Savings Plus Plan (SPP) Frequently Asked Questions

What is the Savings Plus Plan (SPP)?
The Savings Plus Plan is a program developed to minimize members out of pocket expenses through competitive pricing negotiation. This focused health benefit payment program applies to all inpatient and outpatient facility services as well as a limited number of surgical and medical services. These SPP services are identified in your plan booklet. Under the SPP, the provider's reimbursement level for these services will be a percentage of Medicare.

Do I have a provider network as part of my SPP?
Yes, this program will use the Anthem (formerly Blue Cross Blue Shield) National PPO Blue Card Network. When searching on Anthem's site for a provider, members would look for the "National PPO (Blue Card PPO)" option.

What services are subject to SPP?
Below are examples of services that will fall under SPP:

- all inpatient and outpatient facility services
- certain high dollar in-patient and out-patient surgeries
- high-cost imaging such as MRI and PET Scans
- Substance Abuse services
- Dialysis

You should always refer to your Summary Plan Description (plan booklet) for a comprehensive list of SPP services.

Who should I call if I have any questions about my Savings Plus Plan? (Including bills from providers on Savings Plus Plan services)

Should you have any questions about access to care or a medical bill, please contact the dedicated Concierge team at (877) 208-5952.

Will I need to get preauthorization for some services?
Yes, certain services will require preauthorization by your provider. Failing to preauthorize identified services may increase your out-of-pocket portion of payment. Please refer to your Summary Plan Description for a comprehensive list of which services require preauthorization.

How do I obtain a preauthorization?
Your doctor is responsible for preauthorization. He/she should call the phone number on your ID card to confirm that you have coverage, and determine if the service being provided requires preauthorization.

Do I need a referral from my Primary Care Physician in order to see a Specialist?
No, to ensure that members have direct access to specialists, no referral is needed. When seeing a specialist, please make sure that they are participating in the network and that any necessary preauthorization's are obtained .

I had a procedure done and I received a letter in the mail saying my claim is denied pending medical notes. What does that mean? Who is responsible to obtain this?

Medical notes are required for procedures done in an inpatient setting to confirm that the services rendered were for medical necessity. Members should follow up with their doctor or hospital to submit medical documentation for review.

I recently went to the doctor and had lab work done. I'm getting a bill in the mail saying I owe for lab work services. What do I do?

You should always make sure you review your EOB (Explanation of Benefits) when reviewing a bill from your provider. Should you have any questions about a medical bill, please contact the Concierge team at (877) 208-5952.

LEADING EDGE ADMINISTRATORS