Differences between our allowance and the bill

2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 4. Your Costs for Covered Services
Differences between our allowance and the bill

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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 or Participating 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.

  Under Standard Option, your share consists only of your deductible and coinsurance 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, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and the bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $250 for covered services subject to a $35 copayment. Even though our allowance may be $100, you still pay just the $35 copayment. Because of the agreement, your Preferred physician will not bill you for the $215 difference between your copayment and the bill.

- **Participating providers**. These types of **Non-preferred** providers have agreements with the Local Plan to limit what they bill our members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $250, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our $100 allowance ($35). Because of the agreement, your Participating physician will not bill you for the $150 difference between our allowance and the bill.

- **Non-participating providers**. These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our website, www.fepblue.org, or call us at the customer service phone number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

  Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances described in the *No Surprises Act*, later in this section). For example, you see a Non-participating physician who charges $250. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the $100 Plan allowance or $35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $150 difference between our allowance and the bill. This means you would pay a total of $185 ($35 + $150) for the Non-participating physician's services, rather than $15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

- **Remember, under Basic Option 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*.**

The following examples illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only.**

Basic Option benefit levels for physician care begin in Section 5(a) and outpatient hospital or ambulatory surgical facility care begins in Section 5(c).

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $250 and the Plan allowance is $100.

EXAMPLE

Preferred Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 85% of our allowance: 85
You owe - Coinsurance: 15% of our allowance: 15
You owe - Copayment: Not applicable
+ Difference up to charge? No: 0
TOTAL YOU PAY: $15

Participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe - Coinsurance: 35% of our allowance: 35
You owe - Copayment: Not applicable
+ Difference up to charge? No: 0
TOTAL YOU PAY: $35

Non-participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe - Coinsurance: 35% of our allowance: 35
You owe - Copayment: Not applicable
+ Difference up to charge? Yes: 150
TOTAL YOU PAY: $185

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance ($100), which you would pay in full, would count toward your deductible.

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

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges $5,000. The Plan allowance is $2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is $2,500 when the services are provided at a Non-member facility.

EXAMPLE

Preferred Ambulatory Surgical Facility Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 85% of our allowance: 2,465
You owe - Coinsurance: 15% of our allowance: 435
You owe - Copayment: Not applicable
+ Difference up to charge? No: 0
TOTAL YOU PAY: $435

Member Ambulatory Surgical Facility Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 65% of our allowance: 1,885
You owe - Coinsurance: 35% of our allowance: 1,015
You owe - Copayment: Not applicable
+ Difference up to charge? No: 0
TOTAL YOU PAY: $1,015

Non-member Ambulatory Surgical Facility* Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,500
We pay: 65% of our allowance: 1,625
You owe - Coinsurance: 35% of our allowance: 875
You owe - Copayment: Not applicable
+ Difference up to charge? Yes: 2,500
TOTAL YOU PAY: $3,375

Note: If you had not met any of your **Standard Option** deductible in the above example, $350 of our allowed amount would be applied to your deductible before your coinsurance amount was calculated.

***A Non-member facility may bill you any amount for the services it provides. You are responsible**

for paying all expenses over our allowance, regardless of the total amount billed, in addition to your calendar year deductible and coinsurance. For example, if you use a Non-member facility that charges $60,000 for facility care related to outpatient bariatric surgery, and we pay the $1,625 amount illustrated above, you would owe $58,375 ($60,000 - $1,625 = $58,375). This example assumes your calendar year deductible has been met.