

Federal Employee Program (FEP)

The Federal Office of Personnel Management contracts with health care plans throughout the United States to provide health care coverage for federal employees and their families. Use of Blue Cross and Blue Shield provider networks gives eligible Federal Employee Program (FEP) members world-wide access to Participating (Traditional) and Preferred (ValueCare) providers.

All claims are processed according to the benefits, rules, guidelines and regulations of the Federal Government. **These Federal guidelines supersede state laws.** Federal employees select their benefit options during Open Enrollment for each new calendar year. All eligibility and enrollment is handled through the Office of Personnel Management (OPM) in Washington D.C. For those members that select a Blue Cross and/or Blue Shield health plan as their carrier, there are two coverage options available to them: Basic and Standard.

Note: All Federal employees' member numbers start with the letter "R", followed by eight numerical digits. Payment vouchers show the member number with an "8" rather than an "R".

Basic Option

Basic Option is recognizable by the Enrollment codes 111 (Self-Only) and 112 (Self and Family coverage). You can find the Enrollment codes on the Federal Employees' member card. For a sample member card, please refer to the Identifying Members section of this manual.

Basic Option includes coverage for services provided by the local Plan's **Preferred (ValueCare) provider network**. Members receiving care from primary care providers pay lower copayment amounts than when they receive care from a specialist. Some special exceptions allow benefits to be paid for non-Preferred providers.

Note: The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists and physician assistants that are contracted as Preferred (ValueCare) providers.

Basic Option Highlights

- No calendar year deductible.
- All services are subject to copayment
- A higher copayment applies to visits to Preferred (ValueCare) providers who are considered "specialists"
- Limited chiropractic benefits available
- Includes preventive dental benefits
- No referrals required

- Pre-authorization is required for all mental health and substance abuse services prior to the start of treatment. Please print, complete and mail or fax the *Regence Behavioral Health Treatment Plan Request Form*, available on our *Provider Web Site* in the Provider Library section under Forms. The mailing address and fax number are listed on the form. All treatment must be performed by a Preferred (ValueCare) provider
- Information about all services requiring pre-authorization can be found on the *Federal Employee Program Medical Pre-authorization List* in the Care Management section of our *Provider Web Site* under Pre-authorization. Click on the Federal Employee Program (FEP) link in the Medical Pre-authorization Lists table
- Waiting periods do not apply

Standard Option

Standard Option is recognizable by the Enrollment codes 104 (Self-Only Coverage) and 105 (Self and family Coverage). You can find the Enrollment codes on the Federal employees' member card. For a sample card, please refer to the Identifying Members section of this manual.

Standard Option provides coverage for services rendered by each local Plan's Preferred (ValueCare) and Participating (Traditional) provider networks as well as a reduced benefit for services by a non-participating provider. The highest benefit level is realized by using Preferred (ValueCare) providers.

Preferred (ValueCare) Providers

Preferred (ValueCare) providers are paid at the highest benefit level up to the Plan's allowable. The member is responsible for a calendar year deductible, office copayments or applicable coinsurance for covered services. The member is not responsible to pay any balances above the Regence BlueCross BlueShield of Utah (Regence BCBSU) allowable amount for covered services.

Participating (Traditional) Providers

Participating (Traditional) providers are paid at the mid-level benefit up to the Plan's allowable. The member is responsible for a calendar year deductible and coinsurance for covered services. The member is not responsible to pay any balances above the Regence BCBSU allowable amount for covered services.

Non-participating Providers

Non-participating providers are paid at the lowest benefit level up to the Plan's allowable. The member is responsible for a calendar year deductible, coinsurance, and any difference between the Regence BCBSU allowable and the billed amount for covered services.

Standard Option Highlights

- Includes dental coverage according to a limited fee schedule
- No chiropractic care benefit
- A fee-for-service product
- No referrals required
- Pre-authorization is required for all mental health and substance abuse services prior to the start of treatment. Please print, complete and mail or fax the *Regence Behavioral Health Treatment Plan Request Form*, available on our *Provider Web Site* in the Provider Library section under Forms. The mailing address and fax number are listed on the form. Treatment may be performed by any provider; however, the member will receive the highest benefit level when receiving services from a Preferred (ValueCare) or Participating (Traditional) provider. If there is no Treatment Plan, benefits are paid at a lower level up to 25 visits each calendar year
- Information about all services requiring pre-authorization can be found on the *Federal Employee Program Medical Pre-authorization List* in the Care Management section of our *Provider Web Site* under Pre-authorization. Click on the Federal Employee Program (FEP) link in the Medical Pre-authorization Lists table

Additional Information

- Claims for members over the age of 65 are subject to Medicare pricing.
- Pre-approval or predetermination of services is not allowed with the Federal Employee Program except for Managed Mental Health and Substance Abuse benefits.
- Several care management programs are available for FEP members. Our care managers are available to coordinate care for a variety of health conditions. To learn more about these programs, available at no cost to our FEP members, please contact our Care Management Intake department at 1 (866) 543-5765.

How to Submit Claims

We encourage you to submit electronic claims. Paper claims should be submitted on a *CMS-1500* or a *UB-04* claim form to:

Regence BlueCross BlueShield of Utah - FEP
P.O. Box 30272
Salt Lake City, UT 84130-0272

Written correspondence should be submitted to:

Regence BCBSU - FEP
P.O. Box 30270
Salt Lake City, UT 84130-0270

Coordination of Benefits

FEP members may only have benefits under one FEP plan; however, they may have benefits under a non-FEP plan in addition to their FEP coverage. If Regence BCBSU FEP is not the primary insurer, always submit claims to the primary insurer first. When submitting claims to Regence BCBSU FEP for secondary payment, be sure to always submit the primary payment information with your claim. You may also report primary payment information with electronic claims.

Disputed Claims

If the rendering provider disagrees with the payment determination on a particular claim, he or she may request reconsideration. If the claim was denied as a provider write-off, providers may appeal the decision in accordance with the process outlined in the Appeals section of this manual. If the claim was denied as member responsibility, the member may request reconsideration as outlined in their *Blue Cross® and Blue Shield® Service Benefit Plan* brochure (federal benefits brochure). If the member is still dissatisfied with the outcome, he or she may submit a written appeal to the Office of Personnel Management. Parties acting as a representative for the member, such as medical providers, must include a copy of the member's specific written consent with the review request. This procedure is outlined in detail in the federal benefits brochure.

Contact Information

Please contact the FEP Provider Customer Service department at 1 (877) 668-4657 for eligibility, benefits, or if you have any questions about how a claim was processed.