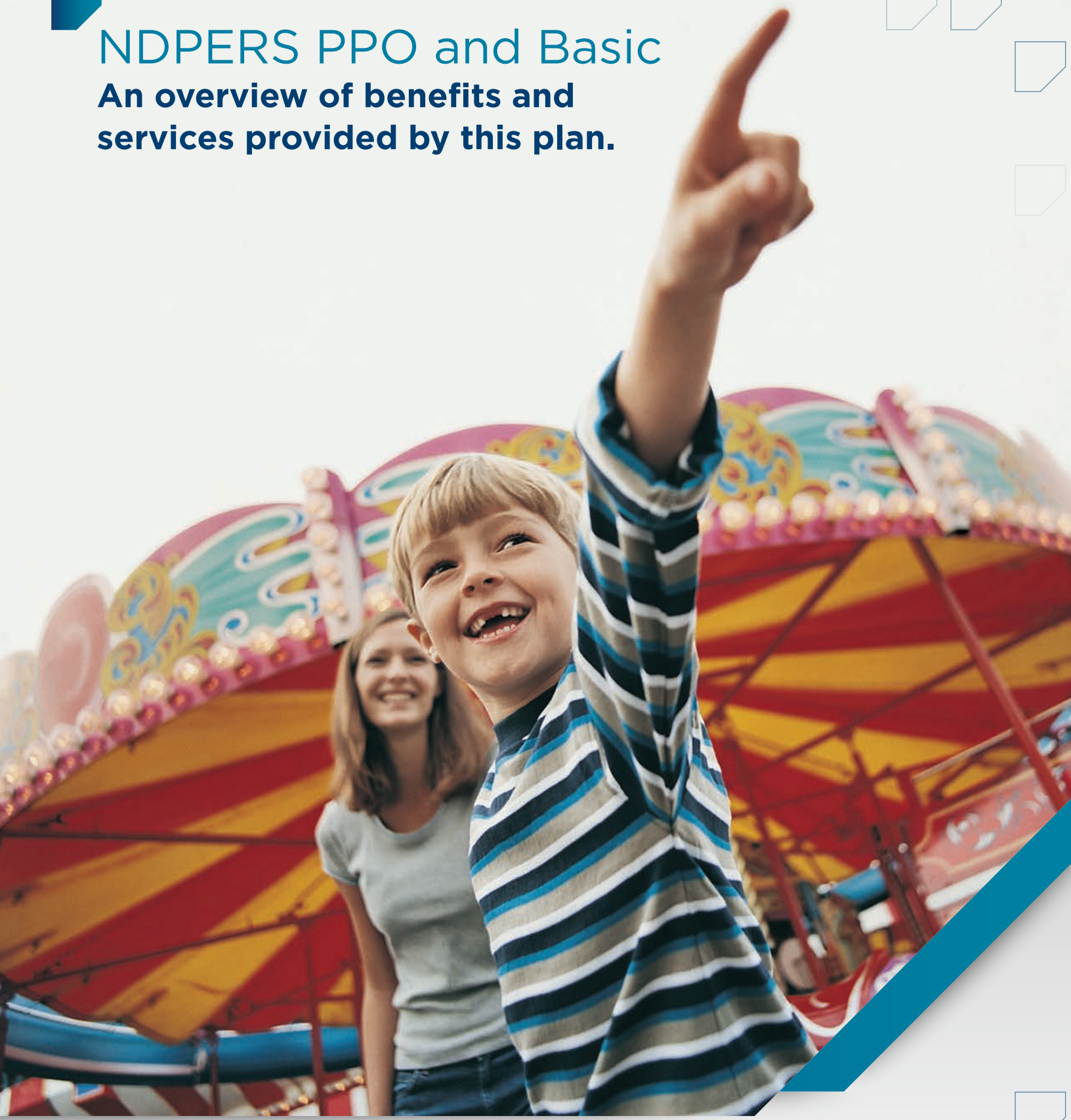
NDPERS PPO and Basic

An overview of benefits and services provided by this plan.



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

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

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.

Preventative Screening Services

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

- Routine physical examination
- Routine diagnostic screenings
- Mammography screening (for members age 35 and older)
- Cervical cancer screening
- Colorectal cancer screening (for members age 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.		Benefit Amount as a % of the allowed charge after the deductible is met.		
	Amount you pay per visit (PPO/Basic)	Before out-of-pocket maximum is met	After out-of-pocket maximum is met	Before out-of-pocket maximum is met	After out-of-pocket maximum is met	
Inpatient Treatment Services		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 Treatment Services						Refer to the Certificate of Insurance for details on other covered outpatient therapy services.
Physical Therapy	$25 / $30	$25, then 80%	100%	$30, then 75%	100%	Benefits are based on the medical guidelines established by Sanford Health Plan. Deductible does not apply.
Occupational & Speech Therapy	$25 / $30	$25, then 80%	100%	$30, then 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. Deductible does not apply.
Professional Health Care Provider Services						
Inpatient, Outpatient & Surgical charges		80%	100%	75%	100%	
Wellness Services						
Immunizations		100%	100%	100%	100%	
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, copayment, or coinsurance requirement that would otherwise apply. As these recommendations change, your coverage may also change. Services performed outside of Plan Preventive Guidelines, and with a medical diagnosis, will be applied to your deductible and coinsurance. Refer to the Certificate of Insurance for details.
Colonoscopy or Sigmoidoscopy		100%	100%	100%	100%	
Mammography, Pap Smear & Fecal Occult Blood Testing		100%	100%	100%	100%	
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.
Contraceptive Services		100%	100%	100%	100%	Deductible does not apply. Prescription contraception medications, obtainable with a Prescription Order, are paid under the Prescription Drug benefit.
Home & Office Visits	$30 / $35	100%	100%	100%	100%	
Diagnostic Services						
Lab, X-ray, MRI		80%	100%	75%	100%	
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%	Deductible does not apply to delivery services received from a PPO provider when enrolled in the Healthy Pregnancy Program.
Mental Health and Substance Use Disorder Treatment Services						
Inpatient Includes acute inpatient admissions and residential treatment		80%	100%	75%	100%	Preauthorization/prior approval is required.
Outpatient						For all outpatient services, 100% of the allowed charge (includes copayment and deductible/coinsurance) is waived for the initial five (5) visits, per member per benefit period.
Office visits	$30 / $35	100%	100%	100%	100%	
All other services, includes intensive outpatient and partial hospitalization		80%	100%	80%	100%	
Emergency Services		80%	100%	80%	100%	Preauthorization/prior approval is not required.
Professional Health Care Provider Charge		80%	100%	80%	100%	Deductible does not apply to the office or emergency room visit.
Emergency Room Visit	$60 / $60	80%	100%	80%	100%	Copayment is waived when member is admitted to inpatient hospital.
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.

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		Benefit Amount as a % of the allowed charge after the deductible is met.		Benefit Amount as a % of the allowed charge after the deductible is met.		
	Amount you pay per visit (PPO/Basic)	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	
Hospice Services		80%	100%	75%	100%	
Chiropractic Services						Refer to the Certificate of Insurance for details on other covered outpatient therapy services.
Home & Office Visits	$30 / $35	100%	100%	100%	100%	
Therapy & Manipulations	$25 / $30	80%	100%	75%	100%	Deductible does not apply.
Diagnostic Services		80%	100%	75%	100%	
Professional Health Care Provider Services						
Inpatient, Outpatient & Surgical charges		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.

Description of Pharmacy Drug and Diabetes Supplies Benefits	Copayment			Special Conditions
	Before out-of-pocket maximum is met	After out-of-pocket maximum is met		Benefits are subject to the Prescription Drug Coinsurance Maximum Amount. Deductible does not apply.
Prescription Medications (Retail and Mail Order)				
Formulary				
Generic	$7.50, then 12%	$7.50	$7.50	Prescription Medication Coinsurance and Copay Amounts accumulate toward a Member's Prescription Drug Out-of-Pocket Maximum. One copayment amount plus applicable coinsurance per prescription order or refill for a 1-34 day supply. Two copayment amounts plus applicable coinsurance per prescription order or refill for a 35-100 day supply.
Brand	$25, then 25%	$25	$25	Insulin and medical supplies for insulin dosing and administration have a $25 copay per 30-day supply.
Nonformulary	$30, then 50%	$30, then 50%	$30	$1,200 maximum out-of-pocket, per benefit period.

Cost Sharing Amounts

Prescription Drug Coinsurance Maximum Amount $1,200 per member per benefit period

When the prescription drug coinsurance maximum amount has been met, copayment amounts will continue to apply, and formulary drugs will be covered at 100% of the allowed charge for the remainder of the benefit period. Prescription Medication Copayment Amounts do not apply toward the Prescription Drug Coinsurance Maximum Amount.

	PPO	Basic
Single Coverage		
Deductible amount	**$500**	**$500**
Coinsurance maximum	$1,000	$1,500
Out-of-pocket maximum	**$1,500**	**$2,000**
Family Coverage - All members in the family contribute to deductible and coinsurance amounts; however an individual family member's contribution cannot be more than the single coverage amount listed above.		
Deductible amount	**$1,500**	**$1,500**
Coinsurance maximum	$2,000	$3,000
Out-of-pocket maximum	**$3,500**	**$4,500**

This chart reflects the cost sharing amounts for each benefit period. PPO and Basic amounts accumulate jointly. Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amounts.

Definitions

Preferred Provider Organizations (PPO)

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

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