BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Out of Network and Emergency Care Policy

How to get care from out-of-network providers

Blue Cross Blue Shield Nebraska MA Core HMO

If you have the Blue Cross and Blue Shield of Nebraska Core HMO plan and are traveling outside the service area in Nebraska and outside of Nebraska, we offer a visitor/traveler program that allows you to receive in-network cost sharing when you are outside of our service area for less than 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

Care that you receive from out-of-network providers within the service area will not be covered unless the care meets one of the following three exceptions

- The plan covers emergency care or urgently needed services that you get from an out-of-network provider.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. You must obtain authorization from Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO prior to seeking out-of-network care. If you do not obtain authorization, your out-of-network care will not be covered. In this situation, you will pay the same as you would pay if you got the care from a network provider.
- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

Blue Cross Blue Shield Nebraska MA Access PPO and Group PPO

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you

may want to ask for a pre-visit coverage decision to confirm that the services you are about asking for coverage decisions.) This is important because:

  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint) to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 of your Evidence of Coverage (Asking us to pay our share of a bill you have received for covered medical services or drugs) for information about what to do if you receive a bill or if you need to ask for reimbursement.

- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount..

How to get covered services when you have an emergency or urgent need for care or during a disaster

Getting Care if you have a Medical Emergency

What is a "medical emergency" and what should you do if you have one?

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- Get help as quickly as possible. Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it world-wide. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of your Evidence of Coverage.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care.

If you need to locate an urgent care provider, you can use the Find a Doctor tool on our website at Medicare.NebraskaBlue.com/MedicareAdvantage/FindADoc or call Customer Service at 888-488-9850, TTY users can call 711. Hours are 8:00 a.m. to 9:00 p.m., Central time, seven days a week. You may receive a messaging service on weekends and holidays from April 1 through September 30. Please leave a message and your call will be returned the next business day.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

Our plan covers worldwide emergency and urgent care services outside of the United States under the following circumstances: services defined as urgent, emergent and post-stabilization care received outside of the United States and its territories. Transportation back to the United States from another country is not covered.

Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: Medicare.NebraskaBlue.com for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 of your Evidence of Coverage for more information**.**