NDPERS BOARD MEETING

Agenda

Bismarck Location:
ND Association of Counties
1661 Capitol Way
Fargo Location:
Sanford Health Plan
1749 38th Street South

June 22, 2017 **Time: 8:30 AM**

I. MINUTES
- A. May 18, 2017

II. PRESENTATIONS
- A. TIAA follow-up

III. RETIREMENT
- A. TIAA Contract – Kathy (Board Action)
- B. Actuarial Factors – Sharon (Board Action)
- C. Disability Consulting Agreement – Kathy (Board Action)
- D. Callan College – Bryan (Information)
- E. Public Safety Retirement Plan Employer Agreement – MaryJo (Board Action)
- F. Quarterly Investment Report – Bryan (Information)

IV. GROUP INSURANCE
- A. Health Plan:
  1. Certificate of Insurance – Kathy (Information)
  2. Administrative Agreement – Kathy (Board Action)
  3. About the Patient – Bryan (Board Action)
  4. Pharmacy – Sparb & Sanford (Board Action)
- B. Dental Renewal – Kathy (Board Action)
- C. Life Plan Contract – Kathy (Board Action)
- D. Vision RFP – Bryan (Board Action) *Executive Session

V. MISCELLANEOUS
- A. Election – Kathy (Board Action)
- B. Legislation Implementation – Sharon (Information)
- C. Retiree Subcommittee Meeting update – Sparb (Information)
- D. July Planning Meeting – Sparb (Information)
- E. Sagitec Agreement – Sharon (Board Action)
- F. Audit Committee Report (Information)

VI. DEFERRED COMP
- A. Hardship Case #450 – Kathy (Board Action) **Executive Session

*Executive Session pursuant to NDCC §44-04-19.1(9) and §44-04-19.2 to discuss negotiating strategy or provide negotiating instructions to its attorney or other negotiator. (Motion is necessary)
**Executive Session pursuant to NDCC §44-04-19.2(1) and/or §54-52-26 to discuss confidential records or confidential member information.

Any individual requiring an auxiliary aid or service must contact the NDPERS ADA Coordinator at 328-3900, at least 5 business days before the scheduled meeting.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **June 22, 2017**

SUBJECT: **TIAA Contract Amendments**

The amendment to the TIAA contract is under review by legal. A draft of the amendment is included for your information. Any comments will be provided under separate cover prior to the meeting.

TIAA Contract attachment

TEACHERS INSURANCE AND ANNUITY ASSOCIATION OF AMERICA

AMENDED AND RESTATED RECORDKEEPING SERVICES AGREEMENT WITH A TIAA BROKERAGE ACCOUNT

THIS AGREEMENT ("Agreement") is entered into as of this _____ day of **_____, _____,** or such later date as the parties shall agree by Notice, by and between Teachers Insurance and Annuity Association of America ("TIAA"), a corporation organized and existing under the laws of the State of New York, and **North Dakota Public Employees Retirement System** ("Employer"). TIAA and Employer are each a "Party" to this Agreement. There are no third party beneficiaries under this Agreement.

WITNESSETH:

WHEREAS, Employer sponsors and maintains the **North Dakota Defined Contribution Retirement Plan** and **North Dakota State Deferred Compensation Plan** (the "Plan(s)"), for the benefit of eligible employees and their beneficiaries ("Participants");

WHEREAS, the Parties entered into that certain Recordkeeping Services Agreement effective October 1, 2011, as amended, (the "Original Agreement") and desire to amend and restate the Orignal Agreement;

WHEREAS, assets of such Plan(s) are allocated to and invested in certain mutual funds, TIAA Brokerage Account and Teachers Insurance and Annuity Association of America-College Retirement Equities Fund ("TIAA-CREF") annuity contracts selected by Employer and made available by Employer under the terms of the Plan(s) for the benefit of Participants;

WHEREAS, Employer and the administrators of the Plan(s) appointed by Employer (the "Plan Administrators") seek the provision of certain record keeping services in connection with the operation and administration of the Plan(s); and

WHEREAS, TIAA desires to continue to provide such services to Employer and the Plan Administrators in connection with the operation and administration of the Plan(s) as set forth in more particularity in this Agreement.

NOW, THEREFORE, in consideration of the promises and mutual covenants, representations and warranties set forth herein, TIAA and Employer agree, as follows:

1. APPOINTMENT; ACCEPTANCE; AUTHORITY TO DIRECT OTHERS

1.1 The Employer hereby appoints TIAA as a record keeper for the Plan(s) to provide "Contracted Services" as defined in this Section 1.1. TIAA shall provide the Contracted Services in accordance with the provisions of the Plan(s), but TIAA shall have no discretionary control over the Plan(s).

"Contracted Services" means solely and exclusively the end-product/services outputs, outcomes, communications to Plan Parties and quality assurance over the foregoing included in the description of services in Part I – Contracted Services of Schedule A to this Agreement; and

"Plan Parties" means, collectively, the Employer, the Plan Administrator, and employees of the Employer eligible to participate in the Plan.

The Contracted Services shall not include any infrastructure or ancillary or supporting activities, functions or operations of TIAA and/or its affiliates or subcontractors, including, without limitation, activities, functions and operations that support TIAA's or its affiliates' lines of business and/or internal corporate infrastructure and operations, which are referred to herein as "TIAA Infrastructure and Other Operations".

TIAA Infrastructure and Other Operations do not constitute a part of the Contracted Services and are not subject to the terms and requirements of this Agreement.

1.2 TIAA hereby accepts the appointment as a record keeper for the Plan(s) and agrees to provide the Contracted Services. TIAA is responsible for exercising reasonable care in providing the Contracted Services. TIAA's responsibility for reasonable care is limited solely to correcting processing errors resulting from malfunction of TIAA equipment, error by TIAA's staff, or error by TIAA's programs. TIAA shall make a good faith effort to correct any error caused by its performance subject to the limitations herein set forth. Correcting an error includes restoring any losses caused by such error to the participant's or beneficiary's account. The Contracted Services performed by TIAA under this Agreement may be performed on TIAA's behalf wholly or in part through subcontractors designated by TIAA. TIAA shall continue to be solely liable for the performance of any Contracted Service performed by such subcontractors and shall be solely responsible for paying the fees such subcontractors charge for the performance of such Contracted Services. To the extent that Contracted Services are to be performed by a broker-dealer as determined solely by TIAA, the Employer agrees that such Contracted Services may be performed by TIAA-CREF Individual & Institutional Services, LLC, a wholly owned subsidiary of TIAA. TIAA will not subcontract any record keeping services set forth in Schedule A to an outside third party vendor without the prior written approval of the Employer.

2. NON- FIDUCIARY STATUS

Except with respect to its offering Contracted Services that delivers investment and savings advice to Plan participants as described in Schedule A, it is intended that the Contracted Services be ministerial in nature and that nothing in this Agreement should be construed as granting any discretionary authority or discretionary responsibility to TIAA with respect to the Plan(s), the Participants, or the investments under the Plan(s).

The power to determine which funding options are made available to Participants under the Plan(s) (as listed in Schedule B of this Agreement) is reserved to the Employer and fiduciary(ies) of the Plan(s). The Employer and fiduciary(ies) of the Plan(s), in their sole discretion, shall select such funding options from the funding options that TIAA makes available on its recordkeeping platform. TIAA shall have no responsibility for the selection of funding options under the Plan(s) and shall not render investment advice to any person in connection with the selection of such options.

3. CHANGES TO ADMINISTRATIVE PROCEDURES

TIAA reserves the right to make changes to any administrative procedures in order to assure quality service; provided, that TIAA agrees to provide the Employer with (i) reasonable advance notice of any changes, and (ii) the opportunity to have input into the manner in which any such changes are made and implemented.

4. DATA REQUIREMENTS; TRANSMITTAL OF DATA

TIAA and the Employer shall work together to develop guidelines for data processing. The Employer shall be responsible for the timely transmittal to TIAA of participant data that is materially correct and complete.

5. PERSONNEL AND RESOURCES

TIAA shall provide sufficient personnel and resources as may be necessary to perform the Contracted Services in a thorough and professional manner. The personnel designated by TIAA to perform the Contracted Services shall have the training and background necessary to perform such Contracted Services.

6. ERRORS, OMISSIONS OR DELAYS

6.1 Each Party to this Agreement will be responsible to the other Party for their own respective errors, omissions or delays in the performance of their responsibilities under this Agreement. Each Party shall notify the other Party (i) of any errors, omissions or interruptions in, or delay or unavailability of, the Contracted Services in the case of TIAA and services performed by the Employer in the case of

Employer or (ii) if it is unable to perform any of its obligations under this Agreement. Such notice shall be provided as promptly as administratively feasible following the discovery of any events covered by (i) or the occurrence of any events covered by (ii) of this paragraph. Notification under this provision shall be in such form as is required by Section 13 of this Agreement. Such notice shall not relieve the notifying Party of its obligations under this Agreement. Within ninety (90) days following the date on which the Employer is furnished with a report in which the claimed error is contained, the Employer shall furnish all data necessary to make the correction.

6.2 The Employer acknowledges that in performing the Contracted Services, TIAA must rely exclusively on the data and information provided to TIAA by the Employer and participants, and that TIAA is not obligated to inquire into and is not responsible for the authenticity or accuracy of such data or information. If TIAA is required to repeat or reprocess any task as a result of incomplete or inaccurate information provided by a Plan, TIAA may charge a reasonable reprocessing fee. In addition, if amounts are sent with incorrect instructions, or in amounts that do not reconcile with the instructions given, TIAA may (1) apply the amounts for which accurate instructions are given and refund any excess amounts to the Employer, or (2) if amounts are less than the instructions call for, refund the entire amounts to the Employer.

6.3 A Plan Administrator of a Plan shall review all record keeping reports and shall immediately notify TIAA of any claimed error with respect to any data or report. TIAA assumes no responsibility for verification and any report not challenged in writing by a Plan Administrator within ninety (90) days of receipt thereof shall be conclusively presumed accurate and complete.

6.4 The foregoing notwithstanding, TIAA will, at the Plan Administrator's request, make a good faith effort to correct any error brought to its attention after the ninety (90) day time period set forth in 6.1 or 6.3 has expired.

7. REPRESENTATIONS, WARRANTIES AND COVENANTS

7.1 Each Party represents that it is free to enter into this Agreement and that by doing so it will not breach or otherwise impair any other agreement or understanding with any other person, corporation or entity. TIAA further represents, warrants and covenants that:

a. It has full power and authority under applicable law, and has taken all action necessary, to enter into and perform this Agreement, and that the person executing this Agreement on its behalf is duly authorized and empowered to execute and deliver this Agreement;

b. This Agreement, when executed and delivered, shall constitute the valid, legal and binding obligation of TIAA, enforceable in accordance with its terms;

c. TIAA is a stock life insurance company duly organized, existing and in good standing under the laws of the State of New York; and

The Employer further represents, warrants and covenants that:

d. It has full power and authority under applicable law, and has taken all action necessary, to enter into and perform this Agreement, and that the person executing this Agreement on its behalf is duly authorized and empowered to execute and deliver this Agreement; and

e. This Agreement, when executed and delivered, shall constitute the valid, legal and binding obligation of the Employer, enforceable in accordance with its terms.

f. In the event TIAA or its affiliates or subsidiaries provide the Employer with communications marked "institutional use" only, the Employer agrees that such materials are for its use and not intended for use with or distribution to plan participants. The Employer agrees not to distribute such materials to plan participants. The parties acknowledge that the requirements of this subsection are subject to limitations in Sections 11.1 and 11.4 of this Agreement.

8. FEES & COMPENSATION FOR SERVICES

8.1 TIAA's annual revenue requirement for the services under this Agreement is X.XX% (XX basis points multiplied by plan assets equals, the "Revenue Requirement") per Plan. TIAA's Revenue Requirement for the Plan(s) will remain in effect for a five (5) year period beginning July 1, 20XX (ending June 30, 20XX) (the "Revenue Requirement Term"). If however this Agreement is executed and received within thirty (30) calendar days of when the first scheduled reconciliation would have been performed then the terms of the Reconciliation Process will begin in the next available reconciliation period. In the event that the Revenue Requirement has not been adjusted after the end of the Revenue Requirement Term, the current Revenue Requirement and how such Revenue Requirement shall be paid will remain in effect until such time as a new Revenue Requirement is established.

TIAA will compare the Revenue Requirement to the revenue generated by the Plan(s) on a semi-annual basis to determine if the Plan generated sufficient revenue to meet TIAA's Revenue Requirement ("Reconciliation Process"). TIAA will provide the Employer a Reconciliation report accessible on PlanFocus, TIAA's administrative web service, which will provide the results of the Reconciliation Process. The revenue generated by the plan(s) that is considered by the Reconciliation Process to pay for TIAA's Revenue Requirement may be attributable to the following:

Investments that revenue share or provide for a Plan Services Expense offset:

The Employer understands and agrees that certain proprietary and non-proprietary mutual fund investments listed in Schedule B may pay to the Plan revenue sharing payments or Plan Services Expense payments to be collected by TIAA. The Employer agrees that the amount of such revenue

sharing payments or Plan Services Expense payments shall be collected by TIAA and used in the Reconciliation Process to pay the Plan(s) Revenue Requirement. The current schedule of investments and their respective revenue share amounts or Plan Services Expense offset amounts are listed in Schedule B. Such revenue shares or Plan Services Expense offset are subject to change at the election of the fund company but in no event shall such changes change TIAA's Revenue Requirement as set forth above.

8.2 In the event that the Reconciliation Process determines that the Plan(s) generated revenue in excess of TIAA's Revenue Requirement, TIAA shall credit the plan(s) Revenue Credit Account in the amount of the excess. A Revenue Credit Account is a suspense account held under the terms of the Plan which is funded with excess revenue generated from that Plan. Notwithstanding the foregoing, no Revenue Credit Account shall be funded if the excess amount determined by the Reconciliation Process is less than $2,500 for any given reconciliation year. In addition, the Revenue Credit Account will be funded with any payments owed to the Empoyer pursuant to Schedule C of this Agreement.

The Revenue Credit Accounts may only be used either to pay direct, reasonable and necessary Plan expenses which the Plan(s) are authorized to pay or to provide benefits for Plan participants and beneficiaries in the form of plan servicing credits. Such credits can be paid to Plan participants' accounts, with at least thirty (30) days' Notice from the Employer to TIAA prior to the plan year end, in a method elected by the Employer provided that TIAA can administer such Employer election and provided that TIAA determines, in its sole discretion, that the elected method will not violate applicable law. Revenue Credit Account money should be paid out in the form of plan servicing credits and/or for plan expenses before the end of the plan year of each of the Plan(s).

Payments from Revenue Credit Accounts directly to the Employer will be made only if the following procedures are followed:

1. Legal counsel for the Employer shall provide, in writing, assurance to TIAA that such legal counsel has reviewed the reimbursement arrangement for plan expenses to be paid directly to the Employer and that in its opinion the program for expense reimbursement, as structured, is set up in accordance with the Plan and state law and covers expenses that would not have been incurred by the Employer but for the retirement plan (e.g., no overhead or settlor expenses, are covered). This will be a onetime certification and will be effective for the duration of the Revenue Requirement Term.

2. Prior to each payment the Employer shall provide TIAA with a written certification that the expenses to be paid meet the requirement that they are reasonable in amount, necessary for the administration of the Plan, are in accordance with Plan terms and would not have been incurred but for the Plan and are expenses that TIAA can pay in accordance with state law.

The Employer, as Named Fiduciary represents that payments from Revenue Credit Accounts shall be used to reimburse direct, reasonable and necessary expenses of the Plan(s) that the Plan(s) are

authorized to pay or to provide revenue credits to Plan Participants Accounts as stated above. No payments shall be made directly to the Employer or the Named Fiduciary of the Plan(s) without adherence to the above requirements. For payments made directly to a Plan service provider, TIAA shall facilitate transactions to cover reasonable and necessary Plan expenses that each Plan itself could pay. To establish a service provider for reimbursement, the Employer shall provide a W-9 to TIAA. Newly established service providers shall be reimbursed through electronic funds transfer (EFT) means only. In addition, the Employer is responsible for any applicable tax-withholding and reporting (e.g., 1099-MISC tax reporting). The service provider invoice must be submitted along with detailed payment instructions. The Employer agrees to utilize PlanFocus, TIAA's administrative web service to manage their Revenue Credit Accounts including establishing service providers, providing a W-9, and submitting reimbursement requests. Once instructed though PlanFocus, payments shall be made directly to the plan service provider within an administratively feasible period of time and no later than thirty (30) days after the date the instructions were received.

8.3 In the event that the Reconciliation Process determines that the plan(s) did not generate sufficient revenue to meet TIAA's Revenue Requirement and therefore results in a shortfall, the Employer understands and agrees that TIAA shall invoice the Employer for such shortfall and the Employer agrees to pay such invoice within thirty days of receipt. Notwithstanding the foregoing, no invoice to the Employer shall be sent if the Plan's shortfall amount determined by the Reconciliation Process is less than $2,500 for any given reconciliation year.

8.4 If, in the good faith determination of both parties the assumptions and terms as determined above have changed substantially, the parties agree to revise this section. The Employer and TIAA will amend this section and any additional agreements in order to reflect the new Revenue Requirement that will be used for the Reconciliation Process. Notwithstanding the foregoing, TIAA agrees to give the Employer sixty (60) days advance notice prior to requesting such a revision. In the event the Revenue Requirement Term expires and a new Revenue Requirement and/or Revenue Requirement Term has not been established, the terms of this Section 8 will continue until the effective date of the new Revenue Requirement and/or Revenue Requirement Term.

8.5 In the event that this Agreement covers a legal plan, as identified by the Employer and/or Plan Document ("Legal Plan"), and such Legal Plan is recordkept on TIAA's recordkeeping platform under separate plan numbers, the Reconciliation Process shall be based on the aggregation of data from each of the plan numbers that constitute a Legal Plan. For the purpose of this Agreement, the table below details each Legal Plan and their associated plan numbers that will be combined for the Reconciliation Process under this Section 8:

Legal Plan Name	TIAA Plan Numbers
North Dakota Defined Contribution Retirement Plan	405545

Legal Plan Name	TIAA Plan Numbers
North Dakota State Deferred Compensation Plan	405546

8.6 Other Fee Assessments not considered in Reconciliation Process include:

1. At the direction of the Employer, TIAA shall facilitate an annual administrative fee of 0.06% (6 basis points) for reasonable and necessary services rendered to the North Dakota Defined Contribution Retirement Plan and agreed to by the Employer. Such basis point fee will be based on assets in each Plan participant's and beneficiary's accounts ("Participant Accounts") held in the and any of the mutual funding options listed in Schedule B. Such fees shall be deducted pro rata from the annuity contracts and mutual funds held in such Participant Accounts and shall be collected in arrears on a quarterly basis (1.5 basis points per quarter). This fee will not apply to any other Plan sponsored by the Employer under this Agreement.

   Such fees shall be sent to the North Dakota Public Employees Retieremnt System as soon as administratively feasible to cover administrative expenses applicable to the North Dakota Defined Contribution Retirement Plan in accordance with applicable North Dakota law.

   For fees deducted from Participant Accounts, with respect to the funds described in Schedule B, the Employer authorizes TIAA, on its behalf, to instruct TIAA-CREF Trust Company, FSB to debit the applicable participant's or beneficiary's accounts under the Plan in the appropriate amount. With respect to the TIAA-CREF Annuity Contracts, the Employer authorizes TIAA to debit the applicable Participant Accounts allocated to such TIAA-CREF Annuity Contracts under the Plan in the applicable amount.

2. The Employer understands and accepts that certain fees and commissions will apply to the TIAA Brokerage Accounts. Such fees and commissions shall be listed in the TIAA-CREF Self-Directed Brokerage Account Customer Agreement and, pursuant to the Agreement, such fees and commissions will be subject to change without prior notice. Certain minimum balance and minimum investment amounts may also be required pursuant to the terms of that Agreement. If such fees cannot be paid from the Self Directed Brokerage Account itself, they may be paid from the participant's or beneficiary's other Plan accounts pursuant to the terms of the Customer Agreement. In addition, the Employer understands, with respect to TIAA's Revenue Requirement as set forth above, that the assets in a TIAA Brokerage Account are counted as Plan assets but any fees and commissions collected under a TIAA Brokerage Account Agreement shall not count for purposes of meeting a Plan's Revenue Requirement.

9. MAINTENANCE OF RECORDS

TIAA agrees that the books, records, accounts, ledgers, documents, and other compilations of data (whether written, electronic, computer related or otherwise) collected and maintained by TIAA for the Employer and/or the Plan(s) under any provision or requirement of this Agreement (the "Records") are the property of the Employer. During the term of this Agreement, TIAA will at all times cooperate with and grant the Employer or its designee reasonable access to the Records during normal business hours. If any litigation, claim, negotiation, audit, or other action involving the Records is commenced prior to the expiration of the applicable retention period, both TIAA and the Employer shall retain all Records until completion of the action and resolution of all issues resulting therefrom, or until the end of the applicable retention period, whichever is later. Upon the expiration or termination of this Agreement, TIAA shall provide Records to the Employer upon such schedule and in such form or format as the Employer and TIAA agree is reasonable.

10. INDEMNIFICATION; INSURANCE

10.1 TIAA agrees to defend, indemnify and hold harmless the Employer, its agencies, officers and its employees (the "Employer Parties") from and against claims based on the vicarious liability of the Employer or tis agents but not against claims based on the Employer's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions. The legal defense provided by TIAA to the Employer under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the Employer is necessary. TIAA also agrees to defend, indemnify, and hold the Employer harmless for all costs, expenses and attorneys' fees incurred if the Employer prevails in an action against TIAA in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this agreement.

10.2 Notwithstanding anything to the contrary herein and in this Section 10, TIAA shall expressly indemnify, defend and hold harmless any of the Employer Parties from all, loss, damage, costs, charges, liability penalties, fines or expense, including without limitation, reasonable attorneys' fees and accountants' fees and disbursements that may be incurred by, imposed upon, or asserted against any of the Employer Parties, on account of any claim or action at law or in equity against any of the Employer Parties to the proportionate extent that it results from the negligence, errors, omissions or wrongdoing of the Custodian, its employees, agents, subcontractors and affiliates under that certain Custodial Account Agreement for a 401(a) Plan and that certain Custodial Account Agreement for a 457(b) Plan between the Employer and TIAA-CREF Trust Company, FSB, entered into on or about the date of the Original Agreement**.**

10.3 If any third party threatens to commence or commences any action for which one Party (the "Indemnifying Party") may be required to indemnify the other Party hereunder (the "Indemnified Party"), the Indemnified Party shall promptly give notice thereof to the Indemnifying Party. Without the prior written consent of the Indemnified Party, which consent shall not be withheld unreasonably, the Indemnifying Party may not settle or compromise the liability of the Indemnified Party in such action, or consent to or permit the entry of any judgment in respect thereof, unless such settlement, compromise, or judgment is exclusively for monetary damages and in connection with such settlement, compromise or consent the Indemnified Party receives from such claimant an unconditional release from all liability in respect of such claim.

10.4 The indemnities granted by the Parties in this Section shall survive the termination of this Agreement.

10.5 TIAA shall secure and keep in force during the term of this agreement the following insurance coverage's:

1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

2) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

3) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.

4) Employer's liability or "stop gap" insurance of not less than $1,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

5) Professional errors and omissions, with minimum liability limits of $1,000,000 per occurrence and in the aggregate.

The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of the TIAA

2) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State.

3) The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.

4) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies.

5) The insurance required in this agreement, through a policy or endorsement, shall include:

   (a) "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State;

   (b) a provision that the policy and endorsements may not be canceled or modified without ten (10) days' prior written notice to the undersigned State representative;

   (c) a provision that any attorney who represents the State under this policy must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54 12 08;

   (d) a provision that TIAA's insurance coverage shall be primary (i.e. pay first) as respects any insurance, self-insurance or self-retention maintained by the State and that any insurance, self-insurance or self-retention maintained by the State shall be in excess of TIAA's insurance and shall not contribute with it;

   (e) The legal defense provided to the State under the policy and any endorsements must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary;

   (f) The insolvency or bankruptcy of the insured Contractor shall not release the insurer from payment under the policy, even when such insolvency or bankruptcy prevents the insured Contractor from meeting the retention limit under the policy.

6) TIAA shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this agreement. All endorsements shall be provided as soon as practicable.

7) Failure to provide insurance as required in this agreement is a material breach of contract entitling the State to terminate this agreement immediately.

11. CONFIDENTIALITY; EMPLOYER/ PLAN(S) NAME; COMPLIANCE WITH PUBLIC RECORDS LAW

11.1 TIAA shall not use or disclose any information it receives from Employer under this contract that Employer has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this contract or as authorized in advance by Employer. Employer shall not disclose any information it receives from TIAA that TIAA has previously identified as confidential and that Employer determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota open records law. The duty of Employer and TIAA to maintain confidentiality of information under this section continues beyond the term of this contract.

11.2 All payroll, employee, and Participant information received by TIAA under this Agreement shall be treated as confidential information and shall be handled by TIAA in accordance with applicable law, TIAA's privacy policy, the terms of the Plan, and in accordance with the requirements of this Agreement.

11.3 Notwithstanding anything herein to the contrary, no obligation or liability shall accrue hereunder with respect to any confidential information that:

a. was in the public domain prior to the date of this Agreement or subsequently came into the public domain through no act of the recipient Party; or

b. was lawfully received by the recipient Party from a third party free of any obligation of confidentiality to such third party; or

c. was already in the lawful possession of the recipient Party prior to receipt thereof from the disclosing Party.

11.4 Subject to the express written consent of the Employer, TIAA shall have the non-exclusive and non-transferable right to use the name of the Employer and the Plan(s) solely in connection with rendering Contracted Services. Any material, including electronic, print, or other media, in which the Employer's or the Plan(s) name may be used shall be submitted to the Employer in hard copy for review and approval prior to use by TIAA. Notwithstanding the foregoing or any other provision of Section 11, the Employer (i) agrees that TIAA may include the names of the Employer and the Plan(s) in any material or presentation that is specifically prepared and used in connection with a process relating to a request for proposal or procurement solicitation from a non-for-profit or governmental entity ("RFP-Related Disclosure"), and (ii) acknowledges that no prior review or approval is required in connection with such RFP-Related Disclosure. For the avoidance of doubt, none of a general solicitation, advertising, or press release shall constitute RFP-Related Disclosure. Upon termination of this Agreement, TIAA agrees to immediately discontinue use of the Employer and the Plan names.

11.5 TIAA understands that, except for disclosures prohibited in this contract, the Employer must disclose to the public upon request any records it receives from TIAA. TIAA further understands that any records that are obtained or generated by TIAA under this contract, except for records that are confidential under this contract, may, under certain circumstances, be open to the public upon request under the North Dakota open records law. Each party agrees to contact the other party immediately upon receiving a request for information under the open records law and to comply with STATE'S instructions on how to respond to the request.

12. WAIVER

The failure of either TIAA or the Employer at any time to require performance of any provisions hereof will in no manner affect its right at a later time to enforce such provision and will not act as a waiver thereof.

13. NOTICE

Any notices that may be required under this Agreement shall be given in writing and delivered personally or mailed by certified mail or courier service to the other Party at the following address or such other address as each Party may give notice to the other. In addition to the methods of providing notice as described herein, any notice required under Section 6.1 may be given by electronic transmission including by facsimile or electronic mail.

If to TIAA, to:
Client Agreement Team
TIAA
730 Third Ave-26th floor
New York, NY 10017-3206
Attention: Director Institutional Client Services

If to the Employer, to:
Mr. Sparb J. Collins
Executive Director
North Dakota Public Employees Retirement System
400 E. Broadway
Suite 500
Bismarck, ND, 58502

14. EFFECTIVENESS; TERMINATION

This Agreement shall become effective as of the date set forth above.

a. Termination without cause. This contract may be terminated by mutual consent of both parties.

b. Termination for lack of funding or authority. Employer by written notice of default to TIAA, may terminate the whole or any part of this contract, under any of the following conditions:

(1) If funding from federal, state, or other sources is not obtained and continued at levels sufficient to allow for purchase of the services or supplies in the indicated quantities or term.

(2) If federal or state laws or rules are modified or interpreted in a way that the services are no longer allowable or appropriate for purchase under this contract or are no longer eligible for the funding proposed for payments authorized by this contract.

(3) If any license, permit, or certificate required by law or rule, or by the terms of this contract, is for any reason denied, revoked, suspended, or not renewed.

Termination of this contract under this subsection is without prejudice to any obligations or liabilities of either party already accrued prior to termination.

c. Termination for cause. Employer may terminate this contract effective upon delivery of written notice to TIAA, or any later date stated in the notice:

(1) If TIAA fails to provide services required by this contract within the time specified or any extension agreed to by Employer; or

(2) If TIAA fails to perform any of the other provisions of this contract, or so fails to pursue the work as to endanger performance of this contract in accordance with its terms.

The rights and remedies of Employer provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this contract.

15. APPLICABLE LAW

This Agreement shall be construed, and the provisions hereof interpreted under, in accordance with the laws of the state or other jurisdiction in which the Employer was organized or established ("Jurisdictional Venue"), as applicable, without regard to such Jurisdictional Venue's principles regarding conflicts of law.

16. COMPLETE AGREEMENT; MODIFICATIONS

This Agreement embodies the entire agreement between the Parties and supersedes all prior agreements and documents relating to the subject matter of this Agreement. All amendments to this Agreement must be in writing and signed by both Parties.

17. COUNTERPARTS

This Agreement may be executed simultaneously in two or more counterparts, each of which taken together shall constitute one and the same Agreement.

18. SEVERABILITY

If any provision of this Agreement shall be held or made invalid by a court decision, statute, rule or otherwise, the remainder of this Agreement shall not be affected thereby.

19. SUCCESSORS AND ASSIGNS

This Agreement will be binding upon, inure to the benefit of, and be enforceable by the respective successors of the Parties. This Agreement will not be assignable by any Party hereto without the written consent of the other Party.

20. NON-EXCLUSIVITY

Each of the Parties acknowledges and agrees that this Agreement and the arrangements described herein are intended to be non-exclusive and that each of the Parties is free to enter into similar agreements and arrangements with other entities.

20. INDEPENDENT ENTITY

TIAA is an independent entity under this contract and is not a STATE employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and

Insurance Act. TIAA retains sole and absolute discretion in the manner and means of carrying out TIAA'S activities and responsibilities under this contract, except to the extent specified in this contract.

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Agreement as of the date first above written.

Teachers Insurance and Annuity Association of America

By: _____ Date: _____

Print Name:

Title:

North Dakota Public Employees Retirement System

By: _____ Date: _____

Print Name:

Title:

SCHEDULE A

Part I – Contracted Services

TIAA shall provide the Contracted Services as listed in this Schedule A.

1. TIAA will provide Plan participants with enrollment kits, education and consulting services. TIAA will provide Plan participants with Plan enrollment kits and shall otherwise aid in the enrollment of employees eligible to participate in a Plan. Such services may include internet based services, voice response unit service and mail service.

2. TIAA will provide the Plan Parties with functionality of record keeping system which will be based solely on information provided to TIAA by the Plan. TIAA shall maintain records of each Plan participant's and beneficiary's account balances including those amounts paid as premiums to and balances in TIAA-CREF annuity contracts. The records of each such account balance shall reflect amounts attributable to employer contributions, participant elective-deferral contributions, rollover contributions (when permitted by the applicable Plan) and transfers, and any after-tax contributions (when permitted by the applicable Plan). If a 403(b) or 401(k) plan accepts after-tax Roth Elective Deferral Contributions as permitted under Code section 402(A), TIAA shall keep records that separately account for such contributions. TIAA shall also maintain records of rollover Roth contributions, as permitted by the Employer's plan, which shall also be accounted for separately.

3. TIAA shall arrange for contributions to and investments in a participant's account to be allocated to the mutual funds under a Plan, in TIAA-CREF annuity contracts available under a Plan, or, if applicable, in a TIAA Brokerage Account as described in Schedule B, as directed by the participant or the participant's beneficiary in the event of the participant's death. The mutual funds, TIAA-CREF annuity contracts and, if applicable, TIAA Brokerage Account initially chosen for the Plans by the Employer and/or fiduciary(ies) of the Plan are set forth in Schedule B. All contributions shall be allocated among such funding options in accordance with the most recent valid instructions. Transfers among plan funding options shall be made pursuant to the instructions of the participant or beneficiary in accordance with the terms of the Plans but subject to any restrictions in the applicable mutual fund, TIAA-CREF annuity contract or, if applicable, brokerage agreement. TIAA shall provide to the participant or beneficiary all of the forms necessary to enable him or her to allocate contributions or transfer amounts among the Plan funding options. TIAA reserves the right, in its sole discretion, to amend or delete funding options that are offered on TIAA's recordkeeping platform and made available to plan sponsors which shall include, if applicable, the addition or deletion of one or more of the TIAA-CREF Lifecycle or Lifecycle Index Funds. TIAA shall provide the Employer Notice of such amendment or deletion at least ninety (90) days prior to such action or, if there are exigent circumstances beyond the control of TIAA (including, but not limited to, a change initiated by a fund company), as soon as administratively practicable following notice to TIAA by the fund company. The

Employer or fiduciary(ies) of the Plan may, in their sole discretion, select another funding option from TIAA's recordkeeping platform to replace the deleted or amended funding option. To the extent permitted by such funding option, amounts in a deleted or amended funding option will be transferred to a funding option directed by the Employer or the fiduciary(ies) of the Plan(s) or, at the election of the Employer or fiduciary(ies) of the Plan(s), shall remain in the amended funding option. TIAA shall work with the Employer to amend Schedule B of this Agreement and transition to the new or amended funding option directed by the Employer or the fiduciary(ies) of the Plans. In the event that the Employer or the fiduciary(ies) of the Plan(s) fail to provide TIAA with instructions, and such Employer or fiduciary(ies) of the Plan(s) have not selected another funding option from TIAA's recordkeeping platform, amounts in a deleted funding option will be transferred to the Plan's default fund until TIAA receives such instructions. If the Plan's default fund has been deleted the Employer agrees to provide TIAA with instructions to transition to a new default fund. Notwithstanding the foregoing, unless otherwise instructed by the Employer and to provide more favorable terms for plan participants, the Employer hereby directs TIAA to replace CREF Annuity funding options with a less expensive class of the same funding option in the event that such less expensive class becomes available. The Employer shall be notified in the event that such less expensive share class becomes available and shall be given the opportunity to reject such change by providing reasonable advance Notice to TIAA directing TIAA not to make the less expensive CREF Annuity class available.

4. TIAA shall send periodic record keeping reports and communications to the Plan Administrators and each Plan participant and beneficiary, including but not limited to information regarding returns and investment performance under the mutual funds and TIAA-CREF annuity contracts used to fund the participant's account under a Plan.

5. TIAA shall send any communication that it is required to provide by mail to a participant or beneficiary to the address provided to TIAA by the Plan or by the participant or beneficiary.

6. TIAA shall, as authorized under a Plan by a Plan Administrator and subject to applicable law, administer and account for plan loans available under the terms of a Plan and shall, as authorized under a Plan by a Plan administrator and subject to applicable law, administer and account for hardship distributions.

7. TIAA shall, as authorized under a Plan by a Plan Administrator and subject to applicable law, provide for the liquidation of amounts in and make plan benefit payment distributions permitted under, the TIAA-CREF annuity contracts in a participant's Plan account. In addition, TIAA shall, as authorized under a Plan by a Plan Administrator and subject to applicable law, provide instructions to TIAA-CREF Trust Company, FSB for the liquidation of investments in and to make plan benefit payment distributions permitted under the mutual funds in a participant's Plan account.

8. TIAA shall maintain records of each participant's designated beneficiaries based on information provided by the participants or the Plan.

9. To the extent permitted under applicable law, TIAA shall assure the performance of any required withholding of income tax from distributions and withdrawals. The foregoing notwithstanding, TIAA shall not provide for the performance of withholding of income tax from distributions and withdrawals from any private tax-exempt Code section 457(b), any Code section 415(m) plan or any Code section 457(f) Plan covered under this Agreement unless appropriate arrangements are made in writing with TIAA. Prior to the distribution of each participant's benefits, TIAA shall provide the appropriate notice as required under section 402(f) of the Code, when applicable.

10. On each day the New York Stock Exchange (the "Exchange") is open for business (each a "Business Day"), TIAA may receive instructions from a Plan and/or Plan participant on behalf of TIAA-CREF Trust Company, FSB for the purchase or redemption of shares of the mutual funds offered under the terms of the Plan ("Instructions"). Instructions which are received in "good order" (defined below) prior to the close of regular trading of the Exchange (generally 4:00 pm Eastern Time) (the "Close of Trading") on any given Business Day, will be executed by TIAA-CREF Trust Company, FSB at the net asset value determined as of the Close of Trading on such Business Day. Instructions which are received in "good order" (defined below) on such day but after the Close of Trading, will be executed by TIAA-CREF Trust Company, FSB at the net asset value determined as the Close of Trading on the next Business Day following the date of receipt of the Instruction. Instructions shall be considered received in "good order" when all necessary information and monies in connection with such Instructions balance and conform to all other operating procedures, including any restrictions or limits set forth in the applicable fund prospectus or as otherwise set forth by TIAA on behalf of TIAA-CREF Trust Company, FSB. The date the Instructions are executed shall be referred to as the "Participation Date". Notwithstanding the foregoing, in the event that the Securities and Exchange Commission promulgates or amends rules under which the foregoing procedures would be impermissible, this paragraph 10 shall be amended to provide a procedure that conforms to such rules.

11. TIAA shall cause to be delivered to the Plan Administrator or at the direction of the Plan Administrator, directly to Plan participants and beneficiaries, all notices, prospectuses, financial statements, proxies and proxy soliciting materials received by TIAA relating to the TIAA-CREF annuity contracts or the mutual fund shares held in a participant's Plan accounts. Proxies shall be voted by, or in accordance with, the instructions of the participants or beneficiaries. If no instructions for voting proxies applicable to mutual fund shares are received, TIAA shall not exercise the voting rights for such shares and shall not be responsible for the failure to vote, or instruct the vote on such shares.

12. TIAA shall, as authorized by a Plan Administrator, offer a Plan level service that delivers investment and savings advice to Plan participants from an independent third party advice provider. The program follows the guidelines set forth in Department of Labor ("DOL") Advisory Opinion 2001-09A (known as the Sun America Opinion). Morningstar Investment Management, LLC is the independent financial expert under this participant advice program. The advice service will be delivered to participants over the phone, through the web, and by TIAA-CREF consultants in the field. TIAA accepts fiduciary responsibility for the provision of advice under this program.

13. At such times as the Plan Administrators and TIAA shall agree, TIAA shall provide reports to the Plan Administrators concerning employee elective deferrals in order to aid in their compliance with the applicable limits on employee elective deferrals in sections 402(g), 457(e) and 414(v) of the Code, as applicable.

14. As authorized by the Plan Administrator and subject to applicable law, TIAA will administer the spousal consent requirements applicable to a Plan and have distributed Plan balances in accordance with any Qualified Domestic Relations Order (as defined in section 414(p) of the Internal Revenue Code) received by TIAA or forwarded to TIAA by a Plan and in accordance with the instructions of the Plan Administrator.

Part II – TIAA Infrastructure and Other Operations

All services, activities and functions performed by or for TIAA which are not expressly included in Schedule A, Part I – "Contracted Services" shall not constitute a part of the Contracted Services to be provided under the Agreement. Activities, functions and operations that are not a part of, and do not constitute Contracted Services include TIAA corporate and business lines systems, quality control, data entry and other activities and operations that are ancillary to the provision of Contracted Services as defined in the Agreement and this Schedule A, Part I.

SCHEDULE B

Plan Funding Options

TIAA-CREF Mutual Funds

Fund Name	Share Class	Annual Plan Services Expense offset (in basis points)	Ticker
TIAA-CREF Lifecycle Funds[1]			
TIAA-CREF Lifecycle 2010 Fund	Retirement	25	TCLEX
TIAA-CREF Lifecycle 2015 Fund	Retirement	25	TCLIX
TIAA-CREF Lifecycle 2020 Fund	Retirement	25	TCLTX
TIAA-CREF Lifecycle 2025 Fund	Retirement	25	TCLFX
TIAA-CREF Lifecycle 2030 Fund	Retirement	25	TCLNX
TIAA-CREF Lifecycle 2035 Fund	Retirement	25	TCLRX
TIAA-CREF Lifecycle 2040 Fund	Retirement	25	TCLOX
TIAA-CREF Lifecycle 2045 Fund	Retirement	25	TTFRX
TIAA-CREF Lifecycle 2050 Fund	Retirement	25	TLFRX
TIAA-CREF Lifecycle 2055 Fund	Retirement	25	TTRLX
TIAA-CREF Lifecycle 2060 Fund	Retirement	25	TLXRX
TIAA-CREF Lifecycle Retirement Income Fund	Retirement	25	TLIRX

Non-Proprietary Mutual Funds

Fund Name	Annual 12b-1 and Revenue Share that TIAA receives (in basis points)	Ticker
AllianzGI NFJ Small-Cap Value Admin	35	PVADX
AMG Managers Fairpointe Mid Cap I	10	ABMIX
Brown Capital Mgmt Small Co Inv	20	BCSIX

[1] The actual Lifecycle Funds currently available as funding options under the Plan(s) are detailed in Schedule B of this Agreement. TIAA will send the Employer an updated Schedule B that can be attached to this Agreement when a new Lifecycle Fund becomes available and is subsequently approved by the Employer to be added as a funding option udner the Plan(s). Any additional funds, that are not part of the Lifecycle family of funds, will need a signed and executed Amendment to the Record keeping Agreement prior to being added as a funding option under the Plan(s).

Fund Name	Annual 12b-1 and Revenue Share that TIAA receives (in basis points)	Ticker
Cohen & Steers Realty Shares	25	CSRSX
Columbia Mid Cap Index A	35	NTIAX
DFA US Small Cap I	0	DFSTX
Franklin Growth Adv	25	FCGAX
Franklin Mutual Global Discovery Z	25	MDISX
Oppenheimer Developing Markets Y	25	ODVYX
PIMCO Real Return Admin	25	PARRX
PIMCO Total Return Admin	25	PTRAX
Prudential High-Yield Z	25	PHYZX
Prudential Jennison Mid Cap Growth Z	25	PEGZX
RidgeWorth Ceredex Mid-Cap Value Equity I	35	SMVTX
T. Rowe Price Capital Appreciation Adv	40	PACLX
T. Rowe Price Equity Income	15	PRFDX
Templeton Global Bond Adv	25	TGBAX
Hartford Dividend and Growth R5	20	HDGTX

TIAA Brokerage Account

Notwithstanding any other provision of the Agreement to which this Schedule is attached to the contrary, the following provisions shall apply to the TIAA Brokerage Account. If so directed by the Employer and subject to TIAA's acceptance of a properly executed TIAA Retirement Plan Self-Directed Brokerage Account Application of a Plan participant or Beneficiary, all or a portion of the assets of the accounts of a Plan shall be segregated into individual TIAA Brokerage Accounts established for the benefit of Plan participants and Beneficiaries. Pursuant to the terms of the applicable Plan, each participant or Beneficiary shall have the power to direct the investment and reinvestment of assets in the TIAA Brokerage Account established for his or her benefit, subject to such administrative rules and procedures as TIAA may establish. Pursuant to the terms of the applicable Plan, participants and Beneficiaries shall provide instructions regarding the investment of the TIAA Brokerage Account directly to the broker appointed for purposes of executing transactions under the account. For 403(b) Plans, investments in the TIAA Brokerage Account shall be limited to mutual funds in accordance with Internal Revenue Code Section 403(b)(7).

SCHEDULE C

SERVICE LEVEL GUARANTEES

TIAA will guarantee the services described and will pay the penalties for noncompliance, as set forth below. The services, quantifiers and plan penalties for non-compliance referenced below apply shall be measured solely with respect to the Employer plans that shall be the subject of the Agreement such that each of the referenced services and quantifiers and plan penalties for non-compliance referenced shall not be aggregated with measurements attributable to plans other than such plans of the Employer.

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Channel Availability	*Quality standard for number of seconds on hold while call transfers to CSR*	80% of calls answered within 30 seconds	This measurement is calculated as the number of calls answered within the standard divided by the total number of telephone calls.	$300 per quarter
	Abandonment Rate	3%	This measurement is calculated as the number of abandoned calls divided by the total number of telephone calls.	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
	Individual/Administrator Web Availability	99% (excluding regularly scheduled maintenance)	Availability is calculated as a percentage of time per quarter functions are available excluding reserved maintenance windows and scheduled application update activities.	$300 per quarter
	VRS Availability	99% (excluding regularly scheduled maintenance)	Availability is calculated as a percentage of time per quarter functions are available excluding reserved maintenance windows and scheduled application update activities.	$300 per quarter
	National Call Center Availability	Call center is available 100% of scheduled hours	Availability is calculated as a percentage of time per month customer service representatives are available to receive calls.	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Transaction Timeliness	*Contribution Remittances*	Same business day as receipt of funds as of 4:00 PM ET or earlier market close; assumes prior receipt of payroll data in good order.	Total number of contribution files received and processed on the same business day compared to the total number of files received within the reporting period.	Provide economic equivalent of investment experience from appropriate trade date through actual processing date
	Termination distributions, lump sum payments, in-service distributions and Purchase Credits.	99% processed within 5 business days after receipt of approved request received within good order.	This measurement is calculated as the number of distribution processed within 5 business days divided by the total number of distribution processed	$350 per quarter
	Fund to Fund Transfers	99% processed within the same business day the request is received within good order by 4:00p.m. ET or earlier market close.	This measurement is calculated as the number of fund transfers processed within the same day divided by the total number of transfer requests received.	$350 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
	Transfers between plans	99% of requests to transfer between like registered plans under the Employer are processed within 3 business days of the request being received in good order by 4:00p.m. ET or earlier market close.	This measurement is calculated as the number of fund transfers between plans processed within 3 days divided by the total number of transfer requests received.	$350 per quarter
	Beneficiary Service (Survivor Benefits Payments)	98% of claims processed within 3 business days of receipt of approved request received in good order.	This measurement is calculated as the total number of claims processed within the standard divided by the total number of claims processed.	$300 per quarter
	QDRO Processing	90% of transactions processed within 15 business days of request received in good order.	This measurement is calculated as the total number of transactions processed the standard divided by the total number of transactions processed.	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Issue Resolution	*Issue Resolution – Time to Resolve w/member*	95% of verbal customer issues closed within 5 business days. Next, 98% of verbal customer issues closed within 10 business days. _____ 90% of written customer issues closed within 18 business days.	This measurement is calculated as the total number of verbal customer issues closed to within the standard divided by the total number of escalated customer issues received.	$350 per quarter
	Issue resolution – Time to Resolve w/NDPERS	NDPERS issues raised by the plans sponsor will be resolved within the agreed upon timeframe. Items will be reviewed and action plan will be implemented.	This measurement is calculated as the total number of NDPERS issues closed to within the agreed upon schedule divided by the total number of escalated issues received.	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Reporting	*Administrative Reporting-Timeliness*	Reporting for the preceding quarter is available on the Plan Sponsor website within 3 business days after the end of the reporting period. ~ Monthly Reporting Package – these reports will be available 15 business days after month end, 90% of the time. Due to peak volume, the January/July reporting package will be available within 30 days after month end and the full year's June reporting package will be available within 45 days after month end.	This measurement is calculated by the availability of the applicable data on TIAA-CREF's reporting systems within 3 business days following the quarter end.	$300 per quarter
	Investment Review and Plan Review	Reporting will be delivered within and agreed upon schedule.	This measurement is calculated as the total number of NDPERS reviews delivered within the agreed upon schedule divided by the total number of reviews delivered.	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
	Benefit Election Confirms–Timeliness	99% of Welcome Confirmations mailed within 2 business days of contract issuance (paper). 99% of Financial Confirmations mailed within 1 business day of transaction posting (paper). 99% of Financial Confirmations available within 1 business day of transaction posting (online).	This measurement is calculated as the number of confirmation statements mailed within the standard divided by the total number of confirmations mailed (paper). This measurement is calculated as a percentage of time confirmations are available within the standard excluding reserved maintenance windows and scheduled application update activities (online).	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
	Participant Statement-Timelines	99% mailed within 5 business days after end of quarter (paper). 99% available within 5 business days after end of quarter (online).	This measurement is calculated as the number of statements mailed within the standard divided by the total number of statements mailed (paper). This measurement is calculated as a percentage of time confirmations are available within the standard excluding reserved maintenance windows and scheduled application update activities (online).	$300 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Satisfaction	*Participant Satisfaction*	85% satisfaction rating (7 or higher on a 10 point scale)	Based on annual results from TIAA-CREF's current SQMP survey gathered from a random sampling of TIAA-CREF's participant base. Results are reported annually.	$1,200 annually
	Plan Sponsor Satisfaction	85% satisfaction rating (7 or higher on a 10 point scale)	Based on annual results from TIAA-CREF's current SQMP survey gathered from a random sampling of our total plan sponsor base. Results are reported at the end of the calendar year.	$1,200 annually

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Transition Services	*Implementation Timeliness*	TIAA-CREF warrants that services will be implemented on the agreed upon date and will include a financial penalty. The implementation is guaranteed contingent upon the plan sponsor meeting prerequisites to the implementation of the service as outlined in a detailed transition plan.	Measured against Transition plan and agreed to dates.	$350 per quarter

	Service Category	SLA	Measurement Criteria	Penalty for Noncompliance
Consulting/Financial Planning Service	*Individual and Group Meetings*	Delivered within the agreed upon schedule and number of days The composite score from 5 client survey questions must produce the result that at least 86% of responding attendees rate the Financial Consultant they met with as "Excellent" or "Very Good" on the following characteristics: • Providing quality Advice • Understanding your needs and goals • Having the expertise required to handle your financial needs • Anticipating additional financial issues and bringing them to your attention; and • Whether the client Agreed or Strongly Agreed that "The Consultant put your interests first."	Report ratings sheet periodically through the year and submit to subcommittee. Based on meeting surveys with a minimum of 15 responses per quarter.	$300 per quarter

Legal Qualifiers

TIAA shall be entitled to a grace period to cure any matter of noncompliance identified by the client as a part of this SLA such that the grace period shall be equal to the period of time noted in the applicable quantifier above. If after the expiration of any such cure period TIAA remains in noncompliance the penalties will be paid as appropriate. The total annual penalty maximum amount across all North Dakota Public Employees Retirement System plans shall not exceed $25,000, which would be payable into a revenue credit account established for North Dakota Public Employees Retirement System.

Notwithstanding the foregoing, TIAA's obligations shall be limited to the following:

(a) The National Contact Center (NCC) shall be available to respond to telephone calls Monday through Friday (excluding holidays observed by TIAA) from 8 a.m. to 10 p.m. Eastern Time and Saturdays from 9 a.m. to 5 p.m. Eastern Time. All calls to the NCC will be recorded to help ensure they are handled properly. Calls may be monitored for training, review and other business purposes. TIAA shall also provide Plan participants toll-free access to the Automated Telephone Service (ATS) modules. The ATS shall be available seven days a week and 24 hours a day, except during maintenance downtime and except at other times due to a failure of telecommunication, electrical, and/or computer systems, or other similar situations. TIAA shall use its best efforts to remedy any such failure. TIAA shall provide North Dakota Public Employees Retirement System with at least 24 hours' advance notice in the event of a scheduled material maintenance of the ATS expected to result in the unavailability of the ATS to North Dakota Public Employees Retirement System participants for any material period of time, and to the extent reasonably feasible, TIAA shall facilitate notification to participants in the plans of such unavailability via the web site.

(b) To the extent any penalty specified within this SLA for noncompliance under the SLA shall otherwise become due and owing, TIAA shall be responsible for the payment of such penalty if and only if payment shall be requested in writing by North Dakota Public Employees Retirement System within a reasonable period of time following the later of: (i) the expiration of the applicable cure period or (ii) the period during which North Dakota Public Employees Retirement System knew or reasonably should have known of TIAA's noncompliance.

(c) North Dakota Public Employees Retirement System shall assume its own liability for any errors, omissions or inaccuracies arising as a result of the failure to provide accurate and complete records to TIAA and TIAA shall not be responsible for any errors, omissions or inaccuracies arising as a result of the failure of North Dakota Public Employees Retirement System or any current or prior service provider(s) to provide accurate and complete records to TIAA; provided, however, TIAA shall not be excused from liability to the extent that TIAA has actual knowledge that such data is erroneous or, in the exercise of ordinary business prudence, would have such actual knowledge. In the event TIAA agrees to calculate a participant's required minimum distribution under IRC section 401(a)(9) and is not supplied with all information necessary to accurately compute the minimum distribution for any individual(s), TIAA shall, to the extent permissible under law and the underlying

funding options, calculate the payment using single life and recalculated annually options in the initial year and all subsequent years for that individual(s).

(d) North Dakota Public Employees Retirement System shall be solely responsible for the timeliness, accuracy and completeness of the data that it (or its agent) submits to TIAA, and for any adverse consequences that may result from errors or inaccuracies caused by the inaccuracy or incompleteness of such data; provided, however, TIAA shall not be excused from liability to the extent that TIAA has actual knowledge that such data is erroneous and does not take reasonable action to notify North Dakota Public Employees Retirement System to obtain corrected data. Subject to the foregoing, TIAA may fully rely on data received, and shall have no obligation beyond the exercise of ordinary business prudence to review it or verify its accuracy.

(e) North Dakota Public Employees Retirement System agrees to promptly provide any information reasonably requested by TIAA to enable the fulfillment of its responsibilities under this Agreement, and to sign miscellaneous certifications and other documentation related to the purposes expressed herein. TIAA shall have no obligation to perform any of the services described in or contemplated under this Agreement, unless and until a reasonable period of time after all information it reasonably may request has been provided by North Dakota Public Employees Retirement System.

(f) North Dakota Public Employees Retirement System agrees that TIAA's performance may deviate from the established expectations from time to time due to causes beyond TIAA's reasonable control, e.g., TIAA's receipt of poor or incomplete data, the periodic failure of information or communications systems (except where such failures are solely attributable to TIAA's negligence), the operation of the capital markets, computer or operational system failures (except where such system failures are solely attributable to TIAA's negligence in maintaining such systems), "Acts of God," fire, flood, civil or labor disturbance, war, terrorism, act of any governmental authority or other act or threat of any authority (de jure or de facto), legal constraint, fraud or forgery, inability to obtain or interruption of external communications facilities, or any cause beyond the reasonable control of TIAA or other unusual circumstances.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: PERS Board

FROM: Sharon Schiermeister

DATE: June 15, 2017

SUBJECT: Actuarial Factors

Attached please find a copy of what is referred to as "heat charts". You will note that:

1. Attachment #1 is for the 50% Joint and Survivor Benefit
2. Attachment #2 is for the 100% Joint and Survivor Benefit
3. Attachment #3 is for the 50 to 100% Joint and Survivor Benefit that is unique to the Judges and the Highway Patrol Plans
4. Attachment #4 is the 10 year term certain
5. Attachment #5 is the 20 year term certain

What these charts show is the percent change to a benefit under these alternative retirement payment options as a result of the new actuarial factors. Please note the legend in the upper right corner of the chart which indicates:

Red – means an increase in benefit of 3% or more
Yellow – means an increase in benefit of 0-3%
Green – means a decrease in benefit of 0-3%
Blue – means a decrease in benefit of 3% or more

The most common age ranges are outlined in black (retiree ages 50-75 with beneficiary ages up to 5 years younger or older than the retiree).

In reviewing the above, you may want to consider the following information from our last actuarial report relating to new retirements awarded during the year:

Payment Option	Normal	Early	Disability	Service*	Beneficiary	Total	Total**
Life	270	93	7	10	9	389	380
Life 1% Graduated Benefits	1	0	0	0	0	1	1
Life 2% Graduated Benefits	4	0	0	0	0	4	4
Level Social Security Payment	0	0	0	0	0	0	0
Joint & 100% Survivor	161	25	6	9	32	233	201
Joint & 100% Survivor 1% Graduated Benefits	0	0	0	0	0	0	0
Joint & 100% Survivor 2% Graduated Benefits	2	0	0	0	0	2	2
Joint & 50% Survivor	80	15	1	1	17	114	97
Joint & 50% Survivor 1% Graduated Benefits	1	0	0	0	0	1	1
Joint & 50% Survivor 2% Graduated Benefits	1	0	0	0	0	1	1
20 Year C & L	0	0	0	0	0	0	0
10 Year C & L	0	0	0	0	0	0	0
10 Year C & L 1% Graduated Benefits	0	0	0	0	0	0	0
5 Year C & L	0	0	0	0	0	0	0
5 Year Certain	0	0	0	0	0	0	0
10 Year Certain	2	1	0	0	0	3	3
10 Year Certain 1% Graduated Benefits	0	0	0	0	0	0	0
20 Year Certain	8	1	0	0	3	12	9
Total	**530**	**135**	**14**	**20**	**61**	**760**	**699**

Age	Normal	Early	Disability	Service*	Beneficiary	Total	Total**
Under 50	0	0	2	0	5	7	2
50 - 54	15	0	3	0	0	18	18
55 - 59	49	15	4	4	6	78	72
60 - 64	113	108	5	10	10	246	236
65 - 69	296	12	0	6	9	323	314
70 - 74	40	0	0	0	11	51	40
75 and Over	17	0	0	0	20	37	17
Total	**530**	**135**	**14**	**20**	**61**	**760**	**699**

The following observations can be made from the above information:

1. 55% of the new Normal and Early retirements were single life benefits which would not be impacted by the change in the actuarial factors
2. 42% of the new retirements were 100% or 50% J & S benefits that would be impacted by the change in factors
3. 79% of the new retirees were between the ages of 60-69 when they retired.

In considering the information above, the following observations can be made:

1. It appears that for most of the people who will be retiring who select the J & S options, the benefit they will get under this option will be higher under the new factor tables than the existing tables.
2. For these members, an earlier implementation may be to their advantage versus a later implementation.

Implementation

At the last meeting, we discussed the change in the return assumption from 8% to 7.75% and its implications on crediting interest on members accounts, assessing interest to employers on delinquent contributions and service purchases. The Board also adopted a new methodology for calculating the actuarial cost for service purchases.

As part of those discussions, the Board felt it would be beneficial to implement these changes along with implementing the new actuarial factors. This would allow for:

- All changes to be communicated at the same time
- All changes would have the same effective date

In recognition of the above discussion, staff feels the earliest concurrent implementation for the new factors, interest rate change and service purchase change would be December 2017 or January 2018. However, we also note that the information we received on the effect the new factors will have indicates that members retiring and using the updated factors between now and the end of the year could be negatively impacted by the delay.

Consequently, an option would be to communicate all the changes at the same time, as discussed at the last meeting, but separate the implementation for the benefit option factors from the purchase of service and interest rate change. If this guidance was provided for implementation, the new benefit option factors could go into place as early as September/October 2017 with the service purchase and interest rate change effective January 2018.

Board Action Requested

Determine implementation dates for the new benefit option factors, service purchase and interest rate change.

Staff Recommendation

Implement the new benefit option factors no earlier than October 2017. Implement the new service purchase methodology and new interest rate for crediting interest on member accounts, assessing interest to employers on delinquent contributions and service purchases no earlier than January 2018.

Main System and Law Enforcement Systems

Normal Form - Life Annuity, Used to Convert from Life Annuity

Joint & 50% Survivor Option Factors With Pop Up

Based on Interest Rate of 7.75% and 0% COLA

RP-2000 Combined Healthy Annuitant mortality tables, sex distinct, with rates set back two years for males and three years for females

and generational mortality improvement from the year 2014 using the Social Security Administration (SSA) 2014 Intermediate Cost scale and birth year based on age in 2017

Mortality rates blended 50% Male and 50% Female

50 Joint Survivor

increase of 3% or more

increase 0-3%

decrease of 0-3%

decrease of 3% or more

	Age 30-89	Retiree Age 50-75
Min Change	-6.57%	-1.65%
Max Change	6.24%	4.24%

Beneficiary Age	Retiree Age 50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
45	0.94%	1.00%	1.06%	1.12%	1.19%	1.26%	1.33%	1.39%	1.47%	1.55%	1.65%	1.75%	1.86%	1.98%	2.11%	2.25%	2.42%	2.59%	2.78%	2.97%	3.19%	3.38%	3.59%	3.81%	4.02%	4.24%
46	0.91%	0.97%	1.02%	1.08%	1.14%	1.21%	1.27%	1.34%	1.41%	1.49%	1.58%	1.68%	1.80%	1.91%	2.03%	2.18%	2.34%	2.51%	2.69%	2.87%	3.08%	3.29%	3.49%	3.69%	3.92%	4.11%
47	0.86%	0.92%	0.97%	1.03%	1.10%	1.15%	1.23%	1.29%	1.36%	1.44%	1.52%	1.61%	1.73%	1.83%	1.95%	2.09%	2.25%	2.42%	2.60%	2.79%	2.99%	3.19%	3.39%	3.59%	3.81%	4.00%
48	0.83%	0.89%	0.94%	0.99%	1.04%	1.11%	1.16%	1.22%	1.29%	1.38%	1.45%	1.54%	1.64%	1.75%	1.88%	2.00%	2.17%	2.32%	2.51%	2.70%	2.89%	3.08%	3.29%	3.49%	3.69%	3.88%
49	0.79%	0.83%	0.90%	0.94%	1.00%	1.06%	1.12%	1.17%	1.23%	1.31%	1.38%	1.48%	1.57%	1.68%	1.80%	1.93%	2.08%	2.23%	2.42%	2.59%	2.78%	2.98%	3.17%	3.37%	3.57%	3.77%
50	0.75%	0.80%	0.84%	0.90%	0.95%	1.00%	1.06%	1.11%	1.17%	1.25%	1.32%	1.40%	1.49%	1.61%	1.71%	1.84%	1.98%	2.13%	2.30%	2.49%	2.68%	2.86%	3.06%	3.26%	3.46%	3.64%
51	0.70%	0.76%	0.80%	0.85%	0.90%	0.95%	1.01%	1.05%	1.10%	1.19%	1.25%	1.33%	1.41%	1.52%	1.63%	1.76%	1.89%	2.04%	2.21%	2.38%	2.56%	2.75%	2.93%	3.13%	3.31%	3.51%
52	0.68%	0.71%	0.77%	0.80%	0.85%	0.90%	0.94%	0.99%	1.05%	1.11%	1.18%	1.25%	1.34%	1.43%	1.54%	1.66%	1.80%	1.94%	2.10%	2.27%	2.45%	2.63%	2.82%	3.01%	3.18%	3.38%
53	0.64%	0.67%	0.72%	0.76%	0.79%	0.84%	0.89%	0.93%	0.98%	1.04%	1.11%	1.19%	1.26%	1.35%	1.45%	1.57%	1.70%	1.84%	2.00%	2.16%	2.33%	2.52%	2.69%	2.87%	3.05%	3.23%
54	0.60%	0.63%	0.67%	0.71%	0.75%	0.79%	0.82%	0.87%	0.91%	0.97%	1.03%	1.11%	1.18%	1.27%	1.36%	1.47%	1.59%	1.73%	1.87%	2.05%	2.21%	2.38%	2.55%	2.73%	2.92%	3.10%
55	0.56%	0.59%	0.62%	0.65%	0.70%	0.73%	0.78%	0.80%	0.85%	0.91%	0.96%	1.02%	1.09%	1.18%	1.26%	1.37%	1.49%	1.62%	1.77%	1.92%	2.09%	2.24%	2.42%	2.58%	2.77%	2.94%
56	0.50%	0.55%	0.58%	0.61%	0.64%	0.67%	0.71%	0.75%	0.78%	0.83%	0.89%	0.95%	1.01%	1.08%	1.16%	1.26%	1.37%	1.50%	1.65%	1.79%	1.95%	2.11%	2.27%	2.43%	2.61%	2.78%
57	0.47%	0.49%	0.53%	0.56%	0.58%	0.61%	0.65%	0.68%	0.72%	0.75%	0.80%	0.86%	0.92%	0.98%	1.06%	1.16%	1.27%	1.38%	1.51%	1.66%	1.81%	1.97%	2.12%	2.29%	2.45%	2.61%
58	0.42%	0.46%	0.48%	0.51%	0.53%	0.56%	0.58%	0.62%	0.64%	0.68%	0.72%	0.77%	0.83%	0.89%	0.95%	1.05%	1.15%	1.26%	1.39%	1.53%	1.66%	1.82%	1.97%	2.12%	2.27%	2.43%
59	0.39%	0.42%	0.43%	0.45%	0.48%	0.50%	0.52%	0.54%	0.57%	0.60%	0.64%	0.68%	0.74%	0.79%	0.86%	0.94%	1.04%	1.14%	1.26%	1.39%	1.52%	1.67%	1.81%	1.95%	2.10%	2.25%
60	0.35%	0.38%	0.39%	0.41%	0.42%	0.45%	0.47%	0.48%	0.50%	0.54%	0.56%	0.60%	0.64%	0.69%	0.75%	0.82%	0.91%	1.01%	1.12%	1.24%	1.38%	1.50%	1.63%	1.78%	1.91%	2.06%
61	0.31%	0.33%	0.35%	0.36%	0.38%	0.39%	0.40%	0.42%	0.43%	0.45%	0.49%	0.51%	0.55%	0.59%	0.65%	0.71%	0.78%	0.88%	0.98%	1.09%	1.21%	1.33%	1.46%	1.59%	1.73%	1.86%
62	0.28%	0.29%	0.30%	0.32%	0.33%	0.33%	0.34%	0.35%	0.37%	0.38%	0.40%	0.43%	0.46%	0.49%	0.54%	0.59%	0.66%	0.74%	0.84%	0.95%	1.06%	1.16%	1.28%	1.40%	1.52%	1.66%
63	0.23%	0.24%	0.26%	0.27%	0.28%	0.29%	0.29%	0.29%	0.29%	0.31%	0.32%	0.34%	0.36%	0.38%	0.42%	0.48%	0.54%	0.62%	0.70%	0.79%	0.89%	0.99%	1.10%	1.21%	1.33%	1.44%
64	0.20%	0.20%	0.21%	0.23%	0.23%	0.23%	0.23%	0.23%	0.22%	0.24%	0.24%	0.25%	0.28%	0.29%	0.31%	0.36%	0.41%	0.47%	0.55%	0.64%	0.73%	0.83%	0.92%	1.01%	1.13%	1.22%
65	0.16%	0.17%	0.17%	0.17%	0.17%	0.17%	0.17%	0.17%	0.17%	0.16%	0.17%	0.17%	0.18%	0.20%	0.21%	0.25%	0.28%	0.34%	0.41%	0.48%	0.56%	0.65%	0.73%	0.82%	0.90%	1.00%
66	0.13%	0.13%	0.13%	0.14%	0.13%	0.12%	0.11%	0.11%	0.10%	0.09%	0.09%	0.09%	0.08%	0.10%	0.11%	0.14%	0.17%	0.22%	0.27%	0.33%	0.40%	0.48%	0.54%	0.62%	0.70%	0.78%
67	0.10%	0.10%	0.10%	0.10%	0.09%	0.07%	0.06%	0.05%	0.03%	0.03%	0.01%	0.01%	0.00%	0.00%	0.00%	0.02%	0.04%	0.09%	0.13%	0.18%	0.23%	0.30%	0.35%	0.43%	0.50%	0.56%
68	0.07%	0.06%	0.06%	0.05%	0.05%	0.03%	0.02%	0.00%	-0.02%	-0.03%	-0.05%	-0.06%	-0.07%	-0.09%	-0.10%	-0.09%	-0.07%	-0.03%	0.00%	0.03%	0.08%	0.13%	0.18%	0.23%	0.29%	0.34%
69	0.04%	0.04%	0.03%	0.02%	0.01%	0.00%	-0.02%	-0.04%	-0.07%	-0.09%	-0.11%	-0.13%	-0.16%	-0.18%	-0.19%	-0.18%	-0.18%	-0.16%	-0.14%	-0.10%	-0.08%	-0.03%	0.00%	0.03%	0.08%	0.13%
70	0.02%	0.01%	0.01%	-0.01%	-0.03%	-0.04%	-0.06%	-0.09%	-0.12%	-0.14%	-0.18%	-0.21%	-0.23%	-0.25%	-0.27%	-0.29%	-0.29%	-0.27%	-0.26%	-0.25%	-0.22%	-0.19%	-0.17%	-0.14%	-0.10%	-0.07%
71	0.00%	-0.02%	-0.02%	-0.04%	-0.06%	-0.07%	-0.10%	-0.13%	-0.16%	-0.21%	-0.24%	-0.27%	-0.30%	-0.32%	-0.36%	-0.38%	-0.38%	-0.38%	-0.39%	-0.38%	-0.36%	-0.35%	-0.33%	-0.31%	-0.30%	-0.28%
72	-0.03%	-0.03%	-0.04%	-0.06%	-0.09%	-0.11%	-0.14%	-0.17%	-0.21%	-0.25%	-0.28%	-0.32%	-0.36%	-0.39%	-0.44%	-0.46%	-0.47%	-0.49%	-0.50%	-0.51%	-0.49%	-0.48%	-0.50%	-0.48%	-0.47%	-0.48%
73	-0.05%	-0.06%	-0.07%	-0.09%	-0.11%	-0.14%	-0.17%	-0.20%	-0.24%	-0.30%	-0.33%	-0.37%	-0.42%	-0.46%	-0.51%	-0.54%	-0.57%	-0.58%	-0.61%	-0.61%	-0.63%	-0.62%	-0.64%	-0.65%	-0.65%	-0.67%
74	-0.06%	-0.08%	-0.10%	-0.12%	-0.14%	-0.16%	-0.20%	-0.23%	-0.29%	-0.33%	-0.38%	-0.42%	-0.47%	-0.53%	-0.57%	-0.61%	-0.65%	-0.68%	-0.70%	-0.72%	-0.74%	-0.76%	-0.79%	-0.80%	-0.82%	-0.85%
75	-0.09%	-0.09%	-0.12%	-0.13%	-0.16%	-0.19%	-0.23%	-0.27%	-0.32%	-0.37%	-0.41%	-0.46%	-0.52%	-0.58%	-0.63%	-0.69%	-0.72%	-0.77%	-0.80%	-0.83%	-0.85%	-0.88%	-0.92%	-0.95%	-0.97%	-1.02%
76	-0.10%	-0.11%	-0.13%	-0.16%	-0.18%	-0.21%	-0.25%	-0.29%	-0.34%	-0.39%	-0.45%	-0.50%	-0.56%	-0.62%	-0.68%	-0.74%	-0.79%	-0.85%	-0.88%	-0.92%	-0.96%	-1.00%	-1.04%	-1.09%	-1.13%	-1.17%
77	-0.12%	-0.12%	-0.14%	-0.17%	-0.19%	-0.22%	-0.26%	-0.31%	-0.37%	-0.42%	-0.48%	-0.53%	-0.59%	-0.67%	-0.73%	-0.79%	-0.85%	-0.91%	-0.95%	-1.00%	-1.05%	-1.10%	-1.15%	-1.20%	-1.26%	-1.31%
78	-0.12%	-0.14%	-0.16%	-0.18%	-0.20%	-0.24%	-0.28%	-0.32%	-0.38%	-0.44%	-0.50%	-0.56%	-0.63%	-0.70%	-0.77%	-0.83%	-0.90%	-0.97%	-1.02%	-1.07%	-1.13%	-1.19%	-1.25%	-1.31%	-1.37%	-1.45%
79	-0.13%	-0.14%	-0.17%	-0.19%	-0.22%	-0.25%	-0.29%	-0.33%	-0.39%	-0.45%	-0.52%	-0.58%	-0.65%	-0.73%	-0.79%	-0.87%	-0.94%	-1.00%	-1.07%	-1.13%	-1.20%	-1.27%	-1.33%	-1.41%	-1.48%	-1.56%
80	-0.14%	-0.15%	-0.17%	-0.20%	-0.22%	-0.26%	-0.30%	-0.35%	-0.40%	-0.47%	-0.53%	-0.59%	-0.66%	-0.74%	-0.82%	-0.90%	-0.97%	-1.04%	-1.12%	-1.19%	-1.25%	-1.32%	-1.40%	-1.49%	-1.57%	-1.65%

Main System and Law Enforcement Systems

Normal Form - Life Annuity, Used to Convert from Life Annuity

Joint & 100% Survivor Option Factors With Pop Up

Based on Interest Rate of 7.75% and 0% COLA

RP-2000 Combined Healthy Annuitant mortality tables, sex distinct, with rates set back two years for males and three years for females

and generational mortality improvement from the year 2014 using the Social Security Administration (SSA) 2014 Intermediate Cost scale and birth year based on age in 2017

Mortality rates blended 50% Male and 50% Female

100 Joint Survivor

increase of 3% or more

increase 0-3%

decrease of 0-3%

decrease of 3% or more

	Age 30-89	Retiree Age 50-75
Min Change	-10.92%	-3.02%
Max Change	9.40%	6.88%

Beneficiary Age \ Retiree Age	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
45	1.82%	1.94%	2.05%	2.16%	2.27%	2.38%	2.51%	2.63%	2.76%	2.91%	3.06%	3.23%	3.42%	3.60%	3.81%	4.05%	4.30%	4.58%	4.87%	5.16%	5.47%	5.76%	6.05%	6.33%	6.61%	6.88%
46	1.75%	1.86%	1.97%	2.07%	2.19%	2.30%	2.41%	2.53%	2.65%	2.80%	2.94%	3.11%	3.28%	3.48%	3.68%	3.91%	4.16%	4.43%	4.72%	5.02%	5.31%	5.59%	5.89%	6.18%	6.44%	6.70%
47	1.68%	1.78%	1.89%	2.00%	2.09%	2.21%	2.31%	2.43%	2.55%	2.69%	2.83%	2.99%	3.16%	3.35%	3.55%	3.77%	4.02%	4.29%	4.57%	4.86%	5.15%	5.44%	5.72%	6.00%	6.27%	6.53%
48	1.61%	1.71%	1.81%	1.90%	2.02%	2.11%	2.23%	2.32%	2.44%	2.57%	2.72%	2.88%	3.03%	3.21%	3.42%	3.64%	3.87%	4.13%	4.41%	4.70%	4.98%	5.27%	5.55%	5.82%	6.10%	6.35%
49	1.53%	1.64%	1.72%	1.82%	1.91%	2.02%	2.12%	2.22%	2.34%	2.46%	2.59%	2.74%	2.90%	3.08%	3.26%	3.48%	3.72%	3.99%	4.24%	4.53%	4.82%	5.11%	5.37%	5.64%	5.92%	6.18%
50	1.46%	1.55%	1.65%	1.74%	1.82%	1.92%	2.02%	2.12%	2.21%	2.34%	2.47%	2.61%	2.77%	2.94%	3.12%	3.33%	3.56%	3.82%	4.08%	4.36%	4.64%	4.93%	5.19%	5.47%	5.72%	5.97%
51	1.39%	1.48%	1.56%	1.64%	1.73%	1.83%	1.91%	2.01%	2.11%	2.22%	2.34%	2.48%	2.63%	2.79%	2.98%	3.19%	3.40%	3.65%	3.91%	4.18%	4.46%	4.73%	4.99%	5.27%	5.53%	5.78%
52	1.31%	1.39%	1.48%	1.55%	1.63%	1.72%	1.80%	1.89%	1.99%	2.09%	2.22%	2.35%	2.49%	2.64%	2.81%	3.02%	3.23%	3.47%	3.73%	4.00%	4.27%	4.53%	4.80%	5.05%	5.32%	5.55%
53	1.23%	1.31%	1.39%	1.46%	1.54%	1.62%	1.71%	1.78%	1.87%	1.97%	2.09%	2.21%	2.34%	2.48%	2.66%	2.85%	3.07%	3.29%	3.54%	3.81%	4.07%	4.34%	4.59%	4.84%	5.10%	5.35%
54	1.17%	1.24%	1.31%	1.37%	1.45%	1.51%	1.59%	1.66%	1.75%	1.85%	1.95%	2.06%	2.19%	2.34%	2.50%	2.68%	2.88%	3.11%	3.35%	3.61%	3.88%	4.13%	4.38%	4.62%	4.89%	5.13%
55	1.08%	1.15%	1.22%	1.27%	1.34%	1.41%	1.49%	1.54%	1.62%	1.71%	1.81%	1.92%	2.04%	2.18%	2.32%	2.50%	2.69%	2.92%	3.16%	3.39%	3.65%	3.90%	4.15%	4.39%	4.65%	4.87%
56	0.99%	1.06%	1.13%	1.18%	1.24%	1.30%	1.37%	1.43%	1.50%	1.58%	1.67%	1.77%	1.88%	2.00%	2.14%	2.31%	2.51%	2.71%	2.94%	3.19%	3.43%	3.67%	3.91%	4.14%	4.39%	4.64%
57	0.91%	0.97%	1.03%	1.09%	1.14%	1.19%	1.24%	1.31%	1.37%	1.44%	1.52%	1.61%	1.71%	1.83%	1.96%	2.13%	2.31%	2.51%	2.72%	2.95%	3.20%	3.43%	3.67%	3.90%	4.14%	4.36%
58	0.84%	0.90%	0.95%	0.99%	1.04%	1.09%	1.14%	1.18%	1.24%	1.31%	1.37%	1.46%	1.54%	1.66%	1.78%	1.93%	2.11%	2.29%	2.51%	2.72%	2.94%	3.18%	3.41%	3.63%	3.87%	4.07%
59	0.76%	0.81%	0.86%	0.90%	0.94%	0.98%	1.02%	1.06%	1.10%	1.16%	1.23%	1.31%	1.38%	1.48%	1.59%	1.72%	1.90%	2.07%	2.26%	2.47%	2.69%	2.92%	3.13%	3.35%	3.58%	3.77%
60	0.68%	0.72%	0.76%	0.79%	0.83%	0.87%	0.91%	0.93%	0.96%	1.02%	1.06%	1.14%	1.21%	1.30%	1.40%	1.53%	1.68%	1.85%	2.02%	2.22%	2.43%	2.65%	2.85%	3.04%	3.26%	3.47%
61	0.61%	0.65%	0.68%	0.70%	0.73%	0.76%	0.78%	0.81%	0.83%	0.87%	0.92%	0.97%	1.04%	1.11%	1.20%	1.32%	1.45%	1.60%	1.78%	1.96%	2.16%	2.37%	2.55%	2.74%	2.94%	3.15%
62	0.54%	0.56%	0.59%	0.61%	0.63%	0.65%	0.66%	0.69%	0.71%	0.73%	0.76%	0.82%	0.86%	0.93%	1.01%	1.10%	1.22%	1.36%	1.53%	1.70%	1.88%	2.07%	2.24%	2.44%	2.62%	2.80%
63	0.46%	0.49%	0.51%	0.52%	0.54%	0.55%	0.55%	0.56%	0.56%	0.59%	0.62%	0.64%	0.69%	0.73%	0.80%	0.89%	1.00%	1.14%	1.27%	1.43%	1.59%	1.77%	1.93%	2.11%	2.29%	2.46%
64	0.39%	0.40%	0.43%	0.43%	0.44%	0.44%	0.45%	0.45%	0.44%	0.44%	0.47%	0.49%	0.51%	0.55%	0.60%	0.66%	0.77%	0.89%	1.01%	1.16%	1.31%	1.46%	1.62%	1.77%	1.93%	2.08%
65	0.32%	0.33%	0.34%	0.34%	0.35%	0.34%	0.34%	0.32%	0.31%	0.31%	0.32%	0.33%	0.33%	0.37%	0.40%	0.46%	0.54%	0.63%	0.75%	0.87%	1.02%	1.17%	1.29%	1.44%	1.57%	1.72%
66	0.26%	0.27%	0.27%	0.26%	0.26%	0.25%	0.23%	0.21%	0.19%	0.18%	0.17%	0.16%	0.18%	0.18%	0.21%	0.25%	0.31%	0.39%	0.49%	0.61%	0.72%	0.85%	0.97%	1.09%	1.23%	1.34%
67	0.20%	0.21%	0.20%	0.19%	0.18%	0.16%	0.14%	0.11%	0.07%	0.05%	0.03%	0.01%	0.01%	0.01%	0.01%	0.05%	0.09%	0.16%	0.24%	0.33%	0.44%	0.55%	0.64%	0.75%	0.86%	0.97%
68	0.13%	0.14%	0.12%	0.10%	0.09%	0.07%	0.04%	0.00%	-0.03%	-0.07%	-0.10%	-0.13%	-0.15%	-0.17%	-0.17%	-0.16%	-0.13%	-0.08%	-0.01%	0.07%	0.15%	0.25%	0.32%	0.41%	0.50%	0.60%
69	0.09%	0.08%	0.06%	0.04%	0.02%	-0.01%	-0.04%	-0.09%	-0.15%	-0.18%	-0.21%	-0.27%	-0.30%	-0.33%	-0.34%	-0.35%	-0.33%	-0.30%	-0.26%	-0.20%	-0.12%	-0.06%	0.01%	0.08%	0.16%	0.23%
70	0.03%	0.02%	0.01%	-0.02%	-0.04%	-0.09%	-0.14%	-0.18%	-0.24%	-0.30%	-0.34%	-0.40%	-0.43%	-0.49%	-0.52%	-0.53%	-0.53%	-0.51%	-0.50%	-0.46%	-0.39%	-0.35%	-0.31%	-0.25%	-0.18%	-0.13%
71	-0.02%	-0.03%	-0.04%	-0.08%	-0.11%	-0.16%	-0.21%	-0.26%	-0.34%	-0.39%	-0.44%	-0.51%	-0.58%	-0.63%	-0.68%	-0.72%	-0.73%	-0.72%	-0.71%	-0.70%	-0.66%	-0.62%	-0.60%	-0.57%	-0.54%	-0.50%
72	-0.06%	-0.08%	-0.10%	-0.13%	-0.17%	-0.23%	-0.28%	-0.34%	-0.41%	-0.48%	-0.55%	-0.63%	-0.71%	-0.76%	-0.83%	-0.88%	-0.91%	-0.92%	-0.93%	-0.92%	-0.91%	-0.90%	-0.90%	-0.88%	-0.86%	-0.84%
73	-0.09%	-0.12%	-0.14%	-0.18%	-0.23%	-0.28%	-0.33%	-0.41%	-0.50%	-0.56%	-0.64%	-0.73%	-0.81%	-0.90%	-0.96%	-1.04%	-1.08%	-1.11%	-1.14%	-1.14%	-1.16%	-1.15%	-1.17%	-1.17%	-1.17%	-1.18%
74	-0.13%	-0.16%	-0.18%	-0.22%	-0.28%	-0.33%	-0.40%	-0.48%	-0.56%	-0.65%	-0.73%	-0.82%	-0.91%	-1.00%	-1.10%	-1.18%	-1.24%	-1.28%	-1.33%	-1.36%	-1.38%	-1.41%	-1.44%	-1.46%	-1.47%	-1.50%
75	-0.17%	-0.19%	-0.22%	-0.28%	-0.32%	-0.38%	-0.44%	-0.54%	-0.61%	-0.71%	-0.80%	-0.91%	-1.01%	-1.11%	-1.21%	-1.30%	-1.38%	-1.45%	-1.51%	-1.56%	-1.59%	-1.64%	-1.69%	-1.74%	-1.77%	-1.82%
76	-0.20%	-0.22%	-0.26%	-0.31%	-0.36%	-0.42%	-0.49%	-0.58%	-0.67%	-0.77%	-0.87%	-0.98%	-1.09%	-1.21%	-1.32%	-1.42%	-1.51%	-1.59%	-1.67%	-1.74%	-1.79%	-1.85%	-1.91%	-1.98%	-2.04%	-2.10%
77	-0.22%	-0.24%	-0.28%	-0.34%	-0.38%	-0.45%	-0.52%	-0.62%	-0.71%	-0.82%	-0.93%	-1.04%	-1.16%	-1.28%	-1.41%	-1.52%	-1.63%	-1.72%	-1.81%	-1.89%	-1.97%	-2.05%	-2.13%	-2.21%	-2.30%	-2.38%
78	-0.24%	-0.27%	-0.31%	-0.37%	-0.42%	-0.48%	-0.55%	-0.64%	-0.75%	-0.85%	-0.96%	-1.09%	-1.22%	-1.35%	-1.48%	-1.61%	-1.73%	-1.84%	-1.93%	-2.03%	-2.12%	-2.22%	-2.32%	-2.42%	-2.52%	-2.62%
79	-0.26%	-0.29%	-0.33%	-0.39%	-0.44%	-0.50%	-0.58%	-0.67%	-0.78%	-0.88%	-1.00%	-1.13%	-1.27%	-1.41%	-1.55%	-1.68%	-1.82%	-1.92%	-2.05%	-2.15%	-2.26%	-2.37%	-2.49%	-2.60%	-2.72%	-2.84%
80	-0.28%	-0.31%	-0.34%	-0.40%	-0.46%	-0.52%	-0.59%	-0.69%	-0.81%	-0.91%	-1.04%	-1.15%	-1.30%	-1.45%	-1.60%	-1.74%	-1.88%	-2.01%	-2.13%	-2.26%	-2.37%	-2.49%	-2.63%	-2.76%	-2.90%	-3.02%

Judges and Highway Patrol Systems

50 to 100 JS

Normal Form - Joint & 50% Survivor Option, Used to Convert from Joint & 50% Survivor Option

Joint & 100% Survivor Option Factors Without Pop Up

Based on Interest Rate of 7.75% and 0% COLA

RP-2000 Combined Healthy Annuitant mortality tables, sex distinct, with rates set back two years for males and three years for females

and generational mortality improvement from the year 2014 using the Social Security Administration (SSA) 2014 Intermediate Cost scale and birth year based on age in 2017

Mortality rates blended 50% Male and 50% Female

increase of 3% or more
increase 0-3%
decrease of 0-3%
decrease of 3% or more

	Age 30-89	Retiree Age 50-75
Min Change	-0.65%	0.14%
Max Change	3.16%	2.70%

Beneficiary Age / Retiree Age	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
45	0.98%	1.02%	1.08%	1.14%	1.19%	1.24%	1.29%	1.35%	1.40%	1.47%	1.54%	1.60%	1.67%	1.75%	1.82%	1.90%	2.00%	2.09%	2.19%	2.27%	2.37%	2.46%	2.52%	2.60%	2.65%	2.70%
46	0.95%	1.00%	1.06%	1.10%	1.16%	1.21%	1.27%	1.32%	1.38%	1.44%	1.49%	1.57%	1.63%	1.70%	1.78%	1.87%	1.96%	2.05%	2.15%	2.23%	2.33%	2.41%	2.49%	2.54%	2.61%	2.66%
47	0.92%	0.97%	1.02%	1.07%	1.13%	1.18%	1.23%	1.28%	1.33%	1.39%	1.46%	1.53%	1.60%	1.67%	1.75%	1.83%	1.93%	2.01%	2.10%	2.19%	2.29%	2.37%	2.45%	2.51%	2.57%	2.61%
48	0.89%	0.95%	0.99%	1.05%	1.09%	1.15%	1.20%	1.25%	1.31%	1.37%	1.42%	1.49%	1.56%	1.63%	1.71%	1.79%	1.88%	1.97%	2.06%	2.15%	2.25%	2.33%	2.39%	2.47%	2.52%	2.57%
49	0.87%	0.91%	0.97%	1.01%	1.06%	1.12%	1.17%	1.21%	1.26%	1.32%	1.39%	1.45%	1.53%	1.58%	1.67%	1.74%	1.84%	1.92%	2.02%	2.11%	2.21%	2.28%	2.36%	2.43%	2.48%	2.52%
50	0.84%	0.89%	0.94%	0.98%	1.03%	1.08%	1.13%	1.18%	1.24%	1.29%	1.35%	1.41%	1.48%	1.56%	1.62%	1.70%	1.80%	1.88%	1.98%	2.07%	2.16%	2.24%	2.32%	2.38%	2.45%	2.48%
51	0.82%	0.86%	0.91%	0.95%	1.00%	1.05%	1.10%	1.15%	1.19%	1.24%	1.32%	1.37%	1.44%	1.51%	1.59%	1.67%	1.75%	1.84%	1.93%	2.02%	2.12%	2.19%	2.28%	2.33%	2.39%	2.45%
52	0.78%	0.84%	0.88%	0.92%	0.97%	1.02%	1.06%	1.11%	1.16%	1.22%	1.28%	1.33%	1.40%	1.46%	1.54%	1.63%	1.71%	1.81%	1.89%	1.98%	2.07%	2.16%	2.22%	2.30%	2.36%	2.40%
53	0.76%	0.81%	0.85%	0.89%	0.94%	0.98%	1.03%	1.08%	1.11%	1.17%	1.23%	1.30%	1.36%	1.42%	1.49%	1.57%	1.66%	1.76%	1.85%	1.94%	2.03%	2.11%	2.19%	2.26%	2.32%	2.36%
54	0.73%	0.77%	0.82%	0.86%	0.91%	0.95%	1.00%	1.04%	1.09%	1.14%	1.20%	1.26%	1.32%	1.38%	1.45%	1.53%	1.61%	1.72%	1.80%	1.90%	1.99%	2.07%	2.14%	2.21%	2.27%	2.33%
55	0.71%	0.74%	0.79%	0.83%	0.87%	0.92%	0.96%	1.00%	1.05%	1.11%	1.15%	1.21%	1.28%	1.34%	1.42%	1.48%	1.57%	1.65%	1.75%	1.85%	1.94%	2.03%	2.08%	2.16%	2.23%	2.27%
56	0.68%	0.72%	0.75%	0.80%	0.84%	0.89%	0.93%	0.97%	1.01%	1.06%	1.11%	1.18%	1.24%	1.30%	1.37%	1.43%	1.52%	1.62%	1.71%	1.80%	1.88%	1.97%	2.04%	2.11%	2.19%	2.23%
57	0.65%	0.69%	0.73%	0.76%	0.81%	0.85%	0.90%	0.93%	0.97%	1.03%	1.07%	1.13%	1.19%	1.26%	1.32%	1.40%	1.47%	1.57%	1.66%	1.75%	1.84%	1.92%	2.00%	2.07%	2.13%	2.17%
58	0.61%	0.66%	0.70%	0.74%	0.78%	0.82%	0.85%	0.89%	0.93%	0.98%	1.04%	1.09%	1.15%	1.21%	1.27%	1.35%	1.44%	1.52%	1.60%	1.70%	1.79%	1.88%	1.94%	2.01%	2.09%	2.12%
59	0.58%	0.63%	0.67%	0.70%	0.74%	0.78%	0.81%	0.86%	0.89%	0.95%	0.98%	1.04%	1.10%	1.16%	1.24%	1.31%	1.38%	1.47%	1.56%	1.65%	1.74%	1.81%	1.89%	1.97%	2.03%	2.08%
60	0.56%	0.59%	0.64%	0.67%	0.70%	0.73%	0.78%	0.81%	0.86%	0.89%	0.95%	1.01%	1.06%	1.12%	1.18%	1.25%	1.33%	1.42%	1.51%	1.60%	1.68%	1.76%	1.84%	1.90%	1.97%	2.02%
61	0.53%	0.57%	0.59%	0.64%	0.67%	0.71%	0.75%	0.78%	0.81%	0.86%	0.91%	0.96%	1.01%	1.07%	1.13%	1.21%	1.28%	1.36%	1.45%	1.54%	1.63%	1.71%	1.78%	1.85%	1.92%	1.96%
62	0.50%	0.54%	0.57%	0.59%	0.64%	0.67%	0.70%	0.74%	0.77%	0.82%	0.86%	0.91%	0.96%	1.02%	1.07%	1.15%	1.23%	1.31%	1.40%	1.49%	1.57%	1.64%	1.72%	1.79%	1.86%	1.91%
63	0.48%	0.51%	0.53%	0.57%	0.61%	0.64%	0.67%	0.69%	0.74%	0.78%	0.82%	0.86%	0.91%	0.97%	1.03%	1.10%	1.17%	1.25%	1.34%	1.42%	1.52%	1.59%	1.66%	1.73%	1.79%	1.85%
64	0.45%	0.48%	0.51%	0.54%	0.57%	0.60%	0.63%	0.66%	0.69%	0.74%	0.77%	0.82%	0.87%	0.91%	0.98%	1.04%	1.13%	1.20%	1.29%	1.36%	1.45%	1.52%	1.61%	1.66%	1.72%	1.78%
65	0.43%	0.46%	0.48%	0.51%	0.54%	0.56%	0.60%	0.63%	0.65%	0.70%	0.73%	0.76%	0.82%	0.88%	0.93%	1.00%	1.07%	1.14%	1.23%	1.30%	1.39%	1.46%	1.54%	1.62%	1.68%	1.72%
66	0.40%	0.43%	0.45%	0.48%	0.50%	0.53%	0.56%	0.59%	0.61%	0.65%	0.69%	0.73%	0.78%	0.82%	0.88%	0.95%	1.01%	1.08%	1.17%	1.24%	1.32%	1.41%	1.48%	1.54%	1.60%	1.66%
67	0.38%	0.40%	0.43%	0.45%	0.48%	0.49%	0.52%	0.55%	0.58%	0.61%	0.65%	0.69%	0.73%	0.78%	0.82%	0.88%	0.95%	1.03%	1.11%	1.19%	1.27%	1.34%	1.42%	1.48%	1.54%	1.60%
68	0.35%	0.37%	0.40%	0.42%	0.45%	0.47%	0.49%	0.51%	0.53%	0.57%	0.60%	0.64%	0.69%	0.72%	0.78%	0.84%	0.90%	0.98%	1.05%	1.12%	1.21%	1.27%	1.34%	1.42%	1.48%	1.53%
69	0.32%	0.35%	0.38%	0.40%	0.42%	0.44%	0.45%	0.48%	0.50%	0.53%	0.57%	0.60%	0.63%	0.68%	0.72%	0.79%	0.84%	0.92%	0.99%	1.07%	1.15%	1.22%	1.29%	1.36%	1.42%	1.47%
70	0.31%	0.32%	0.34%	0.37%	0.39%	0.41%	0.43%	0.45%	0.47%	0.49%	0.53%	0.56%	0.59%	0.64%	0.68%	0.73%	0.79%	0.86%	0.93%	1.01%	1.09%	1.15%	1.23%	1.30%	1.35%	1.40%
71	0.28%	0.30%	0.32%	0.34%	0.36%	0.38%	0.40%	0.41%	0.44%	0.46%	0.48%	0.53%	0.55%	0.58%	0.64%	0.69%	0.75%	0.82%	0.88%	0.96%	1.03%	1.10%	1.17%	1.24%	1.30%	1.35%
72	0.26%	0.28%	0.30%	0.31%	0.33%	0.36%	0.37%	0.39%	0.40%	0.43%	0.45%	0.48%	0.52%	0.55%	0.59%	0.65%	0.70%	0.76%	0.83%	0.90%	0.97%	1.04%	1.12%	1.18%	1.24%	1.28%
73	0.24%	0.26%	0.27%	0.29%	0.30%	0.32%	0.35%	0.36%	0.38%	0.40%	0.42%	0.44%	0.47%	0.51%	0.55%	0.59%	0.65%	0.72%	0.78%	0.85%	0.93%	0.99%	1.06%	1.12%	1.19%	1.24%
74	0.22%	0.24%	0.25%	0.27%	0.28%	0.30%	0.31%	0.34%	0.35%	0.37%	0.39%	0.42%	0.44%	0.47%	0.51%	0.55%	0.61%	0.66%	0.74%	0.80%	0.87%	0.95%	1.01%	1.07%	1.14%	1.19%
75	0.21%	0.22%	0.23%	0.25%	0.27%	0.28%	0.30%	0.30%	0.33%	0.35%	0.36%	0.39%	0.41%	0.43%	0.48%	0.52%	0.57%	0.63%	0.69%	0.76%	0.83%	0.90%	0.96%	1.03%	1.10%	1.14%
76	0.20%	0.21%	0.22%	0.24%	0.25%	0.26%	0.27%	0.28%	0.30%	0.32%	0.34%	0.36%	0.38%	0.41%	0.44%	0.49%	0.53%	0.58%	0.65%	0.71%	0.78%	0.85%	0.91%	0.98%	1.05%	1.10%
77	0.18%	0.19%	0.20%	0.22%	0.23%	0.24%	0.25%	0.26%	0.27%	0.29%	0.31%	0.33%	0.35%	0.38%	0.41%	0.45%	0.49%	0.55%	0.61%	0.67%	0.74%	0.81%	0.88%	0.94%	1.00%	1.06%
78	0.17%	0.18%	0.19%	0.20%	0.21%	0.23%	0.24%	0.24%	0.25%	0.27%	0.28%	0.31%	0.33%	0.35%	0.39%	0.42%	0.45%	0.51%	0.57%	0.64%	0.70%	0.77%	0.83%	0.90%	0.96%	1.02%
79	0.15%	0.16%	0.18%	0.19%	0.20%	0.21%	0.22%	0.22%	0.23%	0.25%	0.26%	0.28%	0.31%	0.33%	0.36%	0.39%	0.44%	0.49%	0.54%	0.60%	0.67%	0.74%	0.79%	0.86%	0.93%	0.99%
80	0.14%	0.15%	0.17%	0.17%	0.18%	0.19%	0.21%	0.21%	0.22%	0.24%	0.25%	0.26%	0.28%	0.31%	0.34%	0.37%	0.41%	0.46%	0.51%	0.57%	0.64%	0.70%	0.76%	0.84%	0.91%	0.97%

Main System and Law Enforcement Systems
Normal Form - Life Annuity, Used to Convert from Life Annuity
10 Year Certain and Life
Based on Interest Rate of 7.75% and 0% COLA
RP-2000 Combined Healthy Annuitant mortality tables, sex distinct, with rates set back two years for males and three years for females
and generational mortality improvement from the year 2014 using the Social Security Administration (SSA) 2014 Intermediate Cost scale and birth year based on age in 2017
Mortality rates blended 50% Male and 50% Female

10 certain

Retiree Age	
50	0.44%
51	0.49%
52	0.55%
53	0.59%
54	0.63%
55	0.69%
56	0.74%
57	0.80%
58	0.87%
59	0.94%
60	1.03%
61	1.13%
62	1.25%
63	1.38%
64	1.54%
65	1.72%
66	1.95%
67	2.20%
68	2.49%
69	2.82%
70	3.20%
71	3.62%
72	4.07%
73	4.57%
74	5.12%
75	5.70%

increase of 3% or more
increase 0-3%
decrease of 0-3%
decrease of 3% or more

	Age 30-89	Age 50-75
Min	0.05%	0.44%
Max	9.14%	5.70%

Main System and Law Enforcement Systems
Normal Form - Life Annuity, Used to Convert from Life Annuity
20 Year Certain and Life
Based on Interest Rate of 7.75% and 0% COLA
RP-2000 Combined Healthy Annuitant mortality tables, sex distinct, with rates set back two years for males and three years for females
and generational mortality improvement from the year 2014 using the Social Security Administration (SSA) 2014 Intermediate Cost scale and birth year based on age in 2017
Mortality rates blended 50% Male and 50% Female

20 Certain

Retiree Age	
50	1.44%
51	1.57%
52	1.70%
53	1.85%
54	2.00%
55	2.17%
56	2.35%
57	2.55%
58	2.77%
59	3.02%
60	3.30%
61	3.62%
62	3.96%
63	4.35%
64	4.78%
65	5.24%
66	5.74%
67	6.27%
68	6.81%
69	7.38%
70	7.95%
71	8.52%
72	9.06%
73	9.58%
74	10.09%
75	10.56%

	increase of 3% or more
	increase 0-3%
	decrease of 0-3%
	decrease of 3% or more

	Age 30-89	Age 50-75
Min	0.15%	1.44%
Max	11.84%	10.56%

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS@state.nd.us ● discovernd.com/NDPERS

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **June 22, 2017**

SUBJECT: **Disability Consultant Agreement**

The agreement with Mid Dakota Clinic for disability consulting services expires June 30, 2017. The Board must determine whether to renew or go out for bid.

This year in addition to requesting a proposal for the next fiscal year, we also requested that Mid Dakota consider providing a 2-year proposal which would be for the period from July 1, 2017 through June 30, 2019. This would make the service period consistent with our other vendor contracts.

Mid Dakota Clinic has indicated they wish to continue to perform these services for NDPERS at the rate of $200 an hour for the period July 1, 2017 through June 30, 2018. This represents no increase in the hourly rate from the current contract period and is the tenth 10 year in which no increase was requested. They declined to commit to a 2-year proposal due to potential business changes. The amount paid in consulting fees for the period beginning July 2016 through May 2017 is $9,300 involving 46.5 hours and 82 cases. Included is a copy of the contract which has been updated and approved by Jan.

Staff is satisfied with the service provided by Mid Dakota and recommends that we renew the disability consulting contract for the period July 1, 2017 through June 30, 2018 at the rate of $200 an hour.

Board Action Requested

Approve staff's recommendation.

Disability Consulting
Agreement Attachment

AGREEMENT

This Agreement is entered into between the State of North Dakota acting through its Public Employees Retirement System (PERS) and Mid Dakota Clinic.

SCOPE OF SERVICES

Mid Dakota Clinic, in exchange for the compensation paid by PERS under this contract, agrees to provide the following services:

1) To review applications for disability benefits and make a recommendation concerning the eligibility of the individual. The medical consultant must respond in writing within thirty (30) days of receiving the application. In order to be eligible, an individual must be permanently and totally disabled. This means they must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than twelve months. Substantial gainful activity is based upon the totality of the circumstances including consideration of an individual's training, education, and experience; their potential for earning at least seventy percent of their pre-disability earnings; and other items deemed significant on a case by case basis. Eligibility is based on an individual's employability and not on actual employment status.

2) Disabled annuitants are recertified approximately every eighteen months. The medical consultant will review any new information and, if necessary, make recommendations.

3) To prepare written finding for the Executive Director of PERS and also the Public Employees Retirement System Board. In the event of an appeal, the medical consultant will review any new information and, if necessary, make recommendations.

4) To provide general consulting services as requested.

5) To provide a monthly status report including the name of each applicant under review and current status of the claim\application by the 10th of each month.

6) To maintain records and to retain such records for six (6) years after the termination of a disability.

TERM

This Agreement shall commence on July 1, 2017 and end on June 30, 2018.

FEES

PERS shall pay Mid Dakota Clinic $200 per hour for work performed pursuant to the agreed upon terms in the proposal dated May 30, 2017 which is incorporated herein by reference.

TERMINATION OF CONTRACT

a. Termination without cause or by mutual consent. This contract may be terminated by mutual consent of both parties or by either party by providing thirty (30) days written notice of termination.

b. Termination for lack of funding or authority. PERS by written notice of default to Mid Dakota Clinic may terminate the whole or any part of this contract, under any of the following conditions:

(1) If funding from federal, state, or other sources is not obtained and continued at levels sufficient to allow for purchase of the services or supplies in the indicated quantities or term.
(2) If federal or state laws or rules are modified or interpreted in a way that the services are no longer allowable or appropriate for purchase under this contract or are no longer eligible for the funding proposed for payments authorized by this contract.
(3) If any license, permit, or certificate required by law or rule, or by the terms of this contract, is for any reason denied, revoked, suspended, or not renewed.

Termination of this contract under this subsection is without prejudice to any obligations or liabilities of either party already accrued prior to termination.

c. Termination for cause. PERS may terminate this contract effective upon delivery of written notice to Mid Dakota Clinic, or any later date stated in the notice:

(1) If Mid Dakota Clinic fails to provide services required by this contract within the time specified or any extension agreed to by PERS; or
(2) If Mid Dakota Clinic fails to perform any of the other provisions of this contract, or so fails to pursue the work as to endanger performance of this contract in accordance with its terms.

The rights and remedies of PERS provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this contract.

FORCE MAJEURE

Neither party shall be held responsible for delay or default caused by fire, flood, riot, acts of God or war if the event is beyond the party's reasonable control and the affected party gives notice to the other party immediately upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default.

RENEWAL

This contract will not automatically renew.

NON-DISCRIMINATION/COMPLIANCE WITH LAWS

Mid Dakota Clinic agrees to comply with all applicable laws, rules, regulations, and policies, including but not limited to those relating to non-discrimination, accessibility, and civil rights. Mid Dakota Clinic agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including but not limited to sales and use taxes and unemployment compensation and workers' compensation premiums. Mid Dakota Clinic shall have and keep current at all times during the term of this Agreement all licenses and permits required by law.

ACCESS TO RECORDS AND AUDIT

The Public Employees Retirement Board, Office of the Attorney General of the State of North Dakota, and their duly authorized representatives shall have access to the books, documents, papers, and records of the Mid Dakota Clinic which are directly pertinent to the specific duties and obligations to be performed pursuant to this Agreement for the purpose of making audit, examination, excerpts, and transcripts. All records, regardless of physical form, and the accounting practices and procedures of Mid Dakota Clinic relevant to this contract are subject to examination by the North Dakota State Auditor or the Auditor's designee, or Federal auditors. Mid Dakota Clinic shall maintain all such records for at least six years following completion of this contract and be able to provide them at any reasonable time. PERS, State Auditor, or Auditor's designee shall provide reasonable notice.

WORK PRODUCT, EQUIPMENT AND MATERIALS

All work product, equipment or materials created or purchased under this contract belong to PERS and must be delivered to PERS at PERS request upon termination of this contract. Mid Dakota Clinic agrees that all materials prepared under this contract are "works for hire" within the meaning of the copyright laws of the United States and assigns to PERS all rights and interests Mid Dakota Clinic may have in the materials it prepares under this contract, including any right to derivative use of the material. Mid Dakota Clinic shall execute all necessary documents to enable PERS to protect its rights under this section.

INDEPENDENT ENTITY

Mid Dakota Clinic is an independent entity under this contract and is not a state of North Dakota employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. Mid Dakota Clinic retains sole and absolute discretion in the manner and means of carrying out Mid Dakota Clinic's activities and responsibilities under this contract, except to the extent specified in this contract.

ASSIGNMENT AND DELEGATION

Mid Dakota Clinic may not assign or otherwise transfer or delegate any right or duty without the express written consent of PERS. However, Mid Dakota Clinic may enter into subcontracts provided that any subcontract acknowledges the binding nature of this Contract and incorporates this Contract, including any attachments. Mid Dakota Clinic is solely responsible for the performance of any subcontractor. Mid Dakota Clinic does not have authority to contract for or incur obligations on behalf of PERS.

CONFIDENTIALITY

Mid Dakota Clinic agrees not to use or disclose any information it receives from PERS under this contract that PERS has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this contract or as authorized in advance by PERS. PERS agrees not to disclose any information it receives from Mid Dakota Clinic that Mid Dakota Clinic has previously identified as confidential and that PERS determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota open records law, N.D.C.C. ch. 44-04. Both parties are aware that information or records may be confidential under state law or federal laws such as HIPAA. Mid Dakota Clinic agrees to comply with the requirements of a separately signed Business Associate Agreement as required under the HIPAA Privacy Rule, 45 C.F. R. 164.502(e)(2) and with respect to any services provided under this agreement, to comply with all applicable requirements of the federal HIPAA privacy rule, 45 CFR pts. 160 and 164. The parties agree that all participation by PERS members and their dependents in programs administered by PERS is confidential under North Dakota law. Failure of Contractor to maintain the confidentiality of such information may be considered a material breach of the contract and may constitute the basis for additional civil and criminal penalties under North Dakota law. Contractor shall not disclose any individual employee or dependent information without the prior written consent of the employee or family member. Contractor has exclusive control over the direction and guidance of the persons rendering services under this Agreement. Upon termination of this Agreement, for any reason, Contractor shall return or destroy all confidential information received from PERS, or created or received by Contractor on behalf of PERS. This provision applies to confidential information that may be in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of the confidential information. In the event that Contractor asserts that returning or destroying the confidential information is not feasible, Contractor shall provide to PERS notification of the conditions that make return or destruction infeasible. Upon explicit written agreement of PERS that return or destruction of confidential information is not feasible. Contractor shall extend the protections of this Agreement to that confidential information and limit further uses and disclosures of any such confidential information to those purposes that make the return or destruction infeasible, for so long as Contractor maintains the confidential

information. The indemnity provisions of this agreement specifically apply to the duty of Mid Dakota Clinic to comply with this confidentiality requirement.

COMPLIANCE WITH PUBLIC RECORDS LAW

Mid Dakota Clinic understands that, except for information that is confidential or otherwise exempt from the North Dakota open records law, PERS must disclose to the public upon request any records it receives from Mid Dakota Clinic. Mid Dakota Clinic further understands that any records that are obtained or generated by Mid Dakota Clinic under this contract, except for records that are confidential or exempt may, under certain circumstances, be open to the public upon request under the North Dakota open records law. Mid Dakota Clinic agrees to contact PERS immediately upon receiving a request for information under the open records law and to comply with PERS instructions on how to respond to the request.

INDEMNITY

Mid Dakota Clinic agrees to defend, indemnify, and hold harmless the State of North Dakota, its agencies, officers and employees, including the North Dakota Public Employees Retirement System, its Board of Trustees, officers and employees (for the purposes of this provision all parties are together referenced as the "State"), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors or omissions. The legal defense provided by Mid Dakota Clinic to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. Mid Dakota Clinic also agrees to defend, indemnify, and hold the State harmless from all costs, expenses and attorneys' fees incurred if the State prevails in an action against Mid Dakota Clinic in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this agreement.

INSURANCE

Mid Dakota Clinic shall secure and keep in force during the term of this agreement, and shall require all subcontractors, prior to commencement of an agreement between Mid Dakota Clinic and the subcontractor, to secure and keep in force during the term of this agreement from insurance companies, government self-insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with

minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

2) Professional errors and omissions with minimum liability limits of $1,000,000 per occurrence and in the aggregate, Mid Dakota Clinic shall continuously maintain such coverage during the contact period and for three years thereafter. In the event of a change or cancellation of coverage, Mid Dakota clinic shall purchase an extended reporting period to meet the time periods required in this section.

3) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

4) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.

5) Employer's liability or "stop gap" insurance of not less than $1,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of Mid Dakota Clinic.

2) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.

3) The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.

4) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this agreement or by the contractual indemnity obligations of Mid Dakota Clinic.

5) The insurance required in this agreement, through a policy or endorsement, shall include:

a) "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State;
b) A provision that Mid Dakota Clinic's insurance coverage shall be primary (i.e. pay first) as respects any insurance, self-insurance or self-retention maintained by the State and that any insurance, self-insurance or self-retention maintained by the State shall be in excess of the Mid Dakota's insurance and shall not contribute with it;
c) Cross liability/severability of interest for all policies and endorsements;
d) The legal defense provided to the State under the policy and any endorsements must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary;
e) The insolvency or bankruptcy of Mid Dakota Clinic shall not release the insurer from payment under the policy, even when such insolvency or bankruptcy prevents Mid Dakota Clinic from meeting the retention limit under the policy.

6) Mid Dakota Clinic shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this agreement. All endorsements shall be provided as soon as practicable.

7) Failure to provide insurance as required in this agreement is a material breach of contract entitling State to terminate this agreement immediately.

8) Mid Dakota Clinic shall provide at least 30 day notice of any cancellation or material change to the policies or endorsements.

APPLICABLE LAW AND VENUE

This Agreement shall be governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this contract must be brought in the State District Court of Burleigh County, North Dakota. Each party consents to the exclusive jurisdiction of such court and waives any claim of lack of jurisdiction or forum non conveniens.

MERGER CLAUSE

This Agreement constitutes the entire agreement between the parties. No waiver, consent, modification, or change of terms of this Agreement shall bind either party unless in writing and signed by both parties. Any such waiver, consent, modification, or change, if made, shall be effective only in the specific instances and for the specific purpose given. There are no understandings, agreements, or representations, oral or written, not specified within this Agreement.

SEVERABILITY CLAUSE

If any term of this Agreement is declared by a court having jurisdiction to be illegal or unenforceable, the validity of the remaining terms shall not be affected, and, if possible, the rights and obligations of the parties are to be construed and enforced as if the contract did not contain that term.

NOTICE

All notices or other communications required under this contract must be given by registered or certified mail and are complete on the date mailed when addressed to the parties at the following addresses:

Kathy M. Allen
Benefit Programs Manager
400 East Broadway, Ste 505
Bismarck ND 58502

Wesley A Woodbury
Worklife Manager
Mid Dakota Clinic
PO Box 5538
Bismarck ND 58502-5538

Notice provided under this provision does not meet the notice requirements for monetary claims against the State found at N.D.C.C. § 32-12.2-04.

SPOLIATION – NOTICE OF POTENTIAL CLAIMS

Mid Dakota Clinic shall promptly notify PERS of all potential claims that arise or result from this contract. Mid Dakota Clinic shall also take all reasonable steps to preserve all physical evidence and information that may be relevant to the circumstances surrounding a potential claim, while maintaining public safety, and grants to PERS the opportunity to review and inspect the evidence, including the scene of an accident.

ATTORNEY FEES

In the event a lawsuit is instituted by PERS to obtain performance due under this contract, and PERS is the prevailing party, Mid Dakota Clinic shall, except when prohibited by N.D.C.C. § 28-26-04, pay to the State of North Dakota reasonable attorney fees and costs in connection with the lawsuit.

ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

The state of North Dakota does not agree to any form of binding arbitration, mediation, or other forms of mandatory alternative dispute resolution. The parties have the right to enforce their rights and remedies in judicial proceedings. The state of North Dakota does not waive any right to a jury trial.

T<u>AXPAYER ID:</u>

CONTRACTOR'S federal employer ID number is: _____.

<u>EFFECTIVENESS OF CONTRACT</u>:

This contract is not effective until fully executed by both parties.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM	**MID DAKOTA CLINIC**
_____	_____
Sparb Collins, Executive Director ND Public Employees Retirement System	Authorized Agent Mid Dakota Clinic
_____	_____
Date	Date

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: PERS Board

FROM: Sparb & Bryan

DATE: June 22, 2017

SUBJECT: Callan College Invitation

The North Dakota State Investment Board (SIB) has arranged for Callan College to be held in Bismarck on Friday, July 28th. Callan is the investment consultant for the SIB. This is an education program that they offer. The SIB is inviting the NDPERS Board members to attend.

Callan College is divided into three major segments: Capital Market Theory; Asset Allocation; and Fiduciary Practices. The session is intended to provide fund sponsor trustees and staff with an understanding of functional investment theory, terminology, and best practices. It is designed for individuals who are relatively new to investment oversight responsibilities.

Attached is the proposed agenda for July 28th.

David Hunter would like members attending to RSVP by June 30th by phone at 328-9889 or by email at: djhunter@nd.gov

If you have any questions, we will be available at the NDPERS Board meeting.

TO: **SIB Client Board Members**

FROM: Dave Hunter on behalf of the State Investment Board (SIB)

DATE: June 1, 2017

SUBJECT: **Callan College Onsite – July 28, 2017**

All SIB client board members are invited to attend Callan College on July 28th. The SIB serves 13 client boards including TFFR, PERS, WSI, City of Bismarck Employees and Police, City of Grand Forks Employees and Park District, City of Fargo (FargoDome), Insurance Commissioner, State Risk Management, North Dakota Association of Counties, Council on the Arts, State Board of Medicine and the Legacy & Budget Stabilization Fund Advisory Board.

Callan College will be held at Bismarck State College Energy Center – Room #335 from 8:30 am to 2:00 pm on Friday, July 28th. The proposed agenda is as follows:

8:30 - 8:45	Introduction and Welcome Remarks
8:45 - 9:45	Callan College - Capital Market Theory
9:45 - 10:00	Break
10:00 - 11:00	Callan College - Asset Allocation
11:00 - 12:00	Callan College - Role of Fiduciary & Investment Policy Statements
12:00 - 12:30	Lunch Break – Callan College discussion may continue over lunch
12:30 - 12:40	United Way Awareness - *Jena Gullo, Executive Director, MSA United Way*
12:40 - 12:45	Callan College Ends
12:50 - 2:00	Fixed Income Manager Interviews

Callan College is divided into three major segments: Capital Market Theory; Asset Allocation; and Fiduciary Practices. The session is intended to provide fund sponsor trustees and staff with an understanding of functional investment theory, terminology, and best practices. It is designed for individuals who are relatively new to investment oversight responsibilities.

Participants will gain a fundamental understanding of the basics behind Capital Market Theory, Asset Allocation, and their role as fiduciaries including their purpose within the structure of investment programs. The session includes:

- An overview of capital market theory, characteristics of various asset classes and the processes by which fiduciaries implement their investment decisions;

- A review of asset allocation and how risk and return objectives are analyzed within the framework of promised benefits and funding responsibilities; and
- An introduction to fiduciary issues as they pertain to fund management and oversight.

Section Descriptions:

Capital Market Theory – The objective of this section is to demystify investment terminology, explain key investment fundamentals, provide sound basis for investment decisions, and discuss how institutional clients apply theory in their board rooms. This course will examine the quantitative tools used in asset allocation, style analysis, manager structure, manager search, investment policy, and performance measurement.

Asset Allocation – The objection of this section is to provide an overview of asset/liability modeling from the standpoint of the plan sponsor, investment manager, and consultant. Callan will delve into why it is important, when sponsors review their allocations and how the review takes place. Integral to this discussion is a description on how capital market assumptions; efficient portfolios (the efficient frontier), correlation, and diversification play a role in creating asset mix alternatives. The trade-off between risk and return is examined in detail. We define risk tolerance, return need and demonstrate how sponsors and consultants select the appropriate mix.

The Role of the Fiduciary – The objective of this section is to define the role of the fiduciary. We do this by tracing the history of fiduciary conduct and describing the appropriate activities of persons responsible for the assets of others. We examine the various laws and concepts governing the activities of fiduciaries and translate these concepts into practical guidelines. We explore and describe the differences among different plan types and the laws governing each.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: PERS Board

FROM: MaryJo

DATE: June 22, 2017

SUBJECT: Public Safety Plan

During the 2017 legislative session, HB 1148 passed expanding the eligibility of the NDPERS Law Enforcement plan to include firefighters effective 8/1/2017. This change requires updates to the employer agreements that NDPERS currently provides to enroll new groups. In addition, we are considering changing the name of "NDPERS Law Enforcement Retirement Plan" to "NDPERS Public Safety Retirement Plan" to reflect the broader membership.

In reviewing with Janilyn Murtha, it was decided to setup two additional agreements for employers electing to participate in the Public Safety Plan.

1. "Public Safety Retirement Plan – Law Enforcement" agreement (Attachment #1)
   For agencies enrolling peace officers only, a signed board resolution and this agreement stating enrollment effective date would be completed.

2. "Public Safety Retirement Plan - Firefighters" agreement (Attachment #2)
   For agencies with already enrolled peace officers or enrolling firefighters only, a signed board resolution and this agreement stating enrollment effective date would be completed.

3. "Public Safety Retirement Plan" agreement (Attachment #3)
   For agencies enrolling both peace officers and firefighters, a signed board resolution and this agreement stating enrollment effective date would be completed.

Jan and NDPERS staff will be available at the Board meeting to answer any questions.

Board Action:
Adopt the Public Safety Retirement Plan agreements for new group enrollment.

Attachment #1

EMPLOYER PARTICIPATION AGREEMENT
IN THE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
PUBLIC SAFETY RETIREMENT PLAN - LAW ENFORCEMENT

This agreement is entered into pursuant to Section 54-52-02.1 of the North Dakota Century Code by and between AGENCY / AGENCY ID, North Dakota, as authorized by the resolution hereto attached and the NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM (NDPERS) as authorized by the Retirement Board through its chairman and executive director and shall be effective on MONTH DATE, YEAR.

Whereas, a referendum has been held of the eligible peace officers and correctional officers of AGENCY, North Dakota, pursuant to Chapter 54-52-02.2 of the North Dakota Century Code, and a majority of such eligible employees have voted in favor of participation in the Retirement System and AGENCY has determined that this agreement should be entered into; and

Whereas, the North Dakota Public Employees Retirement Board agrees to extend the benefits of the Public Employees Retirement System to eligible employees of AGENCY;

Now, therefore, it is agreed and understood that:

1. All of the provisions of Chapter 54-52 of the North Dakota Century Code and the current or later amended rules of the Retirement Board shall apply with regard to benefits, contributions and administration of the system.

2. The employee contribution rate has been actuarially determined to be a percentage of "wages" and "salaries" as defined in Section 54-52 of the North Dakota Century Code for those eligible employees employed at the date of this agreement and for those eligible employees whose date of employment is after the effective date.

3. The employer contribution rate shall be a percentage of "wages" and "salaries" for all eligible employees as defined in Sections 54-52-01 of the North Dakota Century Code, which specific percentage shall be determined by the retirement board. (Ref. N.D.C.C. 54-52-06 and 54-52.1-03.2.)

4. Eligible employees who are employed by AGENCY at the time this agreement is entered into have the option of not participating in the Public Employees Retirement System. Eligible employees who waive participation in the Public Employees Retirement System may not have their pay increased as a result of that waiver, which determination shall be made by the retirement board in its sole discretion, and any violation of this requirement will constitute a breach of this agreement.

5. All eligible employees hired by AGENCY on or after MONTH DATE, YEAR, must participate in the Public Employees Retirement System.

6. Should AGENCY wish to terminate membership with the Public Employees Retirement System, it shall do so only after:

(a) Submitting a request in writing to the Retirement Board at least sixty (60) days prior to the requested date of withdrawal; and

(b) Complying with Section 54-52-02.1 of the North Dakota Century Code and the Rules of the Retirement Board regarding withdrawal from the system.

7. This Agreement may be amended in writing by mutual agreement of both parties.

8. If the AGENCY fails to perform according to its statutory participation requirements and the terms of this agreement, the NDPERS Board may terminate the AGENCY's enrollment in NDPERS. The termination shall be performed pursuant to the withdrawal procedures outlined in N.D.C.C. Chapter 54-52.

Executed at _____, North Dakota, this ____ day of _____, 20____.

AGENCY

By _____

By _____

Executed at Bismarck, North Dakota, this ____ day of _____, 20____.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT BOARD

By _____
Executive Director Date

EMPLOYER PARTICIPATION AGREEMENT
IN THE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
PUBLIC SAFETY RETIREMENT PLAN - FIREFIGHTERS

This agreement is entered into pursuant to Section 54-52-02.1 of the North Dakota Century Code by and between AGENCY / AGENCY ID, North Dakota, as authorized by the resolution hereto attached and the NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM (NDPERS) as authorized by the Retirement Board through its chairman and executive director and shall be effective on MONTH DATE, YEAR.

Whereas, a referendum has been held of the eligible firefighters of AGENCY, North Dakota, pursuant to Chapter 54-52-02.2 of the North Dakota Century Code, and a majority of such eligible employees have voted in favor of participation in the Retirement System and AGENCY has determined that this agreement should be entered into; and

Whereas, the North Dakota Public Employees Retirement Board agrees to extend the benefits of the Public Employees Retirement System to eligible employees of AGENCY;

Now, therefore, it is agreed and understood that:

1. All of the provisions of Chapter 54-52 of the North Dakota Century Code and the current or later amended rules of the Retirement Board shall apply with regard to benefits, contributions and administration of the system.

2. The employee contribution rate has been actuarially determined to be a percentage of "wages" and "salaries" as defined in Section 54-52 of the North Dakota Century Code for those eligible employees employed at the date of this agreement and for those eligible employees whose date of employment is after the effective date.

3. The employer contribution rate shall be a percentage of "wages" and "salaries" for all eligible employees as defined in Sections 54-52-01 of the North Dakota Century Code, which specific percentage shall be determined by the retirement board. (Ref. N.D.C.C. 54-52-06 and 54-52.1-03.2.)

4. Eligible employees who are employed by AGENCY at the time this agreement is entered into have the option of not participating in the Public Employees Retirement System. Eligible employees who waive participation in the Public Employees Retirement System may not have their pay increased as a result of that waiver, which determination shall be made by the retirement board in its sole discretion, and any violation of this requirement will constitute a breach of this agreement.

5. All eligible employees hired by AGENCY on or after MONTH DATE, YEAR, must participate in the Public Employees Retirement System.

6. Should AGENCY wish to terminate membership with the Public Employees Retirement System, it shall do so only after:

(a) Submitting a request in writing to the Retirement Board at least sixty (60) days prior to the requested date of withdrawal; and

(b) Complying with Section 54-52-02.1 of the North Dakota Century Code and the Rules of the Retirement Board regarding withdrawal from the system.

7. This Agreement may be amended in writing by mutual agreement of both parties.

8. If the AGENCY fails to perform according to its statutory participation requirements and the terms of this agreement, the NDPERS Board may terminate the AGENCY's enrollment in NDPERS. The termination shall be performed pursuant to the withdrawal procedures outlined in N.D.C.C. Chapter 54-52.

Executed at _____, North Dakota, this ____ day of _____, 20____.

AGENCY / AGENCY ID

By _____

By _____

Executed at Bismarck, North Dakota, this ____ day of _____, 20____.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT BOARD

By _____
Executive Director Date

EMPLOYER PARTICIPATION AGREEMENT
IN THE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
PUBLIC SAFETY RETIREMENT PLAN

This agreement is entered into pursuant to Section 54-52-02.1 of the North Dakota Century Code by and between AGENCY / AGENCY ID, North Dakota, as authorized by the resolution hereto attached and the NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM (NDPERS) as authorized by the Retirement Board through its chairman and executive director and shall be effective on MONTH DATE, YEAR.

Whereas, a referendum has been held of the eligible peace officers and correctional officers and firefighters of AGENCY, North Dakota, pursuant to Chapter 54-52-02.2 of the North Dakota Century Code, and a majority of such eligible employees have voted in favor of participation in the Retirement System and AGENCY has determined that this agreement should be entered into; and

Whereas, the North Dakota Public Employees Retirement Board agrees to extend the benefits of the Public Employees Retirement System to eligible employees of AGENCY;

Now, therefore, it is agreed and understood that:

1. All of the provisions of Chapter 54-52 of the North Dakota Century Code and the current or later amended rules of the Retirement Board shall apply with regard to benefits, contributions and administration of the system.

2. The employee contribution rate has been actuarially determined to be a percentage of "wages" and "salaries" as defined in Section 54-52 of the North Dakota Century Code for those eligible employees employed at the date of this agreement and for those eligible employees whose date of employment is after the effective date.

3. The employer contribution rate shall be a percentage of "wages" and "salaries" for all eligible employees as defined in Sections 54-52 of the North Dakota Century Code, which specific percentage shall be determined by the retirement board. (Ref. N.D.C.C. 54-52-06 and 54-52.1-03.2.)

4. Eligible employees who are employed by AGENCY at the time this agreement is entered into have the option of not participating in the Public Employees Retirement System. Eligible employees who waive participation in the Public Employees Retirement System may not have their pay increased as a result of that waiver, which determination shall be made by the retirement board in its sole discretion, and any violation of this requirement will constitute a breach of this agreement.

5. All eligible employees hired by AGENCY on or after MONTH DATE, YEAR, must participate in the Public Employees Retirement System.

6. Should AGENCY wish to terminate membership with the Public Employees Retirement System, it shall do so only after:

(a) Submitting a request in writing to the Retirement Board at least sixty (60) days prior to the requested date of withdrawal; and

(b) Complying with Section 54-52-02.1 of the North Dakota Century Code and the Rules of the Retirement Board regarding withdrawal from the system.

7. This Agreement may be amended in writing by mutual agreement of both parties.

8. If the AGENCY fails to perform according to its statutory participation requirements and the terms of this agreement, the NDPERS Board may terminate the AGENCY's enrollment in NDPERS. The termination shall be performed pursuant to the withdrawal procedures outlined in N.D.C.C. Chapter 54-52.

Executed at _____, North Dakota, this ____ day of _____, 20____.

AGENCY / AGENCY ID

By _____

By _____

Executed at Bismarck, North Dakota, this ____ day of _____, 20____.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT BOARD

By _____
Executive Director Date

NDPERS

Memo

To: NDPERS Board

From: Bryan T. Reinhardt

Date: June 22, 2017

Re: 457 Companion Plan & 401(a) Plan 1st Quarter 2017 Report

Here is the 1st quarter 2017 investment report for the 401(a) & 457 Companion Plan. The reports are available separately on the NDPERS web site. The NDPERS Investment Sub-committee reviewed the 1st quarter reports. The two plans have 6,721 participants with an account balance and over $88.5 million in assets.

Assets in the 401(a) plan increased to $11.6 million as of March 31, 2017. The number of active participants is at 110. The largest funds are the TIAA-CREF Lifecycle funds with 60% of assets.

Assets in the 457 Companion Plan increased to $93.4 million as of March 31, 2017. The number of active participants is increasing and is now at 4,681 active. The largest funds are the TIAA-CREF Lifecycle funds with 73% of assets.

Benchmarks:
Fund returns for the quarter were all positive. Core fund performance was mixed when compared to their benchmarks and peer funds. 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 1st quarter plan review, field activity report and investment overview with TIAA. The Subcommittee marked the Wells Fargo Growth Admin Fund (SGRKX) and Allianz NFJ Small Cap Fund (PVADX) as underperforming for the quarter. The investment subcommittee took no action on the funds currently under formal fund review, but will be doing a comprehensive review of the core fund lineup. The committee discussed the asset allocation in the Job Service plan and moved to recommend continuing to de-risk the plan by moving to a 30/70 allocation. David Hunter shared the fund returns as of March 31, 2017. The Main plan is at 8.77% fiscal year to date.

NDPERS
Quarterly Investment Report
1st Quarter
1/1/2017 – 3/31/2017

North Dakota Public Employees Retirement System
400 E Bdwy, Suite 505
Box 1657
Bismarck, ND 58502

NDPERS 401(a) Defined Contribution Plan & 457 Companion Plan - TIAA-CREF

INITIAL OFFERING:

	Hartford Dividend & Growth	Vanguard 500 Index Signal	Franklin Growth Adv
	T.Rowe Price Equity Income	Vanguard Dividend Growth	Wells Fargo Adv Growth Adm
			LARGE
	RidgeWorth Mid Cap Value Equity I	ASTON/Fairpointe Mid Cap I	Prudential Jennison Mid Cap Growth Z
		Columbia Mid Cap Index A	
			MEDIUM
	Allianz NFJ Small Cap Value	DFA US Small Cap	Brown Capital Mgmt Small Co Inv
			SMALL
	VALUE	**BLEND**	**GROWTH**

BALANCED FUND:	T.Rowe Price Capital Appreciation		
INCOME FUNDS:	Wells Fargo Stable Value Fund J	Vanguard Prime Money Market	
BOND FUNDS:	PIMCO Total Return Bond Fund	Vanguard Total Bond Index Fund	Templeton Global Bond
	PIMCO Real Return Admin Bond Fund	Prudential High Yield Z	
REAL ESTATE:	Cohen & Steers Realty Shares		
INTERNATIONAL FUNDS:	Mutual Global Discovery Z	Vanguard Total Intl Stock Index	Oppenheimer Developing Markets Y
LIFESTYLE FUNDS:	TIAA-CREF Lifecycle Ret Income	TIAA-CREF Lifecycle 2025	TIAA-CREF Lifecycle 2045
	TIAA-CREF Lifecycle 2010	TIAA-CREF Lifecycle 2030	TIAA-CREF Lifecycle 2050
	TIAA-CREF Lifecycle 2015	TIAA-CREF Lifecycle 2035	TIAA-CREF Lifecycle 2055
	TIAA-CREF Lifecycle 2020	TIAA-CREF Lifecycle 2040	TIAA-CREF Lifecycle 2060

FUND STYLE CHANGES:

			Vanguard Dividend Growth
			LARGE
	ASTON/Fairpointe Mid Cap I		
		RidgeWorth Mid Cap Value Equity	
			MEDIUM
			SMALL
	VALUE	**BLEND**	**GROWTH**

OTHER FUNDS:

CURRENT LINEUP:

	Hartford Dividend & Growth	Vanguard 500 Index Signal	Franklin Growth Adv
	T.Rowe Price Equity Income		Wells Fargo Adv Growth Adm
			Vanguard Dividend Growth **LARGE**
	ASTON/Fairpointe Mid Cap I	Columbia Mid Cap Index A	Prudential Jennison Mid Cap Growth Z
		RidgeWorth Mid Cap Value Equity	
			MEDIUM
	Allianz NFJ Small Cap Value	DFA US Small Cap	Brown Capital Mgmt Small Co Inv
			SMALL
	VALUE	**BLEND**	**GROWTH**

BALANCED FUND:	T.Rowe Price Capital Appreciation		
INCOME FUNDS:	Wells Fargo Stable Value Fund J	Vanguard Treasury Money Market	
BOND FUNDS:	PIMCO Total Return Bond Fund	Vanguard Total Bond Index Fund	Templeton Global Bond
	PIMCO Real Return Admin Bond Fund	Prudential High Yield Z	
REAL ESTATE:	Cohen & Steers Realty Shares		
INTERNATIONAL FUNDS:	Mutual Global Discovery Z	Vanguard Total Intl Stock Index	Oppenheimer Developing Markets Y
LIFESTYLE FUNDS:	TIAA-CREF Lifecycle Ret Income	TIAA-CREF Lifecycle 2025	TIAA-CREF Lifecycle 2045
	TIAA-CREF Lifecycle 2010	TIAA-CREF Lifecycle 2030	TIAA-CREF Lifecycle 2050
	TIAA-CREF Lifecycle 2015	TIAA-CREF Lifecycle 2035	TIAA-CREF Lifecycle 2055
	TIAA-CREF Lifecycle 2020	TIAA-CREF Lifecycle 2040	TIAA-CREF Lifecycle 2060

NDPERS Investment Benchmarks - 1st Quarter 2017

	Quarter	Y-T-D	1-Year	3-Year	5-Year
Stable Value / Money Market Fund					
Vanguard Treasury Money Market - VUSXX	**0.11%**	**0.11%**	**0.32%**	**0.13%**	**0.08%**
Wells Fargo Stable Return Fund J - WFSJ#	**0.24%**	**0.24%**	**0.97%**	**0.86%**	**0.90%**
3 Month T-Bill Index	0.12%	0.12%	0.34%	0.15%	0.11%
Fixed Income Fund					
PIMCO Real Return Admin - PARRX	**1.81%**	**1.81%**	**2.51%**	**1.48%**	**0.77%**
PIMCO Total Return Bond Fund - PTRAX <ON WATCH>	**1.56%**	**1.56%**	**2.18%**	**2.52%**	**2.70%**
Vanguard Total Bond Market Index Fund - VBTLX	**0.91%**	**0.91%**	**0.43%**	**2.60%**	**2.27%**
Barclays Aggregate Bond Index	0.82%	0.82%	0.44%	2.68%	2.34%
Taxable Corporate Bond Fund Universe	1.40%	1.40%	4.23%	3.40%	3.94%
Prudential High Yield Z - PHYZX	**2.93%**	**2.93%**	**14.85%**	**4.89%**	**6.76%**
ML High Yield Bond Fund Index	2.71%	2.71%	16.88%	4.62%	6.85%
High Yield Bond Fund Universe	2.31%	2.31%	13.52%	3.15%	5.56%
Templeton Global Bond Adv - TGBAX	**4.65%**	**4.65%**	**11.46%**	**2.66%**	**3.88%**
Citi World Govt Bond Index	1.55%	1.55%	-3.65%	-1.20%	-0.58%
World Bond Fund Universe	2.30%	2.30%	1.84%	0.35%	1.37%
Real Estate Fund					
Cohen & Steers Realty Shares - CSRSX	**1.48%**	**1.48%**	**3.31%**	**10.12%**	**9.62%**
FTSE NAREIT All Equity REITs Index	1.16%	1.16%	3.56%	10.26%	9.99%
Real Estate Fund Universe	0.99%	0.99%	3.08%	9.01%	8.82%
Balanced Fund					
T.Rowe Price Capital Appreciation - PACLX	**5.24%**	**5.24%**	**11.40%**	**9.13%**	**11.25%**
60% Large Cap Value Univ & 40% Taxable Bond Universe	2.78%	2.78%	12.16%	5.75%	8.46%
60% Russell 1000 Value & 40% Agg Bond Index	2.31%	2.31%	11.70%	6.29%	8.80%
Large Cap Equities - Value					
Hartford Dividend & Growth - HDGTX	**4.21%**	**4.21%**	**18.05%**	**8.98%**	**12.43%**
T.Rowe Price Equity Income - PRFDX <ON WATCH>	**3.30%**	**3.30%**	**19.94%**	**6.76%**	**11.07%**
Russell 1000 Value Index	3.30%	3.30%	19.20%	8.70%	13.10%
Large Cap Value Fund Universe	3.70%	3.70%	17.44%	7.32%	11.47%
Large Cap Equities - Blend					
Vanguard 500 Index - VFIAX	**6.05%**	**6.05%**	**17.13%**	**10.34%**	**13.26%**
Vanguard Dividend Growth Fund - VDIGX	**5.87%**	**5.87%**	**10.67%**	**8.65%**	**12.00%**
S&P 500 Index	6.07%	6.07%	17.17%	10.37%	13.30%
Large Cap Blend Fund Universe	5.57%	5.57%	15.97%	8.14%	11.74%
Large Cap Equities - Growth					
Wells Fargo Adv Growth Adm - SGRKX <ON WATCH>	**11.76%**	**11.76%**	**17.48%**	**6.54%**	**9.10%**
Russell 3000 Growth Index	8.63%	8.63%	16.27%	10.90%	13.22%
Franklin Growth Adv - FCGAX	**8.28%**	**8.28%**	**17.36%**	**10.60%**	**12.62%**
Russell 1000 Growth Index	8.90%	8.90%	15.80%	11.30%	13.30%
Large Cap Growth Fund Universe	8.63%	8.63%	14.85%	8.53%	11.55%
Mid Cap Equities - Value					
RidgeWorth Mid Cap Value Equity I - SMVTX	**5.16%**	**5.16%**	**23.08%**	**8.44%**	**13.26%**
Russell Mid Cap Value	3.76%	3.76%	19.82%	8.94%	14.07%
Mid Cap Value Fund Universe	3.50%	3.50%	18.86%	7.04%	12.02%
Mid Cap Equities - Blend					
Columbia Mid Cap Index A - NTIAX	**3.77%**	**3.77%**	**20.34%**	**8.84%**	**12.79%**
S&P Mid Cap 400	3.94%	3.94%	20.92%	9.36%	13.32%
ASTON/Fairpointe Mid Cap I - ABMIX	**6.16%**	**6.16%**	**27.38%**	**7.55%**	**14.31%**
Wilshire 4500 Index	4.14%	4.14%	23.61%	8.10%	13.15%
Mid Cap Blend Fund Universe	4.18%	4.18%	17.17%	6.34%	11.50%
Mid Cap Equities - Growth					
Prudential Jennison Mid Cap Growth Z - PEGZX	**8.55%**	**8.55%**	**13.79%**	**6.07%**	**9.45%**
Russell Mid Cap Growth	6.89%	6.89%	14.07%	7.88%	11.95%
Mid Cap Growth Fund Universe	7.30%	7.30%	15.56%	6.06%	10.30%

Fund Returns in RED do not meet both benchmarks. **Fund Returns in BLACK meet both benchmarks.**

NDPERS Investment Benchmarks - 1st Quarter 2017

	Quarter	Y-T-D	1-Year	3-Year	5-Year
Small Cap Equities - Value					
Allianz NFJ Small Cap Value - PVADX <ON WATCH>	**1.82%**	**1.82%**	**23.01%**	**5.24%**	**9.80%**
Russell 2000 Value Index	-0.13%	-0.13%	29.37%	7.62%	12.54%
Small Value Fund Universe	0.29%	0.29%	22.43%	6.11%	11.38%
Small Cap Equities - Blend					
DFA US Small Cap - DFSTX	**0.99%**	**0.99%**	**22.49%**	**7.71%**	**13.49%**
Russell 2000 Index	2.47%	2.47%	26.22%	7.22%	12.35%
Small Blend Fund Universe	1.77%	1.77%	22.08%	5.98%	11.30%
Small Cap Equities - Growth					
Brown Capital Mgmt Small Co Inv - BCSIX	**8.85%**	**8.85%**	**24.77%**	**10.30%**	**15.28%**
Russell 2000 Growth Index	5.30%	5.30%	23.00%	6.70%	12.10%
Small Growth Fund Universe	5.56%	5.56%	22.41%	5.34%	10.73%
International Equity Funds					
Mutual Global Discovery Z - MDISX	**4.43%**	**4.43%**	**19.58%**	**5.49%**	**9.78%**
Vanguard Total Intl Stock Index Inv - VTIAX	**8.47%**	**8.47%**	**13.74%**	**1.10%**	**4.83%**
MSCI EAFE	7.86%	7.86%	13.13%	0.56%	4.36%
International Stock Fund Universe	7.34%	7.34%	13.68%	4.12%	8.27%
Oppenheimer Developing Markets Y - ODVYX	**11.04%**	**11.04%**	**15.46%**	**-0.14%**	**2.34%**
MSCI Emerging Markets Index	11.45%	11.45%	17.22%	1.18%	0.81%
Diversified Emerging Mkts Universe	11.59%	11.59%	16.40%	0.71%	1.20%
Asset Allocation Funds:					
TIAA-CREF Lifecycle Ret Income - TLIRX	**3.52%**	**3.52%**	**7.94%**	**4.04%**	**5.54%**
Income Benchmark	3.06%	3.06%	7.50%	4.04%	5.42%
TIAA-CREF Lifecycle 2010 - TCLEX	**3.72%**	**3.72%**	**8.52%**	**4.28%**	**6.06%**
2010 Benchmark	3.36%	3.36%	8.35%	4.31%	5.88%
TIAA-CREF Lifecycle 2015 - TCLIX	**4.13%**	**4.13%**	**9.33%**	**4.54%**	**6.56%**
2015 Benchmark	3.65%	3.65%	9.17%	4.56%	6.33%
TIAA-CREF Lifecycle 2020 - TCLTX	**4.48%**	**4.48%**	**10.37%**	**4.79%**	**7.19%**
2020 Benchmark	4.11%	4.11%	10.49%	4.94%	7.02%
TIAA-CREF Lifecycle 2025 - TCLFX	**5.00%**	**5.00%**	**11.60%**	**5.09%**	**7.84%**
2025 Benchmark	4.58%	4.58%	11.96%	5.34%	7.75%
TIAA-CREF Lifecycle 2030 - TCLNX	**5.43%**	**5.43%**	**12.70%**	**5.34%**	**8.43%**
2030 Benchmark	5.05%	5.05%	13.44%	5.73%	8.49%
TIAA-CREF Lifecycle 2035 - TCLRX	**5.88%**	**5.88%**	**13.85%**	**5.56%**	**8.93%**
2035 Benchmark	5.49%	5.49%	14.77%	6.07%	9.14%
TIAA-CREF Lifecycle 2040 - TCLOX	**6.40%**	**6.40%**	**15.09%**	**5.78%**	**9.33%**
2040 Benchmark	5.93%	5.93%	16.05%	6.38%	9.77%
TIAA-CREF Lifecycle 2045 - TTFRX	**6.64%**	**6.64%**	**15.49%**	**5.91%**	**9.40%**
2045 Benchmark	5.92%	5.92%	16.03%	6.38%	9.76%
TIAA-CREF Lifecycle 2050 - TLFRX	**6.62%**	**6.62%**	**15.62%**	**5.97%**	**9.43%**
2050 Benchmark	5.93%	5.93%	16.04%	6.38%	9.76%
TIAA-CREF Lifecycle 2055 - TTRLX	**6.67%**	**6.67%**	**15.77%**	**6.02%**	**9.48%**
2055 Benchmark	5.92%	5.92%	16.02%	6.37%	9.75%
TIAA-CREF Lifecycle 2060 - TTRLX	**6.77%**	**6.77%**	**15.91%**	**N/A**	**N/A**
2060 Benchmark	5.92%	5.92%	16.02%	6.37%	9.75%

Income Benchmark is comprised of 27.2% Wilshire 5000, 13.1% MSCI EAFE, 46.6% Ag Bond, 3.0% HY Bond, 10.1% 3 Month T-Bill
2010 Benchmark is comprised of 30.8% Wilshire 5000, 14.6% MSCI EAFE, 43.7% Ag Bond, 3.0% HY Bond, 7.9% 3 Month T-Bill
2015 Benchmark is comprised of 34.3% Wilshire 5000, 16.1% MSCI EAFE, 40.7% Ag Bond, 3.0% HY Bond, 5.9% 3 Month T-Bill
2020 Benchmark is comprised of 39.9% Wilshire 5000, 18.5% MSCI EAFE, 34.7% Ag Bond, 3.0% HY Bond, 3.9% 3 Month T-Bill
2025 Benchmark is comprised of 45.5% Wilshire 5000, 20.8% MSCI EAFE, 27.8% Ag Bond, 4.0% HY Bond, 1.9% 3 Month T-Bill
2030 Benchmark is comprised of 51.1% Wilshire 5000, 23.2% MSCI EAFE, 20.7% Ag Bond, 5.0% HY Bond
2035 Benchmark is comprised of 56.8% Wilshire 5000, 25.5% MSCI EAFE, 12.7% Ag Bond, 5.0% HY Bond
2040 Benchmark is comprised of 62.2% Wilshire 5000, 27.9% MSCI EAFE, 4.9% Ag Bond, 5.0% HY Bond
2045 Benchmark is comprised of 62.1% Wilshire 5000, 27.9% MSCI EAFE, 5.0% Ag Bond, 5.0% HY Bond
2050 Benchmark is comprised of 62.1% Wilshire 5000, 28.0% MSCI EAFE, 4.9% Ag Bond, 5.0% HY Bond
2055&2060 Benchmark is comprised of 62.0% Wilshire 5000, 28.0% MSCI EAFE, 5.0% Ag Bond, 5.0% HY Bond

Wilshire 5000 Index	5.72%	5.72%	18.52%	9.43%	13.01%
MSCI EAFE	7.86%	7.86%	13.13%	0.56%	4.36%
Barclays Aggregate Bond Index	0.82%	0.82%	0.44%	2.68%	2.34%
ML High Yield Bond Fund Index	2.71%	2.71%	16.88%	4.62%	6.85%
3 Month T-Bill Index	0.12%	0.12%	0.34%	0.15%	0.11%

Fund Returns in RED do not meet both benchmarks. **Fund Returns in BLACK meet both benchmarks.**

457(b)	Assets	Pct
TIAA-CREF Lifecycle 2020 Fund Retirement	$14,339,863	15.4%
TIAA-CREF Lifecycle 2025 Fund Retirement	$13,683,497	14.6%
TIAA-CREF Lifecycle 2030 Fund Retirement	$9,995,195	10.7%
TIAA-CREF Lifecycle 2015 Fund Retirement	$8,109,079	8.7%
TIAA-CREF Lifecycle 2035 Fund Retirement	$6,242,241	6.7%
TIAA-CREF Lifecycle 2040 Fund Retirement	$5,269,994	5.6%
TIAA-CREF Lifecycle 2045 Fund Retirement	$4,497,354	4.8%
Vanguard 500 Index Fund Admiral	$3,703,357	4.0%
TIAA-CREF Lifecycle 2050 Fund Retirement	$2,913,642	3.1%
Vanguard Total International Stock Index Fund Admiral	$2,160,730	2.3%
Wells Fargo Stable Return Fund - J	$1,705,465	1.8%
TIAA-CREF Lifecycle 2010 Fund Retirement	$1,692,633	1.8%
AllianzGI NFJ Small Cap Value Fund Administrative	$1,567,944	1.7%
Columbia Mid Cap Index Fund A	$1,247,865	1.3%
Vanguard Dividend Growth Fund Investor	$1,230,378	1.3%
PIMCO Total Return Fund Admin	$1,218,445	1.3%
T. Rowe Price Equity Income Fund	$1,168,260	1.3%
T. Rowe Price Capital Appreciation Fund Advisor	$1,160,345	1.2%
Franklin Growth Fund Advisor	$770,213	0.8%
Brown Capital Management Small Company Fund Institutional	$766,945	0.8%
Cohen & Steers Realty Shares	$746,388	0.8%
Hartford Dividend and Growth Fund R5	$740,321	0.8%
Wells Fargo Growth Fund Administrator	$738,319	0.8%
Templeton Global Bond Fund Advisor	$728,573	0.8%
AMG Managers Fairpointe Mid Cap Fund I	$694,305	0.7%
Vanguard Total Bond Market Index Fund Admiral	$670,624	0.7%
Oppenheimer Developing Markets Fund Y	$658,927	0.7%
RidgeWorth Ceredex Mid Cap Value Equity Fund I	$630,544	0.7%
Prudential High Yield Fund Z	$602,670	0.6%
PIMCO Real Return Fund Administrative	$600,823	0.6%
TIAA-CREF Lifecycle 2055 Fund Retirement	$564,146	0.6%
TIAA-CREF Lifecycle Retirement Income Fund Retirement	$519,158	0.6%
Vanguard Admiral Treasury Money Market Fund Investor	$500,917	0.5%
Self Directed Brokerage Account	$418,661	0.4%
Franklin Mutual Global Discovery Fund Z	$390,221	0.4%
DFA U.S. Small Cap Portfolio Institutional	$374,754	0.4%
Prudential Jennison Mid-Cap Growth Fund Z	$365,707	0.4%
TIAA-CREF Lifecycle 2060 Fund Retirement	$24,259	0.0%
TIAA-CREF Money Market Fund Retirement	$0	0.0%
Total	**$93,412,762**	**100.0%**

401(a)	Assets	Pct
TIAA-CREF Lifecycle 2025 Fund Retirement	$1,364,927	11.8%
TIAA-CREF Lifecycle 2030 Fund Retirement	$1,356,916	11.7%
TIAA-CREF Lifecycle 2020 Fund Retirement	$1,113,269	9.6%
TIAA-CREF Lifecycle 2035 Fund Retirement	$1,000,255	8.6%
TIAA-CREF Lifecycle 2010 Fund Retirement	$801,873	6.9%
Vanguard 500 Index Fund Admiral	$538,470	4.6%
TIAA-CREF Lifecycle 2040 Fund Retirement	$454,523	3.9%
Vanguard Total International Stock Index Fund Admiral	$384,531	3.3%
TIAA-CREF Lifecycle 2050 Fund Retirement	$373,112	3.2%
T. Rowe Price Capital Appreciation Fund Advisor	$318,319	2.7%
TIAA-CREF Lifecycle 2045 Fund Retirement	$277,378	2.4%
PIMCO Total Return Fund Admin	$276,755	2.4%
Wells Fargo Growth Fund Administrator	$266,732	2.3%
AllianzGI NFJ Small Cap Value Fund Administrative	$258,928	2.2%
Prudential High Yield Fund Z	$221,162	1.9%
Franklin Mutual Global Discovery Fund Z	$218,858	1.9%
Wells Fargo Stable Return Fund - J	$211,391	1.8%
Brown Capital Management Small Company Fund Institutional	$203,136	1.8%
TIAA-CREF Lifecycle 2055 Fund Retirement	$201,740	1.7%
Franklin Growth Fund Advisor	$199,935	1.7%
Hartford Dividend and Growth Fund R5	$182,598	1.6%
Cohen & Steers Realty Shares	$164,703	1.4%
RidgeWorth Ceredex Mid Cap Value Equity Fund I	$151,814	1.3%
T. Rowe Price Equity Income Fund	$127,497	1.1%
Templeton Global Bond Fund Advisor	$124,643	1.1%
AMG Managers Fairpointe Mid Cap Fund I	$115,776	1.0%
Vanguard Total Bond Market Index Fund Admiral	$105,270	0.9%
Oppenheimer Developing Markets Fund Y	$84,661	0.7%
Columbia Mid Cap Index Fund A	$83,462	0.7%
Prudential Jennison Mid-Cap Growth Fund Z	$80,327	0.7%
PIMCO Real Return Fund Administrative	$74,911	0.6%
DFA U.S. Small Cap Portfolio Institutional	$74,602	0.6%
Vanguard Dividend Growth Fund Investor	$71,771	0.6%
Vanguard Admiral Treasury Money Market Fund Investor	$63,889	0.6%
TIAA-CREF Lifecycle 2015 Fund Retirement	$41,858	0.4%
TIAA-CREF Lifecycle 2060 Fund Retirement	$14,551	0.1%
Self Directed Brokerage Account	$0	0.0%
TIAA-CREF Lifecycle Retirement Income Fund Retirement	$0	0.0%
TIAA-CREF Money Market Fund Retirement	$0	0.0%
Total	**$11,604,542**	**100.0%**
Grand Total	**$105,017,305**	

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **June 15, 2017**

SUBJECT: **Certificates of Insurance (COI)**

The amendments to the COIs for the following plans were submitted to the State Insurance Department for approval on June 9, 2017:

- Grandfathered Dakota PPO/Basic Plan
- Non-Grandfathered Dakota PPO/Basic Plan
- Non-Grandfathered High Deductible Health Plan

Copies of the above amendments are included for your information

We are available to respond to any questions.

ATTN: NDPERS
PO Box 91110
Sioux Falls, SD 57109
Ph: (800) 499-3416 (toll-free)
TTY/TDD: (877) 652-1844 (toll-free)
Fax: (701) 234-4570
sanfordhealthplan.com/ndpers

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

This Amendment is effective July 1, 2017, and applies to coverage to the North Dakota Public Employees Retirement System (NDPERS) Grandfathered Dakota PPO/Basic Plan Certificate of Insurance. You should keep this Plan Amendment with your Certificate of Insurance. The changes described in this Amendment below have been adopted and executed by the NDPERS Board of Trustees.

Help understanding this document is free.
If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

Help in a language other than English is also free.
Please call (800) 892-0675 *(toll-free)* to connect with us using free translation services.

Section 1: Schedule of Benefits

Benefit Schedule	Basic Plan	PPO Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$500 per Benefit Period	$500 per Benefit Period
Family Coverage	$1,500 per Benefit Period	$1,500 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$1,500 per Benefit Period	$1,000 per Benefit Period
Family Coverage	$3,000per Benefit Period	$2,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$2,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$4,500 per Benefit Period	$3,500 per Benefit Period
Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:		
$1,200 per Member per Benefit Period		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
$500 per Member		

Section 2: Outline of Covered Service

Outpatient Services	Basic Plan	PPO Plan

• **Home and Office Visits**	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
• **Diagnostic Services**	75% of Allowed Charge	80% of Allowed Charge
• **Emergency Services**	$60 Copayment Amount, then Deductible and 80% Coinsurance applies for emergency room facility fee billed by a hospital	$60 Copayment Amount, then Deductible and 80% Coinsurance applies for emergency room facility fee billed by a hospital
	The copayment Amount for the emergency room fee is waived when a Member is admitted directly as an inpatient to a hospital.	The copayment Amount for the emergency room fee is waived when a Member is admitted directly as an inpatient to a hospital.

Outpatient Therapy Services	Basic Plan	PPO Plan
• **Physical Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*

Mental Health & Substance Use	Basic Plan	PPO Plan
• **Mental Health and Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*
	For all Outpatient Services, 100% of the Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.	
Outpatient		
Office Visits	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and subject to Deductible Amounts.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to Deductible Amounts.*

Prescription Drug and Diabetes Supplies Benefits

- **Retail and Mail Order**

Formulary Medication

➢ Generic	$7.50 Copayment Amount, then 88% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*
➢ Brand Name	$25 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*

Non-Formulary Medication

➢ Generic and Brand Name	$30 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*

Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:

$1,200 per Member per Benefit Period

Section 3: Eligibility Requirements for Dependents

Spouse - The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.

Dependent of Dependent Child - To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements:

1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and
2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and
3. The Dependent of Subscriber's Dependent Child must be chiefly dependent on the Subscriber's Dependent Child for support [N.D.C.C. §26.1-36-22 (3)(4)] .

Section 3: When Dependent Coverage Begins

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

Section 4: Services that Require Services that Require Preauthorization/Prior Approval

1. Admissions. *See Sections 5(a), 5(b) and 5(d) for coverage details.*
2. Ambulance Services. *See Section 5(c) for coverage details.*
3. Clinical Trials. *See Section 5(a) for coverage details.*
4. Select Durable Medical Equipment (DME). *See Section 5(a) for coverage details.*
5. Home Health/Hospice services. *See Section 5(a) for coverage details.*
6. Implant Stimulators. *See Section 5(a) for coverage details.*
7. Oncology Services and Treatment. *See Section 5(a) for coverage details.*
8. Outpatient Services. *See Sections 5(a), 5(b), 5(d,) and 5(f) for coverage details.*
9. Outpatient Surgery. *See Sections 5(a), 5(b), and 5(f) for coverage details.*
10. Transplants. *See Section 5(a) for coverage details.*
11. Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

Section 5(a): Medical Services and Supplies Provided by Health Care Practitioners and Providers

Clinical Trials

Clinical Trial coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Prior Authorization in Section 4.)

We cover Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.

Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.

- The Health Care Service that is the subject of the Approved Clinical Trial.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
- Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
- A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
- A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Not covered:

- *Extra care costs related to taking part in a clinical trial such as additional tests that a Member may need as part of the trial, but not as part of the Member's routine care.*
- *Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.*

Healthy Pregnancy Program – DETAILS

To enroll, call Sanford Health Plan's Care Management Department after the first prenatal visit at (877) 652-1847 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*. Members may enroll in the program starting their 8th week of pregnancy, but no later than the 34th week. You may also send a secure message to the Plan by signing into your account at www.sanfordhealthplan.com/memberlogin, and a representative from the Care Management Department will contact you to complete your enrollment in the program.

Durable medical equipment (DME)

DME coverage is available as follows:

- DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Certificate of Insurance guidelines apply (available upon request).
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan guidelines (available upon request).

Note: The following DME require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Airway Clearance Device
- Communication Device
- Continuous Glucose Monitors and Sensors
- Cranial Molding Helmet
- Dental Appliances
- Home INR Monitor
- Insulin Pump
- Selected Orthotics
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Prosthetic Limb

- Beds such as Hospital beds and mattresses
- Power Wheelchairs and Scooters

Implants/Stimulators

Implants/Simulators coverage is as follows:

Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per Certificate of Insurance guidelines apply (available upon request).

Note: The following Implants/Stimulators require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator

Oral and maxillofacial surgery

Oral and maxillofacial surgery coverage is as follows:

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 4.)

- Oral surgical procedures limited to services required because of injury, accident, or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.* .
    - Care must be received within *twelve (12)* months of the occurrence
- Orthognathic Surgery per Plan guidelines. *This is an Outpatient Surgery that requires Certification*
    - Associated radiology services are included
    - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
    - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    - is a child under age nine (9); or
    - is severely disabled or otherwise suffers from a developmental disability; or
    - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

Transplant services

Transplant Coverage is as follows:

Note: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

Coverage is provided for transplants according to the Plan's medical coverage guidelines (available upon request) for the following services:

- Pre-operative care
- Transplant procedure, Facility and professional fees
- Organ acquisition costs including:
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Post-transplant care and treatment
- Medications (including immunosuppressive medications)

- Supplies (must be Preauthorized/Prior Approved)
- Psychological testing
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan, or other coverage arrangement

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan COI requirements, and are performed at Plan Participating Providers or contracted Centers of Excellence, are covered.

Section 5(c): Emergency Services

Ambulance and Transportation Services

Transportation by professional ground ambulance, air ambulance, or on a regularly scheduled flight on a commercial airline is covered when transportation is:

a. Medically Necessary; and
b. To the nearest Participating Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

Prior authorization is required for:

a. Air ambulance services; and
b. Non-emergent transportation.

Section 5(d): Mental Health and Substance Use Disorder Benefits

- For outpatient treatment services, the first five (5) visits of treatment of any calendar year will be covered at 100% (no charge).

Section 5(e): Prescription Drug and Diabetes Supplies Benefits

The following section has been removed-

- **Specialty Medications.** Some specialty medications may be obtained with applicable cost-sharing amounts at a retail pharmacy and some medications must be obtained through the Plan's contracted specialty drug vendor. To enroll, and obtain prior-approval to join the Specialty/Injectable Drugs Program, call toll-free (866) 333-9721. Please refer to your Summary of Pharmacy Benefits handbook for a complete listing of specialty medications that require Preauthorization/Prior Approval.

In Section 5(f): Dental Benefits

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 4.)

- Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
  - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
  - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is a child under age nine (9); or
  - is severely disabled or otherwise suffers from a developmental disability; or
  - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office.

Exclusions Removal

- *Methadone or Cyclazocine therapy not part of an approved treatment program*
- *Synthetic opioids (e.g. Methadone or Cyclazocine)*

- *Gender Reassignment Surgery*

Section 7: Reimbursement of Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Non-Participating Practitioner and/or Providers and they may not accept the Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount, which is required for that service, Members are responsible for any difference between the amount charged and the Plan's payment for covered services. Non-Participating Practitioner and/or Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

(a) the amount charged for a covered service or supply; or
(b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
(c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    i. Fees typically reimbursed to providers for same or similar professionals; or
    ii. Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Practitioner and/or Providers. Sometimes, Non-Participating Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to the Plan within one-hundred-eighty (180) days after the date that the cost was incurred. **If you, or the Non-Participating Practitioner and/or Provider, does not file the claim within one-hundred-eighty (180) days after the date that the cost was incurred, you may be responsible for payment of the claim.**

If you need to file the claim, here is the process:

The Member must give the Plan written notice of the costs to be reimbursed. Claim forms are available from the Plan to aid in this process. Bills and receipts should be itemized, showing:

1. Covered Member's name and ID number;
2. Name and address of the Practitioner and/or Provider or Facility that provided the service or supply;
3. Dates Member received the services or supplies;
4. Diagnosis;
5. Type of each service or supply;
6. The charge for each service or supply;
7. A copy of the explanation of benefits, payments, or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
8. Receipts/Member Costs, if you paid for your services.

Health Care Services Received Outside of the United States. Covered services for medically necessary Emergency and Urgent care services received in a foreign country are covered at the In-Network level. There is no coverage for elective health care services if a Member travels to another country for the purpose of seeking medical treatment outside the United States.

Time Limits. Claims must be submitted to the Plan within *one-hundred-eighty (180)* days after the date that the cost was incurred. If you, or the Non-Participating Practitioner and/or Provider, file the claim after the one-hundred-eighty (180) timely-filing limit has expired, you may be responsible for payment of the claim.

Submit your claims to: Sanford Health Plan, ATTN: NDPERS, PO Box 91110, Sioux Falls, SD 57109-1110

Section 10: Definition Changes

Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
Dependent of Dependent Child	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and 3. The Dependent of Subscriber's Dependent Child must be chiefly dependent on the Subscriber's Dependent Child for support [N.D.C.C. §26.1-36-22 (3)(4)] .

Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for Covered Services and supplies. The Maximum Allowable Amount is the lesser of: (a) the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. Costs for facilities providing the same or similar services, plus a margin factor.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.

Please note: The defined term "Reasonable Cost" has been removed from the Definition section. All references to "Reasonable Cost" throughout the document have been replaced with the term "Maximum Allowed Amount".

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

ATTN: NDPERS
PO Box 91110
Sioux Falls, SD 57109
Ph: (800) 499-3416 (toll-free)
TTY/TDD: (877) 652-1844 (toll-free)
Fax: (701) 234-4570
sanfordhealthplan.com/ndpers

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

This Amendment is effective July 1, 2016, and applies to coverage under the following North Dakota Public Employees Retirement System (NDPERS) Certificates of Insurance:

- **Grandfathered Dakota PPO/Basic Plan**
- **Non-Grandfathered Dakota PPO/Basic Plan**
- **Non-Grandfathered Dakota High Deductible Health Plan**

Please review this document carefully, and keep it with your Policy for future reference.

Help understanding this document is free.
If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

Help in a language other than English is also free.
Please call (800) 892-0675 *(toll-free)* to connect with us using free translation services.

Statement of Eligibility to Receive Benefits

In the Preface and Section 3 Enrollment, the following has been amended as follows:

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. *Eligible employees may also include Medicare eligible retirees who enrolled in the Dakota Retiree Plan and lost eligibility to participate in the Dakota Retiree Plan due to the loss of Medicare Part B*. For a comprehensive description of eligibility, refer to the NDPERS web site at www.nd.gov/ndpers.

Value-Added Program

In the Preface, the following subsection is added:

Value-Added Program

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may access discounted rates from certain vendors for products and services available to the general public. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

Fiduciary Duties

In the Preface, the following subsection is added:

Claims Administrator is a Fiduciary

Except for direct member appeals regarding an infertility services deductible, the North Dakota Public Employees Retirement Board has delegated to the Claims Administrator, herein known as Sanford Health Plan, benefit claims and appeals. Sanford Health Plan is a Plan fiduciary for these benefit claims and appeals only. As such, the Claims Administrator has the final and discretionary authority to determine these claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the Claims Administrator on review is final and binding, subject to your right to file a lawsuit under other applicable laws. This decision making authority is limited only by the duties imposed. Any determination by the Claims Administrator is intended to be given deference by courts to the maximum extent allowed under applicable laws.

Notice of Non-Discrimination

In the Preface, the following subsection is added:

Notice of Non-Discrimination

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender, gender identity, sex or sexual orientation. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender, gender identity, sex or sexual orientation.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Sanford Health Plan Member Services by calling (701) 417-6500 or (800) 499-3416 *(toll-free)* or TTY/TDD: (877) 652-1844 *(toll-free)*or writing PO Box 91110, Sioux Falls, SD 57109-1110.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Sanford Health Plan Member Services by calling(701) 417-6500 or (800) 499-3416 *(toll-free)* or TTY/TDD: (877) 652-1844 *(toll-free)*or writing PO Box 91110, Sioux Falls, SD 57109-1110.

You can file a grievance in person or by mail or phone. If you need help filing a grievance contact Sanford Health Plan Member Services by calling (701) 417-6500 or (800) 499-3416 *(toll-free)* or TTY/TDD: (877) 652-1844 *(toll-free)*or writing PO Box 91110, Sioux Falls, SD 57109-1110.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Limitation Period for Filing Suit

In the Preface, the following physical address is amended as follows:

Physical Address
Sanford Health Plan 1749 38th St. S., Fargo ND 58103
Member Services
(701) 417-6500 or (800) 499-3416 *(toll-free)* or TTY/TDD: (877) 652-1844 *(toll-free)*

Notice of Privacy Practices

In the Preface, the following change has been made:

This Notice applies to Sanford Health Plan. If you have questions about this Notice, please contact Member Services at (800) 499-3416 *(toll-free)* | TTY/TDD (877) 652-1844 *(toll-free)*.

Member Rights

In the Introduction Section, the subsection, *Member Rights* has been expanded to include the following:

The Plan is committed to treating Members in a manner that respects their rights. In this regard, the Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) has the right to the following:

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; *color*; gender; *gender identity*; age; *sex*; sexual orientation; medical condition, including current or past history of a mental health and/or substance use disorder; disability; religious beliefs; or sources of payment for care.

Eligibility Requirements for Dependents

Section 3, Enrollment, subsection, *Eligibility Requirements for Dependents*, is revised. The Plan has expanded its definition of a disabled dependent to include the following:

The following Dependents are eligible for coverage ("Dependent coverage"):

Spouse - The Subscriber's spouse, under a legally existing marriage, is always eligible for coverage, subject to the eligibility requirements as designated by NDPERS.

Dependent Child - To be eligible for coverage, a dependent child must meet all of the following requirements:

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2. Be one of the following:
   a. under age twenty-six (26); or
   b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request. Such a request may be no more than annually following the two year period of the disabled dependent child's attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. *If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.*

NOTE: Dependent coverage does not include the spouse of an adult Dependent child. Coverage will continue to the end of the month in which the adult Dependent child reaches the limiting age. Coverage does not include the adult Dependent child's spouse or child of such Dependent (dependent of dependent) unless that Dependent's child meets other coverage criteria established under state law. The adult Dependent's marital status, financial status, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage.

Dependent of Dependent Child - To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements:

3. Be the natural child of the Subscriber's Dependent child, a child placed with the Subscriber's Dependent child for adoption, a legally adopted child by the Subscriber's Dependent child, a child for whom the Subscriber's Dependent child has legal guardianship, a stepchild of the Subscriber's Dependent child, or foster child of the Subscriber's Dependent child. These same definitions apply to dependents of the Dependent child(ren) of the Subscriber's living, covered Spouse; and
4. 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
5. The dependent of Subscriber's Dependent child must be chiefly dependent on the Subscriber's Dependent child for support.

Telehealth, e-visit, and video visits benefit

In Section 5(a), the following is added:

Telehealth, e-visit, and video visits benefit

Per Plan guidelines *(available upon request)*, telemedicine, e-visit, and video visit services are covered and available through secured interactive audio, video, or email connections.

- Access to services may be done through a smart phone, tablet or computer.
- For non-emergency health issues, coverage under this section includes but is not limited to diagnosis, consultation, or treatment.
- Telemedicine, e-visit, and video visit services must be rendered by a Sanford Health Plan-approved Provider and/or Practitioner.

The following services are covered pursuant to the Plan's medical coverage guidelines:

- **Telemedicine Services**: live, interactive audio and visual transmissions of a physician-patient encounter from one site to another, using telecommunication technologies. Services may include tele-monitoring of patient status and transmittal of the information to another Provider.
- **E-visits**: email, online medical evaluations where providers interact with members through a secured email portal.
- **Video Visits:** virtual visits where providers interact with members using online means; access points may include mobile smart phones; tablets; or computers.

NOTE: Charges for telehealth, e-visit, and video visit services may be subject to deductible/coinsurance; see your SBC for details. Cost sharing for these services does not include any related pharmacy charges. Prescriptions (if any) are covered separately under the Plan's prescription drug benefit. Charges for prescribed medication/drugs are listed in your SBC.

Not Covered:

- Transmission fees
- Services for excluded benefits

- Services not medically appropriate or necessary
- Installation or maintenance of any telecommunication devices or systems
- Provider-initiated e-mail
- Appointment scheduling
- A service that would similarly not be charged for in a regular office visit
- Reminders of scheduled office visits
- Requests for a referral
- Consultative message exchanges
- Clarification of simple instructions

Infertility services

Section 5(a), Medical services and supplies provided by health care Practitioners and Providers, is amended to read as follows:

Not Covered:

- *Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of embryos and unfertilized sperm or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing;*

Other treatment therapies not specified elsewhere

In Section 5(a), Medical services and supplies provided by health care Practitioners and Providers, the following is added:

- Non-Surgical, medically necessary treatment, of Gender Dysphoria (Gender Identity Disorder), including hormone therapy, mental/behavioral services, and laboratory testing to monitor the safety of continuous hormone therapy, per Plan guidelines (available upon request).

Orthotic and prosthetic devices

In Section 5(a), *Medical services and supplies provided by health care Practitioners and Providers*, the following change is made:

Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year.

Durable medical equipment (DME)

In Section 5(a), *Medical services and supplies provided by health care Practitioners and Providers*, the Plan now covers:

- Custom made orthotics

Prescription drug and diabetes supplies benefits

In Section 5(e), *Prescription drug benefits*, the phone number for Pharmacy Management is now toll-free at (877) 658-9194| TTY/TDD: (877) 652-1844 *(toll-free)*.

Calculation of Benefits, Secondary Plan

In Section 9, *Coordination of Benefits*, the following section is added:

Calculation of Benefits, Secondary Plan

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should the Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under the Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

Coordination of Benefits with Governmental Plans

In Section 9, *Coordination of Benefits*, the following section is added to replace the sections *Coordination of Benefits with Medicare* and *Members with End Stage Renal Disease (ESRD):*

Coordination of Benefits with Governmental Plans

After this Plan, Medicare (if applicable), and/or any Medicare Supplementary Insurance (Medigap) have paid claims, then Medicaid and/or TRICARE pay last. The Plan will pay primary to TRICARE and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

Coordination of Benefits with Medicare

1. The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:
   a. determining whether these individuals are eligible to participate in the Plan; or
   b. providing benefits under the Plan.
2. Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Part B regardless of whether the person was enrolled. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Claims Administrator will make this determination based on the information available through CMS.

When MSP Rules Apply to COB

Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Plan and is eligible for insurance under Medicare Part B, (whether or not the Member has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of this Plan.

Coordination with Medicare Part D

This Plan shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage.

The following provisions apply to this Plan's COB with Medicare:

1. When Medicare is the primary payer for a Member's claims:
   a. If you're 65, or older, and have group health plan coverage based on your or your spouse's current employment
   b. If you have retiree insurance (insurance from former employment)

   NOTE: The hospital or doctor will first file claims with Medicare. Once Medicare processes the claim, an Explanation Of Medicare Benefits (EOMB) form will be mailed to the patient explaining what charges were covered by Medicare. Then the health care professional will generally file the claim with us. If a professional does not do so, the Member may file the claim by sending a copy of the EOMB, together with his or her member identification number, to the address shown on his or her member ID card.
2. When Medicare is primary despite the MSP rules:
   a. A Medicare-entitled person refuses coverage under this Plan;*
   b. Medical services or supplies are covered by Medicare but are excluded under the group health plan;
   c. A Medicare-entitled person has exhausted his or her benefits under the group health plan;
   d. A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
   e. A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

   * **NOTE:** *Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual's Medicare benefits.*
3. When the Plan is the primary payer for a Member's claims:
   a. If you're under 65 and disabled, and have coverage under this Plan based on your or a family member's current employment
   b. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
   c. The Member (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
   d. A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Member/Employee.

   NOTE: The Member's claim is filed with us by the hospital or doctor. After the claim is processed, we send the Member an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the health care professionals of the covered charges. If there are remaining charges covered by Medicare, the health care professional may file a claim with Medicare. If the professional will not do so, the Member can file the claim with Medicare. Members may contact their local Social Security office to find out where and how to file claims with the appropriate "Medicare intermediary" (a private insurance company that processes Medicare claims).
4. If a Practitioner and/or Provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Sanford Health Plan's allowable expense is the Medicare allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.
5. Employees who reach age 65 and are still employed at Sanford may remain covered under the Sanford Health Plan. Sanford Health Plan will remain the primary carrier and Medicare will be the secondary carrier. When the Spouse of an Employee reaches the age of 65, they will have the option of selecting Sanford Health Plan or Medicare as their primary insurance carrier.

Members with End Stage Renal Disease (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD. Benefits covered by Medicare, because of ESRD, are for all covered services, not only those related to the kidney failure condition.

Sanford Health Plan does not differentiate in the benefits it provides to individuals who have ESRD, e.g. terminating coverage, imposing benefit limitations, or charging higher premiums.

How Primary vs. Secondary is Determined:

1. When the Plan is the primary payer for a Member's claims under ESRD:
   a. The Plan will pay first for the first 30 months after you become eligible to join Medicare.
   b. During the Medicare coordination period of thirty (30) months, which begins with the earlier of:
      i. The month in which a regular course of renal dialysis is initiated; or
      ii. In the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
      iii. The Medicare COB period applies regardless of whether coverage under the Plan is based on current employment status.
   c. After the 30-month period, if a Member does not enroll in, or is no longer eligible for, Medicare.
   d. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA), or a retirement plan.
2. When Medicare is the primary payer for a Member's claims under ESRD:
   a. If the Member is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

Coordination of Benefits with Medicaid

A Covered Individual's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the applicable State's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state's Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits that are payable under the Plan.

When an individual covered by Medicaid also has coverage under this Plan, Medicaid is the payer of last resort. If also covered under Medicare, this Plan pays primary, then Medicare, and Medicaid is tertiary.

See provisions below on *Coordination of Benefits with TRICARE*, if a Member is covered by both Medicaid and TRICARE.

Coordination of Benefits with TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent that the service provided is also covered under the other plan.

1. This Plan pays first if an individual is covered by both TRICARE and this Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
2. TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
3. When a TRICARE beneficiary is covered under this Plan, and also entitled to either Medicare or Medicaid, this Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).
4. TRICARE-eligible employees and beneficiaries receive primary coverage under this Plan's provisions in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

Sanford Health Plan does not:

1. Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
2. Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this health benefit plan.

Subrogation of Right of Reimbursement

In Section 13, *Subrogation of Right of Reimbursement,* the following section is added as a replacement to the previous section:

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, the Health Plan may be able to "step into the shoes" of the Member to recover health care costs from the party responsible for the injury or illness. This is called "Subrogation," and this part of the Policy covers such situations.

This Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Individual hereby authorizes the Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 11 and 12.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges. The Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Member. This is called "Reimbursement" and this part of the Policy covers such situations.

The Plan will provide Health Care Services to the Member for the illness or injury, just as it would in any other case. However, if the Member accepts the services from the Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

Plan's Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Plan, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, Member's parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and Workers' Compensation insurance or substitute coverage.

The Plan shall be entitled to receive from any such recovery an amount up to the Reasonable Cost for the services provided by the Plan. In providing benefits to a Member, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the Reasonable Costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under the Plan for an illness or injury, the Plan is subrogated to the Member's right to recover the Reasonable Costs of the benefits it provides on account of such illness or injury, even if those Reasonable Costs exceed the amount paid by the Plan.

The Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. The Plan's first priority right applies whether or not the Member has been made whole by any recovery. The Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for any past, present, or future Health Care Services provided to the Member. The Plan may give notice of that lien to any party who may have contributed to the loss.

If the Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits provided or to be provided under this Plan. This includes the Plan's right to bring suit against the third party in the Member's name.

Plan's Right to Reduction and Reimbursement

Sanford Health Plan shall have the right to reduce or deny benefits otherwise payable by the Plan, or to recover benefits previously paid by the Plan, to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

To the extent that federal statutes, or federal courts, eliminate or restrict any such right of reduction or reimbursement provided to the Plan under this Policy; such rights shall thus either be limited or no longer apply, or be limited by the extent of federal actions.

The Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Reasonable Cost for the Health Care Services provided to the Member.

Erroneous Payments

To the extent payments made by this Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of the Plan, Sanford Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which Sanford Health Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

Member's Responsibilities

1. The Member, Member's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan requires to facilitate enforcement of its rights under this Part. The Member shall take no action prejudicing the rights and interests of the Plan under this provision.
2. Neither a Member nor Member's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without the Plan's express written consent.
3. Any Member who fails to cooperate in the Plan's administration of this Part shall be responsible for the Reasonable Cost for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this section. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with the Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness caused by a Third Party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.
4. Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by the Plan. Failure to comply will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Individual(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Payment in Error

If for any reason we make payment under this Certificate of Coverage in error, we may recover the amount we paid.

Free Help in Other Languages

The following section has been added to the beginning of every Certificate of Insurance:

Free Help in Other Languages

This Certificate of Insurance replaces any prior policies you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it.

If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us toll-free at the number below.

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages.

English
This Notice has Important Information. This notice has important information about your application or coverage through Sanford Health Plan. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844 *(toll-free)*. For assistance in a language other than English, call 1-800-892-0675 (toll-free).

Spanish
Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Sanford Health Plan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-892-0675.

German
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Sanford Health Plan. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-892-0675.

Chinese
本通知有重要的訊息。本通知有關於您透過 插入 Sanford Health Plan 項目的名稱 Sanford Health Plan 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-800-892-0675.

Cushite
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Sanford Health Plan tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-800-892-0675 tii bilbilaa.

Vietnamese
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Sanford Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-892-0675.

Bantu

Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye Sanford Health Plan, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara 1-800-892-0675.

Arabic

قماه تامولعم راعشلاا اذه يوحي.للاخ نم ةيطغتلا ىلع لوصحلل كبلط صوصخب ةمهم تامولعم راعشلاا اذه يوحي Sanford Health Plan.
راعشلاا اذه يف ةماهلا خيراوتلا نع ثحبا.عفد يف ةدعاسملل وا ةيحصلا كتيطغت ىلع ظافحلل ةنيعم خيراوت يف ءارجا ذاختلا جاتحت دق
فيلاكتلا.ةفلكت يا نود نم كتغلب ةدعاسملاو تامولعملا ىلع روصحلا يف قحلا كل .ب لصتا 1-800-892-0675.

Swahili

Ilani hii ina Taarifa Muhimu. Ilani hii ina taarifa muhimu kuhusu maombi yako au chanjo kupitia Sanford Health Plan. Angalia kwa ajili ya tarehe muhimu katika ilani hii. Waweza pia hitajika kuchukua hatua katika muda ulio pangwa fulani ili uweze ku hifadhi bima yako ya afya au msaada wa gharama zake. Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Piga nambari hii: 1-800-892-0675.

Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Sanford Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-892-0675.

Japanese

この通知には重要な情報が含まれています。この通知には、 Sanford Health Planの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-892-0675までお電話ください。

Nepali

यो सूचनामा महत्त्वपूर्ण जानकारी छ । यो सूचनामा तपाईंको आवेदन वा Sanford Health Plan **का माध्यमबाट प्राप्त हुने सुदविाबारे महत्त्वपूर्ण जानकारी छ । यो सूचनामा भएका महत्त्वपूर्ण दमदतहरू ख्याल दिनुहोस् । तपाईंले पाइरहेको स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भुक्तानीमा सहायता पाउन केही समय-सीमामा काम-कारवाही दिनुपने हुनसक्छ । तपाईंले यो जानकारी र सहायता आफ्नो मातृभाषामा दन:शुल्क पाउनु तपाईंको अदिकार हो ।** 1-800-892-0675 **मा फोन दिनुहोस् ।**

French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Sanford Health Plan. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-892-0675.

Korean

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Sanford Health Plan 을 통한 커버리지에 관한 정보를 포함하고 있습니다.
본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-892-0675 로 전화하십시오.

Tagalog

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Sanford Health Plan. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-892-0675.

Norwegian

Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom Sanford Health Plan. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helsedekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt språk uten kostnad. Ring 1-800-892-0675.

All other terms and provisions of your benefits policy, including any amendments we may have previously issued, remain unaltered and in effect.

ATTN: NDPERS
PO Box 91110
Sioux Falls, SD 57109
Ph: (800) 499-3416 (toll-free)
TTY/TDD: (877) 652-1844 (toll-free)
Fax: (701) 234-4570
sanfordhealthplan.com/ndpers

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

This Amendment is effective July 1, 2017, and applies to coverage to the North Dakota Public Employees Retirement System (NDPERS) Non-Grandfathered Dakota PPO/Basic Plan Certificate of Insurance. You should keep this Plan Amendment with your Certificate of Insurance. The changes described in this Amendment below have been adopted and executed by the NDPERS Board of Trustees.

Help understanding this document is free.
If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

Help in a language other than English is also free.
Please call (800) 892-0675 *(toll-free)* to connect with us using free translation services.

Section 1: Schedule of Benefits

Benefit Schedule	Basic Plan	PPO Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$500 per Benefit Period	$500 per Benefit Period
Family Coverage	$1,500 per Benefit Period	$1,500 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$1,500 per Benefit Period	$1,000 per Benefit Period
Family Coverage	$3,000per Benefit Period	$2,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$2,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$4,500 per Benefit Period	$3,500 per Benefit Period
Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:		
$1,200 per Member per Benefit Period		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
$500 per Member		

Section 2: Outline of Covered Service

Outpatient Services	Basic Plan	PPO Plan

• **Home and Office Visits**	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
• **Diagnostic Services**	75% of Allowed Charge	80% of Allowed Charge
• **Emergency Services**	$60 Copayment Amount, then Deductible and 80% Coinsurance applies for emergency room facility fee billed by a hospital	$60 Copayment Amount, then Deductible and 80% Coinsurance applies for emergency room facility fee billed by a hospital
	The copayment Amount for the emergency room fee is waived when a Member is admitted directly as an inpatient to a hospital.	The copayment Amount for the emergency room fee is waived when a Member is admitted directly as an inpatient to a hospital.
Outpatient Therapy Services	**Basic Plan**	**PPO Plan**
• **Physical Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
Mental Health & Substance Use	**Basic Plan**	**PPO Plan**
• **Mental Health and Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*	80% of Allowed Charge. *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 5 visits, per Member per Benefit Period.*	
Office Visits	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and subject to Deductible Amounts.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to Deductible Amounts.*

Prescription Drug and Diabetes Supplies Benefits

- **Retail and Mail Order**

Formulary Medication

➢ Generic	$7.50 Copayment Amount, then 88% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*
➢ Brand Name	$25 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*

Non-Formulary Medication

➢ Generic and Brand Name	$30 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*

Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:

$1,200 per Member per Benefit Period

Section 3: Eligibility Requirements for Dependents

Spouse - The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.

Dependent of Dependent Child - To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements:

1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and
2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and
3. The Dependent of Subscriber's Dependent Child must be chiefly dependent on the Subscriber's Dependent Child for support [N.D.C.C. §26.1-36-22 (3)(4)] .

Section 3: When Dependent Coverage Begins

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

Section 4: Services that Require Services that Require Preauthorization/Prior Approval

1. Admissions. *See Sections 5(a), 5(b) and 5(d) for coverage details.*
2. Ambulance Services. *See Section 5(c) for coverage details.*
3. Clinical Trials. *See Section 5(a) for coverage details.*
4. Select Durable Medical Equipment (DME). *See Section 5(a) for coverage details.*
5. Home Health/Hospice services. *See Section 5(a) for coverage details.*
6. Implant Stimulators. *See Section 5(a) for coverage details.*
7. Oncology Services and Treatment. *See Section 5(a) for coverage details.*
8. Outpatient Services. *See Sections 5(a), 5(b), 5(d,) and 5(f) for coverage details.*
9. Outpatient Surgery. *See Sections 5(a), 5(b), and 5(f) for coverage details.*
10. Transplants. *See Section 5(a) for coverage details.*
11. Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

Section 5(a): Medical Services and Supplies Provided by Health Care Practitioners and Providers

Clinical Trials

Clinical Trial coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Prior Authorization in Section 4.)

We cover Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.

Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.

- The Health Care Service that is the subject of the Approved Clinical Trial.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
- Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
- A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
- A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Not covered:

- *Extra care costs related to taking part in a clinical trial such as additional tests that a Member may need as part of the trial, but not as part of the Member's routine care.*
- *Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.*

Healthy Pregnancy Program – DETAILS

To enroll, call Sanford Health Plan's Care Management Department after the first prenatal visit at (877) 652-1847 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*. Members may enroll in the program starting their 8th week of pregnancy, but no later than the 34th week. You may also send a secure message to the Plan by signing into your account at www.sanfordhealthplan.com/memberlogin, and a representative from the Care Management Department will contact you to complete your enrollment in the program.

Durable medical equipment (DME)

DME coverage is available as follows:

- DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Certificate of Insurance guidelines apply (available upon request).
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan guidelines (available upon request).

Note: The following DME require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Airway Clearance Device
- Communication Device
- Continuous Glucose Monitors and Sensors
- Cranial Molding Helmet
- Dental Appliances
- Home INR Monitor
- Insulin Pump
- Selected Orthotics
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Prosthetic Limb

- Beds such as Hospital beds and mattresses
- Power Wheelchairs and Scooters

Implants/Stimulators

Implants/Simulators coverage is as follows:

Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per Certificate of Insurance guidelines apply (available upon request).

Note: The following Implants/Stimulators require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator

Oral and maxillofacial surgery

Oral and maxillofacial surgery coverage is as follows:

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 4.)

- Oral surgical procedures limited to services required because of injury, accident, or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.* .
    - Care must be received within *twelve (12)* months of the occurrence
- Orthognathic Surgery per Plan guidelines. *This is an Outpatient Surgery that requires Certification*
    - Associated radiology services are included
    - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
    - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    - is a child under age nine (9); or
    - is severely disabled or otherwise suffers from a developmental disability; or
    - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

Transplant services

Transplant Coverage is as follows:

Note: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

Coverage is provided for transplants according to the Plan's medical coverage guidelines (available upon request) for the following services:

- Pre-operative care
- Transplant procedure, Facility and professional fees
- Organ acquisition costs including:
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Post-transplant care and treatment
- Medications (including immunosuppressive medications)

- Supplies (must be Preauthorized/Prior Approved)
- Psychological testing
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan, or other coverage arrangement

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan COI requirements, and are performed at Plan Participating Providers or contracted Centers of Excellence, are covered.

Section 5(c): Emergency Services

Ambulance and Transportation Services

Transportation by professional ground ambulance, air ambulance, or on a regularly scheduled flight on a commercial airline is covered when transportation is:

a. Medically Necessary; and
b. To the nearest Participating Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

Prior authorization is required for:

a. Air ambulance services; and
b. Non-emergent transportation.

Section 5(d): Mental Health and Substance Use Disorder Benefits

- For outpatient treatment services, the first five (5) visits of treatment of any calendar year will be covered at 100% (no charge).

Section 5(e): Prescription Drug and Diabetes Supplies Benefits

The following section has been removed-

- **Specialty Medications.** Some specialty medications may be obtained with applicable cost-sharing amounts at a retail pharmacy and some medications must be obtained through the Plan's contracted specialty drug vendor. To enroll, and obtain prior-approval to join the Specialty/Injectable Drugs Program, call toll-free (866) 333-9721. Please refer to your Summary of Pharmacy Benefits handbook for a complete listing of specialty medications that require Preauthorization/Prior Approval.

In Section 5(f): Dental Benefits

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 4.)

- Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
  - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
  - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines.
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is a child under age nine (9); or
  - is severely disabled or otherwise suffers from a developmental disability; or
  - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office.

Exclusions Removal

- *Methadone or Cyclazocine therapy not part of an approved treatment program*
- *Synthetic opioids (e.g. Methadone or Cyclazocine)*

- *Gender Reassignment Surgery*

Section 7: Reimbursement of Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Non-Participating Practitioner and/or Providers and they may not accept the Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount, which is required for that service, Members are responsible for any difference between the amount charged and the Plan's payment for covered services. Non-Participating Practitioner and/or Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

(a) the amount charged for a covered service or supply; or
(b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
(c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    i. Fees typically reimbursed to providers for same or similar professionals; or
    ii. Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Practitioner and/or Providers. Sometimes, Non-Participating Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to the Plan within one-hundred-eighty (180) days after the date that the cost was incurred. **If you, or the Non-Participating Practitioner and/or Provider, does not file the claim within one-hundred-eighty (180) days after the date that the cost was incurred, you may be responsible for payment of the claim.**

If you need to file the claim, here is the process:

The Member must give the Plan written notice of the costs to be reimbursed. Claim forms are available from the Plan to aid in this process. Bills and receipts should be itemized, showing:

1. Covered Member's name and ID number;
2. Name and address of the Practitioner and/or Provider or Facility that provided the service or supply;
3. Dates Member received the services or supplies;
4. Diagnosis;
5. Type of each service or supply;
6. The charge for each service or supply;
7. A copy of the explanation of benefits, payments, or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
8. Receipts/Member Costs, if you paid for your services.

Health Care Services Received Outside of the United States. Covered services for medically necessary Emergency and Urgent care services received in a foreign country are covered at the In-Network level. There is no coverage for elective health care services if a Member travels to another country for the purpose of seeking medical treatment outside the United States.

Time Limits. Claims must be submitted to the Plan within *one-hundred-eighty (180)* days after the date that the cost was incurred. If you, or the Non-Participating Practitioner and/or Provider, file the claim after the one-hundred-eighty (180) timely-filing limit has expired, you may be responsible for payment of the claim.

Submit your claims to: Sanford Health Plan, ATTN: NDPERS, PO Box 91110, Sioux Falls, SD 57109-1110

Section 10: Definition Changes

Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
Dependent of Dependent Child	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and 3. The Dependent of Subscriber's Dependent Child must be chiefly dependent on the Subscriber's Dependent Child for support [N.D.C.C. §26.1-36-22 (3)(4)] .

Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for Covered Services and supplies. The Maximum Allowable Amount is the lesser of: (a) the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. Costs for facilities providing the same or similar services, plus a margin factor.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.

Please note: The defined term "Reasonable Cost" has been removed from the Definition section. All references to "Reasonable Cost" throughout the document have been replaced with the term "Maximum Allowed Amount".

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

ATTN: NDPERS
PO Box 91110
Sioux Falls, SD 57109
Ph: (800) 499-3416 (toll-free)
TTY/TDD: (877) 652-1844 (toll-free)
Fax: (701) 234-4570
sanfordhealthplan.com/ndpers

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

Amendment to the following North Dakota Public Employees Retirement System (NDPERS) Certificates of Insurance:

- Grandfathered Dakota PPO/Basic Plan
- Non-Grandfathered Dakota PPO/Basic Plan
- Non-Grandfathered Dakota High Deductible Health Plan

The purpose of this amendment is to comply with the provisions of the U. S. Supreme Court ruling on same-sex marriage in *Obergefell v. Hodges*, 576 U.S. ____ (2015), as decided June 26, 2015.

This Amendment is effective July 1, 2015, and applies to the following Certificates of Insurance: NDPERS Grandfathered Dakota PPO/Basic Plan, NDPERS Non-Grandfathered Dakota PPO/Basic Plan, and NDPERS Non-Grandfathered Dakota High-Deductible Health Plan. These Certificates of Insurance are the official health benefit plan documents of the North Dakota Public Employees Retirement System, an employee welfare benefit plan fully insured by Sanford Health Plan and issued by Sanford Health Plan.

Please review this amendment carefully, and keep it with your applicable Certificate of Insurance for future reference.

Eligibility Requirements for Dependents in Section 3, is hereby deleted, and replaced with the following:

Eligibility Requirements for Dependents

The following Dependents are eligible for coverage ("Dependent coverage"):

Spouse – The Subscriber's spouse, under a legally existing marriage, is always eligible for coverage, subject to the eligibility requirements as designated by NDPERS.

Dependent Child - To be eligible for coverage, a dependent child must meet all of the following requirements:

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2. Be one of the following:
   a. under age twenty-six (26); or
   b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request. Such a request may be no more than annually following the two year period of the disabled dependent child's attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]; or
   c. the Subscriber's grandchild(ren) or those of the Subscriber's living, covered Spouse, who legally reside(s) with the Certificate holder/Subscriber and (1) the parent of the grandchild(ren) is an Covered Dependent also covered by this Plan; and (2) both the Dependent and child of such Dependent (grandchild) are chiefly dependent upon the Certificate holder/Subscriber for support.

Dependent coverage does not include the spouse of an adult Dependent child. Coverage will continue to the end of the month in which the adult Dependent child reaches the limiting age. Coverage does not include the adult Dependent child's spouse or child of such Dependent (grandchild) unless that grandchild meets other coverage criteria established under state law. The adult Dependent's marital status, financial dependency, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage.

Limitations. A Dependent shall not be covered under this Contract if he or she is eligible to be a Subscriber, already covered as a Dependent of another Subscriber, or already covered as a Subscriber.

When and How to Enroll Dependents; When Dependent Coverage Begins; and Special Enrollment Rights contained in Section 3, are hereby deleted, and replaced with the following:

When and How to Enroll Dependents

When to Enroll Dependents

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "*Coverage from Birth*" and "*Adoption or Children Placed for Adoption*" below. There is also an exception for Spouses and new Dependents as a result of marriage; see "*New Spouses and Dependent Children*" below. For information on the Special Enrollment Period that affects Same-Sex Spouses, married prior to June 26, 2015, see notation 'F' under Special Enrollment Rights in this section.

How to Enroll Dependents

The Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

When Dependent Coverage Begins

1. **General.** If a Dependent is enrolled at the same time the Subscriber enrolls in coverage through NDPERS, the Dependent's effective date of coverage will be the same as the Subscriber's effective date as described in "*When Coverage Begins*" above.
2. **Delayed Effective Date of Dependent Coverage.** Except for newborns (see item 3 below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits from a previous Group health plan or other coverage arrangement, coverage under this Contract shall be subject to benefits payable under the previous plan or coverage arrangement.
3. **Coverage from Birth.** If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth. Depending on the Class of Coverage the Subscriber is enrolled under, the following provisions apply:
   a. **Subscribers with Single Coverage:** For coverage to continue beyond thirty-one (31) days of the newborn's date of birth, coverage must applied for through NDPERS within thirty-one (31) days of the newborn's date of birth.
   b. **Subscribers with Family Coverage:** Subscribers with Family Coverage under the Plan are encouraged to notify the Plan in advance when a pregnancy and expected due date is known. Newborn children will be added to the Certificate automatically if the Subscriber is enrolled in Family Coverage and the Plan and/or NDPERS is notified of the pregnancy.

   An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, shall be covered under this Contract from the date of the newborn child's birth, provided that coverage is applied for through NDPERS within thirty-one (31) days. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

   Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided coverage is applied through NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the newborn child's birth.
4. **Adoption or Children Placed for Adoption.** If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as an Eligible Dependent as of the date specified within a court order or other legal adoption papers. Regardless of the Class of Coverage the Subscriber is enrolled under, the following provisions apply:
   a. **Subscribers with either Single or Family Coverage:** For coverage to continue beyond thirty-one (31) days of the date specified within the court order or other legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage, the Subscriber must submit an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or other legal adoption papers that granted initial eligibility.

   An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, who failed to enroll during a previous enrollment period, shall be covered as of the date specified within a court order or other legal adoption papers, if the Eligible Group Member, and any other Eligible Dependents, submits an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

   Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that an application for coverage is submitted to NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

   Coverage at the time of placement for adoption includes the necessary care and treatment of medical conditions existing prior to the date of placement.
5. **New Spouses and Dependent Children.** If a Subscriber gets married, his or her Spouse, and any of the Spouse's Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for with NDPERS for the Spouse and/or Eligible Dependents within thirty-one (31) days of the date of marriage. If the Subscriber does not submit an application for coverage to NDPERS for the Spouse and/or any Eligible Dependent(s) within thirty-one (31) days of the date of marriage, then Late Enrollee provisions apply and the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st. This includes marriages for which coverage was effective on or after June 26, 2015, regardless of the Spouses'

gender/sex.

If an Eligible Group Member, who is an Employee eligible to enroll in the Plan, but who did not do so during a previous enrollment period, gets married, the employee becomes an eligible Subscriber under the following conditions:

a. The Subscriber, his or her Spouse, and any Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty-one (31) days of the date of marriage or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.

b. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

** **NOTE:** Per Federal laws, guidance, and regulations, the sexual orientation and sex/gender of Spouses, married in a jurisdiction with legal authority to authorize their marriage, is not a factor in the issuance of coverage or benefit determinations. Sanford Health Plan, in compliance with federal guidance for all states, offers coverage to all legally married Spouses, and any Eligible Dependents as a result of marriage, regardless of the jurisdiction in which the marriage occurred. The provisions in this contract regarding Spousal eligibility and Late Enrollees continue to apply, regardless of Spouses' sex/gender.

Special Enrollment Rights

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within thirty-one (31) days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within thirty-one (31) days of the change or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.

1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

   If the membership application is submitted within thirty-one (31) days of the date of marriage, the effective date of coverage for the Eligible Dependent will be the first of the month immediately following the date of marriage. If the membership application is not submitted within thirty-one (31) days of the date of marriage and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan due to legal separation, divorce, annulment, or death, coverage for the Subscriber's Spouse and/or Dependents under Family Coverage will cease, effective the first of the month immediately following timely notice of the event causing ineligibility.

   If living in the Sanford Health Plan Service Area (see *Service Area* in Introduction Section), a Member has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit www.sanfordhealthplan.com/ndpers or call Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)*.

   There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit www.healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and Sanford Health Plan of any change in family status within thirty-one (31) days of the change. The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement, or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within thirty-one (31) days of the date of birth for coverage to continue beyond the first thirty (30) days beginning with the child's birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to NDPERS within thirty-one (31) days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
3. Children who have been placed under the care Subscriber, or the Subscriber's living, covered spouse due to the Subscriber, or the Subscriber's living, covered spouse being appointed legal guardian, may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits

may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

5. If any of the Subscriber's children, or those of the Subscriber's living, covered spouse, who are Eligible Dependents under the Plan, beyond the age of 26, incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance, shall have coverage remain in effect as long as such disabled child remains dependent upon the Certificate holder/Subscriber or the Subscriber's spouse for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.
6. If a child is no longer an Eligible Dependent under this Benefit Plan, and the child is living in the Sanford Health Plan Service Area (see *Service Area* in the above Introduction Section), the Dependent has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit www.sanfordhealthplan.com/ndpers or call Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)*. There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit www.healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.
7. At the time of birth or adoption, other Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to NDPERS within thirty-one (31 days) of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date. Pursuant to N.D.A.C. §71-03-03-01, an Employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:
   1. During the initial enrollment period the employee or dependent states, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
   2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
      a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special enrollment under the Benefit Plan but again choosing not to enroll, or employer contributions toward such coverage were terminated; or
      b. was under COBRA and the coverage was exhausted.
   3. The employee requests such enrollment within thirty-one (31) days after the exhaustion or termination of coverage.

   The effective date of coverage for an employee and/or dependent that previously declined coverage under this Benefit Plan, and is enrolling pursuant to this provision, will be the first of the month following the exhaustion or termination of the employee's and/or dependent's previous coverage. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

   If the membership application is not received in accordance with this provision, and the Employee or Dependent is a Late Enrollee, the Late Enrollee's effective date of coverage will be the Group's anniversary date.

E. Employees and/or Dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:
   1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and the employee's or dependent's coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within sixty (60) days of the date of termination of coverage; or
   2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within sixty (60) days of the date the employee or dependent is determined to be eligible for premium assistance.

      The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

F. In accordance with the decision of the Supreme Court of the United States on June 26, 2015, in *Obergefell v. Hodges*, 576 U.S. ___ (2015), regarding same-sex marriage:
   1. **Same-sex marriages that occurred prior to June 26, 2015:** NDPERS will have a special enrollment period from July 1, 2015 through September 30, 2015. Coverage will be effective retroactive to July 1, 2015. If the Subscriber does not enroll during this eligibility period, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.
   2. **Same-sex marriages that occur on or after June 26, 2015:** The Subscriber must submit an application for coverage within the first thirty-one (31) days of the event. If the Subscriber does not enroll when initially eligible, the Late Enrollee can only enroll

during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.
Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent is enrolled.

** **NOTE:** The following do not qualify for a special enrollment period: 1) Loss of Minimum Essential Coverage due to failure to make premium payment and/or allowable rescissions of coverage; 2) Voluntarily terminating/dropping COBRA coverage before it runs out outside Annual Enrollment. COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment.

Section 10 of your Certificate of Insurance, *Definitions of terms we use in this Certificate of Insurance*, is amended by deleting and replacing the following term and definition:

Spouse	The Subscriber's Spouse under a legally existing marriage.

All other terms and provisions of your Certificate of Insurance, as a benefits policy, including any amendments, remain unaltered and in effect.

ATTN: NDPERS
PO Box 91110
Sioux Falls, SD 57109
Ph: (800) 499-3416 (toll-free)
TTY/TDD: (877) 652-1844 (toll-free)
Fax: (701) 234-4570
sanfordhealthplan.com/ndpers

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

This Amendment is effective July 1, 2017, and applies to coverage to the North Dakota Public Employees Retirement System (NDPERS) Non-Grandfathered High Deductible Health Plan Certificate of Insurance. You should keep this Plan Amendment with your Certificate of Insurance. The changes described in this Amendment below have been adopted and executed by the NDPERS Board of Trustees.

Help understanding this document is free.
If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

Help in a language other than English is also free.
Please call (800) 892-0675 *(toll-free)* to connect with us using free translation services.

Section 1: Schedule of Benefits

Benefit Schedule	Basic Plan	PPO Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$2,000 per Benefit Period	$2,000 per Benefit Period
Family Coverage	$4,000 per Benefit Period	$4,000 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$2,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$4,000 per Benefit Period	$3,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$4,000 per Benefit Period	$3,500 per Benefit Period
Family Coverage	$8,000 per Benefit Period	$7,000 per Benefit Period

Section 2: Outline of Covered Service

Outpatient Services	Basic Plan	PPO Plan

• **Home and Office Visits**	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
• **Diagnostic Services**	75% of Allowed Charge	80% of Allowed Charge
• **Emergency Services**	$60 Copayment Amount, then Deductible and 80% Coinsurance applies for emergency room facility fee billed by a hospital	$60 Copayment Amount, then Deductible and 80% Coinsurance applies for emergency room facility fee billed by a hospital
	The copayment Amount for the emergency room fee is waived when a Member is admitted directly as an inpatient to a hospital.	The copayment Amount for the emergency room fee is waived when a Member is admitted directly as an inpatient to a hospital.
Outpatient Therapy Services	**Basic Plan**	**PPO Plan**
• **Physical Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
Mental Health & Substance Use	**Basic Plan**	**PPO Plan**
• **Mental Health and Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*	80% of Allowed Charge. *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 5 visits, per Member per Benefit Period.*	
Office Visits	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and subject to Deductible Amounts.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to Deductible Amounts.*

Prescription Drug and Diabetes Supplies Benefits

- **Retail and Mail Order**

Formulary Medication

➢ Generic	$7.50 Copayment Amount, then 88% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*
➢ Brand Name	$25 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*

Non-Formulary Medication

➢ Generic and Brand Name	$30 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*

Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:

$1,200 per Member per Benefit Period

Section 3: Eligibility Requirements for Dependents

Spouse - The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.

Dependent of Dependent Child - To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements:

1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and
2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and
3. The Dependent of Subscriber's Dependent Child must be chiefly dependent on the Subscriber's Dependent Child for support [N.D.C.C. §26.1-36-22 (3)(4)] .

Section 3: When Dependent Coverage Begins

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

Section 4: Services that Require Services that Require Preauthorization/Prior Approval

1. Admissions. *See Sections 5(a), 5(b) and 5(d) for coverage details.*
2. Ambulance Services. *See Section 5(c) for coverage details.*
3. Clinical Trials. *See Section 5(a) for coverage details.*
4. Select Durable Medical Equipment (DME). *See Section 5(a) for coverage details.*
5. Home Health/Hospice services. *See Section 5(a) for coverage details.*
6. Implant Stimulators. *See Section 5(a) for coverage details.*
7. Oncology Services and Treatment. *See Section 5(a) for coverage details.*
8. Outpatient Services. *See Sections 5(a), 5(b), 5(d,) and 5(f) for coverage details.*
9. Outpatient Surgery. *See Sections 5(a), 5(b), and 5(f) for coverage details.*
10. Transplants. *See Section 5(a) for coverage details.*
11. Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

Section 5(a): Medical Services and Supplies Provided by Health Care Practitioners and Providers

Clinical Trials

Clinical Trial coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Prior Authorization in Section 4.)

We cover Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.

Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.

- The Health Care Service that is the subject of the Approved Clinical Trial.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
- Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
- A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
- A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Not covered:

- *Extra care costs related to taking part in a clinical trial such as additional tests that a Member may need as part of the trial, but not as part of the Member's routine care.*
- *Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.*

Healthy Pregnancy Program – DETAILS

To enroll, call Sanford Health Plan's Care Management Department after the first prenatal visit at (877) 652-1847 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*. Members may enroll in the program starting their 8th week of pregnancy, but no later than the 34th week. You may also send a secure message to the Plan by signing into your account at www.sanfordhealthplan.com/memberlogin, and a representative from the Care Management Department will contact you to complete your enrollment in the program.

Durable medical equipment (DME)

DME coverage is available as follows:

- DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Certificate of Insurance guidelines apply (available upon request).
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan guidelines (available upon request).

Note: The following DME require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Airway Clearance Device
- Communication Device
- Continuous Glucose Monitors and Sensors
- Cranial Molding Helmet
- Dental Appliances
- Home INR Monitor
- Insulin Pump
- Selected Orthotics
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Prosthetic Limb

- Beds such as Hospital beds and mattresses
- Power Wheelchairs and Scooters

Implants/Stimulators

Implants/Simulators coverage is as follows:

Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per Certificate of Insurance guidelines apply (available upon request).

Note: The following Implants/Stimulators require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator

Oral and maxillofacial surgery

Oral and maxillofacial surgery coverage is as follows:

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 4.)

- Oral surgical procedures limited to services required because of injury, accident, or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.* .
    - Care must be received within *twelve (12)* months of the occurrence
- Orthognathic Surgery per Plan guidelines. *This is an Outpatient Surgery that requires Certification*
    - Associated radiology services are included
    - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
    - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    - is a child under age nine (9); or
    - is severely disabled or otherwise suffers from a developmental disability; or
    - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

Transplant services

Transplant Coverage is as follows:

Note: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

Coverage is provided for transplants according to the Plan's medical coverage guidelines (available upon request) for the following services:

- Pre-operative care
- Transplant procedure, Facility and professional fees
- Organ acquisition costs including:
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Post-transplant care and treatment
- Medications (including immunosuppressive medications)

- Supplies (must be Preauthorized/Prior Approved)
- Psychological testing
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan, or other coverage arrangement

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan COI requirements, and are performed at Plan Participating Providers or contracted Centers of Excellence, are covered.

Section 5(c): Emergency Services

Ambulance and Transportation Services

Transportation by professional ground ambulance, air ambulance, or on a regularly scheduled flight on a commercial airline is covered when transportation is:

a. Medically Necessary; and
b. To the nearest Participating Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

Prior authorization is required for:

a. Air ambulance services; and
b. Non-emergent transportation.

Section 5(d): Mental Health and Substance Use Disorder Benefits

- For outpatient treatment services, the first five (5) visits of treatment of any calendar year will be covered at 100% (no charge).

Section 5(e): Prescription Drug and Diabetes Supplies Benefits

The following section has been removed-

- **Specialty Medications.** Some specialty medications may be obtained with applicable cost-sharing amounts at a retail pharmacy and some medications must be obtained through the Plan's contracted specialty drug vendor. To enroll, and obtain prior-approval to join the Specialty/Injectable Drugs Program, call toll-free (866) 333-9721. Please refer to your Summary of Pharmacy Benefits handbook for a complete listing of specialty medications that require Preauthorization/Prior Approval.

In Section 5(f): Dental Benefits

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 4.)

- Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
  - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
  - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is a child under age nine (9); or
  - is severely disabled or otherwise suffers from a developmental disability; or
  - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office

Exclusions Removal

- *Methadone or Cyclazocine therapy not part of an approved treatment program*
- *Synthetic opioids (e.g. Methadone or Cyclazocine)*

- *Gender Reassignment Surgery*

Section 7: Reimbursement of Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Non-Participating Practitioner and/or Providers and they may not accept the Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount, which is required for that service, Members are responsible for any difference between the amount charged and the Plan's payment for covered services. Non-Participating Practitioner and/or Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

(a) the amount charged for a covered service or supply; or
(b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
(c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    i. Fees typically reimbursed to providers for same or similar professionals; or
    ii. Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Practitioner and/or Providers. Sometimes, Non-Participating Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to the Plan within one-hundred-eighty (180) days after the date that the cost was incurred. **If you, or the Non-Participating Practitioner and/or Provider, does not file the claim within one-hundred-eighty (180) days after the date that the cost was incurred, you may be responsible for payment of the claim.**

If you need to file the claim, here is the process:

The Member must give the Plan written notice of the costs to be reimbursed. Claim forms are available from the Plan to aid in this process. Bills and receipts should be itemized, showing:

1. Covered Member's name and ID number;
2. Name and address of the Practitioner and/or Provider or Facility that provided the service or supply;
3. Dates Member received the services or supplies;
4. Diagnosis;
5. Type of each service or supply;
6. The charge for each service or supply;
7. A copy of the explanation of benefits, payments, or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
8. Receipts/Member Costs, if you paid for your services.

Health Care Services Received Outside of the United States. Covered services for medically necessary Emergency and Urgent care services received in a foreign country are covered at the In-Network level. There is no coverage for elective health care services if a Member travels to another country for the purpose of seeking medical treatment outside the United States.

Time Limits. Claims must be submitted to the Plan within *one-hundred-eighty (180)* days after the date that the cost was incurred. If you, or the Non-Participating Practitioner and/or Provider, file the claim after the one-hundred-eighty (180) timely-filing limit has expired, you may be responsible for payment of the claim.

Submit your claims to: Sanford Health Plan, ATTN: NDPERS, PO Box 91110, Sioux Falls, SD 57109-1110

Section 10: Definition Changes

Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
Dependent of Dependent Child	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and 3. The Dependent of Subscriber's Dependent Child must be chiefly dependent on the Subscriber's Dependent Child for support [N.D.C.C. §26.1-36-22 (3)(4)] .

Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for Covered Services and supplies. The Maximum Allowable Amount is the lesser of: (a) the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. Costs for facilities providing the same or similar services, plus a margin factor.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.

Please note: The defined term "Reasonable Cost" has been removed from the Definition section. All references to "Reasonable Cost" throughout the document have been replaced with the term "Maximum Allowed Amount".

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **June 22, 2017**

SUBJECT: **Administrative Services Agreement (ASA)**

The ASA with Sanford Health Plan is under review by legal. Any comments and a copy of the agreement will be provided under separate cover prior to the meeting.

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Memorandum

TO: PERS Board

FROM: Sparb & Bryan

DATE: **June 22, 2017**

SUBJECT: PERS About the Patient Diabetes Program

PERS Collaborative drug therapy program.

Section 54-52.1-17 of the North Dakota Century requires the PERS Board to:

54-52.1-17. Uniform group insurance program - Collaborative drug therapy program - Funding.

1. The board shall establish a collaborative drug therapy program that is to be available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals with diabetes and to manage health care expenditures.
2. The board shall involve physicians, pharmacists, and certified diabetes educators to coordinate health care for covered individuals with diabetes in order to improve health outcomes and reduce spending on diabetes care. Under the program, pharmacists and certified diabetes educators may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals with diabetes. To encourage enrollment in the plan, the board shall provide incentives to covered individuals who have diabetes which may include waived or reduced copayment for diabetes treatment drugs and supplies.
3. The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize diabetes care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of diabetes care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.
4. The board shall fund the program from any available funds in the uniform group insurance program and if necessary the fund may add up to a two dollar per month charge on the policy premium for medical and hospital benefits coverage. A state agency shall pay any additional premium from the agency's existing appropriation.

Pursuant to the above, we established the PERS diabetes disease management program modeled on the Asheville program with North Dakota pharmacists. This program has been a part of the PERS plan for the last several bienniums.

Attached are the estimated plan costs for the 2015-2017 biennium and the renewal for the 2017-2019 biennium.

Funding for this program comes from the PERS reserves.

Board Action Requested:

Approve the program for the 2017-2019 biennium.

About the Patient

Level of Service July 2015-June 2017

Diabetes	July2015-June 2017
Direct Program Cost	
Provider Visits	$132,000.00
Patient Incentives	$43,000.00
Subtotal	**$175,000.00**

Administration Costs	
Subtotal	**$20,000.00**

Marketing Costs	
Direct to consumer mailings In-pharmacy marketing	$5000.00
Subtotal	**$5000.00**

Biennial Expenses	**$200,000.00**

Expense estimates are for serving ~200 patients (~5% participation rate) over the next biennium. Each patient would be eligible to receive a Comprehensive Medication Review (CMR-$400.00) and up to 2 Targeted Medication Reviews (TMR-$80.00) the first year and one CMR ($200.00) and one TMR ($80.00) in for any subsequent years of participation in the program.

Within the first year of the biennium we have exceeded anticipated enrollment for program. We still anticipate staying within the budget as participation rates trend to decrease in the second year. As discussed, we feel it is mainly because there is no direct marketing in year two.

Hypertension	Oct. 2016-June 2017
Direct Program Cost	
Provider Visits	$39,200.00
Patient Incentives	$10,000.00
Subtotal	**$49,200.00**

Administration Costs	
Subtotal	**ND DoH Grant**

Marketing Costs	
Direct to consumer mailings In-pharmacy marketing	ND DoH Grant
Subtotal	

Estimated Expenses	**$49,200.00**

TOTAL Biennial Expenses	**$249,200.00**

Expense estimates are for serving ~70 patients state wide (~1% participation rate) October 2016 to June 2017 (9 months). Each patient would be eligible to receive a Comprehensive Medication Review (CMR-$400.00) and 2 Targeted Medication Reviews (TMR-$80.00) during this pilot period.

In-kind from NDPhA and NDSU: Telephone (maintaining toll free direct number for patients), office space, office supplies, Training/Credentialing/Certification of providers, patient curriculum, Clinical Coordinator, Data Analysis

About the Patient

Level of Service July 2017-June 2019

Diabetes	July2017-June 2019
Direct Program Cost	
Provider Visits	$140,000
Patient Incentives	$ 45,000
Subtotal	**$185,000**

Administration Costs	
Subtotal	**$20,000.00**

Marketing Costs	
Direct to consumer mailings In-pharmacy marketing	$5,000.00
Subtotal	**$5,000.00**

Biennial Expenses	**$210,000.00**

Hypertension	July2017-June 2019
Direct Program Cost	
Provider Visits	$231,000
Patient Incentives	$ 40,000
Subtotal	**$271,000**

Administration Costs	
Subtotal	**$10,000.00**

Marketing Costs	
Direct to consumer mailings In-pharmacy marketing	$7,500.00
Subtotal	**$7,500.00**

Biennial Expenses	**$288,500.00**

Expense estimates are for serving ~500 patients (~200 Diabetes and ~300 hypertension) at an 5%-7% participation rate over the next biennium. Each patient would be eligible to receive a Comprehensive Medication Review (CMR-$400.00) and up to 2 Targeted Medication Reviews (TMR-$80.00) the first year and one CMR ($200.00) and one TMR ($80.00) for any subsequent years of participation in the program.

In-kind from NDPhA and NDSU: Telephone (maintaining toll free direct number for patients), office space, office supplies, Training/Credentialing/Certification of providers, patient curriculum, Clinical Coordinator, Data Analysis

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Memorandum

TO: PERS Board

FROM: Sparb

DATE: June 22, 2017

SUBJECT: Pharmacy

At the April board meeting we discussed items # 1 & 2 below. It was decided to refer them to Deloitte for their comments which are also attached. Since the April meeting, an additional item has been raised by Sanford related to Epinephrine Injections. Please see item # 3 below.

Sanford will be at the meeting to review these items with you and answer any questions you may have.

1. **Dispense as written (DAW) procedure**. Attachment #1 is the memo from Sanford on this topic. Attachment #2 is the letter from Deloitte sharing their observations on the Sanford memo.

   Board Action Requested
   Determine if PERS should make the change as suggested by Sanford

2. **Glucometer**. Attachment #3 is a memo from Sanford on Glucometers. Also in attachment #4 is a letter from Deloitte sharing their observations on the Sanford memo.

   Board Action Requested
   Determine if PERS should make the change as suggested by Sanford

3. **Epinephrine Injections**. Attachment # 5 is a memo from Sanford on Epinephrine Injections. Staff has provided this information to Deloitte and will share Deloitte's observations at the Board meeting.

   Board Action Requested
   Determine if PERS should make the change as suggested by Sanford

Pharmacy
Attachment #1

Sanford Health Plan
1749 38th St. S.
Fargo, ND 58103
(701) 417-6500
Toll-Free: (800) 499-3416
Fax: (701) 282-8063
sanfordhealthplan.com

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SA HEALTH PLAN

Dispense as Written (DAW)

Previously member rebate programs were discussed by the board, and sustainability was identified as a major concern. While these programs offer positive benefit to the member, questions of sustainability become prevalent, as the board considered what the impact would be if rebate funding declined or was removed completely in the future. The board would be then faced with the difficult decision on whether to continue the program without the financial support of the rebate funding.

To increase the sustainability of this project, Sanford Health Plan has identified an aspect of plan design that can help improve member behavior. This area focuses on the benefit surrounding Ancillary Charges or Dispense as Written benefits.

In the current benefit structure, if a member uses a brand name medication where a generic is available for that exact medication, there is what is called an ancillary penalty. This penalty is an additional charge that makes the member responsible for the difference in cost between the brand and generic medication. The intent of this penalty is to financially incentivize members to use generics whenever possible.

In the current benefit election, if a provider indicates that they request brand for a member, the ancillary penalty is automatically waived. In the majority of cases, when asked, a provider is willing to indicate this to appease a member request. When factoring in the effects of coupon cards, many members can exploit this loophole for personal gain.

It is advised that the board consider allowing the health plan to review any ancillary bypass requests for medical necessity. In rare cases, there is evidence to support this and it is then appropriate to allow member access to brand without the ancillary penalty. This is rare, but usually seen in medications that are known to have a “narrow therapeutic window”.

In 2016, there were 706 claims for members who had physicians bypass their ancillary charge based on data extracted from claims submitted (brand claims with DAW1). The average plan cost per brand was $278. The average plan cost per generic was $30. So for each claim converted, the total plan cost reduces by $248 on average. Because we are taking an average of a large volume of claims, our actuary advises that we take 80% of this difference, as a conservative factor. Applying that 80% conservative factor, for every claim converted from brand to generic, the plan cost reduces by $198. If 90% of these 706 claims are eligible for conversion to brand, the plan will save $125,000 on existing claims, and prevent additional unnecessary brand usage. While this isn’t enough to sustain an entire program, it will contribute to sustainability.

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USA

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www.deloitte.com

Memo

Date: May 15, 2017

To: Sparb Collins, Executive Director
NDPERS

From: Josh Johnson, Drew Rasmussen, and Cheryl Duva, Deloitte Consulting LLP

Subject: ACTUARIAL REVIEW OF NDPERS PHARMACY ANCILLARY PENALTY POLICY CHANGE PROPOSED BY SANFORD HEALTH PLAN

The following summarizes our review of the proposed pharmacy policy change.

OVERVIEW OF PROPOSED CHANGE

Currently, members in the NDPERS medical program are required to pay the difference in cost between brand name and generic medications when they elect to receive a brand drug when a generic is available for the same medication. If a provider indicates on a prescription that the brand drug should be provided (referred to as "Dispense as Written" or "DAW" in the industry), the member is not required to pay the difference between brand and generic. The prevailing thought as indicated by Sanford Health Plan in a memo to the NDPERS board on this topic is that providers often indicate DAW at the request of a member regardless of whether there is medical necessity for the brand medication or not.

Sanford has proposed allowing the plan to review DAW requests for medical necessity before waiving the pay the difference penalty.

EXPECTED ACTUARIAL IMPACT

Sanford reviewed DAW claims for NDPERS members in 2016 and estimated a potential cost savings/avoidance to the plan of approximately $125,000 if the proposed medical necessity requirement were in place. Deloitte reviewed the assumptions stated in the Sanford memo and feel that they are reasonable.

TECHNICAL COMMENTS

Based on our experience with other clients and pharmacy benefit managers (PBM's), review for medical necessity or simply not waiving pay the difference penalties in this situation is a prevalent practice/policy and can be effective in encouraging use of lower cost generic medications.

Sanford Health Plan
1749 38th St. S.
Fargo, ND 58103
(701) 417-6500
Toll-Free: (800) 499-3416
Fax: (701) 282-8063
sanfordhealthplan.com

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SANFORD HEALTH PLAN

Pharmacy
Attachment #3

Prescription Rebate Opportunity – Glucometer Test Strip Formulary

In the February board meeting, the rebate opportunity was discussed pertaining to glucometer test strips. At the time the board was favorable of this concept, and the potential rebates this would generate. Sanford Health Plan committed to deliver the disruption letter draft as well as a coupon for glucometers to the NDPERS team. The letter followed similar format for other disruption notices.

At this time, it is requested that the board authorize Sanford Health Plan to restrict formulary in order to gain rebate opportunities and notify membership with the proposed disruption letter. If this opportunity is desired for July 1, 2017, the disruption letter must be sent in early May, to allow adequate notification to members. If this timeline is not feasible, the next possible opportunity to begin rebate collection would be September 1, 2017. If that date is preferred, it is advised that the board authorize disruption letters to be sent approximately 60-days prior.

Danny Weiss 4/19/17

Deloitte Consulting LLP
50 South Sixth Street
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Minneapolis, MN 55402
USA

Tel: 612 397 4000
Fax: 612 397 4450
www.deloitte.com

Memo

Date: May 11, 2017

To: Sparb Collins, Executive Director
NDPERS

From: Josh Johnson, Drew Rasmussen, and Cheryl Duva, Deloitte Consulting LLP

Subject: ACTUARIAL REVIEW OF GLUCOMETER TEST STRIP FORMULARY PROPOSED BY SANFORD HEALTH PLAN

The following summarizes our review of the proposed formulary change.

OVERVIEW OF PROPOSED CHANGE

Sanford has proposed restricting the NDPERS formulary to include certain glucometer test strips in order to increase manufacturer rebates.

EXPECTED ACTUARIAL IMPACT

Based on the information available at the time of this memo, Deloitte is unable to comment on the potential increase in rebates and whether the savings will be actuarially equivalent.

TECHNICAL COMMENTS

Based on our experience with other clients, restrictive formularies for glucometer test strips are relatively common. Communication will need to be clear to members that will need to change their glucometers and test strips.

Pharmacy attachment #5

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NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SANFORD HEALTH PLAN

Epinephrine Injections (Epi-Pen, Adrenaclick, and Auvi-Q)

Recently, national media attention has scrutinized the price increases for the Epinephrine products. This scrutiny has placed sufficient pressure on the manufacturer to alter their pricing model. As the manufacturers attempt to pacify consumer and political pressures, they were faced with a significant issue; how can they reduce the costs of the medication in a way that will not upset the entire distribution chain of this medication? A sudden price decline at the manufacturer will create a challenging scenario for wholesalers and pharmacies that have already purchased the product at the original (higher price).

The solution manufacturers of Adrenaclick and Epipen have both undertaken is to launch an "authorized generic" (AG). An authorized generic is a situation where a brand still owns a patent, but they allow for a generic to be manufactured. In many cases that generic is made by a different company, but in some cases like this one, the manufacturer makes the "generic" at the same facility, just under a different NDC and package name.

In this circumstance, the manufacturer is making both their traditional product Epi-Pen or Adrenaclick as well as their authorized generic product. The packaging and delivery system is identical in each circumstance, the only difference is the name on the package as well as the price. It is important to note, the manufacturer has decreased total price and total rebate for the new authorized generic.

The Sanford Pharmacy &Therapeutics committee has decided to offer both Epi-Pen AG as well as Adrenaclick AG for our members. Even after the reduced price and rebate, the AG products are lower cost to Sanford Health Plan (SHP) than the original product. We were offered the opportunity to embrace Mylan as an exclusive product in this category. The concerns related to supply integrity as well as the ethical pricing conduct of Mylan pressed SHP to keep both options available, despite modest rebate opportunity.

In addition, SHP has made Auvi-Q a non-covered option. The twin package of Auvi-Q retails for $5,400. The AG products of Adrenaclick and Epi-Pen cost $350-400 per twin pack. In order to get rebates for the Adrenaclick or Epi-Pen, the formulary must exclude Auvi-Q. The Auvi-Q is unique in that is offers vocal instruction. This feature is not necessity provided the simple administration technique for the other products.

Currently, NDPERS has no utilization of Auvi-Q or Adrenaclick products. Elimination of Auvi-Q would have no impact on members. In the last 12 months (April 2016-April 2017), NDPERS has had the following utilization:

	Members	Prescription Count	Ingredient Cost	Plan Cost	Member cost
Epi-Pen	346	388	$245,295	$183,962	$61,333
Epi-Pen Jr	100	134	$85,006	$62,291	$22,715

Danny Weiss: May 9 2017

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NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

Recommendation:

1. Allow SHP to Exclude Auvi-Q based on value proposition
2. Allow SHP to Exclude original formulations of Epi-Pen and Adrenaclick devices, covering the authorized generic for each. Letters would explain this to members prior to adoption of policy

These recommendations will allow the member and the health plan to reduce costs for Epi-pen devices. The member will acquire the medication at a generic benefit (effective 7/1 = $7.50 +12% coinsurance) compared to the brand benefit of $25+25% coinsurance. Because of this benefit difference, the member cost share will reduce by an estimated $120 per prescription. The plan cost will also decrease an estimate of $59 per prescription. The plan cost share is diminished by reduced rebate opportunities as well as decreased member cost share. Applying these estimates to the volumes described above, will equate to member reduction of $62,640 annualized, and $30,800 plan savings annualized.

Danny Weiss: May 9 2017

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Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS@state.nd.us ● discovernd.com/NDPERS

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **June 22, 2017**

SUBJECT: **Delta Dental Plan Renewal**

Delta Dental was initially awarded the contract for our group dental plan January 1, 2013. The last renewal was approved at the June 2016 Board meeting. At that meeting, the Board was presented with two renewal options; a one-year, premium neutral renewal or a two-year renewal with a 3% increase for the contract period. The Board approved the renewal for one year effective January 1, 2017. That contract expires December 31, 2017. Therefore, we requested a one-year renewal for 2018 which will complete six years and we will be required to go out to bid in 2018 for a new contract beginning January 1, 2019. Delta Dental has proposed no increase in the dental premiums to renew for the 2018 calendar year.

Following are the current rates:

	Current
Emp Only	$ 38.64
Emp + Spouse	$ 74.58
Emp + Child(ren)	$ 86.58
Emp + Family	$123.30

Delta Dental's renewal proposal is included for your information.

BOARD ACTION REQUESTED

- Accept the 1-year renewal for 2018 with no increase in premium.
- Go out to bid for dental plan services.

DELTA DENTAL

Delta Dental of Minnesota

DELIVERED VIA EMAIL

May 19, 2017

Sparb Collins, Executive Director
North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, ND 58502-1657

Re: Group Dental Plan # 537482
North Dakota Public Employees Retirement System
Current Contract Term: January 1, 2013 – December 31, 2018
Proposed Renewal Rates: January 1, 2018 – December 31, 2018 (12-months)

Dear Sparb:

Delta Dental of Minnesota has been pleased to provide dental benefits to your employees under our Delta Dental contract. We look forward to the renewal of your dental program for the above noted Contract Term.

Payment of the renewal rates listed below constitutes acceptance of this renewal offer. If you wish to cancel the contract with Delta Dental or any reason, we must have notification 60 days prior to the renewal date. The proposed renewal rates are:

	Current Rates	Renewal Rates
Employee:	**$38.64**	**$38.64**
Employee + Sp:	**$74.58**	**$74.58**
Employee + Ch(n):	**$86.58**	**$86.58**
Family:	**$123.30**	**$123.30**

We thank you for your business and look forward to servicing your group. If you have any questions, please contact your Delta Dental representative, Mark Keller, at 612-224-3271.

Sincerely,

Valerie J. Sorenson

Valerie J. Sorenson
Vice President, Account Management

Copy: Mark Keller

Corporate Address

500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415-1163

Telephone: 612-224-3300
Toll Free: 1-877-268-3384
DeltaDentalMN.org

Mailing Address

PO Box 9304
Minneapolis, MN 55440-9304

DELTA DENTAL®

RENEWAL CALCULATION
12 MONTH CONTRACT

Group Name	North Dakota Public Employees Retirement System		
Group Number	537482		
Renewal Period:	January 1, 2018	through	December 31, 2018
Experience Period:	April 1, 2016	through	March 31, 2017

Earned Premium $8,418,348

Incurred Claims $7,252,869

Estimated Unpaid Claim Liability*: $115,021

* EUCL has already been added to the incurred claim total

Average Experience Period Enrollment:	
Employee	3,997
Ee + Sp	2,371
Ee + Ch (n)	776
Family	2,465
Total	9,609

Trend Factor: 3.95%

Trend is calculated from the mid-point of the experience period to the midpoint of the renewal period.

Current Corporate Trend: 3.50%

Benefit Adjustment Factor (BAF): 0.00%

Benefit Adjustment Factor is needed if any benefit changes are proposed for the upcoming contract period.

Projected Incurred Claims: $7,539,095

Needed Increase: 1.42%

Proposed Increase: 0.00%

Rates:	Current Rates	New Rates
Employee	$38.64	$38.64
Employee+Sp	$74.58	$74.58
Employee+Ch(n)	$86.58	$86.58
Family	$123.30	$123.30

Delta Dental reserves the right to re-evaluate the rates/fees and restrict funding options if during the contract period:

**** the number of enrolled employees deviates from the above enrollment by 10% or more***

**** any changes are made to the plan design, contractual benefits or networks that are utilized.***

This renewal is valid only if the contract is issued in the state of North Dakota

N/A Broker Commission

88.26% Target Loss Ratio

BPM

5/19/17

Note: Our rates include all applicable taxes and fees

North Dakota
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Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **June 22, 2017**

SUBJECT: **Life Plan Contract Amendment**

At the April 20th meeting, the Board approved awarding the contract for our group life plan to VOYA, the incumbent bidder. Draft copies of the contract amendments are included for your information. The first attachment is for plan design changes that will be effective August 1, 2017 and the second attachment if for the increase to the supplemental life benefits that will be effective January 1, 2018. The amendments reflect the action taken by the Board at its May 18th meeting.

The amendments are under review by Jan and her comments will be provided under separate cover prior to the meeting.

Attachment 1

Request for Amendment

ReliaStar Life Insurance Company

A member of the Voya™ family of companies

Administrative Office: P.O. Box 20, Minneapolis, MN 55440

Please confirm the following information:

Group Name: North Dakota Public Employees Retirement System (NDPERS)
Group Number: 673897
Effective Date of Amendment: July 1, 2017

Amendment:

Increase the Basic Life & AD&D benefit for active employees to $7,000.

Revise the first increment of Supplemental Life & AD&D for active employees to $3,000.

The Waiver of Life Insurance Premium Disability Benefit provision includes the Dependent Life insurance coverage.

Add the Line of Duty AD&D benefit

Update the Accelerated Death benefit provision by increasing the maximum benefit to $200,000 and revise the definition of terminal illness to 12 months.

Add portability to Basic and Supplemental life.

Update to our "GAT2" contract.

Applies to the following coverage:

GAT1 Life

Account Number: 0001

Class: All eligible employees and retirees of NDPERS

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Should you have any questions or concerns regarding this request, please feel free to contact me at the telephone number below.

Ruth Bahnemann, 612-342-7050, ruth.bahnemann@voya.com

Voya Internal Servicing/Sales Information
Primary Selling Office: Dallas Regional Office
Primary Servicing Office: Minneapolis Regional Office
Primary Sales Representative: Ted Holt
Primary Client Representative: Ruth Bahnemann
Implementation Manager: n/a

AMD

Attachment 2

Request for Amendment

ReliaStar Life Insurance Company

A member of the Voya™ family of companies

Administrative Office: P.O. Box 20, Minneapolis, MN 55440

Please confirm the following information:

Group Name: North Dakota Public Employees Retirement System (NDPERS)
Group Number: 673897
Effective Date of Amendment: January 1, 2018

Amendment:

Increase the Supplemental Life and AD&D maximum benefit to $400,000. The increase also applies to Retirees that retire after 1/1/18.

Increase the Spouse Supplemental Life maximum benefit to $200,000.

Add two additional Supplemental Dependent Life options of $7,000 and $10,000 for spouses and children.

An employee can elect up to $25,000 of Supplemental life and AD&D at annual enrollment without evidence of insurability.

Applies to the following coverage:

GAT2 Life

Account Number: 0001

Class: All eligible employees and retirees of NDPERS

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Should you have any questions or concerns regarding this request, please feel free to contact me at the telephone number below.

Ruth Bahnemann, 612-342-7050, ruth.bahnemann@voya.com

Voya Internal Servicing/Sales Information
Primary Selling Office: Dallas Regional Office
Primary Servicing Office: Minneapolis Regional Office
Primary Sales Representative: Ted Holt
Primary Client Representative: Ruth Bahnemann
Implementation Manager: n/a

AMD

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● www.nd.gov/ndpers

Memorandum

TO: **NDPERS Board**

FROM: **Election Committee:**
Troy Seibel, Chair
Casey Goodhouse
Kim Wassim

DATE: **June 14, 2017**

SUBJECT: **Board Election**

The Election Committee will be meeting on Monday, June 19, 2017 at 9:00 a.m. in the NDPERS offices to canvass the ballots received for the election of a new active member to the Board.

A full report of the results will be provided for the Board's review at the meeting.

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Memorandum

TO: NDPERS Board

FROM: Sharon Schiermeister

DATE: June 14, 2017

SUBJECT: **Legislation/Operations Update**

Following is a summary of legislation that was passed in the 2017 session and our plan for implementation.

HB 1023 - appropriation
Our appropriation bill added a new subsection to 54-52-04 that states "The Board shall establish policies and implement procedures to make and collect payments in the most cost-effective manner, including the use of electronic transfer of funds". The primary area this will impact is our retirement payments. Staff will be preparing a policy for the Board to consider at the July meeting.

The bill also included this statement of legislative intent:

> Electronic distribution of materials – create operating efficiencies when feasible by discontinuing the distribution of paper materials, including newsletters and benefit statements. Develop procedures to electronically distribute materials or provide access to materials through member self-service website applications.

We have established a special task force to identify areas where we can achieve cost savings by moving to electronic distribution of materials. This will be an ongoing effort. The first area that has been identified to move to electronic distribution is the active member annual statements, which are normally mailed out to members in August of every year. Instead of printing and mailing out the annual statements, the member will be able to access their annual statement by logging in to PERSLink Member Self Service.

HB 1148 – Firefighters
This bill expands the eligibility for the law enforcement plan to include firefighters, effective 8/1/2017. This will require minor modifications to our PERSLink system, as well as updates

to various employer agreements, forms and publications. In addition, we are considering changing the name of the plan to public safety to reflect the broader membership.

SB 2053 – Technical bill
The nature of the changes in this bill are housekeeping. An implementation plan has been developed to incorporate changes into PERSLink and forms/publications as needed.

DC Plan Eligibility
In the 2013 session, eligibility for the 401(a) Defined Contribution Plan was expanded to include all new state employees hired from October 1, 2013 through July 31, 2017. Legislation was not introduced in the 2017 session to extend the effective date of these eligibility provisions, therefore, effective 8/1/2017, eligibility for the DC plan will change back to new permanent non-classified state employees.

In addition to legislative changes, we have the following benefit plan changes:

Health Plan
Effective July 1, 2017, the health premiums and plan design will be changing. NDPERS has provided notification to employers on these changes and also notified retirees of the upcoming rate changes. Sanford Health Plan (SHP) provided members with a revised Summary of Benefits and Coverage and will be sending out new ID cards and an amendment to the COI that will reflect the new plan design.

Employers, Wellness Coordinators, active members and retirees have all been notified of the reinstatement of the $250 wellness benefit effective June 1. We have also worked with SHP to develop an ongoing process to provide employers with monthly redemption reports for tax reporting purposes.

Life Plan
Effective August 1, 2017, the life premiums and basic life amount for active employees will be changing. We will be notifying employers of the premium and benefit changes, and retirees impacted by the premium change will be notified. PERSLink is being modified to reflect the new plan design and employers will be provided with a report showing new coverage levels and premiums for each of their employees.

Benefit Option Factors
We are working on the implementation plan for system modifications and communications related to the adoption of new actuarial benefit option factors for retirement benefits.

Investment return assumption
We are working on the implementation plan for system modifications, along with revisions to publications and communications related to the change in the interest rate for the retirement plan.

Each biennium, NDPERS sponsors a conference for our participating employers to provide them with updates on legislation, plan design changes and administrative processes. This year's payroll conference is scheduled for June 21. An agenda is attached for your information.

2017 NDPERS Payroll Conference
Wednesday - June 21, 2017
Bismarck Event Center Exhibit Hall C
Bismarck, ND

Legislation attachment

Use the Exhibit Hall main entrance on the west side. Parking is available in the west and south lots of the Bismarck Event Center.

7:45 **Doors Open**

8:00 – 8:30 **Registration**

8:30 – 9:00 **Welcome and Introduction**

Kathy Allen

Legislation Update

SPEAKER: *Sparb Collins*

9:00 – 10:15 **Group Insurance Overview**

SPEAKERS: Rebecca Fricke, Sanford Health Plan Staff

- Health Plan Design Changes
- Life Insurance Changes
- Wellness Update
- Vision Plan Update
- FlexComp Plan Update
- Dental Plan Update

10:15 – 10:45 **Break and Vendor Fair**

10:45 – 11:45 **Retirement Overview**

SPEAKER: MaryJo Steffes

- Defined Contribution Plan Eligibility
- Interest Rate Change
- Benefit Option Factors
- Firefighter Eligibility for Public Safety Plan
- Overtime and Written Agreements

11:45 – 1:00 **Lunch (on your own)**

1:00 – 1:15 **Online Communication: Mailings, Website and Facebook**

SPEAKER: Aime Miller

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

1:15 – 2:30 **PERSLink Employer Self Service (ESS) and PERSLink Member Self Service (MSS) Mobile App**

SPEAKERS: Sharmain Dschaak, Derrick Hohbein, Mary Glasser, Cathy Carlson, Robin Mistelski

2:30 – 3:00 **Break and Vendor Fair**

3:00 – 3:45 **TIAA**

SPEAKERS: William Thorne, Paul Krajcir, Denise Bares

- Deferred Compensation Program

3:45 – 4:30 **Employee Assistance Program Presentations**

SPEAKERS: Bryan Reinhardt, EAP Provider Representatives

- CHI St. Alexius Health EAP (10 minutes)
- Live Well Solutions EAP (10 minutes)
- The Village Business Institute (10 minutes)
- Deer Oaks EAP Services (10 minutes)

4:30 **Questions and Closing**

Kathy Allen

This conference will be recorded and available at https://ndpers.nd.gov.

Please visit the vendor booths:

ADP / WageWorks
CHI St. Alexius Health EAP
Deer Oaks EAP Services
Delta Dental
Live Well Solutions EAP
NDPERS
Sanford Health Plan
Superior Vision
The Village Business Institute
TIAA
Voya Financial

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

North Dakota
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Memorandum

TO: **NDPERS Board**

FROM: **Sparb & Bryan**

DATE: **June 22, 2017**

SUBJECT: **Retiree Subcommittee Meeting Update**

The NDPERS Retiree Subcommittee met on May 5th. The presentation and minutes from the meeting are attached.

The group discussed the retirement and health plans. The committee looked at the potential changes and cost savings for the Part-D EGWP plan. They also discussed if the retiree plan should be unbundled or remain bundled. They decided to not recommend any changes to the plan at this time.

If you have any questions, we will be available at the NDPERS Board meeting.

NDPERS RETIREE BENEFITS COMMITTEE

May 5, 2017

MINUTES

* - Present

BOARD MEMBERS: *Yvonne Smith

STAFF: *Sparb Collins, *Bryan Reinhardt, *Kathy Allen, *Rebecca Fricke, *MaryJo Steffes, *Aime Miller, *Sharon Schiermeister

Guests:

Interest Groups:

Membership Representatives:

*Dave Zentner, *Weldee Baetsch, *Bill Lardy, *Ron Leingang, *Denae Kautzman, *Curt Zimmerman

ND Capitol Ft. Totten Room

Minutes

10:00 – Sparb started the meeting and thanked everyone for coming. The presentation started with the retirement plan. The funded ratio is stable, but without the final year of the recovery contribution increase, it will not move to 100% funded status. The plan would move down with the change in the return assumption to 7.75%. The funding increase did not pass this legislative session. One new change is firefighters can now join the law enforcement plans.

The active health rates went up 17.4%, but after plan design changes and buying down premiums the State increase will be 9.8% for the biennium (Same for the Non-Medicare rates). The retiree health rates only increase on the medical side about 6.5% (Part-D increases are in January). The plan is buying down the rates by over 2% using reserves. The total increase will just over 2% for the next two years (Additional increases may come in January of each year depending on the Medicare Part-D renewals).

The group discussed the changes and potential cost savings for the Part-D EGWP plan. The group discussed if the plan should be unbundled or remain bundled with the medical plan. There are advantages/disadvantages to both. Adverse selection is a big unknown and potential problem. At the prior meeting the group discussed surveying the membership. The group discussed the survey questions developed by staff. The topic is complicated and getting the best wording is difficult. It was noted that Federal changes could happen. The committee decided to wait and not do a survey of the membership. These topics could be communicated in the newsletters and the retirement kit.

The group discussed the retirement plan and funding. Sharon discussed the NDPERS budget reductions and the move toward more electronic communications and payments. There were no other questions or issues.

11:30 – Adjourn

PERS RETIREE MEETING

MAY 5, 2017

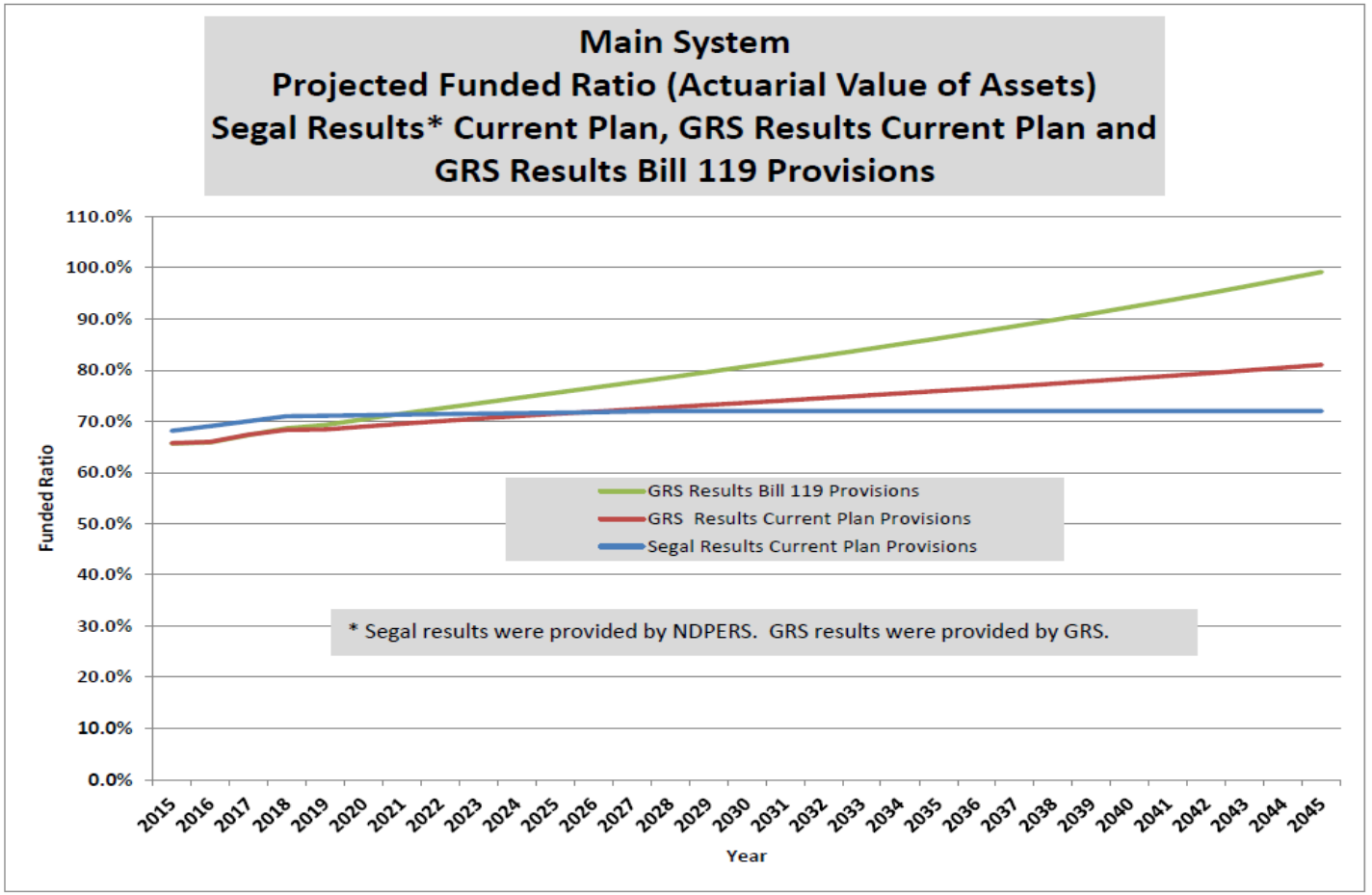
AGENDA

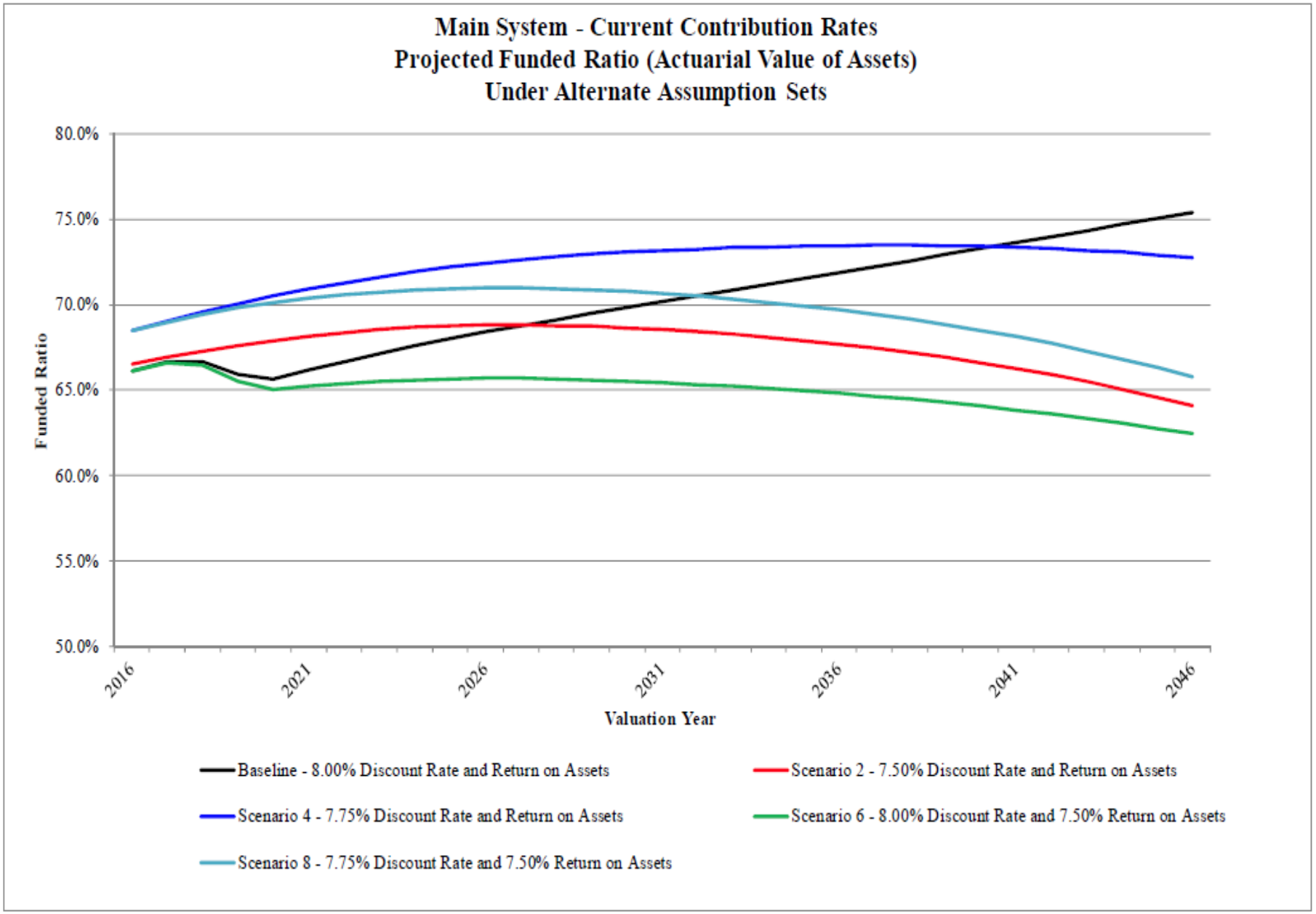
- Retirement Plan Update
- Health Plan Update
- Part D program
- Other items

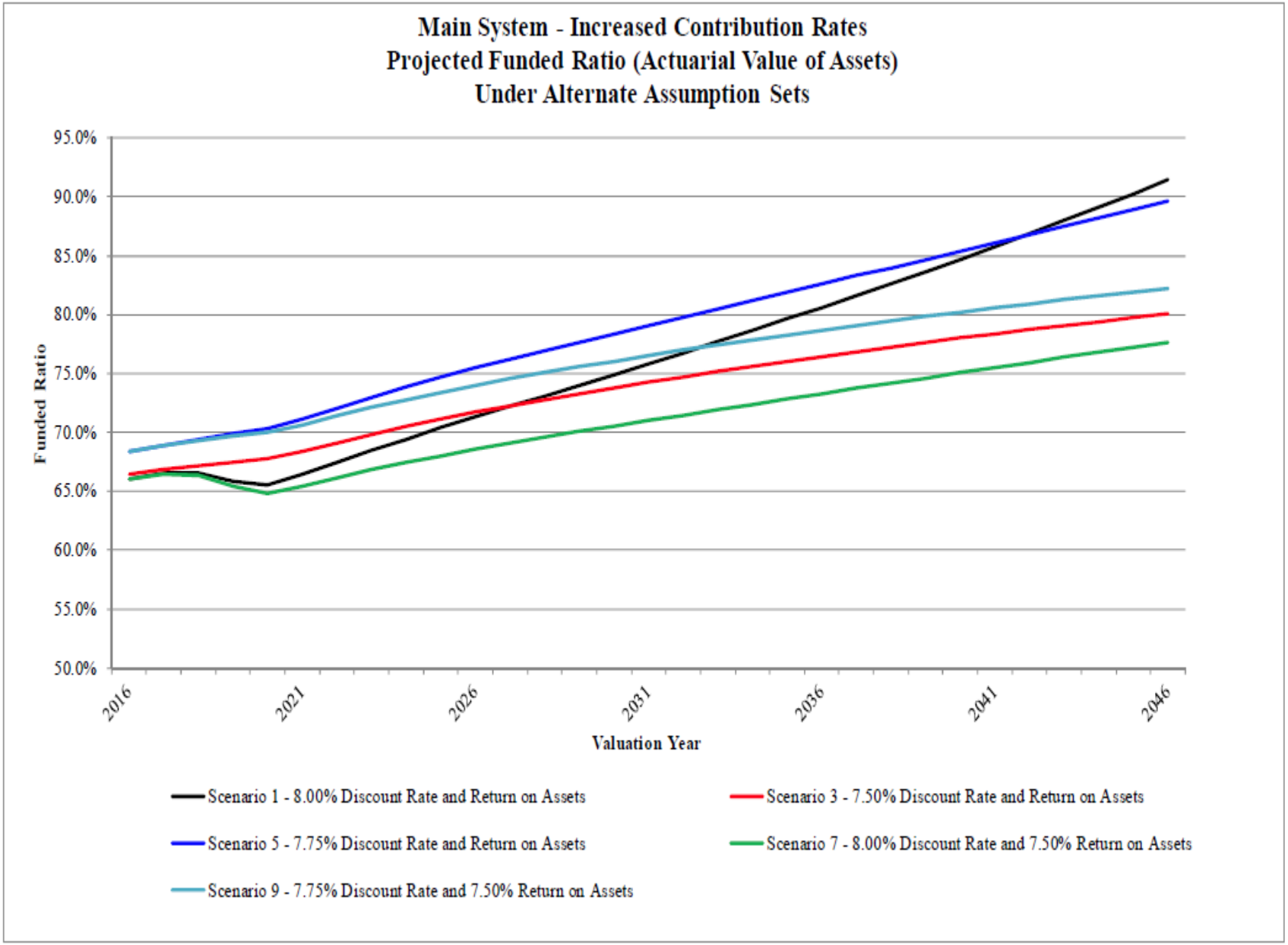
RETIREMENT PLAN

MAIN RETIREMENT PLAN

HB 1053 PERS RECOVERY BILL

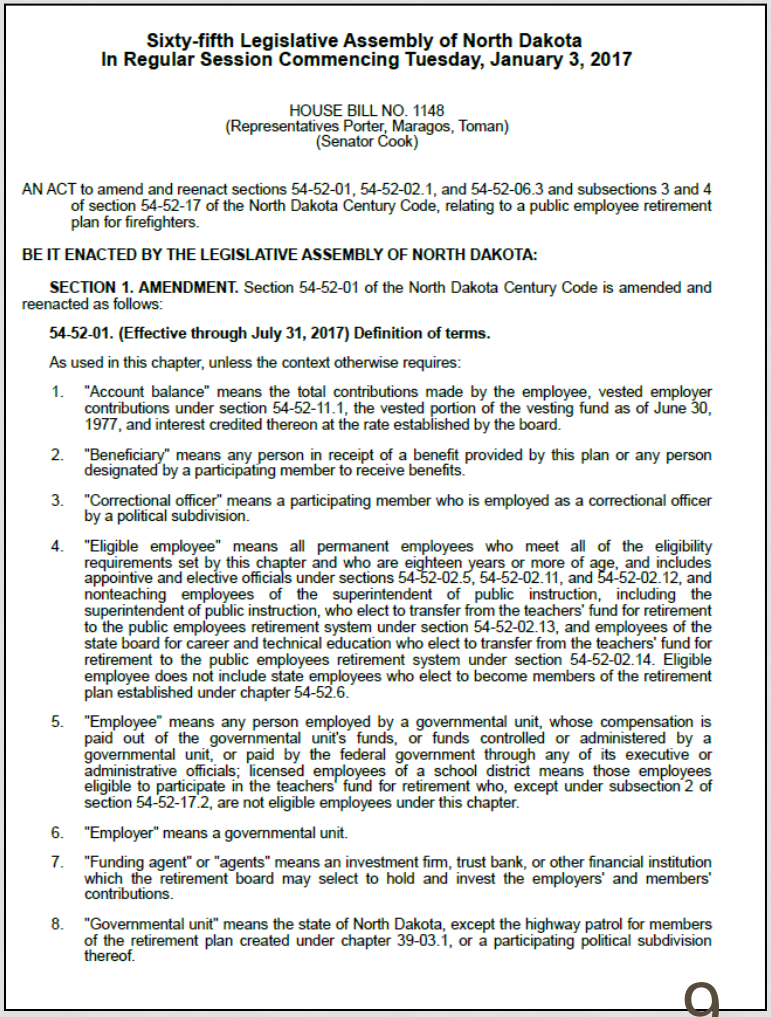



Main System - Current Contribution Rates
Projected Funded Ratio (Actuarial Value of Assets)
Under Alternate Assumption Sets
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Funded Ratio
2016
2021
2026
2031
2036
2041
2046
Valuation Year
Baseline - 8.00% Discount Rate and Return on Assets
Scenario 2 - 7.50% Discount Rate and Return on Assets
Scenario 4 - 7.75% Discount Rate and Return on Assets
Scenario 6 - 8.00% Discount Rate and 7.50% Return on Assets
Scenario 8 - 7.75% Discount Rate and 7.50% Return on Assets


Main System - Increased Contribution Rates
Projected Funded Ratio (Actuarial Value of Assets)
Under Alternate Assumption Sets
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Funded Ratio
2016
2021
2026
2031
2036
2041
2046
Valuation Year
Scenario 1 - 8.00% Discount Rate and Return on Assets
Scenario 3 - 7.50% Discount Rate and Return on Assets
Scenario 5 - 7.75% Discount Rate and Return on Assets
Scenario 7 - 8.00% Discount Rate and 7.50% Return on Assets
Scenario 9 - 7.75% Discount Rate and 7.50% Return on Assets

HB 1148

- Firefighters may join the PERS Law Enforcement Plan



Sixty-fifth Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 3, 2017

HOUSE BILL NO. 1148
(Representatives Porter, Maragos, Toman)
(Senator Cook)

AN ACT to amend and reenact sections 54-52-01, 54-52-02.1, and 54-52-06.3 and subsections 3 and 4 of section 54-52-17 of the North Dakota Century Code, relating to a public employee retirement plan for firefighters.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52-01 of the North Dakota Century Code is amended and reenacted as follows:

54-52-01. (Effective through July 31, 2017) Definition of terms.

As used in this chapter, unless the context otherwise requires:

1. "Account balance" means the total contributions made by the employee, vested employer contributions under section 54-52-11.1, the vested portion of the vesting fund as of June 30, 1977, and interest credited thereon at the rate established by the board.
2. "Beneficiary" means any person in receipt of a benefit provided by this plan or any person designated by a participating member to receive benefits.
3. "Correctional officer" means a participating member who is employed as a correctional officer by a political subdivision.
4. "Eligible employee" means all permanent employees who meet all of the eligibility requirements set by this chapter and who are eighteen years or more of age, and includes appointive and elective officials under sections 54-52-02.5, 54-52-02.11, and 54-52-02.12, and nonteaching employees of the superintendent of public instruction, including the superintendent of public instruction, who elect to transfer from the teachers' fund for retirement to the public employees retirement system under section 54-52-02.13, and employees of the state board for career and technical education who elect to transfer from the teachers' fund for retirement to the public employees retirement system under section 54-52-02.14. Eligible employee does not include state employees who elect to become members of the retirement plan established under chapter 54-52.6.
5. "Employee" means any person employed by a governmental unit, whose compensation is paid out of the governmental unit's funds, or funds controlled or administered by a governmental unit, or paid by the federal government through any of its executive or administrative officials; licensed employees of a school district means those employees eligible to participate in the teachers' fund for retirement who, except under subsection 2 of section 54-52-17.2, are not eligible employees under this chapter.
6. "Employer" means a governmental unit.
7. "Funding agent" or "agents" means an investment firm, trust bank, or other financial institution which the retirement board may select to hold and invest the employers' and members' contributions.
8. "Governmental unit" means the state of North Dakota, except the highway patrol for members of the retirement plan created under chapter 39-03.1, or a participating political subdivision thereof.

HEALTH PLAN

ACTIVE PLAN

Per Contract Per Month Cost

NDPERS Health Plan	Executive Rec		Current Leg Budget Proposal		
Existing state Premium is $1130		% Inc		% inc	Premium reduced
Sanford Proposed 2017-19 Premium	$ 1,326	17.4%	$ 1,326	17.4%	
Less: Plan Design Changes (pd by member)	$ 1,277	4.4%	$ 1,268	5.2%	$ 58
Less: Reserve Funding (Buydown)*	$ 1,249	2.4%	$ 1,241	2.4%	$ 27
State Premium 2017-19	$ 1,249	10.55%	$ 1,241	9.8%	$ 85
Total Proposed Health Inc % paid from: 1) Premium - 56%; Member - 30% & PERS Reserves - 14%)					

NDPERS DAKOTA PLAN - Grandfathered

	2011 – 2017		2017 – 2019	
PLAN FEATURES	BASIC / SELF REFERRAL	PPO	BASIC / SELF REFERRAL	PPO
Deductible for Non-Physician Services				
Single (individual)	$400	$400	$500	$500
Family	$1200	$1200	$1500	$1500
Copayment Amounts				
Office Visits	$30	$25	$35	$30
Emergency Room Visits	$50	$50	$60	$60
Diagnostic Services (per service)				
Coinsurance	75/25	80/20	75/25	80/20
Coinsurance Maximum				
Single (individual)	$1250	$ 750	$1500	$1000
Family	$2500	$1500	$3000	$2000
Total Out-of-Pocket per Benefit Period**				
Single (individual)	$1650	$1150	$2000	$1500
Family	$3700	$2700	$4500	$3500
Lifetime Maximum Per Insured	$0		$0	
Prescription Drugs				
Generic Prescription*	$ 5 copay, 15% coins		$10 copay, 15% coins	
Brand Name Prescription	$20 copay, 25% coins		$25 copay, 25% coins	
Nonformulary Prescription	$25 copay, 50% coins		$30 copay, 50% coins	
Prescription Drug Coinsurance Maximum	$1,000		$1,200	
Notes:	1			

** - Excludes copayments.

NOTES:

1. Dependent to Age 26 Added and Eliminated Lifetime Maximum ACA Provisions.

Plan Design Changes

Plan design changes	Potential % point savings Updated Jan 2017	Effect on Grandfathered status
1. Change Single Deductible from $400 to $500 2. Change Family Deductible from $1,200 to $1,500	.70	None
3. Increase the single co-insurance maximum for the PPO plan from $750 to $1,000 and for the basic plan from $1,250 to $1,500. Increase the family co-insurance max from $1,500 for the PPO plan to $2,000 and for the Basic plan from $2,500 to $3,000	2.11	None
4. Increase office call co-payment for the single PPO plan from $25 to $30 and for the basic plan from $30 to $35. Increase the Emergency room co-pay fro $50 to $60.	1.05	None
5. Increase the co-pay for generic Rx from $5 to $10 Increase the co-pay for Brand Rx from $20 to $25 Increase the co-pay for Non-formulary Rx from $25 to $30	1.29	None
TOTAL	5.15	

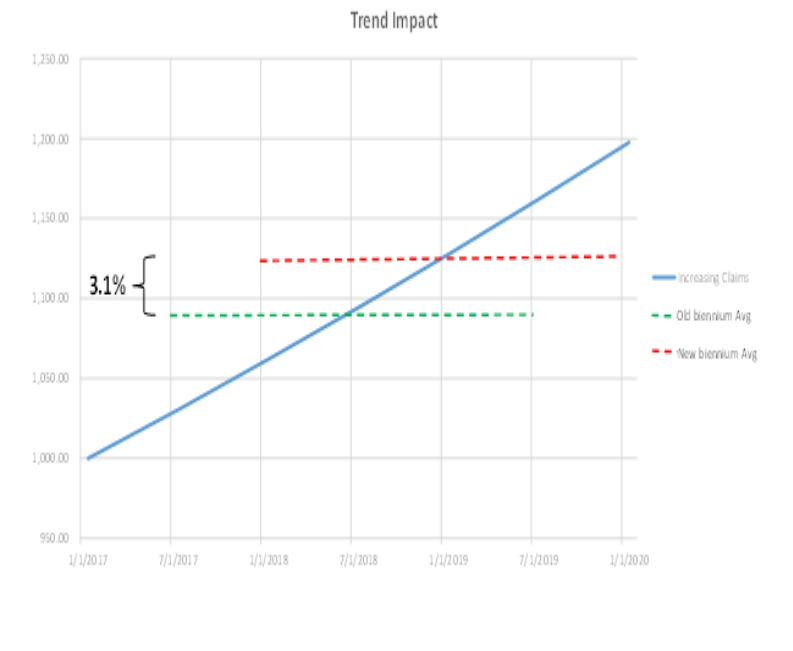
Total Plan Premium and PERS Reserves used for each Member Group

NDPERS Health Plan (Millions)	Premium 2015-2017			Premium 2017-2019		
	General Fund**	Other Funds	Total	General Fund**	Other Funds	Total
State*						
Premium Pd.	$200.6	$235.5	$436.1	$220.2	$258.6	$478.8
Reserves	$0.0	$0.0	$0.0	$0.0	$10.5	$10.5
Total State	$200.6	$235.5	$436.1	$220.2	$269.1	$489.3
Political Subs						
Premium Pd.	$0.0	$151.2	$151.2	$0.0	$166.0	$166.0
Reserves	$0.0	$0.0	$0.0	$0.0	$3.7	$3.7
Total P.S.	$0.0	$151.2	$151.2	$0.0	$169.6	$169.6
Retirees						
Premium Pd.	$0.0	$40.3	$40.3	$0.0	$42.1	$42.1
Reserves	$0.0	$0.0	$0.0	$0.0	$0.9	$0.9
Total Retiree	$0.0	$40.3	$40.3	$0.0	$43.0	$43.0
Total Premium	$200.6	$427.0	$627.6	$220.2	$466.6	$686.9
Total Reserves	$0.0	$0.0	$0.0	$0.0	$15.1	$15.1
Total	$200.6	$427.0	$627.6	$220.2	$481.7	$701.9

* - Assumes 15,938 Executive Budget FTE's & Legislative Assembly

HB 1406
DID NOT PASS SENATE

- Health Insurance contract must be 2 years
- Must begin Jan 1



17.0790.01000

Sixty-fifth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1406

Introduced by

Representatives Carlson, Kasper

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee uniform group health insurance benefits; to provide for application; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health benefits plans - Term of contract - Plan design.

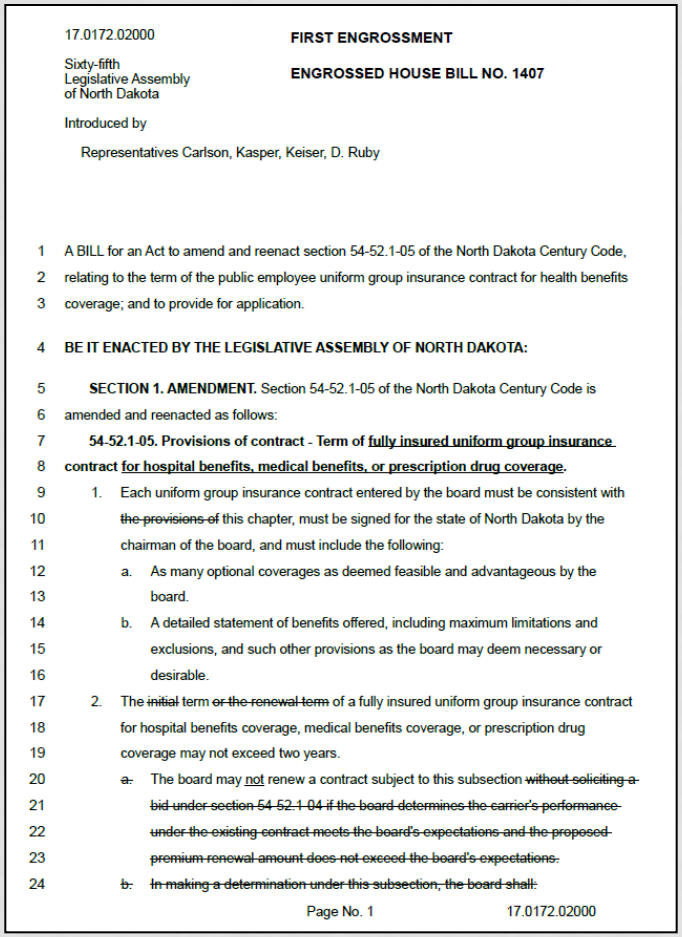
1. This section applies to a contract for hospital and medical benefits coverage under section 54-52.1-04, health maintenance organization coverage under 54-52.1-04.1, or a self-insurance plan for hospital and medical benefits coverage under section 54-52.1-04.2. The term of a contract must be two years and must begin on January first of an even-numbered year.
2. The board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly.

SECTION 2. APPLICATION. Notwithstanding contrary term of contract provisions, the term of a contract subject to section 1 of this Act in effect on the effective date of this Act may be increased or decreased by the shortest period necessary in order to synchronize the contract with a January 1, 2018, start date.

SECTION 3. EMERGENCY. This Act is declared to be an emergency measure.

HB 1407
DIDN'T PASS THE SENATE

- May not exceed two years
- Emergency clause



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Sixty-fifth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1407

Introduced by

Representatives Carlson, Kasper, Keiser, D. Ruby

A BILL for an Act to amend and reenact section 54-52.1-05 of the North Dakota Century Code, relating to the term of the public employee uniform group insurance contract for health benefits coverage; and to provide for application.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52.1-05 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-05. Provisions of contract - Term of fully insured uniform group insurance contract for hospital benefits, medical benefits, or prescription drug coverage.

1. Each uniform group insurance contract entered by the board must be consistent with ~~the provisions of~~ this chapter, must be signed for the state of North Dakota by the chairman of the board, and must include the following:
   a. As many optional coverages as deemed feasible and advantageous by the board.
   b. A detailed statement of benefits offered, including maximum limitations and exclusions, and such other provisions as the board may deem necessary or desirable.
2. The ~~initial~~ term ~~or the renewal term~~ of a fully insured uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage may not exceed two years.
   ~~a.~~ The board may not 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:~~

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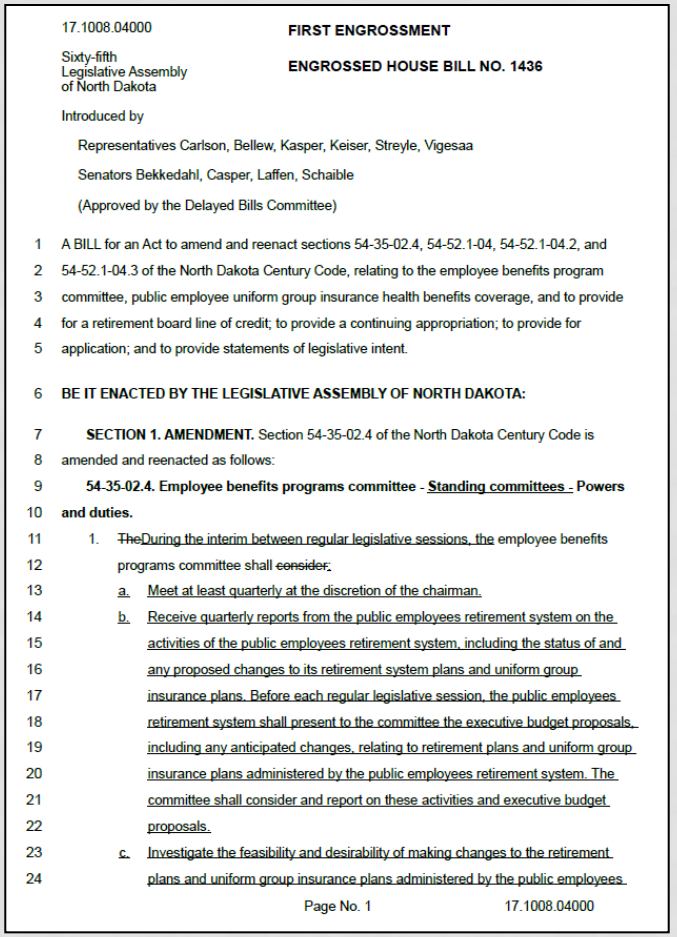
HB 1436
DIDN'T PASS THE SENATE

- Require PERS to be self insured
- Effective Jan 2018
- Provide a 50 million line of credit with the bank



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FIRST ENGROSSMENT

Sixty-fifth
Legislative Assembly
of North Dakota

ENGROSSED HOUSE BILL NO. 1436

Introduced by

Representatives Carlson, Bellew, Kasper, Keiser, Streyle, Vigesaa

Senators Bekkedahl, Casper, Laffen, Schaible

(Approved by the Delayed Bills Committee)

A BILL for an Act to amend and reenact sections 54-35-02.4, 54-52.1-04, 54-52.1-04.2, and 54-52.1-04.3 of the North Dakota Century Code, relating to the employee benefits program committee, public employee uniform group insurance health benefits coverage, and to provide for a retirement board line of credit; to provide a continuing appropriation; to provide for application; and to provide statements of legislative intent.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-35-02.4 of the North Dakota Century Code is amended and reenacted as follows:

54-35-02.4. Employee benefits programs committee - Standing committees - Powers and duties.

1. ~~The~~During the interim between regular legislative sessions, the employee benefits programs committee shall ~~consider~~:
   a. Meet at least quarterly at the discretion of the chairman.
   b. Receive quarterly reports from the public employees retirement system on the activities of the public employees retirement system, including the status of and any proposed changes to its retirement system plans and uniform group insurance plans. Before each regular legislative session, the public employees retirement system shall present to the committee the executive budget proposals, including any anticipated changes, relating to retirement plans and uniform group insurance plans administered by the public employees retirement system. The committee shall consider and report on these activities and executive budget proposals.
   c. Investigate the feasibility and desirability of making changes to the retirement plans and uniform group insurance plans administered by the public employees

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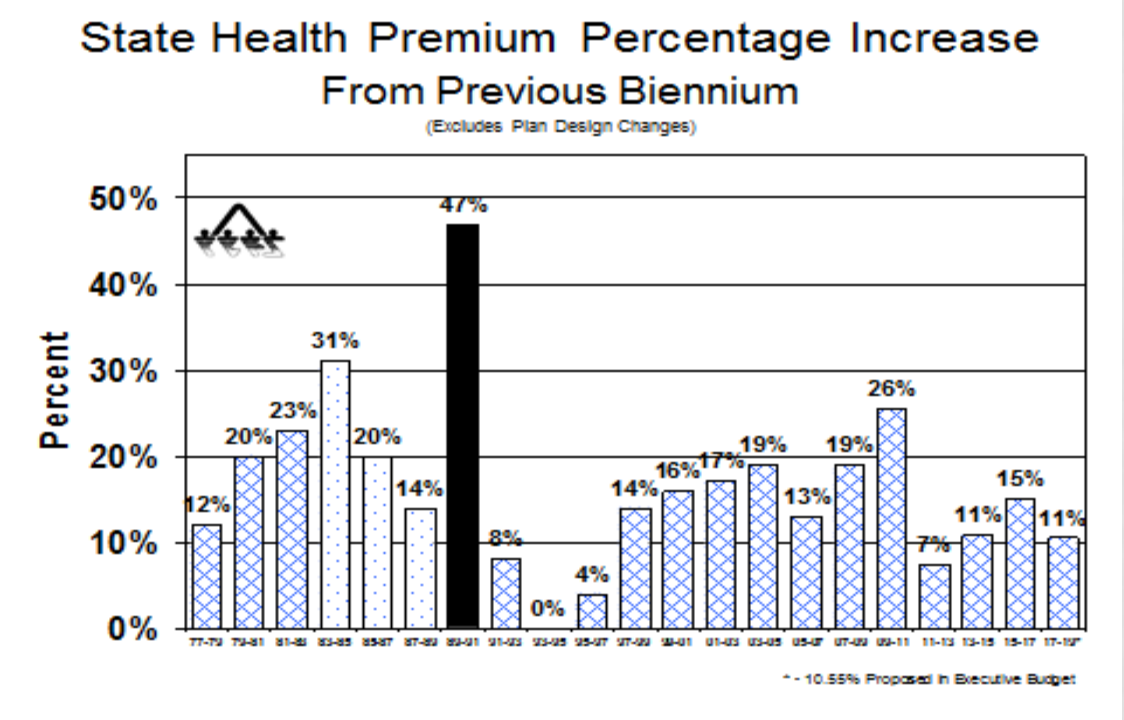


- As we look at the years the plan was self-insured, the plan's average increase was 21.7%.
- If we look at the years the plan was fully insured without the transition biennium, we see the average increase was 14%. With the transition biennium it was about 16%.
- While there are many variables to what causes a rate increase in a given biennium, these numbers do not indicate on their own that one method is superior over the other.

State	State Payment	Total Family Premium
South Dakota	$722	$1047
Idaho	$860	$979
Montana	$1054	$1381
North Dakota	**$1130***	**$1312****
Colorado	$1230	$1783
Minnesota	$1467	$1659
Nebraska	$1551	$1963
Iowa	$1689	$1987
Wisconsin	$1702	$1911
Wyoming	$1714	$1947

*Flat rate payment

** Equivalent Premium

RETIREE PLAN

HEALTH PLAN

RETIREE INCREASE

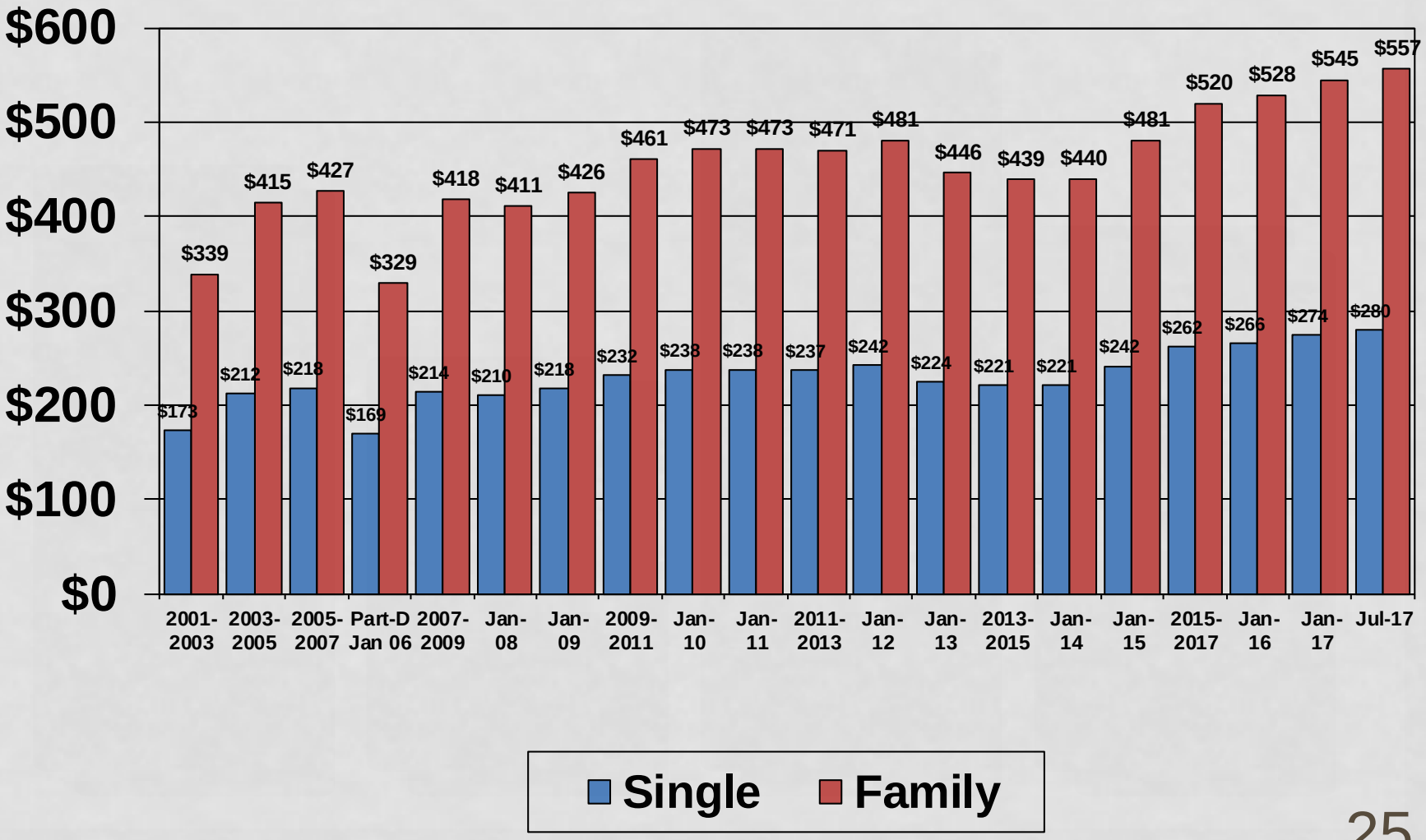
- Avg of 6.5%

BUYDOWN OF PREMIUM

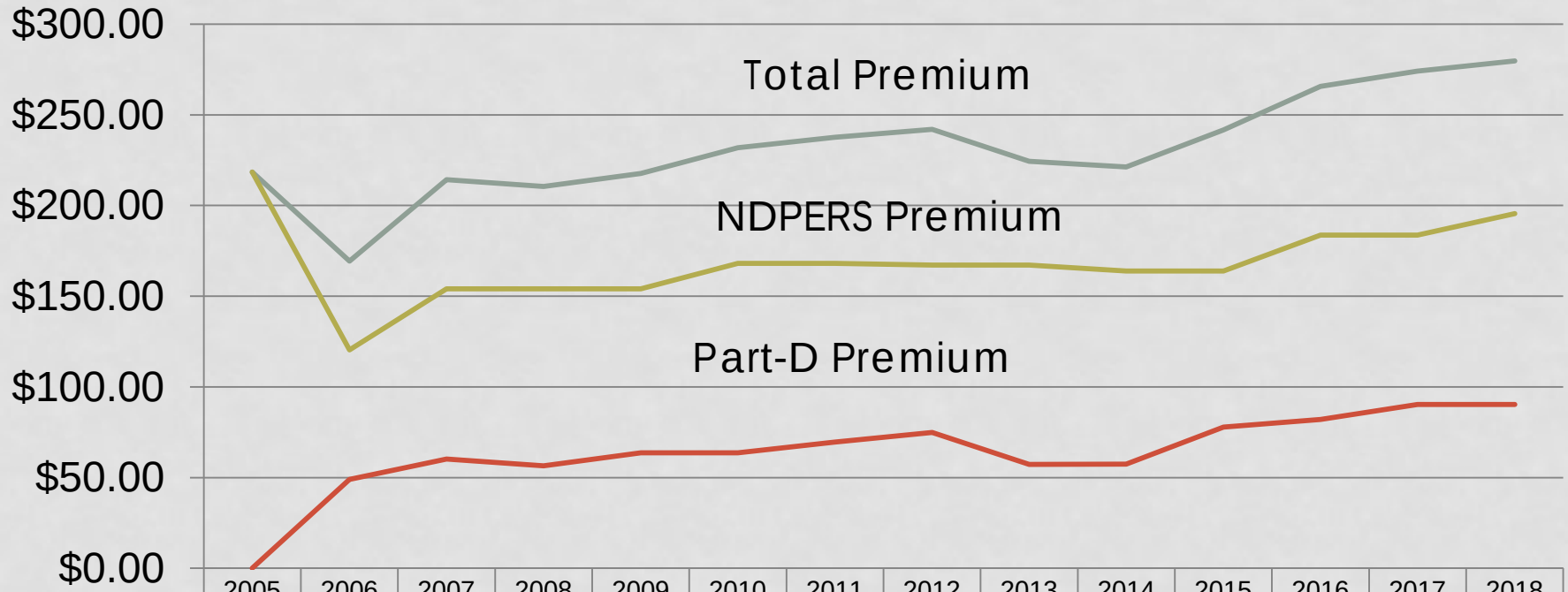
- Buydown of 2.4% for retirees as was done with the active group
  - Positive – reduces premium for 2017-19
  - Negative – needs to be made up in 2019-2021

24	2015-17	2017-19	$ Inc.	% Inc.
1 Medicare	274.08	279.68	5.6	2%
2 Medicare	545.06	556.62	11.56	2%
3 Medicare	816.64	833.58	16.94	2%
4 Medicare	1,087.92	1,110.52	22.6	2%
1 Medicare + others	711.76	760.32	48.56	7%
2 Medicare + others	982.74	1,037.26	54.52	6%
3 Medicare + others	1,254.32	1,314.20	59.88	5%
4 Medicare + others	1,525.6	1,591.16	65.56	4%
Part A Single	551.34	568.6	17.26	3%

NDPERS MEDICARE PREMIUMS



MEDICARE SINGLE PREMIUM



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Single Premium	$218.4	$169.4	$214.2	$210.4	$217.7	$231.8	$237.6	$242.0	$224.3	$221.2	$241.7	$265.7	$274.0	$279.6
Part-D	$0.00	$49.00	$60.14	$56.40	$63.70	$63.70	$69.50	$74.90	$57.20	$57.40	$77.90	$82.00	$90.32	$90.32
NDPERS	$218.4	$120.4	$154.0	$154.0	$154.0	$168.1	$168.1	$167.1	$167.1	$163.8	$163.8	$183.7	$183.7	$195.5

Medicare Supplement benefits	A	B	C	D	F[1]	G	K[2]	L[3]	M	N[4]
Medicare Part A co-insurance and hospital costs	√	√	√	√	√	√	√	√	√	√
Medicare Part B co-insurance or co-payment	√	√	√	√	√	√	50%	75%	√	√
First 3 pints of blood	√	√	√	√	√	√	50%	75%	√	√
Part A hospice care co-insurance or co-payment	√	√	√	√	√	√	50%	75%	√	√
Co-insurance for skilled nursing facility			√	√	√	√	50%	75%	√	√
Medicare Part A deductible		√	√	√	√	√	50%	75%	50%	√
Medicare Part B deductible			√		√					
Medicare Part B excess charges					√	√				
Foreign travel emergency			√	√	√	√			√	√

1. Plan F offers a high-deductible plan. This plan requires you to pay a $2,180 deductible before it covers anything.
2. Plan K has an “Out-of-Pocket” yearly limit of $4,960 (in 2016). After you pay the out-of-pocket yearly limit and yearly Part B deductible, it pays 100% of covered services for the rest of the calendar year.
3. Plan L has an “Out-of-Pocket” yearly limit of $2,480 (in 2016). After you pay the out-of-pocket yearly limit and yearly Part B deductible, it pays 100% of covered services for the rest of the calendar year.
4. Plan N pays 100% of the Part B co-insurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that don’t result in an inpatient admission.

SUPPLEMENT POLICY

- Discussed no change at this time

PART D PROGRAM

RETIREE RX

Tier	Retail Three-Month (90-day) Supply	Home Delivery Three-Month (90-day) Supply
Tier 1: **Generic Drugs**	$5 copayment plus 15% coinsurance	$5 copayment plus 15% coinsurance
Tier 2: **Preferred Brand Drugs**	$15 copayment plus 25% coinsurance	$15 copayment plus 25% coinsurance
Tier 3: **Non-Preferred Brand Drugs**	$25 copayment plus 50% coinsurance	$25 copayment plus 50% coinsurance

Coverage Gap stage	Under your plan, you reach the Coverage Gap stage once your total yearly drug costs reach $3,310. During this stage, your cost-sharing amounts for generic and brand-name drugs will remain the same until your yearly out-of-pocket drug costs reach $4,850.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,850, you will pay **the greater of 5% coinsurance or:** • a $2.95 copayment for covered generic drugs (including brand drugs treated as generics) • a $7.40 copayment for all other covered drugs.

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 1: Current Plan Design, Formulary & Network
Deductible	$0	$0
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	All
2017 Premium Estimate PMPM*	$90.33	$95.98

Existing premium $90.33

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 2: Same as Current Plan Design, Formulary & Network. Add $100 Deductible
Deductible	$0	$100
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	All
2018 Premium Estimate PMPM*	**$95.98**	**$90.88**

Existing premium $90.33

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 3: Same as Current Plan Design, Formulary & Network. Coverage Gap option is Generic Only
Deductible	$0	$0
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	Generic Only
2018 Premium Estimate PMPM*	**$95.98**	**$85.86**

Tier	Retail Three-Month (90-day) Supply	Home Delivery Three-Month (90-day) Supply
Tier 1: **Generic Drugs**	$5 copayment plus 15% coinsurance	$5 copayment plus 15% coinsurance
Tier 2: **Preferred Brand Drugs**	$15 copayment plus 25% coinsurance	$15 copayment plus 25% coinsurance
Tier 3: **Non-Preferred Brand Drugs**	$25 copayment plus 50% coinsurance	$25 copayment plus 50% coinsurance

Coverage Gap stage	Under your plan, you reach the Coverage Gap stage once your total yearly drug costs reach $3,310. During this stage, your cost-sharing amounts for generic and brand-name drugs will remain the same until your yearly out-of-pocket drug costs reach $4,850.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,850, you will pay **the greater of 5% coinsurance or:** • a $2.95 copayment for covered generic drugs (including brand drugs treated as generics) • a $7.40 copayment for all other covered drugs.

Existing premium $90.33

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 4: Same Plan Design & Network. Move to a Closed Formulary	S
Deductible	$0	$0	
Initial Coverage	Same as Current	Same as Current	
Coverage Gap	All	All	
2018 Premium Estimate PMPM*	$95.98	$94.43	

Tier	Retail Three-Month (90-day) Supply	Home Delivery Three-Month (90-day) Supply
Tier 1: **Generic Drugs**	$5 copayment plus 15% coinsurance	$5 copayment plus 15% coinsurance
Tier 2: **Preferred Brand Drugs**	$15 copayment plus 25% coinsurance	$15 copayment plus 25% coinsurance
Tier 3: **Non-Preferred Brand Drugs**	$25 copayment plus 50% coinsurance	$25 copayment plus 50% coinsurance

Existing premium $90.33

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 5: Same as Current Plan Design & Formulary. Move to a Preferred Network
Deductible	$0	$0
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	All
2018 Premium Estimate PMPM*	$95.98	$95.45

Existing premium $90.33

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 6: Current Network & Formulary. Move to CMS Defined Standard Plan Design.
Deductible	$0	$400
Initial Coverage	Same as Current	CMS Defined Standard (25%)
Coverage Gap	All	CMS Defined Standard Minimum
2018 Premium Estimate PMPM*	**$95.98**	**$71.69**

Existing premium $90.33

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 2: Same as Current Plan Design, Formulary & Network. Add $100 Deductible	Scenario 3: Same as Current Plan Design, Formulary & Network. Coverage Gap option is Generic Only
Deductible	$0	$100	$0
Initial Coverage	Same as Current	Same as Current	Same as Current
Coverage Gap	All	All	Generic Only
2018 Premium Estimate PMPM*	$95.98	$90.88	$85.86

	Scenario 4: Same Plan Design & Network. Move to a Closed Formulary	Scenario 5: Same as Current Plan Design & Formulary. Move to a Preferred Network	Scenario 6: Current Network & Formulary. Move to CMS Defined Standard Plan Design.
Deductible	$0	$0	$400
Initial Coverage	Same as Current	Same as Current	CMS Defined Standard (25%)
Coverage Gap	All	All	CMS Defined Standard Minimum
2018 Premium Estimate PMPM*	$94.43	$95.45	$71.69

AUGUST MEETING

NDPERS RETIREE BENEFITS COMMITTEE
August 16, 2016
MINUTES

* - Present

BOARD MEMBERS: *Yvonne Smith

STAFF: *Sparb Collins, *Bryan Reinhardt, *Kathy Allen, *Rebecca Fricke, *Sharon Schiermeister,

Guests:

Interest Groups: *Bill Kalanek - AFPE/NASW, Stuart Savelkohl - NDPEA

Membership Representatives:

*Dave Zentner, *Weldee Baetsch, David Gunkel, *Bill Lardy, *Ron Leingang *Howard Sage, *Denae Kautzman

Fort Union Room (moved from Sakakawea Room)

Minutes

9:05 – Sparb started the meeting and covered the presentation. ESI sent utilization statistics for the retiree EGWP. The data is for the first six months of 2016. The plan will renew on Jan 1st, 2017. The group asked if there were statistics on rejected claims for new specialty drugs. There were not, NDPERS staff just got the ESI information yesterday. The slides moved to the topic of the renewal of the EGWP for 2017. The present plan monthly cost would increase from $82 to $90.33 (10.16%). ESI gave several plan design options to consider that would shift costs and reduce the premium increase.

#1 – Current plan $90.33

#2 – Add a $100 deductible $86.72, the $3.61 savings ($43.32 per year) for potential $100 cost

#3 – Allow only generics in the coverage gap $81.29, big savings but may be hardship for some

#4 – Closed formulary $88.95, $1.38 savings, not much savings but may be hardship for some

#5 – Preferred network $89.86, $.47 savings, not much but may be hardship for some

#6 – Change to standard plan benefits $68.26, big savings, but at this level of coverage it would probably be best to unbundle the plan.

Additional questions were asked:

Number of members with less than $3,310 in costs?

How many reach and go through the "doughnut hole"?

Number of members that use preferred brand drugs?

Can we ID users of nonformulary drugs where a formulary drug is available?

- *The #3 and #4 options should be studied*
- *Should we survey our members*

BUNDLED OR UNBUNDLED

PROGRAM BACKGROUND

- Historically, PERS has offered a Medicare Supplement that includes drug coverage. This was the case before Part D was created by the federal government. Our coverage is bundled, which means it includes medical and Rx and in electing this coverage, the member has to take both.
- When Part D was enacted, BCBS developed a product for us that captured the Part D Subsidy, retained our present plan of benefits for Rx, and had no doughnut hole. We continued to offer our plan as bundled only.
- When part D was implemented, Medicare retirees where offered an annual open enrollment wherein they are provided the opportunity to select Rx coverage from numerous Rx products in the market place with varying plan designs, formularies, and pricing.

PROGRAM BACKGROUND

- This open enrollment has resulted in confusion because our members receive information on the federal open enrollment and think this is something they can do and will enroll for other Part D coverage. Because a member cannot be enrolled in two Part D products, CMS notifies BCBS that they have cancelled the member's Part D coverage with PERS. The unintended outcome of this action is that the member's eligibility for continued medical coverage has been jeopardized because we cannot cancel Rx coverage without also cancelling the medical coverage because the product is bundled. This results in PERS contacting the member to inform them of this policy and providing them the opportunity to reconsider their action.
- Since Part D was enacted, we have found the federal government to be very difficult to deal with concerning enrollments and disenrollments. Consequently, over time premium payments have accrued and we continue to work on resolving them with BCBS.

PERS PART D PLAN

Advantages

- Less confusion with open enrollment
- More choice
- May be able to access lower cost coverage – especially when younger

Disadvantages

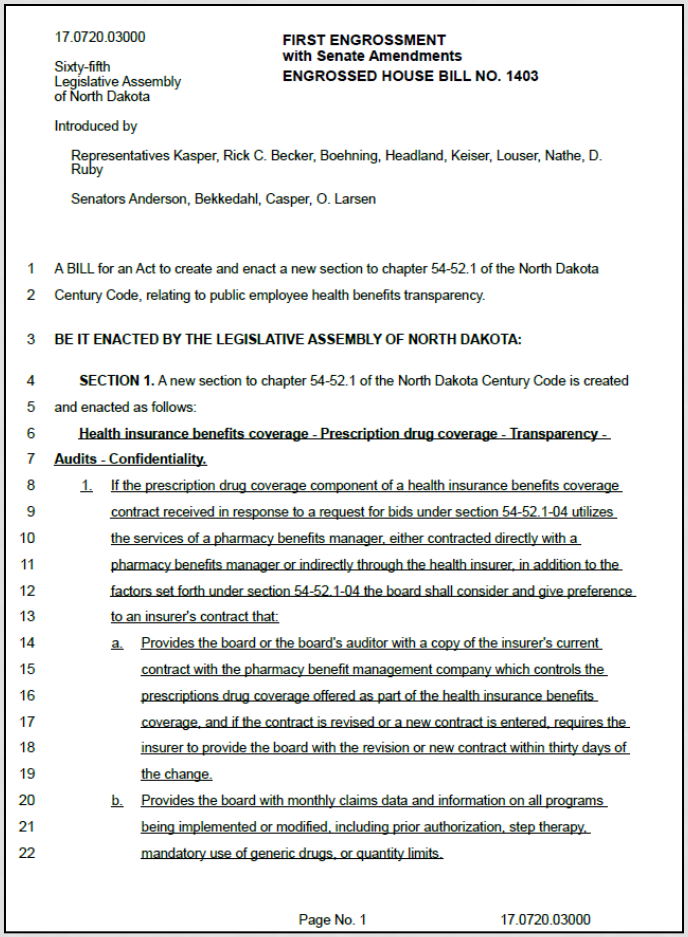
- Rates will likely go up
- In time PERS may no longer be able to be in business – small population – adverse selection
- Would we need to allow open enrollment
- May need to age rate
- May need to change plan design to be less robust

FUTURE ACTIONS

- So we want to look at changing the Part D product?
- Do we want to consider unbundling the Medicare policy?
- Do we want to survey our members about the plan and possible changes?

HB 1403

- PBM Auditing
- Came out of conference committee
- Senate Amendments Adopted



17.0720.03000

Sixty-fifth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT
with Senate Amendments
ENGROSSED HOUSE BILL NO. 1403

Introduced by

Representatives Kasper, Rick C. Becker, Boehning, Headland, Keiser, Louser, Nathe, D. Ruby

Senators Anderson, Bekkedahl, Casper, O. Larsen

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee health benefits transparency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

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 benefit 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.

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PERS APPROPRIATION BILL

HB 1023 AMENDMENTS

DIDN'T PASS THE SENATE

Areas of Consideration	HB 1023 Section	Improve/ Enhance	No change	Diminish/ Inconsistent	Observations
Appropriation of Health Reserves	5 & 33			X	State funds are already appropriated by the legislature when premiums are approved. This change will result in a significant increase in out of pocket costs to members due to the loss of grandfathered status. *See attached Deloitte memo for more detailed information.* **NDPERS Board position: Oppose since it will increase member out of pocket cost**
PERS SIB representation	8			X	NDPERS SIB representation will no longer be from NDPERS governing members but rather advisory members. Also the NDPERS Executive Director will be placed in a supervisory capacity over TFFR. **NDPERS Board position: Cannot support without further study and input from members/employers**
Legislative Change	27			X	Sets precedence by providing for non voting/ non legislative members to be a part of a legislative committee and its deliberations.
Legislative oversight	27 & 28		X		No change except for as noted above. NDPERS already does reporting to this Committee. Requires the committee to meet quarterly instead of at the call of the chair.
Member	32			X	Members would no longer be involved in overseeing the plan **NDPERS Board position: Cannot support without further study and input from members/employers**
Employer	32			X	One employer (State of ND) out of the several hundred employers in the plan would have disproportionate control of the plan **NDPERS Board position: Cannot support without further study and input from members/employers**
Political Subdivisions	32			X	Political Subdivisions employees would lose their representation in program governance **NDPERS Board position: Cannot support without further study and input from members/employers**
Retiree	32			X	Retirees would lose their representation in program governance **NDPERS Board position: Cannot support without further study and input from members**
Governor	32	X			Governor would become the sole fiduciary of the plan and solely responsible for plan administration. *See attached memo from Groom for more detail on Fiduciary implications* **NDPERS Board position: Cannot support without further study and input from members/employers**
Fiduciary oversight	32			X	Creates the potential for conflict and concentrates the fiduciary responsibility in one person. *See attached memos from Groom & Ice Miller Law Firms for more detail on Fiduciary implications* **NDPERS Board position: Cannot support without further study and input from members/employers**
Program administration	32		X		Same staff would do program administration, but would report to the Governor **NDPERS Board position: Cannot support without further study and input from members/employers**
Governance	32			X	Instead of representation of all members involved it would concentrate this responsibility in the Executive Branch with the Governor. *See attached memo from Groom* **NDPERS Board position: Cannot support without further study and input from members/employers**
Legislative Involvement	32			X	Legislative representatives would no longer be able to participate in the administration of the plan, they would only serve in an advisory capacity
Fiscal effect			X		No change in budget
Compliance with EBPC process				X	Did not follow statutory requirements or process
Actuarial effect			X		Does not improve or diminish the actuarial standing of the plans. *See GRS & Deloitte Memos*
EBPC finding				X	EBPC gave the bill an unfavorable recommendation

HB 1023 AS PASSED

What it does do

- We are required to go to bid next biennium
- We will be working with a new committee for next biennium relating to health insurance. (which sunsets)

What did not happen

- Board is still responsible for agency and programs
- Health plan was not changed this upcoming biennium
- Renewal with Sanford not altered
- Bd retains responsibility for use of PERS health funds
- No study to change PERS
- Board

HB 1023

SECTION 6. PUBLIC EMPLOYEE HEALTH INSURANCE PLANS - SOLICITATION OF BIDS AND CONTRACTING.

1. During the 2017-18 interim, in consultation with the public employee health care coverage committee and based on the recommendations of the legislative management, the retirement board shall design requests for proposals and shall solicit bids under section 54-52.1-04 for hospital, medical, and prescription drug benefits coverage for the active employee plan for the 2019-21 biennium. The board's primary bid must be for a self-insurance plan under section 54-52.1-04.2, and in accordance with section 54-52.1-04.2, the solicitation for bids must include a request for proposals for a fully insured plan or hybrid fully insured plan, or both.

2. Notwithstanding contrary provisions of law, upon the bids received under subsection 1, the board shall select the carrier or carriers and shall contract for the plan or plans that best serve the interests of the state and its eligible employees. In considering the interests of the state and its employees, the board's considerations must include consideration of flexibility of plan design, employee out-of-pocket costs, and premium. Except as otherwise provided by the sixty-sixth legislative assembly, the contract entered by the board under this subsection is effective for a term of two years and is subject to renewal and rebidding as provided under chapter 54-52.1.

3. A uniform group insurance program contract for hospital, medical, and prescription drug benefits coverage for active employees in effect for the period July 1, 2017, through June 30, 2019, terminates on June 30, 2019, after which the plan entered under subsection 2 becomes effective. Notwithstanding any law to the contrary, the uniform group insurance program contract for hospital, medical, and prescription drug benefits coverage for active employees entered by the retirement board which becomes effective July 1, 2017, is not subject to renewal for an additional two-year term for the 2019-21 biennium.

Vetoed

HB 1023

SECTION 7. PUBLIC EMPLOYEE HEALTH CARE COVERAGE COMMITTEE STUDY - REPORTS.

1. During the 2017-18 interim, the public employee health care coverage committee shall study, review, and make recommendations regarding the terms of the retirement board's requests for proposals for hospital, medical, and prescription drug benefits coverage for active employees for the 2019-21 biennium as required under section 6 of this Act. In making recommendations, the committee shall consider the interests of the state and its eligible employees, including flexibility of plan design, employee out-of-pocket costs, and premium.

2. Before July 1, 2018, and then again before the end of the interim, the committee shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the legislative management, and the legislative management shall report the findings and recommendations to the retirement board, the public employees retirement system, and the sixty-sixth legislative assembly.

Vetoed

HB 1023

SECTION 8. AMENDMENT. Section 54-35-02.4 of the North Dakota Century Code is amended and reenacted as follows:

54-35-02.4. Employee benefits programs committee - Powers and duties.

Vetoed

1. The employee benefits programs committee shall consider and report on ~~those~~ legislative measures and proposals over which it takes ~~its~~ committee exercises jurisdiction and which affect, actuarially or otherwise, the retirement programs of state employees or employees of any political subdivision~~, and health and retiree health plans of state employees or employees of any political subdivision~~ and the uniform group insurance program. The committee shall make a thorough review of ~~any~~a measure or proposal over which ~~it takes under its~~the committee exercises jurisdiction, including an actuarial review. The committee shall take jurisdiction over any measure or proposal that authorizes an automatic increase or other change in benefits beyond the ensuing biennium which would not require legislative approval. The committee ~~must~~shall include in the report of the committee a statement that the proposal would allow future changes without legislative involvement. The committee shall report its

HB 1023 - SECTION 9

54-35-02.9. Public employee health care coverage committee - Appointment.

1. During each interim, the public employee health care coverage committee must be appointed as follows:

   a. Four members of the senate appointed by the majority leader of the senate;

   b. Two members of the senate appointed by the minority leader of the senate;

   c. Four members of the house of representatives appointed by the majority leader of the house of representatives;

   d. Two members of the house of representatives appointed by the minority leader of the house of representatives; and

   e. No more than four nonvoting members appointed by the governor.

2. The legislative management shall designate the chairman of the committee. The committee shall operate according to the statutes and procedure governing the operation of other legislative management interim committees. However, a committee member appointed by the governor is not entitled to per diem and is entitled to mileage and expenses as provided by law for state officers and employees which is to be paid by the governor or by the employing agency if that member is an employee of the state.

3. The committee shall meet at least quarterly during the interim between regular legislative sessions.

Vetoed

HB 1023 SECTION 10

54-35-02.10. Public employee health care coverage committee - Powers and duties - Standing committees - Legislative management.

1. During the interim between regular legislative sessions, the public employee health care coverage committee shall:

   a. Receive from the pubic employees retirement system quarterly reports on the activities of the retirement board and the public employees retirement system relating to the health care coverage, including the status of and any implemented or proposed changes to the health care coverage. The quarterly report must include status reports on contracts and contract negotiations relating to the health care coverage.

   b. Monitor the health care coverage, which may include receipt of public comment at committee meetings, claims experience, utilization data, wellness initiative reports, and customer satisfaction surveys.

   c. Investigate the feasibility and desirability of making changes to the health care coverage and related contracts for future bienniums and prepare and recommend legislation to pursue any recommended changes.

   d. Study the health care coverage contract bidding and renewal process.

   e. Receive reports regarding the impact of federal law on the health care coverage and the impact federal law may have on any proposed changes to the health care coverage.

   f. Before each regular legislative session, receive from the public employees retirement system the executive budget proposals relating to the health care coverage for the upcoming biennium.

   g. Consider and report on legislative proposals sponsored by the executive branch, judicial branch, and legislative management as provided under subsection 2.

   h. Conduct studies as directed by the legislative assembly or the legislative management.

   i. Report to the legislative management the committee's findings and recommendations, along with any legislation necessary to implement the committee's recommendations.

2. During the interim between regular legislative sessions, the committee may solicit draft legislative proposals from the executive branch, judicial branch, and legislative management. A legislative measure affecting the health care coverage may not be submitted by the executive branch, judicial branch, or legislative management for introduction in either house unless the measure is accompanied by a report from the committee. A majority of the members of the committee, acting through the chairman, has sole authority to determine whether a legislative proposal affects the health care coverage.

   a. If the committee determines a legislative proposal affects the health care coverage, either actuarily or otherwise, the committee shall conduct a thorough review of the proposal and shall prepare a report with the committee's recommendation regarding the legislative proposal. The review may include an actuarial report or other report of a third party.

   b. If a legislative proposal for which the committee conducts a review under this subsection is introduced for consideration by the legislative assembly, a copy of the related committee report must be appended to the copy of that measure referred to a standing committee.

   3. To carry out the committee's responsibilities, the committee may:

      a. Through the legislative management, enter a contract with an actuary or actuarial firm or other expert for expert assistance and consultation. The committee shall notify the public employees retirement system of a contract entered under this subsection and, without need for a prior appropriation, the public employees retirement system shall pay the cost of the third-party assistance provided under the contract.

      b. Direct the public employees retirement system to provide the committee with an actuarial report or other analysis. Without the need for a prior appropriation, the public employees retirement system shall pay the cost of the report or analysis.

      c. Call on personnel from state agencies or political subdivisions to furnish the information and render the assistance the committee may from time to time request.

      d. Establish rules for operation of the committee, including the submission and review of legislative proposals and the establishing of standards for actuarial review.

4. During a legislative session, if a standing committee takes action on a legislative measure sponsored by a legislator or recommends an amendment to a legislative measure which would affect the health care coverage, the standing committee shall consider the impact, actuarily or otherwise, of the amendment or measure and may request the public employees retirement system provide an actuarial report or other analysis of the impact of the measure or amendments. If the public employees retirement system provides an analysis or other report under this subsection, the public employees retirement system may pay for the analysis or other report in the same manner as provided under subdivision b of subsection 3.

5. Upon receipt of findings and recommendations of the committee, the legislative management may make recommendations to the retirement board and the public employees retirement system.

6. This section does not require the retirement board or the public employees retirement system to disclose to the committee confidential or exempt information or records. However, upon request of the committee, the retirement board or public employees retirement system shall provide the committee with aggregate information as appropriate.

Vetoed

SPECIAL SESSION?

OTHER

OTHER

- Wellness program
- Life Insurance Benefit (basic coverage, line of duty, occupational hazard, portability, accelerated death benefit)
- 457 Plan

- EAP
- Vision

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● https://ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Sparb

DATE: June 22, 2017

SUBJECT: Planning Meeting

With the change in the Chairman and Trustees new to the NDPERS Board, July would be an appropriate time to hold the annual NDPERS Board Planning Meeting. We propose to hold the Planning Meeting in the Harold Shafer Leadership Center on the campus of the University of Mary on July 20th in place of the regular meeting. We anticipate this will be an all-day meeting and ask that you plan your schedule accordingly.

Further information will be provided at the June meeting.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
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FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● www.nd.gov/ndpers

Memorandum

TO: NDPERS Board

FROM: Sharon Schiermeister

DATE: June 22, 2017

SUBJECT: **Software Maintenance and Support Agreement**

Attached is the agreement with Sagitec Solutions, LLC for software maintenance and support for the 2017-19 biennium. Jan has reviewed the agreement and all recommended changes have been incorporated into this draft. She also confirmed that the Limitation of Liability provisions in Section 8 are what was previously approved by the AG's office and OMB Risk Management and are in compliance with NDCC 32-12.2-15.

The agreement is for licensing fees and application development services. The table below shows a comparison of the fees for the 2015-17 biennium and the 2017-19 biennium. The fees for the new biennium are $30,312 less than with what was approved by the Board last June to include in our budget request. This past session, our operating budget was cut; therefore, we went back to Sagitec and negotiated a discount on the fees that had originally been quoted.

	July 2015-June 2017	**July 2017-June 2019**	**Amount Increase**	**Percent Increase**
Licensing	$447,892	$483,185	$35,293	7.9%
Application Development	$787,042	$932,625	$145,583	18.5%
Total	$1,234,934	$1,415,810	$180,876	14.6%

Board Action Requested:

Approve maintenance and support agreement with Sagitec Solutions LLC.

MAINTENANCE AND SUPPORT AGREEMENT

This Agreement is made as of July 1, 2017 (the “Effective Date”), by and between Sagitec Solutions LLC, with its principal place of business at 422 County Rd D East, Little Canada, MN 55117 ("Sagitec") and the State of North Dakota, acting through its Public Employees Retirement System (NDPERS), 400 East Broadway Avenue, Suite 505, Bismarck, ND 58502 ("Customer").

RECITALS

Customer has licensed certain software products from Sagitec, Customer desires that Sagitec provide certain maintenance and support services with respect to those software products, and Sagitec desires to provide such services to Customer under the terms and conditions of this Agreement.

NOW THEREFORE, in consideration of the covenants set forth herein, it is agreed as follows:

1. DEFINITIONS. The following words, terms and phrases, where written with an initial capital letter will have the meanings assigned to them below:

1.1 “Documentation” will mean the documentation provided by Sagitec with respect to the Products.

1.2 “Product” or “Products” will mean the Sagitec Neospin™ Framework.

1.2.1 “Product Extensions” will mean Sagitec developed tools and accelerators that are made available to clients to support or enhance the Products or derivative products. This includes, but is not limited to, tools and accelerators code named Sagitec Studio, NeoFlow, and NeoCertify.

1.3 “Major Release” will mean a release of Products that contains substantial changes (e.g., an overhaul of the interface, change in compatibility). Major Releases are numbered as X.0

1.4 “Sagitec Point of Contact” will mean the Sagitec point of contact for support services that is identified in Exhibit D to this Agreement.

1.5 “System Requirements” will mean a Sagitec published list of minimum and recommended computer software and/or hardware components necessary for optimal performance of the Products.

1.6 “Statement of Work” means the description of services to be provided by Sagitec under this Agreement, a form of which is attached as Exhibit E to this Agreement.

2. MAINTENANCE AND SERVICES.

2.1 Sagitec will deliver to Customer all updates, modifications and enhancements to the Products and Product Extensions that Sagitec provides to Sagitec customers that receive similar maintenance services for the Products during the term of this Agreement. Upon delivery to Customer, all such updates, modifications and enhancements to the Products and Products Extensions will be deemed part of the Products and subject to the terms and conditions of the Customer’s license agreement that is applicable to the Products.

2.2 Title to and ownership of all rights in and to the Products and Documentation, including copyright and all other intellectual property rights, will at all times remain with Sagitec. The Customer will acquire no right whatsoever to all or any part of the Products or Documentation except the rights granted to the Products and Documentation in accordance with terms and conditions of the licenses granted by Sagitec in its other agreements with Customer.

2.3 Products and Documentation may not be sold, leased, assigned, sublicensed or otherwise transferred, in whole or in part, directly or indirectly. Customer will not modify the Products, attempt to decompile, cross compile, disassemble, reverse engineer, or use any other means to decode the Products, or permit affiliates, contractors, users

or other third parties to do so. No license is granted to use any Products component in source code form. All proprietary and copyright notices must be retained in any copies made of the Products and Documentation.

2.5 As the parties develop projects to be governed by this Agreement, they shall enter into Statements of Work, a form of which is attached hereto as Exhibit E, which shall contain the detailed terms of each project. In the event of a conflict between the terms of this Agreement and any Statement of Work, the terms of this Agreement shall control unless the Statement of Work explicitly states that such conflicting terms in this Agreement shall not apply, but be superseded by the relevant provisions of that Statement of Work for purposes of that Statement of Work.

2.6 Subject to the terms and conditions of this Agreement, Sagitec will provide the services described in the applicable Statement of Work, at the times, in the manner, and at the prices described in the applicable Statement of Work.

2.7 Customer reserves the right to make changes in the Statement of Work at any time during the term of this Agreement. Within five (5) business days following written notice of such proposed changes, Sagitec will provide Customer with reasonable price and schedule changes, if any, resulting from Customer changes to the Statement of Work. Customer may accept or reject Sagitec's proposal to amend the Statement of Work or present a counter-proposal in Customer's sole discretion. Changes to a Statement of Work will be effective only when an authorized representative of each party executes a written amendment to the Statement of Work that sets forth the changes to the services and any related changes to the schedule and charges.

2.8 Sagitec will not subcontract any portion of the work to be performed without the prior written consent of Customer. Sagitec will be an independent contractor in the performance of this Agreement and will not be deemed an employee or agent of Customer for any purpose whatsoever.

2.7 At any time at Customer's request, Sagitec will, at no additional cost, promptly deliver to Customer work in progress and all related information and documentation with respect to the services provided by Sagitec under this Agreement then in Sagitec's possession or control.

2.8 Customer will have the right to interview and approve all Sagitec staff assigned or replaced to the applicable Statement of Work, and to require a criminal background check or proof of a previous criminal background check performed by Sagitec for any of Sagitec's staff members. Sagitec employees, temporary employees and contractors shall sign and be bound by Customer's Confidentiality Agreement.

2.10 Insurance Coverage: Sagitec shall secure and keep in force during the term of this agreement, from insurance companies authorized to do business in North Dakota, the following insurance coverages:

1) Commercial general liability, including contractual coverage, and products or completed operations coverage (if applicable), with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.
2) Professional errors and omissions, with minimum liability limits of $1,000,000 per occurrence and in the aggregate. Sagitec will ensure that this professional errors and omissions coverage remains in effect for a year after the expiration of this Agreement.
3) Automobile liability, with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.
4) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.

2.10.1 General Insurance Requirements. The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies will be the sole responsibility of Sagitec. The amount of any deductible or self-retention is subject to approval by NDPERS.
2. This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than and "A" rating must be approved by NDPERS. The policies shall be in form and terms approved by NDPERS .

3. The State will be defended, indemnified, and held harmless to the full extent of any coverage actually secured by Sagitec in excess of the minimum requirements set forth above. The duty to indemnify the State under this agreement shall not be limited by the insurance required in this agreement.
4. The State of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insured. State must have the same rights and coverages as Sagitec under said policies. The State shall have all the rights and coverages as Sagitec under said policies.
5. The insurance required in this agreement, through a policy or endorsement, shall include:
   a) a "Waiver of Subrogation" waiving any right of recovery the insurance company may have against State;
   b) a provision that the policy and endorsements may not be canceled or modified without thirty (30) days' prior written notice to the undersigned NDPERS representative;
   c) a provision that any attorney who represents NDPERS under this policy must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08;
   d) a provision that Sagitec's insurance coverage shall be primary (i.e., pay first) as respects any insurance, self-insurance or self-retention maintained by State and that any insurance, self-insurance or self-retention maintained by State shall be excess of Sagitec's insurance and will not contribute with it;
   e) cross liability/severability of interest coverage for all policies and endorsements.

6. The legal defense provided to NDPERS under the policy and any endorsements must be free of any conflicts of interest, even if retention of separate legal counsel for NDPERS is necessary.
7. Sagitec shall furnish a certificate of insurance to the undersigned NDPERS representative prior to commencement of this contract. All endorsements shall be provided as soon as practicable. If at any time it is determined necessary by NDPERS's representative/contract administrator, Sagitec shall deliver to NDPERS's representative upon demand a certified copy of any policy required hereunder for review.
8. Sagitec shall disclose to NDPERS insurance coverages of its subcontractors under this Agreement.
9. New insurance shall be promptly furnished in the event of insolvency, bankruptcy, or failure of any insurance company. Sagitec shall notify NDPERS thirty (30) days in advance of any cancellation, termination, or alteration of insurance policies required hereunder. A renewal policy or certificate shall be delivered to NDPERS at least thirty (30) days prior to the expiration date of each expiring policy.
10) If, at any time, any of the policies shall be or become unsatisfactory to NDPERS as to form or substance, or any of the carriers issuing such policies shall be or become unsatisfactory to NDPERS, Sagitec shall promptly obtain a new satisfactory policy in replacement.

3. Product Support Service Level Agreement.

3.1 Sagitec will provide Customer with the Sagitec support services for the Products that are made generally available by Sagitec to its customers that receive support services.

3.2 Sagitec's support staff will be available to assist Customer with general information regarding the configuration, installation and use of the Products during Sagitec's normal hours of technical assistance operation: Sagitec support hours are as described in Exhibit D.

3.3 Sagitec will provide a first level of response to reported Product defects with written acknowledgment of the report that is delivered to Customer by E-mail. Sagitec will provide a second level of response to Product defect reports with a patch, workaround or other temporary resolution to reported Product defects. Sagitec's final response to reported Product defects will be the provision of an update release or version release, an operations process revision, or another official problem resolution. Sagitec will provide Customer with a copy of their support services procedures.

The timing of Sagitec's responses will be based upon the classification of the reported error. Product errors will be classified as follows:

Classification	
P1	Fatal: Errors preventing critical, time-certain work from being done, or site outage.
P2	Severe Impact: Errors that disable major non-critical, non time-certain functions from being performed, or that have a severe site performance impact.
P3	Degraded Operations: Errors disabling or impacting performance only in certain non-essential functions.

Sagitec's responses to such errors will be provided within the following time periods:

Classification	**Sagitec Response**		
	First Level	**Second Level**	**Third Level**
P1	Within 1 hour when reported during Sagitec support hours. Within 2 hours when reported after Sagitec support hours.	Constant effort until relief provided ; resolution must be provided within 48 hours after reported	Within 15 days after reported
P2	Within 2 hours when reported during Sagitec support hours. Within 4 hours when reported after Sagitec support hours.	Within 7 days after reported	Within 30 days after reported
P3	Within 24 hours after reported	Within 14 days after reported	Within 180 days after reported or as agreed to by parties

3.4 Customer acknowledges and agrees that (i) Sagitec and Customer will jointly determine the appropriate level of severity for all reported errors, (ii) Sagitec has no obligation to correct any error that is caused by Customer fault or error, (iii) except as provided above, Sagitec will make reasonable efforts to correct errors that only minimally reduce efficiency or ease of use, and (iv) Sagitec will make reasonable efforts to assist customer to correct errors that result from changes in the operating environment in which the Products are installed.

3.5 Customer product support requests must be submitted to the Sagitec Point of Contact by Customer's individual support contacts.

4. CUSTOMER OBLIGATIONS.

Sagitec's obligations to provide Product support and remedial services under this Agreement are conditioned upon:

(a) the installation and operation by Customer of the most current Major Release(s) of the Products within twelve (12) months of the date the Major Release is made available to Sagitec's Neospin™ client base, unless an alternative date is mutually accepted;

(b) the Customer will provide information that Sagitec requests as deemed necessary to implement the Products and Product Extensions;

(c) the maintenance of an operating environment for the Products that is consistent with the System Requirements associated with each Major Release of the Product as provided by Sagitec; and

(d) Customer providing Sagitec with the access to the Products that is adequate for Sagitec to perform its obligations under this Agreement.

5. ADDITIONAL SERVICES. In addition to the services described in Sections 2 and 3 of this Agreement, Sagitec will provide the Customer selected services described in Exhibit B to this Agreement..

6. SERVICE LIMITATIONS. Maintenance and support services under this Agreement are limited to (i) those described in Exhibit A, and (ii) those described in Exhibit B. Sagitec has no obligation to address issues arising with respect to other products, or errors in the Products that are caused by other products.

7. FEES. Customer will pay the fees described in Exhibit A to this Agreement, at the times provided in that Exhibit A. The fees described in Exhibit A may be adjusted as described by the Credits in Exhibit C to this Agreement. The Credits will be included in the invoice process described in Exhibit A. Sagitec will not be obligated to perform services hereunder should an undisputed payment be more than thirty (30) days overdue. The foregoing will be in addition to, and not exclusive of Sagitec's right to terminate this Agreement in the event of any payment from Customer is overdue.

8. WARRANTY INDEMNIFICATION AND LIMITATION OF LIABILITY.

Limitation of Liability: EXCEPT FOR THE EXPRESS WARRANTIES AND UNDERTAKINGS SET FORTH IN THIS AGREEMENT OR REFERENCED HEREIN, EACH PARTY DISCLAIMS ALL WARRANTIES RESPECTING THE SYSTEM, ALL SERVICES PROVIDED UNDER THIS AGREEMENT, AND THE PARTY'S OBLIGATIONS, INCLUDING ALL IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. Except for direct loss that cannot be limited under NDCC 32-12.2-15, in no event shall Sagitec's liability hereunder exceed the amount paid to Sagitec in the preceding twelve (12) months under this Agreement at the time of the claim.

SAGITEC HEREBY DISCLAIMS ALL EXPRESS OR IMPLIED WARRANTIES WITH RESPECT TO THE PRODUCTS AND SERVICES PROVIDED UNDER THIS AGREEMENT, INCLUDING WITHOUT LIMITATION ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE, FREEDOM FROM INFRINGEMENT OF ANY INTELLECTUAL PROPERTY RIGHTS OF A THIRD PARTY, OR ARISING FROM COURSE OF PERFORMANCE, COURSE OF DEALING OR USAGE OF TRADE.

Indemnification: Sagitec agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions. The legal defense provided by Sagitec to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Sagitec also agrees to defend, indemnify, and hold the State harmless for all costs, expenses and attorneys' fees incurred if the State prevails in an action against Sagitec in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this Agreement.

PRODUCT CONFORMITY: NDPERS has twelve (12) months following final acceptance of the Product(s) delivered by Sagitec pursuant to this Agreement to verify that the Product(s) conform to the requirements of this Agreement and perform according to Sagitec system design specifications. Upon recognition of an error, deficiency, or defect, by NDPERS, Sagitec shall be notified by NDPERS citing any specific deficiency (deficiency being defined as Sagitec having performed incorrectly with the information provided by NDPERS, not Sagitec having to modify a previous action due to additional and/or corrected information from NDPERS). Sagitec, at no additional charge to NDPERS, shall provide a correction or provide a mutually acceptable plan for correction within thirty-days following the receipt of NDPERS's notice to Sagitec. If Sagitec's correction is inadequate to correct the deficiency, or defect, or the error recurs, NDPERS may, at its option, act to correct the problem. Sagitec shall be required to reimburse NDPERS for any such costs incurred (not exceeding the cost paid to Sagitec) or NDPERS may consider this to be cause for breach of Agreement.

LIQUIDATED DAMAGES: The parties agree that NDPERS may suffer damages due to a failure by Sagitec to provide deliverables or services according to the Agreement. Since it is difficult to fix the actual damages sustained in the event of such failure, NDPERS and Sagitec agree that the amount of damages will be determined as per this section. In the event of any non-performance Sagitec shall pay that amount as liquidated damages and not as a penalty. Amounts due to NDPERS as liquidated damages may be deducted by NDPERS from any fees payable to

Sagitec and any amount outstanding over and above the amounts deducted from the invoice will be promptly tendered by check from Sagitec to NDPERS.

1. If Sagitec fails to complete a Deliverable identified in the Statement of Work or in this Agreement, Sagitec shall pay liquidated damages to the NDPERS in the amount of $250 per calendar day for each day the Deliverable is delayed or services fail to perform as per the Agreement. Notwithstanding the foregoing, the amount of liquidated damages charged against the Sagitec for a specific Deliverable shall in no event exceed the total price for such Deliverable. Liquidated damages actually paid by Sagitec to NDPERS are offset against any damages awarded to NDPERS for claims arising from the Deliverable. Notwithstanding the forgoing, liquidated damages will be limited to the delays caused solely by the actions/inactions of Sagitec.
2. Sagitec shall not be charged with liquidated damages when the delay in delivery or performance is beyond the control and without the fault or gross negligence of Sagitec.
3. NDPERS shall notify Sagitec, in writing, of any claim for liquidated damages no later than 15 days prior to the date NDPERS deducts such sums from money payable to Sagitec and, in any case, within 15 days after Sagitec's failure to perform in accordance with the terms of the Agreement.
4. Amounts due to NDPERS as liquidated damage may be deducted by NDPERS from any fees payable to Sagitec and any amount outstanding over and above the amounts deducted from the invoice will be promptly tendered by check from Sagitec to NDPERS.
5. The liquidated damages called for in this section are based upon the inherent uncertainty in determining loss arising from performance of Sagitec and therefore reflect an estimated foreseeable loss to NDPERS arising from Sagitec's performance under this agreement.

9. CONFIDENTIALITY.

The parties agree that all participation by PERS members and their dependents in programs administered by NDPERS is confidential under North Dakota law. Sagitec may request and NDPERS shall provide directly to Sagitec upon such request, confidential information necessary for Sagitec to provide the services described in this Agreement. Sagitec shall keep confidential all NDPERS information obtained in the course of delivering services. Failure of Sagitec to maintain the confidentiality of such information may be considered a material breach of the contract and may constitute the basis for additional civil and criminal penalties under North Dakota law. The provisions of Section 8 apply to the responsibility of Sagitec under this Section. Sagitec has exclusive control over the direction and guidance of the persons rendering services under this Agreement. Upon termination of this Agreement, for any reason, Sagtiec shall return or destroy all confidential information received from NDPERS, or created or received by Sagitec on behalf of NDPERS. This provision applies to confidential information that may be in the possession of subcontractors or agents of Sagitec. Sagitec shall retain no copies of the confidential information. In the event that Sagitec asserts that returning or destroying the confidential information is not feasible, Sagitec shall provide to NDPERS notification of the conditions that make return or destruction infeasible. Upon explicit written agreement of PERS that return or destruction of confidential information is not feasible, Sagitec shall extend the protections of this Agreement to that confidential information and limit further uses and disclosures of any such confidential information to those purposes that make the return or destruction infeasible, for so long as Sagitec maintains the confidential information.

Sagitec shall not use or disclose any information it receives from NDPERS under this Agreement that NDPERS has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this contract or as authorized in advance by NDPERS. NDPERS shall not disclose any information it receives from Sagitec that Sagitec has previously identified as confidential and that NDPERS determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota open records law, N.D.C.C. ch. 44-04. The duty of NDPERS and Sagitec to maintain confidentiality of information under this section continues beyond the term of this contract.

9.1 Compliance with Public Records Law.

Sagitec understands that, except for information that is confidential or otherwise exempt from the North Dakota open records law, NDPERS must disclose to the public upon request any records it receives from Sagitec. Sagitec further understands that any records that are obtained or generated by Sagitec under this contract, except for records that are confidential or exempt may, under certain circumstances, be open to the public upon request under the North Dakota open records law. Sagitec agrees to contact NDPERS immediately upon receiving a request for information under the open records law and to comply with NDPERS instructions on how to respond to the request.

10. TERM AND TERMINATION.

10.1 This Agreement will take effect on the date first written above and will remain in effect for an initial term provided in Exhibit A to this Agreement or until terminated as provided in this Section 10.

10.2 Sagitec may terminate this Agreement, without cause, at any time upon ninety (90) days notice to Customer. Customer may terminate this Agreement, without cause, at any time upon thirty (30) days notice to Sagitec. If Customer terminates this agreement after a Major Release has been successfully implemented, Customer will pay Sagitec the balance of the annual amount (see Exhibit A) minus any credits, within 30 days after termination becomes effective.

10.3 Either party hereto may terminate this Agreement at any time by giving notice in writing to the other party, which notice will be effective upon dispatch, should the other party file a petition of any type as to its bankruptcy, be declared bankrupt, become insolvent, make an assignment for the benefit of creditors, go into liquidation or receivership, or otherwise lose legal control of its business, or should the other party or a substantial part of its business come under the control of a third party.

10.4 Either party may terminate this Agreement by giving notice in writing to the other party in the event the other party is in material breach of this Agreement and fails to cure such breach within thirty (30) days of receipt of written notice thereof from the first. Termination will be in addition to, and not exclusive of other remedies available with respect to the breach.

10.5 Upon the expiration or termination of this Agreement for any reason, (i) subject to any surviving right to use such Confidential Information, and subject to the requirements of the North Dakota open records laws, each party will promptly return all copies of any Confidential Information of the other party then in its possession, or destroy that Confidential Information as mutually discussed and agreed and certify the destruction to the other party, and (ii) the provisions of Sections 1, 2.2, 2.3, 7, 8, 9 and 11of this Agreement will remain in effect in accordance with their terms. In addition, upon the termination of this Agreement by Customer as provided in Section 10.2 above, within thirty days after the effective date of termination Customer will pay Sagitec all of the fees due for services performed prior to the date of termination, that would be payable under this Agreement if this Agreement was not terminated. Nothing in this paragraph shall prohibit Customer from complying with its obligations under any applicable open records law(s).

10.6 Termination for lack of funding or authority. NDPERS may terminate this contract effective upon delivery of written notice to Sagitec, or on any later date stated in the notice, under any of the following conditions:

1) If funding from federal, state, or other sources is not obtained and continued at levels sufficient to allow for purchase of the services or supplies in the indicated quantities or term. The contract may be modified by agreement of the parties in writing to accommodate a reduction in funds.
2) If federal or state laws or rules are modified or interpreted in a way that the services are no longer allowable or appropriate for purchase under this contract or are no longer eligible for the funding proposed for payments authorized by this contract.
3) 1f any license, permit or certificate required by law or rule, or by the terms of this contract, is for any reason denied, revoked, suspended or not renewed.
4) Termination of this contract under this subsection is without prejudice to any obligations or liabilities of either party already accrued prior to termination.

11. GENERAL.

11.1 This Agreement does not make either party the employee, agent or legal representative of the other for any purpose whatsoever, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. Neither party is granted any right or authority to assume or to create any obligation or responsibility, express or implied, on behalf of or in the name of the other party. In fulfilling its obligations under this Agreement, each party will be acting as an independent contractor and retains sole and absolute discretion in the manner and means of carrying out the respective activities and responsibilities under this contract, except to the extent specified in this contract.

11.2 Neither party may assign or transfer its rights and obligations under this Agreement except with the prior written consent of the other party. Sagitec may assign or otherwise transfer its rights and obligations under this Agreement to another entity under direct control of Sagitec without prior notice to or the consent of Customer. Any prohibited assignment will be null and void. Sagitec may subcontract all, or any portion of the services provided under this Agreement, but will remain responsible for the Services subcontracted.

11.3 Notices permitted or required to be given hereunder will be deemed sufficient if given by (i) registered or certified mail, postage prepaid, return receipt requested, addressed to the respective addresses of the parties that are set forth below, (ii) fax to the respective fax numbers of the parties that are set forth below, or (iii) email to the respective addresses of the parties that are set forth below. Notices given by mail will be effective upon the earlier to occur of receipt by the party to which notice is given, or on the fifth (5th) business day following the date such notice was posted. Notices by fax will be effective on the day a confirming communication is received from the recipient of the notice. Notices by email will be effective on the second (2d) business day after dispatch.

Notices to Sagitec will be sent to:	Notices to Customer will be sent to:
Sagitec Solutions LLC 422 County Rd D East Little Canada, MN 55117	_____ _____ _____
Attn: Rick Deshler	Attn: _____
Fax Number: _____ Email Address: rick.deshler@sagitec.com	Fax Number:_____ Email Address: _____
With a copy to:	With a copy to:
Timothy Keller Lindquist & Vennum PLLP 4200 IDS Center 80 South Eighth Street Minneapolis, MN 55402	_____ _____ _____
Attn: Timothy Keller	Attn: _____
Fax Number: 612-371-3207 Email Address: tkeller@lindquist.com	Fax Number: _____ Email Address: _____

11.4 This Agreement together with Exhibits attached to this Agreement, (i) constitutes the entire agreement between the parties with respect to the subject matter hereof, (ii) supersedes any and all other agreements between the parties related thereto, as well as all proposals, oral or written, and all negotiations, conversations or discussions between the parties related to this Agreement, except the agreements noted in Section 2.2 and 2.3 above,, (iii) may not be altered, amended or otherwise modified without the written agreement signed by the parties hereto, and (iv) may be executed in two or more counterparts, each of which will be deemed an original hereof. No product or service specifications, or terms and conditions that are additional or contrary to the terms of this Agreement, whether contained in any purchase order or other communication from Customer or any third party, will be construed as, or constitute a waiver of these terms and conditions, or acceptance of any such additional terms, conditions or specifications. Sagitec hereby rejects and objects to such additional or contrary terms, conditions or specifications.

11.5 No failure by either party to take any action or assert any right hereunder will be deemed to be a waiver of such right.

11.6 If any of the terms of this Agreement are in conflict with any rule of law or statutory provision or otherwise unenforceable under the laws or regulations of any government or subdivision thereof, such terms will be deemed stricken from this Agreement, but such invalidity or unenforceability will not invalidate any of the other terms of this Agreement and this Agreement will continue in force, unless the invalid or unenforceable provisions comprise an integral part of, or are otherwise inseparable from, the remainder of this Agreement.

11.7 This Agreement will be governed by, and interpreted and construed in accordance with, the laws of the State of North Dakota, excluding its conflicts of law provisions. Any action to enforce this contract must be adjudicated exclusively in the State District Court of Burleigh County, North Dakota.

11.8 ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL: NDPERS does not agree to any form of binding arbitration, mediation, or other forms of mandatory alternative dispute resolution. The parties have the right to enforce their rights and remedies in judicial proceedings. NDPERS does not waive any right to a jury trial

11.9 FORCE MAJEURE - Sagitec shall not be held responsible for delay or default caused by fire, flood, riot, acts of God or war if the event is beyond Sagitec's reasonable control and Sagitec gives notice to NDPERS immediately upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default.

11.10 NONDISCRIMINATION AND COMPLIANCE WITH LAWS - Sagitec agrees to comply with all laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. Sagitec agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes and unemployment compensation and workers' compensation premiums. Sagitec shall have and keep current at all times during the term of this contract all licenses and permits required by law.

11.11 NDPERS AUDIT - All records, regardless of physical form, and the accounting practices and procedures of Sagitec relevant to this contract are subject to examination by the North Dakota State Auditor,the Auditor's designee, or Federal auditors. Sagitec shall maintain all such records for at least three years following completion of this contract and be able to provide them at any reasonable time. State, State Auditor, or Auditor's designee shall provide reasonable notice.

11.12 TAXPAYER ID - CONTRACTOR'S federal employer ID number is: 20-0970684

11.13 EFFECTIVENESS OF CONTRACT – This Agreement is not effective until fully executed by both parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be duly executed.

SAGITEC SOLUTIONS, LLC	CUSTOMER
By_____	By _____
Name _____	Name _____
Title_____	Title _____
Date_____	Date _____

EXHIBIT A

FEES AND PAYMENT

PRODUCT SERVICES FEE
Customer will pay Sagitec the fixed amount of $483,185 for Product Services as described in Exhibit B. This services fee includes a one-time discount of $10,616.

The license fee shall be divided into 24 equal monthly installments of $20,132.71. Services fees will be due and payable within thirty (30) days after the date of Sagitec's invoice.

This fee is effective starting on July 1, 2017 and shall continue through June 30, 2019, unless terminated earlier. If Customer terminates this agreement during mid-year, Customer will pay Sagitec the balance of the fixed amount (see above) minus any credits, within 30 days after termination becomes effective. Sagitec may increase the fee upon the renewal process with the Customer. Sagitec shall notify Customer of any proposed annual increase no later than 90 days prior to the renewal of this agreement for the following year.

APPLICATION DEVELOPMENT OUTSOURCING (ADO) FEE
Customer will pay Sagitec the fixed amount of $932,625 for Application Development Services for the period July 1, 2017 through June 30, 2019. This fixed amount for Application Development Services includes a one-time discount of $19,696.

The ADO fee shall be divided into 24 equal monthly installments of $38,859.38. ADO fees will be due and payable within thirty (30) days after the date of Sagitec's invoice.

Should Customer decide to purchase additional ADO services on a cost-plus basis, the following hourly rates shall apply:

	2017	2018	2019
On Site Resources	$260	$270	$280
Off Site Resources	$160	$170	$180

Hourly rates do not include travel and expenses and are subject to change depending on prevailing market conditions. Sagitec will provide discounted rates for blocks of hours over 1,000.

EXHIBIT B

PRODUCT AND APPLICATION DEVELOPMENT OUTSOURCING SERVICES

PRODUCT SERVICES

For this agreement, NDPERS shall receive services as follows:

- All major and minor Product releases
- Product installation and configuration services
- Enrollment as Beneficiary to Standard Escrow Agreement
- A technical and business overview of the new features of the Product and Product Extensions and implementation pre-requisites prior to the implementation of the Product.
- Enterprise licenses to Product Extensions
- Product Service Desk (e.g. Help Desk) –Non-dispatched service assistance or resolution delivered via phone, e-mail and/or on-line communication.
- Dedicated service desk and account manager

APPLICATION DEVELOPMENT OUTSOURCING (ADO) SERVICES

Sagitec shall provide one (1) onsite resource for up to 1,800 hours, and three (3) offsite full-time equivalent (FTE/1800 hours) for corrective, adaptive, preventative and perfective support activities to be directed by NDPERS.

Hours spent on enhancements to the mobile application, MOBIAS, will also be charged against the ADO hours above.

EXHIBIT C

CREDITS

1. Failure to meet P1 level response times - credit equal to one hundred percent (100%) of the fees due for the calendar month in which the failure occurs.

2. Failure to meet P2 level response times - credit equal to twenty-five percent (25%) of the fees due for the calendar month in which the failure occurs.

3. Failure to meet P3 level response times -a credit equal to ten percent (10%) of the fees due for the calendar month in which the failure occurs.

4. Failure to fulfill Sagitec's agreed upon implementation responsibilities within the Product implementation timeline as stated within the Statement of Work for that project – credit equal to one hundred percent (100%) of the fees due for the calendar month in which the failure occurs. This credit will continue to be applied on a monthly basis until the Product is successfully implemented.

5. Failure to provide complete Documentation to the Customer within 1 month after completion of the Product implementation, or an alternate date as mutually agreed upon – credit equal to one hundred percent (100%) of the fees due for the calendar month in which the failure occurs. This credit will continue to be applied on a monthly basis until the complete Documentation is provided to the Customer.

6. The maximum credit with respect to each calendar month will be the fees due with respect to that calendar month.

7. Customer will receive a credit only once with respect to any reported error, without regard to additional response time failures with respect to that error.

NDPERS SLA EXHIBIT D

POINT OF CONTACT

Vasudevan Sridharan is assigned as the Sagitec Point of Contact to the Customer. All costs for work performed by this person are included in this Agreement.

Support Hours: 8:00a to 5:00p Central Time, Monday through Friday, exclusive of United States Federal holidays as published by the U.S. Office of Personnel Management

NDPERS SLA EXHIBIT E

FORM OF STATEMENT OF WORK

[This form to be completed and executed for each services engagement.]

Introduction

This Statement of Work No. _____ ("SOW") is delivered in accordance with that certain Service Level Agreement (the "Agreement") dated _____, by and between Sagitec and Customer. This SOW is subject to all the terms and conditions of the Agreement.

Objectives

[Describe the project objectives]

Staffing

[Describe who will be involved in the project]

Statement of Tasks

[Describe the services to be performed including Start Criteria, Deliverable Descriptions, Acceptance Criteria, Work Scheduling and Tracking, Post Implementation, Roles and Responsibilities, Confidentiality, Project Plan and implementation timeline, etc.)

System Requirements

[Describe the system requirements for the project]

Assumptions and Dependencies

[List any applicable assumptions and dependencies for this project]

Statement of Cost

[Specify the project cost, payment schedule, and/or fees, if applicable]

Additional Terms and Conditions

[List any additional terms and conditions that are applicable for this project]

Acceptance and Authorization

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • PO Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS-INFO@ND.GOV • www.nd.gov/ndpers

MEMORANDUM

TO: NDPERS Board

FROM: Jamie Kinsella

DATE: May 23, 2017

SUBJECT: **Audit Committee and Internal Audit Charter Activity Review**

The Audit Committee Charter states that it will "17. Confirm annually that all responsibilities outlined in this charter have been carried out. Report annually to the Board, members, retirees and beneficiaries, describing the committee's composition, responsibilities and how they were discharged, and any other information required by rule, including approval of non-audit services." To meet this requirement a matrix was developed to review activities for calendar year 2016 to ensure that the audit committee has met its responsibilities.

Similarly to the Audit Committee Charter, a matrix was developed for the Internal Audit Charter to review activities for calendar year 2016 to ensure internal audit has met its responsibilities.

The attached copies were provided to the audit committee at their May meeting for review. This is for your information.

Internal Audit Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
RESPONSIBILITIES AND ACCOUNTABILITY				
The Internal Audit Manager is responsible for the following in order to meet the mission, objectives and scope of this Charter and the Internal Audit Division:				
1. Select, train, develop and retain a competent internal audit staff that collectively has the abilities, knowledge, skills, experience, expertise and professional certifications necessary to accomplish the mission, objectives and scope of this Charter. Provide opportunity and support for staff obtaining professional training, professional examinations, and professional certifications.	Provide a minimum of 40 hours CPE annually/120 every three years for those with the CIA designation and 20 hours annually/120 hours every three years for those with the CPA designation for each certified staff member.	Seminars/ Conferences	Annually	Internship Work Plan for FY 2017 has been submitted to HRMS. Intern (part-time position) hired 2/2016 to assist with projects. Internship ended 4/2017. Completed 84 hours CPE. Jamie earned 43.5 and Julie 40.5 hours.
2. Establish policies for conducting its activities and directing its technical and administrative functions according to the organization's policies and direction provided by the Audit Committee, and professional standards.	Develop and maintain Internal Audit Manual	Internal Audit Manual	Review annually for revisions in December	There were no policy revisions in 2016. IA Manual has not been updated since December 2007 due to PERSLink. Due to time constraints intern was unable to start review in 2016.
3. Conduct an annual risk assessment and produce a flexible audit plan that will accomplish the mission, objectives and scope of this Charter. This plan will include some unassigned hours in order to provide flexibility for changing conditions. This plan shall in part be based upon risks and control concerns identified by Management. This plan will be periodically updated as necessary.	Conduct and evaluate risk assessment with management. Develop audit plan.	Internal Audit Plan	Annually in October	Risk Assessment for the Agency will be transitioning to the COO. IA will work with COO in developing the process. IA plans to perform an independent fraud risk assessment of the Agency. Limited time spent in this area due to other priorities. Developed audit plan for 2016-2017 based on results of risk assessment and discussion with management.
4. Prepare a time budget that is complementary to the implementation of the audit plan.	Estimate time needed to perform projects.	Internal Audit Plan	Annually in October	Budget was presented with the 2016-2017 audit plan in November 2015.
5. Implement the annual audit plan, as approved, including, as appropriate, any plan amendments, special tasks or projects requested by Management and the Audit Committee.	Conduct audits. Provide updates to AC.	Audit Reports Memos	As audits are completed.	Audits are completed as required, with reports provided to staff, management and the AC.
6. Coordinate with audit clients to finalize recommendations for improvement and identify implementation timelines. Internal audit staff shall consider costs and benefits while formulating and	Audit reports.	Audit Reports	As audits are completed.	Worked with management to complete outstanding and new audit recommendations in a timely manner.

Internal Audit Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
discussing their recommendations.				
7. Evaluate and assess significant merging/consolidating functions and new or changing services, processes, operations, and control processes coincident with their development, implementation, and/or expansion.	Audit reports.	Audit Reports	As audits are completed.	Project mostly completed in 2010. Current role is evaluating PERSLink system when errors are found during audit to determine if problem lies with PERSLink.
8. Conduct periodic follow-up reviews to evaluate the adequacy of Management's corrective actions.	Review quarterly with management status of audit findings	Quarterly Audit Findings Report	Quarterly	A quarterly audit recommendations report is updated by appropriate staff prior to the audit committee (AC) meetings.
9. Issue periodic reports to the Audit Committee and Management summarizing results of audit activities, and summarizing the status of follow-up activities.	Update reports to present at audit committee meetings	Audit/ Project Report, Findings Update Report	Quarterly	A quarterly internal audit report is updated prior to the AC meeting and provided in the AC agenda.
10. Provide periodic summaries of consulting and advisory activities to the Audit Committee.	Write memos/Report	Memo/Report	Quarterly	A quarterly internal audit report is updated prior to the AC meeting and provided in the AC agenda.
11. Attend all Audit Committee meetings, and ensure attendance of additional staff and attendance by auditees as appropriate.	Provide agenda for the AC, and others.	Audit Agenda	Quarterly	Quarterly meetings were scheduled, held, and attended by all appropriate personnel and the AC.
12. Obtain a peer review by other internal auditors as required by professional standards, no less frequently than every five (5) years as mandated by the IIA's *International Standards for the Professional Practice of Internal Auditing.*	Send out a Request for Proposal for a consultant Select consultant	Report	Every 5 years	This responsibility has not been accomplished to date due to time constraints. Audit reports do not state the audits were "conducted in conformance with the *International Standards for the Professional Practice of Internal Auditing"* as it is allowed only if the results of the quality assurance and improvement program support the statement.
13. Inform the Audit Committee of emerging trends and successful practices in internal auditing.	Read publications for emerging trends	Provide copies of publications/ speakers	Quarterly	Publications are provided to the AC when they become available.

Internal Audit Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
14. Assist in the investigation of significant suspected fraudulent activities within the organization and notify the Audit Committee, the Executive Director and Management, as appropriate, of the results.	Determine concerns with management Conduct review as determined	Report to management	As needed	There were none in 2016.
15. Consider the scope of work of the external auditors and regulators, as appropriate, for the purpose of providing optimal audit coverage to the organization at a reasonable overall cost.	Review selected external auditor's proposal for audit work, and discuss with external auditors how to provide audit coverage.	Memo to Audit committee	Annually	Worked with external auditors during 2016, scheduling meetings and office space. Provided requested information for audit as well as for GASB 67/68.
16. Evaluate annually the quality of the annual financial report and suggest improvements in the presentation and disclosures.	.			Reviewed FY 2016 financial statements when the financial statements were compiled.
17. Report to the Audit Committee on all activities and associated costs of work performed by the external financial statement auditors.		Report	Quarterly	Reported to Audit Committee in May, August and November of the external auditors' activities.
18. Consult with the organization's management, as requested, on potential policy and procedure changes.	Meet with management, review potential policy and procedure changes.	Report	As needed	Conducted consultation as needed.
19. Participate, in an advisory capacity, in the planning, design, development, and implementation and modification phases of major information related systems to determine whether: • Adequate controls are incorporated in the systems; • Adequate risk management techniques have been utilized; • Thorough systems testing is performed at appropriate stages; • Systems documentation is complete and accurate; and • The intended purpose and objectives or the system implementation or modifications have been met.	Educate management of the Internal Audit's responsibility in this area. Ensure Internal Audit is included in meetings related to this project. Participate in an advisory capacity only.	Provide report to audit committee	Quarterly	Project mostly completed in 2010. Quarterly reports to the audit committee are no longer necessary as they were updates on the project. Current role is evaluating PERSLink system when errors are found during audit to determine if problem lies with PERSLink. If there is an issue it is noted as part of the audit workpapers and audit report.

Internal Audit Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
20. Participate in professional audit organizations by attending meetings, joining the governing boards, presenting speeches and papers, and networking with other professionals. Network with internal audit staff of other public pension systems to learn and exchange best practices information. Participate in other professional organizations related to the mission of the organization.	Join organizations pertinent to Internal Auditing	Membership to APPFA and IIA	Annually	Renewed memberships to APPFA, IIA, and NDSCPA as they became due. Attended IIA luncheons where speakers are in attendance.
21. Act as the primary point of contact for handling all matter related to audits, examinations, investigations or inquiries of the State Auditor or other appropriate State or Federal Auditors.	Notify State Auditor's Office and External Auditor's of who is the primary contact	RFP/Contract		Worked as liaison with CliftonLarson Allen auditors.
22. Review the organization's fraud policy and ethics policy periodically.	Review the fraud and ethics policy for current trends and propose updates if needed.	Report to AC	As needed	Fraud policy is not in existence at NDPERS. Due to time constraints this has not been implemented.
STANDARDS OF AUDIT PRACTICE				
The Internal Audit Division shall follow the professional standards of relevant professional organizations. These include, but are not limited to, the following:				
➢ International Standards for the Professional Practice of Internal Auditing and the Code of Ethics of Institute of Internal Auditors (IIA).	Comply with the *Standards* as applicable to the IA division.	Review the *Standards* to determine if in compliance.	Periodically.	Did not review in 2016 in its entirety, however did refer to it for specific issues where necessary.
➢ American Institute of Certified Public Accountants (AICPA) Professional Standards and Code of Ethics, as applicable.				
➢ Generally Accepted Government Auditing Standards (GAGAS) from the United States General Accounting Office (GAO), as applicable.				

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
Audit Committee Charter Review Matrix
For Year Ending December 31, 2016

J. Kinsella
05/23/2017

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
STRUCTURE				
1. The audit committee (AC) will consist of two to five members with the majority of the members selected from the Board of Directors, and one may be selected from outside the organization. The Board or its nominating committee will appoint committee members and the committee chair.	The Board of Directors determines who will serve on the AC when they are assigning committees.	Indicate in AC meeting minutes whenever a new member is appointed.	Whenever there is a change in AC members.	No changes to AC during 2016.
2. The Board should attempt to appoint committee members who are knowledgeable and experienced in financial matters, including the review of financial statements.	Ascertain that at least one member of the AC is knowledgeable and experienced in financial matters, including the review of financial statements.	Indicate in AC meeting minutes which member of the AC is knowledgeable and experienced in financial matters, including the review of financial statements.	Whenever there is a change in board members.	No changes were made to the Board during 2016.
MEETINGS				
3. The AC will meet as often as it determines is appropriate, but not less frequently than quarterly. All committee members are expected to attend each meeting, in person or via tele- or video-conference, with a minimum of two required for a quorum.	Hold meetings at least once each quarter.	Prepare minutes that document decisions made and action steps following meetings and review for approval. Meeting minutes should be filed with the board of directors.	Quarterly, or more often if necessary, but no later than prior to the next meeting.	Meeting minutes for 3/10/16, 5/18/16, 8/31/16, and 11/16/2016 were prepared and presented for approval at the next quarterly meeting. These minutes are made available on the NDPERS web site after approval. The approved minutes are reported to the board at the next board meeting.
4. All committee members are expected to attend each meeting, in person or via tele- or video-conference.	Accommodations should be made available to committee members to encourage attendance.	Note in the AC meeting minutes the members who were in attendance at the meeting.	Quarterly, or more often if necessary, but no later than prior to the next meeting.	All AC members were in attendance at all meetings.
5. The committee periodically will hold individual meetings with management, the internal auditor and the external auditor.	Establish these sessions in conjunction with quarterly meetings or as necessary.	Contact appropriate people to arrange time for meetings.	Annually, or more often if necessary.	An individual meeting with the Internal Auditor was held 3/10/16. On 11/16/16, the AC met with the external auditors separately. They also reviewed the audit report.
6. The AC may invite any officer or employee of the agency, the	Establish these sessions in conjunction with quarterly	Contact appropriate people to arrange time for meetings.	Annually, or more often if necessary.	Bryan Reinhardt, Manager, Benefit Program Development and Research

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
external auditor, the agency's outside counsel, or others to attend meetings and provide pertinent information.	meetings or as necessary			was invited and spoke at the August 2016 meeting, providing the committee an update on the Loss Control Committee activities.
7. Meeting agendas will be prepared by the Chief Audit Executive (CAE) and provided in advance to members, along with appropriate briefing materials.	The agendas for meetings should be prepared and provided to members in advance, along with appropriate briefing materials.	Prepare and provide meeting agenda, previous meeting minutes, and appropriate briefing materials to members in advance.	Quarterly, or more often if necessary	Meeting agendas were mailed to the AC on 3/02/16, 5/11/16, 8/24/16, and 11/9/2016.
8. Minutes will be kept by a member of the AC or a person designated by the AC.	Designate the appropriate person to keep the minutes of meetings.	Prepare minutes documenting decisions made and future action steps and review for approval at the next meeting.	Quarterly, or following each meeting.	The Internal Audit Manager provides meeting minutes to the administrative assistant to prepare for the next quarterly meeting. These minutes were provided to the AC at the next quarterly meeting for their approval. See #3.
9. Members of the audit committee will be compensated for attendance at committee meetings in accordance with NDPERS' policy for compensation in effect at the time for Board members. Audit Committee members who are not NDPERS board members will be compensated at the same rate.	A memo with the date and length of time of the AC meeting is provided to the NDPERS Payroll Administrator for payment.	Prepare memo with attendance information and length of meeting time following meeting and deliver to payroll administrator.	Quarterly following each AC meeting.	Memo was provided to Payroll Administrator following each meeting with required information.
AUTHORITY				
10. The AC has authority to conduct or authorize examinations into any matters within its scope of responsibility. It is empowered to: ➢ Seek any information it requires from NDPERS employees, external auditors, consultants, and external parties. All parties are directed by the Board to	Please see the responsibility section for more information.	Please see the responsibility section for more information.	Please see the responsibility section for more information.	Please see the responsibility section for more information.

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
cooperate with the Committee's requests. ➢ Oversee the work of all external auditors employed by the organization. ➢ Assist in resolving any disagreements between management and the external auditors regarding financial reporting, if necessary. ➢ Oversee the retention of independent counsel, accountants or others to advise or assist the Committee in the performance of its responsibilities. ➢ Approve the consultants, or others retained by the organization to assist in the conduct of an audit, review, and/or a special investigation. ➢ Meet with management, external and internal auditors, or outside counsel as necessary.				

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
RESPONSIBILITIES				
11. The AC will carry out the following responsibilities:				
1) Financial Reporting:				
a. Obtain information and/or training to enhance the committee members' expertise in financial reporting standards and processes so the committee may adequately oversee financial reporting.	Provide information related to financial reporting standards and processes to the AC. Bring external auditors in to explain new changes to accounting reporting and how they impact NDPERS.	Articles, publications, external auditors, speakers with information regarding changes to accounting rules.	Quarterly, or as they become available.	Articles from the Institute of Internal Auditors are provided as they become available.
b. Review significant accounting and reporting issues, including complex or unusual transactions and highly judgmental areas, recent professional and regulatory pronouncements, and understand their impact on the financial statements.	Review with management and AC any proposed significant adjustments.			External auditors provided the statement of management responsibility and reviewed with staff prior to commencement of audit.
c. Review with management, the external auditors, and the internal auditors the results of the external audit, significant adjustments or revisions to the financial statements, including attestation on the effectiveness of the internal control structure and procedures for financial reporting and any difficulties encountered.	Review management letter with management and AC. Ensure the external auditors provided the statement of management responsibility and review with them.	Submit annual audit reports and any audit findings and their status at the November AC meeting.		External auditors discussed with the staff/AC significant accounting and reporting issues as they develop.
d. Inquire as to the external auditors' independent				

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
judgment about the appropriateness, not just the acceptability, of the accounting principles adopted by the organization and clarity of financial statements.				
e. Review the annual financial statements, consider whether they are complete, consistent with information known to the Committee, and reflect appropriate accounting principles.	Invite the external auditors to present the financial statements upon completion of their audit.	Audited Financial Statements, including the Independent Auditor's Report, management Discussion and Analysis, financial Statements, Required Supplementary Information, Supplementary Information, Independent Auditor's Report on Internal Control over Financial	Annually	Staff reviewed the annual financial statements for completeness, consistency of information and accounting principles. External audit firm presented the financial statements and associated reports to the AC at the November 2016 meeting.
f. Review with management and the external auditors all matters required to be communicated to the Committee under generally accepted auditing standards.	Inquire of management and external auditors if there are any matters required to be communicated to the committee under GAAS.	Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Governmental Auditing Standards, and Special Comments Requested by the Legislative Audit and Fiscal Review Committee.		
g. Review the responsiveness and timeliness of management's actions to address findings and recommendations resulting from the financial statement audit or internal audits.	Provide a quarterly audit recommendation report to the AC.	Audit Recommendation Report	Quarterly	A report of all audit recommendations is provided to the AC quarterly, with a progress update for each audit issue.

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
h. Review with the General Counsel the status of legal matters that may have an effect on the financial statements, as deemed appropriate.	Bring to the General Counsel's attention any legal matters that may have an effect on the financial statements. AC should ask of management if the annual financial statements are complete.		As needed.	There were no legal matters relating to financial statements.
2) Risk Management				
a. Obtain information and/or training to enhance the Committee's understanding of organization and its related risk management processes.	Provide the AC members with information regarding risk management.	Articles, publications, etc. relating to risk management.	Quarterly.	Articles, publications, etc. relating to risk management are provided as they become available.
b. Review the adequacy of the organization's policy on risk management.	Review risk management policy periodically.	Current risk management policy and most recent information relating to risk management.	As needed	It is required by Risk Management of OMB to have a Loss Control Committee. The Chairperson presented an overview of the committee at the August 2016 meeting. In addition, quarterly agendas and minutes of the Loss Control Committee were provided to the Audit Committee at each meeting.
c. Review the effectiveness of the organization's system for assessing, monitoring, and controlling significant risks or exposures.	Create a portfolio that documents the material risks that the agency faces. Update as events occur. Review with management and the CAE periodically to make sure it is up-to-date.			
d. Review management's reports on risks and related risk mitigations.	Provide AC a summary of results of self-assessment of risks, and how these risks are mitigated. Provide the AC information on how external and internal audit review risk management over financial reporting.	Submit a risk report including mitigation strategies and quantifiable risks and insurance to cover such risks, e.g., loss of business.		Risk Assessment for the Agency will be transitioning to the COO. IA will meet with COO to assist her in developing the process IA plans to perform an independent fraud risk assessment of the Agency. Limited time spent in this area due to other priorities.

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
e. Hire outside experts and consultants in risk management, as necessary, subject to full board approval.	Develop a request for proposal if an outside expert is deemed necessary.			
3) Internal Control a. Obtain information and/or training to enhance the Committee's understanding of the organization's system of internal control. b. Consider the effectiveness of the organization's internal control system, including information technology security and control. c. Understand the scope of the external auditor's review of the organization's internal control over financial reporting. d. Review internal and external audit findings and recommendations, together with management's responses.	Provide the AC members with information regarding internal control process. Review periodically the policy on internal controls, ethics, code of conduct and fraud. Review the reports of the internal audit team for all audits completed since the prior AC meeting. Review key internal controls with the CAE, and understand how these controls will be tested during the year. Determine that all internal control weaknesses are quantified, reviewed, and addressed. Review these plans with the independent auditor to understand their scope with respect to key controls	Report to the board on issues relating to internal controls, with emphasis on management's ability to override and related monitoring and testing.	Quarterly for all activities as needed.	Information relating to internal control is provided as they become available. Internal periodic reviews on ethics, code of conduct and fraud have not been conducted consistently. These issues are addressed during the benefit programs, business processes, accounting functions and enterprise risk management assessments. Internal controls are reviewed as part of each audit project and/or special examinations. External auditors conduct a review of internal accounting controls annually. There have been no areas of concern as a result of these reviews. Internal audit includes a review of internal controls as part of each audit, consulting project, and/or special examinations.

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
4) Internal Audit				
a. Obtain information and/or training to enhance the Committee's understanding of the internal audit function.	Provide information and/or training.		As they become available.	Articles are provided to Audit Committee when available.
b. Periodically review and approve the Internal Audit Division Charter.	Review charter periodically. Assess the suitability of each point in the charter based on past experiences (since the last review). Evaluate completeness of the charter against best practices and legal or regulatory requirements. Revise charter as needed and obtain AC and Board approval for changes.	Revised Internal Audit Charter, as needed.	As needed.	A revised Internal Audit charter was approved by the board 9/18/2008. No changes were made since. IA charter was not reviewed during 2016 due to time constraints.
c. Concur in the appointment, replacement, or dismissal of the CAE.	Hold special meetings as necessary to address appointment, reassignment, or dismissal of CAE.		As needed.	
d. Review the performance of the CAE and the internal audit function annually.	Meet annually with other members of executive management and the external auditors to discuss the performance of CAE. Discuss job satisfaction and other employment issues with the CAE.	Job performance review.	Annually	A performance review was written by the Executive Director and approved by the AC in June 2016.
e. Review and confirm, through organizational structure and/or by other means, the independence of the internal audit function annually.		Various documentation	Annually	No change in internal auditors this period. No change in reporting structure this period. Structure is in a accordance with best practices.

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
f. Review with management and the CAE the charter, objectives, plans, activities, and organizational structure of the internal audit function.			As needed.	
g. Review and approve the risk-based internal audit annual plan.	Review and approve Annual audit plan	Annual audit plan	Annually in the Fall	An update was given to AC on progress regarding the 2016-2017 Internal Audit Plan in November 2016.
h. Review internal audit reports provided to the audit committee.	Review all internal audit reports provided. Maintain workload project management worksheet, audit recommendation worksheets	Report on the status of all current internal audits and audits planned for the next quarter and/or year.	Quarterly	Reports were reviewed at each AC meeting.
i. Review the responsiveness and timeliness of management's follow-up activities pertaining to any reported findings and recommendations.	Provide a quarterly audit recommendation report to the AC.	Provide quarterly audit recommendation report	Quarterly	A report of all audit recommendations was provided to the AC quarterly, with a progress update for each audit issue.
j. Bring to the attention of the Board any internal audit issues the Committee determines significant and appropriate for consideration by the Board.	The AC chair should be available if any unforeseen issues arise between meetings relating to the CAE.		As needed.	AC Chair is available at all times if needed.
k. On a regular basis, meet separately with the CAE to discuss any matters the committee or internal audit believes should be discussed privately (subject to open meeting laws).				Private meeting with Internal Audit Manager was held March 2016.
l. Designate the CAE as the primary point of contact for				The Internal Audit Division is the primary contact for the external

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
handling all matters related to audits, examinations, investigations or inquiries of the state auditor and other state or federal agencies.				auditors, and coordinated all matters to the 2016 financial audits.
5) Engagement of External Auditors				
a. Obtain the information and/or training to enhance the Committee's understanding of the organization's financial statements audit and the role of external auditors.	Provide the AC members with information regarding the selection of the external audit firm(s).	Document the meeting in the AC meeting minutes.	Provide information and training as needed.	The contract is for the fiscal years ending June 2015 through June 2017;
b. Review the performance of the external financial statement audit firm, and review the State Auditor's recommendation for the final approval on the request for proposal for, and the appointment, retention or discharge of the audit firm. Obtain input from the CAE, management and other parties as appropriate.	Provide input on the external audit performance to the State Auditor's Office. Provide input to the State Auditors Office on the request for proposal for the appointment of the next audit firm.		Every three years	Input was provided in November 2014 to the State Auditor's Office on the RFP for the 2015-2017 contract period.
c. Review the external auditor's audit scope and approach, including coordination of efforts with internal audit.	Meet with independent audit partner, the accounting manager and CAE to discuss scope of the previous year's audit, and lessons learned. Later, discuss planned scope for audit of current year.		Annually	No meeting held (2016 is the second year of a 3 year contract).
d. Review the independence of the external auditors by obtaining statements from	Obtain from external audit firm and/or management any documentation of any		Annually	Not performed (2016 is the second year of a 3 year contract).

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
the auditors on relationships between the auditors and the organization for all audit and non-audit services.	activity or issues between the audit firm and organization if information should be provided to the AC.			
e. On a regular basis, meet separately with the external financial statement audit firm to discuss any matters the committee or auditors believe should be discussed privately (subject to open meeting laws).	Review at the exit conference with management, and again with the AC. Provide opportunity at the time external auditors are at meeting to present audit report.	Annual financial audit report presentation	Annually	The AC did meet separately with the external auditors to discuss the FY 2016 audit report.
	Provide a quarterly report to the board of all external audit costs.	Consultant Fees report		Quarterly consultant reports are provided to the Audit Committee when they are available.
6) Compliance a. Review the effectiveness of the organization's system for monitoring compliance with laws and regulations, contracts, and policies and the results of management's investigation and follow-up (including disciplinary action) of any instances of noncompliance.	Review the reports of compliance with laws and regulations. Discuss compliance issues and resolutions.	Record discussion and any action steps in the AC meeting minutes.	Review as necessary.	Compliance with laws and regulations are reviewed for each specific audit by both the external auditors and internal auditors. Any concerns will be brought before management, the AC and/or board as necessary.
b. Review the findings of any examinations by regulatory agencies, any auditor observations related to compliance, and the responsiveness and timeliness of management's actions to address the	Report to AC as necessary.	Report to AC at meeting, if matters arise.	As they occur.	

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
findings/observations. c. Obtain updates from management and organization legal counsel regarding compliance matters, as needed.	Report to AC as needed.	Report to AC of changes in laws, regulations and rules.	As they occur.	There were none during 2016.
7) Special Investigations and Whistleblower Process a. Institute and oversee special investigations, as needed. b. Ensure the creation and maintenance of an appropriate whistleblower mechanism for reporting any fraud, noncompliance, and/or inappropriate activities. c. Retain independent counsel, accountants, or other specialist to advise the Committee or assist in the conduct of an investigation, subject to full board approval.	Review procedures with CAE and the general counsel. Review all complaints that have been received and the status of resolution. . Ensure proper steps are taken to investigate and resolve complaints timely.	Review an original of each complaint received, no matter the media used to submit. Discuss the status or resolution of each complaint. Review a cumulative list of complaints submitted to date to review for patterns or other observations.	Review at each meeting.	There were none during 2016.
8) Other Responsibilities a. Report at least annually to the Board of Directors the Committee activities, audit issues, and related recommendations.	Submit AC meeting minutes to the board after AC approval.	Submit AC meeting minutes after AC approval to the board for their next meeting.	Following each AC meeting provide the approved AC minutes to the Administrative Services Manager to include in the next board meeting materials.	Copies of the AC minutes are provided to the board after the AC's approval of the minutes.
b. Confirm annually all responsibilities outlined in this charter have been	Utilize a matrix to determine if all responsibilities outlined in	An AC Charter review matrix will be updated each year and presented to the AC to	Annually.	

Audit Committee Charter Objective	Steps to Accomplish the Objective	Deliverable	Achieve (Frequency Due Date)	Status
carried out. Review and assess periodically the adequacy of the Committee charter, request Board approval for proposed changes, and ensure appropriate disclosure as may be required by law or regulation.	the charter are carried out.	present a report to the Board for approval.		
c. Evaluate the Committee's performance and report the results of the evaluation to the Board annually.		Report to the board on the appropriateness of the AC charter and any revisions recommended.	Annually.	An updated AC review matrix was provided to the AC at the March 2016 meeting.
d. Provide an open avenue of communication between the internal auditors, external auditors, management and the Board.	Have at minimum annual meeting with internal auditor, external auditor, management, and Board of Directors to discuss issues.			
e. Avoid conflicts of interest, paying strict attention to board matters.	Require staff to sign off on ethics/code of conduct and fraud policy annually during their performance reviews.	Review signed form stating the employee read the policies		NDPERS' policy is to have staff review and sign off annually on ethics/code of conduct during their annual performance evaluations
f. Perform other activities related to this Charter as requested by the Board.	Review charter periodically. Assess the suitability of each point in the charter based on past experiences Evaluate completeness of the charter against best practices and legal or regulatory requirements. Revise charter as needed and obtain AC and Board approval for changes.		As needed.	AC Charter was reviewed, updated, and approved by the board December 2014.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • PO Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
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FAX: (701) 328-3920 • EMAIL: NDPERS-INFO@ND.GOV • www.nd.gov/ndpers

MEMORANDUM

TO: NDPERS Board

FROM: Jamie Kinsella

DATE: May 23, 2017

SUBJECT: **March 8, 2017 PERS Audit Committee Minutes**

Attached are the approved minutes from the March 8, 2017 meeting. Those who attended the meeting are available to answer any questions you may have.

The minutes may also be viewed on the NDPERS web site at www.nd.gov/ndpers.

The next audit committee meeting is currently scheduled for August 16, 2017 at 10:00 a.m. in the NDPERS Conference Room.

Attachment

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Public Employees Retirement System
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Bismarck, North Dakota 58502-1657

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MEMORANDUM

TO: Audit Committee
Jon Strinden
Arvy Smith
Pamela Anderson
Rebecca Dorwart

FROM: Jamie Kinsella, Internal Auditor

DATE: March 29, 2017

SUBJECT: **March 8, 2017 Audit Committee Meeting**

In Attendance:
Jon Strinden
Arvy Smith
Rebecca Dorwart
Representative Pamela Anderson
Jamie Kinsella
Julie McCabe
Sharon Schiermeister
Derrick Hohbein
Sparb Collins

The meeting was called to order at 12:07 p.m.

I. November 16, 2016 Audit Committee Minutes

The audit committee minutes were examined and approved by the Audit Committee.

II. Internal Audit Reports

A. Quarterly Audit Plan Status Report – A summary of the internal audit staff time spent for the past quarter was included with the audit committee materials. Of the total hours reported, 49.18% was spent in audit and 10.87% in consulting. This is in line with the audit plan of 50-60% auditing and 5-10% consulting.

Discussion followed. Suggestion was made to develop a target or goal for benefit calculation accuracy. Management will work on this.

B. Outstanding Issues Status Report – As stated in the Audit Policy #103, the Internal Audit Division is to report quarterly to management and the audit committee the status of the audit recommendations of the external auditors as well as any found by the internal auditor. The report has been updated to reflect what has been accomplished during November 1, 2016 through January 31, 2017.

Sharon stated currently IT resources are being used where they can get the most value. When they are completed the outstanding issues will then be addressed.

C. Benefit/Premium Adjustments Report – The quarterly benefit adjustment report was provided to the audit committee. The report is in two sections, Retirement and Insurance. This report has 12 retirement adjustments. The adjustments resulted from a variety of reasons as shown on a report to the committee.

III. Administrative

A. Audit Committee Meeting Date & Time - The next audit committee meeting is scheduled for May 17, 2017 at 10:00 a.m.

IV. Miscellaneous

A. Retirement Payment Status Report (Sharon) - The Refunds, Retirement & RHIC Benefits Payment Status Report will be presented at the May meeting.

B. Travel Expenditures Update - The travel expenditures incurred by the Board and/or Executive Director for out-of-state travel for the period November 1, 2016 through January 31, 2017 were provided to the committee.

C. Risk Management Report - The Loss Control Committee provides quarterly to the Audit Committee a copy of the Loss Control Committee's agenda from their last meeting as well as the approved minutes. Copies of the September 8, 2016 minutes and the agenda for the December 7, 2016 meeting were provided to the audit committee.

D. Report on Consultant Fees - According to the Audit Committee Charter, the audit committee should "Periodically review a report of all costs of and payments to the external financial statement auditor. The listing should separately disclose the costs of the financial statement audit, other attest projects, agreed-upon-procedures and any non-audit services provided." A copy of the report showing the actuary/consulting audit, legal, investment and administrative fees paid during the quarter ended December 2016 was attached for the audit committee's information.

E. Publications – The February 2017 publication of the Tone at the Top was provided to the audit committee for their perusal.

Meeting adjourned at 12:35 p.m.