Hartford Dividend and Growth	Yes	Yes	No	Yes	Yes						Stable
T. Rowe Price Equity Income	Yes	Yes	Yes	Yes	Yes						Stable
Mid U.S. Equity											
PGIM Jennison Mid-Cap Growth	Yes	Yes	Yes	Yes	Yes						Stable
Virtus Ceredex Mid-Cap Value	Yes	No	No	No	No						Stable
Small U.S. Equity											
Brown Small Compay Fund	Yes	No	Yes	No	No						Stable
DFA U.S. Small Cap	Yes	Yes	Yes	Yes	No						Stable
Northern Small Cap Value Fund	Yes	No	No	No	No						Stable
Global Equity											
AF New Perspective	Yes	Yes	Yes	Yes	Yes						Stable
Invesco Developing Markets	Yes	No	No	No	No						Stable
Fixed Income											
Baird Core Plus Bond	Yes	Yes	Yes	Yes	Yes						Stable
MM Premier Infl-Pr and Inc Srvc	Yes	No	No	No	No						Stable
PGIM High Yield Fund	Yes	Yes	Yes	Yes	Yes						Stable
Templeton Global Bond	Yes	No	No	No	No						On Watch
Sector Fund											
Cohen & Steers Realty Shares	Yes	Yes	Yes	Yes	Yes						Stable

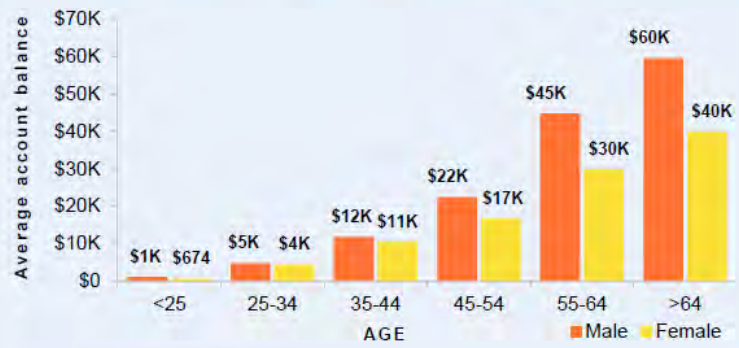
Assessment	Status and Actions
Stable	Firm, Team, Strategy are performing as expected
In Review	Callan is proposing that the fund be added to the watchlist
On Watch	Staff is reviewing strategy with consultant and scheduling an update meeting with manager
Terminating	Following staff review and consultant recommendation, manager will be terminated following a successful replacement search

Employee summary: Gender and age[1]

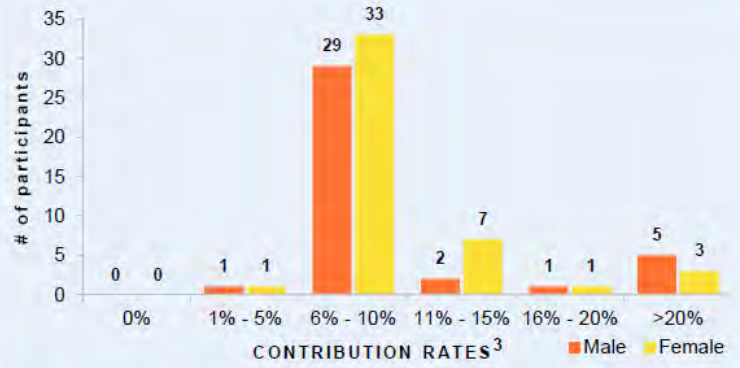
Demographics by Age and Gender



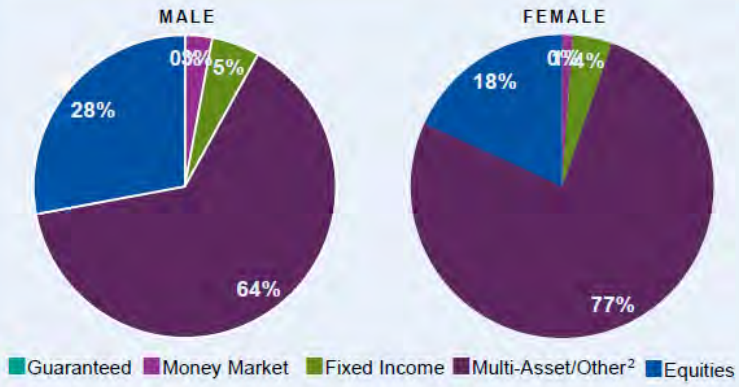
Average Account Balance by Age and Gender



Employee Contribution Rates by gender



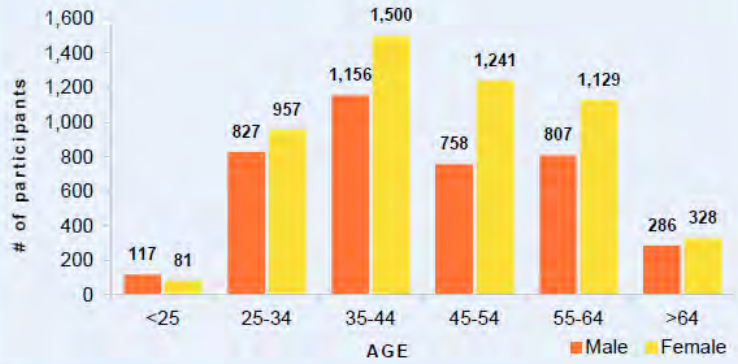
Diversification by Gender



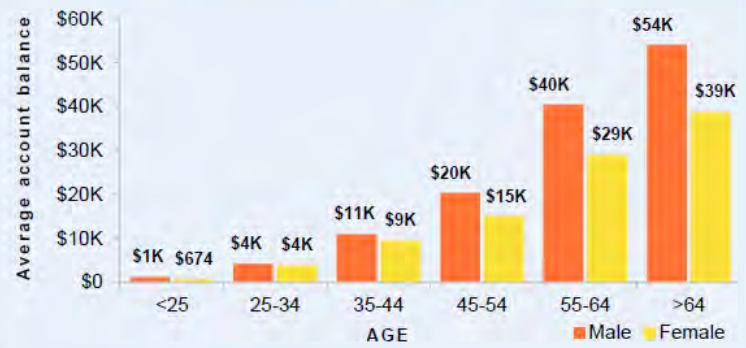
This report is as of the period ending 06/30/2022 and reflects the trailing 12 months of activity unless otherwise noted. The report includes all TIAA plans except 457(f), 457(b) Private, Nonqualified Deferred Compensation, and Retirement Healthcare plans. 1. Data reflected is for all participant statuses except Employee Contribution Rates by Gender which applies additional filters. Does not include 277 participants with no age or gender on file. 2. Multi-Asset/Other includes Lifecycle, Real Estate, and Brokerage. 3. Contribution data reflects the trailing 12 months of data.

Employee summary: Gender and age[1]

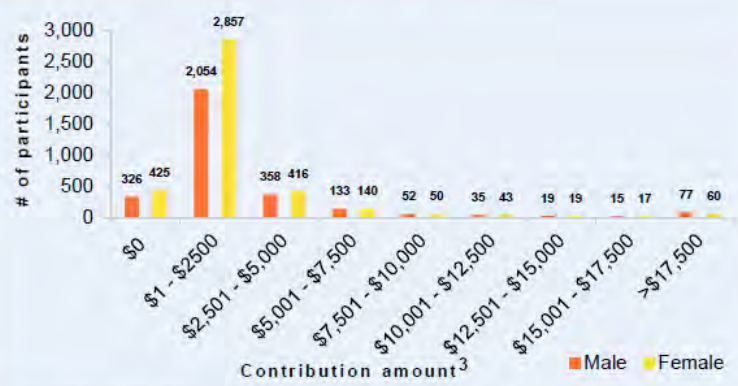
Demographics by Age and Gender



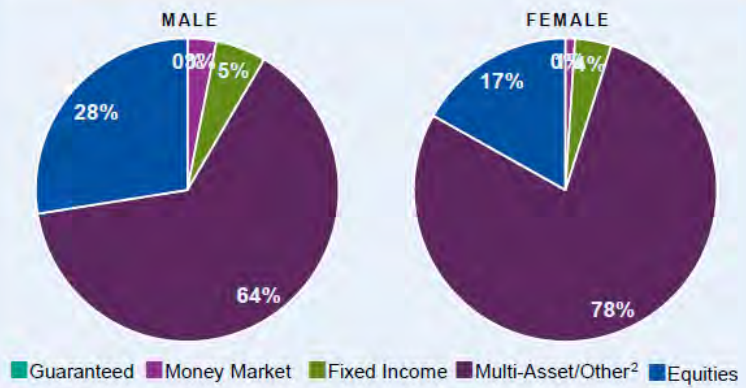
Average Account Balance by Age and Gender



Employee Contribution Amounts by Gender



Diversification by Gender



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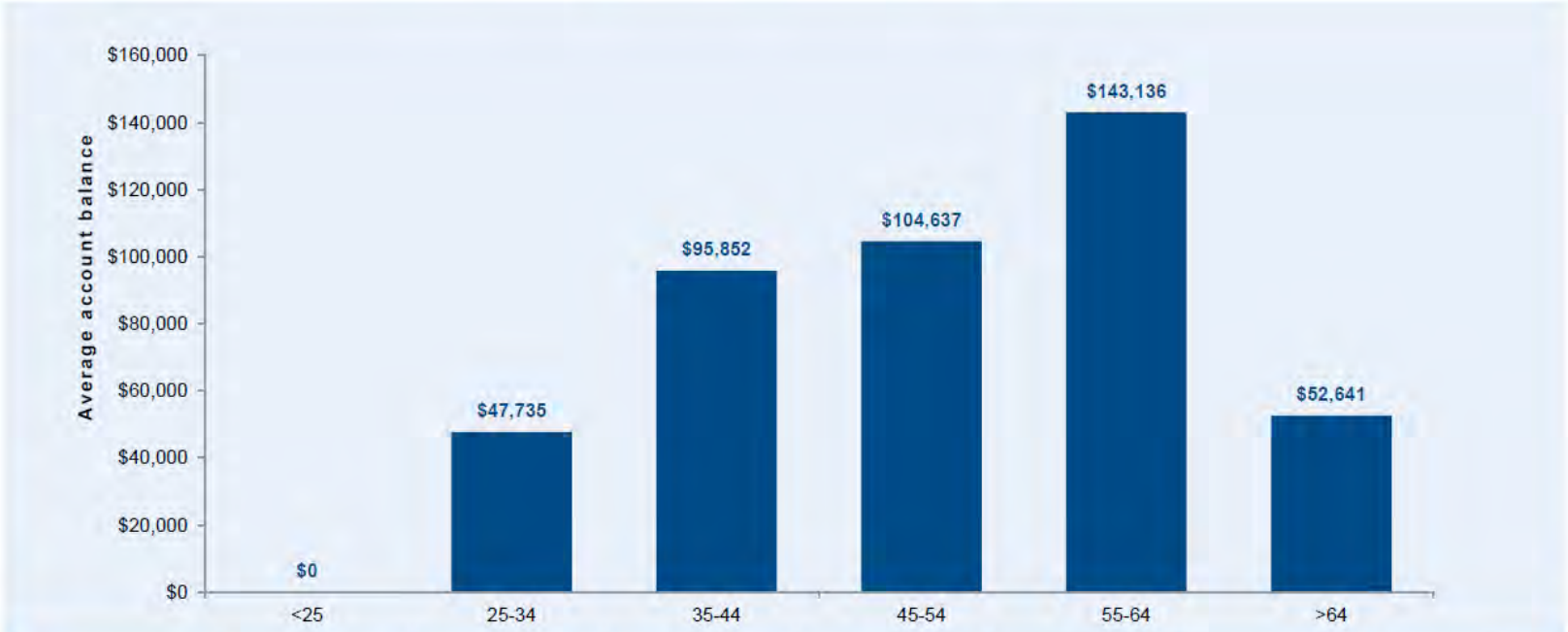
Active participants: Average account balance by age

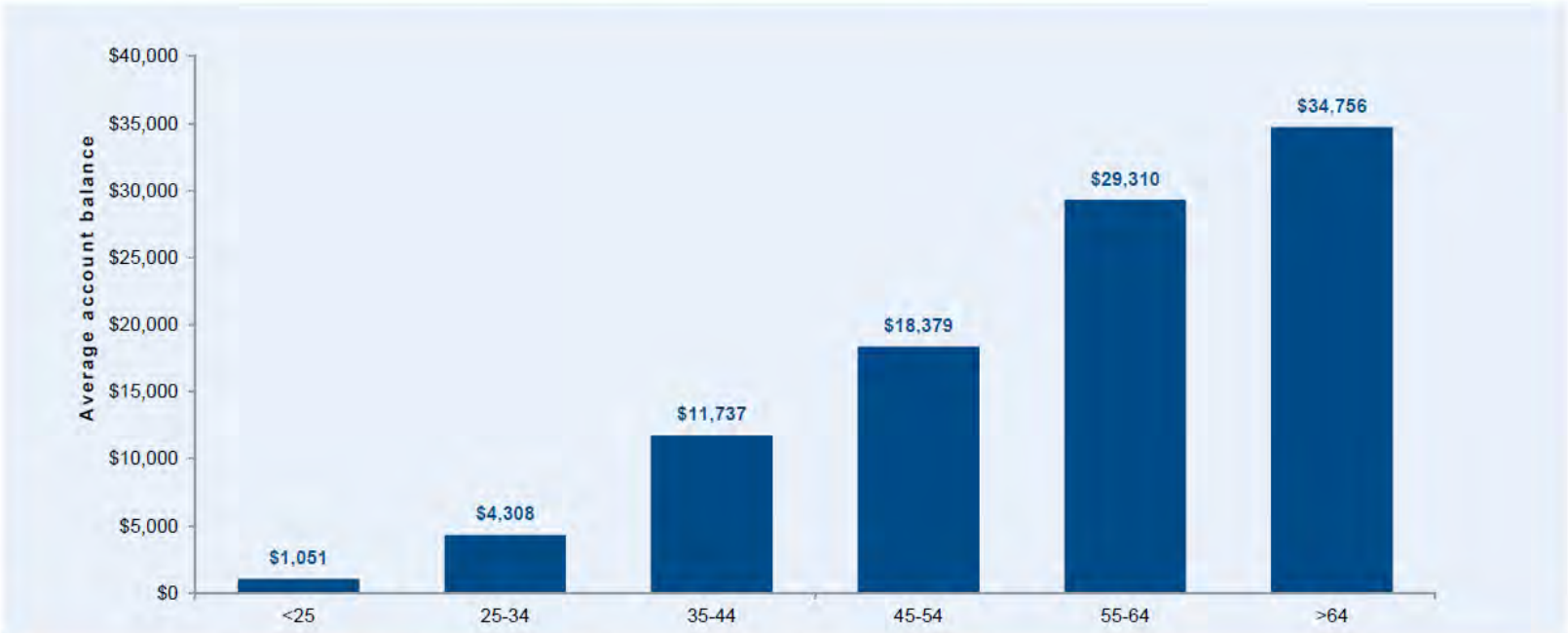


	<25	25-34	35-44	45-54	55-64	>64	Total
# of Active Participants	0	19	28	24	18	3	92
% of Total Active Participants	0%	21%	30%	26%	20%	3%	100%
Total Active Assets	$0	$906,974	$2,683,845	$2,511,290	$2,576,452	$157,922	$8,836,483
% of Total Active Assets	0%	10%	30%	28%	29%	2%	100%

This report is as of the period ending 06/30/2022 and reflects the trailing 12 months of activity unless otherwise noted. The report includes all TIAA plans except 457(f), 457(b) Private, Nonqualified Deferred Compensation, and Retirement Healthcare plans.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM COMPANION PLAN

Active participants: Average account balance by age



	<25	25-34	35-44	45-54	55-64	>64	Total
# of Active Participants	148	1294	1961	1557	1362	173	6,495
% of Total Active Participants	2%	20%	30%	24%	21%	3%	100%
Total Active Assets	$155,563	$5,574,966	$23,016,355	$28,616,379	$39,920,106	$6,012,808	$103,296,177
% of Total Active Assets	0%	5%	22%	28%	39%	6%	100%

This report is as of the period ending 06/30/2022 and reflects the trailing 12 months of activity unless otherwise noted. The report includes all TIAA plans except 457(f), 457(b) Private, Nonqualified Deferred Compensation, and Retirement Healthcare plans.

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

Scott A. Miller
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: September 13, 2022

SUBJECT: Investment Options Summary

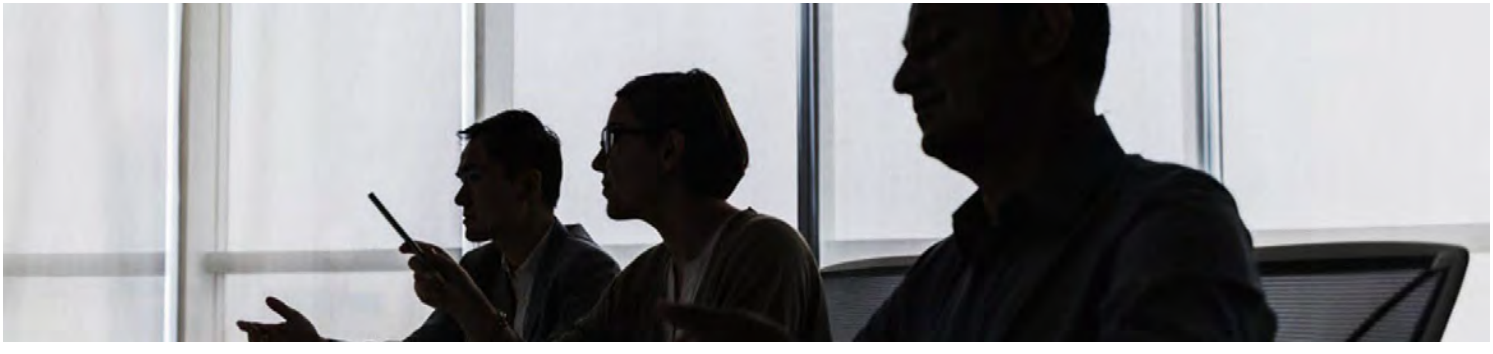
The updated Investment Options Summary for the NDPERS 457 Deferred Compensation Plan is now available. The booklet contains information on all the providers and investment options available in the plan. Inside you will find a description of the investment options available and the website link for the contact information for all the providers. For each active provider, all the investments are listed along with their investment objective, associated expenses, and historical performance.

Once a decision is made on the provider status of Waddell & Reed, The investment options summary will be placed on the NDPERS website:

https://www.ndpers.nd.gov/sites/www/files/documents/about/investments/investment-options.pdf

Attachment

2022 - 2023



Inve$tment Options

A SUMMARY FOR THE

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

DEFERRED
COMPENSATION PLAN

TABLE OF CONTENTS

SUMMARY OF INVESTMENT OPTIONS
NORTH DAKOTA EMPLOYEE'S RETIREMENT SYSTEM

Introduction

The information in this summary is organized into three sections. Section I details the investment options that are available through the NDPERS Deferred Compensation Companion Plan. Section II lists the other investment options currently available through the NDPERS Section 457 Deferred Compensation Plan. This information has been organized in alphabetical order by provider company. The investment objective, annual expenses, and historical performance information is provided for each investment option. Due to the inception date of some investment funds, historical performance information is not available and is indicated with "N/A" (not available). Instances in which information was not provided by the provider companies are indicated by "N/P" (not provided). Section III lists the representatives you can contact at each provider company for more information as of the date this summary was published. Updates to the list of registered provider representatives are published on the NDPERS website at the end of each quarter.

The annual expense column includes fund expense ratios and any applicable fees to pay for service, distribution, and marketing costs (12b-1 fees), operating expenses, asset management fees, separate account charges, or mortality and expense charges imposed by the provider. It does not, however, include any withdrawal, surrender or deferred sales charges or miscellaneous administrative fees. Whenever possible, withdrawal, surrender or deferred sales charges, etc. have been noted at the bottom of the page. Please refer to your prospectus or contact your provider company for more complete information. The column entitled "Other Fees" indicates whether additional information is footnoted below the table about fees and/or withdrawal provisions (Y=yes, N=no).

Performance results provided herein reflect all fund expense ratios and any applicable 12b-1 fees, operating expenses, asset management fees, separate account charges, or mortality and expense charges imposed by the provider company. They do not, however, reflect any withdrawal, surrender or deferred sales charges or account maintenance fees footnoted below each table in the sections entitled "Other Fees" and "Withdrawal Provisions".

Although all applicable fees for each provider company should be provided in this ***Summary of Investment Options***, you should discuss fees in detail with a provider company representative.

The following abbreviations are used in the "Type of Investment" column on the following pages:

FA – Fixed Annuity

MF – Mutual Fund

VA – Variable Annuity

CF – Commingled Fund

ANNUITIES VERSUS MUTUAL FUNDS

Annuities

The investment options currently offered through the NDPERS Section 457 Deferred Compensation Plan are set up primarily as annuities, although some are offered in the form of mutual funds. Deferred annuities are essentially tax-sheltered accounts offered by life insurance companies. They come in two basic forms, fixed or variable, and offer different benefits each suited to achieving very different retirement objectives. Fixed annuities pay a fixed nominal interest rate per period and guarantee a minimum rate of return. Variable annuities can range from conservative to aggressive investments and pay a rate linked to the investment performance of some underlying portfolio; therefore, the returns of variable annuity contracts are not guaranteed by the offeror. Many variable annuities are invested in mutual funds as the underlying investment. The annuity fund structure typically offers a guaranteed death benefit which provides safety of principal for beneficiaries. This structure results in an additional layer of fees above those that are paid for the underlying investment vehicle. Typically, the annual expenses associated with annuity solutions reflect a mortality and expense risk charge (insurance component, investment management expenses, administrative and recordkeeping charges, and declining surrender charges). Sales loads and marketing and distribution charges may apply but are often waived for institutional clients.

Mutual Funds

Mutual funds are registered with the Securities and Exchange Commission (SEC) and their prices and performance are usually reported daily in the newspapers. Commingled funds are pooled investment vehicles that are similar to mutual funds but are not registered with the SEC and may or may not be reported in the newspapers.

Mutual funds can range from conservative to aggressive, and their values will fluctuate according to the volatility of the securities in which the funds are invested. Mutual funds do not offer a guaranteed death benefit; therefore, their fees do not include an insurance component. Typically, the annual expenses associated with mutual funds reflect the investment management expenses and administrative and recordkeeping fees charged by the provider company. Again, sales loads and marketing and distribution charges may apply but are typically waived in the case of institutional accounts.

The investment funds that are available through the NDPERS Companion Plan consist of a series of mutual funds and a commingled fund. In the case of the Companion Plan, the annual fees

charged by mutual fund organizations to pay for service, distribution and marketing costs (12b-1 fees) are currently rebated back to participants by TIAA CREF. In addition, any front and deferred sales loads are currently waived by TIAA CREF.

The information included in this summary is strictly quantitative in nature and is intended to provide an evaluation of the returns and expenses associated with the investment options available through NDPERS deferred compensation program.

This summary does not present factors that are more subjective in nature such as: 1) the quality, availability, and responsiveness of client service; 2) verification of the investment style underlying the investment options; 3) the longevity and stability of the investment professionals managing the investment options; and 4) internet access and voice response systems. These factors should also be taken into consideration when selecting provider companies and investment options. Please contact your provider companies to obtain this information.

Please keep in mind when reviewing the historical performance information that past performance does not guarantee future performance. This ***Summary of Investment Options*** is not a prospectus. It is only intended to provide basic information about the available investment options. Please contact the individual provider companies for a prospectus containing more detailed information.

The material presented in this Summary of Investment Options has been compiled from information supplied by the provider companies to the NDPERS to the NDPERS Section 457 Deferred Compensation Plan. To the best of our knowledge this information is accurate and complete although we have not independently verified its accuracy or completeness.

ND Public Employees Retirement System, P.O. Box 1657, Bismarck, ND 58502-1657 Phone: 701-328-3900 • FAX: 701-328-3920 • Toll-free outside the Bismarck calling area: 1-800-803-7377
PERS Website: www.nd.gov/ndpers • PERS e-mail address: NDPERS@nd.gov

SECTION I

SUMMARY OF INVESTMENT OPTIONS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SECTION 457 DEFERRED COMPENSATION COMPANION PLAN

(INFORMATION CURRENT AS OF JUNE 30, 2022)

Fund/Ticker Symbol	Investment Type	Asset Class / Product Type	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/22	Net Historical Performance as of 12/31/2021			
					1 YR	3 YR	5 YR	10 YR
Allspring Growth Admin (SGRKX)	Large Growth	Equities / Mutual Fund	1.08% / 0.96%	-34.69%	7.61%	30.15	24.44	17.29
American Funds New Perspective R4 (RNPEX)	World Large Stock	Equities / Mutual Fund	0.76% / 0.76%	-27.17%	17.70%	26.84%	19.86%	15.41%
Baird Core Plus Bond Investor (BCOSX)	Intermediate Core-Plus Bond	Fixed Income / Mutual Fund	0.55% / 0.55%	-11.24%	-1.23%	5.57%	4.06%	3.68%
Brown Capital Mgmt Small Co Inv (BCSIX)	Small Growth	Equities / Mutual Fund	1.25% / 1.25%	-34.26%	-4.17%	21.62%	18.16%	17.11%
Cohen & Steers Realty Shares (CSRSX)	Real Estate	Equities / Mutual Fund	0.93% / 0.88%	-18.69%	42.61%	22.55%	13.56%	12.52%
Columbia Mid Cap Index A (NTIAX)	Mid-Cap Blend	Equities / Mutual Fund	0.58% / 0.45%	-19.69%	24.20%	20.85%	12.55%	13.67%
DFA US Small Cap I (DFSTX)	Small Blend	Equities / Mutual Fund	0.27% / 0.27%	-18.85%	30.61%	20.91%	11.36%	13.66%
Franklin Growth Adv (FCGAX)	Large Growth	Equities / Mutual Fund	0.54% / 0.54%	-26.52%	22.10%	28.44%	21.14%	17.31%

Fund/Ticker Symbol	Investment Type	Object	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/22	Net Historical Performance as of 12/31/2021			
					1 YR	3 YR	5 YR	10 YR
Invesco Oppenheimer Developing Markets Fund Class Y (ODVYX)	Diversified Emerging Markets	Equities / Mutual Fund	0.95% / 0.95%	-25.31%	-7.25%	10.65%	10.02%	6.47%
MassMutual Premier Infl-Protected and Income Svc (MIPYX)	Inflation-Protected Bond	Fixed Income / Mutual Fund	0.67% / 0.67%	-9.93%	6.14%	8.45%	5.34%	3.04%
Northern Small Cap Value (NOSGX)	Small Value	Equities / Mutual Fund	1.15% / 1.00%	-15.49%	26.37%	14.72%	6.76%	10.89%
PGIM High Yield Fund Class Z (PHYZX)	High Yield	Fixed Income / Mutual Fund	0.50% / 0.50%	-13.51%	6.33%	9.23%	6.75%	6.96%
PGIM Jennison Mid-Cap Growth Fund Class Z (PEGZX)	Mid-Cap Growth	Equities / Mutual Fund	0.70% / 0.70%	-29.07%	11.70%	29.90%	19.80%	15.12%
T. Rowe Price Capital Appreciation Adv (PACLX)	Allocation--50% to 70% Equity	Equities / Mutual Fund	0.99% / 0.97%	-14.41%	18.22%	20.04%	14.83%	13.46%
T. Rowe Price Equity Income (PRFDX)	Large Value	Equities / Mutual Fund	0.63% / 0.63%	-8.38%	25.68%	17.25%	11.17%	11.95%
Templeton Global Bond Adv (TGBAX)	World Bond	Fixed Income / Mutual Fund	0.73% / 0.72%	-6.85%	-4.74%	-2.71%	-0.84%	1.74%
The Harford Dividend and Groth Fund Class R5 (HDGTX)	Large Value	Equities / Mutual Fund	0.73% / 0.73%	-12.20%	31.25%	21.99%	15.22%	14.45%

Fund/Ticker Symbol	Investment Type	Object	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/22	Net Historical Performance as of 12/31/2021			
					1 YR	3 YR	5 YR	10 YR
TIAA-CREF Lifecycle Retirement Income Fund (Retirement) (TLIRX)	Target-Date Retirement	Multi-Asset / Mutual Fund	0.78% / 0.62%	-13.01%	6.84%	10.83%	7.87%	6.99%
TIAA-CREF Lifecycle 2010 Fund (Retirement) (TCLEX)	Target-Date 2000-2010	Multi-Asset / Mutual Fund	0.77% / 0.62%	-12.95%	6.65%	10.85%	7.98%	7.39%
TIAA-CREF Lifecycle 2015 Fund (Retirement) (TCLIX)	Target-Date 2015	Multi-Asset / Mutual Fund	0.78% / 0.63%	-13.54%	7.43%	11.70%	8.57%	7.99%
TIAA-CREF Lifecycle 2020 Fund (Retirement) (TCLTX)	Target-Date 2020	Multi-Asset / Mutual Fund	0.78% / 0.64%	-14.35%	8.22%	12.54%	9.21%	8.69%
TIAA-CREF Lifecycle 2025 Fund (Retirement) (TCLFX)	Target-Date 2025	Multi-Asset / Mutual Fund	0.81% / 0.66%	-15.45%	9.48%	13.90%	10.13%	9.53%
TIAA-CREF Lifecycle 2030 Fund (Retirement) (TCLNX)	Target-Date 2030	Multi-Asset / Mutual Fund	0.83% / 0.67%	-16.70%	10.97%	15.30%	11.07%	10.36%
TIAA-CREF Lifecycle 2035 Fund (Retirement) (TCLRX)	Target-Date 2035	Multi-Asset / Mutual Fund	0.85% / 0.68%	-17.87%	12.43%	16.68%	11.97%	11.12%
TIAA-CREF Lifecycle 2040 Fund (Retirement) (TCLOX)	Target-Date 2040	Multi-Asset / Mutual Fund	0.87% / 0.69%	-18.90%	13.99%	18.06%	12.86%	11.73%

Fund/Ticker Symbol	Investment Type	Object	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/22	Net Historical Performance as of 12/31/2021			
					1 YR	3 YR	5 YR	10 YR
TIAA-CREF Lifecycle 2045 Fund (Retirement) (TTFRX)	Target-Date 2045	Multi-Asset / Mutual Fund	0.89% / 0.70%	-19.86%	15.62%	19.36%	13.59%	12.10%
TIAA-CREF Lifecycle 2050 Fund (Retirement) (TLFRX)	Target-Date 2050	Multi-Asset / Mutual Fund	0.90% / 0.70%	-20.27%	16.09%	19.63%	13.76%	12.21%
TIAA-CREF Lifecycle 2055 Fund (Retirement) (TTRLX)	Target-Date 2055	Multi-Asset / Mutual Fund	0.91% / 0.70%	-20.39%	16.35%	19.82%	13.88%	12.29%
TIAA-CREF Lifecycle 2060 Fund (Retirement) (TLXRX)	Target-Date 2060	Multi-Asset / Mutual Fund	0.96% / 0.70%	-20.43%	16.59%	20.01%	14.01%	n/a
TIAA-CREF Lifecycle 2065 Fund (Retirement) (TSFRX)	Target-Date 2065+	Multi-Asset / Mutual Fund	4.04% / 0.70%	-20.39%	17.15%	n/a	n/a	n/a

Fund/Ticker Symbol	Investment Type	Object	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/22	Net Historical Performance as of 12/31/2021			
					1 YR	3 YR	5 YR	10 YR
Vanguard Dividend Growth Inv (VDIGX)	Large Blend	Equities / Mutual Fund	0.27% / 0.27%	-11.02%	24.84%	22.36%	16.97%	14.65%
Vanguard Institutional Index I (VINIX)	Large Blend	Equities / Mutual Fund	0.035% / 0.035%	-19.97%	28.67%	26.05%	18.44%	16.52%
Vanguard Total Bond Market Index Adm (VBTLX)	Intermediate-Term Bond	Fixed Income / Mutual Fund	0.05% / 0.05%	-10.42%	-1.67%	4.82%	3.58%	2.86%
Vanguard Total Intl Stock Index Admiral (VTIAX)	Foreign Large Blend	Equities / Mutual Fund	0.11% / 0.11%	-18.16%	8.62%	13.67%	9.90%	7.68%
Vanguard Treasury Money Mkt Inv (VUSXX)	Money Market - Taxable	Money Market / Mutual Fund	0.09% / 0.09%	0.17%	0.01%	0.87%	1.04%	0.55%
VIRTUS CEREDEX MID-CAP VALUE EQUITY I (SMVTX)	Mid-Cap Value	Equities / Mutual Fund	0.99% / 0.99%	-19.38%	28.99%	19.26%	11.79%	13.34%
Galliard Stable Stable Return Fund – J	Stable Value	Stable Value / Other Investment	0.866% / 0.866%	0.58%	1.24%	1.49%	1.39%	1.16%

Additional investment options are available through the self-directed brokerage (Mutual Fund Window).

SECTION II

SUMMARY OF INVESTMENT OPTIONS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SECTION 457 DEFERRED COMPENSATION PLAN

(INFORMATION CURRENT AS OF JUNE 30, 2022)

The NDPERS Board provides this Summary as a service to the deferred compensation participants to help them make an informed decision regarding their investments. The NDPERS Board has not examined the investment options described in Section II of this Summary, and makes neither recommendation nor warranty regarding those options. The investment options offered are those the individual provider companies have determined they will offer to the participants using the provider's services.

Unless otherwise noted, performance results provided herein reflect all fund expense ratios and any applicable 12b-1 fees, operating expenses, asset management fees, separate account charges, or mortality and expense charges imposed by the provider company. They do not, however, reflect any withdrawal, surrender, or deferred sales charges or account maintenance fees footnoted below each table in the sections entitled "Other Fees" and "Withdrawal Provisions."

BANK OF NORTH DAKOTA INVESTMENT OPTIONS

For more information, call Bank of North Dakota at (701) 328-5617 or (701) 328-5652 or refer to List of Representatives in Section III

Fund/Ticker Symbol	Type of Investment	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended June 30, 2022	Net Historical Performance As of December 31, 2021 1 Year	3 Years	5 Years	10 Years
Open Savings Statement (Variable Rate Account)	Savings	Stability of Principal	None	N	0.50%*	N/P	N/P	N/P	N/P

Other Fees: None

Withdrawal Provisions: No fee unless account is moved prior to eighteen months. Applicable fee is six months of interest.

**Rate presented is an annual interest rate that changes January 1. Call Bank of North Dakota to obtain the current new money rate.*

N/P – Not provided

Fund / Ticker Symbol	Type of Investment		Annual Expense (Net)	Other Fees (Y/N)	Return 6 mos. Ended	Historical Performance as of DECEMBER 31, 2021			
					Jun 30, 2022	1 Year	3 Years	5 Years	10 Years
Federated Government Obligations Fund/GOFXX	Mutual Fund	Stable Value	0.15%	Y*	0.17	0.02	0.84	1.01	-
Vanguard Retirement Savings Trust/VRSTX	Mutual Fund	Stable Value	0.45%	Y *	0.61	1.33	1.91	1.92	1.93
BlackRock Inflation Protected Bond K/BPLBX	Mutual Fund	Treasury Inflation Protected Securities (TIPS/Fixed Income)	0.30%	Y *	-8.72	5.84	8.63	5.36	2.99
Vanguard GNMA/VFIJX	Mutual Fund	Bond/Fixed Income	0.11%	Y *	-7.95	-1.02	2.87	2.31	2.18
Western Asset Core Bond IS/WACSX	Mutual Fund	Bond/Fixed Income	0.43%	Y *	-13.71	-1.80	5.81	4.37	3.98
Principal High Yield R-6/PHYFX	Mutual Fund	Bond/High Yield	0.52%	Y *	-12.07	5.72	8.64	5.80	6.37
Vanguard Index 500 Admiral/VFIAX	Mutual Fund	Large Cap Blend/Equity	0.04%	Y*	-19.98	28.66	26.03	18.43	16.51
American Funds American Mutual R6/RMFGX	Mutual Fund	Large Cap Value/Equity	0.27%	Y *	-8.24	25.33	17.17	13.26	13.01
JP Morgan Equity Income R6/OIEJX	Mutual Fund	Large Cap Value/Equity	0.46%	Y*	-8.71	25.44	18.16	13.23	13.64
PRIMECAP Odyssey Growth/POGRX	Mutual Fund	Large Cap Growth/Equity	0.65%	Y*	-19.52	18.54	19.72	16.69	16.53
MFS Growth R6/MFEKX	Mutual Fund	Large Cap Growth/Equity	0.49%	Y *	-29.30	23.76	30.98	24.76	19.26
Vanguard Mid Cap Index Admiral/VIMAX	Mutual Fund	Mid Cap Blend/Equity	0.05%	Y*	-22.21	24.51	24.48	15.86	15.12
Baird Mid Cap Inst/BMDIX	Mutual Fund	Mid Cap Growth/Equity	0.80%	Y*	-30.68	22.51	31.06	22.96	16.58
Vanguard Small Cap Value Index Admiral/VSIAX	Mutual Fund	Small Cap Value/Equity	0.07%	Y*	-15.48	28.09	18.51	10.31	13.30
JP Morgan Small Cap EquityR6/VSENX	Mutual Fund	Small Cap Growth/Equity	0.74%	Y*	-20.31	16.29	21.16	13.46	14.45
MFS International Diversification R6/MDIZX	Mutual Fund	International/Equity	0.73%	Y*	-20.22	7.78	16.19	12.72	9.56
Vanguard Developed Markets Index Admiral/VTMGX	Mutual Fund	International/Equity	0.07%	Y*	-19.26	11.43	14.46	10.15	8.51
Principal Diversified Real Asset Fund R6/PDARX	Mutual Fund	Real Asset/Equity	0.78%	Y *	-4.82	17.42	11.98	7.37	4.41

Fund / Ticker Symbol	Type of Investment		Annual Expense (Net)	Other Fees (Y/N)	Return 6 mos. Ended	Historical Performance as of DECEMBER 31, 2021			
					JUN 30, 2022	1 Year	3 Years	5 Years	10 Years
T Rowe Price Science & Technology/TSNIX	Mutual Fund	Sector/Equity	0.65%	Y*	-31.38	5.60	31.01	23.90	19.82
Vanguard Health Care/VGHAX	Mutual Fund	Sector/Equity	0.25%	Y *	-8.47	14.36	16.59	13.93	15.37
Vanguard REIT Index Fund Admiral/VGSLX	Mutual Fund	Sector/Equity	0.12%	Y*	-20.51	40.40	19.95	11.24	11.51
Vanguard Conservative/VSCGX	Mutual Fund	Lifestrategy	0.12%	Y *	-14.21	6.05	11.01	8.05	7.09
Fidelity® Balanced Z/FZAAX	Mutual Fund	Lifestrategy	0.45%	Y *	-18.10	18.32	21.68	15.03	12.43
Vanguard Moderate/VSMGX	Mutual Fund	Lifestrategy	0.13%	Y *	-16.22	10.08	14.28	10.30	9.12
Vanguard Growth/VASGX	Mutual Fund	Lifestrategy	0.14%	Y *	-18.19	14.35	17.58	12.53	11.12
Vanguard Target Retirement Income Inv/VTINX	Mutual Fund	Target Date	0.08%	Y *	-11.79	5.25	9.43	6.85	5.88
Vanguard Target Retirement 2015 Inv/VTXVX	Mutual Fund	Target Date	0.08%	Y *	-11.84	5.78	10.24	7.71	7.46
Vanguard Target Retirement 2020 Inv/VTWNX	Mutual Fund	Target Date	0.08%	Y *	-13.80	8.17	12.55	9.26	8.71
Vanguard Target Retirement 2025 Inv/VTTVX	Mutual Fund	Target Date	0.08%	Y *	-15.63	9.80	14.17	10.35	9.60
Vanguard Target Retirement 2030 Inv/VTHRX	Mutual Fund	Target Date	0.08%	Y *	-16.66	11.38	15.45	11.23	10.36
Vanguard Target Retirement 2035 Inv/VTTHX	Mutual Fund	Target Date	0.08%	Y *	-17.37	12.96	16.66	12.06	11.10
Vanguard Target Retirement 2040 Inv/VFORX	Mutual Fund	Target Date	0.08%	Y *	-18.08	14.56	17.89	12.88	11.69
Vanguard Target Retirement 2045 Inv/VTIVX	Mutual Fund	Target Date	0.08%	Y *	-18.82	16.16	19.06	13.55	12.04
Vanguard Target Retirement 2050 Inv/VFIFX	Mutual Fund	Target Date	0.08%	Y *	-19.06	16.41	19.19	13.62	12.07
Vanguard Target Retirement 2055 Inv/VFFVX	Mutual Fund	Target Date	0.08%	Y *	-19.07	16.44	19.18	13.61	12.05
Vanguard Target Retirement 2060 Inv/VTTSX	Mutual Fund	Target Date	0.08%	Y *	-19.07	16.44	19.17	13.61	-
Vanguard Target Retirement 2065 Inv/VLXVX	Mutual Fund	Target Date	0.08%	Y *	-19.03	16.46	19.13	-	-

Other Fees:

Withdrawal Provisions – None

*Bravera Wealth Fee: 0.60%
*Investment/Advisor: 0.50%

Termination/Distribution/In-Service Processing Fee $85 paper; $50 on-line
Transaction fees apply for the following services (fee quoted to participant at time of request): Certified mail, express delivery, cashier's check, wire transfers, and returned/lost/stop payment and reissued checks
QDRO Processing Fees: Review and Communication $250; Account Division $100; Alternate Payee Distribution $85

Bravera Wealth will track the trades and provide a warning notice when the shareholder hits the first violation and will block the second as defined below. The first time a shareholder completes a roundtrip transaction, defined as a buy in and sell out of greater than $10,000 that occurs within a 30 calendar day period, a warning letter will be sent to the shareholder reminding them of the policy.

VANGUARD GNMA-ADM, VANGUARD HEALTH CARE-ADM, VANGUARD INDEX 500-ADM, VANGUARD MID CAP IDX-ADM, VANGUARD REIT INDEX ADM, VANGUARD SELECTED VALUE, VANGUARD SMALL CAP VALUE INDEX ADM, Life Strategy-CONSERVATIVE, Life Strategy-GROWTH, and Life Strategy-MODERATE, VANGUARD TARGET DATE INCOME, 2015, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060, 2065:
A round trip is defined as a buy and sell that occur within 30 days. Excessive trading violation will result in a trading restriction period of 30 days. Maximum of 1 round trip allowed per 30 days period.

T. ROWE PR SCI & TECH
Maximum of 1 round trip allowed per 30 days period. In addition to restricting transactions in accordance with the 30-Day Purchase Block, T. Rowe Price may, in its discretion, reject any purchase or exchange into a fund from a person whose trading activity could disrupt the management of the fund or dilute the value of the fund's shares, including trading by persons acting collectively. Such persons may be barred from further purchases of T. Rowe Price funds for a period longer than 30 calendar days or permanent.

JPMORGAN EQ INC
Excessive trading violation will result in a trading restriction period of 90 days. Maximum of 1 round trip allowed per 60 days period.

JPMORGAN SM CAP EQ
Excessive trading violation will result in a trading restriction period of 90 days. Maximum of 1 round trip allowed per 60 days period

BAIRD MID CAP INST
In addition, if market timing is detected in an omnibus account held by a financial intermediary, the Funds may request that the intermediary restrict or prohibit further purchases or exchanges of Fund shares by any shareholder that has been identified as having violated the Market Timing Policy. The Funds may also request that the intermediary provide identifying information, such as social security numbers, and trading information about the underlying shareholders in the account in order to review any unusual patterns of trading activity discovered in the omnibus account..

WESTERN ASSET CORE BOND FUND IS
The policies apply to any account, whether a direct account or accounts with financial intermediaries such as investment advisers, broker/dealers or retirement plan administrators, commonly called omnibus accounts, where the intermediary holds fund shares for a number of its customers in one account. The fund's ability to monitor trading in omnibus accounts may, however, be severely limited due to the lack of access to an individual investor's trading activity when orders are placed through these types of accounts. There may also be operational and technological limitations on the ability of the fund's service providers to identify or terminate frequent trading activity within the various types of omnibus accounts. The distributor has entered into agreements with intermediaries requiring the intermediaries to, among other things, help identify frequent trading activity and prohibit further purchases or exchanges by a shareholder identified as having engaged in frequent trading.

FIDELITY® BALANCED K
Shareholders with two or more roundtrip transactions in a single fund within a rolling 90-day period will be blocked from making additional purchases or exchange purchases of the fund for 85 days. Shareholders with four or more roundtrip transactions across all Fidelity® funds within any rolling 12-month period will be blocked for at least 85 days from additional purchases or exchange purchases across all Fidelity® funds. Any roundtrip within 12 months of the expiration of a multi-fund block will initiate another multi-fund block. Repeat offenders may be subject to long-term or permanent blocks on purchase or exchange purchase transactions in any account under the shareholder's control at any time. In addition to enforcing these roundtrip limitations, the fund may in its discretion restrict, reject, or cancel any purchases or exchanges that, in the Adviser's opinion, may be disruptive to the management of the fund or otherwise not be in the fund's interests.

MFS GROWTH, MFS INTERNATIONAL DIVERSIFICATION
MFSC will generally restrict, reject or cancel purchase and exchange orders into the fund if MFSC determines that an accountholder has made two exchanges, each in an amount of $15,000 or more, out of an account in the fund during a calendar quarter ("two exchange limit").

PRINCIPAL DIVERSIFIED REAL ASSET FUND, PRINCIPAL HIGH YIELD
Principal may require a holding period of a minimum of 30 days before permitting exchanges among the Fund where there is evidence of at least one round-trip exchange (exchange or redemption of shares that were purchased within 30 days of the exchange/redemption).

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.22	Net Historical Performance as of 12.31.21			
						1 Year	3 Years	5 Years	10 Years
Nationwide Investor Destination Aggressive (Service Class) NDASX	VA	Asset Allocation	0.91	Y	-21.15	17.15	18.66	12.45	11.42
Nationwide Investor Destination Moderately Aggressive (Service Class) NDMSX	VA	Asset Allocation	0.92	Y	-19.79	14.68	17.02	11.47	10.25
Nationwide Investor Destination Moderate (Service Class) NSDMX	VA	Asset Allocation	0.91	Y	-17.16	11.31	13.93	9.45	8.31
Nationwide Investor Destination Moderately Conservative (Service Class) NSDCX	VA	Asset Allocation	0.89	Y	-14.36	7.42	10.66	7.25	6.29
Nationwide Investor Destination Conservative (Service Class) NDCSX	VA	Asset Allocation	0.90	Y	-11.42	3.61	7.33	5.02	4.18
Putnam International Equity Fund (Class A) POVSX	VA	Foreign Stock	1.23	Y	-20.97	8.72	15.09	9.23	8.19
Templeton Foreign Fund (Class A) TEMFX	VA	Foreign Stock	1.10	Y	-10.14	5.07	5.55	3.19	5.02
Janus Henderson Global Research (Class T) JAWWX	VA	World Stock	0.97	Y	-22.69	17.86	22.14	16.53	12.77
Invesco Global (Class A) OPPAX	VA	World Stock	1.03	Y	-31.91	15.36	24.65	17.93	14.00

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.22	Net Historical Performance as of 12.31.21			
						1 Year	3 Years	5 Years	10 Years
Templeton Global Smaller Companies Fund (Class A) TEMGX	VA	World Stock	1.31	Y	-25.91	15.14	17.52	10.85	10.06
Brown Capital Management Small Company Fund (Investor Class) BCSIX	VA	Small Growth	1.25	Y	-34.26	-4.17	21.62	18.16	17.11
NVIT Small Company Fund (Class 1)	VA	Small Blend	1.06	Y	-21.40	30.84	26.35	14.87	14.77
DFA US Micro Cap Portfolio (Institutional Class) DFSCX	VA	Small Blend	0.41	Y	-17.77	33.50	19.75	11.03	13.69
American Century Small Cap Value (Investor Class) ASVIX	VA	Small Value	1.09	Y	-16.44	36.91	25.80	12.73	13.89
BNY Mellon Mid Cap Index Fund (Investor Class) PESPX	VA	Mid Blend	0.50	Y	-19.73	24.16	20.81	12.54	13.66
Nationwide Mellon Dynamic U.S. Core Fund (Class R6) MUIGX	VA	Large Blend	0.50	Y	-23.32	30.29	28.79	21.79	17.32
Janus Henderson Research Fund (Class T) JAMRX	VA	Large Growth	0.79	Y	-30.43	20.27	29.23	21.46	17.63
Invesco American Franchise Fund (Class A) VAFAX	VA	Large Growth	0.97	Y	-27.90	11.85	29.48	21.57	17.15

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.22	Net Historical Performance as of 12.31.21			
						1 Year	3 Years	5 Years	10 Years
Invesco Capital Appreciation (Class A) OPTFX	VA	Large Growth	0.95	Y	-28.17	22.35	31.40	21.97	16.49
Aberdeen U.S. Sustainable Leaders Fund (Institutional Service Class) GXXIX	VA	Large Growth	0.97	Y	-26.97	25.05	29.14	19.49	15.34
Invesco Diversified Dividend Fund (Investor Class) LCEIX	VA	Large Value	0.70	Y	-7.89	19.04	14.31	8.32	11.39
Davis NY Venture Fund (Class A) NYVTX	VA	Large Blend	0.89	Y	-20.30	12.51	17.95	11.76	12.53
Nationwide Fund (Institutional Service Class) MUIFX	VA	Large Blend	0.65	Y	-20.66	24.97	26.13	17.72	15.62
Neuberger Berman Large Cap Value Fund (Trust Class) NBPTX	VA	Large Value	1.04	Y	-8.52	27.82	21.81	15.13	14.42
American Century Value Fund (Investor Class) TWVLX	VA	Large Value	1.01	Y	-7.70	24.21	16.63	9.30	11.76
Invesco Growth & Income Fund (Class A) ACGIX	VA	Large Value	0.80	Y	-13.10	28.63	18.14	10.26	12.32
BNY Mellon Balanced Opportunity Fund (Class Z) DBOZX	VA	Moderate Allocation	0.97	Y	-17.91	14.84	15.13	10.36	10.26

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.22	Net Historical Performance as of 12.31.21			
						1 Year	3 Years	5 Years	10 Years
MFS Total Return (Class A) MSFRX	VA	Moderate Allocation	0.72	Y	-12.83	13.98	14.55	9.70	9.45
PIMCO Int'l Bond Fund (Class A) PFOAX	VA	World Bond	0.91	Y	-8.62	-2.06	3.45	3.13	4.36
Janus Henderson High Yield Fund (Class T) JAHYX	VA	High Yield Bond	0.87	Y	-16.48	5.56	8.70	5.72	6.14
Federated Hermes Corporate Bond Fund (Class A) FDBAX	VA	Corporate Bond	0.86	Y	-13.47	0.03	7.41	5.10	4.82
PIMCO Total Return Fund (Admin Class) PTRAX	VA	Intermediate Term Bond	0.71	Y	-11.42	-1.09	5.07	3.89	3.42
Franklin U.S. Government Secs (Class A1) FKUSX	VA	Intermediate Govt Bond	0.77	Y	-7.25	-2.06	2.23	1.54	1.34
Nationwide Gvt Money Market Fund (Investor Shares) MIFXX	VA	Money Market	0.56	Y	0.06	0.01	0.65	0.72	0.36

Past performance is no guarantee of future performance.

Investment returns and principal value will fluctuate and the investors' units, when redeemed, may be worth more or less than their original cost.

** New money rates are set every quarter, please call Nationwide to obtain the current new money rate.*

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Securian Global Real Estate Fund (Class A) IREAX	MF	Total Return	1.48%	N	15.86	-4.94	2.66	3.55	N/A
Deleware Ivy Securian Global Real Estate Fund (Class I) ERESX	MF	Total Return	1.05%	N	16.09	-4.50	3.12	3.89	N/A
Deleware Ivy Pictet Emerging Markets Local Currency Debt Fund (Class A) IECAX	MF	Total Return	1.20%	N	12.90	4.64	0.92	3.96	N/A
Deleware Ivy Pictet Emerging Markets Local Currency Debt Fund (Class I) IECIX	MF	Total Return	0.81%	N	13.06	4.99	1.33	4.33	N/A
Deleware Ivy Mid Cap Income Opportunities Fund (Class A) IVOAX	MF	Total Return	0.81%	N	23.76	7.81	9.14	12.24	N/A
Deleware Ivy Mid Cap Income Opportunities Fund (Class I) IVOIX	MF	Total Return	1.24%	N	24.05	8.27	9.55	12.64	N/A
Deleware Ivy Apollo Multi-Asset Income Fund (Class A) IMAAX	MF	High Income	1.21%	N	15.51	3.87	4.57	6.23	N/A
Deleware Ivy Apollo Multi-Asset Income Fund (Class I) IMAIX	MF	High Income	0.76%	N	15.77	4.35	5.00	6.60	N/A
Deleware Ivy Apollo Strategic Income Fund (Class A) IAPOX	MF	High Income	1.06%	N	9.13	7.25	5.07	5.43	N/A

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Apollo Strategic Income Fund (Class I) IIPOX	MF	High Income	0.68%	N	9.22	7.55	5.42	5.77	N/A
Deleware Ivy Pictet Targeted Return Bond Fund (Class A) IRBAX	MF	Total Return	1.22%	N	3.14	3.35	3.65	N/A	N/A
DelewareIvy Pictet Targeted Return Bond Fund (Class I) IRBIX	MF	Total Return	1.00%	N	3.25	3.56	3.86	N/A	N/A
Deleware Ivy California Municipal High Income Fund (Class A) IMHAX	MF	High Income	0.81%	N	3.95	2.97	3.80	N/A	N/A
Deleware Ivy California Municipal High Income Fund (Class I) IMHIX	MF	High Income	0.61%	N	4.06	3.18	4.01	N/A	N/A
Deleware Ivy International Small Cap Fund (Class A) IVJAX	MF	Capital Growth	1.37%	N	28.62	14.28	4.59	N/A	N/A
Deleware Ivy International Small Cap Fund (Class I) IVJIX	MF	Capital Growth	0.99%	N	28.78	14.74	5.00	N/A	N/A
Deleware Ivy Proshares SP500 Div Aristocrats Index Fund (Class A) IDAAX	MF	Total Return	0.95%	N	19.87	7.88	9.74	N/A	N/A
Deleware Ivy Proshares SP500 Div Aristocrats Index Fund (Class I) IDAIX	MF	Capital Growth	1.23%	N	20.01	8.15	10.00	N/A	N/A

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Proshares Russell 2000 Div Growers Index Fund (Class A) IRUAX	MF	Index Return	0.88%	N	19.35	-5.36	2.98	N/A	N/A
Deleware Ivy Proshares Russell 2000 Div Growers Index Fund (Class I) IRUIX	MF	Index Return	0.65%	N	19.49	-5.20	3.23	N/A	N/A
Deleware Ivy Proshares Interest Rate Hedged HY Index Fund (Class A) IAIRX	MF	Index Return	0.90%	N	10.48	0.38	2.84	N/A	N/A
Deleware Ivy Proshares Interest Rate Hedged HY Index Fund (Class I) IIIRX	MF	Index Return	0.65%	N	10.74	0.63	3.14	N/A	N/A
Deleware Ivy ProShares S&P 500 Bond Index Fund (Class A) IAPRX	MF	Index Return	0.65%	N	3.79	9.84	6.52	N/A	N/A
Deleware Ivy ProShares S&P 500 Bond Index Fund (Class I) IPRIX	MF	Index Return	0.40%	N	4.10	10.21	6.85	N/A	N/A
Deleware Ivy ProShares MSCI ACWI Index Fund (Class A) IMWAX	MF	Index Return	0.90%	N	23.54	16.14	9.80	N/A	N/A
Deleware Ivy ProShares MSCI ACWI Index Fund (Class I) IMWIX	MF	Index Return	0.66%	N	23.58	16.43	10.04	N/A	N/A
Deleware Ivy Crossover Credit Fund (Class A) ICKAX	MF	Total Return	0.90%	N	6.82	13.30	7.84	N/A	N/A

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Crossover Credit Fund (Class I) ICKIX	MF	Total Return	0.65%	N	6.95	13.58	8.11	N/A	N/A
Deleware Ivy PineBridge High Yield Fund (Class A) IPNAX	MF	Total Return	0.99%	N	11.03	7.36	5.76	N/A	N/A
Deleware Ivy PineBridge High Yield Fund (Class I) IPNIX	MF	Total Return	0.72%	N	11.18	7.65	6.05	N/A	N/A
Deleware Ivy Corporate Bond Fund (Class A) IBIAX	MF	Income Return	1.00%	N	4.18	10.49	6.60	5.50	4.11
Deleware Ivy Corporate Bond Fund (Class I) IBJIX	MF	Income Return	0.71%	N	4.32	10.64	6.93	5.83	4.40
Deleware Ivy Government Securities Fund (Class A) IGIAX	MF	Income Return	0.97%	N	-0.52	5.02	3.55	2.47	1.95
Deleware Ivy Government Securities Fund (Class I) IGIIX	MF	Income Return	0.72%	N	-0.39	5.28	3.82	2.75	2.25
Deleware Ivy Accumulative Fund (Class A) IATAX	MF	Capital Growth	1.10%	N	32.57	44.46	22.45	16.86	14.18
Deleware Ivy Accumulative Fund (Class I) IATIX	MF	Capital Growth	0.87%	N	32.55	44.57	22.72	17.11	14.44

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Wilshire Global Allocation Fund (Class A) IWGAX	MF	Total Return	1.13%	N	16.82	10.88	6.58	6.43	4.96
Deleware Ivy Wilshire Global Allocation Fund (Class I) IWGIX	MF	Total Return	0.83%	N	17.16	11.28	6.95	6.80	5.30
Deleware Ivy Cash Management Fund (Class A) IAAXX	MF	Current Income	0.63%	N	0.01	0.36	1.17	0.79	0.41
Deleware Ivy Asset Strategy (Class A) WASAX	MF	Total Return	1.11%	N	19.93	13.46	9.28	7.88	5.70
Deleware Ivy Asset Strategy (Class I) IVAEX	MF	Total Return	0.87%	N	20.08	13.75	9.57	8.17	5.97
Deleware Ivy Balanced (Class A) IBNAX	MF	Total Return	1.07%	N	18.14	14.35	10.51	8.92	8.73
Deleware Ivy Balanced (Class I) IYBIX	MF	Total Return	0.86%	N	18.31	14.63	10.78	9.19	9.02
Deleware Ivy Securian Core Bond Fund (Class A) IBOAX	MF	Current Income	0.87%	N	3.50	6.69	4.77	4.71	4.18
Deleware Ivy Securian Core Bond Fund (Class I) IVBIX	MF	Current Income	0.45%	N	3.71	7.14	5.25	5.17	4.57

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Core Equity (Class A) WCEAX	MF	Capital Growth	1.00%	N	23.07	21.78	15.06	13.68	12.48
Deleware Ivy Core Equity (Class I) ICIEX	MF	Capital Growth	0.81%	N	23.14	22.01	15.28	13.94	12.80
Deleware Ivy Pzena International Value (Class A) ICDAX	MF	Capital Appr	1.55%	N	29.59	6.00	1.26	6.23	4.04
Deleware Ivy Pzena International Value (Class I) ICVIX	MF	Capital Appr	1.12%	N	29.95	6.48	1.72	6.71	4.54
Deleware Ivy Energy (Class A) IEYAX	MF	Capital Growth	1.35%	N	19.33	-38.71	-25.21	-13.36	-9.05
Deleware Ivy Energy (Class I) IVEIX	MF	Capital Growth	0.99%	N	19.59	-38.51	-24.96	-13.06	-8.70
Deleware Ivy Natural Resources Fund (Class A) IGNAX	MF	Capital Growth	1.84%	N	13.69	-12.38	-9.99	-1.47	-6.14
Deleware Ivy Natural Resources Fund (Class I) IGNIX	MF	Capital Growth	1.20%	N	14.02	-11.86	-9.47	-0.91	-5.67
Deleware Ivy Global Bond (Class A) IVSAX	MF	Income	0.96%	N	5.68	7.98	5.02	5.59	3.25

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Global Bond (Class I) IVSIX	MF	Income	0.74%	N	5.79	8.22	5.27	5.88	3.50
Deleware Ivy High Income (Class A) WHIAX	MF	Total Return	0.97%	N	15.28	5.32	4.45	7.51	6.32
Deleware Ivy High Income (Class I) IVHIX	MF	Total Return	0.75%	N	15.40	5.55	4.69	7.77	6.58
Deleware Ivy International Core Equity (Class A) IVIAX	MF	Capital Growth	1.23%	N	19.96	7.08	1.34	5.30	4.63
Deleware Ivy International Core Equity (Class I) ICEIX	MF	Capital Growth	0.79%	N	20.25	7.56	1.79	5.71	5.03
Deleware Ivy Global Growth (Class A) IVINX	MF	Capital Growth	1.34%	N	23.82	20.54	12.40	11.28	8.60
Deleware Ivy Global Growth (Class I) IGIIX	MF	Capital Growth	1.06%	N	24.01	20.87	12.72	11.62	8.96
Deleware Ivy Large Cap Growth (Class A) WLGAX	MF	Capital Growth	0.98%	N	20.10	30.76	22.11	18.91	15.73
Deleware Ivy Large Cap Growth (Class I) IYGIX	MF	Capital Growth	0.64%	N	20.30	31.19	22.51	19.25	16.06

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Limited-Term Bond (Class A) WLTAX	MF	Current Income	0.89%	N	0.98	3.79	2.85	2.46	1.84
Deleware Ivy Limited-Term Bond (Class I) ILTIX	MF	Current Income	0.68%	N	1.08	4.01	3.09	2.69	2.09
Deleware Ivy Managed International Opportunities (Class A) IVTAX	MF	Capital Growth	1.33%	N	27.42	14.49	5.05	7.81	4.99
Deleware Ivy Managed International Opportunities (Class I) IVTIX	MF	Capital Growth	1.03%	N	27.30	14.59	5.31	8.11	5.28
Deleware Ivy Mid Cap Growth (Class A) WMGAX	MF	Capital Growth	1.16%	N	32.78	48.43	26.94	22.47	15.07
Deleware Ivy Mid Cap Growth (Class I) IYMIX	MF	Capital Growth	0.79%	N	32.99	49.00	27.43	22.88	15.44
Deleware Ivy Government Money Market (Class A) WRAXX	MF	Current Income	0.66%	N	0.01	0.27	1.00	0.67	0.34
Deleware Ivy Municipal Bond (Class A) WMBAX	MF	Current Income	0.84%	N	2.76	3.91	3.29	2.71	3.73
Deleware Ivy Municipal Bond (Class I) IMBIX	MF	Current Income	0.71%	N	2.83	4.04	3.44	2.87	3.92

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Emerging Markets Equity Fund (Class A) IPOAX	MF	Capital Growth	1.39%	N	39.48	35.00	10.07	15.86	6.12
Deleware Ivy Emerging Markets Equity Fund (Class I) IPOIX	MF	Capital Growth	0.99%	N	39.78	35.55	10.57	16.35	6.57
Deleware Ivy Securian Real Estate Securities Fund (Class A) IRSAX	MF	Total Return	1.45%	N	11.51	-3.48	4.18	4.38	7.60
Deleware Ivy Securian Real Estate Securities Fund (Class I) IREIX	MF	Total Return	1.08%	N	11.77	-3.10	4.58	4.77	8.07
Deleware Ivy Science and Technology (Class A) WSTAX	MF	Capital Growth	1.14%	N	29.64	36.07	24.71	21.23	17.16
Deleware Ivy Science and Technology (Class I) ISTIX	MF	Capital Growth	0.96%	N	29.76	36.32	24.96	21.52	17.48
Deleware Ivy Small Cap Growth (Class A) WSGAX	MF	Capital Growth	1.27%	N	38.00	38.49	18.00	18.18	13.59
Deleware Ivy Small Cap Growth (Class I) IYSIX	MF	Capital Growth	0.90%	N	38.28	39.05	18.46	18.61	14.03
Deleware Ivy Small Cap Core (Class A) IYSAX	MF	Capital Appr	1.38%	N	28.78	7.06	5.89	11.57	8.95

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.21	Net Historical Performance as of 12.31.20			
						1 Year	3 Years	5 Years	10 Years
Deleware Ivy Small Cap Core (Class I) IVVIX	MF	Capital Appr	0.89%	N	29.10	7.56	6.37	12.04	9.46
Deleware Ivy Value (Class A) IYVAX	MF	Capital Appr	1.20%	N	23.30	1.53	5.87	8.08	8.70
Deleware Ivy Value (Class I) IYAIX	MF	Capital Appr	0.92%	N	23.45	1.76	6.18	8.41	9.07
Deleware Ivy Municipal High Income (Class A) IYIAX	MF	Current Income	0.89%	N	4.04	4.09	3.82	3.27	4.86
Deleware Ivy Municipal High Income (Class I) WYMHX	MF	Current Income	0.61%	N	4.21	4.39	4.09	3.51	5.08
Deleware Ivy Global Equity Income (Class A) IBIAX	MF	Total Return	1.22%	N	19.29	3.58	4.62	7.29	N/A
Deleware Ivy Global Equity Income (Class I) IBIIX	MF	Total Return	0.92%	N	19.56	3.90	4.95	7.63	N/A

Other Fees: The returns shown above (average annual returns, except for year-to-date returns which are annualized) reflect the performance of the funds for the periods indicated that would have been realized IF AND ONLY IF a shareholder had invested in the Fund PRIOR to the first day of the period. These returns include no impact of any sales load as the North Dakota Public Employees Retirement System purchases are made at 0% sales charge.

Withdrawal Provisions: None

SECTION III

PROVIDER REPRESENTATIVES

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM **SECTION**

457 DEFERRED COMPENSATION PLAN

You are responsible for meeting with your provider to set up your account, monthly payroll contribution, and beneficiaries.

Use the Investment Provider Listing on the NDPERS web site to find a provider near you:

https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-457-deferred-comp/provider-list.pdf

Contact the North Dakota Securities Department to check the background of an investment professional before doing business.

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

Scott A. Miller
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: Shawna Piatz

DATE: September 13, 2022

SUBJECT: Audit Committee Minutes

Attached are the approved minutes for the May 16, 2022 meeting. The minutes may also be viewed on the NDPERS web site at www.nd.gov/ndpers.

The next audit committee meeting is scheduled virtually and in person for November 7, 2022 at 3:00 p.m. This is for your information.

Attachments

Attachment

MEMORANDUM

TO: Audit Committee
Mona Rindy
Adam Miller
Julie Dahle
Dirk Wilke
Senator Dick Dever

FROM: Shawna Piatz, Chief Audit Officer

DATE: May 16, 2022

SUBJECT: **May 16, 2022 Audit Committee Meeting**

In Attendance:

Mona Rindy
Adam Miller
Dirk Wilke
Julie Dahle
Shawna Piatz
Scott Miller
Derrick Hohbein
Rebecca Fricke

The meeting was called to order at 3:00 p.m. by Ms. Rindy. The committee began the meeting with approving the prior Audit Committee minutes.

I. February 7, 2022 Audit Committee Minutes

A. The Audit Committee minutes were examined. Mr. Wilke moved approval of the minutes. The motion was seconded by Ms. Dahle. This was followed and approved by voice vote.

III. Administrative

C. Audit Plan 2022 – 2023 – This item was discussed first. Internal Audit coordinates the agency risk assessments each October and uses the results to determine the high-risk areas and establish audit priorities for the upcoming biennium. The Chief Audit Officer provided the 2022 – 2023 Internal Audit Plan to the Audit Committee for review and approval. Ms. Dahle moved approval of the 2022 – 2023 Audit Plan. The motion was seconded by Mr. Miller. This was followed and approved by voice vote.

II. Internal Audit Reports

A. Quarterly Audit Plan Status Report – A summary of the Internal Audit staff time spent for the past quarter along with a status update on each area of the 2022 – 2023 Audit Plan was included with the Audit Committee materials. Of the total hours reported, 54.23% was spent in audit, 7.14% in consulting, and 38.63% in administrative hours. The audit hours were spent on the monthly retirement program audit, the Sanford Interest Calculation Report Audit, and the Service Purchases Audit. The consulting hours were attributable to Internal Audit's assistance with the proposed final average salary calculations, Job Service deferred benefit calculations, and various reviews and reconciliations for the Benefits and Accounting divisions.

B. 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 procedure, system, compliance, or employer issues. Fiscal year to date, a total of 423 new retirees out of the 894 were audited, which equates to $1,718,805.66 of $3,714,240.45 being audited. An accuracy rate of 95.04% was achieved fiscal YTD as of May 2022 for new retirement benefit payments, which is below the 97% goal. Fiscal year to date, a total of 67 of the 1,788 refunds issued were audited, which equates to $2,833,257.72 of $15,614,981.74. An accuracy rate of 91.04% was achieved fiscal YTD as of April 2022 for retirement refunds, which fell below the 97% accuracy rate goal. A limited number of retirement refunds were audited and a portion of the sample continues to be focused on those refunds in which a known system issue is likely to have occurred.

C. 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 corrections. The dollar amount and the number of errors did show an increase in both the number and amount of errors. There were 22 adjustments that were new this quarter and 15 previously reported adjustments remain outstanding.

D. Outstanding Issues Status Report –The Outstanding Issues Status report has been updated to reflect all new issues and what has been accomplished February 1, 2022 through April 30, 2022. There were two existing recommendations where progress has been made and two new recommendations added to this report. One item was closed from the prior quarter. Staff have been proactive about addressing recommendations as they are made in which case they would not be included on this report.

III. Administrative Cont.

A. Audit Committee Charter Matrix – In order to confirm all responsibilities outlined in the Audit Committee charter are carried out annually, a matrix was developed

to review each objective and ensure that the Audit Committee is meeting its responsibilities. The matrix was reviewed and discussed for progress made over the past quarter.

B. Internal Audit Charter Matrix – A copy of the Internal Audit Charter matrix with progress made over the previous quarter was provided to the Audit Committee for their review and information. Continued discussion took place around obtaining a quality assessment as required by professional standards. The Chief Audit Officer is in the process of reaching out to other local internal audit departments and the IIA to gauge interest and obtain quotes on completing the external assessment part of the quality assessment. The CAO is starting work on the internal assessment to start this process and will continue to look into the cost and timeframe to complete the full assessment. Updates will be provided at future Audit Committee meetings.

D. CAO Annual Performance Evaluation – The Audit Committee has completed the CAO's Annual Performance Evaluation. The evaluation was reviewed and discussed. Mr. Miller made a motion to approve the Chief Audit Officer's evaluation with an overall rating to fall within the range of 3.65 to 3.75, rounding up if necessary. The motion was seconded by Ms. Dahle, followed by voice vote and approved.

E. Audit Committee Meeting Dates & Times – The next Audit Committee meeting is scheduled for Monday, August 15, 2022 at 3:00 p.m. It will be held both in person and with an option for virtual attendance.

IV. Miscellaneous

A. Travel Expenditures – A summary of out-of-state travel expenditures incurred by the Executive Director for the period February 1, 2022 through April 30, 2022 was provided for the Audit Committee's information. There were no out of state travel expenditures for the Board during that time.

B. Risk Management Report – Updates were presented to the Audit Committee related to the Loss Control Committee activities over the past quarter. The Audit Committee was provided the minutes from the Loss Control Committee's December 17, 2021 meeting. The Loss Control Committee reviewed a number of action items for the previous quarter including HIPAA Privacy/Security, AED training, the Disaster Recovery Plan and the Quarterly Audit Report. The Audit Committee agreed that risk management reports could be presented annually in the future unless there is a significant issue that needs to be reported sooner.

C. Report on Consultant Fees – A copy of the Report on Consultant Fees from showing the consulting, investment and administrative fees paid during the quarter ended March 2022 was provided for the Audit Committee's information. The requirement to provide this report was removed from the Audit Committee Charter in 2014 and the Audit Committee agreed that this report no longer needed to be provided in the future since it is presented quarterly to the NDPERS Board.

D. CPEs and Webinars – A report on the continuing professional education webinars, luncheon meetings and seminars Internal Audit participated in for the period February 1, 2022 through April 30, 2022 was provided to the committee. Multiple outside CPE webinars were attended by the CAO and internal audit staff.

E. Publications – An article from the Wall Street Journal entitled Board Practices Reflect Long-Term Pandemic Effects was provided to the audit committee for their information.

The meeting adjourned at 4:06 p.m, by Ms. Rindy.

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Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: September 13, 2022

SUBJECT: Budget Status

Twice a year staff provides the Board with an update on the status of the current budget and answers any questions or concerns the Board may have. The expenses for the biennium through June 30, 2022, as well as our total appropriation, are summarized in the table below:

	2021-2023 Appropriation	Expenditures to Date	Remaining Appropriation	% Remaining
Salaries & Wages	7,209,060	3,470,511	3,738,549	52%
Operating	2,500,736	1,170,277	1,330,459	52%
Capital Assets	257,600	257,600	-	0%
Contingency	250,000	-	250,000	100%
Total	10,217,396	4,898,388	5,319,008	52%

The biennium runs through June 30, 2023, meaning we have 50% of the biennium remaining for these expenditures.

Please let me know if you have any questions on the summary.

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: Special Board Election Update

This is a placeholder to give the Board an update on any activities regarding the ongoing Special Board Election.

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: Legislative Relations/Update

There have been no Legislative Committee meetings since the last Board meeting, and no other contact from the Legislature, as of the date I wrote this memo. We do have a Health Care Committee meeting on September 15th, at which they will discuss several bills, including two that would affect NDPERS: bill draft 92 (prescription drug reference rate pilot program) and bill draft 104 (a study of value-based purchasing).

This is informational.

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Memorandum

TO: NDPERS Board

FROM: Scott Miller

DATE: September 13, 2022

SUBJECT: Contracts under $10,000

Attached is a document that shows the contracts under $10,000 that I have signed this calendar year. Please let me know if you have any questions on any of these contracts.

This topic is informational only.

Attachment

Contracts Signed During 2022:

Vendor	Amount	Frequency Incurred
TIAA	$ -	MOU to reduce DC participant fees
Inter Office	$ 1,947.36	Two chairs for our training room
Inter Office	$ 486.26	Tackboards for IT & Training Room
Inter Office	$ 1,006.18	Chair for member services
State Treasurer	$ -	Authorization to pick up checks
Advanced Business Methods	$ 231.00	Adding fax capability to leases Cannon
Milliman	$ -	DB closure study
Sanford	$ -	PBM audit data transfer
Secretary of State	$ -	Director's ability to use E-Signature

New Contracts:

Vendor	Amount	Frequency Incurred
Inter Office	$ 4,354.50	4 Replacement chairs for staff

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Memorandum

TO: NDPERS Board

FROM: Scott

DATE: September 13, 2022

SUBJECT: Board Self-Evaluation

Two years ago, the Board requested that we do a Board Self-Evaluation process every other year, shortly after the Fiduciary Responsibility presentation. Since we are hoping to have a new Board member join us at the October meeting, and our October agenda is packed, I thought that might be a good time to send out the self-eval survey, and review the results at the November meeting. This agenda topic is to let you know my thoughts and re-direct me if you would like to proceed in a different manner.