In-Network Benefits for Out-of-Network Providers

The following covered services and supplies provided by out-of-network providers will always be covered at the in-network level of benefits:

- Emergency care for a medical emergency. This plan provides worldwide coverage for emergency care.

  The benefits of this plan will be provided for covered emergency care without the need for any pre-approval and without regard as to whether the health care provider furnishing the services is an in-network provider. Emergency care furnished by an out-of-network provider will be reimbursed at the in-network benefit level. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.

- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.

- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.

- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage provider who doesn't have admitting privileges at a Heritage hospital.

- Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

- If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. However, you must request this before you get the care.

Pre-Approval For Out-Of-Network Providers
This plan provides benefits for non-emergency services from out-of-network providers at a lower benefit level. You may receive benefits for these services at the in-network cost-share if the services are medically necessary and only available from an out-of-network provider. You or your provider may request a pre-approval for the in-network benefit before you see the out-of-network provider.

The pre-approval request must include the following:

- A statement that the out-of-network provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from an in-network provider
- Any necessary medical records supporting the request.

If the request is approved, you pay the in-network cost-share for covered services. However, the allowed amount is still the amount allowed for out-of-network providers.

If the request is denied but the plan does cover the services, you will have to pay the out-of-network cost-share.