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Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan that offers covered services through Preferred providers. You can choose your own physicians, hospitals, and other healthcare providers within our Preferred Provider Organization (PPO) network. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
 - URAC (www.URAC.org).
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General features of FEP Blue Focus

We have a Preferred Provider Organization (PPO)

Our fee-for-service Plan offers services through a PPO. This means that certain hospitals and other healthcare providers are "Preferred providers." Your Local Plan (or, for Preferred retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also visit www.fepblue.org/provider/ to use our National Doctor & Hospital FinderSM. You can reach our website through the FEHB website, www.opm.gov/healthcare-insurance.

You must use Preferred providers in order to receive benefits. See page [18](#) for the exceptions to this requirement.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other healthcare facilities, physicians, and other healthcare professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as “Preferred.”** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. When you use Preferred providers your out-of-pocket costs are limited to your copayment, deductible, and/or coinsurance. See Section 3 (page [18](#)) and 5(d) *Emergency Services/Accidents* for the exceptions to this requirement.

In Local Plan areas, Preferred providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable deductible, coinsurance or copayments for covered services, and any charges for noncovered services.

- **Non-preferred providers.** This is a PPO-only contract. There are no benefits for care performed by Non-preferred providers (Participating/Non-participating) or Non-preferred facilities (Member/Non-member). You must use Preferred providers in order to receive benefits. See page [18](#) for the exceptions to this requirement.
 - **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure.
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