NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Board Meeting Agenda

Location: WSI Board Room, 1600 East Century Avenue, Bismarck ND
By phone: 701.328.0950 Conference ID: 501 960 686#
Date: **Tuesday, October 8, 2024**
Time: 8:30 A.M. Click here to join the meeting

I. MINUTES
- A. September 10, 2024

II. CONFLICT OF INTEREST DISCLOSURE CONSIDERATION

III. PRESENTATIONS
- A. House Bill 1040 Overview – Marcy

IV. DEFINED CONTRIBUTION PLAN IMPLEMENTATION
- A. House Bill 1040 Implementation Update – Rebecca (Information)

V. DEFINED BENEFIT
- A. Asset Liability Study Contract - Katheryne (Board Action)

VI. DEFERRED COMPENSATION / DEFINED CONTRIBUTION
- A. Investment Summary Options Book – Katheryne (Information)

VII. GROUP INSURANCE / FLEXCOMP
- A. Life Insurance Plan Contract Amendment –Katheryne (Board Action)
- B. 2023 Active Health Care Report – Katheryne (Information)
- C. FlexComp Plan Document – Lindsay (Board Action)
- D. Insulin/Diabetic Supplies Report and Recommendation – Rebecca (Information)
- E. Sanford Health Plan Update on Humira – Rebecca (Information)

VIII. OPERATIONS / ADMINISTRATIVE
- A. Collection Services – Derrick (Board Action)
- B. Budget Request for Data Integrity Dashboard – Derrick (Board Action)
- C. Contracts Under $10,000 – Rebecca (Information)
- D. Board Meetings During Legislative Session and Quorum Requirement – Rebecca (Board Action)
- E. Next Meeting Date: 10/29/2024 (4th Tuesday)

IX. MEMBER *EXECUTIVE SESSION
- A. Unforeseeable Financial Hardship Case # 884 -- Marcy (Board Action)

*Executive Session pursuant to N.D.C.C. §44-04-19.2, §44-04-19.2(1) and/or §54-52-26 to discuss confidential records or confidential member information.

House Bill (HB) 1040

WHAT YOU NEED TO KNOW

Agenda

1. What is HB 1040?
2. Difference between a Defined Benefit and Defined Contribution Plan
3. Eligibility Criteria for Special Election
4. Electing to Transfer from Main to Defined Contribution
   - Special election window details
     - HOW WILL THE TRANSFER WORK?
     - ACCOUNT BALANCE
     - INCENTIVE FAQ
5. New Defined Contribution 2025 Plan
6. Funding of the Main Defined Benefit Plan

Part 1: Closes the Main Retirement Plan to [Political Subdivisions & State] new hires, first enrolled, on or after January 1, 2025, **and** creates a special election window for eligible [State] employees to change plans

Part 2: Establishes Tier 3 in the NDPERS Defined Contribution Plan

Part 3: Defines how the Main Defined Benefit Plan will be funded

What is HB 1040?

Part 1

Defined Benefit (DB)	Defined Contribution (DC)
Monthly benefit (pension) is guaranteed for life	Benefit is determined by your investment strategy
Funds are invested on your behalf	You and your provider map your investment strategy
Monthly benefit based on the benefit formula – not how much is in your account	Stream of income is your choice and is subject to your account balance
Employee contributions (member account) - 100% vested on day one! **Employer** contributions – Cliff vesting – all or nothing! must have 36 months of service OR turn age 65 while actively employed Note: most NDPERS Defined Benefit Plans have a vesting period of 36 months – excludes Judges, Bureau of Criminal Investigation(BC) and Highway Patrol (HP)	**Employee** contributions (member account) - 100% vested on day one! **Employer** contributions -Gradual Vesting 2 years – 50% 3 years – 75% 4 years – 100% Note: an employee is 100% vested in employer contributions if turns age 65 while actively employed

Differences between Defined Benefit & Defined Contribution

Eligibility Criteria for Special Election

- ☑ Actively employed with a State governmental unit
- ☑ First enrolled in the Main Plan before 1/1/2025
  Main does not include Public Safety, Judges, National Guard, Bureau of Criminal Investigation (BCI), Highway Patrol
- ☑ Have no more than 5 years of service on 1/1/2025 *(includes service credit purchases)*

How are 5 years defined?

The 5 years of service are **cumulative**.

Example:

- Member had 2 years of service more than 5 years ago, switched jobs but left the money intact in their PERS Main
- They returned to an eligible State Employer 2 years ago
- Never purchased service credit
- That is 4 years of service

☑Eligible for Special Election

How are 5 years defined?

The 5 years of service are **cumulative**.

Example:

- Member had 2 years of service more than 5 years ago, switched jobs and took their money out of the plan when leaving
- They returned to an eligible State Employer 2 years ago
- Purchased 60 months of service credit
- That’s 7 years of service

NOT Eligible for Special Election

When will eligible members be notified?

Goal: December 2024

More details to come

Electing to Transfer from Main to DC

HB 1040 Special Election Window

January 1, 2025, through March 31, 2025, for eligible State Employees

Election Window Details

- January 1, 2025, through March 31, 2025.
- Eligibility Criteria applies: **Employees of State governmental units** with no more than 5 years of service.
- Choice to move from their existing Main Plan Tier (1, 2, 3) to the corresponding DC Tier (1 or 2).
- Financial incentive to transfer.
- This transfer is **not the HB 1040 DC 2025 Tier 3** available to those first enrolled on or after January 1, 2025.
- This opportunity is **not available to employees of political subdivisions** or state employees with more than 5 years of service.

Main	Contribution Rate	Vesting Schedule	Lifetime Benefit
Main Tier 1 Prior to Jan 2016	7% EE 8.12% ER 1.14% RHIC	36 months	Final Average Salary **x** Years of Service **x** Benefit Multiplier
Main 2016 Tier 2 January 2016 to December 2019			

These plans have Retiree Health Insurance Credit (RHIC) upon retirement

DC	Contribution Rate	Vesting Schedule	Benefit
DC Tier 1 Prior to January 2020	7% EE 7.12% ER 1.14% RHIC	Less than 2 years: 0% 2 years: 50% 3 years: 75% 4 years: 100%	Based on your investment strategy

Main	Contribution Rate	Vesting Schedule	Lifetime Benefit
Main 2020 Tier 3 January 2020 to December 2024	7% EE 9.26% ER NO RHIC	36 months	Final Average Salary **x** Years of Service **x** Benefit Multiplier

These plans are not RHIC eligible

DC	Contribution Rate	Vesting Schedule	Benefit
DC 2020 Tier 2 January 2020 to December 2024	7% EE 8.26% ER NO RHIC	Less than 2 years =0% 2 years =50% 3 years = 75% 4 years = 100%	Based on your investment strategy

What amount will transfer?

Special Election transfers on or after January 1, 2025, until March 31, 2025.

Transfer amount based on the actuarial equivalent of the accrued benefit.

NDPERS plans to provide eligible members projections between the Main and Defined Contribution Plan in November 2024.

Incentive FAQ

EMPLOYMENT: Must be employed by an **eligible state agency** at the time the installment payment is due.

TRANSFER: If the state employee transfers to a political subdivision or terminates employment before the first incentive installment is to be paid, they will not receive any of the incentive payment.

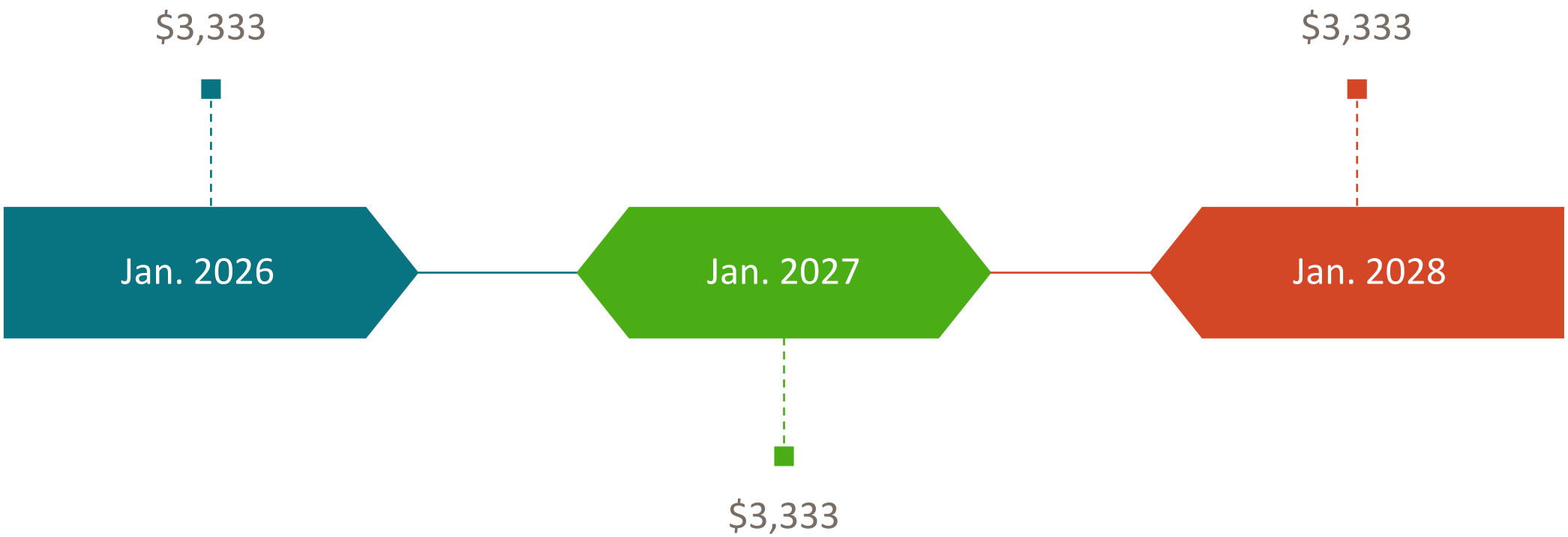
NOT A CASH INCENTIVE: The incentive payment is paid into the Employer contribution “bucket” in the member’s DC plan account.

4 YRS: The employer contribution vesting schedule to receive 100% of the employer funds is 4 years of service credit. Main service is transferred to the DC Plan for vesting purposes.

Note: an employee is 100% vested in employer contributions if turns age 65 while actively employed.

Incentive: NOT CASH

Three pre-tax installments totaling $9,999



Employee must maintain eligibility for the incentive each calendar year through active eligible state employment or incentive will be forfeited. No proration.

FYI

- Future communications will provide more information.
- NDPERS cannot advise members.
- Consult their financial advisor.

Part 2: Establishes Tier 3 in the NDPERS Defined Contribution Plan

What is HB 1040?

Part 2

Mandatory Participation in the DC2025, Tier 3

Must be 18 years of age, regularly funded, permanent employee working at least 20/20.

Note: Like today, temporary employees or regularly funded, permanent working fewer than 20/20, can voluntarily participate at their own expense within first 180 days.

Newly Enrolled = does not have an existing, intact NDPERS Main Defined Benefit (DB) plan.

If ‘new hire’ has left previous NDPERS Main DB plan intact, will be grandfathered under the plan they left intact.

Excludes: All other NDPERS Defined Benefit Plans (Public Safety, BCI Law Enforcement, National Guard, Judges, Highway Patrol).

Defined Contribution Plan 2025, Tier 3

Minimum Contributions

- 4.00% Employee

Vesting

- 100% Vesting in **Employee** Contributions

- 5.26% Employer

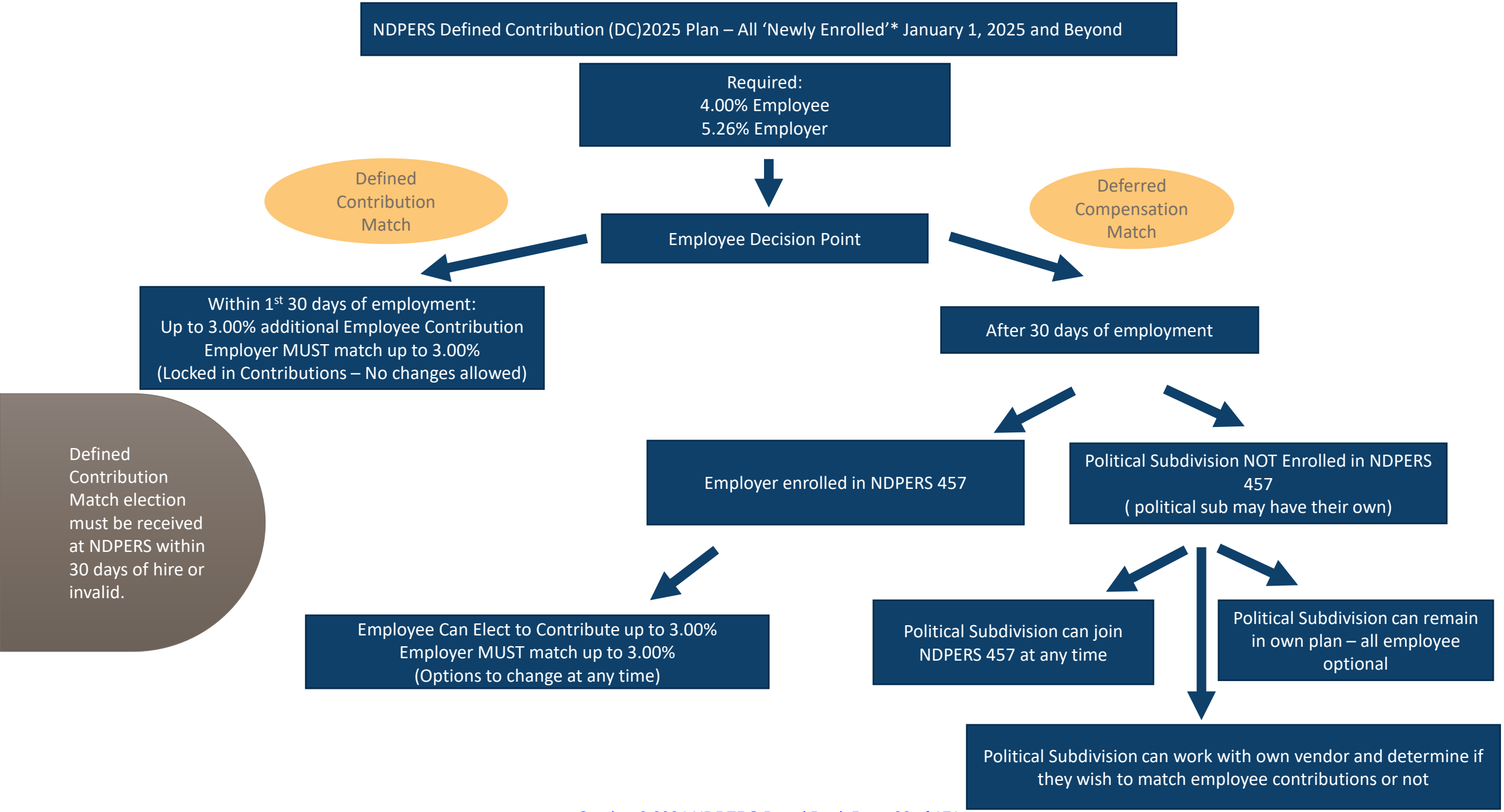
- Gradual Vesting in **Employer** Contributions
  - 2 years – 50%
  - 3 years – 75%
  - 4 years – 100%

  Note: an employee is 100% vested in employer contributions if turns age 65 while actively employed.

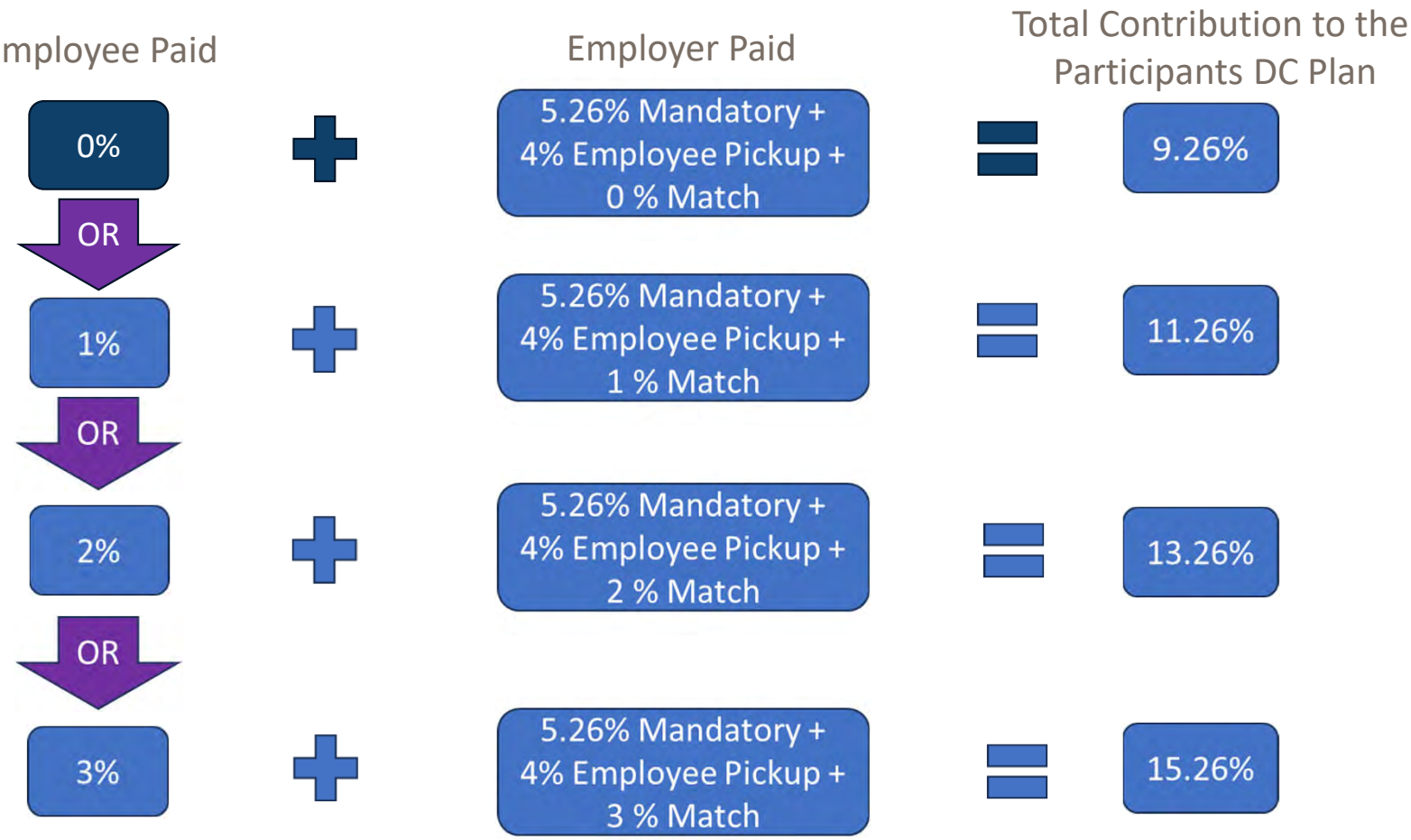
- No RHIC

ADD MORE

WITH EMPLOYER MATCHING FUNDS


NDPERS Defined Contribution (DC)2025 Plan – All 'Newly Enrolled'* January 1, 2025 and Beyond
Required:
4.00% Employee
5.26% Employer
Defined Contribution Match
Employee Decision Point
Deferred Compensation Match
Within 1st 30 days of employment:
Up to 3.00% additional Employee Contribution
Employer MUST match up to 3.00%
(Locked in Contributions – No changes allowed)
After 30 days of employment
Defined Contribution Match election must be received at NDPERS within 30 days of hire or invalid.
Employer enrolled in NDPERS 457
Political Subdivision NOT Enrolled in NDPERS 457
(political sub may have their own)
Employee Can Elect to Contribute up to 3.00%
Employer MUST match up to 3.00%
(Options to change at any time)
Political Subdivision can join NDPERS 457 at any time
Political Subdivision can remain in own plan – all employee optional
Political Subdivision can work with own vendor and determine if they wish to match employee contributions or not

DC 2025 Elections – Effective January 1, 2025



Contributions can be split between Defined Contribution & Deferred Compensation Plans

Example of splitting contributions

Elect 1% in first 30 days for Defined Contribution

Elect 2% in Deferred Compensation in first 30 days or later

Where does the match go?

Deferred Compensation Match (with State of ND 457 provider) = Match in the Employ**ee** Deferred Compensation Plan.

Defined Contribution Match (with Empower) = Match in the Employ**er** Bucket. Then, moves to Employee Bucket based on vesting schedule.

Note: The Defined Contribution match election is irrevocable [for regularly funded, permanent employees]. It cannot be changed – even if an employee leaves and returns to work.

Temporary Employees

- Can voluntarily elect to contribute the entire mandatory 9.26% into the Defined Contribution Plan [post-tax].
- Can contribute up to an additional 6% in the Defined Contribution plan because temporary employees do not receive an employer match.
- Are not eligible to participate in the Deferred Compensation Plan.

If the temporary becomes permanent

- Mandatory 4% employee and 5.26% employer.
- Will have the 30-day window for any new Defined Contribution election like a new hire.

Part 3: Defines how the Main Defined Benefit Plan will be funded

What is HB 1040?

Part 3

Main Funding

- One-time transfer of $135 million from The Strategic Investment & Improvements Fund.
- Each biennium, if revenues warrant, there will be a transfer of $65 million from the state general fund oil and gas taxes revenue.
- The State and participating political subdivisions were charged an additional 1% employer contribution on January 1, 2024.
- State governmental units will pay the Actuarially Determined Employer Contribution (ADEC) effective January 1, 2026, and will continue through December 31, 2056.
- Any cash injection(s) received will help fund both state and participating political subdivisions unfunded liabilities.

Source: HB 1040 Overview | ND Legislative Branch

What exactly is ADEC?

Stands for Actuarially Determined Employer Contribution (ADEC).

It's the rate an employer needs to pay based on all the other funding (i.e., employee contributions) to pay off the unfunded liability.

This rate varies and changes each biennium. The ADEC will be charged to State governmental units based on the salary of all employees (Main and Defined Contribution).

More about the funding of the Main DB Plan

Plans that will be subject to ADEC and ‘spill over’ January 2026

Main Defined Benefit Plan - ADEC

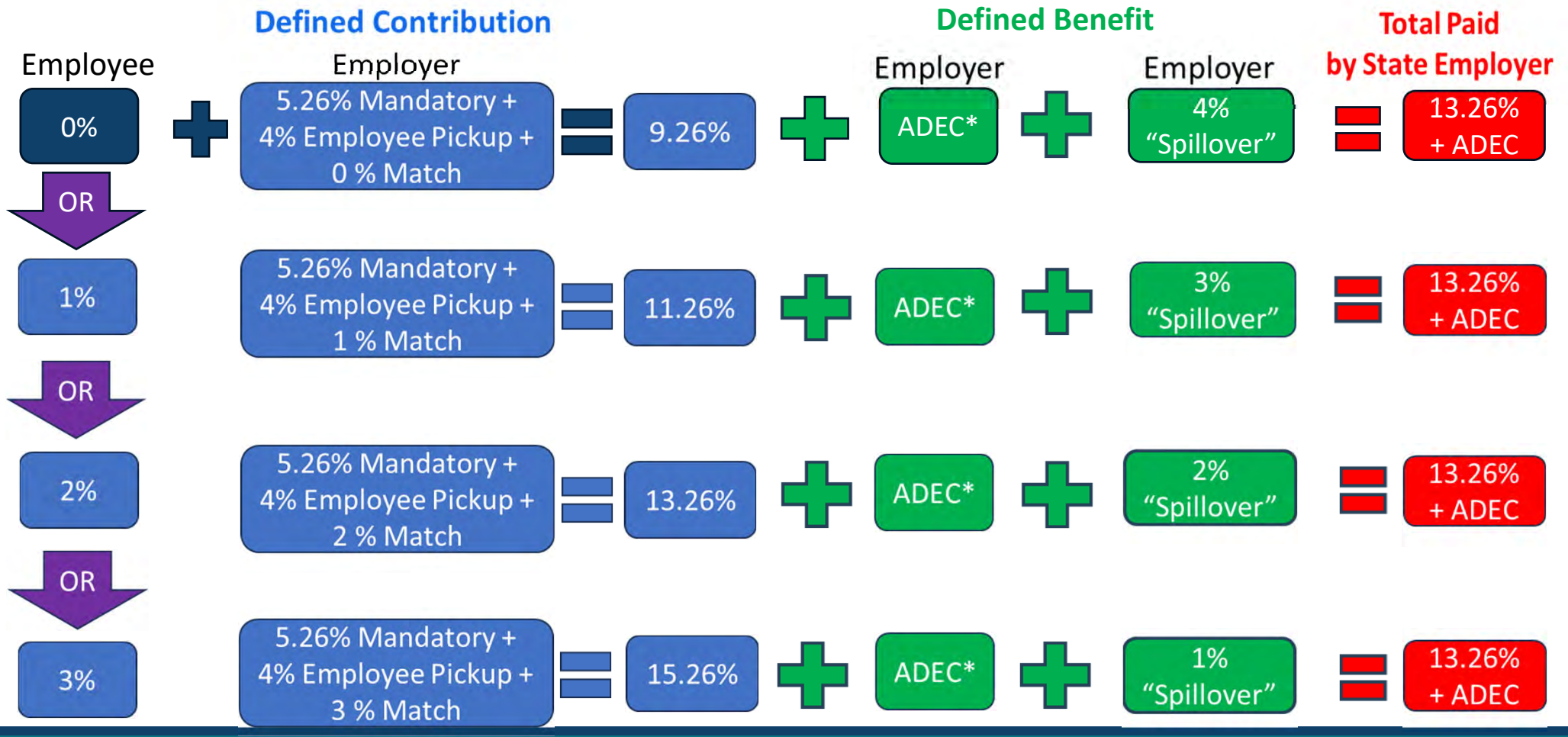
Main 2020 Defined Benefit Plan - ADEC

Defined Contribution Plan - ADEC

Defined Contribution 2020 Plan- ADEC

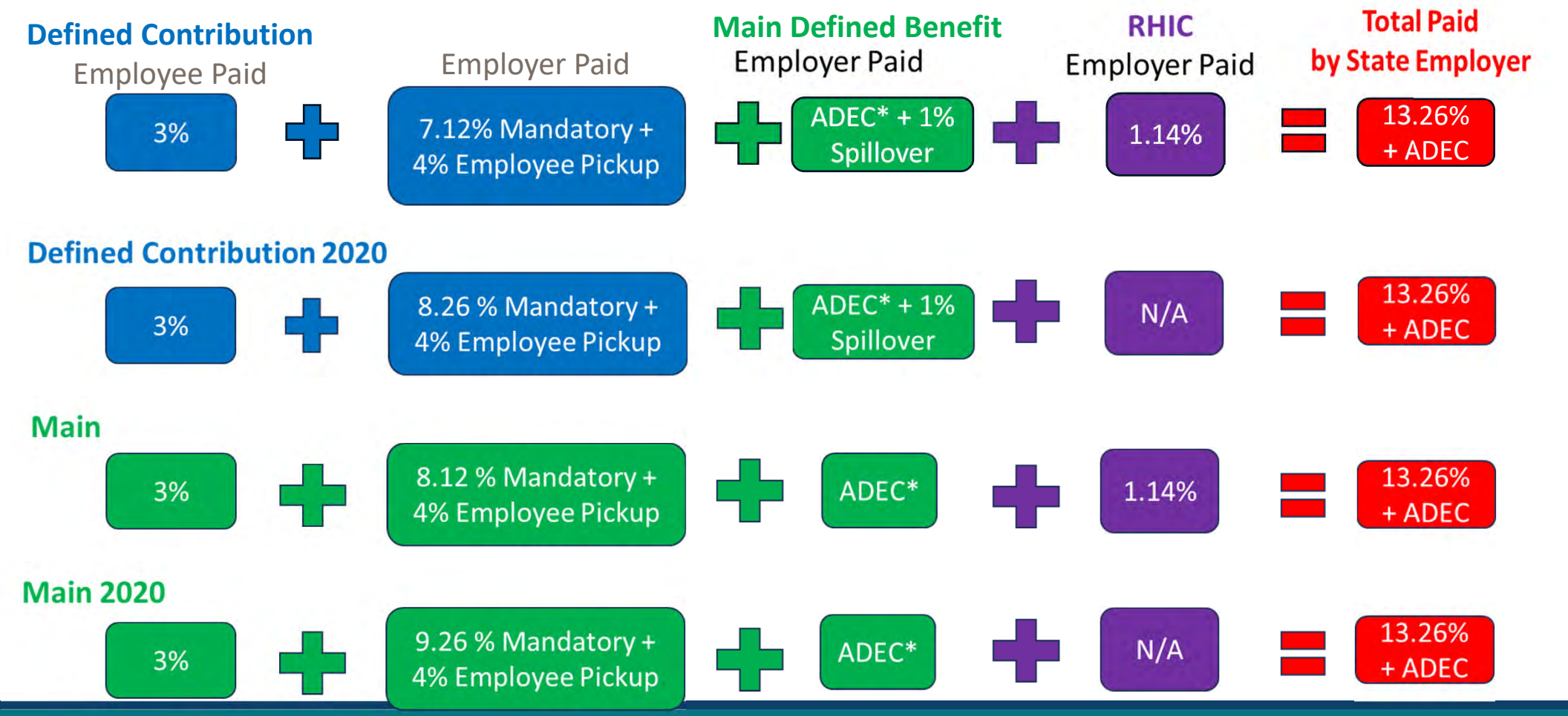
Defined Contribution 2025 Plan – ADEC and ‘spill over’

State DC 2025 Elections – Effective January 1, 2026



*ADEC = Actuarially Determined Employer Contribution Rate – Changes Biennially

Other Plan Contribution Rates – Effective January 1, 2026



*ADEC = Actuarially Determined Employer Contribution Rate – Changes Biennially

Questions?

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: October 8, 2024

SUBJECT: House Bill 1040 Implementation Update

The following activities have occurred for House Bill 1040 implementation since our last Board discussion:

- Weekly meetings are continuing with both the Enrollment and Accounting Divisions to test the modifications made to our business system relating to HB 1040. On a weekly basis, updates continue to be submitted to Sagitec, our business system vendor, for additional modifications that need to be made based on user acceptance testing.
- Have discussions with Sagitec as vendor has questions.
- Distributed second “short clip” to Team ND and participating employers to forward to their employees. Topics included:
  - Funding of the Main Plan
  - Special Election Eligibility Criteria
- Developing third “short clip” to distribute in October. Topics include:
  - Years of Service and Tier
  - Special Election and Transfer Incentive
- Programmatic updates and testing continued within the State’s Central Payroll reporting platform (PeopleSoft). The payroll files for both retirement and deferred compensation have been successfully tested. The deposit files still remain.
- Planning meetings held focused on special election window for eligible state employees.
- Bi-weekly meetings held with Empower to discuss collaboration for special election window education, fund transfer files and ongoing member education for new hires as of 1/1/2025 and after.
- Outward facing communication pieces being reviewed and updated to include plan handbooks, new hire and termination guides and website updates.

- Appeared before the Retirement Committee on September 11 and the Employee Benefits Programs Committee on September 12 to provide updates regarding implementation.
- Presented to the ND League of Cities at their Annual Conference on September 19.

In addition, legal counsel reviewed the question raised during the September Board meeting regarding the language in House Bill requiring in-plan annuities. The question was whether the language limited the annuity options to in-plan only, or if the language could be interpreted to require “in-plan” annuities, but also allow out-of-plan annuities. The Board asked counsel to review and provide a response to the Board. Attachment 1 is the analysis prepared by Dean DePountis regarding his analysis. As you will see, it is his opinion that, as currently written, NDCC 54-52.6-05(3) limits annuity options to those in-plan. Staff has been tracking potential policy considerations for the Legislature, and this talking point was added so the Assembly can consider updating this language, if desired.

Attachment 2 and Attachment 3 are included as an overview of work efforts and timelines identified.

Attachment 1

From: DePountis, Dean
To: Hohbein, Derrick L.
Subject: "In-plan" analysis
Date: Wednesday, September 25, 2024 9:25:39 AM

Good morning Derrick,

At the September 10, 2024 NDPERS Board meeting, there was discussion regarding interpretation of N.D.C.C. 54-52.6-05(3). The provision requires the board to "...provide a diversified menu of mutual funds and *in-plan* lifetime annuity options, either fixed, variable, or a combination of both." (Emphasis added). A question was whether that meant the annuity options were limited to "in-plan" - or were annuities outside the plan also eligible.

A fundamental rule of statutory interpretation is that "[w]ords used in any statute are to be understood in their ordinary sense, unless a contrary intention plainly appears...." N.D.C.C. 1-02-02. Moreover, "[w]hen the wording of a statute is clear and free of all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit." N.D.C.C. 1-02-05. The North Dakota Supreme has opined that "...interpretation of a statute, when statutory language is clear and unambiguous, ...cannot be disregarded under the pretext of pursuing legislative intent as intent is presumed to be clear from the face of the statute." Adams County Record v. Greater North Dakota Ass'n, 529 N.W. 2d 830 (1995).

From my perspective, when the aforementioned guidance is applied to the question at hand, "in-plan" serves as an adjective, a qualifier, for "lifetime annuity options." The qualifier clearly identifies the source of annuity options as "in-plan." Had the intent been to confer eligibility to both in-plan and out-of-plan annuities, then the qualifier would not have been necessary. As such, it is my opinion that, as currently written, N.D.C.C. 54-52.6-05(3) limits annuity options to those in-plan.

A review of N.D.C.C. 54-52.6-05(3)'s legislative history revealed no contrary intention. Please let me know if further discussion would be helpful.

Best,

Dean

Constantinos (Dean) DePountis
Assistant Attorney General
State of North Dakota
600 E. Boulevard Ave., Dept. 125
Bismarck, ND 58505-0040
(701) 328-2210

Attachment 2

House Bill 1040 Administrative Implementation

	2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
HB 1040 Administrative Implementation													
Marketing intern recruitment		★											
1% employer contribution increase launched		★											
Inventory the PERSLink correspondence updates				★									
Targeted communications to subs in main but not public safety					★								
Targeted communications to subs in main but not deferred comp					★								
Recordkeeper transition							★						★
PERSLink correspondence updates							★				★		
PERSLink correspondence testing							★				★		
Form updates							★				★		
Plan document updates											★		
Plan handbook updates											★		
Special election window education for eligible employees												★	
Administrative rule making promulgation													★
Employer training													★
Website updates													★
Revise new hire, transfer, termination guides													★
Staff training													★
Biweekly internal administrative implementation meetings													★
Communication team biweekly meetings													★
Education on new plan provision to members						★			★			★	★
Education on new plan provision to employers				★			★			★			★

KEY

★ Deadline

Task Completed

Work Effort

Deadline Missed

Attachment 3

House Bill 1040 Programming Implementation Timeline

	2023	Jul	Aug	Sep	Oct	Nov	Dec	2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
HB 1040 Programming Implementation																				
Funding for development effective		★																		
HB 1040 section-by-section analysis to determine system enhancements			★																	
Meet with GRS to discuss the incentive, and get programming parameters			★																	
NDPERS updates file layout documentation for employers													★							
NDPERS develops sample file layouts for employers													★							
Biweekly meetings to discuss section-by-section coding																		★		
NDPERS user acceptance testing of enhancements																		★		
State PeopleSoft development																			★	
Higher Ed PeopleSoft development																			★	
Political sub development																			★	
Employer file testing																				★

KEY

★ Deadline

Task Completed

Work Effort

Deadline Missed

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: October 8, 2024

SUBJECT: Asset Liability Study Contract

At the September Board meeting, the Board awarded the contract for the NDPERS Asset Liability Study to RVK. The attached contract was drafted by NDPERS legal staff and approved by representatives from RVK.

Board Action Requested: Approve the contract for the NDPERS Asset Liability Study starting November 1, 2024, and authorize the Executive Director to sign.

Attachment

AGREEMENT FOR SERVICES BETWEEN (RVK, Inc.) AND NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

1. PARTIES

The parties to this contract (Contract) are the state of North Dakota, acting through its ***North Dakota Public Employees Retirement System*** (STATE), and ***Name of Business a type of business [RVK, Inc.]*** having its principal place of business at ***principal business address [222 SW Columbia Street, Suite 600, Portland, OR 97201]*** (CONTRACTOR);

2. SCOPE OF WORK

CONTRACTOR agrees to provide the service(s) as specified in the 2024 bid document and VENDOR proposal (attached hereto and incorporated by reference Exhibit A).

3. COMPENSATION – PAYMENTS

a. Contractual Amount

NDPERS will pay for the services provided by CONTRACTOR under this contract pursuant to Exhibit B.

The Contractual Amount is firm for the duration of this Contract and constitutes the entire compensation due CONTRACTOR for performance of its obligations under this Contract regardless of the difficulty, materials or equipment required, including fees, licenses, overhead, profit and all other direct and indirect costs incurred by CONTRACTOR, except as provided by an amendment to this Contract.

b. Payment

1) Payment made in accordance with this Compensation section shall constitute payment in full for the services and work performed and the deliverables and work(s) provided under this Contract and CONTRACTOR shall not receive any additional compensation hereunder.

2) STATE shall make payment under this Contract within forty-five (45) calendar days after receipt of a correct invoice.

3) Payment of an invoice by STATE will not prejudice STATE's right to object to or question that or any other invoice or matter in relation thereto. CONTRACTOR's invoice will be subject to reduction for amounts included in any invoice or payment made which are determined by STATE, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute allowable costs. At STATE's sole discretion, all payments shall be subject to reduction for amounts equal to prior overpayments to CONTRACTOR.

4) For any amounts that are or will become due and payable to STATE by CONTRACTOR, STATE reserves the right to deduct the amount owed from payments that are or will become due and payable to CONTRACTOR under this Contract.

c. Travel

CONTRACTOR acknowledges travel costs are covered by the Contractual Amount and shall not invoice STATE for travel costs.

d. Prepayment

STATE will not make any advance payments before performance or delivery by CONTRACTOR under this Contract.

e. Payment of Taxes by STATE

STATE is not responsible for and will not pay local, state, or federal taxes. STATE sales tax exemption number is E-2001. STATE will furnish certificates of exemption upon request by the CONTRACTOR.

f. Taxpayer ID

CONTRACTOR'S federal employer ID number is: ***[93-0910652]***.

4. TERM OF CONTRACT

The term of this contract shall commence on November 1, 2024.

a. No Automatic Renewal

This Contract will not automatically renew.

5. TIME IS OF THE ESSENCE

CONTRACTOR hereby acknowledges that time is of the essence for performance under this Contract unless otherwise agreed to in writing by the Parties.

6. TERMINATION

a. Termination by Mutual Agreement

This Contract may be terminated by mutual consent of both Parties executed in writing.

b. Early Termination in the Public Interest

STATE is entering this Contract for the purpose of carrying out the public policy of the State of North Dakota, as determined by its Governor, Legislative Assembly, Agencies and Courts. If this Contract ceases to further the public policy of the State of North Dakota, STATE, in its sole discretion, by written notice to CONTRACTOR, may terminate this Contract in whole or in part.

c. Termination for Lack of Funding or Authority

STATE by written notice to CONTRACTOR, 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 or continued at levels sufficient to allow for purchase of the services or goods in the indicated quantities or term.

2) If federal or state laws or rules are modified or interpreted in a way that the services or goods 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.

d. Termination for Cause.

STATE may terminate this Contract effective upon delivery of written notice to CONTRACTOR, or any later date stated in the notice:

1) If CONTRACTOR fails to provide services or goods required by this Contract within the time specified or any extension agreed to in writing by STATE; **or**

2) If CONTRACTOR 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 STATE provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

7. FORCE MAJEURE

Neither Party shall be held responsible for delay or default caused by fire, riot, terrorism, pandemic (excluding COVID-19), acts of God, or war if the event was not foreseeable through the exercise of reasonable diligence by the affected Party, the event is beyond the Party's reasonable control,

and the affected Party gives notice to the other Party promptly upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default. If CONTRACTOR is the affected Party and does not resume performance within fifteen (15) days or another period agreed between the Parties, then STATE may seek all available remedies, up to and including termination of this Contract pursuant to its Termination Section, and STATE shall be entitled to a pro-rata refund of any amounts paid for which the full value has not been realized, including amounts paid toward software subscriptions, maintenance, or licenses.

8. INDEMNIFICATION

CONTRACTOR 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 CONTRACTOR 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. 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. CONTRACTOR 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 CONTRACTOR in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this Agreement.

9. INSURANCE

Contractor shall secure and keep in force during the term of this agreement and Contractor shall require all subcontractors, prior to commencement of an agreement between Contractor 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 $2,000,000 per occurrence.
2) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 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 $2,000,000 as an endorsement on the workers compensation or commercial general liability insurance.
5) Professional errors and omissions with minimum limits of $1,000,000 per claim and in the aggregate, Contractor shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, Contractor shall purchase an extended reporting period to meet the time

periods required in this section.

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 Contractor. The amount of any deductible or self-retention is subject to approval by the State.
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 the Contractor.
5) A "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State.
6) The Contractor 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.
8) Contractor shall provide at least 30 day notice of any cancellation or material change to the policies or endorsements. Contractor shall provide on an ongoing basis, current certificates of insurance during the term of the contract. A renewal certificate will be provided 10 days prior to coverage expiration.

10. WORKS FOR HIRE

CONTRACTOR acknowledges that all work(s) under this Contract is "work(s) for hire" within the meaning of the United States Copyright Act (Title 17 United States Code) and hereby assigns to STATE all rights and interests CONTRACTOR may have in the work(s) it prepares under this Contract, including any right to derivative use of the work(s). All software and related materials developed by CONTRACTOR in performance of this Contract for STATE shall be the sole property of STATE, and CONTRACTOR hereby assigns and transfers all its right, title, and interest therein to STATE. CONTRACTOR shall execute all necessary documents to enable STATE to protect STATE's intellectual property rights under this section.

11. WORK PRODUCT

All work product, equipment or materials created for STATE or purchased by STATE under this Contract belong to STATE. Return and/or destruction of such work product, equipment or materials is subject to the terms of the MOU on pp. 10-11 of this Agreement.

12. NOTICE

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

STATE	CONTRACTOR
Name: Rebecca Fricke	Name **J. Randy Borek**
Title: Executive Director	Title **Chief Financial Officer, Principal**
Address: 1600 East Century Ave, Suite 2 PO Box 1657	Address **222 SW Columbia St., Ste 600**
City, State, Zip: Bismarck, ND 58502-1657	City, State, Zip **Portland, OR, 97201**

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.

13. CONFIDENTIALITY

CONTRACTOR shall not use or disclose any information it receives from STATE under this Contract that STATE 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 STATE. STATE shall not disclose any information it receives from CONTRACTOR that CONTRACTOR has previously identified as confidential and that STATE determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota public records law, N.D.C.C. ch. 44-04. The duty of STATE and CONTRACTOR to maintain confidentiality of information under this section continues beyond the Term of this Contract.

14. COMPLIANCE WITH PUBLIC RECORDS LAWS

Under the North Dakota public records law and subject to the Confidentiality clause of this Contract, certain records may be open to the public upon request.

Public records may include: (a) records STATE receives from CONTRACTOR under this Contract, (b) records obtained by either Party under this Contract, and (c) records generated by either Party under this Contract.

CONTRACTOR agrees to contact STATE immediately upon receiving a request for information under the public records law and to comply with STATE's instructions on how to respond to such request.

15. INDEPENDENT ENTITY

CONTRACTOR 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. CONTRACTOR retains sole and absolute discretion in the manner and means of carrying out CONTRACTOR's activities and

responsibilities under this Contract, except to the extent specified in this Contract.

16. ASSIGNMENT AND SUBCONTRACTS

CONTRACTOR may not assign or otherwise transfer or delegate any right or duty without STATE's express written consent.

CONTRACTOR may enter subcontracts provided that any subcontract acknowledges the binding nature of this Contract and incorporates this Contract, including any attachments. CONTRACTOR is solely responsible for the performance of any subcontractor with whom CONTRACTOR contracts. CONTRACTOR does not have authority to contract for or incur obligations on behalf of STATE.

17. SPOLIATION – PRESERVATION OF EVIDENCE

CONTRACTOR shall promptly notify STATE of all potential claims that arise or result from this Contract. CONTRACTOR 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 STATE the opportunity to review and inspect such evidence, including the scene of an accident.

18. MERGER AND MODIFICATION, CONFLICT IN DOCUMENTS

This Contract, including the following documents, constitutes the entire agreement between the Parties. There are no understandings, agreements, or representations, oral or written, not specified within this Contract. This Contract may not be modified, supplemented, or amended, in any manner, except by written agreement signed by both Parties.

Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Contract, the documents must control in this order of precedence:

a. The terms of this Contract, including any BAA and/or MOU (if applicable), as may be amended;

b. STATE's Request for Proposal ("RFP")

c. Contractor's proposal in response to RFP (attached hereto and incorporated by reference Exhibit A)

d. Contractor's BAFO in response to RFP (attached hereto and incorporated by reference Exhibit B)

e. All automated end-user agreements (e.g., click-through, shrink-wrap, or browse-wrap) are specifically excluded and null and void. Clicking shall not represent

acknowledgement or agreement to any terms or conditions contained in those agreements.

19. SEVERABILITY

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

20. APPLICABLE LAW AND VENUE

This Contract is governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this Contract must be adjudicated exclusively 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*.

21. ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

By entering this Contract, STATE does not agree to binding arbitration, mediation, or any other form of mandatory Alternative Dispute Resolution. The Parties may enforce the rights and remedies in judicial proceedings. STATE does not waive any right to a jury trial.

22. ATTORNEY FEES

In the event a lawsuit is instituted by STATE to obtain performance due under this Contract, and STATE is the prevailing Party, CONTRACTOR shall, except when prohibited by N.D.C.C. § 28-26-04, pay STATE's reasonable attorney fees and costs in connection with the lawsuit.

23. NONDISCRIMINATION AND COMPLIANCE WITH LAWS

CONTRACTOR agrees to comply with all applicable federal and state laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. (*See* N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women.)

CONTRACTOR agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.

CONTRACTOR shall have and keep current all licenses and permits required by law during the Term of this Contract all licenses and permits required by law.

CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE to terminate in accordance with the Termination for Cause section of this Contract.

CONTRATOR is prohibited from boycotting Israel for the duration of this Contract. (See N.D.C.C § 54-44.4-15.) CONTRACTOR represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If STATE receives evidence that CONTRACTOR boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if CONTRACTOR has fewer than ten full-time employees.

24. STATE AUDIT

Pursuant to N.D.C.C. § 54-10-19, all records, regardless of physical form, and the accounting practices and procedures of CONTRACTOR relevant to this Contract are subject to examination by the North Dakota State Auditor, the Auditor's designee, or Federal auditors, if required. CONTRACTOR shall maintain these records for at least three (3) years following completion of this Contract and be able to provide them upon reasonable notice. STATE, State Auditor, or Auditor's designee shall provide reasonable notice to CONTRACTOR prior to conducting examination.

25. COUNTERPARTS

This Contract may be executed in multiple, identical counterparts, each of which is to be deemed an original, and all of which taken together shall constitute one and the same contract.

26. EFFECTIVENESS OF CONTRACT

This Contract is not effective until fully executed by both Parties. If no start date is specified in the Term of Contract, the most recent date of the signatures of the Parties shall be deemed the Effective Date.

CONTRACTOR	**STATE OF NORTH DAKOTA**
RVK, Inc.	Acting through its **NDPERS**
BY:	BY:
J. Randy Borek	Rebecca Fricke
Chief Financial Officer, Principal	NDPERS Executive Director
Date: September 24, 2024	Date:

MEMORANDUM OF UNDERSTANDING BETWEEN THE NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM AND VENDOR RELATING TO MAINTAINING CONFIDENTIAL INFORMATION

This Memorandum of Understanding is between the State of North Dakota acting through its North Dakota Public Employees Retirement System (NDPERS) and VENDOR relating to maintenance and destruction of NDPERS Confidential Information held by VENDOR and its subsidiaries.

WHEREAS, NDPERS has previously entered into contracts with VENDOR to provide services related to administration of the NDPERS RFP (Contracts).

WHEREAS, the services provided by VENDOR under these Contracts required the exchange of information between the parties that is confidential under North Dakota Century Code §§ 54-52-26 and 54-52.1-11, 54-52.1-12 (Confidential Information).

WHEREAS, the parties acknowledge that these Contracts, including the Business Associate Agreements between the parties, required VENDOR to return or destroy Confidential Information subsequent to the termination of the applicable Contract, or if return or destruction of this information was infeasible to maintain its confidentiality.

WHEREAS, these Contracts have terminated and VENDOR has asserted and NDPERS agrees that member service, applicable audit, record keeping, and other required functions make the return or destruction of all Confidential Information infeasible at this time.

WHEREAS, VENDOR has provided and NDPERS has reviewed the VENDOR records retention policy (Policy) applicable to the Confidential Information and VENDOR has affirmed that it will maintain the confidentiality of NDPERS information pursuant to this Policy until such time as the information is destroyed in a manner designated by this Policy.

NOW THEREFORE, in consideration of the foregoing premises and in furtherance of the aforementioned contractual obligations, the parties agree as follows:

1. VENDOR shall continue to maintain the confidentiality of Confidential Information which it still possesses, in accordance with its Policy in a manner that is at least as secure and diligent as was done during the term of the applicable Contract, until such time as the Confidential Information is destroyed or returned.
2. Upon the request of NDPERS, VENDOR shall confirm the destruction of Confidential Information under its Policy.
3. Upon the request of NDPERS, VENDOR shall provide NDPERS a copy of any change to the Policy provided NDPERS on DATE.
4. NDPERS agrees these actions are consistent with VENDOR obligations under these Contracts.
5. This Memorandum of Understanding will terminate upon notice to NDPERS by VENDOR that all Confidential Information has either been returned to NDPERS or destroyed, or earlier, upon thirty (30) days' notice by NDPERS to VENDOR if NDPERS determines that the Policy has been modified in a manner that is inconsistent with state or federal law.

6. This Memorandum of Understanding shall be governed by, and construed in accordance with, the laws of the State of North Dakota.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

BY: _____

Executive Director
ND Public Employees Retirement System

Date: _____

VENDOR

BY: 

Its: Chief Financial Officer, Principal

Date: September 24, 2024

Attach Contractor Records Retention Policy

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: October 8, 2024

SUBJECT: Investment Options Summary Book

The updated Investment Options Summary for the NDPERS 457 Deferred Compensation Plan is now available. The booklet contains information on all the providers and investment options available in the plan. Inside you will find a description of the investment options available and the contact information for all the providers. For each active provider, all the investments are listed along with their investment objective, associated expenses, and historical performance.

The investment options summary is available on the NDPERS website:
https://www.ndpers.nd.gov/sites/www/files/documents/about/investments/investment-options.pdf

This item is informational and does not require any action by the Board.

Attachment

Attachment

2024 - 2025

Inve$tment Option$

A SUMMARY FOR THE

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

DEFERRED
COMPENSATION PLAN

TABLE OF CONTENTS

SUMMARY OF INVESTMENT OPTIONS
NORTH DAKOTA EMPLOYEE'S RETIREMENT SYSTEM

Introduction

The information in this summary is organized into three sections. Section I details the investment options that are available through the NDPERS Deferred Compensation Companion Plan. Section II lists the other investment options currently available through the NDPERS Section 457 Deferred Compensation Plan. This information has been organized in alphabetical order by provider company. The investment objective, annual expenses, and historical performance information is provided for each investment option. Due to the inception date of some investment funds, historical performance information is not available and is indicated with "N/A" (not available). Instances in which information was not provided by the provider companies are indicated by "N/P" (not provided). Section III lists the representatives you can contact at each provider company for more information as of the date this summary was published. Updates to the list of registered provider representatives are published on the NDPERS website at the end of each quarter.

The annual expense column includes fund expense ratios and any applicable fees to pay for service, distribution, and marketing costs (12b-1 fees), operating expenses, asset management fees, separate account charges, or mortality and expense charges imposed by the provider. It does not, however, include any withdrawal, surrender or deferred sales charges or miscellaneous administrative fees. Whenever possible, withdrawal, surrender or deferred sales charges, etc. have been noted at the bottom of the page. Please refer to your prospectus or contact your provider company for more complete information. The column entitled "Other Fees" indicates whether additional information is footnoted below the table about fees and/or withdrawal provisions (Y=yes, N=no).

Performance results provided herein reflect all fund expense ratios and any applicable 12b-1 fees, operating expenses, asset management fees, separate account charges, or mortality and expense charges imposed by the provider company. They do not, however, reflect any withdrawal, surrender or deferred sales charges or account maintenance fees footnoted below each table in the sections entitled "Other Fees" and "Withdrawal Provisions".

Although all applicable fees for each provider company should be provided in this ***Summary of Investment Options***, you should discuss fees in detail with a provider company representative.

The following abbreviations are used in the "Type of Investment" column on the following pages:

FA – Fixed Annuity

MF – Mutual Fund

VA – Variable Annuity

CF – Commingled Fund

ANNUITIES VERSUS MUTUAL FUNDS

Annuities

Deferred annuities are essentially tax-sheltered accounts offered by life insurance companies. They come in two basic forms, fixed or variable, and offer different benefits each suited to achieving very different retirement objectives. Fixed annuities pay a fixed nominal interest rate per period and guarantee a minimum rate of return. Variable annuities can range from conservative to aggressive investments and pay a rate linked to the investment performance of some underlying portfolio; therefore, the returns of variable annuity contracts are not guaranteed by the offeror. Many variable annuities are invested in mutual funds as the underlying investment. The annuity fund structure typically offers a guaranteed death benefit which provides safety of principal for beneficiaries. This structure results in an additional layer of fees above those that are paid for the underlying investment vehicle. Typically, the annual expenses associated with annuity solutions reflect a mortality and expense risk charge (insurance component, investment management expenses, administrative and recordkeeping charges, and declining surrender charges). Sales loads and marketing and distribution charges may apply but are often waived for institutional clients.

Mutual Funds

Mutual funds are registered with the Securities and Exchange Commission (SEC) and their prices and performance are usually reported daily in the newspapers. Commingled funds are pooled investment vehicles that are similar to mutual funds but are not registered with the SEC and may or may not be reported in the newspapers.

Mutual funds can range from conservative to aggressive, and their values will fluctuate according to the volatility of the securities in which the funds are invested. Mutual funds do not offer a guaranteed death benefit; therefore, their fees do not include an insurance component. Typically, the annual expenses associated with mutual funds reflect the investment management expenses and administrative and recordkeeping fees charged by the provider company. Again, sales loads and marketing and distribution charges may apply but are typically waived in the case of institutional accounts.

The investment funds that are available through the NDPERS Companion Plan consist of a series of mutual funds and a

Commingled fund. In the case of the Companion Plan, the annual fees charged by mutual fund organizations to pay for service, distribution, and marketing costs (12b-1 fees) are currently rebated back to participants by Empower. In addition, any front and deferred sales loads are currently waived by Empower.

The information included in this summary is strictly quantitative in nature and is intended to provide an evaluation of the returns and expenses associated with the investment options available through NDPERS' deferred compensation program.

This summary does not present factors that are more subjective in nature such as: 1) the quality, availability, and responsiveness of client service; 2) verification of the investment style underlying the investment options; 3) the longevity and stability of the investment professionals managing the investment options; and 4) internet access and voice response systems. These factors should also be taken into consideration when selecting provider companies and investment options. Please contact your provider companies to obtain this information.

Please keep in mind when reviewing the historical performance information that past performance does not guarantee future performance. This ***Summary of Investment Options*** is not a prospectus. It is only intended to provide basic information about the available investment options. Please contact the individual provider companies for a prospectus containing more detailed information.

The material presented in this Summary of Investment Options has been compiled from information supplied by the provider companies to the NDPERS to the NDPERS Section 457 Deferred Compensation Plan. To the best of our knowledge, this information is accurate and complete although we have not independently verified its accuracy or completeness.

ND Public Employees Retirement System, P.O. Box 1657, Bismarck, ND 58502-1657 Phone: 701-328-3900 • FAX: 701-328-3920 • Toll-free outside the Bismarck calling area: 1-800-803-7377
PERS Website: www.nd.gov/ndpers • PERS e-mail address: NDPERS@nd.gov

SECTION I

SUMMARY OF INVESTMENT OPTIONS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SECTION 457 DEFERRED COMPENSATION COMPANION PLAN

(INFORMATION CURRENT AS OF JUNE 30, 2024)

Fund/Ticker Symbol	Investment Type	Asset Class / Product Type	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/24	Net Historical Performance as of 12/31/2023			
					1 YR	3 YR	5 YR	10 YR
Nuveen Lifecycle Retirement Income R6 (TLRIX)	Target Date Retirement	Asset Allocation / Mutual Fund	0.54% / 0.37%	4.65%	10.81%	1.26%	5.87%	4.77%
Nuveen Lifecycle 2010 R6 (TCTIX)	Target Date 2010	Asset Allocation / Mutual Fund	0.51% / 0.37%	4.49%	11.00%	1.29%	5.94%	4.89%
Nuveen Lifecycle 2015 R6 (TCNIX)	Target Date 2015	Asset Allocation / Mutual Fund	0.52% / 0.38%	4.79%	11.08%	1.41%	6.32%	5.17%
Nuveen Lifecycle 2020 R6 (TCWIX)	Target Date 2020	Asset Allocation / Mutual Fund	0.54% / 0.39%	5.27%	12.06%	1.67%	6.83%	5.53%
Nuveen Lifecycle 2025 R6 (TCYIX)	Target Date 2025	Asset Allocation / Mutual Fund	0.55% / 0.41%	5.88%	13.15%	2.12%	7.61%	6.01%
Nuveen Lifecycle 2030 R6 (TCRIX)	Target Date 2030	Asset Allocation / Mutual Fund	0.56% / 0.42%	6.77%	14.59%	2.64%	8.48%	6.50%
Nuveen Lifecycle 2035 R6 (TCIIX)	Target Date 2035	Asset Allocation / Mutual Fund	0.58% / 0.43%	7.88%	16.38%	3.29%	9.38%	7.00%
Nuveen Lifecycle 2040 R6 (TCOIX)	Target Date 2040	Asset Allocation / Mutual Fund	0.61% / 0.44%	9.14%	18.39%	4.09%	10.34%	7.53%
Nuveen Lifecycle 2045 R6 (TTFIX)	Target Date 2045	Asset Allocation / Mutual Fund	0.62% / 0.45%	10.12%	19.47%	4.63%	11.08%	7.90%

Fund/Ticker Symbol	Investment Type	Asset Class / Product Type	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/24	Net Historical Performance as of 12/31/2023			
					1 YR	3 YR	5 YR	10 YR
Nuveen Lifecycle 2050 R6 (TFTIX)	Target Date 2050	Asset Allocation / Mutual Fund	0.64% / 0.45%	10.52%	20.03%	4.81%	11.28%	8.01%
Nuveen Lifecycle 2055 R6 (TTRIX)	Target Date 2055	Asset Allocation / Mutual Fund	0.64% / 0.45%	10.66%	20.25%	4.89%	11.37%	8.08%
Nuveen Lifecycle 2060 R6 (TLXNX)	Target Date 2060	Asset Allocation / Mutual Fund	0.68% / 0.45%	10.77%	20.46%	4.97%	11.53%	N/A
Nuveen Lifecycle 2065 R6 (TSFTX)	Target Date 2065	Asset Allocation / Mutual Fund	1.17% / 0.45%	10.93%	20.59%	5.15%	N/A	N/A
MFS International Diversification R6 (MDIZX)	Foreign Large Blend	Equities / Mutual Fund	0.74% / 0.73%	5.49%	14.44%	0.77%	8.29%	5.48%
Vanguard Total International Stock Index I (VTSNX)	Foreign Large Blend	Equities / Mutual Fund	0.09% / 0.09%	5.14%	15.53%	1.80%	7.37%	4.12%
Cohen & Steers Realty Shares L (CSRSX)	Real Estate	Equities / Mutual Fund	0.94% / 0.88%	0.11%	12.67%	6.43%	9.25%	8.71%
JP Morgan SMID Cap Equity R6 (WOOSX)	Mid Cap Blend	Equities / Mutual Fund	0.71% / 0.59%	1.66%	13.57%	4.48%	9.76%	7.30%
Vanguard Institutional Index I (VINIX)	Large Cap Blend	Equities / Mutual Fund	0.04% / 0.04%	15.27%	26.24%	9.96%	15.66%	12.00%

Fund Ticker Symbol	Investment Type	Asset Class / Product Type	GROSS / NET EXPENSE RATIO	Return 6 Mos. Ended 06/30/24	Net Historical Performance as of 12/31/2023			
					1 YR	3 YR	5 YR	10 YR
Baird Core Plus Bond Institutional (BCOIX)	Intermediate Core Plus Bond	Fixed Income / Mutual Fund	0.30% / 0.30%	0.12%	6.89%	-2.67%	2.01%	2.54%
Vanguard Total Bond Market Index Admiral (VBTLX)	Intermediate-Term Bond	Fixed Income / Mutual Fund	0.05% / 0.05%	-0.62%	5.70%	-3.36%	1.11%	1.79%
Galliard Stable Return Fund C	Stable Value	Stable Value / Other Investment	0.37% / 0.37%	1.41%	2.65%	2.10%	2.13%	1.84%
Vanguard Treasury Money Market Investor (VUSXX)	Money Market - Taxable	Money Market / Mutual Fund	0.09% / 0.09%	2.67%	5.05%	2.17%	1.82%	1.19%

Additional investment options are available through the self-directed brokerage (Mutual Fund Window).

SECTION II

SUMMARY OF INVESTMENT OPTIONS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SECTION 457 DEFERRED COMPENSATION PLAN

(INFORMATION CURRENT AS OF JUNE 30, 2024)

The NDPERS Board provides this Summary as a service to the deferred compensation participants to help them make an informed decision regarding their investments. The NDPERS Board has not examined the investment options described in Section II of this Summary, and makes neither recommendation nor warranty regarding those options. The investment options offered are those the individual provider companies have determined they will offer to the participants using the provider's services.

Unless otherwise noted, performance results provided herein reflect all fund expense ratios and any applicable 12b-1 fees, operating expenses, asset management fees, separate account charges, or mortality and expense charges imposed by the provider company. They do not, however, reflect any withdrawal, surrender, or deferred sales charges or account maintenance fees footnoted below each table in the sections entitled "Other Fees" and "Withdrawal Provisions."

BANK OF NORTH DAKOTA INVESTMENT OPTIONS

For more information, call Bank of North Dakota at (701) 328-5615 or refer to List of Representatives in Section III

Fund/Ticker Symbol	Type of Investment	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended June 30, 2024	Net Historical Performance As of December 31, 2023 1 Year	3 Years	5 Years	10 Years
Open Savings Statement (Variable Rate Account)	Savings	Stability of Principal	None	N	2.00%*	N/P	N/P	N/P	N/P

Other Fees: None

Withdrawal Provisions: No fee unless account is moved prior to eighteen months. Penalty is three months of interest using the current interest rate in effect at withdrawal.

**Rate presented is an annual interest rate that changes January 1. Call Bank of North Dakota to obtain the current rate.*

N/P – Not provided

Fund / Ticker Symbol	Type of Investment	Category	Annual Expense (Net)	Other Fees (Y/N)	Return 6 mos. Ended June 30th, 2024	Historical Performance as of December 31st, 2023			
						1 Year	3 Years	5 Years	10 Years
Federated Hermes Government Obligations / GOFXX	Mutual Fund	Money Market	0.15%	Y*	2.64%	5.36%	3.07%	2.11%	-
JHancock Stable Value Fund I6 / 47810T701	CIT	Stable Value	0.42%	Y*	1.26%	2.54%	2.13%	2.16%	2.04%
BlackRock Inflation Protected Bond K / BPLBX	Mutual Fund	Treasury Inflation Protected Securities (TIPS) / Fixed Income	0.79%	Y*	1.05%	2.48%	-1.26%	2.34%	1.80%
Vanguard GNMA Adm / VFIJX	Mutual Fund	Core Bond / Fixed Income	0.11%	Y*	-0.91%	2.39%	-2.47%	-0.50%	0.98%
Federated Hermes Total Return Bond R6 / FTRLX	Mutual Fund	Core Bond / Fixed Income	0.38%	Y*	-0.46%	2.98%	-2.76%	0.67%	1.93%
Vanguard Total Bond Market Index Adm / VBTLX	Mutual Fund	Core Bond / Fixed Income	0.05%	Y*	-0.62%	2.76%	-3.01%	-0.20%	1.33%
Vanguard Total International Bond Index Adm / VTABX	Mutual Fund	Core Bond / Fixed Income	0.11%	Y*	-0.54%	4.37%	-2.00%	-0.41%	1.92%
Principal High Yield R-6 / PHYFX	Mutual Fund	High Yield Bond / Fixed Income	0.53%	Y*	3.03%	10.44%	2.68%	4.45%	4.30%
Vanguard 500 Index Adm / VFIAX	Mutual Fund	Large Cap Blend / Equity	0.04%	Y*	15.27%	24.51%	9.97%	15.00%	12.82%
Vanguard Total Stock Market Index Adm / VTSAX	Mutual Fund	Large Cap Blend / Equity	0.40%	Y*	13.57%	23.19%	7.90%	14.06%	12.10%
American Funds American Mutual R6 / RMFGX	Mutual Fund	Large Cap Value / Equity	0.27%	Y*	7.73%	14.08%	7.74%	10.12%	9.58%
Schwab Fundamental US Large Company Index / SFLNX	Mutual Fund	Large Cap Blend / Equity	0.25%	Y*	9.06%	18.45%	9.07%	13.81%	11.06%
JPMorgan Equity Income R6 / OIEJX	Mutual Fund	Large Cap Value / Equity	0.45%	Y*	5.47%	10.88%	5.50%	9.22%	9.32%
PRIMECAP Odyssey Growth / POGRX	Mutual Fund	Large Cap Growth / Equity	0.66%	Y*	7.29%	18.33%	4.85%	11.52%	11.70%
MFS Growth R6 / MFEKX	Mutual Fund	Large Cap Growth / Equity	0.51%	Y*	24.48%	36.51%	8.57%	15.91%	15.22%
Vanguard Mid Cap Index Adm / VIMAX	Mutual Fund	Mid Cap Blend / Equity	0.05%	Y*	4.90%	11.80%	2.21%	9.38%	9.10%
Vanguard Mid Cap Value Index Adm / VMVAX	Mutual Fund	Mid Cap Value / Equity	0.07%	Y*	4.93%	11.33%	4.64%	8.68%	8.08%
Baird Mid Cap Growth Instl / BMDIX	Mutual Fund	Mid Cap Growth / Equity	0.82%	Y*	-4.66%	-1.70%	-2.41%	8.08%	9.21%
Vanguard Small Cap Index Adm / VSMAX	Mutual Fund	Small Cap Blend / Equity	0.05%	Y*	3.07%	11.50%	0.50%	8.45%	8.08%
Vanguard Small Cap Value Index Adm / VSIAX	Mutual Fund	Small Cap Value / Equity	0.07%	Y*	2.47%	12.86%	3.89%	9.18%	7.89%

Fund / Ticker Symbol	Type of Investment	Category	Annual Expense (Net)	Other Fees (Y/N)	Return 6 mos. Ended June 30th, 2024	Historical Performance as of December 31st, 2023			
						1 Year	3 Years	5 Years	10 Years
JPMorgan Small Cap Equity R6 / VSENX	Mutual Fund	Small Cap Growth / Equity	0.74%	Y*	1.40%	7.39%	-0.02%	7.25%	8.27%
MFS New Discovery R6 / MNDKX	Mutual Fund	Small Cap Growth / Equity	0.90%	Y*	2.63%	6.04%	-8.23%	5.58%	8.06%
Federated Hermes Kaufmann Small Cap R6 / FKALX	Mutual Fund	Small Cap Growth / Equity	0.89%	Y*	3.94%	7.43%	-8.21%	4.92%	10.80%
Vanguard Total International Stock Index Adm / VTIAX	Mutual Fund	International / Equity	0.12%	Y*	5.13%	10.96%	0.34%	5.75%	4.02%
Vanguard Developed Markets Index Adm / VTMGX	Mutual Fund	International / Equity	0.08%	Y*	4.42%	10.59%	1.79%	6.52%	4.51%
MFS International Diversification R6 / MDIZX	Mutual Fund	International / Equity	0.73%	Y*	5.49%	9.28%	0.32%	6.14%	5.60%
T. Rowe Price Science & Technology I / TSNIX	Mutual Fund	Sector / Equity	0.69%	Y*	26.72%	38.89%	4.87%	17.71%	16.78%
Vanguard Energy Index Adm / VENAX	Mutual Fund	Sector / Equity	0.10%	Y*	10.51%	16.67%	23.56%	21.96%	2.36%
Vanguard Health Care Adm / VGHAX	Mutual Fund	Sector / Equity	0.30%	Y*	8.30%	10.21%	5.42%	10.89%	9.60%
Vanguard REIT Index Adm / VGSLX	Mutual Fund	Sector / Equity	0.13%	Y*	-3.06%	4.75%	-2.55%	2.96%	5.30%
Principal Diversified Real Asset R6 / PDARX	Mutual Fund	Real Asset / Equity	0.78%	Y*	1.34%	4.09%	1.44%	4.58%	1.97%
Fidelity Advisor® Balanced Z / FZAAX	Mutual Fund	Balanced Fund	0.41%	Y*	10.18%	17.62%	5.33%	11.51%	9.50%
Vanguard Target Retirement Income Inv / VTINX	Mutual Fund	Target Date	0.08%	Y*	3.00%	7.96%	0.46%	3.72%	3.95%
Vanguard Target Retirement 2020 Inv / VTWNX	Mutual Fund	Target Date	0.08%	Y*	3.91%	9.24%	0.94%	5.15%	5.35%
Vanguard Target Retirement 2025 Inv / VTTVX	Mutual Fund	Target Date	0.08%	Y*	5.11%	11.02%	1.51%	6.12%	6.03%
Vanguard Target Retirement 2030 Inv / VTHRX	Mutual Fund	Target Date	0.08%	Y*	6.00%	12.39%	2.07%	6.95%	6.58%
Vanguard Target Retirement 2035 Inv / VTTHX	Mutual Fund	Target Date	0.08%	Y*	6.87%	13.52%	2.65%	7.77%	7.12%
Vanguard Target Retirement 2040 Inv / VFORX	Mutual Fund	Target Date	0.08%	Y*	7.68%	14.74%	3.23%	8.59%	7.65%
Vanguard Target Retirement 2045 Inv / VTIVX	Mutual Fund	Target Date	0.08%	Y*	8.48%	15.81%	3.78%	9.40%	8.12%
Vanguard Target Retirement 2050 Inv / VFIFX	Mutual Fund	Target Date	0.08%	Y*	9.05%	16.63%	4.15%	9.68%	8.26%
Vanguard Target Retirement 2055 Inv / VFFVX	Mutual Fund	Target Date	0.08%	Y*	9.03%	16.61%	4.15%	9.67%	8.24%
Vanguard Target Retirement 2060 Inv / VTTSX	Mutual Fund	Target Date	0.08%	Y*	9.04%	16.60%	4.16%	9.68%	8.23%
Vanguard Target Retirement 2065 Inv / VLXVX	Mutual Fund	Target Date	0.08%	Y*	9.05%	16.63%	4.19%	9.66%	-

Other Fees:
*Bravera Wealth Fee: 0.60%
*Investment/Advisor: 0.50%

Withdrawal Provisions:
*None

Termination/Distribution/In-Service Processing Fee: Paper - $85; Online - $50
Transaction fees apply for the following (fee quoted to participant at time of request): Certified mail, express delivery, cashier's check, wire transfers, and returned/lost/stop payment and reissued checks.
QDRO Processing Fees: Review and Communication - $250; Account Division - $100; Alternate Payee Distribution - $85

Bravera Wealth will track the trades and provide a warning notice when the shareholder hits the first violation and will block the second as defined below. The first time a shareholder completes a roundtrip transaction, defined as a buy in and sell out of greater than $10,000 that occurs within a 30 calendar day period, a warning letter will be sent to the shareholder reminding them of the policy:

VANGUARD GNMA ADM, VANGUARD ENERGY INDEX ADM, VANGUARD DEVELOPED MARKETS INDEX ADM, VANGUARD HEALTH CARE ADM, VANGUARD INDEX 500 ADM, VANGUARD MID CAP INDEX ADM, VANGUARD MID CAP VALUE INDEX ADM, VANGUARD SMALL CAP INDEX ADM, VANGUARD SMALL CAP VALUE INDEX ADM, VANGUARD REIT INDEX ADM, VANGUARD SMALL CAP VALUE INDEX ADM, VANGUARD TOTAL BOND MARKET INDEX ADM, VANGUARD TOTAL INTERNATIONAL BOND INDEX ADM, VANGUARD TOTAL STOCK MARKET INDEX ADM, VANGUARD TOTAL INTERNATIONAL STOCK INDEX ADM, & VANGUARD TARGET DATE INCOME, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060, & 2065:
A round trip is defined as a buy and sell that occur within 30 days. Excessive trading violation will result in a trading restriction period of 30 days. Maximum of 1 round trip allowed per 30 days period.

T. ROWE PRICE SCIENCE & TECHNOLOGY I
Maximum of 1 round trip allowed per 30 days period. In addition to restricting transactions in accordance with the 30-Day Purchase Block, T. Rowe Price may, in its discretion, reject any purchase or exchange into a fund from a person whose trading activity could disrupt the management of the fund or dilute the value of the fund's shares, including trading by persons acting collectively. Such persons may be barred from further purchases of T. Rowe Price funds for a period longer than 30 calendar days or permanent.

JPMORGAN EQUITY INCOME R6 & JPMORGAN SMALL CAP EQUITY R6
Excessive trading violation will result in a trading restriction period of 90 days. Maximum of 1 round trip allowed per 60 days period.

BAIRD MID CAP INSTL
In addition, if market timing is detected in an omnibus account held by a financial intermediary, the Funds may request that the intermediary restrict or prohibit further purchases or exchanges of Fund shares by any shareholder that has been identified as having violated the Market Timing Policy. The Funds may also request that the intermediary provide identifying information, such as social security numbers, and trading information about the underlying shareholders in the account in order to review any unusual patterns of trading activity discovered in the omnibus account.

FIDELITY® BALANCED K
Shareholders with two or more roundtrip transactions in a single fund within a rolling 90-day period will be blocked from making additional purchases or exchange purchases of the fund for 85 days. Shareholders with four or more roundtrip transactions across all Fidelity® funds within any rolling 12-month period will be blocked for at least 85 days from additional purchases or exchange purchases across all Fidelity® funds. Any roundtrip within 12 months of the expiration of a multi-fund block will initiate another multi-fund block. Repeat offenders may be subject to long-term or permanent blocks on purchase or exchange purchase transactions in any account under the shareholder's control at any time. In addition to enforcing these roundtrip limitations, the fund may in its discretion restrict, reject, or cancel any purchases or exchanges that, in the Adviser's opinion, may be disruptive to the management of the fund or otherwise not be in the fund's interests.

MFS GROWTH R6, MFS INTERNATIONAL DIVERSIFICATION R6, & MFS NEW DISCOVERY R6
MFSC will generally restrict, reject or cancel purchase and exchange orders into the fund if MFSC determines that an accountholder has made two exchanges, each in an amount of $15,000 or more, out of an account in the fund during a calendar quarter ("two exchange limit").

PRINCIPAL DIVERSIFIED REAL ASSET R6 & PRINCIPAL HIGH YIELD R-6
Principal may require a holding period of a minimum of 30 days before permitting exchanges among the Fund where there is evidence of at least one round-trip exchange (exchange or redemption of shares that were purchased within 30 days of the exchange/redemption).

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.24	Net Historical Performance as of 12.31.23			
						1 Year	3 Years	5 Years	10 Years
Nationwide Investor Destination Aggressive (Service Class) NDASX	VA	Asset Allocation	0.89	Y	8.58	19.92	4.65	10.33	7.02
Nationwide Investor Destination Moderately Aggressive (Service Class) NDMSX	VA	Asset Allocation	0.90	Y	7.28	17.78	3.51	9.15	6.36
Nationwide Investor Destination Moderate (Service Class) NWWJX	VA	Asset Allocation	0.55	Y	5.62	15.09	2.64	7.66	5.56
Nationwide Investor Destination Moderately Conservative (Service Class) NSDCX	VA	Asset Allocation	0.91	Y	3.48	11.44	0.87	5.30	4.04
Nationwide Investor Destination Conservative (Service Class) NDCSX	VA	Asset Allocation	0.93	Y	1.81	8.21	-0.66	3.19	2.71
Putnam International Equity Fund (Class A) POVSX	VA	Foreign Stock	1.26	Y	5.14	18.62	3.19	9.03	3.61
Templeton Foreign Fund (Class A) TEMFX	VA	Foreign Stock	1.10	Y	1.74	19.95	6.71	6.34	2.27
Janus Henderson Global Research (Class T) JAWWX	VA	World Stock	0.80	Y	17.02	26.61	6.24	13.14	8.85
Invesco Global (Class A) OPPAX	VA	World Stock	1.06	Y	13.95	34.03	1.61	11.99	8.22

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.24	Net Historical Performance as of 12.31.23			
						1 Year	3 Years	5 Years	10 Years
Templeton Global Smaller Companies Fund (Class A) TEMGX	VA	World Stock	1.32	Y	1.70	16.64	0.70	7.56	3.95
Brown Capital Management Small Company Fund (Investor Class) BCSIX	VA	Small Growth	1.28	Y	-6.16	19.12	-10.88	5.85	7.43
NVIT Small Company Fund (Class 1)	VA	Small Blend	1.05	Y	3.35	13.99	6.60	13.31	8.47
DFA US Micro Cap Portfolio (Institutional Class) DFSCX	VA	Small Blend	0.41	Y	1.44	17.86	11.26	12.12	8.05
American Century Small Cap Value (Investor Class) ASVIX	VA	Small Value	1.09	Y	0.10	16.08	10.67	14.54	8.72
BNY Mellon Mid Cap Index Fund (Investor Class) PESPX	VA	Mid Blend	0.50	Y	5.93	15.89	7.56	12.06	8.76
Nationwide Mellon Dynamic U.S. Core Fund (Class R6) MUIGX	VA	Large Blend	0.50	Y	14.77	23.92	8.05	15.64	12.41
Janus Henderson Research Fund (Class T) JAMRX	VA	Large Growth	0.74	Y	24.86	42.96	6.36	16.64	12.40
Invesco American Franchise Fund (Class A) VAFAX	VA	Large Growth	0.99	Y	22.70	40.91	2.76	16.07	11.56

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.24	Net Historical Performance as of 12.31.23			
						1 Year	3 Years	5 Years	10 Years
Invesco Capital Appreciation (Class A) OPTFX	VA	Large Growth	0.97	Y	23.50	35.51	4.54	16.20	11.32
Aberdeen U.S. Sustainable Leaders Fund (Institutional Service Class) GXXIX	VA	Large Growth	0.96	Y	6.95	15.18	1.89	12.75	9.03
Invesco Diversified Dividend Fund (Investor Class) LCEIX	VA	Large Value	0.72	Y	6.02	8.86	8.45	9.86	7.63
Davis NY Venture Fund (Class A) NYVTX	VA	Large Blend	0.92	Y	13.43	30.00	6.48	11.98	8.70
Nationwide Fund (Institutional Service Class) MUIFX	VA	Large Blend	0.64	Y	14.39	25.53	8.24	15.28	11.23
Neuberger Berman Large Cap Value Fund (Trust Class) NBPTX	VA	Large Value	0.95	Y	6.11	-1.95	7.32	11.81	9.28
American Century Value Fund (Investor Class) TWVLX	VA	Large Value	1.00	Y	2.92	8.73	10.60	11.55	8.23
Invesco Growth & Income Fund (Class A) ACGIX	VA	Large Value	0.79	Y	7.63	12.56	10.85	11.79	8.23
BNY Mellon Balanced Opportunity Fund (Class Z) DBOZX	VA	Moderate Allocation	0.98	Y	7.49	17.57	4.37	8.60	6.70

Fund / Ticker Symbol	Investment Type	Objective	Annual Expense	Other Fees (Y/N)	Return 6 Mos. Ended 06.30.24	Net Historical Performance as of 12.31.23			
						1 Year	3 Years	5 Years	10 Years
MFS Total Return (Class A) MSFRX	VA	Moderate Allocation	0.73	Y	3.37	10.31	4.33	8.41	6.40
PIMCO Int'l Bond Fund (Class A) PFOAX	VA	World Bond	1.03	Y	1.16	9.05	-1.38	1.63	3.04
Janus Henderson High Yield Fund (Class T) JAHYX	VA	High Yield Bond	0.88	Y	3.30	11.48	0.01	4.01	3.44
Federated Hermes Corporate Bond Fund (Class A) FDBAX	VA	Corporate Bond	0.86	Y	-0.14	7.79	-2.74	2.65	2.85
PIMCO Total Return Fund (Admin Class) PTRAX	VA	Intermediate Term Bond	0.74	Y	0.24	6.04	-3.49	1.06	1.68
Franklin U.S. Government Secs (Class A1) FKUSX	VA	Intermediate Govt Bond	0.75	Y	-1.09	4.37	-2.86	0.00	0.69
Nationwide Gvt Money Market Fund (Investor Shares) MIFXX	VA	Money Market	0.54	Y	2.44	4.66	1.95	1.56	0.94

Past performance is no guarantee of future performance.

Investment returns and principal value will fluctuate and the investors' units, when redeemed, may be worth more or less than their original cost.

**** New money rates are set every quarter, please call Nationwide to obtain the current new money rate.***

SECTION III

PROVIDER REPRESENTATIVES

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM **SECTION**

457 DEFERRED COMPENSATION PLAN

You are responsible for meeting with your provider to set up your account, monthly payroll contribution, and beneficiaries.

Use the Investment Provider Listing on the NDPERS web site to find a provider near you:

https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-457-deferred-comp/provider-list.pdf

Contact the North Dakota Securities Department to check the background of an investment professional before doing business.

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: October 8, 2024

SUBJECT: Life Insurance Plan Contract Amendment

At the September meeting, the Board approved the contract renewal for the NDPERS group life insurance plan with Voya Financial. The renewal was approved for the July 1, 2025, through June 30, 2027, contract period. The attached document is the contract amendment drafted by NDPERS legal staff and approved by representatives from ReliaStar Life Insurance Company. ReliaStar Life Insurance Company is the contracting entity for Voya Financial.

Board Action Requested: Approve the contract amendment for the NDPERS group life insurance plan for the July 1, 2025, through June 30, 2027, contract period and authorize Chairman Seminary to sign.

Attachment

Attachment

FIRST ADDENDUM TO AGREEMENT FOR SERVICES BETWEEN NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM AND RELIASTAR LIFE INSURANCE COMPANY

This First Addendum is between the State of North Dakota, acting through its North Dakota Public Employees Retirement System (STATE), and ReliaStar Life Insurance Company (CONTRACTOR).

NDPERS and CONTRACTOR entered into an Agreement for Services (Agreement), effective July 1, 2023, to June 30, 2025. In its Renewal Offer to NDPERS, with an effective term of July 1, 2025 until June 30, 2027, and incorporated into this Amendment as Exhibit A, CONTRACTOR offered to continue services with no rate increase. The NDPERS Board reviewed the offer, considered the matter, and passed a motion to accept the proposal.

NDPERS and CONTRACTOR therefore agree as follows:

1) CONTRACTOR will continue to provide services, with no rate increase, through June 30, 2027.

2) Paragraph 18 of the Agreement is deleted in its entirety and replaced with the language below:

> CONTRACTOR agrees to comply with all applicable federal and state laws, rules, and policies, including those relating to nondiscrimination, accessibility, and civil rights (See N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women).
>
> CONTRACTOR agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.
>
> CONTRACTOR shall have and keep current all licenses and permits required by law during the Term of this Contract.
>
> CONTRATOR is prohibited from boycotting Israel for the duration of this Contract. (See N.D.C.C § 54-44.4-15.) CONTRACTOR represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If STATE receives evidence that CONTRACTOR boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if CONTRACTOR has fewer than ten (10) full-time employees.
>
> CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE to terminate in accordance with the Termination for Cause section of this Contract.

3) All other terms and conditions remain the same.

The undersigned execute this First Addendum to Agreement for Services on the most recent date below.

CONTRACTOR ReliaStar Life Insurance Company	STATE OF NORTH DAKOTA Acting through its ND Public Employees Retirement System
By: Mona Zielke	By: _____
Title: SVP	Title: _____
Date: 9/19/2024	Date: _____

From: Kutscheid, N. (Nicholas)
To: Fricke, Rebecca D.; Machamer, L. (Lisa)
Cc: Schaf, Lindsay J.
Subject: RE: July 1, 2025-June 30, 2027 Life Insurance Rate Guarantee/Renewal
Date: Friday, July 12, 2024 8:47:55 AM
Attachments: image001.png
image002.png

Hi Rebecca, Happy Friday!

You are correct, the current rates are in guarantee through 6/30/27.

I've met with the Underwriter and, unfortunately, she has confirmed that Voya is not able to make any additional rate concessions during the current rate guarantee period. We will be sure to re-review at the end of the current rate guarantee period, however.

Thank you for checking! We value our partnership with NDPERS very much.

Please let me know if you have any further questions.

Thank you,

Nicholas D. Kutscheid
National Account Executive
Voya Financial®
Tel: (612) 342-7849
Email: nicholas.kutscheid@voya.com
Voya.com

NYSE: VOYA

From: Fricke, Rebecca D. <rfricke@nd.gov>
Sent: Wednesday, July 10, 2024 8:12 AM
To: Kutscheid, N. (Nicholas) <nicholas.kutscheid@voya.com>; Machamer, L. (Lisa) <lisa.machamer@voya.com>
Cc: Fricke, Rebecca D. <rfricke@nd.gov>; Schaf, Lindsay J. <lschaf@nd.gov>
Subject: July 1, 2025-June 30, 2027 Life Insurance Rate Guarantee/Renewal

Good morning, Voya Team.

Per the terms of the RFP that was released in 2022 by NDPERS, of which Voya was the successful bidder, it is time for us to begin discussions on the renewal rates for the July 1, 2025 through June

30, 2027 renewal period. It appears that the Best and Final Offer provided by Voya (attached) guaranteed the rates for 4 years, thus through this upcoming contract period. I am reaching out to confirm this to be the case. However, as part of renewals, we also ask vendors to review whether the experience warrants a rate reduction for consideration by the NDPERS Board.

Please review and confirm the renewal premiums for the upcoming renewal period July 1, 2025 through June 30, 2027. I'll need confirmation no later than August 31, 2024.

SECTION I: INTRODUCTION

1. Background and Objectives

The North Dakota Public Employees Retirement System (NDPERS) desires to provide Basic and Supplemental Life and Accidental Death & Dismemberment (AD&D) benefits to all eligible active and retired state, university, and participating political subdivision employees and their eligible dependents. NDPERS is soliciting proposals for an initial coverage period to be effective July 1, 2023 to June 30, 2025. Additionally, NDPERS is requesting two additional renewal periods, each of two years in duration (07/01/2025 – 06/30/2027 and 07/01/2027 – 06/30/2029) for a potential total of six years. The rates for the renewal periods will be negotiated separately at least 10 months in advance of the respective renewal.

Please let me know if you have any questions.

Thanks.

Rebecca Fricke

North Dakota Public Employees Retirement System
Visit us at 1600 East Century Avenue|Suite 2 | Bismarck
Send mail to PO Box 1657 | Bismarck, ND 58502-1657
W www.ndpers.nd.gov | Subscribe to receive news
P 701.328.3978|**TF** 800.803.7377|**F** 701.328.3920
email rfricke@nd.gov**| Find us on** facebook

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

Rebecca Fricke
Executive Director
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1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: October 8, 2024

SUBJECT: 2023 Active Healthcare Report

Please find the NDPERS Active Healthcare Report for the 2023 calendar year attached.

Hospital utilization (56% of total charges) increased 2%, physician/clinical utilization (33% of total charges) decreased 2%, and pharmacy utilization (11% of total charges) was level. The combined utilization results in an overall per capita cost increase of 8.7% for the calendar year ending 2023.

A similar agency-specific report is developed for the large groups on the NDPERS Health Plan (over 100 employees).

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

This item is informational and does not require any action by the Board.

Attachment

Attachment

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

2023 NDPERS Healthcare Report

The NDPERS Healthcare Report provides your agency with a snapshot of your agency's participation and utilization of the Health Insurance Plan.

During 2023, 18,023 active North Dakota state employees were enrolled as the main subscriber in the Plan. These employees have an additional 30,924 dependents.

Hospital

The state's health plan members incurred 490,701 hospital claims/services from January to December 2023. These claims amounted to $434,888,893 in total charges. The NDPERS Health Plan paid $139,975,668 toward these charges.

HOSPITAL UTILIZATION

ADMISSION: 01/2023 - 12/2023

	CLAIMS	%	CHARGES	PAID
OTHER	11,118	2	$30,282,718	$9,261,322
IP NEWBORN	3,641	1	$14,270,329	$4,490,579
IP MEDICAL	101,779	21	$102,344,631	$27,730,551
IP MATERNITY	304	0	$514,481	$192,995
IP SURGICAL	13,972	3	$101,264,441	$31,646,194
IP PSYCH	1,745	0	$6,963,383	$1,924,034
IP CHEM DEP	421	0	$2,039,946	$561,651
OP SURGICAL	3,750	1	$11,845,906	$5,030,298
OP MEDICAL	352,182	72	$164,567,907	$58,680,140
SNF, HOSPICE & SWING BED	577	0	$339,462	$169,013
HOME HEALTH AG	1,212	0	$455,691	$288,891
TOTAL	490,701	100	$434,888,893	$139,975,668

CLAIM TYPE: IP=Inpatient OP=Outpatient

Physician/Clinic

ND active employees incurred 1,180,548 physician/clinic services from January to December 2023. These services amounted to $258,091,371 in total charges. The NDPERS Health Plan paid $115,456,245 toward these charges.

PHYSICIAN/CLINIC UTILIZATION

SERVICE DATE: 01/2023 - 12/2023

	SERVICES	%	CHARGES	PAID
OTHER	4	0	$1,742	$260
SURGERY-OP	7,543	1	$10,100,205	$4,637,823
IP VISITS	100,733	8	$47,698,298	$20,242,447
OP / ER VISITS	24,515	2	$9,349,543	$3,850,279
OFFICE CALLS	917,145	78	$175,436,795	$81,939,257
CHEM/PSYCH	1,010	0	$207,685	$111,854
THERAPIES	38	0	$33,267	$9,484
DIAGNOSTIC	129,560	11	$15,263,837	$4,664,842
TOTAL	1,180,548	100	$258,091,371	$115,456,245

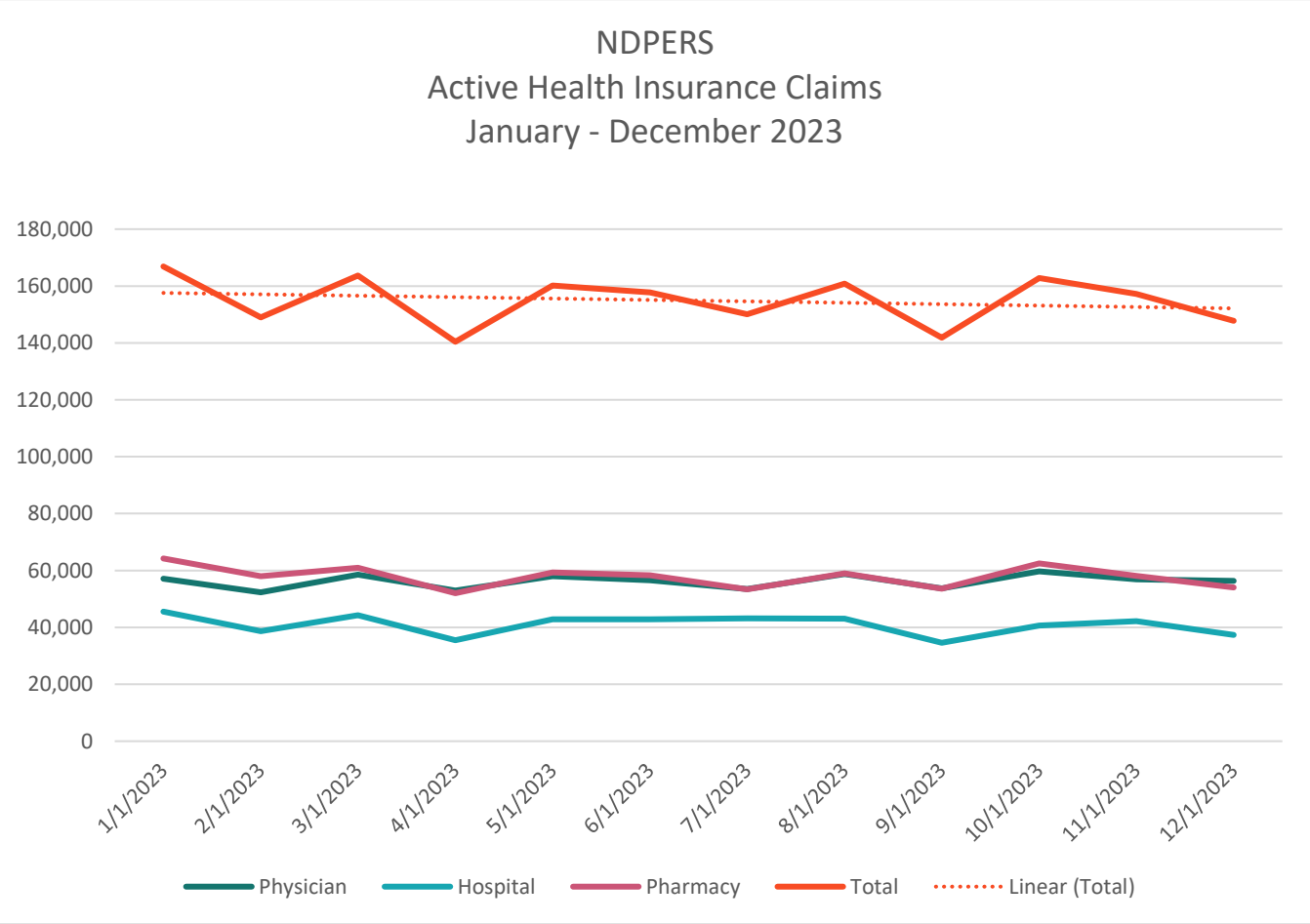
Prescription Drugs

ND active employees incurred 674,245 pharmacy claims from January to December 2023. These claims amounted to $88,838,521 in total charges. The NDPERS Health Plan paid $80,972,926 toward these charges.

PRESCRIPTION DRUGS UTILIZATION

FILL DATE: 01/2023 - 12/2023

	CLAIMS	%	CHARGES	PAID
NON-GENERIC	110,614	16	$78,041,154	$73,639,328
GENERIC	563,631	84	$10,797,367	$7,333,597
TOTAL	674,245	100	$88,838,521	$80,972,926

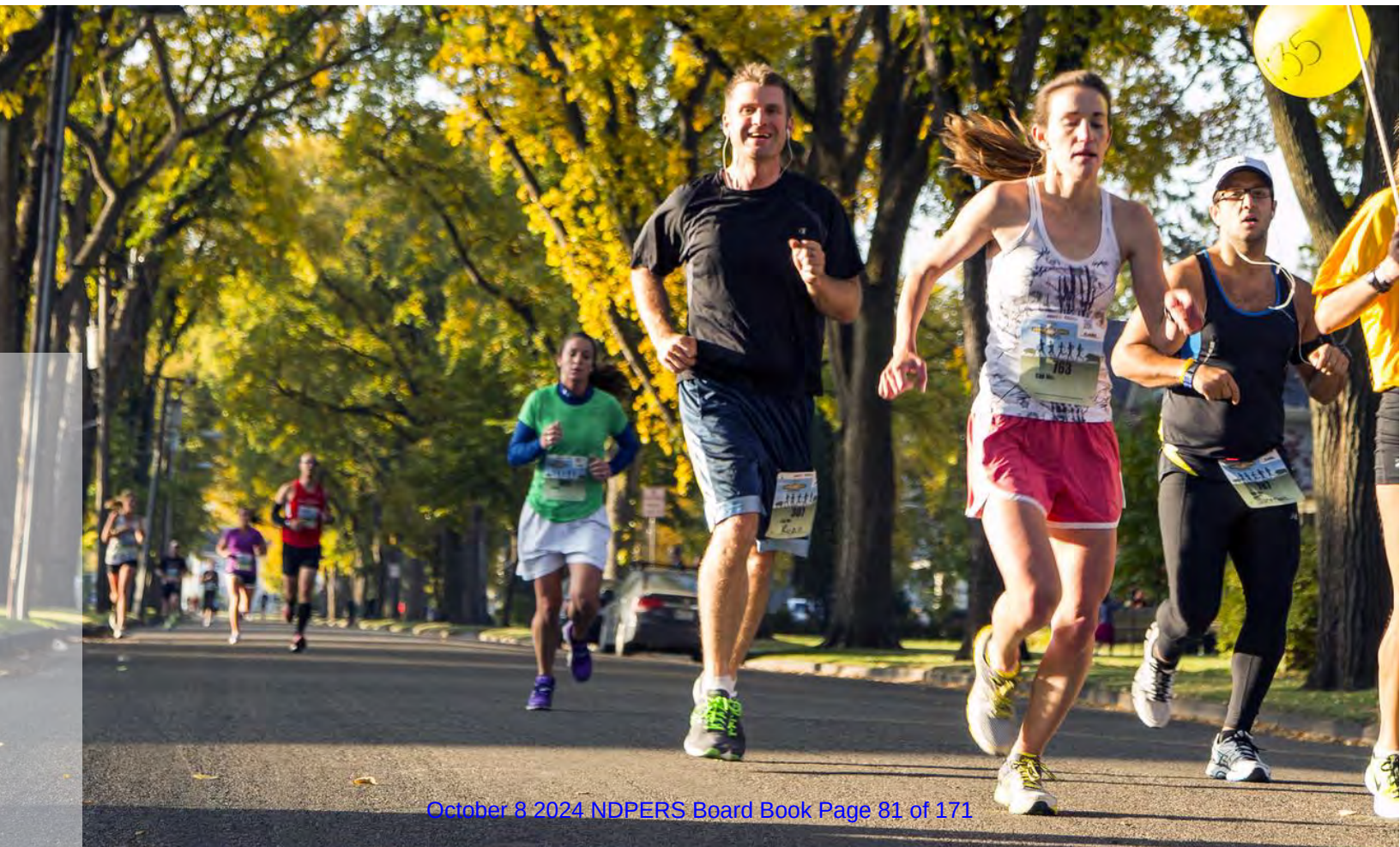


Percentages

EMPLOYEES, SPOUSES, & CHILDREN BY MEMBERSHIP & CLAIM TYPE

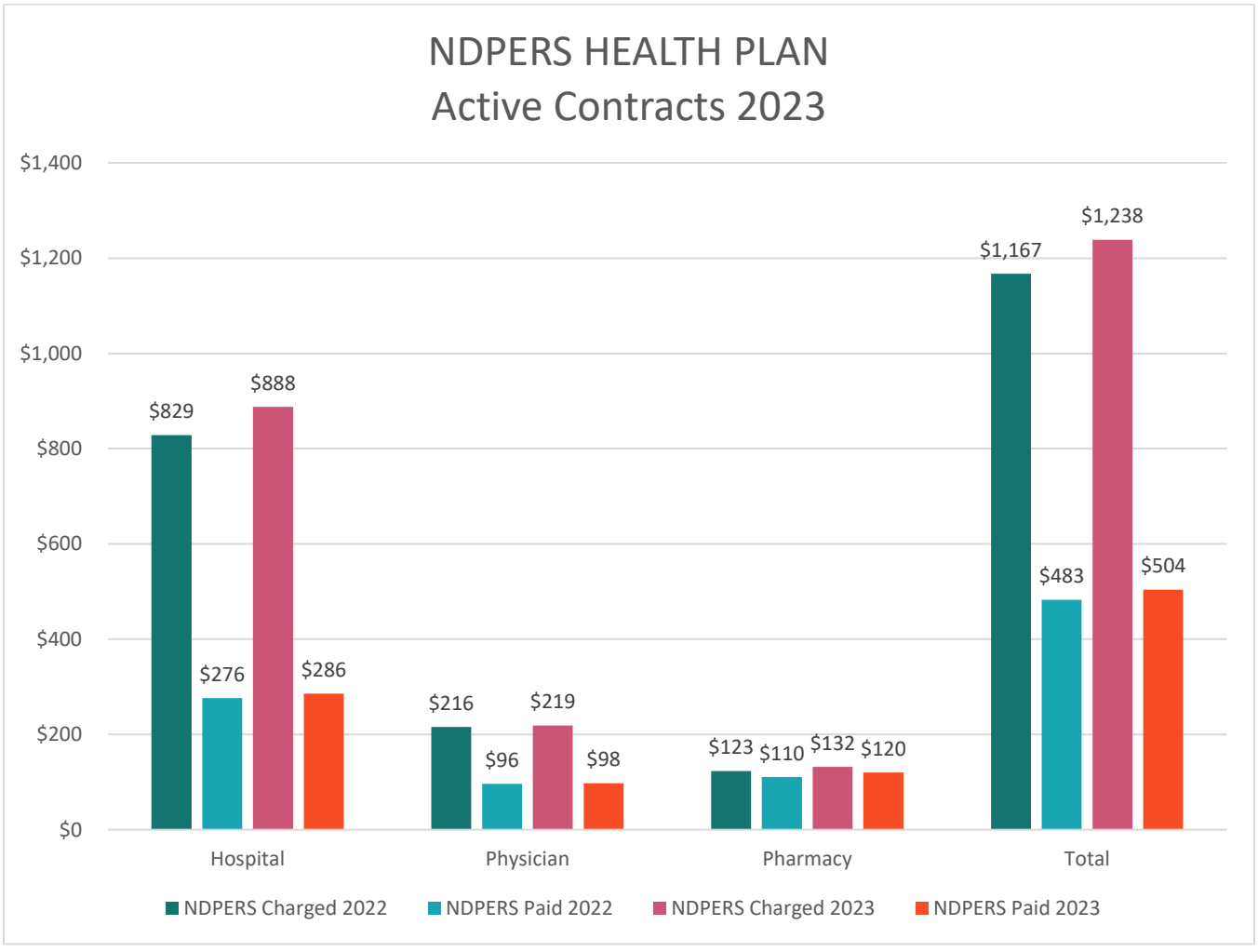
MEMBERSHIP DATE: 01/2023 - 12/2023

	MEMBERSHIP		HOSPITAL CLAIMS		PHYSICIAN SERVICES		PHARMACY CLAIMS	
	Sum	%	Sum	%	Sum	%	Sum	%
CHILDREN	19,692	40	109,516	22	351,542	30	133,242	20
EMPLOYEE	18,023	37	220,706	45	509,959	43	339,137	50
SPOUSE	11,232	23	160,479	33	319,047	27	201,866	30
TOTAL	48,947	100	490,701	100	1,180,548	100	674,245	100



Summary

The following chart shows that the 2023 NDPERS per capita charged and paid claims were higher than in 2022.



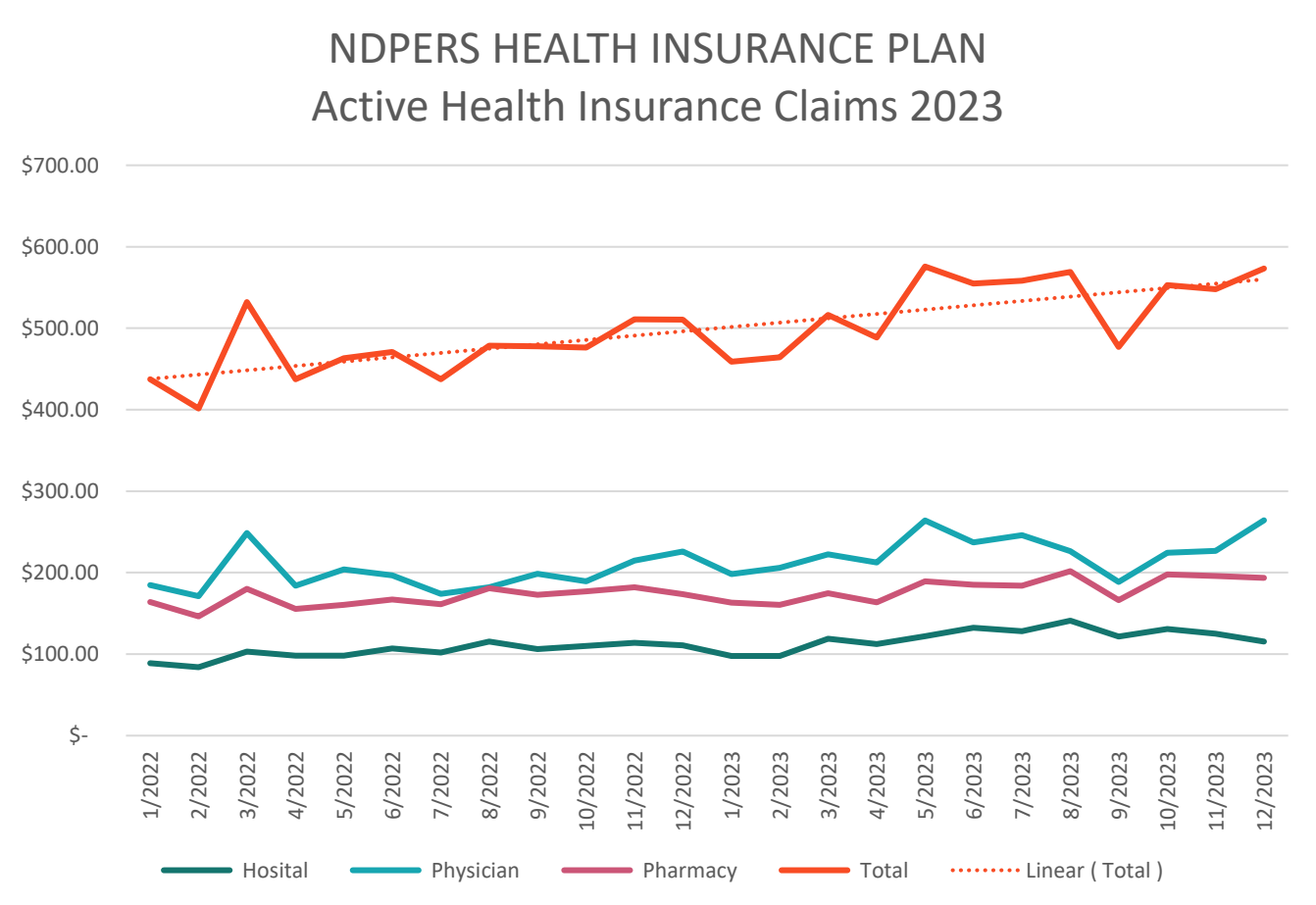
At a Glance

TOTAL NDPERS PLAN PARTICIPATION

This graph depicts the average amount the NDPERS Health Plan paid per member per month (per capita) in the last two years.

Active employees claims and services amount to $714 per capita level. The cost for dependents of active employees in the Plan ranges at about $491 per person per month. The retired membership's per capita costs are close to $317 per retiree and $227 per dependent.

Overall, this graph reflects the 2023 NDPERS health plan cost per person per month stands at $526 per person per month vs $472 in 2022. In addition to this, the NDPERS health plan currently pays $38.03 per month per contract in administration costs.



ND Public Employees Retirement System
1600 East Century Avenue, Suite 2 | PO Box 1657 | Bismarck, ND 58502-1657
P: 701.328.3900 | TF: 800.803.7377 | F: 701.328.3920
https://www.ndpers.nd.gov/

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

Rebecca Fricke
Executive Director
(701) 328-3900
(800) 803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Lindsay Schaf

DATE: October 8, 2024

SUBJECT: FlexComp – Plan Document

NDPERS staff reviewed and made minor edits to the FlexComp Plan Document. The edits are not due to changes within state or federal law, but rather to provide clarification on how the plan is being administered based upon member inquiries made over the past year since the Plan Document was last approved by the Board. These updates have been reviewed by ASIFlex and legal counsel. The attachment has the suggested changes tracked for the Board's review. Upon approval, the Table of Contents and/or formatting will be updated as needed.

Staff is requesting approval of the updates to the Plan Document effective with the new plan year effective January 1, 2025.

Board Action Requested

Approve the updates to the NDPERS FlexComp Plan Document effective January 1, 2025.

Attachment

STATE OF NORTH DAKOTA

FLEXCOMP PLAN DOCUMENT

Effective January 1, 2025~~4~~

ADOPTION RESOLUTION

Resolved, that effective January 1, 2024~~4~~5, the State of North Dakota has adopted the attached amended and restated Section 125 FlexComp Plan. The Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code, as amended, and its associated regulations.

By: _____

Title: _____

Dated: _____

TABLE OF CONTENTS

ARTICLE I. PURPOSE OF PLAN

The purpose of the State of North Dakota FlexComp Plan ("Plan") is to allow Employees to pay medical, dental, vision, group term life, ~~disability and cancer~~and other eligible insurance premiums, along with ~~and~~ other medical and dependent care expenses using pre-tax dollars.

The Board (pursuant to North Dakota Century Code Section 54-52-04) has, therefore, adopted the Plan as set forth herein and as amended from time to time, effective January 1, 2024 for the exclusive benefit of those Employees.

The Plan is intended to qualify as a cafeteria plan within the meaning of Code section 125 and shall be construed in a manner consistent with that section such that salary reduction elections will be eligible for exclusion from a Participant's taxable income. The Dependent Care FSA Plan is intended to qualify as a dependent care assistance program within the meaning of Code section 129, and the Health FSA Plan is intended to qualify as a self-insured medical reimbursement plan under Code section 105. The tax implications of this Plan, however, are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, neither the Board nor an Employer represents or warrants to any Participant that any particular tax consequence will result from participation in this Plan. By participating in the Plan, each Participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Board or an Employer.

This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited group under Code sections 105, 125, and 129. The Plan provisions shall apply uniformly to all Employees.

ARTICLE II. DEFINITIONS

The following words and phrases have the following meaning, unless a different meaning is plainly required by the text:

2.01 **Board.** "Board" means the North Dakota Public Employees Retirement System (PERS) board.

2.02 **Benefit Package Option.** "Benefit Package Option" means a qualified benefit under Code section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan

2.03 **Benefit Plan.** "Benefit Plan" means the life insurance, medical, dental, vision, cancer insurance and in some cases disability plans and any alternate medical coverage under a health maintenance organization approved by the Board.

2.04 **Code.** "Code" means the Internal Revenue Code of 1986, as amended.

2.05 **Dependent Care Center.** "Dependent Care Center" means any facility which:

a. complies with all applicable laws and regulations of the State of North Dakota and unit of local government in which it is located;

b. provides care for more than six (6) individuals (other than individuals who reside at the center); and

c. receives a fee, payment or grant for providing services for any such individuals (regardless of whether such facility is operated for profit).

2.06 **Dependent Care FSA Plan.** "Dependent Care FSA Plan" means the dependent care assistance plan under this Plan that permits Employees to receive reimbursements from Qualified Dependent Care Expense accounts.

2.07 **Dependent Child.** For purposes of payment of the Pre-Tax Premiums to a Benefit Plan, "Dependent Child" means a child who is the Participant's "qualifying child" or "qualifying relative" as those terms are defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rule in Code section 152(e) for divorced or separated parents or a child (within the meaning of Code section 152(f)(1)) who has not attained age 27 as of the end of the year. For purposes of the Qualified Health Care Expense accounts, "Dependent Child" means a child (within the meaning of Code section 152(f)(1)) who is either (1) a "qualifying child" as that term is defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rules in Code section 152(e) for divorced or separate parents or (2) a child (within the meaning of Code section 152(f)(1)) who has not attained age 27 as of the end of the year.

Notwithstanding the foregoing, a child named in a qualified medical child support order (QMCSO) as defined in section 609 of the Employee Retirement Security Income Act (ERISA) shall be a Dependent Child to the extent specified in the QMCSO. The preceding sentence applies only to the Pre-Tax Premiums for a Benefit Plan and the Qualified Health Care Expense accounts under this Plan.

2.08 **Earned Income.** "Earned Income" means earned income as set forth in Code section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

2.09 **Employee.** "Employee" means employees of the State of North Dakota and district health units that are eligible to participate in the Plan. In addition, members of the Legislative Assembly are considered employees and eligible to participate in the Plan. Employees of higher education and political subdivisions are excluded from participation in the Plan.

Eligible employees who are eighteen (18) years of age, whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employed at least seventeen and one-half (17 ½) hours per week and at least five (5) months each year, or those first employed after August 1, 2003 who are employed at least twenty (20) hours per week and at least twenty (20) weeks each year, are eligible to participate in the Plan.

2.10 **Employer.** "Employer" means the State of North Dakota, excluding higher education, and any participating district health units as defined in Section 54-52.3-01 of the North Dakota Century Code.

2.11 **Grace Period.** "Grace Period" shall mean the period that begins immediately following the close of a Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year.

2.12 **Health Care Expense.** "Health Care Expense" means expenses incurred by a Participant for "medical care" within the meaning of Code section 213(d), incurred by a Participant, Spouse, or Dependent Child, but do not include premium payments for other medical plan coverage, including premiums paid for medical coverage under a plan maintained by the employer of a Spouse or Dependent Child or "qualified long-term care services," as described in Code section 213(d)(1)(C). For over-the-counter (OTC) drugs and medicines (other than insulin) which are for medical care as defined in Code section 213(d) will not be reimbursable as a Health Care Expense unless the Participant, Spouse or Dependent Child has a prescription for such drug or medicine. However, OTC products that are not considered drugs or medicines continue to be reimbursable if the product is for medical care as defined in Code section 213(d) and is not merely for good health or for cosmetic purposes.

2.13 **Health FSA Plan**. "Health FSA Plan" means the health flexible spending arrangement plan under this Plan that permits Employees to receive reimbursements from Qualified Health Care Expense accounts.

2.14 **Health Savings Account (HSA).** "Health Savings Account" or "HSA" means a health savings account established under Code section 223 as an individual trust or custodial account, each separately established and maintained by an Employee with a qualified trustee or custodian.

2.15 **Participant.** "Participant" means an Employee who is participating in the Plan.

2.16 **Plan.** "Plan" means the State of North Dakota FlexComp Plan, as set forth herein.

2.17 **Plan Administrator.** "Plan Administrator" means the North Dakota Public Employees Retirement System (PERS) with the authority and responsibility to manage and direct the operation and administration of the Plan. Plan Administrator includes any designated agent to which specified administrative functions under the Plan have been delegated, to the extent of such delegation.

2.18 **Plan Year.** "Plan Year" means a twelve (12) consecutive month period beginning January 1 and ending December 31.

2.19 **Pre-Tax Premium(s).** "Pre-Tax Premium(s)" means the cost of life, disability, medical, dental, vision and cancer insurance under the Benefit Plan which a Participant is required, as a condition for coverage, to defray. The amount of the Pre-Tax Premium(s) under the Benefit Plan shall be approved by the Board in accordance with the Board's policies that are applied to all Employees in a consistent manner.

2.20 **Qualified Beneficiary.** "Qualified Beneficiary" means an individual who, on the day before a Qualifying Event, is a Spouse or Dependent Child of a Participant in the Health FSA Plan. A person who becomes a new Spouse of an existing Qualified Beneficiary during a period of continuation coverage is not a Qualified Beneficiary.

In the case of a Qualifying Event that is termination of employment or reduction in hours, Qualified Beneficiary also includes an individual, who on the day before such Qualifying Event, is a Participant in the Health FSA Plan.

A newborn child or adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not a covered Employee will be entitled to the same continuation coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary. A newborn child or adopted child of a Qualified Beneficiary or child placed for adoption with a Qualified Beneficiary who was a covered Employee shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.

A Qualified Beneficiary must notify the Board within thirty (30) days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

2.21 **Qualified Dependent Care Expense.** "Qualified Dependent Care Expense" means any employment-related dependent care expense eligible for

reimbursement under the Plan as determined under Code sections 129(e)(1) and 21(b)(2). Such expense includes amounts paid for household services and for the care of Qualifying Individuals enabling the Employee and his/her Spouse to be gainfully employed or if the Spouse is physically or mentally unable to care for self, or if the Spouse is a Student.

2.22 **Qualified Health Care Expense.** "Qualified Health Care Expense" means any Health Care Expense which is not otherwise reimbursable under a Benefit Plan or other plan or entity.

2.23 **Qualifying Event.** "Qualifying Event" means any of the following with respect to continued participation in the Health FSA Plan under Section 3.07, if it results in termination of coverage:

a. The death of a Participant.

b. The voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a Participant.

c. The divorce or legal separation of a Participant from his/her Spouse.

d. A Dependent Child ceasing to be a Dependent Child.

2.24 **Qualifying Individual.** "Qualifying Individual" means, for purposes of a Qualified Dependent Care Expense account, any individual who is:

a. The Participant's dependent child (as defined in Code section 152(a)(1) and who has not attained age thirteen (13); or

b. The Participant's dependent (as defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof)), who (i) is physically or mentally incapable of caring for himself or herself; and (ii) has the same principal place of abode as the Participant for more than one-half of the Plan Year; or

c. The Participant's Spouse if the Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of the Plan Year.

Notwithstanding the foregoing, in the case of divorced or separated parents (within the meaning of Code section 152(e) or parents that were never married, a Qualifying Individual who is a child shall, as provided in Code section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code section 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

Expenses incurred outside the Participant's household for a Qualifying Individual under (b) or (c) above shall constitute Qualified Dependent Care Expenses only if the Qualifying Individual regularly spends at least eight (8) hours each day in the Participant's household.

2.25 **Salary Reduction Agreement.** "Salary Reduction Agreement" means an agreement by a Participant to reduce his/her salary or wage to pay for applicable Pre-Tax Premiums, to allocate to a Qualified Health Care Expense account or Qualified Dependent Care Expense account, or to contribute to an HSA.

2.26 **Spouse.** "Spouse" means the spouse of a Participant but shall not include an individual legally separated from a Participant under a decree of divorce or of separate maintenance. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

2.27 **Student.** "Student" means an individual who, during each of five (5) calendar months during a taxable year is a full-time student at an educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.01 **Eligibility.** All Employees eligible to participate in a Benefit Plan are eligible to participate in the Plan for purposes of payment of Pre-Tax Premiums under section 4.01. All Employees are eligible to participate in the Plan for purposes of payment of eligible Qualified Health Care Expenses under Section 4.02, except that an Employee with any contributions to a Health Savings Account in a Plan Year cannot participate in the Qualified Health Care Expense Account portion of the Plan for such Plan Year. All Employees are eligible to participate in the Plan for purposes of payment of Qualified Dependent Care Expenses under Section 4.03.

An employee who becomes an eligible Employee during the Plan Year ~~shall~~ ~~are~~is eligible to~~be allowed to~~ participate the first day of the month following the date he or she becomes an Employee, contingent upon the month in which the first payroll deduction will occur. An Employee shall also be allowed to participate if he or she experiences a change in participation status, as described in section 3.03.

3.02 **Participation.** Participation is established on a Plan Year to Plan Year basis. Each Employee shall be a Participant in the Plan for a Plan Year as follows:

a. For purposes of receiving Pre-Tax Premium benefits under Section 4.01 and HSA benefits under Section 4.04, participation will become effective when the appropriate Salary Reduction Agreement has been submitted as outlined in Article VI.

For the purpose of receiving employee supplemental life insurance Pre-Tax Premium benefits for the first $50,000 in coverage, participation will be automatic unless an employee elects not to participate under this Plan for the Plan Year for the purpose of Pre-Tax Premium. An Employee who is eligible to participate may elect not to participate by completing and ~~submitting the Premium Conversion declination~~ submitting an appropriate declination form with the Employer within the election period established by the Board. An Employee who elects not to participate with regard to payment of Pre-tax Premiums for life insurance shall pay for such Pre-tax Premiums for life insurance under the Benefit Plan on an after–tax basis.

b. For purposes of receiving reimbursement for Qualified Health Care Expenses and/or Qualified Dependent Care Expenses, participation will begin when the appropriate Salary Reduction Agreement(s)have been submitted and become effective under Article VI.

A Participant's Salary Reduction Agreement shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year.

3.03 **Changes in Participation Status.** With respect to the Pre-Tax Premiums, Qualified Health Care Expense accounts, and Qualified Dependent Care Expense

accounts, a Participant may revoke or amend participation in the Plan during a Plan Year only on account of and consistent with a change in status or other circumstances allowed under applicable law or regulation. Unless otherwise specified, a revocation or amendment of participation must be made within thirty-one (31) days after the change in status occurs and will be effective for the balance of the Plan Year in which the election is made, beginning with the first appropriate pay period after the election is received.

A Participant reducing his/her election, based on a change in status, cannot reduce his/her Salary Reduction Agreement election to the point where his/her contributions to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for the Plan Year are less than the amount already reimbursed for that Plan Year.

With respect to the HSA, a Participant who makes an election to contribute an amount on a pre-tax salary reduction basis to his or her HSA may change such election on a prospective basis at any time during the Plan Year.

a. Change in Status Events. *(Applies to Pre-Tax Premiums, Qualified Health Care Expense accounts and Qualified Dependent Care Expense accounts.)*

1. Change in the Participant's legal marital status, including marriage, divorce, death of Spouse, legal separation, or annulment.

2. Change in number of the Participant's Dependent Children, including birth, adoption, placement for adoption, or death.

3. Change in the employment status of the Participant, Spouse, or Dependent Child, including the following:

   (a) Termination or commencement of employment.

   (b) A reduction or increase in hours of employment by the Employee, the Employee's Spouse or the Employee's Dependent Child, including a switch between part-time and full-time status or commencement of or return from an unpaid leave of absence.

   (c) A change in employment status that results in the Participant, Spouse, or Dependent Child becoming or ceasing to be eligible for benefits under the individual's plan (such as switching from part-time to full-time or from full-time to part-time employment status).

   (d) Any situation where the Employee, the Employee's Spouse or the Employee's Dependent Child has special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in Section 3.04.

4. Dependent Child satisfies (or ceases to satisfy) dependent eligibility requirements, such as attainment of age, Student status or any similar circumstances.

b. Change in Residence. *(Applies to Pre-Tax Premiums only.)* A change in residence of the Employee, Spouse, or Dependent Child is considered a status change event. An election change is permissible if the change in residence affects the Participant's eligibility for coverage.

c. Change in Cost. *(Applies to Pre-Tax Premiums and the Dependent Care Expense accounts.)* A Participant may make election changes as a result of changes in cost under the following circumstances:

   1. If the cost of a qualified benefits plan increases (or decreases), the Plan may automatically make a prospective increase (or decrease) in Employee contributions for the Plan.

   2. If the cost of a Benefit Package Option significantly increases or significantly decreases, a Participant may make a prospective increase or decrease in payments or revoke his/her election and, in lieu thereof, choose another Benefit Package Option providing similar coverage, prospectively. This paragraph only applies in the case of the dependent care expense accounts if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

      For purposes of the dependent care expense accounts, a change in provider is a significant change in coverage similar to a Benefit Package Option becoming available, and may permit an election change under this Section 3.03.

d. Change in Coverage. *(Applies to Pre-Tax Premiums)* A Participant may make election changes as a result of changes in coverage under the following circumstances:

   1. If the coverage under the Benefit Plan is significantly curtailed without a loss of coverage, a Participant may revoke his/her election for that coverage. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Benefit Plan so as to constitute reduced coverage to Participants generally.

      If the coverage under the Benefit Plan is significantly curtailed and a loss of coverage occurs, a Participant may revoke his/her election. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage or to drop coverage if no similar Benefit Package Option is available. A loss of coverage means a complete loss of coverage under the Benefit Package Option, or other coverage option, or the individual losing all

coverage under the option by reason of an overall lifetime or annual limitation.

2. If the Benefit Plan adds a new Benefit Package Option or improves a Benefit Package Option, or other coverage option (or eliminates an existing option) a Participant may elect the newly added option (or elect another option if an option has been eliminated) prospectively and may make corresponding election changes with respect to other Benefit Package Options providing similar coverage. The Plan may permit eligible Employees who have not previously made an election to make an election on a prospective basis for coverage under a new or improved Benefit Package Option.

e. With the exception of Qualified Health Care Expense accounts, a Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan, including a plan of the same employer or of another employer, if:

1. The other plan permits the Participant to make an election change that would be permitted under federal regulations; or

2. The plan permits Participants to make an election for a period of coverage that is different from the period of coverage under this Plan.

f. A Participant may make an election change on a prospective basis to add coverage under a Benefit Plan for the Employee, Spouse or Dependent Child if the Employee, Spouse or Dependent Child loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

1. A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;

2. A medical care program of an Indian Tribal government (as defined in Code section 7701(a)(40)), the Indian Health Service, or a tribal organization;

3. A state health benefits risk pool; or

4. A foreign government group health plan.

g. When a Participant, Participant's Spouse, or Participant's Dependent(s) gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Participant's Dependent(s), a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Participant's Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Participant's Spouse's or Dependent's employer's plan unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

h. Judgement, Decrees and Orders. *(Applies to Pre-Tax Premiums and Qualified Health Care Expense accounts.)* In the case of a Benefit Plan that provides health or accident coverage, and for Qualified Health Care Expense accounts, a Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

1. If a judgment, decree, or order (collectively, "Order") results from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO) defined in ERISA section 609) that requires accident or health coverage for an Employee's Dependent Child or for a foster child who is a dependent of the Employee; and

2. The Employee changes his/her election to provide coverage for the Dependent Child or foster child if the Order requires coverage under the Employee's plan; or

3. The Employee changes his/her election to revoke coverage for the Dependent Child or foster child if the Order requires the former spouse to provide coverage.

i. Entitlement to Medicare and Medicaid. *(Applies to Pre-Tax Premiums and Qualified Health Care Expense accounts.)* In the case of a Benefit Plan that provides health or accident coverage, a Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

1. If the Employee, Spouse, or Dependent Child becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); and

2. If the Employee changes his/her election to revoke coverage for that Employee, Spouse or Dependent Child under the Benefit Plan or Qualified Health Care Expense account.

j. Consistency Rules Applicable to Change in Status Events. A Participant's mid-year election change under this Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects the Participant's, Spouse's or Dependent Child's eligibility or loss of eligibility for coverage under an employer's plan.

If the change in status event is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent Child, or a Dependent Child ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent Child, or the Dependent Child that ceased to satisfy the eligibility

requirements. Canceling coverage for any other individual under these circumstances fails to correspond with the change in status event.

If a Participant, Spouse or Dependent Child gains eligibility for coverage under a cafeteria plan or qualified benefits plan of the employer of the Spouse or Dependent Child as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other plan. The Plan may rely on the Participant's certification that such individual has obtained or will obtain coverage under the other plan unless the Plan has reason to believe that the Participant's certification is incorrect.

Notwithstanding the foregoing, for purposes of the Qualified Dependent Care Expense account, a Participant's mid-year election change under Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects expenses described in Code section 129 (including employment-related expenses as defined in Code section 21(b)(1) with respect to dependent care assistance.

The Plan Administrator, in its sole discretion, shall determine, based on the surrounding facts and circumstances and prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change in status event.

3.04 **HIPAA Special Enrollment Rights.** *(Applies to Pre-Tax Premiums only.)* A Participant may make a change to an annual election during the Plan Year if the change corresponds to a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Code section 9801(f), whether or not the change is permitted under any other section of this Plan, as follows:

a. Acquisition of a new Spouse or Dependent Child as a result of marriage, birth, adoption or placement for adoption.

b. Loss of eligibility under another group health plan or other health insurance by anyone who would otherwise be eligible under this Plan, including for (but not limited to) the following reasons:

1. Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation, cessation of dependent status, or

2. Loss of coverage through an HMO that does not provide benefits to individuals who do not reside, live or work in the service area, or

3. Termination of employer contributions toward that other coverage, or

4. If the other coverage was COBRA continuation coverage and the coverage was exhausted.

c. Loss of eligibility for coverage under Title XIX of the Social Security Act (Medicaid) or under Title XXI of the Social Security Act that is coverage under a state children's health insurance program (SCHIP) or becoming eligible for a premium assistance subsidy from Medicaid or SCHIP. A Participant has sixty (60) days after the date of the event to change his or her election.

d. For individuals losing other coverage, an Employee may revoke participation in a Benefit Plan and make a new election if the Employee is eligible, but not enrolled, for coverage under the terms of the Benefit Plan (or a Spouse or Dependent Child of such an Employee if the Spouse or Dependent Child is eligible, but not enrolled, for coverage); and

1. The Employee, Spouse or Dependent Child was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee.

2. The Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.

3. The Employee's, Spouse's or Dependent Child's coverage under a group health plan or health insurance was under a COBRA continuation provision and the coverage under such provision was exhausted, or not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or the Employer contributions towards such coverage were terminated.

Under this subsection d., a revocation or amendment of participation must be made within thirty-one (31) days after the date of exhaustion of coverage described in paragraph 1. or the termination of coverage or Employer contribution described in paragraph 3. and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made.

e. For acquisition of a Spouse or Dependent Child, an Employee may revoke participation in a Benefit Plan and make a new election if:

1. A person becomes a Spouse or a Dependent Child of the Participant through marriage, birth, or adoption or placement for adoption, and

2. The Participant elects to enroll himself/herself, the Spouse, and/or the Participant's Dependent Child or Children in the Plan, to the extent that the Spouse or Dependent Children are otherwise eligible for coverage.

Under this subsection e., a revocation or amendment of participation must be made within thirty-one (31) days after the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption and will be effective for the balance of the Plan Year in which the election is made, and in the case of marriage, beginning with the first appropriate pay period after the election is received; or in the case of a Dependent Child's birth, as of the date of such birth; or in the case of a Dependent Child's adoption or placement for adoption, the date of such adoption or placement for adoption.

f. An election change on account of birth, adoption or placement for adoption will be effective retroactive to the date of birth, adoption or placement for adoption, provided the request to change the annual election is made within thirty-one (31) days of the birth, adoption or placement for adoption. Except as otherwise provided for herein, election changes for other special enrollment events (e.g., marriage or loss of other health coverage) will be effective as soon as practicable once a request for such election changes has been received, provided the request to change the annual election is made within thirty-one (31) (or sixty (60) days, as applicable) of the event.

g. Retroactive coverage of a newly acquired Dependent Child on account of birth, adoption or placement for adoption applies to the Pre-Tax Premiums under section 4.01, but not to the Qualified Dependent Care Expense accounts. The effective date of coverage of a new Spouse or Dependent Child under the Qualified Dependent Care Expense account in accordance with Section 3.03 will be prospective for the balance of the Plan Year beginning as soon as practicable after the date the new Salary Reduction Agreement is received by the Plan Administrator.

h. Payroll changes made in accordance with special enrollment under this Section 3.04 will be effective with the first pay period following approval of a request to change a salary reduction election amount even if the effective date of a Dependent Child's coverage is retroactive.

3.05 Additional Election Change Pursuant to IRS Notice 2014-55. *(Applies to Pre-Tax Premiums for accident and health coverage only.)* An Employee who is eligible to enroll in a government sponsored exchange (marketplace coverage) during a marketplace special enrollment or open enrollment period may drop Benefit Plan accident and health coverage midyear, but only if the change corresponds to the Employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in marketplace coverage that is effective no later than the day after the last day of the original coverage.

3.06 Termination of Participation.

a. Pre-Tax Premium(s). Participation with regard to Pre-Tax Premium(s) provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. The end of the month following the month of termination of employment;

2. The date the applicable Salary Reduction Agreement is revoked;

3. The date the Plan or applicable Benefit Plan is terminated; or

4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week.

b. Qualified Health Care Expenses. Participation with regard to Qualified Health Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. The last day of month in which a Participant ceases to be an Employee;

2. The date the applicable Salary Reduction Agreement is revoked;

3. The date the Plan or the Health FSA Plan is terminated; ~~or~~

4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week; or~~.~~

4. Upon exhaustion of the annual election once during the Plan Year in which the Employee ceases employment.

~~Upon exhaustion of the annual election once during the Plan Year in which the Employee ceases employment;~~

c. Qualified Dependent Care Expenses. Participation with regard to Qualified Dependent Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. ~~1.~~ The last day of month in which a Participant ceases to be an Employee;

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~~1. Upon exhaustion of the annual election once during the Plan Year in which the Employee ceases employment;~~

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3~~2~~. The date the applicable Salary Reduction Agreement is revoked;

4~~3~~. The date the Plan or the Dependent Care FSA Plan is terminated; or

5~~4~~. The date of a change in employment status from permanent to temporary or reduction in hours to less that twenty (20) hours per week.

Notwithstanding any provision of the Plan to the contrary, a former Participant shall be entitled to submit a request for reimbursement of Qualified Health Care Expenses, in accordance with Article VII, as if he/she were a Participant, provided such Qualified Health Care Expenses were incurred while the former Participant participated in the Plan.

If participation terminates because the Participant ceases to be an Employee and the individual returns to eligible employment with the Employer in the same Plan Year within thirty (30) days, and without any other intervening event that would permit a Participant to revoke or amend participation, then the Employee will be required to take the same benefit election for the remaining portion of the Plan Year as he/she had before he/she terminated. Participation shall be effective the first of the month following termination date with prior employer.~~such election.~~

If the individual returns to employment, with the Employer, after more than thirty (30) days he/she will not be eligible to participate in the Pre-tax Premium benefit, the Qualified Health Care Expense account or the Qualified Dependent Care Expense account for the remainder of the Plan Year. Notwithstanding the foregoing, an individual who returns to employment with the Employer after more than thirty (30) days and within thirteen (13) weeks is eligible to participate in the Pre-tax Premium benefit with respect to group health plan and life insurance coverage only.

Notwithstanding any provisions of the Plan to the contrary, a Qualified Beneficiary may elect to continue coverage for Qualified Health Care Expenses by electing continuation coverage as set forth in Section 3.07.

3.07 Continuation Coverage.

a. Eligibility. A Qualified Beneficiary may continue coverage under the Health FSA Plan under this Section 3.07 by making election to do so with the Employer and submitting the applicable continuation coverage contribution, subject to all conditions and limitations under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The amount of the monthly contribution will be established by the Plan Administrator and will be paid on an after-tax basis on a uniform and consistent basis. However, Qualified Beneficiaries who elect COBRA are permitted to pay the COBRA premiums on a pre-tax basis through the end of the current Plan Year from their final paychecks.

b. Maximum Self-Payment Period. A Qualified Beneficiary may elect continuation coverage because of a Qualifying Event described in Section 2.23 only for the remainder of the Plan Year in which the Qualifying Event occurs (plus the Grace Period).

c. Procedures to Elect Continuation Coverage.

1. In the case of a Qualifying Event described in Section 2.23, a. or b (death, termination of employment or reduction in hours) a Qualified Beneficiary will receive information concerning continuation coverage, including the rates, within ~~forty-four~~sixty (60~~44~~) days of loss of coverage.

2. In the case of a Qualifying Event as described in Section 2.23, c. or d, (legal separation or divorce, or a child no longer qualifies as a Dependent Child) a Qualified Beneficiary must notify the Plan Administrator within sixty (60) days of the Qualifying Event. If notice is not received within sixty (60) days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage.

   Following receipt of timely notice of a Qualifying Event and within fourteen (14) days of receipt of such notice, the Plan Administrator will provide the Qualified Beneficiary with information concerning continuation coverage and rates.

3. After notification of continuation coverage, the Qualified Beneficiary will have sixty (60) days to elect continuation coverage, after the **later** of:

   (a) the date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or

   (b) the date that the Qualified Beneficiary is sent such the COBRA election notice.

   If a Qualified Beneficiary chooses to waive coverage, a waiver of continuation coverage will be effective on the date that the waiver is received by the Plan Administrator.

   A Qualified Beneficiary who, during the election period, waives continuation coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives continuation coverage later revokes the waiver within the sixty (60) day eligibility period, coverage will be reinstated retroactive to the the loss of coverage occurred~~effective on the date that the revocation of the waiver and election to continue is received by the Plan Administrator~~.

4. The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Plan Administrator within forty-five (45) days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is elected, and

shall be considered timely if received within thirty (30) days of the date due.

5. If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Plan Administrator in accordance with paragraph 4. above.

6. The election must specify which Qualified Beneficiaries are electing COBRA continuation coverage. If it does not specify the Qualified Beneficiaries, the election shall be deemed to be an election on behalf of all Qualified Beneficiaries.

d. Termination of Continuation Coverage. Continuation coverage as provided under this section will terminate on the **earliest** of the following dates, as applicable:

1. The date after election of continuation coverage that the Qualified Beneficiary first becomes covered under any other group medical coverage as an employee or dependent.

2. The end of the period for which the last payment was made for coverage in a timely manner.

3. The end of the Plan Year in which the Qualifying Event occurs (plus the Grace Period).

4. The date the Qualified Beneficiary becomes entitled to Medicare.

5. Under any circumstance where a non-COBRA beneficiary would have benefits terminated for cause (e.g., fraud).

6. The date the Board or the applicable Employer ceases to provide any group health plan.

3.08 Death of a Participant. With respect to Qualified Dependent Care Expenses, if a Participant dies, his/her participation in the Plan shall cease. However, such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year or, if earlier, until the account balance is exhausted.

With respect to Qualified Health Care Expenses, if a Participant dies, his/her participation in the Plan shall cease on the last day of such month. However, there are two ways for a deceased Participant's family members to access the money in the Participant's Qualified Health Care Expense account. Such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year. In addition, a Qualified Beneficiary may be eligible to elect COBRA continuation coverage in accordance with Section 3.07 and obtain reimbursement for their own health care expenses incurred after the Participant's death through the end of the Plan Year and Grace Period. A copy of the death certificate may need to be provided to the Plan Administrator or designated agent.

ARTICLE IV. BENEFITS

4.01 **Pre-Tax Premium(s).** An Employee may elect to pay Pre-Tax Premium(s) for a Benefit Plan subject to the provisions of Section 5.01.

4.02 **Qualified Health Care Expenses.** The Plan Administrator or designated agent shall reimburse a Participant for Qualified Health Care Expenses incurred by the Participant or the Participant's Spouse or Dependent Child in accordance with the provisions of Section 5.02. Reimbursement for Qualified Health Care Expenses during a Plan Year is limited to the annualized amount elected by the Participant to the Qualified Health Care Expense account under a valid Salary Reduction Agreement. The annual amount elected by the Participant for a Qualified Health Care Expense account under a valid Salary Reduction Agreement (minus any reimbursed expenses for the Plan Year) shall be available at all times during the applicable period of coverage regardless of the actual amount deducted from the Participant's salary for the Plan Year. An Employee who is enrolled in a High Deductible Health Plan with contributions to a Health Savings Account cannot participate in the Qualified Health Care Expense account portion of this Plan.

4.03 **Qualified Dependent Care Expenses.** The Plan Administrator or designated agent shall reimburse a Participant for Qualified Dependent Care Expenses in accordance with the provisions of Section 5.03. Reimbursement for Qualified Dependent Care Expenses during a Plan Year is limited to the amount of expenses incurred, not to exceed the amount in the Participant's account at the time a claim is made.

4.04 **HSA.** An Employee may elect to contribute on a pre-tax basis to a HSA.

4.05 **Determination of Noncompliance.** It is the intent of this Plan to provide a benefits plan that is nondiscriminatory and provide benefits to a classification of Employees while not discriminating in favor of any group, as set forth in Code sections 125, 105, and 129. In the event that a determination is made that all or any part of the contributions to the Plan do not qualify as non-taxable contributions under Code sections 125, 105, and/or 129, the affected contributions made by any Participant shall be treated as taxable salary and, to the extent not yet expended, returned to such Participant. The Participant shall pay:

a. Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed thereon;

b. The Participant's share (as determined in good faith) of any applicable FICA contributions which would have been withheld from such amounts, had such amounts been treated as taxable salary and not as Qualifying Dependent Care Expenses or Qualified Health Care Expenses.

ARTICLE V. SALARY REDUCTIONS

5.01 **Pre-Tax Premium(s).** A Participant agrees to reduce the Participant's salary or wage each month by the amount of the Pre-Tax Premium(s) under the Benefit Plan under a Salary Reduction Agreement.

5.02 **Qualified Health Care Expense Account.**

a. Qualified Health Care Expenses shall be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement.

b. A Participant's salary or wage may be reduced under this Section 5.02 in an amount not to exceed the federally allowed maximum as adopted by the NDPERS Board, as adjusted in accordance with Code section 125(i) to the extent such adjustment is approved by the Board.

1. The salary reduction amount so elected shall be paid pro rata over the number of consecutive pay periods in the Plan Year. The salary reduction amount for any single pay period may not exceed the amount of the Participant's salary or wage for that period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period; however, the total amount of salary reduction must equal the annual election amount.

c. The Plan Administrator or designated agent shall establish individual Qualified Health Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.02. The Plan Administrator or designated agent shall reimburse Participants for Qualified Health Care Expenses in accordance with Article VII.

5.03 **Qualified Dependent Care Expense Account.**

a. Qualified Dependent Care Expenses may be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement, not to exceed the amount in the Participant's account at the time reimbursement is required.

b. A Participant's salary or wage may be reduced under this Section 5.03 each Plan Year in an amount not to exceed the lesser of (1) the earned income limitation described in Code section 129(b) or (2) $5,000 or $2,500 if the Participant is married, but filing separately. In the case of a married Participant who elected an amount in excess of $2,500, the Plan Administrator shall be entitled to rely on the Participant's election as

constituting a certification by the Participant that he or she will file a joint tax return.

1. The salary reduction amount so elected shall be paid pro rata over the number of consecutive pay periods in the Plan Year. The salary reduction amount for any single pay period may not exceed the amount of the Participant's salary or wage for the pay period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period; however, the total amount of salary reduction must equal the annual election amount.

c. The Plan Administrator or designated agent shall establish individual Qualified Dependent Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts contributed under this Section 5.03. The Plan Administrator or designated agent shall reimburse Participants for Qualified Dependent Care Expenses in accordance with Article VII.

5.04 Funding of Health Savings Accounts (HSA).

Effective January 1, 2019. An Employee can elect to participate in the Health Savings Account portion of the Plan by electing to make pre-tax contributions to a HSA via a valid Salary Reduction Agreement. Such amounts will be contributed to a Health Savings Account established and maintained outside this Plan by a trustee or custodian. The benefits under the HSA portion of the Plan consist solely of an Employee's ability to make pre-tax contributions to a Health Savings Account. The terms and conditions of each applicable Participant's HSA is governed by the Health Savings Account trust and/or custodial agreement. An Employee's election under a Salary Reduction Agreement to contribute to a Health Savings Account can be increased, decreased or revoked prospectively at any time during the Plan Year. Contributions to an HSA cannot be elected with benefits under a Qualified Health Care Expense account.

A participant who has an election for Qualified Health Care Expenses that is in effect on the last day of a Plan Year cannot elect HSA contributions for any of the first three months following the close of that Plan Year, unless the Participant's Qualified Health Care Expense account balance is $0 as of the last day of that Plan Year.

In no event shall the amount contributed to a Participant's Health Savings Account, including pre-tax contributions under this Plan, any after-tax employee contributions, and any employer contributions, exceed the maximum amount under Code section 223(b), as prorated for the number of months the Participant is eligible to contribute to a HSA, in accordance with Code section 223(b).

5.05 **Accounting.** The Plan Administrator or designated agent shall maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Qualified Health Care Expenses or Qualified Dependent Care Expenses on behalf of any Participant for six (6) years.

ARTICLE VI. SALARY REDUCTION ELECTIONS

6.01 Election Period for Salary Reduction.

a. In order to contribute to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for a Plan Year, a Participant must submit to the Plan Administrator an appropriate Salary Reduction Agreement election form within the applicable election period.

b. An Employee who elects salary reduction for Pre-Tax Premium(s) must submit to the Plan Administrator an appropriate Salary Reduction Agreement within the applicable election period.

c. For the purpose of employee supplemental life insurance Pre-tax Premium benefits for the first $50,000 of coverage, an employee may elect not to participate by completing an appropriate Salary Reduction Agreement declination form within the applicable election period.

6.02 Termination, Revocation, or Amendment of Salary Reduction Elections.

a. A Participant's Salary Reduction Agreement for a Plan Year shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year. Failure to make such an election will result in waiving participation in the Plan for the Plan Year.

b. The employee supplemental life insurance Pre-tax benefits for the first $50,000 of coverage will be automatic unless an Employee declines this action.

c. Termination, revocation or amendment of salary reduction elections may only be made by a Participant in accordance with Article III.

6.03 Limitations on Exclusion from Gross Income for Dependent Care Expense Account.

a. Reimbursements under the Plan for Qualified Dependent Care Expenses shall be excluded from the gross income of a Participant during a Plan Year in accordance with Code section 129. An Employee's exclusion from gross income under the Plan in a calendar year shall not exceed the lesser of:

1. $5,000 if the Employee is married and filing a joint return or if the Employee is a single parent or $2,500 if the employee is married, but filing separately; or

2. In the case of an Employee who is not married at the close of such Plan Year, the Earned Income of such Employee for such Plan Year; or

3. In the case of an Employee who is married at the close of such Plan Year, the lesser of the Earned Income of such Employee or the Earned Income of the Spouse of such Employee for such Plan Year.

To the extent reimbursements exceed the maximum amount excludable from a Participant's gross income, the reimbursements shall be treated as taxable income to the Participant.

b. The amount excluded from the income of an Employee under the Plan for any Plan Year shall not include:

1. Payments made or incurred to an individual who can be claimed as a Dependent Child of the Employee or the Spouse of such Employee; or

2. Payments made or incurred to an individual who is a child, under the age of nineteen (19), of such Employee or the Spouse of such Employee.

6.04 Forfeiture of Salary Reduction Amounts.

a. If a Participant fails to claim any amounts in the Qualified Health Care Expense account or Qualified Dependent Care Expense account by the time allowed in Section 7.04, d., and Section 7.05, d., such amounts shall not be carried over to reimburse the Participant for expenses incurred during a subsequent Plan Year and rights to such amounts shall be forfeited by the Participant.

b. All forfeitures under this Plan shall be used first to offset any losses experienced by the Board during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the amounts paid by such Participant via salary reductions. Second, forfeitures shall be used to reduce the Board's cost of administering this Plan during the Plan Year.

6.05 Amendment of Salary Reduction Elections Due To Leave of Absence, Family and Medical Leave Act (FMLA) or Military Leave.

a. Pre-Tax Premiums and Qualified Health Care Expense Account.

1. *Leave with taxable compensation.* Pre-tax contributions during a leave will continue to be made if taxable compensation is due to the Participant while on leave of absence, FMLA leave, or military leave.

2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.

3. *FMLA.* A Participant commencing a qualifying leave under FMLA may, to the extent required by the FMLA, continue to maintain coverage

under the Benefit Plan and Qualified Health Care Expense Account under the terms and conditions set forth hereafter.

4. With respect to a Benefit Plan, for unpaid leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in 6.05, a., 2., then the same election the Participant had before the leave must be maintained for the remainder of the Plan Year upon return from the leave.

   (a) *"Pre-pay option":* A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.

   (b) *"Catch-up option":* Employer will continue coverage during the leave. A Participant must make pre-tax contributions after he or she returns from leave to make up missed contributions.

5. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis or by after tax contributions described in paragraph 4 above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed for Qualified Health Care Expenses as described in section 4.02 herein.

6. *USERRA.* If a Participant returns from a qualified military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2 above, or to elect not to participate for the remainder of the Plan Year.

7. For the Qualified Health Care Expense account, if a Participant revokes coverage upon commencement of the leave and elects to be reinstated upon return from the leave, the Participant has a choice between two options:

   (a) *Full Coverage:* The Participant may maintain the same election the Participant had before the leave and reinstate the level of coverage in effect when the leave began, provided that the Participant makes contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account for the contributions that were missed during the leave.

(b) *Prorated Coverage:* The Participant may reinstate a level of coverage that is reduced by the amount of contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account that were missed during the leave.

b. Qualified Dependent Care Expense Account.

1. *Leave with taxable compensation.* Pre-tax contributions during a leave may be made if taxable compensation is due to the Participant while on leave of absence, FMLA leave, or military leave and the employee has Qualified Dependent Care Expenses.

2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.

3. *FMLA.* A Participant commencing a qualifying leave under FMLA may continue to maintain coverage under the Qualified Dependent Care Expense Account under the terms and conditions set forth hereafter. For unpaid leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in paragraph 2 above, then the same election the Participant had before the leave must be maintained for the remainder of the calendar year upon return from the leave.

(a) *"Pre-pay option":* A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.

(b) *"Catch-up option":* Employer will continue coverage during the leave. A Participant must make pre-tax contributions after he or she returns from the leave to make up missed contributions.

~~4.~~5. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis described in paragraph 3 above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed as described in section 4.03 herein. Eligible expenses are only those expenses that enable the Employee or the Employee and the Employee's Spouse to be gainfully employed or the Spouse to be a Student. Any other expenses would not be reimbursable during the leave of absence period.

~~5.~~6. *USERRA*. If a Participant returns from a qualified military leave under USERRA and commences employment again, he/she may choose to

become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2 above, or to elect not to participate for the remainder of the Plan Year.

ARTICLE VII. PAYMENT OF CLAIMS

7.01 **Determination of Status of Eligible Expenses**. After receiving an appropriately submitted claim and the information required under Section 7.04 or Section 7.05, the Plan Administrator shall determine whether such expenses are Qualified Health Care Expenses or Qualified Dependent Care Expenses. The Plan Administrator may delegate the authority to administer claims under the Plan to a designated agent.

7.02 **Payment of Claims**. The Plan Administrator will authorize payment of properly submitted claims for reimbursement at such intervals, as it may consider appropriate.

7.03 **Expenses**. All administrative expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan shall be paid as authorized by the Plan Administrator.

7.04 **Claims Reimbursement for Qualified Health Care Expenses**.

a. The Participant must submit a properly completed claim form to the Plan Administrator or the designated agent along with written evidence from an independent third party describing the Health Care Expense that has been incurred, the person on whose behalf such Health Care Expense has been incurred, the date such expense was incurred, the amount of such expense, and such other information as the Plan Administrator may find necessary.

b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Health Care Expenses.

c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Health Care Expenses.

d. All claims for reimbursement must be submitted no later than April 30 following the end of the Plan Year in which the expense was incurred.

e. Claims reimbursement for Qualified Health Care Expenses using a debit card shall be made in accordance with the terms of the debit card agreement and Proposed Treasury Regulations section 1.125-6 and other applicable IRS rulings.

7.05 **Claims Reimbursement for Qualified Dependent Care Expenses.**

a. To make a claim for reimbursement of Qualified Dependent Care Expenses, the Participant shall submit a statement to the Plan Administrator or the designated agent on an appropriate form adopted by the Plan Administrator which may contain the following information:

1. The Qualifying Individual(s) for whom the Qualified Dependent Care Expenses were incurred;

2. A statement to substantiate that the dependent or dependents are Qualifying Individuals, such as the age of the dependent or a statement as to the physical or mental capacity of the dependent;

3. The nature of the services which will generate the Qualified Dependent Care Expenses;

4. Written evidence from an independent third party stating the expenses have been incurred, the amount of such expense, the date of such expense, and such other information as the Plan Administrator in its sole discretion may request;

5. The name of the person, organization or entity to who the expense was paid, including the taxpayer identification number, and the relationship, if any, of the person performing the services to the Participant;

6. A statement as to where the services were performed;

7. If the services are to be performed in a Dependent Care Center, a statement verifying that each of the requirements for a Dependent Care Center specified in Section 2.05 of the Plan are met;

8. A statement indicating whether the services are necessary to enable the Participant to be gainfully employed;

9. If the Participant is married, a statement:

   (a) that the Spouse is employed; or

   (b) if the Spouse is not employed, a statement that he/she is incapacitated or that he/she is a Student within the meaning of Section 2.25 of the Plan.

   If an Employee's Spouse is not employed, not incapacitated, nor a Student as defined in Section 2.25 at the time the expense was incurred, the expense is not a Qualified Dependent Care Expense; and

10. A statement that the Qualified Dependent Care Expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.

b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator or designated agent certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Dependent Care Expenses.

c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Dependent Care Expenses.

d. All claims for reimbursement must be submitted not later than April 30 following the end of the Plan Year in which the expense was incurred.

7.06 Grace Period for Qualified Health Care Expenses. Amounts remaining in a Participant's Qualified Health Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Health Care Expenses that are incurred during Grace Period under the following conditions:

a. Applicability. In order for an individual to be reimbursed for Qualified Health Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Health Care Expense account at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) a Participant with Health Care Expense account coverage that is in effect on the last day of that Plan Year; or (2) a Qualified Beneficiary (as defined under COBRA) who has COBRA coverage under the Health Care Expense account component on the last day of that Plan Year.

b. No Cash-Out or Conversion. Prior Plan Year Qualified Health Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a prior Plan Year Health Care Expense account may not be used to reimburse Qualified Dependent Care Expenses.

c. Reimbursement of Grace Period Expenses. Qualified Health Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Health Care Expense account component will be reimbursed and charged first from any available prior Plan Year Qualified Health Care Expense account balance. If a current Plan Year Qualified Health Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Health Care Expense account component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.

d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Health Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from prior Plan Year Qualified Health Care Expense account amounts. Any prior Plan Year Qualified Health Care Expense account amounts that remain after all reimbursement have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in section 6.04 of the Plan.

e. Qualified Health Care Expense Account Balance, Grace Period and Health Savings Accounts. This Plan's Qualified Health Care Expense account operates with a Grace Period. Under IRS rules regarding a Qualified Health Care Expense Account's Grace Period, if a Participant's Qualified Health Care Expense Account is in effect with any balance in that account on the last day of a Plan Year, the Participant (and their Spouse, if married), nor an Employer on behalf of the Participant, can contribute to a Health Savings Account during the first three (3) months following the close of the Plan Year.

f. Employee Participation in a Qualified Health Care Expenses Account Prevents Spouse or Dependent Child from Contributing to an HSA. Since this Plan's Qualified Health Care Expenses account is a general purpose account that permits reimbursement of qualifying medical expenses of Employees, Spouses and Dependent Children, under IRS rules, if the Spouse (or Dependent Child) of the Employee is enrolled in a High Deductible Health Plan with Health Savings Account, the Spouse (and Dependent Child) cannot contribute to an HSA while the Employee is enrolled in a general purpose Qualified Health Care Expenses account.

7.07 **Grace Period for Qualified Dependent Care Expenses**. Amounts remaining in a Participant's Qualified Dependent Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Dependent Care Expenses that are incurred during the Grace Period under the following conditions:

a. Applicability. In order for an individual to be reimbursed for Qualified Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Dependent Care Expense Account at the end of the Plan Year to which that Grace Period relates, he or she must be a Participant with Qualified Dependent Care Expense account coverage that is in effect on the last day of that Plan Year.

b. No Cash-Out or Conversion. Prior Plan Year Qualified Dependent Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a Prior Plan Year Qualified Dependent Care Expense account may not be used to reimburse Qualified Health Care Expenses.

c. Reimbursement of Grace Period Expenses. Qualified Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Dependent Care Expense account will be reimbursed and charged first from any available prior Plan Year Qualified Dependent Care Expense account. If a current Plan Year Qualified Dependent Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Dependent Care Expense account will be paid in the order in which they are approved.

Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.

d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Dependent Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from a prior Plan Year Qualified Dependent Care Expense account balance. Any prior Plan Year Qualified Dependent Care Expense account balance that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

   The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in Section 6.04 of the Plan.

e. Grace Period Effect on Dependent Care Expense Account Exclusions. Grace Periods may have an adverse effect on the exclusions or credits that individuals report on their personal income tax return. There may be taxable income to an individual if the Qualified Dependent Care Expense account reimbursements exceed IRS permitted Qualified Dependent Care Expense Account exclusion amounts as a result of the Grace Period. For example, if as a result of the Grace Period, a participant receives Qualified Dependent Care Expense account reimbursements for services incurred in a year that exceed his or her maximum Qualified Dependent Care Expense account exclusion, the excess may be included in the Participant’s taxable income. Individuals should be guided by the advice of their tax professional(s).

ARTICLE VIII. ADMINISTRATION

8.01 **Board Powers and Duties.** The Board shall interpret the Plan and decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Board with respect to any matter under the Plan shall be conclusive and binding on all persons. The Board shall:

a. Make and enforce administrative rules or policies.

b. Decide questions concerning the Plan.

c. Provide a review to any Participant whose claim for benefits has been denied in whole or in part.

8.02 **Plan Administrator Duties.** The Plan Administrator or designated agent shall manage and administer the Plan. The Plan Administrator shall:

a. Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.

b. Prescribe the use of administrative policies and procedures as it considers necessary for the efficient administration of the Plan.

c. Determine the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.

d. Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan.

8.03 **Additional Operating Rules.** A Participant's salary reduction amount will generally not be subject to federal income tax withholding or to applicable Social Security (FICA) tax withholding. Salary reduction amounts will generally not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

8.04 **Use and Disclosure of Protected Health Information.** The Health FSA Plan will use protected health information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). Specifically, the Health FSA Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Health FSA Plan rarely, if ever, uses or discloses PHI for treatment purposes. In addition, the Health FSA Plan does not use or disclose PHI that is genetic information (as defined in 45 CFR 160.103) for underwriting purposes, as set forth in 45 CFR 164.502(a)(5)(1)).

The Health FSA Plan may disclose PHI to a Benefit Plan for purposes related to administration of these plans, as permitted by law.

The Health FSA Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Employer, as Plan sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Health FSA Plan document or as required by law;

b. Ensure that any agents to whom the Health FSA Plan sponsor provides PHI received from the Health FSA Plan agree to the same restrictions and conditions that apply to the Health FSA Plan sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

d. Not use or discloses PHI in connection with any other benefit or employee benefit plan of the Health FSA Plan sponsor unless authorized by an individual;

e. Report to the Health FSA Plan any PHI use or disclosure that is inconsistent with the uses or disclosure provided for of which it becomes aware;

f. Make PHI available to an individual in accordance with HIPAA's access requirements;

g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

h. Make available the information required to provide an accounting of disclosures;

i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Health FSA Plan available to the HHS Secretary for the purposes of determining the Health FSA Plan's compliance with HIPAA;

j. If feasible, return or destroy all PHI received from the Health FSA Plan that the Plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

k. If a breach of unsecured protected health information (PHI) occurs, the Health FSA Plan will notify affected individuals in accordance with applicable federal law and regulations.

In accordance with HIPAA, only the Executive Director of the Public Employees Retirement System and staff designated by the Executive Director may be given

access to PHI. Such persons may only have access to and use and disclose PHI for Health FSA Plan administration functions that the Plan sponsor performs for the Health FSA Plan. If such persons do not comply with this Section 8.04, the Health FSA Plan sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

In addition, the Health FSA Plan sponsor will comply with the following HIPAA security standards:

a. **Safeguards**. The plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Health FSA Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

b. **Agents**. The plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information

c. **Security Incidents**. The plans sponsor shall report to the Health FSA Plan any security incident under the HIPAA Security Standards of which it becomes aware.

d. **Adequate Separation**. The plan sponsor shall establish reasonable and appropriate security measures to ensure adequate separation between the Health FSA Plan and plan sponsor.

ARTICLE IX. APPEALS PROCEDURE

9.01 **Notice to Employee.** Any person who claims he/she has been denied a benefit under the Plan shall be entitled, upon written request to the Plan Administrator to receive, within sixty (60) days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefore, citing pertinent provisions of the Plan and a statement of the procedure to be followed in requesting a review of his/her claim.

9.02 **Late Claim Appeal.** Claims for the reimbursement of Qualified Health Care Expenses incurred in a Plan Year shall be paid as soon after a claim has been filed as is administratively practicable. If a Participant fails to submit a claim within the four (4) month period immediately following end of the Plan Year, those Health Care Expense claims shall not be considered for reimbursement by the Plan Administrator or designated agent; provided however, after four (4) months from the close of the Plan Year and before the end of three hundred sixty (360) days following the close of the Plan Year, a Participant may request the Board to authorize reimbursement of a Qualifying Health Care Expense incurred during the Plan Year by the Participant. The Participant must submit a written request to the Board specifying the request and the reason(s) why the Qualifying Health Care Expense was not submitted on or before the end of the 4th month following the close of the Plan Year. The Board may authorize payment for any reason constituting good cause not involving fault on the part of the Participant if such payment would be permitted under the Plan. Upon authorization of the Board, the Plan Administrator or designated agent shall reimburse the Participant for the amount not to exceed the Qualified Health Care Expense account balance for that Plan Year. The decision of the Board shall be final.

9.03 **Appeal of Denial of Benefit.** If the claimant wishes further consideration of his/her claim, he/she may request a review. The Plan Administrator shall schedule a review by the Board on the issue within sixty (60) days following receipt of the claimant's request for such review. The decision following such review shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Board as to all claims shall be final.

ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN

The Board reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modifications or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Board reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Board shall determine.

ARTICLE XI. GENERAL PROVISIONS

11.01 **No Right to be Retained in Employment.** Nothing contained in the Plan shall give any Employee the right to be retained in the employment of any Employer or affect the right of the Employer to dismiss any Employee.

11.02 **Alienation of Benefits.** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so is void.

11.03 **Use of Form Required.** All communications in connection with the Plan made by a Participant are effective only when submitted to the Plan Administrator or designated agent.

11.04 **Applicable Law.** The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of North Dakota.

11.05 **Statement of Benefits.** On or before January 31 of each year, the Board or a designated agent will furnish each Participant who received Qualified Dependent Care Expense account benefits under the Plan a written statement on appropriate forms required by the Internal Revenue Service, showing the amounts paid or incurred by the Plan in providing reimbursement under the Plan for Qualified Dependent Care Expenses with respect to the Participant for the prior Plan Year.

11.06 **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of a Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan shall, to the extent it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he/she is properly entitled under the Plan. Such actions by the Plan may include withholding any amounts due to the Plan or the Employer from compensation paid by the Employer.

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca Fricke

DATE: October 8, 2024

SUBJECT: Insulin/Diabetic Supplies Report and Recommendation

Attached for your information is the final report and recommendation submitted to the Employee Benefits Programs Committee and discussed at their September 12 meeting. As a reminder, this required report and recommendation was due to the passing of SB 2140 during the 68th Legislative Assembly. Specifically, Section 4 of SB 2140 provides:

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

This item is informational and does not require any action of the Board.

Attachment

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: Employee Benefits Programs Committee

FROM: NDPERS Board

DATE: September 12, 2024

SUBJECT: Insulin/Diabetic Supplies Report and Recommendation

SB 2140 was passed during the 68th Legislative Session and requires a NDPERS pilot program for the 2023-2025 biennium. SB 2140 specifically required a monthly cap of $25/month for insulin and diabetic supplies within the NDPERS health insurance active plans and became effective July 1, 2023. The provisions expire at the end of the biennium.

Section 4 of SB 2140 is shown below and requires that the NDPERS Board submit a bill in the upcoming Session that would roll this coverage out to the commercial market in North Dakota. Draft bill # 118 (Attachment 1) is the bill that the Board approved for submission to the Employee Benefits Programs Committee.

In addition to the bill submission, Section 4 of SB 2140 requires the Board to "append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued."

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

In order for the NDPERS Board to meet the obligation of appending a report to the bill, NDPERS requested that Sanford Health Plan (SHP) provide data for the year prior to and year following the July 1, 2023 SB 2140 effective date for comparison purposes.

NDPERS also requested our group insurance consultant, Deloitte, to prepare a cost and technical analysis of Draft Bill # 118 (Attachment 11). In addition, they were asked to conduct a market analysis of insulin and/or diabetic supply caps (Attachment 12).

Some observations of the NDPERS active health insurance plan experience during the pilot program:

- For the 2023-2025 biennium, the cost in premium to provide the enhanced coverage of the cap was .14% of premium. There was not funding provided for this cost during the pilot program and therefore, reserves are being used to cover this expense.
- Sanford Health Plan found that the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap so there was minimal impact to member cost share after the cap was implemented related to diabetic supplies.
- There are a number of states that have some form of cap on insulin and diabetic supplies. Specific details regarding these states is provided in Attachment 9 and Attachment 12.
- Sanford Health Plan found that even though NDPERS members were paying a lower portion of the charge for insulin at the pharmacy, the health plan's total reimbursements were lower after the cap. This is due to a change that two pharmaceutical companies (Eli Lilly and Novo Nordisk) made effective January 1, 2024 to reduce their prices on insulin (Attachment 10). Those reduced prices resulted in less reimbursement by the plan (Attachment 4) for the final 6 months that data was provided for.
- Estimated member savings per month was $80.15 per member due to the cap based upon comparison with prior year claims data (Attachment 3).
- The insulin rate cap eliminated coinsurance on insulin claims between 7/1/2023-6/30/2024. Therefore none of claims for insulin contributed any coinsurance to the $1,200 coinsurance maximum on the grandfathered plan. However coinsurance continued to apply to other pharmacy claims so the $1,200 coinsurance expense may have been paid by the member on other pharmacy claims during the calendar year.
- Utilization for insulin and diabetic supplies did not change significantly after the inclusion of the insulin rate cap.
- Note that the information provided by Sanford Health Plan are as of the date the data was generated. It is anticipated that there are still claims pending that have not been submitted to SHP for processing that may result in changes.

RECOMMENDATION OF NDPERS BOARD:

Given the experience to the NDPERS active health insurance plan during the pilot program, the NDPERS Board recommends that the insulin and diabetic supplies cap of $25/month be continued for the NDPERS active health insurance plans beyond the 2023-2025 biennium.

Included for the Committee's review are the following attachments:

	Provided By	Description
Attachment 1	NDPERS	Draft Bill # 118
Attachment 2	Sanford Health Plan	Insulin Dashboard/Overview
Attachment 3	Sanford Health Plan	Insulin Member Savings Per Member/Per Month
Attachment 4	Sanford Health Plan	Average Paid for Insulin by Member and Plan
Attachment 5	Sanford Health Plan	Insulin Utilization & Adherence
Attachment 6	Sanford Health Plan	NDPERS Type 1 and Type 2 Diabetes Membership Data
Attachment 7	Sanford Health Plan	Insulin Details
Attachment 8	Sanford Health Plan	Diabetic Supplies Details
Attachment 9	Sanford Health Plan	Information regarding what other states have experienced that have implemented caps
Attachment 10	Sanford Health Plan	Details regarding changes that have occurred in the amount that the drug manufacturers are charging for insulin
Attachment 11	Deloitte	Consultant cost and technical analysis of Draft Bill # 118
Attachment 12	Deloitte	Market analysis related to SB 2140
Attachment 13	Sanford Health Plan	Per Member Per Month medical expense for Type 1 diabetics 12 months before and 12 months after the Insulin cap

25.0118.01000

Sixty-ninth
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

(North Dakota Public Employees Retirement System)

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations.

1. As used in this section:

   a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:

      (1) Rapid-acting insulin;

      (2) Short-acting insulin;

      (3) Intermediate-acting insulin;

      (4) Long-acting insulin;

      (5) Premixed insulin product;

      (6) Premixed insulin/GLP-1 RA product; and

      (7) Concentrated human regular insulin.

   b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical

emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

(1) Blood glucose meters;

(2) Blood glucose test strips;

(3) Lancing devices and lancets;

(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;

(5) Glucagon, in injectable and nasal forms;

(6) Insulin pen needles; and

(7) Insulin syringes.

c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a prescription.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits for insulin drug and medical supplies for insulin dosing and administration which complies with this section.

3. The health benefit plan must limit out-of-pocket costs for a thirty-day supply of:

a. Covered insulin drugs, which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.

b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

4. The health benefit plan may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies

for insulin dosing and administration in an amount exceeding the out-of-pocket limits under subsection 3.

5. The health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount under subsection 3.

6. Subsection 3 does not require the health benefit plan to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. This section does not limit whether the health benefit plan classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.

7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has met the minimum deductible under section 26 U.S.C. 223.

8. This section does not apply to the Medicare part D prescription drug coverage plan.

SECTION 2. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. ~~(Expired effective July 31, 2025)~~

~~1. As used in this section:~~

~~a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:~~

~~(1) Rapid-acting insulin;~~

~~(2) Short-acting insulin;~~

~~(3) Intermediate-acting insulin;~~

~~(4) Long-acting insulin;~~

~~(5) Premixed insulin product;~~

~~(6) Premixed insulin/GLP-1 RA product; and~~

~~(7) Concentrated human regular insulin.~~

~~b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:~~

~~(1) Blood glucose meters;~~

~~(2) Blood glucose test strips;~~

~~(3) Lancing devices and lancets;~~

~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;~~

~~(5) Glucagon, in injectable and nasal forms;~~

~~(6) Insulin pen needles; and~~

~~(7) Insulin syringes.~~

~~c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.~~

~~2.~~ The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration ~~which complies with this section~~as provided under section 1 of this Act.

~~3. The coverage must limit out-of-pocket costs for a thirty-day supply of:~~

~~a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.~~

~~b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.~~

4. The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.
5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.
6. Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.
7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.
8. This section does not apply to the Medicare part D prescription drug coverage plan.

Rx Type	Members with Pharmacy Claims for Insulin Before Insulin cap	Members with Pharmacy Claims for Insulin After Insulin cap	Change in Members	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount**	Cost Share Amount (Copay + Coins) Before Insulin cap	Cost Share Amount After Insulin cap	Change in Cost Share Amounts
1-INSULIN	824	831	7	**5,480**	**5,440**	-40	$3,880,454	$3,110,731	($769,723)	$1,076,143	$250,567	**($825,576)**

Insulin Days of Supply (DOS) Group	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	% Change in claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount	Cost Share Amount Before Insulin cap	Average Member Cost Share Before Insulin cap	Cost Share Amount After Insulin cap	Average Member Cost Share after Insulin cap*	Change in Cost Share Amount
01-30 DOS	2,009	1,950	-59	-3%	$1,184,018	$941,455	($242,563)	$321,298	$160	$47,573	$24	($273,725)
31-60 DOS	2,119	2,071	-48	-2%	$1,512,316	$1,151,299	($361,017)	$404,759	$191	$99,934	$48	($304,825)
61+ DOS	1,352	1,419	67	5%	$1,184,119	$1,017,976	($166,143)	$350,087	$259	$103,110	$73	($246,977)
Total	**5,480**	**5,440**	**-40**	**-1%**	**$3,880,454**	**$3,110,731**	**($769,723)**	**$1,076,143**	**$196**	**$250,617**	**$46**	**($825,526)**

Before time period: July 1, 2022-June 30, 2023
After time period: July 1, 2023-June 30, 2024

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.
**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Member Impact on Insulin Claims

	Before Insulin Cap (7/1/2022-6/30/2023)	After Insulin Cap (7/1/2023-6/30/2024)	Change	Percent Change
Total Member Months	10,153	9,694	(459)	-4.5%
Member Copay Amounts	$ 644,434.40	$ 250,566.93	$ (393,867.47)	-61.1%
Member Coinsurance Amounts	$ 431,709.02	$ -	$ (431,709.02)	-100.0%
Member Copay Per Member Per Month (PMPM)	$63.47	$25.85	($37.62)	-59.3%
Member Coinsurance Per Member Per Month (PMPM)	$42.52	$0.00	($42.52)	-100.0%
Total Member Cost Share PMPM	**$105.99**	**$25.85**	**($80.15)**	**-75.6%**

Note: Coinsurance may have applied to other pharmacy claims.

DATE FILLED MONTH		2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	Total
Rx Type	Days of Supply (DOS) Group	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	**Average of Member Cost Share for 12 mos**
1-INSULIN	**Total**	**$152**	**$134**	**$115**	**$118**	**$106**	**$100**	**$404**	**$373**	**$325**	**$268**	**$197**	**$162**	**$45**	**$46**	**$48**	**$47**	**$48**	**$48**	**$46**	**$48**	**$48**	**$47**	**$47**	**$36**	**$121**
	01-30 DOS	$114	$104	$102	$83	$97	$94	$350	$312	$259	$203	$154	$110	$24	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$19	**$93**
	31-60 DOS	$143	$118	$109	$106	$95	$107	$436	$360	$304	$251	$187	$158	$48	$49	$49	$50	$49	$49	$50	$50	$50	$50	$50	$35	**$120**
	61+ DOS	$240	$204	$139	$191	$136	$98	$430	$531	$446	$391	$291	$238	$72	$74	$75	$73	$75	$74	$74	$74	$74	$74	$74	$58	**$164**

Member Cost Share=Copay + Coinsurance

Rx Type	Days of Supply (DOS) Group	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	**Average Paid by SHP for 12 mos**
1-INSULIN	**Total**	**$747**	**$724**	**$802**	**$766**	**$743**	**$854**	**$531**	**$583**	**$612**	**$670**	**$686**	**$698**	**$793**	**$760**	**$792**	**$805**	**$789**	**$851**	**$336**	**$341**	**$340**	**$321**	**$317**	**$372**	**$640**
	01-30 DOS	$585	$622	$639	$627	$625	$667	$463	$477	$566	$571	$597	$595	$665	$653	$635	$662	$688	$679	$301	$274	$301	$324	$273	$329	**$537**
	31-60 DOS	$764	$735	$739	$797	$774	$798	$579	$643	$587	$696	$680	$727	$761	$779	$770	$797	$753	$757	$308	$379	$281	$306	$325	$366	**$636**
	61+ DOS	$1,027	$864	$1,096	$931	$860	$1,144	$552	$695	$712	$776	$850	$797	$1,030	$913	$1,026	$1,007	$982	$1,174	$435	$373	$463	$339	$368	$433	**$795**

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 5

Rx Type	Days of Supply (DOS) Group	Total claims before Insulin cap	Total claims after to Insulin cap	Change in insulin claim count before & after Insulin cap
1-INSULIN	**Total**	**5,480**	**5,440**	**-1%**
	01-30 DOS	2,009	1,950	-3%
	31-60 DOS	2,119	2,071	-2%
	61+ DOS	1,352	1,419	5%

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

PDC Adherence	Before Insulin Cap	After Insulin Cap	Difference
<80%	30.70%	28.10%	-2.6%
>=80%	69.30%	71.90%	2.6%

*The proportion of days covered (PDC) is used to estimate medication adherence.

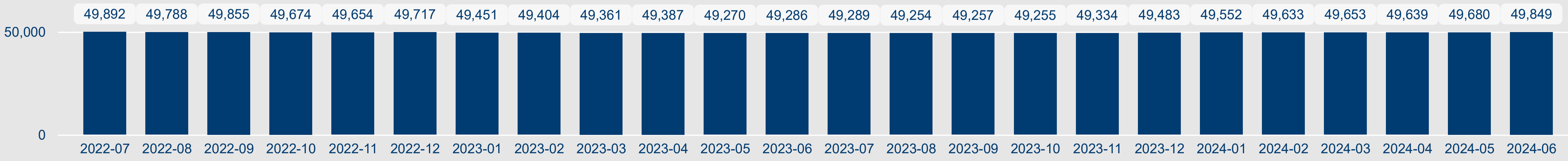
*PDC **>=80%** is considered adhering to their medication while **<80%** is considered not adhering.

*PDC calculation= (number of days covered) / (total days in time period) x 100

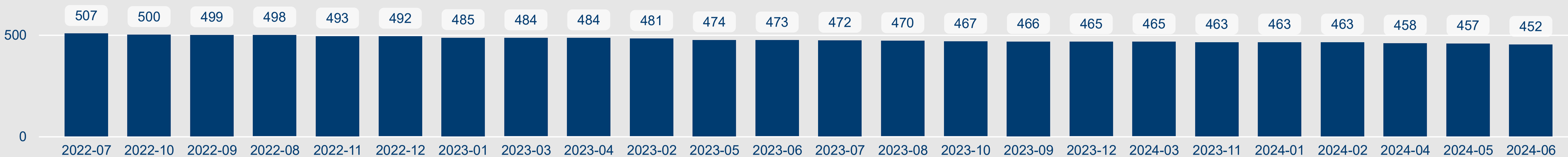
NDPERS COI Insulin & Diabetes Supplies Impact Analysis

Attachment 6

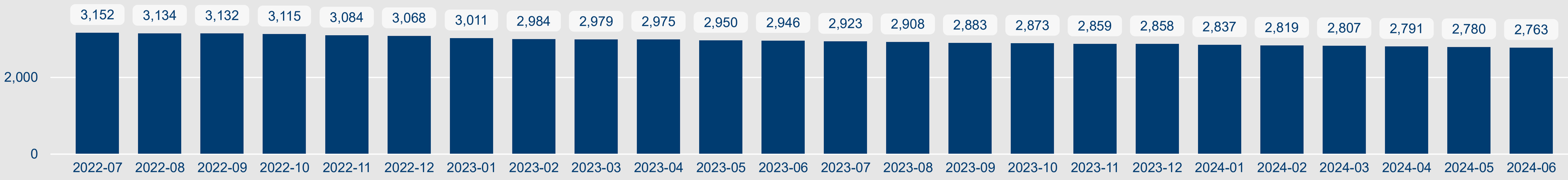
Total Members Months by Year Month



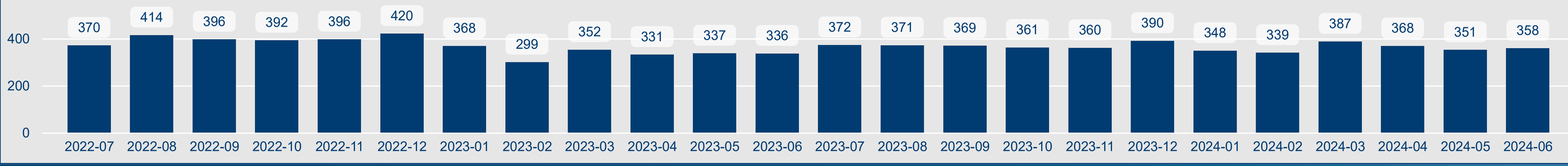
Member Months for Members with Type 1 Diabetes Diagnosis



Member Months for Members with Type 2 Diabetes Diagnosis



Distinct Count of Patient ID's with Insulin Rx Claims by Month Filled



Last Data Refresh: 08-15-2024 02:40 PM CT

Notice: This report and any exported data is for internal use only and should not be sent outside of Sanford.

Attachment 7

Rx Type	Days of Supply Group	DrugDESC	Members with Pharmacy Claims Before Insulin Cap	Members with Pharmacy Claims After Insulin Cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin Cap	Pharmacy Claims After Insulin Cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Cap	SHP Paid Amount After Insulin Cap	SHP PAID Amount Change	Copay Amount Before Insulin Cap	Copay Amount After Insulin Cap	Copay Amount Change	Coinsurance Amount Before Insulin Cap	Coinsurance Amount After Insulin Cap	Coinsurance Amount Change	Total Member cost Share before to Insulin cap	Ave Member Cost Share before Insulin Cap	Total Member cost Share after Insulin Cap	Ave Member cost Share after Insulin Cap	Member Savings from Insulin Cap
1-INSULIN	**Total**		**1,964**	**2,119**	**155**	**5,480**	**5,440**	**-40**	**$ 3,880,454**	**$ 3,110,731**	**$ (769,723)**	**$ 644,434**	**$ 250,567**	**$ (393,867)**	**$ 431,709**	**0**	**$ (431,709)**	**$ 1,076,143**	**$196**	**$ 250,567**	**$46**	**$ (825,576)**
	01-30 DOS	**Total**	**541**	**562**	**21**	**2,009**	**1,950**	**-59**	**$1,184,018**	**$941,455**	**($242,563)**	**$186,043**	**$47,523**	**($138,519)**	**$135,255**	**$0**	**($135,255)**	$321,298	**$160**	$47,523	**$24**	**($273,775)**
		BASAGLAR INJ	10	8	-2	39	36	-3	$5,546	$10,553	$5,007	$6,716	$900	($5,816)	$5,546	$0	($5,546)	$12,263	**$314**	$900	**$25**	($11,363)
		FIASP INJ	9	5	-4	27	27	0	$15,318	$22,286	$6,968	$2,816	$675	($2,141)	$2,141	$0	($2,141)	$4,957	**$184**	$675	**$25**	($4,282)
		FIASP FLEX INJ TOUCH	18	18	0	69	59	-10	$39,827	$44,458	$4,631	$7,243	$1,475	($5,768)	$4,682	$0	($4,682)	$11,925	**$173**	$1,475	**$25**	($10,450)
		FIASP PENFIL INJ U	3	2	-1	7	7	0	$3,458	$4,093	$635	$815	$175	($640)	$640	$0	($640)	$1,454	**$208**	$175	**$25**	($1,279)
		HUMALOG INJ		1	1	0	4	4	$0	$40	$40	$0	$100	$100	$0	$0	$0	$0	**#DIV/0!**	$100	**$25**	$100
		HUMALOG KWIK INJ	7	7	0	26	22	-4	$20,946	$41,683	$20,737	$21,726	$550	($21,176)	$20,946	$0	($20,946)	$42,672	**$1,641**	$550	**$25**	($42,122)
		HUMULIN R INJ U	3	3	0	34	20	-14	$58,502	$41,713	($16,788)	$3,398	$500	($2,898)	$2,548	$0	($2,548)	$5,947	**$175**	$500	**$25**	($5,447)
		INS DEGL FLX INJ	7	17	10	11	62	51	$3,293	$16,459	$13,166	$918	$1,525	$607	$643	$0	($643)	$1,562	**$142**	$1,525	**$25**	($37)
		INSULIN ASPA INJ	1	1	0	14	9	-5	$177	$181	$4	$558	$225	($333)	$177	$0	($177)	$735	**$53**	$225	**$25**	($510)
		INSULIN ASPA INJ FLEXPEN	1		-1	4	0	-4	$0	$0	$0	$20	$0	($20)	$0	$0	$0	$20	**$5**	$0	**#DIV/0!**	($20)
		LANTUS INJ	15	7	-8	32	9	-23	$17,758	$4,939	($12,819)	$3,281	$225	($3,056)	$2,481	$0	($2,481)	$5,763	**$180**	$225	**$25**	($5,538)
		LANTUS SOLOS INJ	75	88	13	305	278	-27	$118,902	$64,772	($54,130)	$18,698	$6,528	($12,170)	$11,073	$0	($11,073)	$29,771	**$98**	$6,528	**$23**	($23,242)
		LEVEMIR INJ		2	2	0	5	5	$0	$814	$814	$0	$125	$125	$0	$0	$0	$0	**#DIV/0!**	$125	**$25**	$125
		LEVEMIR INJ FLEXPEN	20	34	14	49	128	79	$25,106	$51,066	$25,959	$3,638	$3,200	($438)	$2,413	$0	($2,413)	$6,052	**$124**	$3,200	**$25**	($2,852)
		LEVEMIR INJ FLEXTOUC	28		-28	115	0	-115	$51,216	$0	($51,216)	$7,490	$0	($7,490)	$4,615	$0	($4,615)	$12,106	**$105**	$0	**#DIV/0!**	($12,106)
		NOVOLIN INJ	1		-1	8	0	-8	$1,740	$0	($1,740)	$449	$0	($449)	$249	$0	($249)	$697	**$87**	$0	**#DIV/0!**	($697)
		NOVOLIN N INJ	1	1	0	2	1	-1	$549	$231	($318)	$233	$25	($208)	$183	$0	($183)	$416	**$208**	$25	**$25**	($391)
		NOVOLIN R INJ U		1	1	0	7	7	$0	$2,429	$2,429	$0	$150	$150	$0	$0	$0	$0	**#DIV/0!**	$150	**$21**	$150
		NOVOLOG INJ	99	92	-7	367	396	29	$250,980	$200,688	($50,292)	$38,789	$9,795	($28,994)	$29,769	$0	($29,769)	$68,558	**$187**	$9,795	**$25**	($58,763)
		NOVOLOG INJ FLEX REL		1	1	0	1	1	$0	$59	$59	$0	$25	$25	$0	$0	$0	$0	**#DIV/0!**	$25	**$25**	$25
		NOVOLOG INJ FLEXPEN	148	154	6	507	510	3	$336,948	$226,716	($110,233)	$42,781	$12,400	($30,381)	$30,181	$0	($30,181)	$72,962	**$144**	$12,400	**$24**	($60,562)
		NOVOLOG INJ PENFILL	8	10	2	46	47	1	$17,126	$15,460	($1,666)	$3,846	$1,175	($2,671)	$2,696	$0	($2,696)	$6,542	**$142**	$1,175	**$25**	($5,367)
		NOVOLOG MIX INJ FLEXPEN	1	5	4	3	8	5	$1,507	$2,468	$960	$82	$200	$118	$7	$0	($7)	$89	**$30**	$200	**$25**	$111
		SEMGLEE INJ	1	1	0	1	1	0	$3	$25	$22	$33	$25	($8)	$3	$0	($3)	$35	**$35**	$25	**$25**	($10)
		SOLIQUA INJ	5	3	-2	28	16	-12	$20,590	$13,112	($7,478)	$2,102	$400	($1,702)	$1,402	$0	($1,402)	$3,504	**$125**	$400	**$25**	($3,104)
		TOUJEO MAX INJ	10	19	9	41	35	-6	$30,760	$26,925	($3,835)	$2,976	$825	($2,151)	$1,951	$0	($1,951)	$4,928	**$120**	$825	**$24**	($4,103)
		TOUJEO SOLO INJ	28	41	13	117	101	-16	$34,894	$34,795	($99)	$6,277	$2,350	($3,927)	$3,627	$0	($3,627)	$9,903	**$85**	$2,350	**$23**	($7,553)
		TRESIBA FLEX INJ	39	40	1	144	151	7	$114,978	$102,587	($12,390)	$9,024	$3,700	($5,324)	$5,474	$0	($5,474)	$14,499	**$101**	$3,700	**$25**	($10,799)
		XULTOPHY INJ	3	1	-2	13	10	-3	$13,893	$12,902	($991)	$2,133	$250	($1,883)	$1,808	$0	($1,808)	$3,941	**$303**	$250	**$25**	($3,691)
	31-60 DOS	**Total**	**679**	**739**	**60**	**2,119**	**2,071**	**-48**	**$1,512,316**	**$1,151,299**	**($361,017)**	**$248,465**	**$99,934**	**($148,531)**	**$156,294**	**$0**	**($156,294)**	$404,759	**$191**	$99,934	**$48**	**($304,825)**
		BASAGLAR INJ	15	14	-1	40	43	3	$5,476	$16,806	$11,330	$7,847	$2,150	($5,697)	$5,477	$0	($5,477)	$13,323	**$333**	$2,150	**$50**	($11,173)
		FIASP INJ	5	8	3	14	28	14	$10,165	$20,837	$10,672	$1,750	$1,350	($400)	$1,100	$0	($1,100)	$2,851	**$204**	$1,350	**$48**	($1,501)
		FIASP FLEX INJ TOUCH	7	18	11	20	53	33	$10,292	$35,885	$25,593	$1,718	$2,650	$932	$868	$0	($868)	$2,586	**$129**	$2,650	**$50**	$64
		HUMALOG KWIK INJ	3	3	0	12	11	-1	$14,426	$25,271	$10,845	$14,996	$550	($14,446)	$14,426	$0	($14,426)	$29,422	**$2,452**	$550	**$50**	($28,872)
		HUMULIN R INJ U	2		-2	3	0	-3	$5,480	$0	($5,480)	$497	$0	($497)	$372	$0	($372)	$869	**$290**	$0	**#DIV/0!**	($869)
		INS DEGL FLX INJ	7	21	14	15	47	32	$2,246	$8,229	$5,983	$1,046	$2,150	$1,104	$296	$0	($296)	$1,341	**$89**	$2,150	**$46**	$809
		INSULIN ASPA INJ	1		-1	2	0	-2	$61	$0	($61)	$151	$0	($151)	$61	$0	($61)	$212	**$106**	$0	**#DIV/0!**	($212)
		LANTUS INJ	10	11	1	42	36	-6	$29,238	$19,564	($9,673)	$4,560	$1,700	($2,860)	$2,610	$0	($2,610)	$7,171	**$171**	$1,700	**$47**	($5,471)
		LANTUS SOLOS INJ	122	144	22	403	420	17	$175,193	$112,512	($62,681)	$40,430	$20,080	($20,351)	$22,015	$0	($22,015)	$62,446	**$155**	$20,080	**$48**	($42,366)
		LEVEMIR INJ	2	1	-1	3	1	-2	$581	$231	($349)	$294	$50	($244)	$194	$0	($194)	$487	**$162**	$50	**$50**	($437)
		LEVEMIR INJ FLEXPEN	22	32	10	50	112	62	$23,960	$47,669	$23,709	$5,630	$5,475	($155)	$3,445	$0	($3,445)	$9,074	**$181**	$5,475	**$49**	($3,600)
		LEVEMIR INJ FLEXTOUC	27		-27	70	0	-70	$40,557	$0	($40,557)	$7,250	$0	($7,250)	$4,125	$0	($4,125)	$11,375	**$162**	$0	**#DIV/0!**	($11,375)
		NOVOLIN INJ	1	1	0	1	5	4	$371	$1,415	$1,045	$174	$250	$76	$124	$0	($124)	$297	**$297**	$250	**$50**	($47)
		NOVOLIN N INJ	3		-3	3	0	-3	$877	$0	($877)	$417	$0	($417)	$292	$0	($292)	$710	**$237**	$0	**#DIV/0!**	($710)
		NOVOLIN N INJ U	1	1	0	1	1	0	$63	$4	($59)	$71	$50	($21)	$21	$0	($21)	$92	**$92**	$50	**$50**	($42)
		NOVOLIN R INJ U	2	1	-1	7	8	1	$472	$227	($245)	$448	$370	($78)	$98	$0	($98)	$546	**$78**	$370	**$46**	($177)
		NOVOLOG INJ	105	91	-14	361	352	-9	$309,214	$207,740	($101,474)	$45,031	$17,310	($27,721)	$30,568	$0	($30,568)	$75,600	**$209**	$17,310	**$49**	($58,290)
		NOVOLOG INJ FLEX REL	1		-1	5	0	-5	$196	$0	($196)	$261	$0	($261)	$11	$0	($11)	$271	**$54**	$0	**#DIV/0!**	($271)
		NOVOLOG INJ FLEXPEN	165	176	11	517	467	-50	$474,597	$259,790	($214,807)	$56,701	$22,250	($34,451)	$34,998	$0	($34,998)	$91,699	**$177**	$22,250	**$48**	($69,449)
		NOVOLOG INJ PENFILL	6	7	1	27	28	1	$25,521	$24,062	($1,459)	$4,509	$1,400	($3,109)	$3,284	$0	($3,284)	$7,793	**$289**	$1,400	**$50**	($6,393)
		NOVOLOG MIX INJ FLEXPEN	4	6	2	21	18	-3	$18,290	$12,888	($5,403)	$2,321	$900	($1,421)	$1,546	$0	($1,546)	$3,867	**$184**	$900	**$50**	($2,967)
		SOLIQUA INJ	6	5	-1	19	15	-4	$11,877	$11,602	($274)	$3,496	$750	($2,746)	$2,546	$0	($2,546)	$6,042	**$318**	$750	**$50**	($5,292)
		TOUJEO MAX INJ	13	32	19	30	44	14	$36,768	$51,357	$14,588	$2,938	$1,900	($1,038)	$1,588	$0	($1,588)	$4,526	**$151**	$1,900	**$43**	($2,626)
		TOUJEO SOLO INJ	40	75	35	90	104	14	$78,357	$84,480	$6,122	$8,103	$5,150	($2,953)	$4,578	$0	($4,578)	$12,680	**$141**	$5,150	**$50**	($7,530)
		TRESIBA FLEX INJ	109	92	-17	363	278	-85	$238,037	$210,730	($27,307)	$37,827	$13,450	($24,377)	$21,652	$0	($21,652)	$59,478	**$164**	$13,450	**$48**	($46,028)
	61+ DOS	**Total**	**744**	**818**	**74**	**1,352**	**1,419**	**67**	**$1,184,119**	**$1,017,976**	**($166,143)**	**$209,927**	**$103,110**	**($106,817)**	**$140,160**	**$0**	**($140,160)**	$350,087	**$259**	$103,110	**$73**	**($246,977)**
		BASAGLAR INJ	8	15	7	22	31	9	$5,300	$15,762	$10,462	$6,620	$2,325	($4,295)	$5,300	$0	($5,300)	$11,919	**$542**	$2,325	**$75**	($9,594)
		FIASP INJ	8	11	3	20	22	2	$27,305	$38,480	$11,175	$4,855	$1,650	($3,205)	$3,855	$0	($3,855)	$8,710	**$436**	$1,650	**$75**	($7,060)
		FIASP FLEX INJ TOUCH	13	13	0	22	28	6	$25,122	$38,064	$12,942	$3,941	$2,100	($1,841)	$2,841	$0	($2,841)	$6,781	**$308**	$2,100	**$75**	($4,681)
		FIASP PENFIL INJ U		2	2	0	3	3	$0	$2,265	$2,265	$0	$225	$225	$0	$0	$0	$0	**#DIV/0!**	$225	**$75**	$225

GLARGIN YFGN INJ		1	1	0	1	1	$0	$0	$0	$0	$65	$65	$0	$0	$0	$0	#DIV/0!	$65	$65	$65
HUMALOG INJ		1	1	0	1	1	$0	$1,810	$1,810	$0	$75	$75	$0	$0	$0	$0	#DIV/0!	$75	$75	$75
HUMALOG KWIK INJ		2	2	0	3	3	$0	$13,697	$13,697	$0	$225	$225	$0	$0	$0	$0	#DIV/0!	$225	$75	$225
HUMULIN R INJ U	1		-1	1	0	-1	$0	$0	$0	$15	$0	($15)	$0	$0	$0	$15	$15	$0	#DIV/0!	($15)
INS DEGL FLX INJ	6	51	45	8	80	72	$3,096	$20,187	$17,090	$497	$5,745	$5,248	$97	$0	($97)	$593	$74	$5,745	$72	$5,152
INSULIN ASPA INJ	1	5	4	1	6	5	$30	$2,817	$2,787	$90	$450	$360	$30	$0	($30)	$120	$120	$450	$75	$330
INSULIN GLAR INJ	1		-1	3	0	-3	$0	$0	$0	$135	$0	($135)	$0	$0	$0	$135	$45	$0	#DIV/0!	($135)
INSULIN LISP INJ	1	2	1	2	4	2	$397	$284	($113)	$517	$300	($217)	$397	$0	($397)	$914	$457	$300	$75	($614)
LANTUS INJ	9	5	-4	16	11	-5	$19,683	$10,374	($9,309)	$3,688	$825	($2,863)	$2,888	$0	($2,888)	$6,576	$411	$825	$75	($5,751)
LANTUS SOLOS INJ	181	202	21	341	351	10	$184,707	$115,903	($68,804)	$43,274	$25,395	($17,879)	$26,016	$0	($26,016)	$69,290	$203	$25,395	$72	($43,895)
LEVEMIR INJ	2	1	-1	4	4	0	$2,096	$1,946	($150)	$539	$300	($239)	$339	$0	($339)	$877	$219	$300	$75	($577)
LEVEMIR INJ FLEXPEN	25	36	11	29	62	33	$14,512	$33,791	$19,279	$4,057	$4,500	$443	$2,657	$0	($2,657)	$6,713	$231	$4,500	$73	($2,213)
LEVEMIR INJ FLEXTOUC	41	1	-40	59	1	-58	$34,413	$423	($33,989)	$6,776	$0	($6,776)	$3,826	$0	($3,826)	$10,601	$180	$0	$0	($10,601)
NOVOLIN N INJ	4	5	1	5	6	1	$871	$1,383	$512	$397	$375	($22)	$147	$0	($147)	$543	$109	$375	$63	($168)
NOVOLIN N INJ U	3	3	0	7	7	0	$2,998	$2,688	($310)	$1,349	$525	($824)	$999	$0	($999)	$2,349	$336	$525	$75	($1,824)
NOVOLIN R INJ		1	1	0	1	1	$0	$159	$159	$0	$75	$75	$0	$0	$0	$0	#DIV/0!	$75	$75	$75
NOVOLIN70/3	2	2	0	5	2	-3	$1,136	$455	($681)	$376	$150	($226)	$126	$0	($126)	$502	$100	$150	$75	($352)
NOVOLOG INJ	124	125	1	236	280	44	$332,261	$279,531	($52,730)	$56,318	$20,364	($35,954)	$43,107	$0	($43,107)	$99,425	$421	$20,364	$73	($79,061)
NOVOLOG INJ FLEX REL	2	4	2	2	6	4	$55	$306	$252	$118	$425	$307	$18	$0	($18)	$136	$68	$425	$71	$289
NOVOLOG INJ FLEXPEN	134	142	8	244	242	-2	$230,703	$174,500	($56,203)	$33,428	$17,441	($15,987)	$21,623	$0	($21,623)	$55,051	$226	$17,441	$72	($37,610)
NOVOLOG INJ PENFILL	6	7	1	9	11	2	$12,584	$13,122	$538	$1,915	$825	($1,090)	$1,465	$0	($1,465)	$3,380	$376	$825	$75	($2,555)
NOVOLOG INJ RELION	1	1	0	2	4	2	$701	$1,449	$748	$334	$300	($34)	$234	$0	($234)	$567	$284	$300	$75	($267)
NOVOLOG MIX INJ FLEXPEN	3	2	-1	7	3	-4	$8,005	$2,897	($5,108)	$926	$225	($701)	$576	$0	($576)	$1,502	$215	$225	$75	($1,277)
SOLIQUA INJ	5	1	-4	8	1	-7	$13,283	$720	($12,562)	$1,287	$75	($1,212)	$987	$0	($987)	$2,273	$284	$75	$75	($2,198)
TOUJEO MAX INJ	12	29	17	17	22	5	$12,145	$20,452	$8,307	$1,930	$1,575	($355)	$1,115	$0	($1,115)	$3,046	$179	$1,575	$72	($1,471)
TOUJEO SOLO INJ	32	62	30	55	53	-2	$42,520	$49,060	$6,539	$6,827	$3,825	($3,002)	$4,177	$0	($4,177)	$11,003	$200	$3,825	$72	($7,178)
TRESIBA INJ	1	2	1	4	5	1	$3,361	$5,358	$1,997	$461	$375	($86)	$261	$0	($261)	$722	$180	$375	$75	($347)
TRESIBA FLEXTINJ	117	83	-34	222	167	-55	$206,700	$168,964	($37,736)	$29,165	$12,300	($16,865)	$17,036	$0	($17,036)	$46,201	$208	$12,300	$74	($33,901)
XULTOPHY INJ	1	1	0	1	1	0	$136	$1,129	$993	$95	$75	($20)	$45	$0	($45)	$141	$141	$75	$75	($66)

No filters applied

Rx Type	Days of Supply (DOS) Group		Members with Pharmacy Claims Before Insulin Cap	Members with Pharmacy Claims After Insulin Cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin Cap	Pharmacy Claims After Insulin Cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Cap	SHP Paid Amount After Insulin Cap	SHP PAID Amount Change	Copay Amount Before Insulin Cap	Copay Amount After Insulin Cap	Copay Amount Change	Coinsurance Amount Before Insulin Cap	Coinsurance Amount After Cap Insulin	CoinsuranceA mount Change	Total Member cost Share before to Insulin cap	Ave Member Cost Share before Insulin Cap	Total Member cost Share after Insulin Cap	Ave Member Cost Share after Insulin Cap	Member Savings from Insulin Cap
2-BLOOD GLUCOSE METERS	**Total**		**200**	**151**	**-49**	**143**	**103**	**-40**	**$2,436**	**$1,692**	**($744)**	**$634**	**$463**	**($171)**	**$634**	**$424**	**($211)**	**$1,268**	**$9**	**$886**	**$9**	**($382)**
	01-30 DOS	**Total**	190	141	-49	136	96	-40	$2,331	$1,608	($723)	$599	$414	($185)	$599	$414	($185)	$1,198	$9	$828	$9	($370)
	61+ DOS	**Total**	10	10	0	7	7	0	$106	$84	($21)	$35	$49	$14	$35	$10	($25)	$70	$10	$59	$8	($12)
3-BLOOD GLUCOSE TEST STRIPS	**Total**		**916**	**693**	**-223**	**1,729**	**1,226**	**-503**	**$156,322**	**$116,411**	**($39,911)**	**$33,349**	**$24,804**	**($8,545)**	**$32,285**	**$21,504**	**($10,781)**	**$65,634**	**$38**	**$46,308**	**$38**	**($19,326)**
	01-30 DOS	**Total**	247	190	-57	520	374	-146	$36,163	$26,476	($9,687)	$7,975	$5,745	($2,230)	$7,403	$4,679	($2,724)	$15,378	$30	$10,424	$28	($4,954)
	31-60 DOS	**Total**	335	256	-79	699	496	-203	$56,048	$40,930	($15,118)	$12,886	$9,739	($3,146)	$12,608	$8,868	($3,740)	$25,493	$36	$18,607	$38	($6,887)
	61+ DOS	**Total**	334	247	-87	510	356	-154	$64,110	$49,005	($15,106)	$12,488	$9,319	($3,169)	$12,274	$7,957	($4,317)	$24,762	$49	$17,277	$49	($7,486)
4-LANCETS AND LANCET DEVICES	**Total**		**448**	**372**	**-76**	**637**	**492**	**-145**	**$5,490**	**$4,160**	**($1,330)**	**$1,301**	**$1,153**	**($149)**	**$1,244**	**$992**	**($252)**	**$2,546**	**$4**	**$2,145**	**$4**	**($400)**
	01-30 DOS	**Total**	128	119	-9	199	160	-39	$1,541	$1,225	($315)	$376	$329	($47)	$350	$289	($61)	$726	$4	$618	$4	($108)
	31-60 DOS	**Total**	130	87	-43	189	125	-64	$1,541	$1,046	($495)	$386	$300	($87)	$377	$261	($117)	$763	$4	$560	$4	($203)
	61+ DOS	**Total**	190	166	-24	249	207	-42	$2,409	$1,888	($520)	$540	$524	($15)	$516	$442	($74)	$1,056	$4	$967	$5	($89)
5-KETONE TESTING	**Total**		**4**	**5**	**1**	**29**	**8**	**-21**	**$19,921**	**$4,360**	**($15,561)**	**$449**	**$15**	**($435)**	**$449**	**$15**	**($435)**	**$898**	$31	$29	$4	**($869)**
	01-30 DOS	**Total**	4	4	0	29	7	-22	$19,921	$4,352	($15,569)	$449	$12	($437)	$449	$12	($437)	$898	$31	$24	$3	($874)
	31-60 DOS	**Total**		1	1	0	1	1	$0	$8	$8	$0	$3	$3	$0	**$3**	**$3**	$0	#DIV/0!	$5	$5	$5
6-GLUCAGON	**Total**		**71**	**72**	**1**	**80**	**78**	**-2**	**$27,475**	**$34,864**	**$7,389**	**$6,623**	**$1,367**	**($5,257)**	**$5,028**	**$967**	**($4,062)**	**$11,652**	**$146**	**$2,334**	**$30**	**($9,318)**
	01-30 DOS	**Total**	71	72	1	80	78	-2	$27,475	$34,864	$7,389	$6,623	$1,367	($5,257)	$5,028	$967	($4,062)	$11,652	$146	$2,334	$30	($9,318)
7-SYRINGE/PEN NEEDLE	**Total**		**938**	**802**	**-136**	**1,638**	**1,391**	**-247**	**$112,768**	**$96,953**	**($15,815)**	**$7,502**	**$8,786**	**$1,284**	**$7,346**	**$7,587**	**$241**	**$14,848**	**$9**	**$16,374**	**$12**	**$1,525**
	01-30 DOS	**Total**	223	200	-23	544	463	-81	$26,042	$24,416	($1,626)	$1,827	$2,548	$720	$1,827	$2,111	$284	$3,654	$7	$4,659	$10	$1,005
	31-60 DOS	**Total**	161	173	12	322	294	-28	$25,803	$21,477	($4,326)	$1,593	$1,984	$391	$1,593	$1,889	$296	$3,185	$10	$3,872	$13	$687
	61+ DOS	**Total**	554	429	-125	772	634	-138	$60,922	$51,060	($9,863)	$4,082	$4,255	$173	$3,926	$3,587	($339)	$8,009	$10	$7,842	$12	($166)
	Grand TOTAL		**2,577**	**2,095**	**-482**	**4,256**	**3,298**	**-958**	**$ 324,411**	**$ 258,440**	**$ (65,971)**	**$ 49,860**	**$ 36,587**	**$ (13,273)**	**$ 46,987**	**$ 31,489**	**$ (15,498)**	**$ 96,847**		**$ 68,076**		**($28,771)**

NOTEWORTHY COMMENTS:

Continuous Glucose Monitors and Insulin Pumps may replace the need for some of these supplies.

252 NDPERS members enrolled in Livongo Diabetes program bewteen July 1, 2023- June 30, 2024. Livongo provides Blood Glucose Monitors & test strips to the participants.

Blood Glucose Meters, Test Strips & Lancets can be used by any diabetic including those not using insulin.

INSULIN & DIABETIC SUPPLY BRIEF

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

In the landscape of healthcare affordability, few issues resonate as profoundly as the accessibility of insulin and diabetic supplies, especially within the United States. The soaring prices of these life-sustaining medications have sparked national outcry, prompting legislative actions in several states aimed at implementing price caps. As diabetes prevalence continues to rise, individuals facing this chronic condition grapple not only with its daily management but also with the financial burden imposed by escalating medication costs. Understanding the varied approaches and efficacy of state-level price caps is essential in assessing the impact on patients, healthcare systems, and the broader socio-economic landscape.

CURRENT LANDSCAPE OVERVIEW

In a recent discussion, it was highlighted that diabetics nationwide are set to benefit from reduced out-of-pocket costs for insulin, thanks to efforts by pharmaceutical companies. Sanofi has joined Eli Lilly and Novo Nordisk in capping insulin co-pays at $35. This move follows pressure from President Biden, lawmakers, and activists to lower drug prices.

Laura Barron-Lopez, White House correspondent, emphasized the significance of these measures. She noted that while Medicare beneficiaries automatically benefit from the $35 co-pay cap, those with private insurance or without insurance must navigate more complex processes to access the reduced costs. Advocates like Shaina Kasper of T1International suggest that a federal mandate is needed to ensure consistency in cost reductions.

Beyond insulin, other healthcare reforms are underway. For Medicare recipients, drug costs will be capped annually, starting at $3,300 in 2024 and decreasing to $2,000 by 2025. Additionally, Medicare now has the authority to negotiate drug prices, potentially saving billions over the next decade.

Despite these changes, there's a notable gap in public awareness. Many Americans are unaware of these reforms, complicating efforts to credit President Biden politically for these achievements. Analysts suggest that effective communication will be crucial for the administration to highlight these reforms ahead of the upcoming elections[1].

A gathering of families and advocates convened with Governor Doug Burgum at the North Dakota Capitol to commemorate a recent law that limits the cost of insulin for state employees' health insurance beneficiaries. Under this law, those covered by the state employee health plan now pay no more than $25 per month for insulin. Additionally, the law extends this monthly price cap to medical supplies needed to administer insulin.

Danelle Johnson, who supported the legislation during her testimony in 2023, expressed mixed feelings about its scope. Originally proposed to benefit all North Dakotans, the law was amended by lawmakers to apply solely to individuals under the Public Employees Retirement System's health insurance. Johnson acknowledged the legislation as a significant advancement but expressed a desire for broader accessibility to the price caps. She emphasized the importance of incremental progress over a stalemate in legislative action.

Insulin, critical for diabetes management, can cost hundreds of dollars per vial. A 2023 report by the Health Care Cost Institute indicated that average monthly insulin costs in the U.S. rose from $271 in 2012 to about $499 in 2021. The exorbitant prices often lead diabetes patients to ration their insulin or even skip

[1] https://www.pbs.org/newshour/show/new-law-caps-insulin-prices-for-some-with-diabetes-but-cost-remains-high-for-millions

treatment, risking severe health complications. In 2022, approximately 100,000 Americans died from diabetes, a figure similar to the number of deaths from drug overdoses reported by the CDC.

State Senator Tim Mathern, the bill's primary sponsor, highlighted the dire consequences of unaffordable medication, stressing the need for reform. Angela and Nina Kritzberger, also advocates for insulin affordability, were present at the ceremony. Both families recounted instances where insufficient access to insulin necessitated emergency medical interventions. Looking ahead, Mathern noted efforts to garner support for broader reforms in the upcoming legislative session. The law, effective since August 1, 2023, will remain in force until July 31, 2025, with an estimated cost of $900,000 over the 2023-2025 budget cycle. Although signed over a year ago, logistical issues delayed the official signing ceremony, according to Mathern. Additionally, the federal government implemented a $35 monthly insulin price cap for Medicaid patients through the Inflation Reduction Act signed by President Joe Biden in 2022[2].

Healthcare executives faced intense scrutiny from lawmakers on Capitol Hill during a House Energy and Commerce Committee hearing focused on insulin prices. Representative Jan Schakowsky of Illinois directly challenged panelists, expressing disbelief over their actions and warning of consequences. Amid the hearings, a social media suggestion resurfaced: patients should opt for Walmart's affordable insulin. Over the past decade, the cost of popular insulin brands has tripled, leading many Americans with Type 1 or Type 2 diabetes to ration their doses or skip treatments entirely.

Walmart provides Novo Nordisk's Novolin ReliOn Insulin for less than $25 per vial without a prescription. However, healthcare professionals caution that this "human" insulin, introduced in the 1980s, lacks the refined capabilities of newer analogs in preventing severe blood sugar fluctuations. Critics argue that relying on Walmart's insulin overlooks the complexities of diabetes management and the risks associated with unsupervised treatment. Advocates emphasize that while this option may suit some patients, it's far from a comprehensive solution to the ongoing insulin affordability crisis. The blame for rising insulin prices has been volleyed between drug manufacturers and pharmacy benefit managers. While executives defend financial assistance programs, lawmakers assert that unchecked price hikes by pharmaceutical companies are at the heart of the issue. Unlike many other countries, the U.S. allows drug companies considerable freedom in setting prices, resulting in disproportionately high insulin costs despite the country representing a minority share of the global insulin market. Recent efforts, such as Cigna and Express Scripts capping insulin costs at $25 per month, are viewed as temporary fixes by critics like Elizabeth Pfiester of TIInternational. She insists that true resolution requires systemic changes to reduce insulin's list prices permanently.

As the debate intensifies, healthcare professionals and advocates continue to call for legislative intervention to protect diabetic patients from the financial and health risks posed by exorbitant insulin costs[3],[4]

State Copay Caps[5]

- Alabama: $100 cap for 30-day supply
- Colorado: $100 collective cap for 30-day supply
- Connecticut: $25 cap for 30-day supply of insulin or other diabetes medications, $100 cap for 30-days' worth of devices and supplies
- Delaware: $100 collective cap for 30-day supply, $0 for insulin pumps, and collective $35 cap per month for other specified diabetes equipment and supplies
- District of Columbia: $30 cap for a 30-day supply of insulin and $100 cap for a 30-day supply of covered diabetes devices

[2] https://northdakotamonitor.com/2024/05/28/patient-advocates-plan-to-continue-pushing-for-insulin-price-cap/
[3] https://www.vox.com/science-and-health/2019/4/10/18302238/insulin-walmart-relion)
[4] https://www.novonordisk-us.com/patient-help/access-and-affordability.html
[5] https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps

- Illinois: $100 collective cap for 30-day supply
- Kentucky: $30 cap for 30-day supply
- Louisiana: $75 cap for 30-day supply
- Maine: $35 cap for 30-day supply
- Maryland: $30 cap for 30-day supply
- Minnesota: State-required manufacturer assistance program has a $35 cap for one per year emergency 30-day supply, $50 cap for 90-day supply
- Montana: $35 for 30-day supply
- Nebraska: $35 cap for 30-day supply
- New Hampshire: $30 cap for 30-day supply
- New Jersey: $30 cap for 30-day supply
- New Mexico: $25 cap for 30-day supply
- New York: $100 cap for 30-day supply
- North Dakota: $25 cap for a 30-day supply*
- Oklahoma: $30 cap for 30-day supply, $90 cap for 90-day supply
- Oregon: $75 cap for a 30-day supply, $225 cap for a 90-day supply
- Rhode Island: $40 cap for a 30-day supply
- Texas: $25 cap for a 30-day supply
- Utah: $30 cap for 30-day supply
- Vermont: $100 collective cap for 30-day supply
- Virginia: $50 cap for 30-day supply
- Washington: $35 cap for 30-day supply
- West Virginia: $35 collective cap for 30-day supply; $100 collective cap on a 30-day supply of specified diabetes equipment and supplies.

The State of Utah conducted a study and published their findings regarding Insulin costs. Insulin costs have become a major issue for diabetes patients in the U.S. In response, Utah passed House Bill 207, capping insulin copayments at $30 per month, effective January 1, 2021.

This study evaluated changes in basal insulin adherence, out-of-pocket expenses, health plan costs, overall insulin expenditures, and hemoglobin A1c (A1c) levels before and after the policy's implementation. Conducting a retrospective analysis using data from a Utah health plan between October 2019 and September 2021, the study included commercially insured members who filled insulin prescriptions in both pre- and post-policy periods. Insulin adherence was assessed using the proportion of days covered (PDC), and statistical tests compared health and economic outcomes. Out of 24,150 individuals, 244 patients were analyzed. Results showed a **58.5% reduction** in median monthly out-of-pocket costs for insulin (from $65 to $27), while health plan costs increased by **22%** (from $346 to $444). Total monthly insulin costs remained unchanged. Among 74 patients analyzed for PDC, no significant change was observed (P = 0.43). Similarly, A1c levels did not significantly improve (mean A1c rose from 8.2% to 8.6%). The $30 copayment cap reduced patient out-of-pocket costs but led to higher costs for health plans without improving adherence or A1c levels. Further research over longer periods and with larger populations is necessary to assess long-term impacts.

The Utah study highlights that capping insulin copayments effectively reduced patient costs but shifted financial burdens to health plans. While adherence and health outcomes remained unchanged, further investigation is essential to determine if this policy yields long-term benefits for diabetes management[6].

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10839465/

MANUFACTURER'S INSULIN CHARGE CHANGE

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

Since 2023, insulin manufacturers have reduced prices on their insulin and diabetic supplies in response to mounting public pressure and advocacy efforts highlighting the exorbitant costs faced by diabetic patients. These reductions come amidst growing awareness of the essential nature of insulin for millions of individuals worldwide, many of whom have struggled with affordability and access issues for years. Additionally, regulatory scrutiny and legislative initiatives have pushed manufacturers to reassess their pricing strategies, aiming to make these life-saving medications more accessible and affordable. These changes mark a significant step towards addressing healthcare inequities and ensuring that essential treatments are within reach for those who need them most.

CURRENT LANDSCAPE OVERVIEW

Eli Lilly and Company has taken significant steps to enhance insulin affordability with recent initiatives. Starting May 1, 2023, Lilly will reduce the list price of Insulin Lispro Injection to $25 per vial, making it the most affordable mealtime insulin available. Humalog® and Humulin® will see a 70% price cut from Q4 2023, and RezvoglarTM, a biosimilar basal insulin, will be priced at $92 per five-pack of KwikPens®, a 78% discount compared to Lantus®. Lilly has also capped out-of-pocket costs at $35 per month for commercial insurance users immediately and offers uninsured individuals Lilly insulin for $35 monthly through the Lilly Insulin Value Program. These measures aim to address healthcare system gaps hindering affordable insulin access, with CEO David A. Ricks stressing the need for broader collaboration for comprehensive diabetes care. Lilly's efforts build on prior initiatives such as low-list-price insulins since 2019 and participation in the Medicare Part D Senior Savings Model, reducing average out-of-pocket costs for Lilly insulins to $21.80 over five years. Future plans include a national awareness campaign to promote these solutions and advocate systemic insulin accessibility improvements, alongside ongoing innovation in diabetes care.[1]

Novo Nordisk will significantly lower US list prices for insulin products by up to 75% effective January 1, 2024, following Eli Lilly's lead in reducing insulin prices by 70% and capping out-of-pocket costs at $35 monthly. President Joe Biden commended Eli Lilly's initiative, urging other insulin makers to follow. Novo Nordisk's price cuts cover NovoLog and Levemir, aiming to ease financial burdens for uninsured and high-deductible patients, with Medicare seniors benefiting from an Inflation Reduction Act cap. Advocacy groups like T1International applaud these steps while noting ongoing insulin affordability challenges relative to production costs. Novo Nordisk reaffirms commitment to insulin affordability through support programs, contrasting with Sanofi, which has yet to announce price cuts, focusing instead on existing assistance for uninsured and privately insured individuals. The US insulin price gap compared to other countries remains a concern, reflecting broader American healthcare drug pricing and access challenges[2].

Over the past two decades, insulin list prices by pharmaceutical manufacturers have risen annually, posing affordability challenges for insured patients facing soaring out-of-pocket costs. Simultaneously, insurers and pharmacy benefit managers (PBMs) negotiated increasing rebates and confidential discounts, significantly lowering net prices despite gross sales doubling for leading insulin products from 2012 to 2019.

[1] https://investor.lilly.com/news-releases/news-release-details/lilly-cuts-insulin-prices-70-and-caps-patient-insulin-out-pocket#:~:text=Today%2C%20Lilly%20is%20reducing%20the,Humalog%C2%AE%20vial%20in%201999.
[2] https://www.nbcnews.com/health/health-news/novo-nordisk-lower-list-price-insulin-rcna74836

Eli Lilly, Novo Nordisk, and Sanofi responded with substantial list price cuts of 65% to 80% in March 2023, driven by impending 2024 Medicaid rebate changes under the American Rescue Act. The gross-to-net price bubble persists for many brand-name drugs, reflecting opaque pricing and rebate structures. Future policy efforts, such as Medicare price negotiation and enhanced transparency, are crucial for equitable patient access to vital medications amid systemic pharmaceutical market challenges[3].

In 2024, Sanofi and other insulin manufacturers are implementing transformative initiatives to significantly reduce insulin costs for millions of Americans with diabetes. Sanofi has introduced price caps and savings programs, ensuring many patients pay no more than $35 monthly for insulin, responding to public outcry and legislative changes. The Inflation Reduction Act capped Medicare enrollees' out-of-pocket expenses, alleviating financial burdens and addressing insulin rationing risks. These actions aim to enhance affordability and equity in healthcare, signaling collaborative efforts among policymakers, patient advocates, and industry leaders to improve insulin accessibility and support a sustainable healthcare system[4].

CONCLUDING

In conclusion, the landscape of insulin pricing in the United States is undergoing significant shifts as major manufacturers like Eli Lilly and Novo Nordisk respond to longstanding affordability challenges. These companies have taken proactive steps to reduce list prices by substantial margins, with Eli Lilly cutting prices by up to 70% and Novo Nordisk following suit with reductions of up to 75% effective January 2024. These efforts, applauded by President Joe Biden and advocacy groups like T1International, aim to alleviate financial burdens on patients, particularly the uninsured and those with high deductibles. The implementation of caps on out-of-pocket costs under the Inflation Reduction Act further supports affordability for Medicare enrollees.

Despite these positive developments, disparities persist in insulin pricing between the U.S. and other countries, reflecting broader complexities in drug pricing and access within the American healthcare system. The ongoing challenge of insulin affordability underscores the need for continued policy reforms, including enhanced transparency in pricing practices and potential Medicare negotiations on drug prices. These reforms could further address the gross-to-net price discrepancies observed not only in insulin but also in other essential medications.

Looking forward, the commitment of pharmaceutical companies to affordability initiatives, alongside advocacy efforts and legislative changes, offers hope for more equitable access to insulin and other critical medications. As industry leaders navigate these reforms, the focus remains on ensuring that patients can affordably access the medications they need to manage chronic conditions effectively. This collaborative approach between stakeholders sets a precedent for addressing broader healthcare affordability issues and advancing towards a more inclusive and sustainable healthcare system in the United States.

[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806020
[4] https://www.cnn.com/2024/01/01/politics/insulin-price-cap/index.html

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: June 7, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0118.01000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The Bill would create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- defines "insulin drug", "medical supplies for insulin dosing and administration", and "pharmacy or distributer"
- restricts insurers and plan sponsors from offering any health insurance coverage unless the coverage meets the cost-sharing and covered service requirements listed in the Bill
- provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration regardless of the quantity or type of insulin drug
- restricts pharmacy benefit managers from collecting payment in excess of the cost-sharing requirements covered in the Bill
- restricts health plans from imposing a cost-sharing structure like a deductible or coinsurance that would require a member to pay more than the cost-share limit to receive insulin services

- allows for plans to impose cost-sharing limits that are lower than the $25 member cost-share limit included in the Bill
- stipulates that high-deductible health plans that qualify for health savings accounts are exempt from this cost-share limit until a member reaches their minimum deductible

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated the proposed legislation will have a financial impact on the Uniform Group Insurance Program. It is estimated the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $1,000,000 in the 2025-2027 biennium ending 6/30/2027.

The Uniform Group Insurance Program requires members to pay a copayment and coinsurance for insulin. Depending on the cost of the insulin prescribed and/or the cost of the supplies purchased, the member cost-share can exceed the proposed $25 limit. Therefore, it is expected that imposing this limit will shift costs from members to the Uniform Group Insurance Program.

Using 12 months of NDPERS claims data from September 2021 through August 2022, Sanford Health Plan estimated that a $25 per month limit on member cost share would have shifted $445,000 from the member to the Uniform Group Insurance Program in that period. Assuming prescription drug trend of 9.4% per year, the cost in the 2025-2027 biennium is estimated to be approximately $1,000,000 (or 0.12% increase to the estimated Program total claims costs). The estimate does not assume changes to drug mix or formulary changes that could impact member out-of-pocket payments (pharmacy benefit managers typically update their formularies at least twice per year).

OTHER CONSIDERATIONS

By limiting or capping the out-of-pocket cost to members for specific services, a smaller amount of those related costs will accumulate towards a member's deductible. As a result, members may have to pay for other services out-of-pocket until they reach their deductible, which may negate a component of the estimated 0.12% increase to the estimated Program total claims costs. Therefore, the $1,000,000 estimated increase in cost can be treated as a conservative estimate, assuming no other change in utilization.

Clinical outcomes associated with lowering member out-of-pocket costs on insulin drugs and medical supplies for insulin dosing and administration may have a favorable impact on the Uniform Group Insurance Program, but such effects are difficult to quantify. If insulin and supplies are more affordable, member adherence may increase and result in fewer adverse health effects that result in expenditures to the Program, such as increased doctor and emergency department visits and prolonged hospitalization.

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Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: August 2, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **MARKET ANALYSIS RELATED TO BILL 23.0532.03000**

In the 2023 legislative session, the North Dakota legislature passed SB 2140 which, among other items, requires the NDPERS Board to evaluate and report on the feasibility of extending the $25/month cap on insulin and diabetic supplies from a pilot to the commercial market statewide. Deloitte Consulting LLP (Deloitte [i]) was commissioned to analyze similar initiatives in other states and industries to assess their impact on adherence among diabetic populations and other relevant outcomes to inform the legislative review.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF BILL

The amended bill would create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- Defines "insulin drug" and "medical supplies for insulin dosing and administration"
- Directs the Board to provide health insurance benefits coverage that complies with the defined cost-share provisions
- Provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration
- Clarifies that cost-sharing is not limited for insulin pumps, electronic insulin-administering smart pens, or continuous glucose monitors
- Declares the application of this legislation to be June 30, 2023, to June 30, 2025
- Requires that the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for

this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies, and;

- Directs the public employees retirement system to provide a report on the effect of the insulin drug and supplies requirements on the system's health insurance programs, including utilization and cost, and a recommendation on continuing the coverage

CONSIDERATIONS AND RELATED LEGISLATION

Currently, 24 other states plus the District of Columbia have set caps on insulin cost-sharing for state-regulated commercial health plans, as reported by the American Diabetes Foundation. The caps vary significantly across the states:

- Alabama: $100 cost-share cap for a 30-day supply
- Colorado: $100 collective cost-share cap for any 30-day supply regardless of dosage
- Connecticut: $25 cost-share cap for 30-day supply of insulin or any other diabetic medication; $100 cap for 30-day supply of devices and supplies
- Delaware: $100 collective cost-share cap for 30-day supply, $0 for insulin pumps, and collective $35 cost-share monthly cap for other diabetic specific equipment and supplies
- District of Columbia: $30 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices
- Illinois: $35 collective cost-share cap for 30-day supply (effective 7/1/2025)
    - Current provision through 6/30/2025 is a $100 collective cost-share cap for a 30-day supply
- Kentucky: $30 cost-share cap for 30-day supply
- Louisiana: $75 cost-share cap for 30-day supply
- Maine: $35 cost-share cap for 30-day supply
- Maryland: $30 cost-share cap for 30-day supply
- Minnesota: $25 cost-share monthly cap for diabetes medications; $50 cost-share monthly cap for supplies; State-required manufacturer assistance program has a $35 cost-share cap for one per year emergency 30-day supply, $50 cost-share cap for 90-day supply
- Montana: $35 cost-share cap for 30-day supply
- Nebraska: $35 cost-share cap for 30-day supply
- New Hampshire: $30 cost-share cap for 30-day supply
- New Jersey: $35 cost-share cap for 30-day supply
- New Mexico: $25 cost-share cap for 30-day supply

- New York: $0 cost for 30-day supply of insulin (effective 1/1/2025)
    - Current provision is a $100 cost-share cap for a 30-day supply
- Oklahoma: $30 cost-share cap for 30-day supply; $90 cost-share cap for 90-day supply
- Oregon: $35 cost-share cap for 30-day supply; $105 cost-share cap for 90-day supply (effective 1/1/2025)
    - Current provision is a $85 cost-share cap for 30-day supply
- Rhode Island: $40 cost-share cap for 30-day supply
- Texas: $25 cost-share cap for 30-day supply
- Utah: $30 cost-share cap for 30-day supply
- Vermont: $100 collective cost-share cap for 30-day supply
- Virginia: $50 cost-share cap for 30-day supply
- Washington: $35 cost-share cap for 30-day supply
- West Virginia: $35 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices

Effective July 1, 2023, the federal government, under the Inflation Reduction Act, has introduced a $35 copay cap for Medicare retirees purchasing insulin. According to the Department of Health and Human Services, this measure is estimated to save retirees over $500 annually.

Additionally, the Inflation Reduction Act includes a provision that expands the coverage of insulin under High Deductible Health Plans (HDHPs). This legislation formalizes IRS Notice 2019-45, which permits certain preventive care for chronic conditions, such as insulin, to be covered without requiring members to meet a deductible first.

Colorado was the first state to implement an insulin cost-share cap in May 2019 with HB19-1216. The initial legislation faced challenges due to ambiguities over applicable insulin types and coverage for multiple prescriptions. These issues led to confusion and potentially higher costs for patients requiring multiple types of insulin[1].

In response, Colorado passed an amendment effective January 1, 2022 with HB21-1307, clarifying that the $100 cap covers all prescribed insulin medications combined per 30-day supply. The amendment also introduced an insulin affordability program for uninsured individuals, offering a 12-month supply at $50 per month and an emergency supply at $35.

The implementation of insulin cost-share caps across various states and at the federal level represents a step towards reducing the financial burden on individuals with diabetes. However, ongoing evaluation is necessary to address potential unintended consequences and ensure the sustainability of these measures. Due to the infancy of a majority of these bills and implementation of the cost-share caps in other states, states are still analyzing the impact of the cost-share caps on members' out-of-pocket costs as well as the impact to premiums.

While these caps reduce out-of-pocket costs for insulin and increase costs for plan sponsors, they do not decrease the overall cost of the drug. However, the lower cost of insulin for members can

potentially lead to better adherence to their medication regimen. Improved adherence can result in lower healthcare costs overall, as members are more likely to avoid costly inpatient care due to better management of their condition.

It remains uncertain whether the potential cost savings from improved drug adherence will offset other rising costs. Over the past decade, insulin prices have tripled, raising concerns that cost-share caps might shift expenses to other areas, such as insurance premiums.

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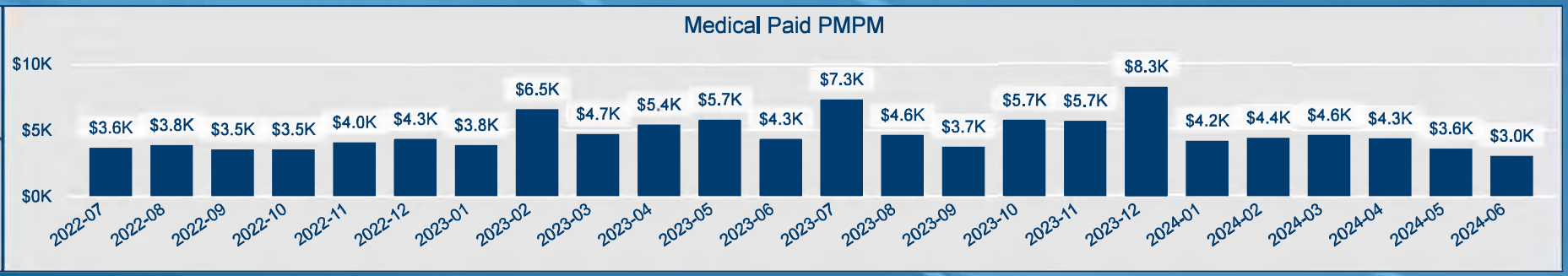
[1] Endocrine Today. (2013). "How Colorado's insulin cap law evolved" Retrieved from https://www.healio.com/news/endocrinology/20230510/how-colorados-insulin-cap-law-evolved#:~:text=In%20May%202019%2C%20Colorado%20became,of%20insulin%20for%20Colorado%20residents.

NDPERS - Medical Utilization for Members with Type 1 Diabetes Diagnosis Only and Insulin and Diabetes Supplies Claims - All LOB's

Medical PMPM Before
$4,428

Medical PMPM After
$4,932



ER Visits/1000 Before
877.1

ER Visits/1000 After
915.4

IP Admits/1000 Before
747.5

IP Admits/1000 After
592.4

Last Data Refresh: 07-24-2024 01:02 PM CT

Notice: This report and any exported data is for internal use only and should not be sent outside of Sanford.

Not all medical claims have been paid. Providers have 180 days to submit claims to Sanford Health Plan
Does not include Medical PMPM for NDPERS Members diagnosed with Type 2 Diabetes that were prescribed Insulin

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: October 8, 2024

SUBJECT: Update from Sanford Health Plan Regarding Humira

Sanford Health Plan (SHP) has provided Attachment 1 to NDPERS regarding the prescription drug Humira and a change that they will be implementing effective January 1, 2025. The change will remove Humira as a drug on the NDPERS formulary, meaning it will be processed as a tier 3 non-formulary drug. Notification was sent in September to the 20 impacted members to notify them of this upcoming change (Attachment 2).

You may recall that SHP already removed Humira as a preferred drug on the NDPERS formulary and notified impacted members at the time of 3 biosimilar therapies as preferred options. At that time, there were 169 members impacted.

Representatives from SHP will be available to answer questions you may have.

This item is informational and requires no action by the Board.

Attachment 1

SANFORD HEALTH PLAN

Memo

To: Rebecca Fricke

From: Kim Haug

Date: 9/25/2024

Re: Formulary change for Humira

In December 2023 Sanford Health Plan added a **Brand Penalty** to Humira due to the availability of less expensive Biosimilar medications used to treat the same conditions.

> **Brand Penalty** - Medication may be subject to penalty because there is a generic alternative or biosimilar equivalent that is available. Penalties do not apply to your deductible or maximum out of pocket

In January 2025 SHP Pharmacy and Therapeutics Committee will be removing Humira from the NDPERS Formulary. Nonformulary medications have a $30 copay then 50% of the allowed charge for employees on the grandfathered PPO plan.

There were 20 members identified that have filled Humira in the past 6 months. Those members were mailed a letter informing them of the change effective 1/1/2025.

Attachment 2

October 1, 2024

«Member_First_Name» «Member_Last_Name»
« Member_Address_1» « Member_Address_2»
«Member_City», «Member_State» «Member_ZIP»

Dear «Member_First_Name»,

Sanford Health Plan's covered drug list (formulary) is changing January 1, 2025. The drug below will be changing to Non-formulary as of January 1, 2025. This means the medication will not be covered after January 1 without a prior authorization. If you no longer take this drug, please disregard this letter.

We encourage you to speak with your doctor about other possible drug option(s) that may be available to suit your needs.

Current Non-Preferred Drug	**Preferred Drug Option(s)**
Humira Pen	Adalimumab-adaz, adalimumab-fkjp, Hadlima, and Simlandi

If you or your doctor feel you should not stop taking the current drug or change to the new preferred drug option, please have your doctor complete and submit a request for prior authorization through our provider portal.

We apologize for any inconvenience this disruption has caused. If you have questions about this change, your prescription drug benefits, or would like a free copy of your formulary, please call us Monday through Friday from 8 a.m. to 5 p.m. CST at (855) 305-5062 (TTY: 711). You can also contact us through your secure member portal at **sanfordhealthplan.com/memberlogin**.

Sincerely,

Pharmacy Management
Department Sanford Health Plan

Enc: HP-0251 Appeal Rights COM-IND-PERS
Non-discrimination Notice

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: October 8, 2024

SUBJECT: Collection Services

Historically, NDPERS has utilized the Attorney General's Civil Litigation Department to collect overpayments on our behalf. From the end of 2021 until recently, there was not a dedicated resource in the Attorney General's Office focused on collections.

Currently there are 22 past due accounts totaling $16,565.85 that are considered recoverable within the Statute of Limitations. Staff is interested in exploring the use of a collection service as part of a State Contract to try and recoup some of our outstanding balances. Staff believes the use of the State Contract can save us money in the long run, as it is our understanding that fees are not collected from the Vendor(s) unless they are successful in obtaining the overpayment from the member. Preliminary estimates have indicated any amounts recovered would require a fee ranging from 14-25% of the recovery. Even with a dedicated resource in the Attorney General's office, we would be paying flat hourly fees for any work being done on these accounts, even if recovery is unsuccessful.

Staff believes getting a portion of the recovery is better than getting no recovery at all. Because utilizing a collection service would result in the Agency not recovering the full amount due, Staff wanted the Board to consider the approach and guidance on the appropriate way to try and recover outstanding balances owed to our Agency.

The Audit Subcommittee heard this topic at their August meeting and is recommending to the full Board that Staff begin utilizing a collection service through the State's Contract versus escalating these to the Attorney General's Office in the future.

Board Action Requested

Provide direction to Staff on the preferred method to try and collect overpayments.

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: October 9, 2024

SUBJECT: Budget Request for Data Integrity Dashboard

Staff is interested in developing a Data Integrity Dashboard. The goal of this dashboard is to assist us in maintaining high-quality data by catching data inconsistencies before running each of our major batches (including billing members, paying members, and providing coverage enrollments to our carriers).

As you are aware, we are trying to establish and progress our Business Process Management upgrade in our system, where we try and automate the system and eliminate data entry as much as possible for our users. Accurate data is the key element for reliable process automation, ensuring accurate benefit calculations, and the generation of clear, easy-to-use reports and analytics. In contrast, poor data quality can result in costly manual reviews, embarrassing inaccuracies in member-facing correspondence and MSS, and confusion among members, employers, and internal staff. These issues come with significant hidden costs and threaten our reputation.

Based on the quote from NDIT, the dashboard will provide a framework and create initial queries allowing access based on user, roles, and divisions. The dashboard will help ensure NDPERS staff have access to review only the pertinent data elements that are needed to perform the duties of their job. NDPERS IT staff will utilize these examples to develop additional data points, enabling quick and easy identification of data integrity issues. Example data points include: duplicate people, employers without primary authorized agents,

and members with missing member demographic data and ensuring benefit coverage makes sense for the dynamics of the members situation.

Given the additional appropriation authority received to implement HB 1040, and some of the internal cost shifting that has occurred as a result of the implementation, we believe we could implement the dashboard without having to use our contingency appropriation, but that will be an option if we have other unexpected expenses that occur throughout the biennium. Staff did build in the $80 monthly cost into our appropriation request for 2025-2027, in the event the Board decided to move forward with this project.

Board Action Requested:
Consider the need for a data integrity dashboard.

Attachment

NORTH Dakota | Information Technology
Be Legendary.

Data Division Estimate

To: NDPERS	Date Issued: 7/9/24 (Updated)	Prior Est. Date:
	From: Data Division (BI Team-1)	
	Prepared By: Scrum Team BI-1 (Darvin Fitzgerald)	
Project Description: **Convert existing Excel spreadsheet that is maintained by one person that extracts data from several sources and displays various values that indicate data inconsistencies, missing information, or new action items to a Power BI dashboard that will be shared to a larger audience through the Power BI app functionality.**		
WMS Work Order: PPA2740 - PERSLink Dashboard	WMS Service Request:	Estimate Type:

NDIT is recommending your agency budget in the range of **$29,000 - $32,000** for this project. If desired, a more accurate estimate can be prepared, following a more extensive planning effort by the team.

What you get for your money from ITD

ITD estimates this project to take **4-6 weeks**. This timeframe is a projected timeframe based on typical project staffing levels. The work will be done in sprints following the Agile methodology. At the start of the project ITD will review any estimate over 90 days old. If necessary, a revised estimate will be issued.

ITD suggests you budget **$80 per month** for the on-going cost of hosting the dashboard. This amount includes the hosting costs for the Power BI workspaces and estimated charges for the data storage and refreshes. All ITD services will be billed to your department monthly at actual cost.

Should you decide to proceed with this project, please approve the cost estimate via the online Work Management System. Upon your approval, you will be prompted to submit a service request under the existing work order. All ITD services relating to this project will be billed to your department monthly at actual cost.

'ITD - Software that works'

ITD Request Number: PPA2740 - PERSLink Dashboard

Project Description

Convert existing Excel spreadsheet that is maintained by one person that extracts data from several sources and displays various values that indicate data inconsistencies, missing information, or new action items to a Power BI dashboard that will be shared to a larger audience through the Power BI App functionality.

Assumptions

The one-time costs (development) of the routines and artifacts are based on the following assumptions:

- NDPERS will request access be granted to SQL Server databases (Parallel & PROD environments)
  - NDIT BI-1 developers (state employees only) – access to create views, tables, and stored procedures to replicate data queried by the existing Excel spreadsheet.
  - Service account with read access to read data from views and/or tables for Power BI dashboard (Parallel & PROD environments)

  NOTE: If any data is needed for reporting that does not exist in the SQL Server database and exists in Excel spreadsheets, CSV files, or similar:
    - ***NDPERS will identify an existing SharePoint site/folder or create a request for a new SharePoint site/folder for files/links.***
      - ***NDPERS will request a service account for read access to above SharePoint site.***
      - ***NDPERS will request a service account with read access to source locations for files and write access to above SharePoint site.***
      - ***NDIT will submit MoveIT request to move these files on a schedule to the SharePoint site***

- NDPERS will identify the most important dashboard elements/drilldown pages that it wants NDIT to prioritize replicating.
- NDIT will create views (not to exceed 10 of the queries per this estimate) for the dashboard elements identified by NDPERS. These views will replicate the queries used in the existing Excel spreadsheet to gather data from SQL Server databases.
- NDIT will provide up to 8 hours of cross training/instruction to NDPERS staff to create the remaining views to replicate the queries used in the existing Excel spreadsheet to gather data from SQL Server databases.
- NDIT will use the existing Power BI workspace NDPERS-Power Bi Reports (will become PROD) and convert it to premium capacity to allow for the creation of a Power BI application.
- NDIT will create an additional premium workspace for the parallel environment (test). NDPERS will submit a request to create this workspace.
- NDIT will create a Power BI deployment pipeline to publish data from the parallel to production workspaces.
- NDIT will create Power BI data flows for the following:
  - SQL Server databases (Parallel & PROD environments)
  - Non-database sources of data (if applicable)
- NDIT will create a Power BI dashboard to replicate the data displayed in the existing Excel spreadsheet using the above Power BI dataflows
  - Main dashboard page(s)
  - Drilldown elements/report pages (Approximate 10 dashboard elements with drill-down capability to different detail report pages per this estimate)

- NDIT will configure the PERSLink dashboard with row level security to control what users should see certain data.
- NDPERS will submit request for AD groups to manage any necessary tenant settings (ex. Exporting to Excel, downloading reports, publish to web).
- NDIT will create a Power BI app and add the PERSLink dashboard to it.
  - NDPERS will provide a list of users or active directory group(s) that should have access to view the dashboard via the Power BI App
  - NDIT will configure the audience (permissions) to the Power BI App. Any admins of the workspace (including NDPERS staff) can update the audience of the Power BI App in the future.
- NDIT staff will provide up to 8 hours of training/mentoring on Power BI report development, workspace administration, and Power BI App maintenance.

Determining Costs

The cost estimate includes the following processes:

Process	**Description**
Set up MoveIT (if applicable)	Submit requests to schedule MoveIT jobs to bring the files from the shared file location to the SharePoint storage location.
SQL Server views/queries	Creation of views to replicate the queries used in the existing Excel spreadsheet to be used by Power BI dataflows to populate the dashboard.
Load/Model Data	Create Power BI dataflows to connect to the data sources. Create data model to be used by the dashboard
Row Level Security	NDIT will configure the dashboard with row level security to control the data users can view.
Dashboard development	Create a Power BI dashboard to replicate the data displayed in the existing Excel spreadsheet using Power BI dataflows. Main dashboard page(s). Drilldown dashboard items/pages (Approximate 10 dashboard elements with drill-down capability to different detail report pages)
Power BI workpace/portal configuration	Upgrade existing Power BI workspace NDPERS-Power Bi Reports to premium capacity. Create workspace for Parallel (test) environment. Create deployment pipeline. Modify permissions and tenant settings.
Power BI App development	Create Power BI App, add PERSLink dashboard content to it, configure audience (permissions)
Training/mentoring	Instruction on Power BI report development, SQL view creation, Power BI workspace and application administration (up to 8 hours)

One-Time Cost for System Development

NDIT is recommending your agency budget in the range of **$30,000 - $32,000** for this project. If desired, a more accurate estimate can be prepared, following a more extensive planning effort by the team.

On-Going Monthly Costs.

On-going monthly costs are estimated as follows:

Power BI Premium Workspaces: 2 workspaces (Parallel & Prod), $15 each = $30
Power BI dataflow/dataset refresh fees: $50 per month ($25 per workspace, if data is not refreshed in a month, it will not incur this charge)

Providing Customer-Centric Services

The Information Technology Department (ITD) provides technology leadership for state government and the people of North Dakota. ITD exists solely to help State agencies discover, assess, and implement information technologies. ITD's Software Development Division develops, implements, operates and supports software solutions that meet our customer's need as provided in this cost estimate. ITD also provides server computing, local and wide area network support, voice and data technologies, video conferencing, and other emerging technologies. The following overview describes the services ITD considers valuable to our customers. We hope you'll find this helpful in assessing the value of our services.

State Government IT Partner

ITD knows the business of North Dakota State government and understands inter-agency relationships. We've been servicing State agencies since 1968. Upon request, we'll provide references offering honest referrals about our services.

Our customer relationships are long-term partnerships.

Affordable Cutting Edge Technology

ITD helps agencies discover best fit solutions for their agency at affordable rates. ITD charges only to recover costs – we retain no profit with our low rates. Our staff is trained in many new and existing technologies, so we can readily assess customer requirements and provide solutions that best fit an agency's needs. ITD implements and supports IT solutions on modern hardware in modern facilities, using operating systems and software no older than current version minus 1.

Whenever it's necessary to extend our capabilities, we augment our current staff with outside vendors to meet demands.

Quality

ITD develops applications within the processes of a structured systems development methodology. This includes functional testing and all applications are tested for usability and performance (load tested). ITD Meets State & Federal Audit Compliance. Our infrastructure and operation processes are reviewed by and meet state and federal audit requirements. ITD Supports State Enterprise Architecture Standards, and our software and infrastructure meet North Dakota Enterprise Architecture standards.

We build compliance into our service offerings which relieves the customer of State standard compliance concerns.

Dedicated & Experienced Staff

ITD employees submit to an FBI background check and are bound by the same confidentiality requirements as agency staff. ITD's staff is cross-trained to provide continuous backup. We provide dedicated architects to design effective, top-notch infrastructure for security, system hosting, software development, and telecommunications. Our staff applies formal project management practices to all projects.

ITD strives to retain innovative, talented, and dedicated staff. ITD's staff is tenured with an average of 13 years of service.

Support Structure

ITD offers several levels of customer support, including 24 x 7 support for applications and infrastructure.

Customer Service Surveys indicate 99% of customers are very satisfied with our support.

Flexible Infrastructure

ITD's infrastructure and support structure are designed to meet varied needs. ITD designs and builds applications that can operate in a redundant environment. If one server fails, another server picks up the workload with little or no down time.

We can design and host any size application.

Disaster Recovery

ITD has the tools and resources required to monitor software applications and computer system infrastructure to assure adequate performance and up-time. Applications can be monitored on a 24 x 7 basis. If a disaster occurs in our Computer Systems area or Statewide Network, customer applications can be running within hours.

ITD's standard practice is to keep all data, applications, and systems backed up in a secure location to meet customer expectations.

Security

By investing in the infrastructure and training required to prevent malicious activity within our IT environment, ITD has dedicated staff to assure that customer data and applications are secure.

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

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: October 8, 2024

SUBJECT: Contracts under $10,000

Attached is a document that shows the contracts under $10,000 that have been signed since the last update. Please let me know if you have any questions on any of these contracts.

This topic is informational only.

Attachment

All Contracts Signed During 2024:

Vendor	Amount	Notes
CliftonLarsonAllen	$ -	GASB 68 & 75 Representation Lettess
TIAA	$ -	Termination notice due to recordkeeper award
BND	$ 909.00	Staff Years of Service Awards (Gift Cards)
City of Berthold	$ -	Joined Life Insurance Plan 3/1/2024
Mandaree Public Schools	$ -	Joined Deferred Compensation Plan 3/1/2024
Interoffice	$ 1,179.44	Office Chair
Emmons County	$ -	Joined Public Safety Plan 4/1/2024
City of Leeds	$ -	Joined Defined Benefit Plan 4/1/2024
City of Leeds	$ -	Joined Deferred Compensation Plan 4/1/2024
City of Emerado	$ -	Joined Public Safety Plan 2/1/2024
City of Riverdale	$ -	Joined Defined Benefit Plan 4/1/2024
City of Riverdale	$ -	Joined Deferred Compensatoin Plan 4/1/2024
Fireside	$ 3,079.80	5 year total lease on multi-function printer
Advanced Business Methods	$ 5,713.20	5 year total lease on document scanner
Eddy County	$ -	Joined Life Insurance Plan 5/1/2024
Galliard Fund Agreements	$ -	Lowering the share class in the Galliard investments in the 401(a) & 457 Plans
Larimore Public School	$ -	Joined Deferred Compensation Plan 1/1/2025
TIAA Deconversion Guide	$ -	Strategy guide with TIAA for deconvertig to Empower
TIAA Letter of Direction	$ -	Direction to pay out RMDs & scheduled installments early with TIAA prior to blackout
Empower Letter of Instruction	$ -	Letter of instruction on brokerage account in 457 and 401(a) plans
Empower Brokerage Application	$ -	Application on brokerage account in 457 and 401(a) plans
TIAA Custodial Agreement Terminations	$ -	Termination of Custodial Agreements with TIAA for both the 457 and 401(a) Plans
TIAA Record Keeper Amendment	$ -	Authorization for TIAA to pull recordkeeper fees through June 2024
Beulah Public School # 27	$ -	Joined Deferred Compensation Plan 7/1/2024
TIAA Brokerage Re-Registration Letter	$ -	Authorizes the transfer of brokerage acocunts on both the 457 and 401(a) Plans
Empower Brokerage Transfer Request Form	$ -	Authorizes the transfer of brokerage acocunts on both the 457 and 401(a) Plans
Empower Plan Asset Transfer & Investment Direction	$ -	Directs the investments of brokerage acocunts on both the 457 and 401(a) Plans
Inter Office	$ 824.76	Rising legs for standing desk
Advanced Business Methods	$ 3,930.00	5 year total lease on multi-function printer
Steele County	$ -	Joined Public Safety Plan 7/1/2024
City of Grand Forks	$ -	Joined Deferred Compensation Plan 9/1/2024
Fargo Public Schools	$ -	Joined Deferred Compensation Plan 1/1/2025
Garrison Public Schools	$ -	Joined Deferred Compensation Plan 7/1/2024
Empower	$ -	Staff setup on plan sponsor website
Oliver Mercer Special Education	$ -	Joined Deferred Compensation Plan 7/1/2024
Central Cass School District	$ -	Joined Deferred Compensation Plan 7/1/2024
Grand Forks Public Library	$ -	Joined Deferred Compensation Plan 9/1/2024
Tri-County Water District	$ -	Joined Defined Benefit Plan and Deferred Compensation Plan 8/1/2024
Inter-office	$ 1,206.66	Office Chair
Northern Cass School District	$ -	Joined Deferred Compensation Plan 1/1/2025
Empower	$ -	401(a) NDPERS Admin Fee Agreement
Oakes Public School District	$ -	Joined Deferred Compensation Plan 1/1/2025
Western Education Regional Cooperative	$ -	Joined Defined Benefit Plan, Deferred Compensation Plan and Life Plan 10/1/2024
Parshall School District	$ -	Joined Defined Benefit Plan 9/1/2024

Contracts Signed Since Last Reported:

Vendor	Amount	Notes
City of Jamestown	$ -	Joined Public Safety Plan 11/1/2024
City of Rugby	$ -	Joined Public Safety Plan 11/1/2024
Lake Metigoshe Recreation Service District	$ -	Joined Deferred Compensation Plan 10/1/2024
IRS	$ -	Power of Attorney & Penalty of Perjury Statement for 401(a) IRS Determination Letter
Jamestown Parks & Recreation District	$ -	Joined Deferred Compensation Plan 1/1/2025
Tri-County Water District	$ -	Terminated election to join Defined Benefit 8/1/2024

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Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: October 8, 2024

SUBJECT: Board Meetings During Legislative Session and Quorum Requirement

At the September meeting, the Board discussed options for regular meetings in 2025 when Session is occurring given the requirement under NDCC 54-52-03(6) that eight of the eleven members constitute a quorum. Six votes are necessary for resolution or action by the Board at any meeting. Counsel did clarify that in order to conduct business, eight members must always be present during a meeting, with at least six members voting on any action items.

The Board directed staff to review options to bring back for the Board's consideration. As a reminder, virtual attendance will continue to be an option for the meetings.

If the Board wishes to hold their regular monthly meetings during normal working hours, the following choices are available for each month:

January 6 (Monday):	Meet prior to start of Session on January 7
February 7 (Friday):	Meet in the afternoon
March 4 (Tuesday):	Meet during crossover and the day prior to Session reconvening
April 4 or 11 (Friday):	Meet in the afternoon

Staff also inquired if the WSI Board Room is available for use outside of normal business hours. Building management has confirmed that the room may be used outside normal business hours, including earlier in the morning, evenings and on weekends. If the wishes of the Board are to hold their regular meetings outside normal business hours, staff will need direction on what dates work for each month so that the room can be reserved.

Dean has indicated there is not statutory or regulatory provisions restricting holding a board meeting on a weekend.

As discussed last month, it is likely that there will need to be special meetings throughout Session in order to request the Board's direction regarding proposed legislation. However, until Session begins, it cannot be anticipated the number needed and when.

Board Action Requested: Provide direction to staff regarding dates they wish to hold their regular monthly meetings during the 2025 Session.

IX. MEMBER *EXECUTIVE SESSION

A. Unforeseeable Financial Hardship Case # 884

***Executive Session pursuant to N.D.C.C. §44-04-19.2, §44-04-19.2(1) and/or §54-52-26 to discuss confidential records or confidential member information.**