NOTICE OF TRANSFER GUIDE
(Rev. 01-2024)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
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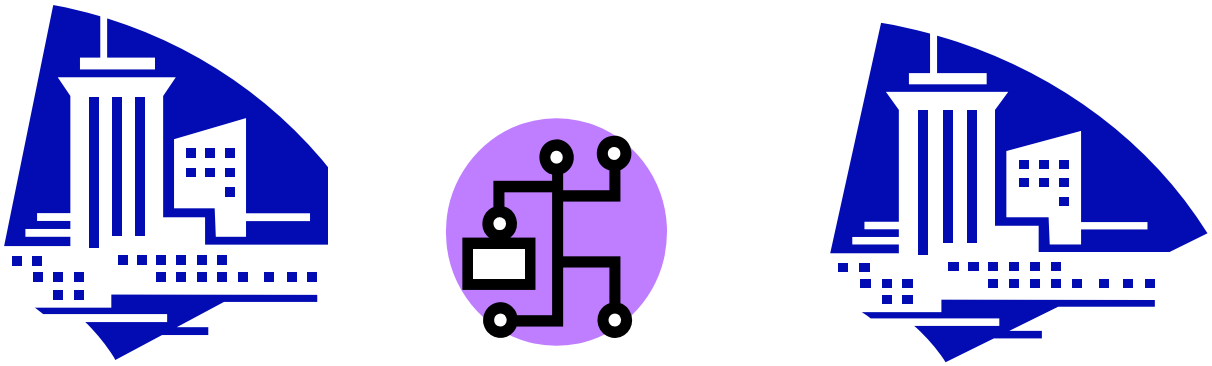


This publication contains information, forms, and instructions necessary for an employee to transfer current benefits to his/her new employer or to apply for continuation of benefits if coverage does not transfer. This publication is to be completed by BOTH the Employers and Employee.

This publication is intended to provide general information and may not be considered to be a legal interpretation of law. Statements contained in this publication do not supersede the North Dakota Century Code or Administrative Code or restrict the authority granted to the Retirement Board.

The information in this publication is subject to changes made by the North Dakota legislature, by the Board of the North Dakota Public Employees Retirement System (NDPERS), and its agents.

NAVIGATING THE NOTICE OF TRANSFER GUIDE

COMPLETE FORMS IN BLUE OR BLACK INK

EMPLOYER Responsibility:

The "Notice of Transfer SFN 53706" may be completed by your current and new employer, but is not required.

Forms should be submitted to NDPERS by fax/pdf or original should be mailed. Any forms that are not legible will require resubmission to NDPERS.

Transfer Policy:

- ✓ Retirement service record will transfer.
- ✓ Employees cannot change their level of health insurance coverage.
- ✓ Employees cannot change their level of life insurance coverage.
- ✓ If enrolled in the dental, vision or long-term care plans, no change in level of insurance coverage is allowed.
- ✓ If enrolled in the NDPERS Administered FlexComp plan, no change in deduction is allowed unless there is an IRS Qualified Change of Status as a result of the transfer.
- ✓ If enrolled in the deferred compensation plan, the amount authorized for deduction by the previous employer will automatically transfer to the new employer. The employee may change the deduction amount by completing a new participation agreement.

In recognition of the fact that the current employer may not be aware of the circumstances regarding a departing employee's employment plans and subsequently a new employer will not receive any transfer information, NDPERS has developed a series of scenarios along with the required administrative procedures to follow depending on the particular situation. These procedures are designed to ensure transfers are processed consistently based on "what the employer knows at the time of separation of employment." Please refer to the Employer Guide for details.

EMPLOYEE Responsibility:

1. Group Retirement Plans

Transfer of Coverage:

The benefits described in this section only pertain to members of NDPERS Defined Benefit Plan or Defined Contribution Plan. Read the "Group Retirement Plans" section carefully before proceeding.

- ✓ If you transfer employment from one participating employer to another participating employer without terminating eligible employment, NDPERS will record unused sick leave of a participating member if the new employer certifies that it will not transfer that leave. The certification must include documentation from the previous employer detailing the number of hours of sick leave. NDPERS must receive the certification

within sixty days after the member leaves employment with the former employer. Complete the Transfer of Unused Sick Leave Verification SFN 53404.

- ✓ If you change retirement status from contributing to "non-contributing" participation (no longer accruing sick leave as a part-time or temporary employee) **or** change to any position in which you are "no longer accruing sick leave" without terminating eligible employment, you must submit SFN 58358 Conversion of Unused Sick Leave Application and purchase unused sick leave in the month in which this change occurs.

- ✓ If you change employment and are no longer participating in the NDPERS retirement plan (ex. change to ND University System or TFFR retirement plan) but continue to accrue unused sick leave, you may not purchase your unused sick leave under the NDPERS retirement.

Termination of Coverage:

- ✓ Complete either a "Refund/Rollover Guide", a "Deferred Retirement Guide", or a "Retirement Guide".

2. Group Health Insurance

The benefits described in this section only pertain to members of NDPERS. Read the "Dakota Plan Features" section carefully before proceeding.

Transfer of Coverage:

- ✓ You cannot increase your level of health insurance coverage.

Termination/Decrease Level of Coverage:

- ✓ Complete the "Continuation of Group Insurance Coverage (COBRA) SFN 14120" if you are continuing OR waiving continuation of your current coverage.

3. Group Life Insurance

The benefits described in this section **only** pertain to members of NDPERS.

Transfer of Coverage:

- ✓ You cannot change your level of life insurance coverage.

Termination/Decrease of Coverage:

- ✓ You will receive a packet from Voya Financial that will provide options regarding portability of your life insurance or converting to an individual plan.

- ✓ Complete the "Group Life Insurance Enrollment/Change SFN 53803" if you are continuing but at a reduced level of coverage.

4. Group Dental Insurance

The benefits described in this section only pertain to members of NDPERS. Read the "Dental Coverage" section carefully before proceeding.

Transfer of Coverage:

- ✓ You cannot increase your level of dental insurance coverage.

Termination/Decrease Level of Coverage:

- ✓ Complete the "Continuation of Group Insurance Coverage (COBRA) SFN 14120" if you are continuing OR waiving continuation of your current coverage.

5. Group Vision Insurance

The benefits described in this section only pertain to members of NDPERS. Read the "Vision Coverage" section carefully before proceeding.

Transfer of Coverage:

- ✓ You cannot increase your level of vision insurance coverage.

Termination/Decrease of Coverage:

- ✓ Complete the "Continuation of Group Insurance Coverage (COBRA) SFN 14120" if you are continuing OR waiving continuation of your current coverage.

COBRA Notification Letter
Federal COBRA Law: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers provide employees and their dependents who lose their eligibility to participate in a group health, dental, and vision insurance plans an opportunity to continue comparable coverage at their own expense.

6. NDPERS Administered FlexComp Plan

The benefits described in this section only pertain to participants of NDPERS Administered FlexComp Plan. Read the "Transfer of Coverage" section carefully before proceeding.

Transfer of Coverage:

- ✓ No change in your deductions is allowed unless there is a qualified IRS Change in Status Event as a result of the transfer.

Termination of Coverage:

- ✓ Complete the "Continuation of Coverage in a Medical Spending Account (COBRA) SFN 53512" if you participate in the NDPERS Administered FlexComp Plan and are transferring to an employer group not on the State of North Dakota FlexComp Plan.

Under the provisions of the Internal Revenue Service (IRS) COBRA regulations you have the opportunity to extend your participation in the NDPERS Medical Spending Account to the end of the current plan year on December 31.

7. Deferred Compensation Plan

The benefits described in this section only pertain to members of NDPERS 457 Deferred Compensation Plan. Read the "The Deferred Compensation Plan" section carefully before proceeding.

Transfer of Coverage:

- ✓ If enrolled in the deferred compensation plan, the amount authorized for deduction by the previous employer will automatically transfer to the new employer. You may change the deduction amount online through your Member Self Service account or by completing a new "457 Deferred Compensation Plan Enrollment/Change SFN 3803". A transfer is not a distributable event under the 457 regulations.

Termination of Coverage:

- ✓ Upon termination of employment, your North Dakota Section 457 Deferred Compensation Plan becomes available for distribution after a 30-day period of separation from covered employment.

8. Employee Assistance Program

Transfer of Coverage:

- ✓ Transfers automatically

Termination of Coverage:

- ✓ Cancels automatically

GROUP RETIREMENT PLAN

DEFINED BENEFIT PLAN:

Transfer of Employment:

Your member account balance and service credits with NDPERS are "portable" if you move from one participating employer to another. Even though you may have had several different participating employers, all service credit and employee contributions are maintained by NDPERS.

If you transfer employment from one participating employer to another participating employer without terminating eligible employment, NDPERS will record unused sick leave of a participating member if the new employer certifies that it will not transfer that leave. The certification must include documentation from the previous employer detailing the number of hours of sick leave. NDPERS must receive the certification within sixty days after the member leaves employment with the former employer. Complete the Transfer of Unused Sick Leave Verification SFN 53404.

Termination of Coverage:

To be eligible for benefits listed below, you must terminate employment**. "Termination of employment" for the purposes of determining eligibility for benefit payments means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence or reemployment with any covered employer prior to receiving a lump sum distribution of the member's account balance does not constitute termination of employment.**

Member Account Balance:

The member account balance consists of the monthly employee contributions, the vested portion of your employer contributions, any purchase payments and interest. This interest is compounded monthly up to the time you receive a refund/rollover of your account or begin receiving a monthly benefit. The interest paid on your account is based on a rate established by the NDPERS Board and builds on a tax deferred basis. If you take a refund or rollover, your retirement funds will not be available until you have been terminated for approximately 60-90 days, subject to tax notification requirements. See the "Special Tax Notice Regarding Plan Payments".

Option 1

You can choose to have your member account balance paid directly to you. If you choose this option, only 80 percent of the taxable amount of your member account balance is payable to you because NDPERS is required to withhold 20% (percent) of the payment for federal tax purposes. In addition, if you are under age 59 1/2, you may be subject to an additional 10 percent penalty for early withdrawal. If you elect this option, then you will need to complete a "Refund/Rollover Guide".

Option 2

You can choose to have all or a portion of your member account balance directly rolled over into an IRA or another employer plan. If you have all or a portion of the amount rolled over, any taxable amount not rolled over will automatically be mailed to you and subject to the taxes indicated in

“Option 1”. The portion rolled over is not taxed until you take it out of the IRA or other employer plan. (NOTE**:** Be sure to check to see if the other employer plan will accept a rollover from a 401(a) plan and request a letter of acceptance be forwarded to NDPERS from the named financial institution). If any portion of your rollover includes non-taxable income, the letter of acceptance is required before your request will be processed. If you elect this option, you will need to complete a “Refund/Rollover Guide”.

Option 3
Whether vested or not, you can leave your member account balance intact with NDPERS and take a refund or rollover at a later date. If you elect to leave your member account balance intact with NDPERS, you must complete a **“**NDPERS Deferred Retirement Guide**”**.

Option 4 *[This option is only available for vested members]*
To be vested in a defined benefit program means that you have become legally entitled to a monthly benefit from NDPERS when you reach retirement age and terminate employment. Under NDPERS you become vested at:

Retirement Plan	Months For Vesting
Disability	6
Main Public Safety State Public Safety State National Guard State BCI agents hired before 8/1/2023	36
Judges	60
BCI agents hired on or after 8/1/2023 Highway Patrol	120

You can elect a Deferred Vested Benefit. Under this option, you leave your account with NDPERS and elect to receive a monthly benefit at a later date. The earliest age a member can begin to receive a monthly benefit may be either age 50 or age 55. Under the Deferred Vested Benefit Option, unreduced monthly benefits may begin at age 65 or by meeting the “Rule”, whichever happens first. Interest continues to compound on your member account balance until you begin receiving a monthly benefit. If you choose this option you will need to complete a “NDPERS Deferred Retirement Guide”.

Option 5
You are eligible to receive NDPERS retirement benefits upon termination of employment if:

Retirement Plan	Eligibility
Main Plan	EARLY RETIREMENT ✓ age 55 or older and have 3 years of eligible service credit; or NORMAL RETIREMENT ✓ meets the Rule of 85; (Rule of 90 with minimum age 60 for members hired on or after 01-01-2016) ✓ attained age 65 while actively employed with a NDPERS participating agency.
Public Safety, National Guard & BCI agents hired before 8/1/2023	EARLY RETIREMENT ✓ age 50 or older and have 3 years of eligible service; or NORMAL RETIREMENT ✓ meets the Rule of 85 ✓ attained age 55 and have 3 years of eligible service.
BCI Agents hired on or after 8/1/2023	EARLY RETIREMENT ✓ age 50 or older and have 10 years of eligible service; or NORMAL RETIREMENT ✓ meets the Rule of 85 ✓ attained age 55 and have 10 years of eligible service.
Judges	EARLY RETIREMENT ✓ age 55 or older and have 5 years of eligible service; or NORMAL RETIREMENT ✓ meets the Rule of 85 ✓ attained age 65 while actively employed with a NDPERS participating agency.
Highway Patrol	EARLY RETIREMENT ✓ age 50 or older and have 10 years of eligible service; or NORMAL RETIREMENT (Max. age 60) ✓ meet the Rule of 80 ✓ attained age 55 and have 10 years of eligible service.

Eligible service credit may include dual membership service.

See the NDPERS Group Retirement Plan handbook for specific information on early retirement reductions, meeting the “Rule”, eligible service credit, and dual membership service.

You and your employer must complete a “NDPERS Retirement Guide”.

If you are not vested, your member account balance is less than $1,000 and you do not indicate you wish to leave your account intact, you will be issued a refund automatically upon termination.

CONVERTING UNUSED SICK LEAVE:

Transfer of Employment:

If you transfer employment from one participating employer to another participating employer without terminating eligible employment, NDPERS will record unused sick leave of a participating member if the new employer certifies that it will not transfer that leave. The certification must include documentation from the previous employer detailing the number of hours of sick leave. **NDPERS must receive the certification within sixty days after the member leaves employment with the former employer.**

You, your current employer, and your new employer must complete a "Transfer of Unused Sick Leave Verification SFN 53404".

Termination of Employment:

At termination, you may purchase all or part of your sick leave for retirement service credit. **To elect to convert your unused sick leave, the Conversion of Unused Sick Leave Application – Defined Benefit SFN 58358 must be completed and received by NDPERS before the last day of the month in which you terminate employment or are no longer eligible to accrue sick leave hours.**

Why convert unused sick leave?
Converting unused sick leave means that NDPERS will use the balance of your unused sick leave hours at time of termination to offer you an additional number of months for retirement service credit that you may choose to purchase. People purchase additional service credit for the following reasons: 1) to obtain normal retirement or meet "Rule" 2) to increase the monthly benefit amount payable at regular retirement date or 3) obtain both.

Sick leave conversion with NDPERS is available to you, even if your employer pays out a portion of your sick leave at time of separation. Whether or not you choose to convert and purchase service using your remaining unused sick leave hours, your employer will still honor any unused sick leave payout agreement you have with them. Payout of unused sick leave at termination by an employer to an employee and converting unused sick leave with NDPERS are two different things. Please confirm any rules that may apply to unused sick leave payout with your employer.

Purchase of Unused Sick Leave Conversion Process

Step 1: To elect to convert your unused sick leave, the Conversion of Unused Sick Leave Application SFN 58358 must be completed and received by NDPERS before the last day of the month in which you separate employment or are no longer eligible to accrue sick leave hours. If using pre-tax dollars for your purchase, please ask your Employer to complete Part F on the form. Please review the terms on the conversion application carefully.

Step 2: You may purchase all or part of your unused sick leave for retirement service credit. One month of service credit may be purchased with NDPERS for each 173.3 hours of unused sick leave.

$$\frac{\text{Number of unused sick leave hours}}{\text{173.3 (\# of working hours in a month)}} = \text{Number of months eligible to purchase (rounded up)}$$

Step 3: The cost to purchase sick leave is determined as follows:

Number of months eligible to purchase (rounded up)
X
Final Average Salary (FAS)
X
Plan Contribution Rate (16.26% for Main Plan Members)
=
Cost to Purchase Unused Sick Leave*

***After receiving a completed application, the final payment amount will be calculated by NDPERS and mailed to you.** NDPERS will send you a request for payment, which will include a purchase payment election form, SFN 53757. If needed, a rollover form, SFN 52059, will also be included to complete your purchase.

Step 4: Complete all required forms and submit payment in full to NDPERS prior to deadline.

- Payment may be made either on an after-tax basis through personal check or pre-tax basis with qualified funds (457, 403(b), 401K, IRA, etc.) through direct rollover/transfer.
- You must return the purchase payment election form, SFN 53757, with a personal check for the retiree health insurance credit (RHIC) amount of the purchase, if applicable. If making the entire purchase payment with after-tax dollars, write a check for the full amount.
- If electing to rollover/transfer funds, you must work with your provider to complete the rollover form SFN 52059.
- **The unused sick leave completed forms and payment(s) must be paid by the 15th of the month following the month of your termination.**

2024 Required Contribution Rates:

16.26%	= Main System
18.04%	= Public Safety with Prior Service
15.80%	= Public Safety w/o Prior Service
21.48%	= State Public Safety
18.04%	= State National Guard
30.40%*	= State BCI
26.66%	= Judges
37.14%**	= Highway Patrol System

** 1/1/25 – 31.40% BCI*
*** 1/1/25 – 38.14% HP*

DEFINED CONTRIBUTION PLAN:

Transfer of Employment:

You shall remain a participant in the Plan regardless of whether you return to State employment or become employed by a political subdivision that participates in NDPERS. However, this rule does not apply to participants who are reemployed with the State as a highway patrolman, as a teacher, or as an employee of the board of higher education who becomes covered under the TIAA retirement plan.

You and your employer must complete a **"**NDPERS Transfer Guide**"**.

Termination of Employment:

Deferred Member Account Balance
When you terminate employment, you can apply to defer your entire vested account balance. Under this option you leave your account balance with the Trustee Company until you either take it out as a lump sum or periodic distribution. If you choose this option you and your employer must complete a **"**NDPERS Deferred Retirement Guide**"** to elect this option.

Lump Sum Distributions
If you elect this option, your entire vested account balance will be paid to you as a lump-sum distribution. You may elect to roll this lump-sum distribution into an IRA or another eligible employer plan. If you choose this option you will need to complete a **"**NDPERS Refund/Rollover Guide**"** and a **"**Trustee Company Distribution Form**",** which you must obtain from NDPERS.

Periodic Distributions
If you elect this option, your vested account balance will be paid to you in monthly, quarterly, semiannual or annual periodic payments until your account is exhausted and you must receive a payment at least annually. If you choose this option you will need to complete a **"**NDPERS Retirement Guide**"** and a **"**Trustee Company Distribution Form**",** which you must obtain from NDPERS.

Distributions will be subject to the following rules:

1.) Refund Distribution

Any taxable distribution paid by the Trustee Company directly to you will be subject to mandatory Federal income tax withholding of 20% of the requested distribution. You cannot elect out of this tax withholding but you can avoid it by electing a direct rollover distribution. This withholding is not a penalty but rather a prepayment of your Federal income taxes, although there may also be an IRS penalty assessed in certain circumstances. If you are under age 59 1/2 at the time the distribution occurs, you may be subject to a 10% penalty at the time you file your income tax return for the year you took the distribution.

2.) Direct Rollover Distribution
As an alternative to a cash distribution, you may request that your entire distribution be rolled directly into an IRA or another eligible employer plan (if it accepts rollover contributions). Federal income taxes will not be withheld on any direct rollover distribution.

a.) Rollover to an IRA –
You must complete a Qualified Plan Distribution Form and indicate the name and address of the custodian or trustee, and account number for your IRA. After authorizing your distribution, NDPERS will forward the form to the Trustee Company. A check will be issued by the Trustee Company payable to the IRA custodian or trustee for your benefit. The check will contain the notation 'Direct Rollover' and it will be mailed directly to you. You will be responsible for forwarding it on to the custodian or trustee. You must provide NDPERS with complete information to facilitate your direct rollover distribution.

b.) Rollover to another Eligible Employer Plan –
You should check with your employer to determine if its plan will accept rollover contributions. If allowed, then you must complete a Qualified Plan Distribution Form and indicate the name, address and plan number of your employer's qualified plan. After authorizing your distribution, NDPERS will forward the form to the Trustee. A check will be issued by the Trustee Company payable to the trustee of your eligible employer plan. The check will contain the notation 'Direct Rollover' and it will be mailed directly to you. You will be responsible for forwarding it on to the new trustee. You must provide NDPERS with complete information to facilitate your direct rollover distribution.

3.) Combination Refund Distribution and Direct Rollover Distribution
You may request that part of your distribution be paid directly to you and the balance to be directly rolled into a traditional IRA or another eligible employer Plan. Any cash distribution you receive will be subject to the Federal income tax withholding rules referred to in the "Special Tax Notice Regarding Plan Payments" section of this guide.

You will pay income tax on the amount of any taxable distribution you receive from the Plan unless it is rolled into a traditional IRA or another eligible employer Plan. A 10% IRS premature distribution penalty tax may also apply to your taxable distribution unless it is rolled into an IRA or another eligible plan. The 20% Federal income tax withheld under this section may not cover your entire income tax liability.

If your vested account balance is less than $1,000, the entire amount will be automatically distributed to you unless you request in writing that the vested account balance remain in the Plan within 120 days after termination.

CONTINUATION OF INSURANCE COVERAGE (COBRA)
Retiring or Terminating Employees

Revised 11/2023

Please read this information carefully. You should retain this notice for your records.
Please disregard this notice if: 1. you transferred employment to another NDPERS covered employer, or 2. you are still employed with your current employer and just experienced a change in your employment status.

As a result of a recent "Qualifying Event", your insurance coverage has or will terminate. Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you and/or your covered dependents that are losing coverage are entitled to continue your group insurance coverage under the plan sponsored by your employer beyond the date coverage would normally end. You may have already made an election; however, we are required by federal law to provide you this notice for your records.

You and/or your covered dependents that are losing coverage are "Qualified Beneficiaries". A family member added to the covered employee's contract due to marriage or birth or placement for adoption during a period of continuation coverage will also be deemed a qualified beneficiary for COBRA purposes. The spouse or child must be added to COBRA coverage within 31 days from the date of the qualifying event.

As qualified beneficiaries, you and/or your eligible dependents losing coverage are entitled to continue the same group insurance coverage that you had on the day before the qualifying event (provided that the company has not eliminated the policy or changed insurance carriers since the qualifying event). Additionally, you are also entitled to COBRA continuation coverage if you have other insurance coverage *prior* to electing COBRA coverage (including entitlement to Medicare).

Under the law, you have a 60-day election period during which you must inform your employer in writing or by completing an application that you want continuation coverage. This election period begins on the later of (1) the date you lose coverage due to the qualifying event or (2) the date you are provided your COBRA notification. If you are or become mentally or physically incapacitated during this election period, an appointed guardian or responsible party may elect and/or pay for COBRA continuation coverage on your behalf. If you choose COBRA continuation coverage, your election is considered made on the date you send your application and payment to the Plan Administrator.

PLAN OR BENEFIT CHANGES

If you elect continuation coverage, you will receive the same level of benefits under the plan as similarly situated active employees. Plan benefits may be modified or amended during the period of continuation coverage that may result in a change of premiums in accordance with federal COBRA regulation. As a qualified beneficiary, you are entitled to the same open enrollment rights as active employees. This includes special enrollment rights such as adding coverage for newly acquired family members.

Please be advised that notification to an individual, who is a qualified beneficiary as the spouse of a covered employee, shall be considered notification to all other qualified beneficiaries residing with such spouse at the time such notice is made.

HIGH DEDUCTIBLE PLAN MEMBERS

If you participate in the NDPERS High Deductible Health Plan with a Health Savings Account (HSA) and terminate employment, NDPERS is not responsible for any further employer contributions to your HSA. However, prior to depleting your funds or closing your account, please contact NDPERS to verify that all contributions have been deposited.

OTHER COVERAGE OPTIONS

There may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, or other group plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based insurance coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice it can be difficult or impossible to switch to another coverage option.

Additional details on the Health Insurance Marketplace is provided later in this notice.

CONTINUATION PERIOD

Your Qualifying Event entitles you and/or your covered dependents to continue coverage for the period of 18 months if you are qualifying due to the member's termination of employment or reduction in hours. This period begins on the date your coverage under the group insurance plan would normally cease as a result of the Qualifying Event. If you have signed an Early Retirement Agreement, whereby your employer will pay the premiums for a specified period of time, any portion of employer paid premium is counted towards the 18 months of COBRA continuation coverage.

Continuation coverage may end before the maximum continuation period in certain circumstances, such as failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

EXTENDED COBRA CONTINUATION COVERAGE PERIOD

Any qualified beneficiary in connection with a qualifying event may be entitled to an extension of continuation coverage from 18 to 29 months if an individual is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. The disability extension applies only if any of the qualified beneficiaries provides notice to the plan administrator of the disability determination within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period. The affected individual must also notify NDPERS within 31 days of any final determination that the individual is no longer disabled. The disability extension applies separately to each qualified beneficiary including non-disabled family members who are qualified beneficiaries due to the termination or reduction in hours of employment.

In addition, if you are the spouse or dependent of an employee who has been terminated from employment or whose hours of employment have been reduced, you may receive an extension of continuation coverage if a second qualifying event occurs (such as employee death, divorce, legal separation, employee Medicare entitlement or losing dependent status under the Plan) during the original 18-month continuation coverage period. In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months. This extension applies only if the Plan Administrator is notified in writing within 60 days of the second qualifying event and within the original 18 or 29-month coverage period. This extension applies to individuals who are qualified beneficiaries as a result of the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. A reduction in hours followed by a termination of employment is not considered a second qualifying event for COBRA purposes.

For more information about extending the length of COBRA continuation coverage, visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

PREMIUMS FOR COBRA CONTINUATION COVERAGE

You will be charged 102% of the applicable group premium rate for the level of coverage you select.

Unless you expressly elect otherwise, the coverage to be continued will be that which you and/or your dependents (if any) had on the day before the qualifying event. However, be aware that each qualified beneficiary has independent COBRA election rights. The initial premium for continuation coverage must be made within 45 days of your COBRA election.

Insurance rates are subject to change. Contact the NDPERS office for premium information and additional details. The initial premium for continuation coverage must be made within 45 days of your COBRA election.

Your continuation coverage will not be effective until the initial premium payment is received. If the initial premium payment is not made within the indicated period, you will forfeit your right to continuation coverage. Subsequent monthly premium payments are due and payable on the 1st day of each month for that month's coverage. Pursuant to COBRA law, your continuation coverage will be terminated if your premium is not received by the last day of the month for which coverage was due.

MARKETPLACE INSURANCE COVERAGE

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you’ll also learn if you qualify for free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered continuation coverage won’t limit your eligibility for coverage or for a tax credit through the marketplace.

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace as a “special enrollment” event. **After 60 days, your special enrollment period will end, and you may not be able to enroll.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

ENROLLMENT IN ANOTHER GROUP PLAN

You may be eligible to enroll in coverage under another group plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group plan for which you are eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

If you need a Certificate of Coverage (COC), please contact your insurance carrier for health and dental insurances. For vision, please contact your employer for verification of coverage.

ENROLLMENT IN MEDICARE

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of

- The month after your employment ends, or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information, visit https://www.medicare.gov/medicare-and-you.

HOW TO ELECT COBRA CONTINUATION OF INSURANCE COVERAGE

1. Obtain and complete by following the instructions on the 'CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA) SFN 14120' and return it to the NDPERS office before the Election Period Expiration Date. The form can be found on the NDPERS website at www.ndpers.nd.gov.
2. Pay the initial premium required for COBRA continuation coverage within forty-five (45) days of your COBRA election date. See the Premiums for COBRA Continuation Coverage section. You're responsible for making sure that the amount of your first payment is correct. Please contact NDPERS to confirm the correct amount of your first payment.

TERMINATION OF CONTINUATION COVERAGE

You may lose your continuation coverage before the end of your maximum coverage period for any of the following reasons:

1. If any required premium is not paid in a timely manner, coverage will cease for you and your qualified beneficiaries.
2. If you or any of your qualified beneficiaries become covered under another group insurance plan after the date of COBRA election that does not contain any applicable exclusion or limitation with respect to any pre-existing condition.
3. If all of our group insurance plans are terminated (including successor plans), coverage will cease for you and your qualified beneficiaries.
4. If coverage was extended to 29 months due to a disability, coverage will cease if there is a determination that the individual is no longer disabled. **Please note:** Federal law requires that you inform the plan administrator within 31 days of a final determination that the individual is no longer disabled.
5. If you or your qualified beneficiaries become entitled to coverage under Medicare after the date of COBRA election, coverage will cease for each individual so eligible. If you are age 65 or over and receive or have applied for Social Security (or qualify for Social Security at an earlier age due to a disabling condition) you are considered to be entitled to Medicare.
6. If you request cancellation of COBRA continuation coverage in writing. Cancellation requests are only prospective from the date NDPERS receives such request.
7. If the group insurance plan terminates the coverage for cause for similarly situated active employees, then the qualified beneficiary's coverage can be terminated on the same basis (such as for submission of fraudulent claims, etc.).

IMPORTANT: The plan is required to make a complete response to any inquiry from a insurance provider regarding your right to coverage under the plan during the election period. Similar requirements exist to provide the status of COBRA coverage inquiries made by insurance care providers during any applicable premium payment grace periods. If you elect the continuation coverage, the initial payment will cover the first period of continuation coverage beginning immediately after the date that your coverage under the group insurance plan ceased. Please see Premiums for COBRA Continuation Coverage section of this document.

MORE INFORMATION

For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at http://www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

ADDRESS CHANGES

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy in any notices you send to the Plan Administrator.

DAKOTA PLAN

This contains information regarding your eligibility for the Dakota Plan. The plan is underwritten by Sanford Health Plan (SHP).

TRANSFER OF COVERAGE:

In most circumstances, you cannot increase your current level of health insurance coverage when transferring from one NDPERS participating employer to another. You may decrease coverage or cancel at any time. If you have questions regarding eligibility to increase coverage at the time of Transfer, contact the NDPERS office.

EMPLOYMENT CHANGE FROM PERMANENT TO TEMPORARY STATUS:

If you change from Permanent to Part-Time/Temporary Status:

Your eligibility to continue on this plan will be determined based upon the Part-Time/Temporary employee requirements.

Note: Your coverage provided by your employer for your permanent employment will stop at the end of the month of your change in status.

EMPLOYMENT CHANGE FROM TEMPORARY TO PERMANENT STATUS:

If you change from Part-Time/Temporary to Permanent Status:

If you were already enrolled in the NDPERS Health Plan as a Part-Time/Temporary employee, no action is needed unless you want to change the level of coverage. This must be completed within 31 days of the permanent employment start date.

Note: If no action is taken, your existing level of coverage will remain in effect. The permanent health plan premium will be effective first of month following the final date of temporary employment.

COBRA COVERAGE:

If the new employer does not provide health insurance, your NDPERS health coverage will end one month after your date of separation from employment. You and your covered dependents may apply for COBRA coverage within 60 days of your separation of employment if you, as an active employee, and your covered dependents were enrolled in the NDPERS health plan

You will have the option to continue COBRA coverage for a maximum period of 18 months. COBRA coverage will be terminated if:

- ✓ You or your covered dependents become eligible for an employer sponsored health plan
- ✓ You or your eligible dependents become enrolled in Medicare.

The following COBRA premiums are in effect through June 30, 2025:

	Single	Family
State Agencies	$806.62	$1,945.26

Political Subdivisions enrolled prior to July 1, 2023:

	Single	Family
Grandfathered	$861.82	$2,083.36
Non-Grandfathered	$874.92	$2,115.06

Political Subdivisions enrolled after July 1, 2023:

	Single	Family
Premiums from July 1, 2023 to June 30, 2024:		
Non-Grandfathered	$852.24	$2,060.14
Premiums from July 1, 2024 to June 30, 2025:		
Non-Grandfathered	$897.60	$2,169.98

If you are a family of two on the health insurance, it may cost less for you to split your coverage into two separate contracts during the 18 months COBRA period. Please contact your NDPERS counselor for further details and to discuss of this option is best for you.

High Deductible Health Plan (HDHP):

If you are an active state employee covered on the High Deductible Health Plan (HDHP) at the time you terminate, your coverage in this plan will continue while you are on COBRA. You will have opportunity to discontinue your participation in the HDHP plan and switch to the PPO/Basic Plan during annual enrollment.

Once terminated, there is no longer an employer contribution to a Health Savings Account (HSA) on your behalf.

However, the premium that you are required to pay reflects that the state does not pay an employer contribution and are lower than the PPO/Basic COBRA rates. The premiums for HDHP COBRA are:

Single:	$ 702.86
Family:	$1,694.16

EXTENDED COBRA:

Disability

A member or their dependent determined to have been disabled for Social Security purposes may extend the continuation of coverage to 29 months. If member or their dependent becomes disabled at any time during the first 60 days of COBRA continuation coverage the member must provide notice of such determination to NDPERS within 60 days after the date of any final determination of disability and before the end of the 18-month continuation period.

Death
Continuation of coverage may be extended for a period up to 36 months for an eligible dependent.

CANCELLATION OF HEALTH COVERAGE:

If you wish to cancel your NDPERS health coverage you must submit a written request providing the contract holder's name, PERSLink Member ID number or last four digits of Social Security number, and effective cancellation date. Cancellations will only be done at the end of the month. We cannot cancel your policy for a partial month or do a retroactive cancellation of a policy. NDPERS must receive your cancellation request by the 15th of the month prior to the effective cancellation date.

REFERENCE MATERIALS AVAILABLE:

As a health plan accredited with the National Committee for Quality Assurance (NCQA), Sanford Health Plan is required to provide you with additional information as you make decisions regarding your medical benefit plan. This information, including accessing your provider network, pharmacy information and other important notices can be found at https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-health/reference-material-grandfathered.pdf.

Provider Network
- Networks available

Member Handbook
- How to read an Explanation of Benefits (EOB)
- What to do in an emergency
- Special communication services
- How claims are paid

Special Notices
- Learn about Sanford Health Plan's privacy policy
- Find out more about the claims appeal process

Feel free to contact Sanford Health Plan with any questions that you may have at (701) 751-4125 or toll-free at (800) 499-3416.

NON-GRANDFATHERED PPO/BASIC PLAN:

Some political subdivisions participate in the NDPERS Non-Grandfathered PPO/Basic Plan. Contact your employer to determine if this applies to you. If so, details on the plan are available on the NDPERS website.

Additional Features of Dakota PPO/Basic and HDHP Plans:

DISEASE MANAGEMENT PROGRAM

A disease management program is offered through SHP. Please contact the SHP Care Management Department at 1-877-652-1847.

DAKOTA WELLNESS PROGRAM

Wellness Portal, powered by WebMD:

Resources available on the portal include a Health Assessment (a confidential report and custom resources), Wellness Tracking, and Daily Habits (guided programs to help with healthy habits and condition management). Covered members and their eligible spouses can earn points to be redeemed towards gift cards and prizes.

After you receive your health insurance ID cards, you will receive a member packet that will explain the wellness program in detail.

Fitness Center Reimbursement:

Covered members and their eligible spouse can earn up to a $20 credit monthly for visiting a participating health club a minimum of 12 days a month.

DAKOTA HEALTH PLAN FEATURES
PPO/BASIC

For complete features of the Dakota Plan visit https://www.ndpers.nd.gov/

Eligibility:

Eligible employees are those who are at least 18 years of age, work at least 20 hours per week for 20 or more weeks per year, and whose positions are regularly funded and not of limited duration (i.e., permanent).

Part-Time /Temporary Employees:

A Part-Time/Temporary Employee may be eligible to participate if the employee is employed at least 30 hours per week or 130 hours per month and meets the definition of a full-time employee as defined in the Affordable Care Act (ACA). Coverage will be effective the first of the month following date of employment. If application is not made within the first 31 days, the provisions of the Special Enrollment Periods will apply. The employer is responsible for determining eligibility and offering coverage when applicable.

Enrollment Period:

You have an initial enrollment period of 31 days from your date of employment. Applications received within the enrollment period will be accepted with no restrictions or limitations for you and any eligible dependents. Coverage will be effective the first of the month following your hire date.

If you do not enroll during the initial 31-day eligibility period when hired or do not enroll within 31 days of a qualifying event, you may apply for coverage during the designated Annual Enrollment Season with coverage effective the following January 1.

Employment Change from Permanent to Temporary Status:

If you change from Permanent to Part-Time/Temporary Status:

Your eligibility to continue on this plan will be determined based upon the Part-Time/ Temporary employee requirements.

Note: Your coverage provided by your employer for your permanent employment will stop at the end of the month of your change in status.

Employment Change From Temporary To Permanent Status:

If you change from Part-Time/Temporary to Permanent Status:

If you were already enrolled in the NDPERS Health Plan as a Part-Time/Temporary employee, no action is needed unless you want to change the level of coverage. This must be completed within 31 days of the permanent employment start date.

Note: If no action is taken, your existing level of coverage will remain in effect. The permanent health plan premium will be effective first of month following the final date of temporary employment.

Preferred Provider Organization (PPO/BASIC):

The Preferred Provider Organization (PPO) is a group of hospitals, clinics and physicians who have agreed to discount their services to members of NDPERS. You have "freedom of choice" in selecting which physician or medical facility to use for services. No referral is needed. If you choose a provider who participates in the PPO program, you will have lower out-of-pocket expenses. PPO benefits are only available in the State of North Dakota, unless the medical facility provides services at a satellite location in another State.

DEDUCTIBLE AND COINSURANCE:

Deductible, copayments, and coinsurance maximums accrue on a "Calendar-Year" basis, January 1 - December 31.

Plan Features:	**Basic (Self-Referral or Out-of-State)**	**PPO**
Deductible for All Services		
-Per Person	$500	$500
-Per Family	$1500	$1500
Copayment for Physician Office Visits (no limit)	$ 35	$ 30
Copayment for Emergency Room	$ 60	$ 60
Coinsurance on all covered services except Physician Office Visits	75/25	80/20
Annual Coinsurance Maximum		
-Individual	$1500	$1000
-Family	$3000	$2000
Annual Out-of-Pocket Maximums (Deductible and Coinsurance)**		
-Individual	$2000	$1500
-Family	$4500	$3500

*Out-of-network coverage is at the Basic level.
**Office visit and emergency room copayments and prescription drug copayments and coinsurance are additional

DISEASE MANAGEMENT PROGRAM:

A disease management program is offered through SHP. Please contact the SHP Care Management Department at 1-877-652-1847.

PREVENTIVE SCREENING SERVICES-PPO/BASIC COVERAGE:

Wellness Services				
	Copayment	PPO Plan	Basic Plan	Special Conditions
Well Child Care ***(to member's 6th birthday)***	$30/$35	100%	100%	Deductible does not apply.
Preventive Screening Services ***(members 6 and older)***	$30/$35	100%	100%	Maximum benefit allowance of $200 per member per benefit period for any non-routine screening services. Deductible does not apply. Benefits beyond the maximum benefit allowance will be subject to cost sharing amounts. Deductible does not apply.
Immunizations		100%	100%	Deductible does not apply.
Mammography & Pap Smear Screening Services		100%	100%	The number of visits for mammography varies by age group. Maximum benefit allowance of 1 Pap smear per benefit period. Refer to benefit plan for details.
Prostate Cancer Screening Services	$30/$35	80%	75%	Refer to the benefit plan for details. Deductible does not apply.

For a Complete list of benefits please refer to the Certificate of Insurance

SUMMARY OF BENEFITS AND COVERAGE (SBC):

The Affordable Care Act (ACA) added a new requirement for the disclosure of a Summary of Benefits and Coverage (SBC). The Summary of Benefits & Coverage (SBC) for the various NDPERS group health insurance plans are located on the NDPERS website and can be found under the Publications listing for each plan (PPO/Basic - Grandfathered, PPO/Basic Non-Grandfathered and High Deductible Health Plan (HDHP)). These documents provide a comprehensive resource for the purposes of comparing coverage levels across all plans.

PRESCRIPTION DRUG COVERAGE:

Deductible, copayments, and coinsurance maximums accrue on a "Calendar-Year" basis, January 1 - December 31.

Prescription Drug Coverage:	**Basic (Self-Referral or Out-of-State)**	**PPO**
Prescription Formulary Generic Drug		
-Copayment	$7.50	$7.50
- Coinsurance ($1,200 maximum per person per benefit period, covered at 100% after $1,200 maximum is met)	12%	12%
Prescription Formulary Brand-Name Drug***		
-Copayment	$25	$25
- Coinsurance ($1,200 maximum per person per benefit period, covered at 100% after $1,200 maximum is met)	25%	25%
Prescription Non-Formulary Drug		
-Copayment	$30	$30
-Coinsurance	50%	50%

***One copayment amount per prescription order or refill for a 1–34-day supply. Two copayment amounts per prescription order or refill for a 34–100-day supply. Benefits are subject to the Outpatient Prescription Drug Coinsurance Maximum Amount. Deductible does not apply

MAIL ORDER PRESCRIPTION DRUGS:

Please contact Optum RX at 1-866-833-3463 regarding the mail order prescription plan.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Information regarding the High Deductible Health Plan (HDHP) including deductibles, coinsurance amounts and preventive services is available on the NDPERS website at https://www.ndpers.nd.gov/.

Sanford Health Plan

Member Handbook 2023–24

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 752-5863 (رقم هاتف الصم والبكم:711)

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶችማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 752-5863 (መስማት ለተሳናቸው:711).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 752-5863 (TTY: 711)。

Cushite (Oromo) – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 752-5863 (TTY: 711).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 752-5863 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 752-5863 (TTY: 711).

Karen – ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့ါ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၢ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး (800) 752-5863 (TTY: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 752-5863 (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 752-5863 (TTY: 711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 752-5863 (телетайп: 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 752-5863 (TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 752-5863 (TTY: 711).

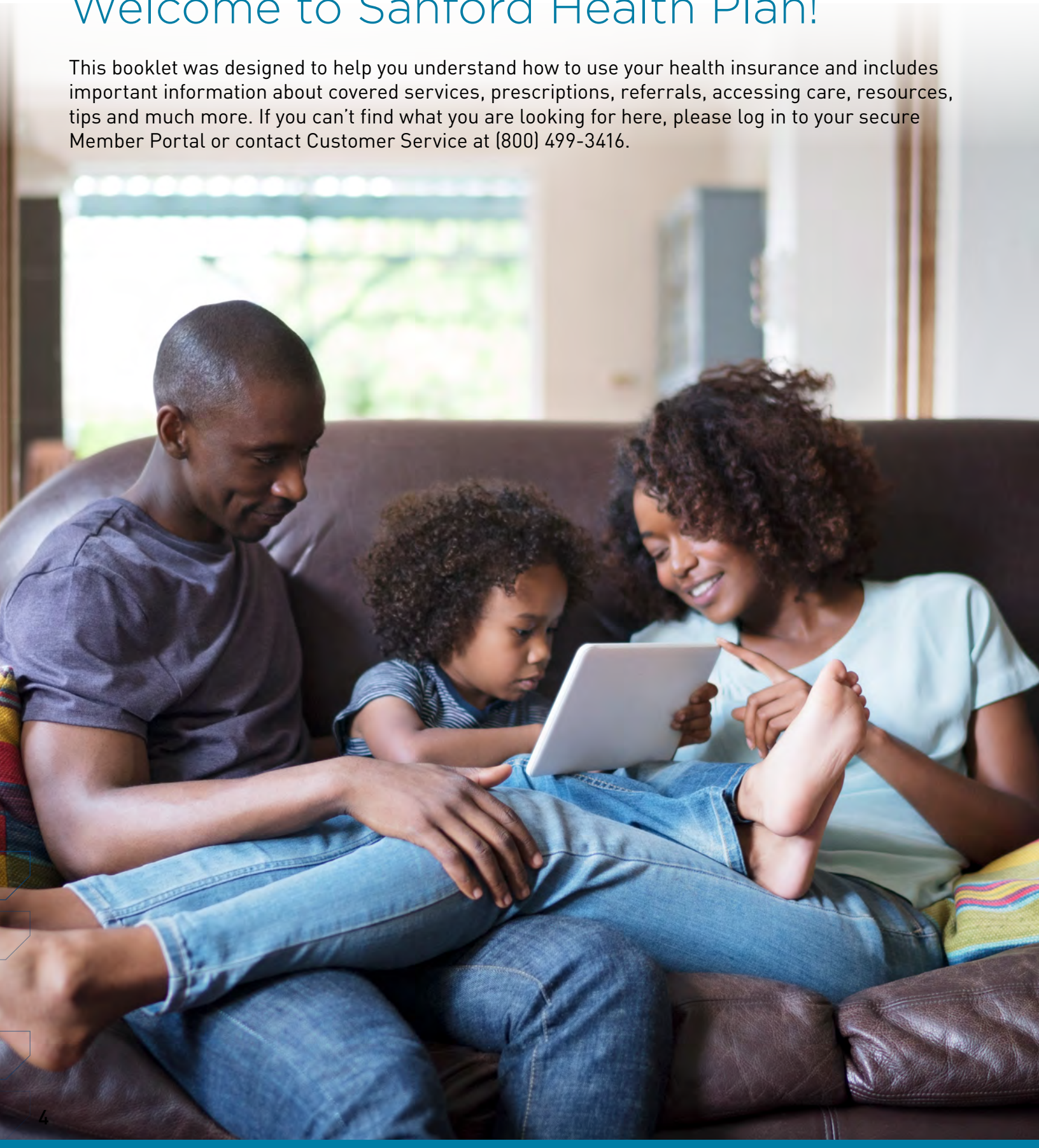
Thai – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 752-5863 (TTY: 711).

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 752-5863 (TTY: 711).

Table of Contents

Welcome to Sanford Health Plan!

This booklet was designed to help you understand how to use your health insurance and includes important information about covered services, prescriptions, referrals, accessing care, resources, tips and much more. If you can't find what you are looking for here, please log in to your secure Member Portal or contact Customer Service at (800) 499-3416.



Contact Information

Sanford Health Plan is ready to help Monday through Friday, 8 a.m. to 5:00 p.m. CST and a confidential voicemail is available after hours and on weekends. You can also contact us by logging into your Member Portal online at sanfordhealthplan.com or go to **sanfordhealthplan.com/memberlogin**. All calls and emails will be returned within one business day.

Department	Questions about:	Phone Number	Email
Customer Service	Benefit questions, claim inquiries/status, eligibility and enrollment, provider access, complaints, appeals and order ID cards	(800) 499-3416 TTY: 711	memberservices@sanfordhealth.org
Pharmacy Management	Prior approval (authorization) of prescription drug coverages and covered medication list (formulary)	(800) 499-3416	pharmacyservices@sanfordhealth.org
Utilization Management	Prior approval of medical services and utilization review	(888) 315-0885	um@sanfordhealth.org
Care Management	Care management, health management and quality activities	(888) 315-0884	shpcasemanagement@sanfordhealth.org
Vision impaired services	Large print materials or recorded versions of our documents are available upon request.	(800) 499-3416	N/A
Language assistance	Free language assistance is available for those who speak a language other than English.	(800) 499-3416	N/A

Member feedback

Please contact Customer Service or visit sanfordhealthplan.com and click "Share Your Experience" if you would like to provide feedback on how we can continue to improve our service.

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

Coverage Information

You can find specific information about your benefits in the following documents, which are located within your secure Member Portal or by contacting Customer Service.

Summary of Benefits & Coverage (SBC): Deductible and copay information, out of pocket limits, information about covered services, provider network, referral information, pharmacy information and costs.

Covered medication list (formulary): A list of regular and specialty medications that are covered, not covered, require pre-approval or step therapy.

Plan document (Certificate of Insurance): Complete overview and description of all benefits, exclusions, prescriptions, appeals, denials, claims, enrollment, notices, policies and more.

Member Portal

Visit **sanfordhealthplan.com** to sign in or register for 24/7 access to all of your benefit information including:

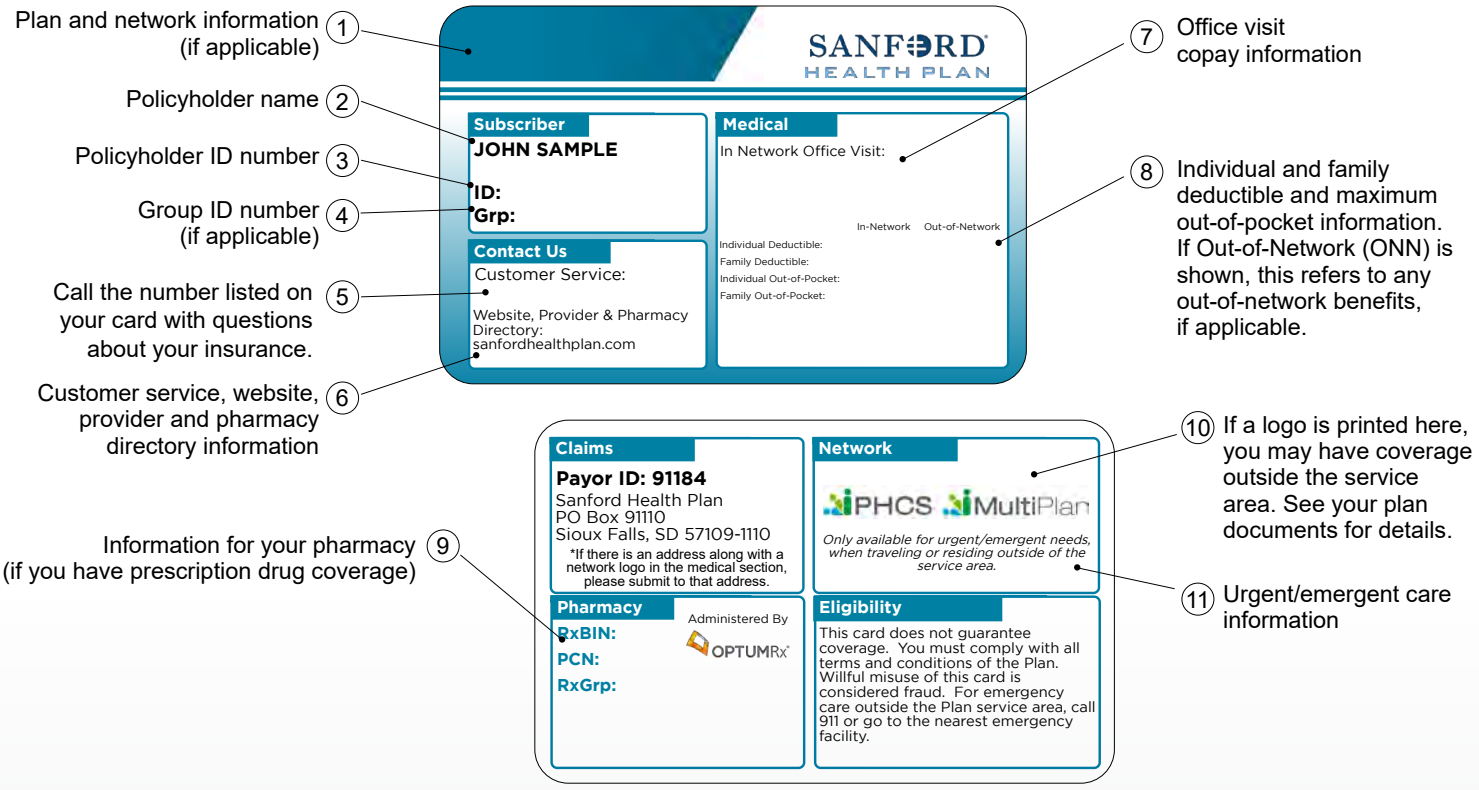
- Summary of Benefits and Coverage (SBC)
- Plan document (policy)
- Pharmacy benefit information
- Claims and explanation of benefits (EOB)
- Preventive care
- Specialty programs
- Provider and pharmacy directory
- Referral information
- Wellness Portal
- Health insurance forms
- Federal and state guidelines and notices

Any dependent, such as a child or spouse, on your plan over age 18 requires a separate Member Portal due to privacy law. Complete the consent form, located in the Member Portal to provide separate access.

Member ID Card

Your Member ID card should be used at each provider visit or when filling a prescription. An explanation of the important information shown on your card is below for your reference. Member ID cards should be received before the policy is activated. If you have not received your ID card or you've lost your ID card and need medical care, log in to the Member Portal to view or print a temporary card or request a new one. A provider can also contact Sanford Health Plan to verify your insurance coverage.

- If you need to fill a prescription and do not have your ID card, you will have to pay for the medication and submit a paper claim to the plan for reimbursement.



** Actual ID Card for your plan may vary.*

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

Navigating Your Network

Sanford Health Plan NDPERS Members have access to a Preferred Provider Organization (PPO) and Basic Network.

How much you pay for care will depend on your choice of provider; those contracted with Sanford Health Plan will be paid at the PPO level and those not directly contracted will be paid at the Basic Plan level.

If a PPO provider is not available in your area, you decide to travel outside of the service area for care without pre-approval from the plan, or you see a non-PPO provider, claims will be processed under the Basic Plan level benefits. For more information, refer to your Policy Document.

To find a participating provider or pharmacy, visit sanfordhealthplan.com or log in to your Member Portal at sanfordhealthplan.com/memberlogin. Customer Service is available to help if you'd like more information about a provider or assistance finding a PPO provider or pharmacy.

Participating and Non-Participating Providers

When you receive health care services from a Participating Provider, they will send all necessary information to Sanford Health Plan to process claims per your plan benefits. You will be responsible for any applicable cost sharing (copay, deductible and/or coinsurance) or services that may not be covered by your plan.

If you receive health care services from a Non-Participating Provider that is not directly contracted with Sanford Health Plan, we may ask for additional information to ensure claims for your care process per your plan benefits. We will contact you if assistance or additional information may be needed.

The Plan allows you the flexibility to choose your own providers, including in-network specialists without a referral, however, choosing to receive covered services from a PPO provider helps Members save on out-of-pocket costs as the Plan is able to receive a greater discount on healthcare services when a contract is in place. Refer to the Referrals and Pre-approval section for more information on the prior authorization process.

Our Provider Directory can be found at **sanfordhealthplan.com/findadoctor**. This directory includes in-network and participating providers information as well as the following:

- Name
- Address
- Telephone numbers
- Gender
- Website
- Specialty/Professional qualifications
- Languages spoken
- Accepting new patients
- Hospital affiliation
- Medical group affiliation
- Board certification
- Last credentialed date
- Has taken cultural competence training

Please contact us if you would like more information on medical school or residency information.

Care Options

You have multiple choices regarding when and where you receive care. Choosing the appropriate care setting helps you to maximize your health insurance benefits and save on out-of-pocket costs.

Routine office visit

Your primary care provider (PCP) is best for routine, preventive or visits that could wait 24 to 48 hours or longer. If same day care is needed, your PCP may be able to see you or the clinic may be able to help you find another available provider. If you need behavioral health care, you are covered at the same cost as your other benefits under your plan.

Experimental and investigational procedures or services are not covered; however, you may request a review of a denied request through the appeal process. Your request will be considered by the plan based on our medical policy guidelines.

Urgent (acute) care

An urgent care situation is not a serious health threat, but requires medical attention within 24 hours, and may include stitches, pain, urinary tract or respiratory infections, fever, or flu.

During the day:

First, contact your primary care provider:

- If your provider is unable to see you that day, ask if another provider in the clinic may be available

After hours, on weekends or holidays:

- Visit a participating urgent care clinic (check the Provider Directory for options)

Specialty care

If you need to see a specialist, you do not need a referral from the Health Plan, however the provider may require one to schedule an appointment.

Behavioral healthcare services

If you need assistance locating Behavioral Healthcare Services, please call our Care Management department at (888) 315-0884.

Emergency care

Emergency medical conditions require immediate care to avoid serious harm. Emergent conditions may include severe pain, suspected heart attack or stroke, difficulty breathing, bleeding that won't stop, severe burns, seizures, poisoning, or trauma. For emergency care, call 911 or visit the nearest emergency department. If you receive care in an emergency situation:

- Pre-approval is not necessary in a true emergency situation.

Hospital services

If you require elective or emergent inpatient (hospital) services, please notify us as soon as possible.

Emergency transportation

Ground transportation, air ambulance or a commercial flight will be covered per your plan if deemed medically necessary.

Care when traveling

Care outside of the service area will be covered per your plan in urgent or emergent situations. If you need urgent or emergent care while traveling, please contact Sanford Health Plan within 48 hours of seeking care. Treatment facilities outside the United States may not bill your insurance and may require you to pay in full for services. If this occurs, save your receipts, and ask for a detailed list of charges in English. Submit a paper claim, and we will reimburse you for covered services.

If traveling outside the U.S., look up the local emergency number, as it may not be 911.

On-demand health services

- **Nurse Line:** This free resource is available to address medical questions and get medical advice. Call (888) 315-0886 to visit with a Registered Nurse or log in to your Member Portal to send a secure message. If you contact us through the portal, you will receive a response within 1 business day.

Pharmacy and Medication Benefits

The Sanford Health Plan Pharmacy Department will help you get the most out of your medication benefits. A brief explanation of your benefits is described below; for full details on your medication coverage, participating pharmacies and more, log in to your secure Member Portal.

Drugs that are not considered medically necessary (such as cosmetic medications) are excluded from coverage. Check your Formulary or plan documents for details on covered and excluded medications.

Sanford Health Plan has a list (formulary) of FDA approved brand name and generic medications that are covered under your benefit plan. Selection criteria for medications on the list include effectiveness, safety and cost. Changes are made throughout the year as necessary, with a complete review performed each year.

By following the formulary and asking your provider for generic medications when available, you will save money and help control the costs of your health care. Refer to your Summary of Benefits and Coverage (SBC) for information on medication costs under your plan. If you request a brand name medication when there is an equivalent generic or biosimilar alternative available, you will be required to pay the price difference between the brand and the generic or biosimilar product, in addition to your copay (with the traditional copay plan).

For medications to be covered, they must be:

1. Prescribed or approved by a physician, physician assistant, nurse practitioner or dentist;
2. Listed in the plan formulary, unless pre-approval (authorization) is given by the plan;
3. Provided by a participating pharmacy except in the event of a medical emergency;
   NOTE: If a prescription is filled at a non-participating and pharmacy, you will be responsible for the prescription drug cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Additional medication information

- With certain medications, you must first try lower cost and/or generic versions before higher cost alternatives will be covered. This is called "step therapy". If the first step medication does not work, you have side effects, or your situation falls into one of the other step therapy exceptions, the next step may be tried.
- For safety reasons, some medications (such as pain medications and psychotherapeutic drugs) have quantity limits, meaning only so much medication can be provided over a certain time period. Check the formulary to see which medications have a quality limit (labeled as "QL").
- Like some services, certain medications must also be pre-approved (preauthorized). To receive pre-approval, the prescribing provider must submit a letter of medical necessity and supporting medical information. Refer to your formulary to determine which medications require pre-approval (labeled as "PA").
- Any medications administered in a provider's office, such as injections or infusions, will apply to your medical benefit (deductible/coinsurance may apply based on your plan). If a medication you need is not on the formulary, you or your provider can request an exception. Complete the Formulary Exception Form (available at sanfordhealthplan.com) and return to the Pharmacy Management Department for consideration.
- Interested in signing up for mail order delivery of your prescriptions? Call (866) 833-3463 for information or to sign up.
- The Affordable Care Act (ACA) requires certain medications be provided at no charge if the Member meets certain criteria, if prescribed by a provider and filled at a participating pharmacy. Please reference the table below for additional details or contact us for more information.

No Cost Medications	Details/Dose	Criteria
Aspirin	Over the counter generic (with prescription), dose less than or equal to 81 mg	
Bowel Prep Agents	Select generic prescription for colonoscopy preparation	2 prescriptions per 365 days
Breast Cancer Prevention	Generic risk-reducing medications	Adults greater than or equal to 35 years old
Cholesterol Lowering Medications	Generic statin prescriptions	Adults age 40 to 75, presence of one or more cardiovascular risk factor, no presence of cardiovascular disease
Contraceptives (Birth Control)	Generic and select brand-name birth control products	
Fluoride	Select generic prescriptions and over the counter options	6 months through 5 years of age
Folic Acid	Over the counter products (with prescription), 0.4-0.8 mg	
HIV Preventive Medication	Truvada, generic tenofovir, Discovy	Prior Authorization confirming using for PrEP therapy
Tobacco Cessation Medications	All generic and over the counter medication options	Adults 18 and older, 180-day supply within 365 days

ACA benefits apply only to non-grandfathered plans.

A complete list of in-network pharmacies and all other pharmacy related benefit information can be found in the Member Portal or by contacting Customer Service.

Referrals, Pre-approvals and Other Insurance Coverage

Medical referrals

Sanford Health Plan does not require a referral to see a PPO specialty care provider, but some clinics may still require a referral for you to make an appointment. If you need help finding a provider, refer to the provider directory or contact Customer Service. Remember, some services may be excluded, even if your doctor recommends them, such as acupuncture and cosmetic procedures. See your plan document for additional details on non-covered services.

Pre-approval (preauthorization or precertification) of services

You **must** contact Sanford Health Plan to get pre-approval for select outpatient and all inpatient procedures or admissions. Pre-approval is also needed for dental anesthesia, specialty medications, home health care, select medical equipment, cancer services and treatment, genetic testing and transplants. Please **contact us at least three days before the requested service** to ensure timely processing of your request. A complete list of services requiring pre-approval is available in your plan document, the Member Portal or by contacting Customer Service.

New technology, treatment and clinical trial prior authorization. We are dedicated to the work of health and healing and have a process for consideration of benefit coverage for specific new medical services or products. As a collaborating partner in the health care industry, our internal process of review includes factors such as medical impact, safety, efficacy, clinical trial phase and cost-to-benefit ratios. Our goal is to deliver a timely and thorough determination in that process.

Motor vehicle accidents and on-the-job injuries

If you need medical care and another person or company is responsible, please contact us. We have partnered with Optum, a company who helps us handle claims that could be someone else's responsibility. If you receive a call or form in the mail from Optum, please respond within 10 days or your claims may be denied. You can reach Optum by phone (800) 529-0577 or complete the form online at *icc.optum.com*.

If you have other health insurance (coordination of benefits)

If you are covered by another insurance policy or are eligible for Medicaid or Medicare, we will work with the other insurance company to coordinate benefits to ensure claims are processed in a timely manner. Please complete any forms you receive or contact us, if requested, to ensure your claims are not denied.

Wellness

Sanford Health Plan believes that health goes beyond exercise and nutrition. Considering the whole self leads to a healthier life where you can thrive. Our dimensions of well-being provide you with a framework to examine your health. We have provided suggestions below on how you can improve your well-being in each dimension.

Physical well-being
Aim for 30 minutes of physical activity each day.

Sleep for seven to nine hours each night.

Plan meals ahead of time to avoid making unhealthy decisions about food.

Career well-being
Utilize your strengths every day at work or through volunteering.

Have a best friend at work.

Social well-being
Spend intentional time each day socializing with a friend or family member.

Work on having more positive interactions during your day than negative ones.

Financial well-being
Buy experiences such as vacations and outings with friends and loved ones.

Set up defaults like automatic bill pay and transfers to savings to reduce your financial worries.

Emotional well-being
Strive for progress, not perfection.
Be kind to yourself.

Set aside at least five minutes a day to reflect. Spend this time journaling, expressing gratitude or thinking in silence.

Control what you can control (your reaction), and let the rest go.

Community well-being
Practice informal volunteering by helping out a friend, family member or neighbor each day.

Think outside of the box, and give back as a special way to celebrate a birthday, anniversary or other occasion.

Talk with friends, family and co-workers about your interest in giving back to find new volunteering opportunities.

Wellness Portal

Within your secure Member Portal, you also have access to a Wellness Portal powered by WebMD, which contains a variety of wellness resources, recipes, and more. After completing a health assessment, the Portal becomes personalized to support your personal health and wellness goals.

Dakota Wellness Program

Each year, NDPERS employees and spouses covered by Sanford Health Plan can earn a $250 ($500 per household) wellness benefit by practicing healthy habits.

Step 1: Take your annual health assessment

Log into your account at sanfordhealthplan.com/memberlogin. (Forgot username and password options are available, if necessary.) If you do not have an account, select the "Request Access for Yourself" button. Click on Menu and under the Insurance header, click Portals and Links, then select Wellness Portal to complete your yearly assessment.

Step 2: Engage in health and wellness activities

Earn your $250 wellness benefit by:

- Going to the gym.
- Attending work site wellness events. Be sure to complete and return the Dakota Wellness Program Voucher for credit toward your Wellness Benefit.
- Earning points in the online wellness portal.

For detailed information on how the Dakota Wellness Program works and how to earn your yearly benefit, go to sanfordhealthplan.com/ndpers/dakotawellnessprogram.

Fitness center reimbursements

Sanford Health Plan will pay up to $20 per Member per month when you use your home fitness center 12 days per month. To sign up, go to **NIHCArewards.org** to enroll online. Under "Member Options", click "First Time Enrollment" and select Sanford Health Plan from the drop down menu. Select your home fitness center location click "Enroll Online." Read and agree to the terms of service, and enter your contact, health plan and banking information and click "Submit."

If you visit your home fitness center at least 12 times per month, most participants receive an automatic deposit into a bank account around the 21st of each month. If your fees are less than $20 per month, the credit will reflect the amount you pay each month. You can view the status of your reimbursements in your NIHCA Member account at **NIHCArewards.org**. Please contact your fitness center directly if you find any errors regarding reimbursement. For other errors, please contact Sanford Health Plan at (800) 499-3416 for assistance. Please note, it is the Member's responsibility to ensure your gym visits are recorded and payments are received.

If you end your fitness center membership or become delinquent in your membership dues, you will not be eligible for reimbursement. If you move your gym membership to a new facility, log on to **NIHCArewards.org** and select your new gym to continue receiving reimbursements.

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

Healthy Pregnancy Program

If your family is expecting, NDPERS and Sanford Health Plan want to make sure you have the tools and support you need to give your baby the healthiest start possible. This free program offers over $850 in savings and additional benefits, including:

- Deductible waiver (for women who participate in a Grandfathered/Non-Grandfathered PPO/ Basic Plan and deliver with a participating provider)
- Free prenatal vitamins
- Support from a care management nurse
- Educational information on pregnancy, childbirth and postpartum
- A baby gift from Sanford Health Plan

You can also access Text4baby to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more. Text BABY (or BEBE) to 511411 to sign up.

To sign up for the Healthy Pregnancy Program, contact us between your 8th and 34th week of pregnancy at **(888) 315-0884** or visit **sanfordhealthplan.com/ndpers**.

Advance Care Planning

Advance care planning is the process of planning and deciding your future health care in case you are suddenly unable to make your own decisions because of illness or injury. Advance care planning allows you to:

- Think about and discuss treatment options with your family and health care providers to make treatment decisions based on your goals, values and preferences.
- Document and communicate your decisions to those who need to know.
- Select someone you trust to make decisions on your behalf when you are unable to speak for yourself.

Sanford Health Plan encourages all Members to complete an advance directive. A copy should be provided to the person responsible for making decisions in case you cannot speak for yourself, the hospital where you are most likely to receive treatment and your primary provider. For access to free advance care planning resources and documents, go to **sanfordhealth.org**, keywords: '*advance care planning*'.

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

Making Changes to Your Plan

After the open enrollment period, you may be able to enroll in health insurance if you experience a life-changing event, such as job status changes, a change in residence for yourself and/or your dependents, you get married or divorced, have or adopt a child, or become eligible for state premium assistance. This is known as a special enrollment period; see your plan document for full details.

Additionally, if you declined enrollment for yourself or your dependents (children or spouse) because you had other health insurance, including state or federal coverage, you or your dependents may be eligible to enroll in your plan if eligibility for the other coverage is lost.

To enroll or remove dependents outside of open enrollment, contact your employer:

- 31 days after a life changing event or other group health plan coverage ends
- 60 days after the date of eligibility for state premium assistance is determined or terminated

If we request additional information, it must be returned within 30 days. Additionally, verification may be required for any dependent covered on your policy who is disabled or over age 26.

Claims and Payment of Services

After you receive medical care, most providers will file a claim for you. However, you may need to file a claim if your provider did not file one for you. Claim forms can be found in the Member Portal or by contacting Customer Service. A copy of an itemized statement (breakdown of charges) from your provider and proof of payment will be needed to process the claim.

After your claim is received and processed according to your benefits, Sanford Health Plan will send payment to the provider, and an Explanation of Benefits (EOB) to you.

All claims must be received within 180 days from the date of service or within 365 with a national network provider. If your claim is not received within the allotted time, you may be responsible for all costs.

Explanation of benefits

After you receive health care services and we process the claim, you will receive an explanation of benefits (EOB) that explains how your insurance benefits were applied. A claim for services is typically received and processed within 30 days. If you've signed up to receive electronic EOBs, you will receive email notification stating that a new EOB is available to view in the Member Portal. If you have not signed up for electronic EOBs, you will receive a paper EOB in the mail. The EOB will provide specific information about all services/claims from th last 30 days.
The EOB is NOT a bill or invoice.

To ensure benefits are applied correctly, wait until you receive your EOBs before paying medical bills.

Complaints

To file a complaint, contact Sanford Health Plan through the Member Portal, by phone or by mail at Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

Appeals

You have a right to appeal any decision made by Sanford Health Plan to not pay for an item or service. To file an appeal, complete an Appeal Form in the Member Portal, or contact Customer Service to file an appeal over the phone or to have a form mailed to you.

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

How to Read Your Explanation of Benefits (EOB)

Sanford Health Plan wants to help you understand your health care coverage. An Explanation of Benefits (EOB) is not a bill; it explains how your benefits have been applied. It also shows what Sanford Health Plan paid for your care and what amount you may be responsible for. Review your EOB carefully along with any bills you receive to make sure both statements match.

B Claim Number: 1234567

D Provider/Vendor Name: DOCTOR NAME / FACILITY NAME/PLACE OF SERVICE

A Date of Service	Medical Service Details		Member Benefit		Amount Provider May Bill You				**L** Notes*
	C Type of Service	**E** Amount Billed	**F** Plan Discount	**G** Amount Paid by Plan	**H** Copay	**I** Deductible	**J** Coinsurance	**K** Amount Not Covered	
XX/XX/XXXX – XX/XX/XXXX	<type of service>	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	<claim notes>
	Claim Total:	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	
						Amount You May Owe		$XXXXX.XX	

L

*Notes
<claim notes>

A **Date of Service:** The date(s) you received care.

B **Claim Number:** Reference number Sanford Health Plan assigned to the submitted claim.

C **Type of Service:** Type of medical service received.

D **Provider/Vendor Name:** The provider or facility you received the service from.

E **Amount Billed:** Amount the provider or facility billed for the service.

F **Plan Discount:** Amount saved by using an in-network or participating provider (if applicable). Sanford Health Plan negotiates lower rates with these providers to help save money.

G **Amount Paid by Plan:** The maximum amount Sanford Health Plan allows a provider or facility to charge for the service(s).

H **Copay:** A set amount you pay for certain services, such as an office visit.

I **Deductible:** The amount of covered expense that must be paid by the member before Sanford Health Plan begins to pay. For example, if your deductible is $1,500, Sanford Health Plan won't pay for covered benefits until you've paid $1,500 for services that are subject to the deductible, which may include labs, imaging, procedures and hospitalizations.

J **Coinsurance:** The percentage of the payment that you are responsible for, once the deducible has been met. Coinsurance amount is calculated on the amount paid by the plan. For example, if you have a $100.00 service after you've met your deductible and your coinsurance is 80/20, the Plan will pay for 80 percent ($80) and you will pay 20 percent ($20).

K **Amount Not Covered:** Any amount that may not be covered by your benefit plan.

L **Notes:** Important information; these numbers and/or codes explain more about how claim was processed.

Saving Money on Your Healthcare

Even if you have insurance, there are additional ways you can save time and money on health care, and Sanford Health Plan wants to help. Follow the tips below to help keep your health care affordable.

Live a healthy lifestyle. Choosing to eat well, exercise regularly, lose weight or quit smoking (if needed) and getting enough sleep will help you feel good and stay healthy. If you have been diagnosed with a medical condition, take prescribed medications and follow up as directed to keep your condition well controlled.

Choose the plan that's right for you. Health insurance is not one size fits all. Take some time to research your options and pick the plan that's right for you and your family. This simple step can help you maximize your benefits and save you money in the long run.

Know your coverage. Review the specifics of your policy each year so you know what to expect when using your benefits.

Use your preventive care benefits. Sanford Health Plan offers free preventive health care services to help you stay healthy. Regular physicals, screenings and immunizations can help detect medical problems early. The Member Portal also offers a Wellness Portal to help you stay healthy.

Use a PPO provider. Using PPO providers and facilities will help you pay less for services and prescriptions.

Choose the right setting for care. Avoid the emergency room if urgent care or a visit with your primary doctor will address your problem.

Use generic prescription drugs. Generic drugs are FDA approved and as safe and effective as name brand medications. Generics contain the same active ingredients, which means they work the same and cost much less.

Take advantage of special programs. Sanford Health Plan offers case management programs for those with complex medical or behavioral health needs, undergoing treatment for kidney disease, cancer, high risk pregnancy, transplant or are transitioning from hospital to home.

Pay your bill early. If you receive care at Sanford Health, you can save 10 percent if you pay your bill within 30 days.

Member Rights and Responsibilities

Each Member (or Member's parent, legal guardian, attorney or representative) have the following rights and responsibilities:

1. A right to receive information about Sanford Health Plan, its services, its providers and Member rights and responsibilities.
2. A right to be treated with respect and recognition of your dignity and right to privacy.
3. A right to participate with providers in making decisions about your health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about Sanford Health Plan or the care we provide.
6. A right to make recommendations regarding Sanford Health Plan's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that Sanford Health Plan and our providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that you have agreed to with your providers.
9. A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Refer to your Plan document for a complete list.

Glossary of Terms

Allowed Amount: Shown on the explanation of benefits (EOB), this is the maximum amount the plan pays a provider for a covered service. Even with the same service, the allowed amount may be different for in-network versus national network providers.

Ancillary Service: Supplemental healthcare services such as laboratory work, x-rays or physical therapy that are provided in conjunction with medical or hospital care. Ancillary fees may also be associated with obtaining prescription drugs that are not on the formulary (covered medication list).

Basic Plan Benefits: Care received from a facility, provider or supplier that is not a part of the Preferred Provider Organization (PPO). Benefit payment will be paid per the Basic Plan Benefit level as specified in the plan documents.

Claim: The document sent to the plan from your provider showing the services or products provided to you.

Coinsurance: The percentage of costs for covered services you are responsible for after you meet your deductible. Coinsurance is based on the allowed amount for the service. If you've met your deductible and your coinsurance is 20 percent, the plan will pay 80 percent of the allowed amount for a service and you pay 20 percent. For example, if you've met your deductible and the allowed amount for a service is $100, the plan would pay $80 and you would be responsible for $20.

Copay or copayment: The dollar amount you pay each time you visit the doctor or fill a prescription. For example, if your office visit copay is $20, you would pay this amount and the plan would cover the rest of the allowed amount. Depending on your plan, you may or may not have a copay option for certain services. Copays do not apply to your deductible, but they do apply to your out of pocket expenses.

Deductible: The cost of covered services you pay at 100 percent before Sanford Health Plan begins to pay. For example, if your deductible is $1,500, the plan won't pay until you've met your $1,500 deductible for certain services, such as labs, imaging, procedures and hospitalizations.

Excluded (non-covered) services: Sanford Health Plan does not allow coverage for certain services or products. Charges incurred from non-covered services do not apply to your deductible and/or coinsurance. Please review your plan document for specific information on non-covered services.

Experimental and/or investigational services or procedures: A drug, device, medical treatment, diagnostic procedure, technology, or procedure has not been proven as effective or there are concerns relating to safety, effectiveness, effect on health outcomes or requires governmental approval which has not been granted.

Formulary: A list of medications covered by the plan, which may be updated throughout the year.

Medically necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

Out-of-network (non-participating) provider: A health care provider not contracted with Sanford Health Plan. There is no discount for services, so you will pay more (or all) for medical services.

Out-of-pocket maximum (limit): The maximum cost to you in a calendar year for covered medical expenses before your insurance plan begins to pay 100 percent.

PPO Provider: Participating facilities, providers and suppliers who provide discounted services to the Members of NDPERS. PPO providers charge the Plan less for care and savings are passed on to Members in the form of less out of pocket cost(s).

Pre-approval (preauthorization or precertification): A request that must be submitted for approval of certain services including procedures, hospitalizations and medications before the services are received (except in an emergency). Sanford Health Plan will review the request to determine if it is medically necessary. Prior authorization does not guarantee the plan will cover the cost.

Preferred (in-network) provider: A provider contracted with Sanford Health Plan that allows you to receive health services at a discounted rate. You can save money by using in-network providers.

Premium: The amount you pay on a monthly basis for your health insurance coverage. This amount does not apply toward your deductible and/or coinsurance.

Utilization review: A process which compares requests for medical services (utilization) to recommended treatment guidelines. Also confirms requested services are appropriate and medically necessary.

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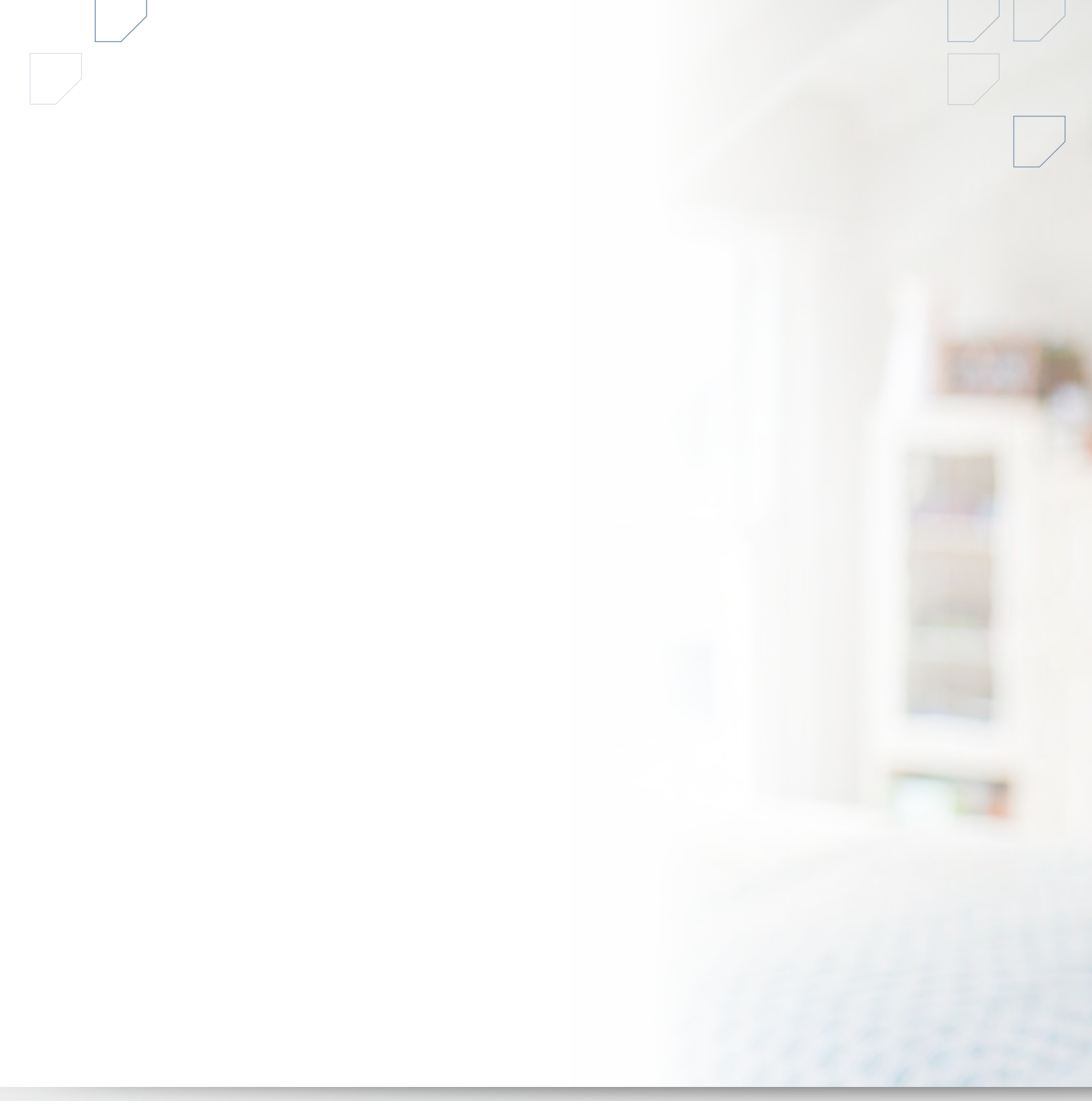

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

SANFORD
HEALTH PLAN

616-925-625 Rev. 10/23 NPP-NPR-NPS

NDQuits reduces the harms of nicotine dependence by helping North Dakotans quit

NDQuits
1-800-QUIT-NOW (1-800-784-8669)
hhs.nd.gov/ndquits

NDQuits is North Dakota's tobacco and nicotine treatment quitline. Anyone in North Dakota can call NDQuits (1-800-QUIT-NOW) or sign up online for free treatment services, including phone counseling, NRT (nicotine patches, gum, or lozenges), and other resources. The U.S. Surgeon General reported, "Since the 1990s, a large body of clinical literature had consistently demonstrated the effectiveness of tobacco quitlines." *

- Participating in multiple sessions of phone counseling makes you 1.4 times more likely to quit
- Combining counseling with NRT (as you can in NDQuits) is the "gold standard" in treating tobacco and nicotine dependence.

*Office of the Surgeon General: https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf

	Phone	Web
Enrollment	• Enroll by calling **1-800-QUIT-NOW** or text **start** to **300500** • Eligible to re-enroll every 60 days after last contact	• Enroll at **hhs.nd.gov/ndquits** • Lifetime enrollment
Counseling calls	5+ calls with North Dakota quit coaches	*Can be accessed by adding the phone program*
Web portal	*Can be accessed by adding the phone program*	Online access to quit resources
NRT benefits (Nicotine replacement therapy)* **Individuals insured by Medicaid may be eligible for additional NRT*	*If you do not have insurance or your insurance does not cover NRT:*	
	For NDPERS members, up to 16 weeks of **patches, gum, or lozenges, or combination NRT** (patches *and* gum or lozenges)	For NDPERS members, up to 16 weeks of **patches, gum, or lozenges**
Available add-ons	• Printed quit guide • Emails • Texts	• Online quit guide • Emails

The **American Indian Commercial Tobacco Program** and the **Pregnancy/Postpartum Protocol** each offer additional counseling calls than the general NDQuits program. Both programs have specially trained coaches and a tailored treatment and recovery guide.
Note for these programs, quit coaches may not be located in ND.

NDQuits also offers **My Life, My Quit**, a program specially tailored for youth under age 18 who want to quit.

December 2023

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LIFE INSURANCE CONTINUATION

TRANSFER OF COVERAGE:

You cannot increase your current level of life insurance coverage. You may decrease coverage at any time.

TERMINATION OF COVERAGE:

You will receive a packet from Voya Financial that will include details on converting your life insurance to an individual policy or applying for portability of your existing term life insurance policy. If you have questions on conversion or portability options, please call Voya Customer Service at 1-800-955-7736.

DENTAL COVERAGE

Underwritten by Delta Dental

TRANSFER OF COVERAGE:

Only employees of the State of North Dakota and the University System are eligible to participate in this plan as an active employee. You cannot increase or decrease your current level of coverage unless you have a loss of dependent eligibility or a qualifying event.

EMPLOYMENT CHANGE FROM TEMPORARY TO PERMANENT STATUS:

If you change from Part-Time/Temporary to Permanent Status:

You are newly eligible for the NDPERS dental insurance. Application must be completed within 31 days of the permanent employment start date.

COBRA COVERAGE:

If the **new** employer does not provide dental insurance your NDPERS dental coverage will end upon your separation from employment. You and your covered dependents may apply for COBRA coverage within 60 days of your separation of employment if:

- ✓ If you, as an active employee, and your covered dependents were enrolled in the NDPERS dental plan

You will have the option to continue COBRA coverage for a maximum period of 18 months. COBRA coverage will be terminated if:

- ✓ You or your covered dependents become eligible for an employer sponsored dental plan

The following premiums are in effect through December 31, 2024:

Individual Only	$ 41.00
Individual and Spouse	$ 79.12
Individual and Child(ren)	$ 91.86
Family	$130.82

Late applications must include a check payable to NDPERS for the first months' premium. Applications received after the 60-day COBRA enrollment period will not be accepted.

COVERAGE QUESTIONS?

For additional information concerning coverage call 1-800-448-3815. Reference Group # 537482.

DELTA DENTAL

Delta Dental of Minnesota
Serving North Dakota

Delta Dental PPO™ & Delta Dental Premier®

Monthly Premium Rates	
Employee:	$41.00
Employee + Spouse:	$79.12
Employee + Child(ren):	$91.86
Family:	$130.82

North Dakota Public Employees Retirement System
Client #537482

Plan Benefit Highlights			
Network(s)	**Delta Dental PPO™**	**Delta Dental Premier®**	**Non-Participating***
Calendar Year Plan Maximum Per person	**$1,000**		
Lifetime Ortho Maximum Per eligible covered person	**$1,500**		
Deductible Per person per calendar year No deductible for diagnostic and preventive services or orthodontics	**$50 per person**		
Eligible Dependents	**Spouse** **Dependent children up to age 26**		
Covered Services	**Dental Benefit Plan Coverage**		
	Delta Dental PPO™	**Delta Dental Premier®**	**Non-Participating***
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Space Maintainers Sealants	**100%**	**100%**	**100%**
Basic Services Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) and posterior (back) teeth	**80%**	**80%**	**80%**
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	**80%**	**80%**	**80%**
Periodontics Surgical/Nonsurgical periodontics	**80%**	**80%**	**80%**
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	**80%**	**80%**	**80%**
Major Restorative Crowns and Crown repair	**50%**	**50%**	**50%**
Prosthetic Repairs and Adjustments Denture adjustments and repairs	**80%**	**80%**	**80%**
Prosthetics Dentures (full and partial) Bridges	**50%**	**50%**	**50%**
Orthodontics Treatment for the prevention/ correction of malocclusion Available for dependent children only, ages 8 and up	**50%**	**50%**	**50%**

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

DELTA DENTAL®

Make the Most of Your Benefits

Thank you for choosing Delta Dental of Minnesota as your partner in oral health. Dental insurance is designed to pay a portion of the costs associated with your dental care. Having dental insurance is essential to keeping your mouth healthy by providing access to preventative care, such as cleanings and X-rays, and helps cover extensive dental procedures such as crowns and fillings.

Online Tools for Members:

www.DeltaDentalMN.org

Save Money, Go In Network:
Search for a participating dentist or specialist, clinic or location. By seeking care from a Delta Dental network dentist, you will save the most money because the dentist is not allowed to bill you more than our allowable charge.

Dental Insurance 101:
Robust member tools including commonly defined insurance terms, videos and frequently asked questions.

Oral Health Resources:
Access dental and health information including a section dedicated to kids' oral health.

Cost Estimator:
Use our cost estimator to find out what a dental procedure will cost, or you can always request a pre-treatment estimate from your dentist.

Prefer to Speak to Someone?

Call our national customer service

Toll Free: 1-800-448-3815
Local: 651-406-5901
Monday-Friday: 7 a.m.-7 p.m. central

Tools Available in the Secure Member Portal

Coverage Summary:
Review your dental plan information including eligibility, waiting periods, plan maximums and frequency limitations.

Claims Inquiry:

View claim status, procedure details, dates of service and applied deductibles.

View your explanation of benefits (EOB) online.

Check out our new feature to opt-out of the paper delivery of your EOB.

Print ID Cards:
Print a digital or replacement ID card.

Secure Member Portal Registration

1. On DeltaDentalMN.org, go to the member page and click "Access My Secure Portal"
2. Select the Employer Plan option click "Log In Here" and follow the steps to register.
3. Remember your username and password because you will need them each time you log in.

Learn more about how your oral heath connects to your overall health at:
DeltaDentalMN.org

DELTA DENTAL®
Delta Dental of Minnesota
Serving North Dakota

VISION COVERAGE

Underwritten by: Superior Vision

TRANSFER OF COVERAGE:

Only employees of the State of North Dakota and the University System are eligible to participate in this plan as an active employee. You cannot increase or decrease your current level of coverage unless you have a loss of dependent eligibility or a qualifying event.

EMPLOYMENT CHANGE FROM TEMPORARY TO PERMANENT STATUS:

If you change from Part-Time/Temporary to Permanent Status:

You are newly eligible for the NDPERS vision insurance. Application must be completed within 31 days of the permanent employment start date.

COBRA COVERAGE:

If the new employer does not provide vision insurance your NDPERS vision coverage will end upon your separation from employment. You and your covered dependents may apply for COBRA coverage within 60 days of your separation of employment if:

- ✓ If you, as an active employee, and your covered dependents were enrolled in the NDPERS vision plan

You will have the option to continue COBRA coverage for a maximum period of 18 months. COBRA coverage will be terminated if:

- ✓ You or your covered dependents become eligible for an employer sponsored vision plan

The following premiums are in effect through December 31, 2025:

Individual Only	$ 5.03
Individual and Spouse	$ 10.06
Individual and Child(ren)	$ 9.16
Family	$ 14.19

Late applications must include a check payable to NDPERS for the first months' premium. Applications received after the 60-day COBRA enrollment period will not be accepted.

COVERAGE QUESTIONS

For additional information concerning coverage call 1 (800) 507-3800.

SuperiorVision®

superiorvision.com | 1 (800) 507-3800

Vision Care Plan for North Dakota Public Employees Retirement System

Benefits through Superior National network

Frequency	
Exam	1 per calendar year
Frame	1 per calendar year
Contact lens fitting	1 per calendar year
Eyeglass lenses	1 pair per calendar year
Contact Lenses	1 allowance per calendar year

Need help? Contact 1 (800) 507-3800 or visit superiorvision.com for assistance.

Exams

Eye exam copay:
$0

Materials[1]

Materials copay:
$35

Frames

In-network allowance:
$100

Contact Lens Fitting Exam

Contact lens fitting copay[2] (standard and specialty):
$35

Standard Contact lens fitting:
Covered in full after copay

Specialty Contact lens fitting
In-network allowance: **$100**

Contacts[4]
in lieu of glasses

In-network allowance:
$100

Monthly Premiums

Employee only:	$5.03
Employee + spouse:	$10.06
Employee + child(ren):	$9.16
Employee +family:	$14.19

Lenses (per pair)	In-Network Coverage	Out-of-Network Reimbursement
Single vision	Covered-in-full	Up to $35
Bifocal	Covered-in-full	Up to $50
Trifocal	Covered-in-full	Up to $70
Progressives	See description[3]	Up to $70

Shop with convenience while using your benefits through these in-network online retailers.

1800contacts® GLASSES.COM contactsdirect befitting eyewear

Lens Add-On Discounts[5]	Your Cost
Anti-scratch coating	$15
Ultraviolet coating	$12
Tints - solid / gradient	$15 / $18
Polycarbonate lenses	$40
Blue light filtering	$15
Digital single vision	$30
Progressive lenses (standard / premium / ultra / ultimate)	$55 / $110 / $150 / $225
Anti-reflective coating (standard / premium / ultra / ultimate)	$50 / $70 / $85 / $120
Polarized lenses	$75
Plastic photochromic lenses	$80
Hi-index (1.67 / 1.75)	$80 / $120

Overage Discounts[5]	Amount
Frames	20% off amount over allowance
Conventional contacts	20% off amount over allowance
Disposable contacts	20% off amount over allowance

Non-Covered Services Discounts[5]	Amount
Exams, frames, prescription lenses	30% off retail
Contacts, miscellaneous options	20% off retail
Disposable contact lenses	10% off retail
Retinal imaging	$39 cost

Additional Out-of-Network Reimbursements	Amount
Eye exam (MD)	Up to $45
Eye exam (OD)	Up to $45
Frame	Up to $47
Contact lens fitting (standard / specialty)[2]	Not covered
Contact lenses	Up to $100

LASIK Discounts[5]

Multiple discounts on laser vision correction procedures may be available to you. To learn more, visit superiorvision.com or contact your benefits coordinator.

Hearing Aid Discounts[5]

Through Your Hearing Network, you have access to discounts on hearing services, devices, and accessories. To learn more, visit superiorvision.com or contact your benefits coordinator.

Free Mobile App

With the free Superior Vision app (available for Android and Apple devices), you can create an account, check your eligibility and benefits, find providers, and view your member ID card.

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Superior Vision Services, Inc. ("Superior Vision"), a Delaware corporation. Superior Vision is part of the MetLife family of companies. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements 1. Materials co-pay applies to lenses and frames only, not contact lenses. 2. Standard contact lens fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty contact lens fitting applies to new contact wearers and/or a member who wear toric, gas permeable, or multi-focal lenses. 3. Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay 4. Contact lenses are in lieu of eyeglass lenses and frames benefit. 5. Not all providers support these discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if they offer the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all providers / all locations.

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NDPERS FLEXCOMP PLAN

Third Party Administrator: ASIFlex

The NDPERS FlexComp Plan is available to eligible employees of the State of North Dakota, participating District Health Units and members of the Legislative Assembly. Employees of the university system and political subdivisions are excluded from participation in the plan.

TRANSFER OF COVERAGE:

If you are employed with an employer participating in the NDPERS Flex Comp Plan and take a job with another employer who is also participating in the NDPERS Flex Comp Plan your coverage will transfer to your new employer.

MEDICAL SPENDING ACCOUNT:

If you transfer to an employer group not on the NDPERS FlexComp Plan, you will be offered continuation coverage through the end of the Plan year on December 31. You will have sixty (60) days from the date the notice of your right to continue coverage is provided to you in which to elect continuation coverage and, complete the Continuation of Coverage in Medical Spending Account (COBRA) SFN 53512. Unless you elect COBRA, your coverage will end on the last day of the month of your separation from service.

Employees who elect continuation coverage are permitted to pre-tax the premiums and pre-pay the premium through the end of the plan year from their final salary pay check with the eligible employer participating in the NDPERS Flex Comp Plan.

Continuation of coverage payments may also be paid with after-tax dollars by personal check or money order throughout the plan year. If you elect to pay for continuation coverage with after-tax dollars throughout the plan year, your premium will be the amount currently being payroll deducted, plus a 2% administrative fee. Continuation coverage will be extended to the end of the current plan year but may terminate sooner if the premiums are not paid within 30 days of their due date which is the 1st of every month.

If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period" from January 1 through March 15 of the new plan year, reimbursed from that balance.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT:

If you transfer to another employer group not on the NDPERS Flex Comp Plan, your contributions will cease and payroll deductions will stop the end of the month of your separation of service. Qualifying expenses will be reimbursed, through the last day of the month of your separation of service, up to the remaining balance in your account.

The final day for accepting claims for the plan year from either your Medical Spending or Dependent Care Reimbursement account for services received while you were a participant is four months after the plan year ends on December 31, or April 30.

If participation terminated due to a separation of service and you return to state employment within 30 days in the same plan year, your election will be reinstated as it was immediately prior to the separation of service. If you return to state employment after 30 days but in the same plan year, you cannot participate for the remainder of the plan year. This includes medical and dependent care flexible spending accounts and ability to pre-tax eligible insurance premiums through the NDPERS flexcomp program.

ASIFlex Quick Guide
FSA Debit Card and Account Access

Manage Your FSA Account at www.asiflex.com

- Register to file claims and view your account statement 24/7!
- Account Detail – Know your balance! You can view details of your account including deposits, claims, payments, and current account balance.
- Read Your Messages – View secure messages sent to you from ASIFlex regarding claim payments or additional documentation that may be needed.
- Submit Claims – Just scan your claim documentation, log into your account and file online for rapid reimbursement!
- Update Preferences – You can change your user name, security image, security questions, or password at any time.
- FSA Store – FSA Store – View thousands of FSA eligible over-the-counter health care products.
- Eligible Expenses – View an listing of eligible/ineligible expenses.
- IRS Rules on How to Use the Debit Card – Go to asiflex.com/debitcards.

ASIFlex FSA Debit Card

Present the card for payment for health care services. Each time you use the card, you must ask the provider for an itemized statement. **An itemized statement must include:**

1. Provider name/address
2. Patient name
3. Date the service was provided (regardless when paid or billed)
4. Description of the service or health care supply
5. Dollar amount owed

Note: **A credit card receipt, cancelled check, paid-on-account statement, or balance-forward statement is not sufficient.**

You can also provide your insurance plan Explanation of Benefits (EOB) to document expenses.

What Needs Documentation?

IRS regulations require you to submit documentation for certain card transactions. The only items that do not require follow-up documentation are:

- Flat dollar copayments under the plan you enrolled in through your employer
- Identified recurring expenses (such as a regular monthly payment to the same provider for the exact same dollar amount)
- Prescriptions or over-the-counter health care products purchased at pharmacies/merchants that identify which products are qualified health care items

All other expenses require documentation.

HOW TO ACCESS YOUR BENEFITS

ASIFlex Card
Ask your provider for itemized documentation each time you use the card or provide insurance plan EOB.

ASIFlex Mobile App
-Check your balance anywhere, anytime
-File claims on the go

Online Claim Filing
-Scan your documentation
-Log in to your account
-Upload documentation to submit claim

Fax or Mail
-Complete the claim form in full and sign
-Submit with documentation

Contact
www.asiflex.com
asi@asiflex.com
Phone: 800.659.3035

Customer Service Hours:
7 am to 7 pm CT Mon-Fri
9 am to 1 pm CT Sat

Fax: 877.879.9038

PO Box 6044
Columbia, MO 65205-6044

How will I know if documentation is required? What are the timelines?

ASIFlex will send you three notifications if documentation is required. If you receive a request, provide the itemized statement or the insurance plan's Explanation of Benefits (EOB) statement.

The three requests for documentation are sent by email/text alert as follows:

1. **Initial Notice** – Sent approximately five days after ASIFlex receives notice of the card transaction.
2. **Reminder Notice** – Sent 21 days after the initial notice.
3. **Deactivation Notice** – Sent 21 days after the reminder notice and card is temporarily deactivated, and future claim submissions may be offset by the outstanding amount.

You can submit the documentation online through your account, via the mobile app, or by mail or fax. To submit via mobile app or online, just follow the online instructions and click on the highlighted claim.

If you do not submit the requested documentation, IRS rules require that your card be temporarily deactivated and future claim submissions will be offset by the outstanding amount.

For additional details regarding IRS regulations governing use of the card, visit asiflex.com/debitcards.

ASIFlex Mobile App

Check your balance and file claims on the go anytime from anywhere!

Just take a picture of your claim documentation and submit via the mobile app for rapid reimbursement!

The app is free and available on Google Play or the App Store.

Go Green!

Save time, save postage, save trees!

Sign up for Direct Deposit!
You can have payments deposited to your bank account instead of waiting for a check!

Switch from Mail Box to In Box!
Don't risk delayed or lost mail. Sign up to receive email and/or text alerts!

Dependent Day Care Flexible Spending Account

What is a Dependent Day Care Flexible Spending Account?

A Dependent Day Care Flexible Spending Account (DCFSA) allows you to set aside money from your paycheck pretax to pay child day care expenses and, in some cases, elder care expenses. When you pay less in taxes, you have more money in your pocket. Most people save at least 30 percent on each dollar set aside pretax.

How much can I contribute to my DCFSA?

Your contribution limit is determined by your tax filing status.

Tax filing status	Limit
Married, filing separately	$2,500
Single, head of household	$5,000
Married, filing jointly	$5,000

What types of expenses qualify?

Eligible expenses are those incurred while you and your spouse, if married, work or are looking for work. This can include: daycare; general purpose day camps (overnight camp is not eligible); regular babysitting; before and after school care; nursery or preschool; and pre-kindergarten expenses.

Does a DCFSA impact the tax credit on my income tax return?

You cannot claim a tax credit for amounts contributed to your DCFSA. However, you may be able to claim a tax credit for amounts, up to IRS limits, not contributed to your DCFSA.

How do I submit claims?

Your funds are available as you contribute throughout the year. ASIFlex offers several easy ways to submit claims.

- **ASIFlex Automatic Reimbursement** Download and complete the claim form. Submit annually to receive automatic reimbursement during the plan year.
- **ASIFlex Recurring Direct Payment** Log in to your account at asiflex.com to schedule recurring payments to be sent directly to your day care provider.
- **ASIFlex Reimbursement** Download the general claim form. Submit each time you want to receive a reimbursement.
- **ASIFlex mobile app** Download the app and log in to your account. Then, just snap a picture of your itemized receipt and submit a claim via the app.
- **ASIFlex Online** Log in to your online account to submit a claim.

Reimbursements will be made to you within three business days following receipt of a complete claim, provided you have available funds in the account. Log in to your ASIFlex account to sign up for direct deposit, as well as email and text alerts.

For more information, view the employer plan document or visit ASIFlex.com to obtain IRS Publication 503 Child and Dependent Care Expenses; a list of eligible expenses; and general plan information. Be sure to consult with a qualified tax advisor for questions related to your personal tax situation.

01_2022

Manage your account Register your account at ASIFlex.com to see your account statement and balance, submit claims, sign up for email, text alerts and direct deposit.

Get the ASIFlex app!

- Submit claims.
- Submit documentation.
- Access your balance and account statement.

Search ASIFlex Self Service and download the app today.

ASIFlex Customer Service
ASIFlex.com
asi@asiflex.com
P:800.659.3035
F:877.879.9038
P.O. Box 6044
Columbia, MO 65205-6044

457 DEFERRED COMPENSATION PLAN

TRANSFER OF COVERAGE:

If you are enrolled in the NDPERS 457 Deferred Compensation Plan, the amount authorized for deduction by the previous employer will automatically transfer to the new employer. You may change the deduction amount by completing a new SFN 3803 – 457 Deferred Compensation Plan Enrollment/Change Form.

If the transfer of employment is to an employer not participating in the NDPERS deferred compensation plan, the employee will have terminated participation in the NDPERS plan. Terminating employees may not begin to receive distributions from a deferred compensation account until they have been off the payroll of a covered employer for one month. At that time, you may elect to begin distribution immediately, regardless of your age, or you may defer payments to a future date.

If you elect a lump sum distribution of your deferred compensation plan account, you will be subject to a 20% Federal income tax withholding requirement. The Provider Company will send you a 1099R statement the year in which you receive distribution from your account. There is no IRS 10% penalty for withdrawal prior to 59 ½.

You also have the option to do a direct rollover to an eligible 401(a), 401(k), 457(b), 403(b), IRA or another qualified plan that accepts eligible rollover distributions from your account. If you elect a direct rollover, taxes will not be withheld and are not payable until you receive a distribution from the 457 account.

Please consult with your investment Provider representative for assistance in selecting a payment option or if you have any questions regarding your tax liability or withdrawal penalties.