



NORTH DAKOTA  
PUBLIC EMPLOYEES  
RETIREMENT SYSTEM

# NDPERS PPO and Basic

*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.

DESCRIPTION OF BENEFITS	COPAYMENT Amount you pay per visit (PPO/Basic)	PPO PLAN		BASIC PLAN <small>WITH A PARTICIPATING BCBSND PROVIDER</small>		SPECIAL CONDITIONS
		Amounts are a % of the allowed charge after deductible has been met. Before out-of-pocket maximum is met	Amounts are a % of the allowed charge after deductible has been met. After out-of-pocket maximum is met	Amounts are a % of the allowed charge after deductible has been met. Before out-of-pocket maximum is met	Amounts are a % of the allowed charge after deductible has been met. After out-of-pocket maximum is met	
<b>Inpatient Hospital Services</b>		80%	100%	75%	100%	Preauthorization may be required.
<b>Outpatient Hospital Services</b>		80%	100%	75%	100%	
Physical Therapy		80%	100%	75%	100%	Benefits are based on the medical guidelines established by Blue Cross Blue Shield of North Dakota.
Occupational Therapy		80%	100%	75%	100%	Maximum of 90 consecutive calendar days per condition beginning on the date of the 1st therapy treatment for the condition.
Speech Therapy		80%	100%	75%	100%	Prior Approval is required.
<b>Professional Health Care Provider Services</b> Inpatient, Outpatient & Surgical Services		80%	100%	75%	100%	
<b>Wellness Services</b>						
Well Child Care (through age 5)		80%	100%	75%	100%	Refer to benefit plan for details. Deductible does not apply.
Preventive Screening Services Ages 6-18		80%	100%	75%	100%	Refer to benefit plan for details. Deductible does not apply.
Preventive Screening Services Ages 19 & over		100%	100%	100%	100%	Refer to Preventative Screening Chart on back for details. Deductible does not apply.
Mammography & Pap Smear Screening Services		100%	100%	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. Deductible does not apply.
Prostate Cancer Screening Services		80%	100%	75%	100%	Refer to the benefit plan for details. Deductible does not apply.
<b>Home &amp; Office Visits</b>	\$20/\$25	100%	100%	100%	100%	Deductible does not apply.
<b>Diagnostic Services</b> Lab, X-ray, MRI		80%	100%	75%	100%	
<b>Radiation Therapy, Chemotherapy &amp; Dialysis</b>		80%	100%	75%	100%	
<b>Maternity Services</b> Inpatient, Outpatient, Pre & Postnatal Care		80%	100%	75%	100%	Deductible does not apply to delivery services received from a PPO 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 Outpatient Services		80%	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.
		100%/80%	100%	100%/80%	100%	
<b>Emergency Services</b>		80%	100%	75%	100%	Preauthorization is not required.
Professional Health Care Provider Visit		80%	100%	75%	100%	Deductible does not apply to the office or emergency room visit.
Emergency Room Charge	\$50/\$50	80%	100%	75%	100%	Copayment is waived when Member is admitted inpatient hospital.
<b>Ambulance Services</b>		80%	100%	75%	100%	
<b>Skilled Nursing Facility Services</b>		80%	100%	75%	100%	Preauthorization is required.
<b>Home Health Care Services</b>		80%	100%	75%	100%	Preauthorization is required.
<b>Hospice Services</b>		80%	100%	75%	100%	Preauthorization is required.
<b>Chiropractic Services</b>						
Home & Office Visit	\$20/\$25	100%	100%	100%	100%	Deductible does not apply.
Manipulations	\$20/\$25	100%	100%	100%	100%	Deductible does not apply.
Therapy and Diagnostic Services		80%	100%	75%	100%	
<b>Medical Supplies &amp; Equipment</b>		80%	100%	75%	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)		80%	100%	75%	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 Amount you pay per prescription	PPO/BASIC PLAN		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	\$15	75%	100%	
Nonformulary	\$25	50%	50%	

## COST SHARING AMOUNTS

	PPO	Basic
<b>Single Coverage</b> Or an individual family member		
Deductible amount	\$250	\$250
Coinsurance maximum	\$750	\$1,250
Out-of-pocket maximum	\$1,000	\$1,500
<b>Family Coverage</b>		
Deductible amount	\$750	\$750
Coinsurance maximum	\$1,500	\$2,500
Out-of-pocket maximum	\$2,250	\$3,250

This chart reflects the cost sharing amounts for each benefit period. PPO and Basic 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

Members Age and Benefit Schedule	PPO and Basic
Members age 19-39 receive once every five (5) years	Fecal Occult Blood Testing Total Serum Cholesterol Testing Blood Sugar Testing
Members age 40-49 receive once every two (2) years	Fecal Occult Blood Testing
Members age 40-64 receive once every two (2) years	Total Serum Cholesterol Testing Blood Sugar Testing
Members age 50 and older receive once per benefit period	Fecal Occult Blood Testing
Members age 65 and older receive once per benefit period	Total Serum Cholesterol Testing Blood Sugar Testing

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

## PREFERRED PROVIDER ORGANIZATION (PPO)

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.



**BlueCross BlueShield  
of North Dakota**

*An independent licensee of the Blue Cross & Blue Shield Association*

**Call toll-free 1-800-223-1704**

**Fargo area call 282-1400**

**[www.BCBSND.com](http://www.BCBSND.com)**