RECENT CHANGES

This section lists recent changes, which may include additions, deletions or revisions to your benefit booklet. These changes supersede language that appears elsewhere in your benefit booklet.

Revisions to Your Benefits Due to the No Surprises Act (effective January 1, 2022).

Due to federal legislation, the following clarifications concerning coverage for EMERGENCY and ambulance services apply:

1. OUT-OF-NETWORK Benefit Exceptions

The section entitled "OUT-OF-NETWORK Benefit Exceptions" is deleted in its entirety and replaced with the following:

You will only be responsible for your IN-NETWORK share of the cost and PROVIDERS may not bill you more than your IN-NETWORK share of the cost in the following situations:

- When EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER or an OUT-OF-NETWORK EMERGENCY facility*
- When you receive EMERGENCY MEDICALLY NECESSARY ground or air transport ambulance from an OUT-OF-NETWORK PROVIDER*
- When you receive MEDICALLY NECESSARY air transport ambulance from an OUT-OF-NETWORK PROVIDER*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER at an IN-NETWORK health care facility*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by the CORPORATION's access to care standards
- In continuity of care situations

*These situations may not qualify for an OUT-OF-NETWORK benefit exception if the MEMBER gives consent. Please see **https://www.cms.gov/nosurprises** for notice regarding surprise billing describing your rights and how consent may impact these situations.

For more information, see one of the following sections: "EMERGENCY Services" in "COVERED SERVICES," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about the CORPORATION'S access to care standards, see the website at **www.bcbsnc.com/members/ncbar**] and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling the CORPORATION before receiving care from an OUT-OF-NETWORK PROVIDER.

2. EMERGENCY and Ambulance Services

The section entitled "EMERGENCY and Ambulance Services" is deleted in its entirety and replaced with the following:

EMERGENCY SERVICES

The PLAN provides benefits for EMERGENCY SERVICES. An EMERGENCY is the sudden and unexpected onset of a medical condition, including a mental health or substance use disorder condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual or with respect to a pregnant MEMBER, the health of the pregnant MEMBER or their unborn child in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of EMERGENCIES.

What to Do in an EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. PRIOR REVIEW is not required for EMERGENCY SERVICES.

What are my benefits when I receive EMERGENCY SERVICES?

Situation	Benefit
• You receive IN-NETWORK or OUT-OF-NETWORK ground or air ambulance services prior to admission to an EMERGENCY department (ED)	• Ambulance benefits apply. • PRIOR REVIEW and CERTIFICATION are required for non-EMERGENCY air ambulance services. • PROVIDERS may not bill you for more than your IN-NETWORK share of the cost for these services.*
• You go to an IN-NETWORK OR OUT-OF-NETWORK HOSPITAL ED. • You go to an IN-NETWORK or OUT-OF-NETWORK ED and then are held for observation or admitted inpatient to the HOSPITAL for additional EMERGENCY SERVICES. • You receive IN-NETWORK or OUT-OF-NETWORK EMERGENCY ground or air ambulance services after admission to an ED.	• EMERGENCY benefits apply for all COVERED SERVICES in the event of an EMERGENCY until you are considered stable by your provider. • PRIOR REVIEW and CERTIFICATION are not required for EMERGENCY SERVICES. • PROVIDERS may not bill you for more than your IN-NETWORK share of the cost for these services.*
• You get non-EMERGENCY follow-up care (such as OFFICE VISITS or therapy) after you are considered stable by your PROVIDER and you leave the emergency room or are discharged.	• Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.

*If you have questions or feel that you have been billed more than your IN-NETWORK share of the cost, in addition to the rights under "Need to Appeal a Decision?", please see [**https://www.cms.gov/nosurprises**] for additional options and a full statement of your rights under federal law regarding surprise billing.

Ambulance Services

The PLAN covers services in a ground ambulance traveling:

- From a MEMBER'S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER'S home when MEDICALLY NECESSARY.

The PLAN covers services in an air ambulance only when:

- Ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land, or
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest HOSPITAL that can provide COVERED SERVICES appropriate to your condition.

Nonemergency air ambulance services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Ambulance Services Exclusions (Ground or Air)

- Services provided primarily for the convenience of travel of the MEMBER or caregiver.
- Transportation to or from a DOCTOR'S office or dialysis center

- Transportation for the purpose of receiving services that are not considered COVERED SERVICES, even if the destination is an appropriate facility.

3. Continuity of Care

The section entitled "Continuity of Care" is deleted in its entirety and replaced with the following:

Continuity of care is a process that allows MEMBERS to continue receiving care from an OUT-OF-NETWORK PROVIDER for an ongoing special condition at the IN-NETWORK benefit level when you or your EMPLOYER changes health benefit plans or when the PROVIDER is no longer in the PPO network. If the PCP or SPECIALIST leaves the Blue Options PROVIDER network and they are currently treating a MEMBER for an ongoing special condition that meets this continuity of care criteria, the CORPORATION will notify you in writing 30 days before the PROVIDER'S termination, as long as the CORPORATION receives timely notification from the PROVIDER. To be eligible for continuity of care, the MEMBER must be actively being seen by an OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by the CORPORATION'S requirements for continuity of care.

An ongoing special condition means:

- Serious and complex condition
- Course of institutional or inpatient care
- Scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Terminally ill acute illness (required specialized medical treatment to avoid death or permanent harm)
- Chronic illness (life threatening, degenerative, potentially disabling, or congenital requiring treatment over a prolonged period of time.

The allowed transitional period end on the earlier of (i) 90 days from the date of the PROVIDER termination; or (ii) the date on which the MEMBER is no longer a patient undergoing care of the ongoing special condition with respect to such PROVIDER or facility, except in the cases of:

- Scheduled SURGERY, organ transplantation, or inpatient care which shall extend through the date of discharge and post-discharge follow-up care or other inpatient care occurring within 90 days of the date of discharge; and
- Terminal illness which shall extend through the remainder of the individual's life for care directly related to the treatment of the terminal illness; and
- Pregnancy which shall extend through the provision of 60 days of postpartum care.

Continuity of care requests must be submitted to the CORPORATION within 45 days of the PROVIDER termination date or within 45 days of EFFECTIVE DATE for MEMBERS new to the PLAN. Continuity of care requests will be reviewed by a medical professional based on the information given about specific medical conditions. If your continuity of care request is denied, you may request a review through our appeals process (see "Need to Appeal a Decision?"). Claims for approved continuity of care services will be paid at the IN-NETWORK benefit level. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be given when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

Please call Customer Service at the number listed in "Who to Contact?" for more information.

4. DEFINITIONS

This portion of the section entitled "Glossary" is revised and replaced with the following:

EMERGENCY(IES)

A medical condition including a mental health or substance use disorder condition, manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a) placing the health of an individual, or with respect to a pregnant woman, the health of the woman or their unborn child, in serious jeopardy,
b) serious impairment to bodily functions,
c) serious dysfunction of any bodily organ or part.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

EMERGENCY SERVICES

Health care items and services furnished or required to screen for or treat an EMERGENCY medical condition, including but not limited to, pre-HOSPITAL care and ancillary services routinely available in the EMERGENCY department.

The definition below in the section entitled "Glossary" has been deleted in its entirety:

STABILIZE

To provide medical care that is appropriate to prevent a material deterioration of the MEMBER'S condition, within reasonable medical certainty.

The definition below in the section entitled "Glossary" is added:

SERIOUS AND COMPLEX CONDITION

The term "serious and complex condition" means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
b) in the case of a chronic illness or condition, a condition that is:
    i. life-threatening, degenerative, potentially disabling, or congenital; and
    ii. requires specialized medical care over a prolonged period of time.

5. Summary of Benefits

In the section, entitled "Summary of Benefits" the following change applies:

Any reference to "Emergency Room" has been replaced with "EMERGENCY SERVICES".

If you have a **Blue Options Copay** plan, the following information is deleted in its entirety:

If admitted to the HOSPITAL from the emergency room, the emergency room copayment does not apply; instead, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all COVERED SERVICES provided in both the emergency room and during observation. If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.