2026 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 4. Your Costs for Covered Services
Page 29

Waivers

In some instances, a provider may ask you to sign a “waiver” prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service phone number on the back of your ID card.

Differences between our allowance and the bill

Our “**Plan allowance**” is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider’s bill is more than a fee-for-service Plan’s allowance. It is possible for a provider’s bill to exceed the Plan’s allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider’s bill for covered care is limited.

  Your share consists only of your deductible, coinsurance, and/or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $250, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 30% of our $100 allowance ($30). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and their bill.

Remember, you must use Preferred providers in order to receive benefits.

- **Non-preferred Providers:**

- **Participating provider/Member facility. There are no benefits for care performed by Participating providers; you pay all charges.**

- **Non-participating providers/Non-member facility. There are no benefits for care performed by Non-participating providers; you pay all charges.**

  Remember you must use Preferred providers in order to receive benefits. There are no benefits for care performed by Participating and Non-participating providers. See Section 3 for exceptions under *What you must do to get covered care*.

  You should also see section *Important Notice About Surprise Billing – Know Your Rights* below that describes your protections against surprise billing under the No Surprises Act.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out of network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care - when you have little or no say in the facility or provider from whom you receive care, or for

- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating healthcare facilities, or for

- air ambulance services furnished by nonparticipating air ambulance providers