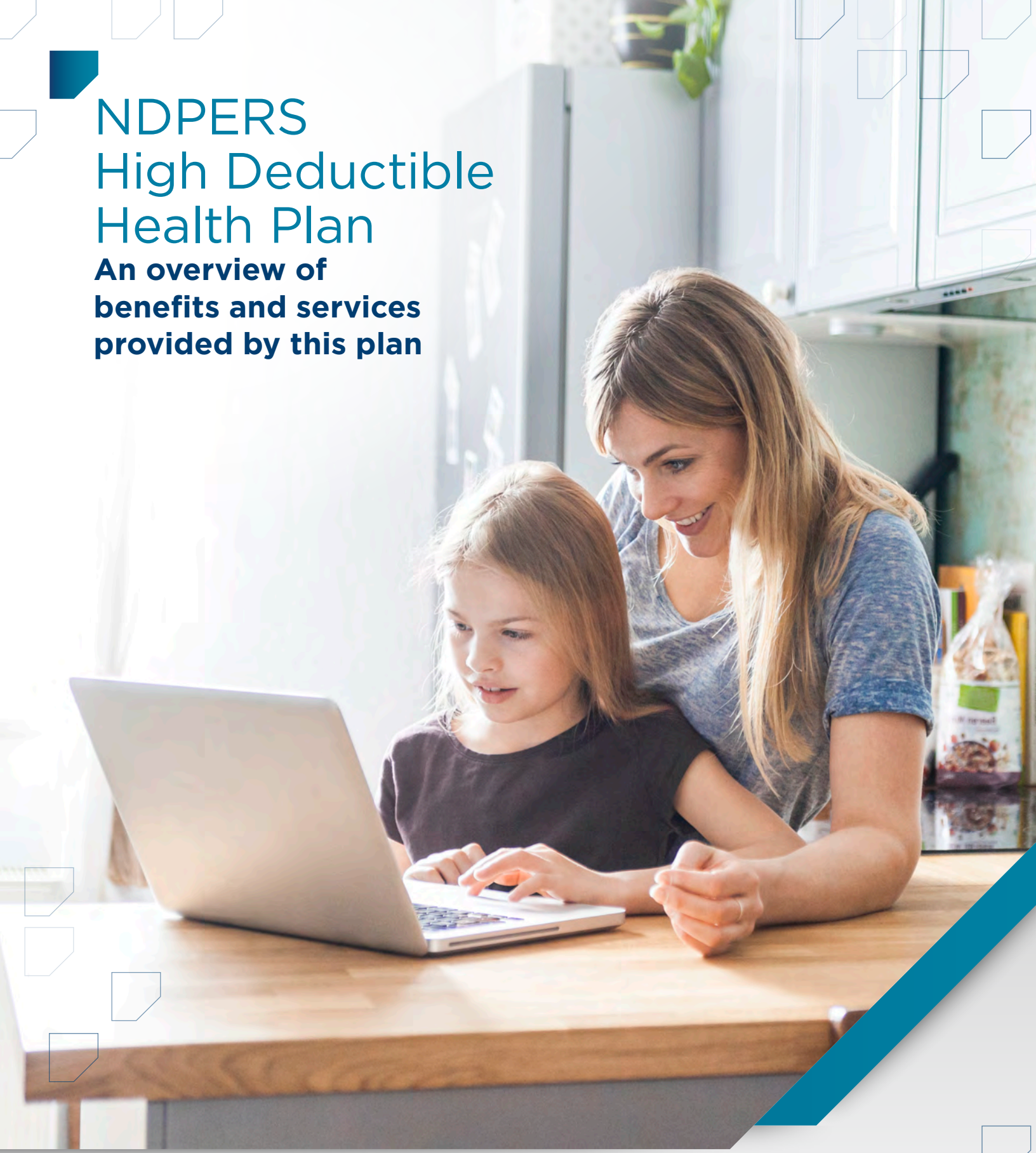
NDPERS High Deductible Health Plan

An overview of benefits and services provided by this plan



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

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SANFORD HEALTH PLAN

THIS BENEFIT PLAN COVERS THESE SERVICES AND MORE.

Who is eligible for benefits?

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

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

Prescription Drug and Diabetes Supplies Benefits

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

Prescriptions are categorized as follows:

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

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

Benefits are available nationwide at any pharmacy participating in the Plan's pharmacy network. To locate a participating pharmacy, call OptumRx at (866) 833-3463.

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

Preventive Screening Services

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

- One routine physical examination
- Routine diagnostic screenings
- Mammography screening (for members age 35 and older)
- Cervical cancer screening
- Colorectal cancer screening (for members age 45 and older)
- Certain nutritional counseling
- Tobacco cessation services

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

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

Emergency Services	80%	100%	80%	100%	Preauthorization/prior approval is not required.
Professional Health Care Provider Charges	80%	100%	80%	100%	
Emergency Room Visit	80%	100%	80%	100%	
Ambulance Services	80%	100%	80%	100%	
Skilled Nursing Facility Services	80%	100%	75%	100%	Preauthorization/prior approval is required.
Home Health Care Services	80%	100%	75%	100%	Preauthorization/prior approval is required.
Hospice Services	80%	100%	75%	100%	
Chiropractic Services					
Home & Office Visits	80%	100%	75%	100%	
Therapy & Manipulations	80%	100%	75%	100%	
Diagnostic Services	80%	100%	75%	100%	
Medical Supplies & Equipment	80%	100%	75%	100%	
Hearing Aids	80%	100%	75%	100%	Limited to one hearing aid, per ear, per Member every 3 years. For Members ages 18 and older, excludes hearing aids to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors.

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

Description of Pharmacy Drug and Diabetes Supplies Benefits			**Special Conditions**
Benefit Amount as a % of the allowed charge after the deductible is met.	Before out-of-pocket maximum is met	After out-of-pocket maximum is met	
Prescription Medications (Retail and Mail Order)			When the Out-of- Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications.
Formulary and Diabetes Supplies	80%	100%	
Nonformulary	50%	100%	Insulin and medical supplies for insulin dosing and administration $25 copay per 30-day supply. Deductible amount waived for insulin only.

Cost Sharing Amounts			**Special Conditions**
	PPO	Basic	
Single Coverage			
Deductible amount	**$2,000**	**$2,000**	
Coinsurance maximum	$1,500	$2,000	
Out-of-pocket maximum	**$3,500**	**$4,000**	*You must meet the Out-of-Pocket Maximum before this Benefit Plan begins to pay 100% of covered services. The coinsurance maximum listed is for illustrative purposes only.*
Family Coverage			
Deductible amount	**$4,000**	**$4,000**	
Coinsurance maximum	$3,000	$4,000	
Out-of-pocket maximum	**$7,000**	**$8,000**	*You must meet the Out-of-Pocket Maximum before this Benefit Plan begins to pay 100% of covered services. The coinsurance maximum listed is for illustrative purposes only.*

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

Preferred Provider Organizations (PPO)

PPO stands for "Preferred Provider Organization" and is a group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge Sanford Health Plan less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts. To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing at www.sanfordhealthplan.com/ndpers.

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