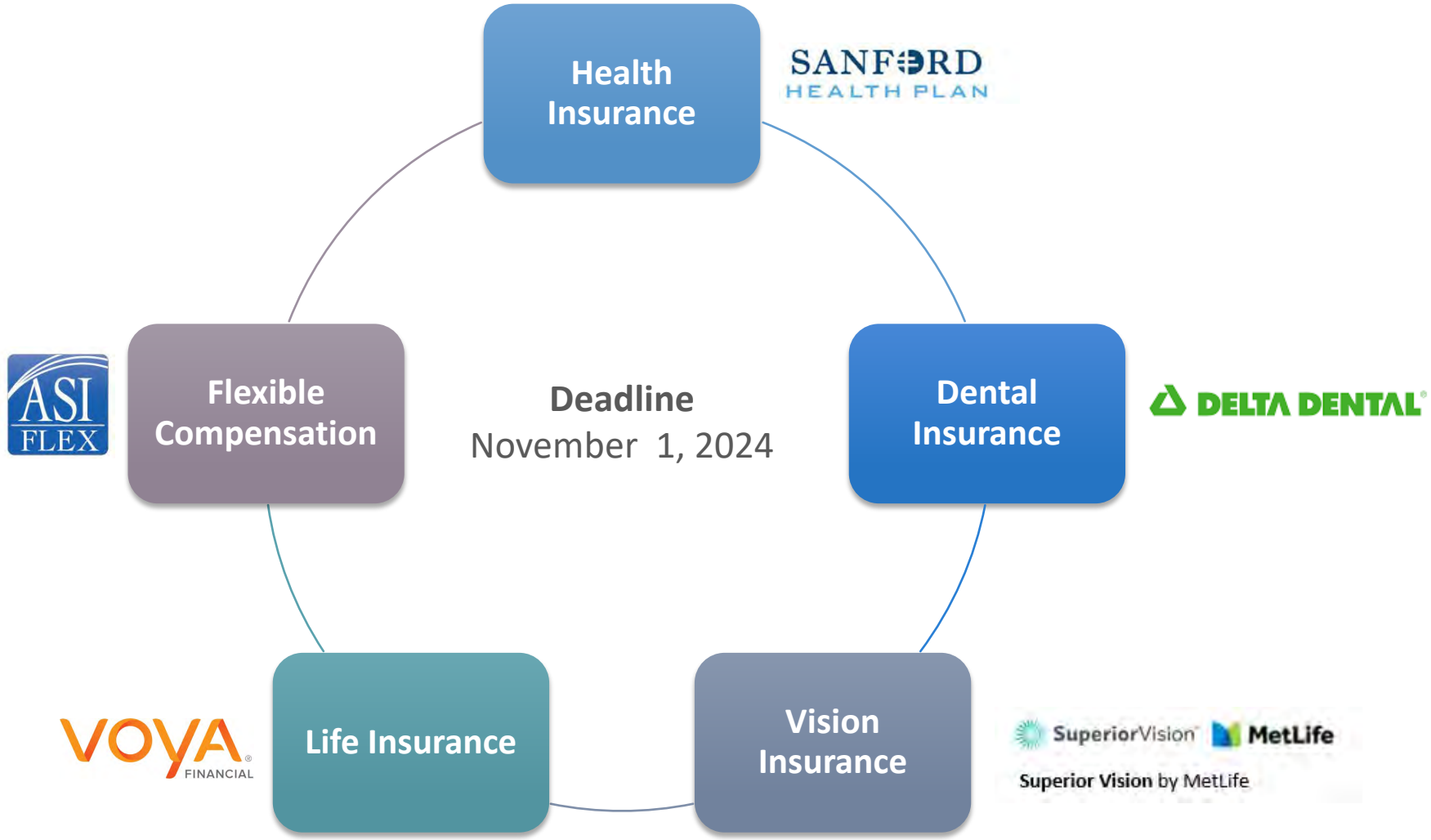
NDPERS Annual Enrollment

Update your benefit elections for 2025 starting Monday, October 14 through Friday, November 1, 2024

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Five Insurance Plans

Update your insurance plans elections for 2025 in NDPERS Member Self Service (MSS) starting October 14 through November 1, 2024



NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Health Insurance

Consult your family financial planner to discuss which plan (coverage) is best for you.

Dakota Plan

- **Basic**
  - Coverage for services received in North Dakota not provided by a PPO provider
  - Out-of-state services
- **Preferred Provider Organization (PPO)**
  - Coverage for services received in North Dakota provided by a PPO provider
  - Less out-of-pocket expense

High Deductible Health Plan (HDHP)

- Includes Health Savings Account (HSA)

SANFORD HEALTH PLAN

HDHP Facts

- Higher annual deductible and out-of-pocket costs
- Includes HSA
- Preventive services covered as designated by Affordable Care Act (ACA)

HSA Facts

- Helps cover medical expenses until your annual deductible and out-of-pocket maximum are met
- HSA funds do not expire

NDPERS High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

Contributions to Health Savings Account

State employees: Monthly employer paid contribution

- **Single:** $101.74
- **Family:** $246.16

2025 IRS Limits for HSA Contributions

Coverage	Annual Limit	NDPERS Contribution*	Max Employee Contribution
Single	$4,300	$1,220.88	$3,079.12
Family	$8,550	$2,953.92	$5,596.08
55+ *(Single or Family)*			$1,000 extra

*The NDPERS Contribution amounts are subject to change July 1 of odd years based upon premiums for the new contract period.

Vision Insurance

- Premiums can be pre-taxed.

Employee only	$ 5.03
Employee & spouse	$10.06
Employee & child(ren)	$ 9.16
Family	$14.19

Vision Plan Coverage

Benefits through Superior National network

	In-network	Out-of-network
Exam (ophthalmologist)	Covered in full	Up to $45 retail
Exam (optometrist)	Covered in full	Up to $45 retail
Frames	$100 retail allowance	Up to $47 retail
Contact lens fitting (standard[2])	Covered in full	Not covered
Contact lens fitting (specialty[2])	$100 retail allowance	Not covered
Lenses (standard) per pair		
Single vision	Covered in full	Up to $35 retail
Bifocal	Covered in full	Up to $50 retail
Trifocal	Covered in full	Up to $70 retail
Progressives lens upgrade	See description[3]	Up to $70 retail
Contact lenses[4]	$100 retail allowance	Up to $100 retail

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses*

[2] *Standard contact lens fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty contact lens fitting applies to new contact wearers and/or a member who wear toric, gas permeable, or multi-focal lenses.*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay.*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit*

No waiting periods!

Dental Insurance

- **NDPERS dental insurance carrier is Delta Dental of Minnesota.**
- Premiums can be pre-taxed.

Employee only	$ 42.24
Employee & spouse	$ 81.50
Employee & child(ren)	$ 94.62
Family	$134.74

- TIP: *Total Dental Administrators* (TDA) is <u>not</u> the NDPERS Dental Plan provider. **You <u>cannot</u> enroll in TDA through NDPERS Member Self Service.**

Dental Plan Coverage

Covered Services	Dental Benefit Plan Coverage		
	Delta Dental PPO™	Delta Dental Premier®	Non-Participating*
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Space Maintainers Sealants	100%	100%	100%
Basic Services Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) and posterior (back) teeth	80%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
Major Restorative Crowns and Crown repair	50%	50%	50%
Prosthetic Repairs and Adjustments Denture adjustments and repairs	80%	80%	80%
Prosthetics Dentures (full and partial) Bridges	50%	50%	50%
Orthodontics Treatment for the prevention/ correction of malocclusion Available for dependent children only, ages 8 and up	50%	50%	50%

Dental Plan Coverage

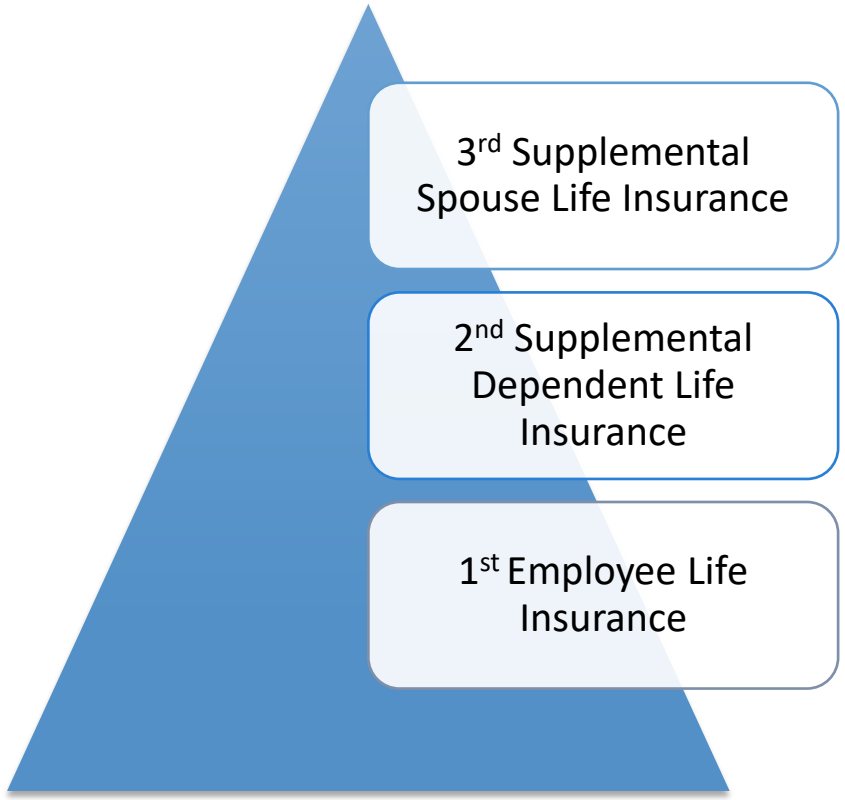
Plan Benefit Highlights			
Network(s)	**Delta Dental PPO™**	**Delta Dental Premier®**	**Non-Participating***
Calendar Year Plan Maximum Per person	**$1,000**		
Lifetime Ortho Maximum Per eligible covered person	**$1,500**		
Deductible Per person per calendar year No deductible for diagnostic and preventive services or orthodontics	**$50 per person**		
Eligible Dependents	**Spouse** **Dependent children up to age 26**		

Dental & Vision Insurance Participation Policy

If you enroll in the vision or dental insurance plan(s), you are required to remain in the plan through the calendar year.

You can only discontinue participation during the year if you terminate employment.

Levels of Life Insurance



VOYA FINANCIAL

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

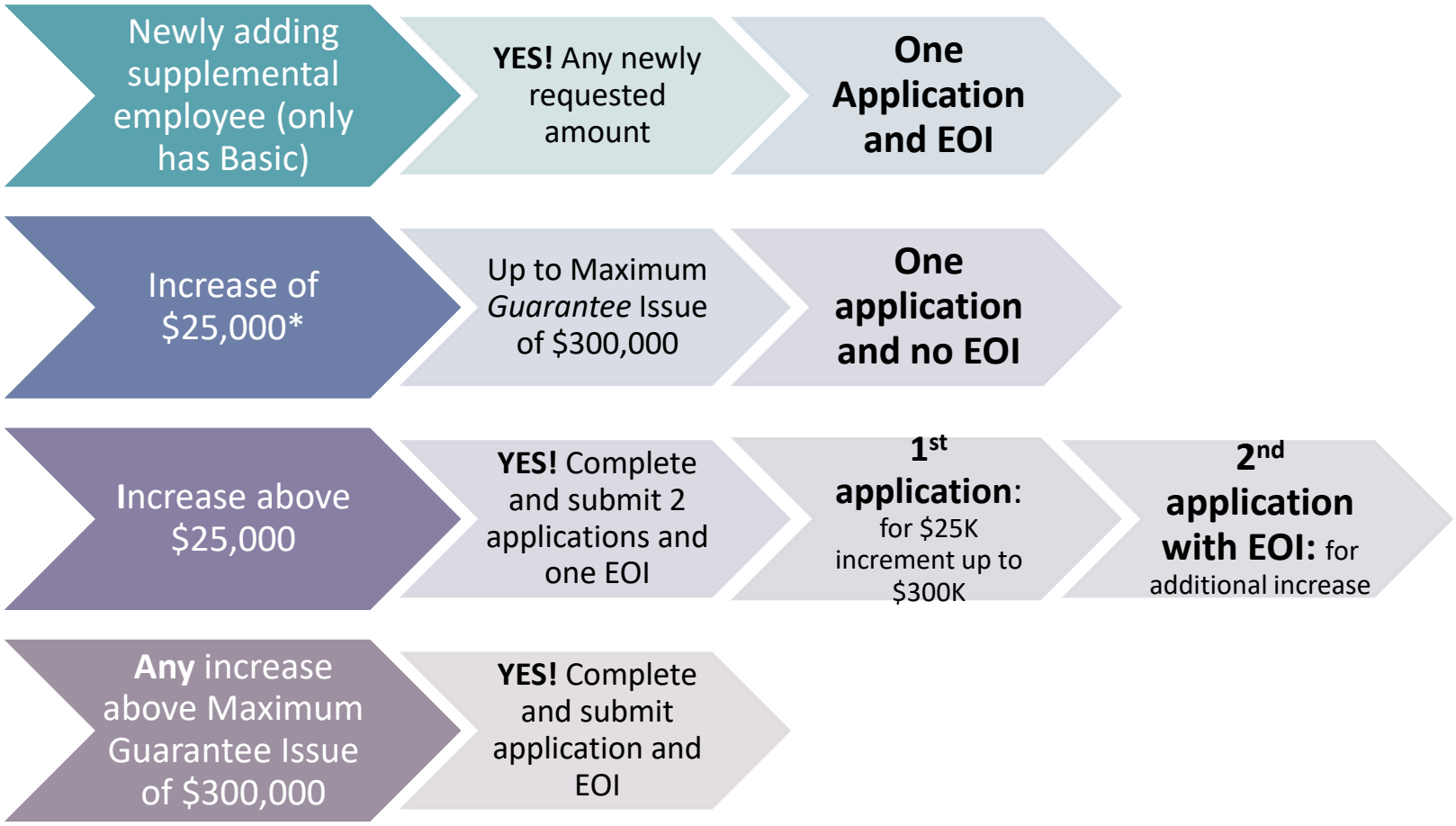
Employee Life Insurance

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Life Insurance

Evidence of Insurability (EOI) and Supplemental Employee Life Insurance

Understanding which increase options require an EOI for Supplemental Employee Life Insurance



NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Coverage Options for Spouse and Children

Supplemental Dependent - Spouse and/or Child(ren)

- $2,000, $5,000, $7,000 or $10,000

Supplemental Spouse – Spouse only

- Up to 50% of Supplemental Employee

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Coverage Options for Spouse and Children

Supplemental Dependent - Spouse and/or Child(ren)

- $2,000, $5,000, $7,000 or $10,000

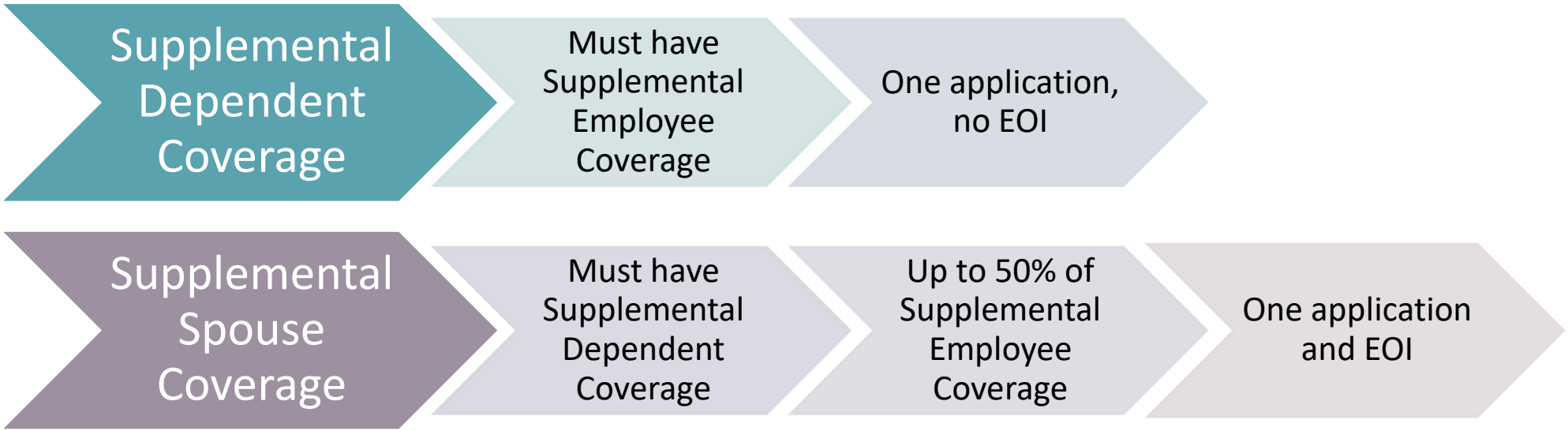
Supplemental Spouse – Spouse only

- Up to 50% of Supplemental Employee

Life Insurance

Evidence of Insurability (EOI) and Supplemental Dependent and Spouse Life Insurance

Options to increase and understanding which options require an EOI:



NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

When is the Evidence of Insurability (EOI) required?

- Evidence of Insurability is required for the following situations:
  - Newly adding supplemental employee life insurance for the first time (currently have Basic $12,000 only)
  - Increasing existing supplemental employee life insurance by more than $25,000
  - Requesting total supplemental employee life insurance higher than the guarantee issue of $300,000 (up to $600,000)
  - Newly adding supplemental spouse life insurance for the first time
  - Increasing existing supplemental spouse life insurance (any amount)

How do I complete the EOI?

- Form available on NDPERS website: https://www.ndpers.nd.gov/sites/www/files/documents/forms/active-life/life-evidence-of-insurability.pdf
- Complete Sections A, C (if applicable), D, and E (3 pages total)
  - **NDPERS will complete Section B**
- Complete Authorization for Release of Health-Related Information
- **Return completed EOI and Release to NDPERS.** NDPERS will send to the carrier for processing.
- VOYA outreach:
  - By phone if an appointment is needed for additional screening
  - Send letters in the mail requesting additional information or documentation
  - Inaction or unresponsiveness may result in request being denied

RESET FORM

EVIDENCE OF INSURABILITY (ND)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
PO Box 20, Medical Underwriting, Minneapolis, MN 55440
Phone: 855.817.1665 Fax: 612.467.8721

Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number 673897 Account Number 0001 Employer Name NDPERS

Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Personal Email Address _____ Birth Date _____

Address _____ City _____ State ____ ZIP _____

Home Phone (____) _____ Cell Phone (____) _____

Hire Date _____ Salary $_____ Occupation _____

Primary Health Practitioner _____ Practitioner Phone (____) _____

Practitioner Address _____ City _____ State ____ ZIP _____

B. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
☐ Employee Supplemental Life	$	$	$	$
☐ Spouse Supplemental Life	$	$	$	$

C. SPOUSE INFORMATION

Spouse Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Personal Email Address _____ Birth Date _____

Home Phone (____) _____ Cell Phone (____) _____

☐ Same Primary Health Practitioner as Employee *(See information above.)*

Primary Health Practitioner _____ Practitioner Phone (____) _____

Practitioner Address _____ City _____ State ____ ZIP _____

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION *(HIPAA compliant)*

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")

PROPOSED INSURED INFORMATION *(Please print.)*

Proposed Insured Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

Birth Date *(mm/dd/yyyy)* _____

AUTHORIZATION INFORMATION

This will authorize a physician, clinic or hospital to release medical information to the Life Insurance Carrier(s) named above (the "Company"), or its reinsurers.

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I authorize any organization, insurance company or medically related facility to release to the Life Insurance Carrier named above any and all records and information regarding me, the proposed insured, and any minor children who are to be insured according to the terms of this authorization. This includes records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions or prescription records; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency/Carrier(s) named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I authorize MIB, LLC to give to the Life Insurance Carrier(s) named above (the "Company"), or its reinsurers, any records or knowledge of me or my health.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency/Carrier(s) may provide the information to the listed carrier(s) so that they may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Insurance Agent/Agency/Carrier(s).

I give my permission to the Life Insurance Carrier named above to send any information obtained to MIB, LLC or its reinsurers.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency/Carrier(s) named above at the following address: **Attention:** Privacy Official, 250 Marquette Ave, Suite 900, Minneapolis, MN 55401

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by any applicable state privacy laws, state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

➥ Proposed Insured Signature _____ Date *(mm/dd/yyyy)* _____

➥ Authorized Signer *(if Proposed Insured is a minor)* _____ Date *(mm/dd/yyyy)* _____

Description of Personal Representative's Authority or Relationship to Proposed Insured:
☐ Attorney in Fact ☐ Grandparent ☐ Guardian ☐ Parent ☐ Other _____

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PROPOSED INSURED.

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Flexible Compensation "FlexComp"

Three ways to participate

Medical Flexible Spending Account (FSA)

- Set aside up to $3,200
- Not available if enrolled in HDHP

Dependent Care Flexible Spending Account (FSA)

- $5,000 maximum (for a married couple filing a joint tax return or a single parent)
- $2,500 maximum (for a married couple filing separate tax returns)

Pre-tax eligible insurance premiums

- Dental & Vision Insurance
- Other optional insurance products
- Life Insurance
  - First $50,000 of employee supplemental pre-taxed automatically

Permanent employees of a state agency or participating district health unit are eligible to participate. This excludes employees of the ND University System.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Ask your HR representative

Use NDPERS Resources starting Monday, October 14

Questions?

Contact Information

- Call us at 701.328.3900 or toll-free at 800.803.7377
- Email at ndpers-info@nd.gov
- Send a message through Member Self Service (MSS)
- Visit us at https://www.ndpers.nd.gov/