

PROVIDERFACTS



FEP Benefit Changes for 2010

Effective January 1, 2010, members of the Federal Employees Health Benefits Program (FEP) have the following changes to their benefits:

Changes to Standard Option Only

- Your share of the non-postal premium will increase for “Self Only” or increase for “Self and Family.”
- At Preferred retail pharmacies, you may be eligible to receive your first four generic prescriptions filled (and/or refills ordered) per drug per calendar year at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement.
- The amount you pay for your calendar year deductible no longer accumulates toward your Catastrophic Protection out-of-pocket maximum. In addition, the coinsurance and copayment amounts you pay for mental health and substance abuse care performed by non-preferred providers are now included in your Catastrophic Protection out-of-pocket maximum.
- Your copayment for office visits to preferred specialists is now \$30 per visit.
- Your coinsurance amount for certain non-preferred professional and outpatient facility services is now 35 percent of the plan allowance.
- You now pay 35 percent of the Plan allowance (plus any difference between our allowance and the billed amount) for anesthesia provided by a non-participating anesthesiologist or certified registered nurse anesthetist (CRNA) (deductible applies).
- Your copayment for inpatient care at non-preferred hospitals is now \$350 per admission.
- Benefits for outpatient mental health and substance abuse care are no longer limited to 25 visits per year. However, you must now obtain prior approval for outpatient mental health and substance abuse care in order to receive benefits.
- Benefits for inpatient mental healthcare at non-preferred facilities are no longer limited to 100 days per calendar year.
- Benefits for inpatient care at non-preferred facilities to treat substance abuse are no longer limited to a 28-day stay per lifetime.
- We clarified that we waive your copayments for professional care provided in an emergency room by non-participating providers when Medicare Part B is the primary payor.
- We clarified those situations in which your responsibility for the difference between the non-participating provider allowance (NPA) and the billed amount may be limited.

Important Information

The following disclaimer is applicable to all telephone inquiries and automated communications systems (i.e., InfoSolutions®, telephone, and fax) to Blue Cross and Blue Shield of Alabama:

The information provided is only general benefit information and is not a guarantee of payment. Benefits are always subject to the terms and limitations of the plan and no employee of Blue Cross and Blue Shield of Alabama has authority to enlarge or expand the terms of the plan. The availability of benefits is always conditioned upon the patient's coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur under certain circumstances. There will be no benefits available if such circumstances occur.

Note: Please refer to our web site, www.bcbsal.com, for the most current benefit and policy information.

Changes to Basic Option Only

- Your share of the non-postal premium will increase for “Self Only” or increase for “Self and Family.”
- Your copayment for office visits to preferred specialists is now \$35 per visit. Your \$25 copayment for office visits to preferred primary care providers has not changed.
- Your copayment for inpatient care at preferred hospitals is now \$150 per day, up to \$750 per admission.
- Your total responsibility for facility-billed maternity services provided at preferred facilities is now limited to \$150 per admission.
- Your copayment for most outpatient facility care at preferred hospitals is now \$75 per day per facility.
- Your copayment for screening colonoscopies provided in the outpatient department of a preferred hospital is now \$25.
- We clarified that your coinsurance for non-preferred brand-name drugs does not accumulate toward your Catastrophic Protection out-of-pocket maximum.
- We clarified that you pay 30 percent of our allowance for drugs and supplies administered or obtained in connection with your care.
- We clarified that we provide benefits in full for screening procedures billed by the outpatient department of a hospital or ambulatory surgical center (does not include screening colonoscopies).
- We have discontinued our Basic Consumer Option High Deductible Health Plan (HDHP).

Changes to Standard and Basic Options

- Preferred and member hospitals **will not** be able to bill you for any inpatient services related to specific types of medical errors and hospital-acquired conditions known as Never Events. In addition, we will no longer provide benefits to preferred and member hospitals for inpatient services related to Never Events.
- We now provide preventive care benefits for individual counseling on prevention and reducing health risks. In addition, we now provide preventive care benefits for the administration and interpretation of a Health Risk Assessment (HRA) questionnaire. You must use a preferred provider in order to receive these benefits.
- We clarified that you now have access to our online “Blue Health Assessment” tool, which confidentially assesses your overall health, identifies potential health risks, and provides you with a personal health action plan at no charge.
- You may be entitled to receive your annual physical examination or one visit for counseling on prevention and reducing health risks at no charge when you complete a Blue Health Assessment questionnaire and see a preferred healthcare provider.
- Children ages 5 through 17 who meet certain Body Mass Index (BMI) criteria may be eligible to participate in our new *Jump 4 Health* Weight Management Program and receive up to four nutritional counseling visits at no cost when they use preferred providers.
- We now provide benefits for the H1N1 influenza (swine) vaccine.
- We clarified the advantages of using generic drugs.
- Many of our preferred retail pharmacies now participate in our vaccine network, allowing members the convenience of receiving certain vaccines at no charge at pharmacies in the vaccine network.
- We now provide benefits for human papilloma virus (HPV), meningococcal, pneumococcal and herpes zoster (shingles) vaccines provided by preferred retail pharmacies that participate in our vaccine network.
- We now provide benefits for speech-generating devices, limited to \$1,000 per calendar year.
- We now provide benefits for oxygen billed for by skilled nursing facilities, nursing homes and extended care facilities.
- We now provide benefits for up to 6 nutritional counseling visits per year.
- We now provide benefits for additional types of stem cell transplants.

- We now provide benefits for up to 7 days of inpatient hospice care for members not previously enrolled in a home hospice care program. This is in addition to 7 days of inpatient care every 21 days for members enrolled in a home hospice care program.
- We now also provide benefits for up to 7 days of continuous home hospice care.
- Case-Management Accreditation for this plan is now provided whether through Utilization Review Accreditation Commission (URAC) or through Health Plan Accreditation from National Committee for Quality Assurance (NCQA).
- Chiropractors/Doctors of Chiropractic (D.C.) are now listed as “physicians.”
- Licensed mental health and substance abuse professionals who provide mental health and/or substance abuse services within the scope of their license were added to the list of covered healthcare professionals.
- You must now obtain prior approval for outpatient intensity-modulated radiation therapy (IMRT).
- We clarified that you may request prior approval and receive specific benefit information in advance for surgical procedures (including maternity care) to be provided by a non-participating physician when the charge for that care will be **\$5,000 or more**.
- We clarified the benefit payment levels that apply to routine physical examinations and screening procedures performed in the outpatient department of a hospital.
- We clarified the benefit payment levels that apply to colonoscopies.
- We clarified U.S. Food and Drug Administration (FDA) limitations on the use of immunizations and vaccines.
- We clarified that benefits are not available for telephone consultations related to your medical care.
- We clarified that benefits are not available for genetic screening.
- We clarified that maternity care benefits are not provided for oral tocolytic agents.
- We clarified that benefits are not available for deluxe lens features for eyeglasses.
- We clarified that benefits are not available for private duty nursing in any setting.
- We clarified that benefits are not available for wheelchair van services or gurney van services.
- We clarified that benefits are not available for professional charges for shift differentials.

The information provided above is only general benefit information and is not a guarantee of payment. Click the link below for the official statement of benefits.

www.fepblue.org/whatsnew/downloads/bcbs-2010-RI71-005.pdf

The availability of benefits is always conditioned upon the patient’s coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur under certain circumstances. There will be no benefits available if such circumstances occur. Be sure to verify eligibility and benefits through your e-Practice Management (e-PM) software system or *ProviderAccess* via the Internet to obtain the current contract informations.