



NORTH DAKOTA  
PUBLIC EMPLOYEES  
RETIREMENT SYSTEM

# NDPERS EPO

*An overview of benefits and services provided by this plan.*

*Benefits are pending approval by the North Dakota Insurance Department. This information is intended to provide a brief summary of your benefit plan.*



**BlueCross BlueShield**  
of North Dakota

An independent licensee of the Blue Cross & Blue Shield Association

**This benefit plan covers these services...and more,  
up to a lifetime maximum of \$2,000,000 per member.**

### **Who is eligible for benefits?**

If you have family coverage, benefits are available for you, your spouse and eligible children. Eligible children must be unmarried and financially dependent on you or your covered spouse for their support. These include:

- Children under age 23.
- Children who are full-time students under age 26.
- Children placed with you or your covered spouse for adoption or whom you or your covered spouse have legally adopted.
- Children for whom you or your covered spouse have been appointed legal guardian by court order.
- Grandchildren of yours or your covered spouse if:
  - The parent of the grandchild is a covered eligible dependent.
  - The parent and grandchild are primarily dependent on you or your covered spouse for their support.
- Children for whom you or your covered spouse are required by court order to provide health benefits.
- Children incapable of self-support because of mental retardation or a physical handicap that began before they reached 23 years of age and who are primarily dependent on you or your covered spouse.

### **Outpatient prescription drug benefits.**

This benefit plan includes a preferred pharmacy network. When you use this national network, your claims are filed for you. Participating pharmacists also use a computer database to:

- Check for possible interactions between prescriptions.
- Find any drug duplications.
- Identify overuse or underuse of your medication.
- Determine if a generic equivalent is available for your prescription drug and if the medication appears on a list of quality and cost-effective drugs. Drugs on this list, called formulary drugs, are covered at the maximum benefit amount.

Prescription drugs are categorized as formulary, nonformulary, nonpayable or restricted-use drugs. A restricted-use drug may have a dispensing limit and/or require prior approval.

Benefits are available nationwide at any pharmacy participating in the preferred pharmacy network. To locate a participating pharmacy, call the special toll-free number listed on the back of your ID card.

*This benefit grid presents a brief overview of covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written benefit plan governs the benefits available.*

DESCRIPTION OF BENEFITS	COPAYMENT	EPO AFFILIATION OR WITH AN AUTHORIZED REFERRAL		EPO SELF-REFERRAL WITH A PARTICIPATING BCBSND PROVIDER		SPECIAL CONDITIONS
		Benefit Amount as a % of the allowed charge after deductible has been met	Benefit Amount as a % of the allowed charge after deductible has been met	Benefit Amount as a % of the allowed charge after deductible has been met	Benefit Amount as a % of the allowed charge after deductible has been met	
<b>Inpatient Hospital Services</b>		85%	100%	75%	100%	Preauthorization may be required.
<b>Outpatient Hospital Services</b>		85%	100%	75%	100%	Benefits are based on the medical guidelines established by Blue Cross Blue Shield of North Dakota.  Benefits are available for 90 consecutive calendar days per condition beginning on the date of the 1st therapy treatment for the condition. Additional benefits may be allowed after the 90 days when medically appropriate and necessary.
Physical Therapy		85%	100%	75%	100%	
Occupational & Speech Therapy		85%	100%	75%	100%	
<b>Professional Health Care Provider Services</b> Inpatient, Outpatient & Surgical Services		85%	100%	75%	100%	
<b>Wellness Services</b>						
Well Child Care (through age 5)		85%	100%	no coverage	no coverage	Refer to benefit plan for details. Deductible does not apply.
Preventive Screening Services Ages 6-18		85%	100%	no coverage	no coverage	Refer to benefit plan for details. Deductible does not apply.
Preventive Screening Services Ages 19 & over		100%	100%	no coverage	no coverage	Refer to Preventative Screening Chart on back for details. Deductible does not apply.
Mammography & Pap Smear Screening Services		100%	100%	no coverage	no coverage	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. Deductible does not apply.
<b>Home &amp; Office Visits</b>	\$20/\$30	100%	100%	100%	100%	Deductible does not apply.
<b>Diagnostic Services</b>						
Lab, X-ray, MRI		85%	100%	75%	100%	
<b>Radiation Therapy, Chemotherapy &amp; Dialysis</b>		85%	100%	75%	100%	
<b>Maternity Services</b> Inpatient, Outpatient, Pre & Postnatal Care		85%	100%	75%	100%	Deductible does not apply for delivery services received from an EPO Provider when the member is enrolled in the Prenatal Plus Program.
<b>Psychiatric &amp; Substance Abuse Services</b> Inpatient, Ambulatory Behavioral Health Care (Partial Hospitalization), Residential Treatment		85%	100%	75%	100%	The number of visits, hours or days and the benefit level vary. Out-of-state admissions require prior approval. Preauthorization may be required. Refer to the benefit plan for details.
Outpatient Services		100%/85%	100%	100%/80%	100%	
<b>Emergency Services</b>		85%	100%	85%	100%	Preauthorization is not required.
Professional Health Care Provider Visit		85%	100%	85%	100%	Deductible does not apply to the office or emergency room visit.
Emergency Room Charge	\$50/\$50	85%	100%	85%	100%	Copayment is waived when Member is admitted inpatient hospital.
<b>Ambulance Services</b>		85%	100%	85%	100%	
<b>Skilled Nursing Facility Services</b>		85%	100%	75%	100%	Preauthorization is required.
<b>Home Health Care Services</b>		85%	100%	75%	100%	Preauthorization is required.
<b>Hospice Services</b>		85%	100%	75%	100%	Preauthorization is required.
<b>Chiropractic Services</b>						
Home & Office Visit	\$20/\$30	100%	100%	100%	100%	Deductible does not apply.
Manipulations	\$20/\$30	100%	100%	100%	100%	Deductible does not apply.
Therapy and Diagnostic Services		85%	100%	75%	100%	
<b>Medical Supplies &amp; Equipment</b>		85%	100%	85%	100%	Maximum benefit allowance of \$6,000 per member per benefit period. Additional benefits are available for prosthetic limbs.
Home Medical Equipment, Prosthetics, Orthotics, Therapeutic Devices, Ostomy & Oxygen Supplies						
Hearing Aids (For Members to age 18)		85%	100%	85%	100%	Maximum benefit allowance of \$3,000 per member every 3 years. Prior approval is required. Benefits are subject to the Medical Supplies & Equipment \$6,000 maximum benefit allowance.

DESCRIPTION OF BENEFITS	COPAYMENT	EPO/SELF-REFERRAL		SPECIAL CONDITIONS
		Before prescription drug coinsurance maximum	After prescription drug coinsurance maximum	
<b>Outpatient Prescription Medications &amp; Drugs (Retail and Mail Order)</b>				When a generic drug is available but not accepted, the member is responsible for the difference between the cost of the generic and brand name drug. Prescriptions filled at a nonparticipating pharmacy must be paid in full and a paper claim submitted. All costs above the allowance are the member's responsibility. Benefits are subject to the Outpatient Prescription Drug Coinsurance Maximum Amount. Deductible does not apply.
Formulary				
Generic	\$5	85%	100%	
Brand	\$20	75%	100%	
Nonformulary	\$25	50%	50%	

## COST SHARING AMOUNTS

	EPO	Self-Referral
<b>Single Coverage</b>		
Or an individual family member		
Deductible amount	\$200	\$400
Coinsurance maximum	\$500	\$1,250
Out-of-pocket maximum	\$700	\$1,650
<b>Family Coverage</b>		
Deductible amount	\$600	\$1,200
Coinsurance maximum	\$1,000	\$2,500
Out-of-pocket maximum	\$1,600	\$3,700

This chart reflects the cost sharing amounts for each benefit period. EPO and Self-Referral amounts accumulate jointly. Outpatient prescription drug cost sharing amounts do not apply to the out-of-pocket maximum.

**Outpatient Prescription Drug Coinsurance Maximum Amount** \$1,000 per member per benefit period

When the prescription drug coinsurance maximum amount has been met, copayment amounts will continue to apply, and formulary drugs will be covered at 100% of the allowed charge for the remainder of the benefit period. Copayment amounts and nonformulary coinsurance amounts do not apply to this coinsurance maximum.

## PREVENTIVE SCREENING CHART

For the complete schedule of Wellness Services refer to benefit plan for details.

Members Age and Benefit Schedule	EPO Benefits Allowed at 100%	Self-Referral
Regardless of age receive once per benefit period	TB Test	No Coverage
Members age 19-39 receive once every five (5) years	Fecal Occult Blood Testing Total Serum Cholesterol Testing Blood Sugar Testing Prostate Specific Antigen (PSA) Hemoglobin and Urinalysis One Office Visit	No Coverage
Members age 40-49 receive once every two (2) years	Fecal Occult Blood Testing	No Coverage
Members age 40-64 receive once every two (2) years	Total Serum Cholesterol Testing Blood Sugar Testing Hemoglobin and Urinalysis One Office Visit	No Coverage
Members age 40 and older receive once per benefit period	Prostate Specific Antigen (PSA) One Office Visit	No Coverage
Members age 50 and older receive once per benefit period	Fecal Occult Blood Testing	No Coverage
Members age 65 and older receive once per benefit period	Total Serum Cholesterol Testing Blood Sugar Testing Hemoglobin and Urinalysis One Office Visit Influenza Viral Vaccine & Pneumovax	No Coverage

## EXCLUSIVE PROVIDER ORGANIZATION (EPO)

The Exclusive Provider Organization (EPO) is a managed care program and encourages the use of a Primary Care Physician. You and each of your eligible family members may use any Primary Care Physician affiliated with your designated EPO provider. You may change your Primary Care Physician at any time. The medical practices included under primary care are: General/Family Practice, Obstetrics/Gynecology, Pediatrics and Internal Medicine. If you enroll in the EPO you will have lower out-of-pocket expenses for annual deductibles and reduced copayments for office visits. Your affiliation is for one year. The plan year runs from July 1 through June 30 of the following year.

## AUTHORIZED REFERRAL PROCESS

An Authorized Referral is required if services are not available from the EPO Health Care Provider. Benefit payment for Authorized Referrals will be at the EPO level.

An Authorized Referral does not guarantee payment of benefits. Benefits for services received as a result of an Authorized Referral are subject to the conditions, limitations and exclusions of this Benefit Plan. Benefit payment will be denied if the Member is not covered under this Benefit Plan on the date the services are provided. Refer to Benefit Plan for details.



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Call toll-free 1-800-223-1704

Fargo area call 282-1400

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