Bright HealthCare™

BRIGHT HEALTHCARE REMAINING OPERATIONS - MEMBER FAQ'S

2/7/24

This document is intended to provide instruction to former members of Bright Healthcare, particularly those who live in these states: AL, AZ, CO, FL, IL, OK, NC, NE, SC, or TN. These instructions are for the business operations which remain as we wind down the business around Bright Healthcare insurance plans.

Members from Texas *- to get additional support and information about the Texas receivership decision, click here* https://brighthealthcaretxsdr.com/

Member Premium Refunds

Many former Members have been notified by letter that they have a refund due. The letter included the account number, amount of the refund due, a phone number to call, and a deadline to make a request for a refund. If the Member does not make their request, they will need to contact their state and follow the unclaimed property steps required in their state.

Important items to note about obtaining your refund

- If a letter was received, please call the number on the letter and be prepared to provide:
  - Account number
  - Current address (especially if the address has changed)
  - Refund amount
- Members resided in one of the states listed above will be asked to leave a voicemail.
- It may take up to 90 days to receive your refund.
- If you do not request your refund by the deadline or do not provide the proper information that allows us to execute your refund, the funds will be turned over to the state and become available through the state unclaimed property process.
- Unclaimed property will not be available at each state until the second half of 2024 at the earliest.

1095 Tax Forms

If you have a question about your 1095 or you're requesting a duplicate:

- Those who received a tax credit (had an "on-exchange" plan), contact the marketplace through where you enrolled.
- Those who did not enroll through the marketplace (had a "direct" or "off-exchange" plan), call and leave a detailed voicemail at 855-827-4448.

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Member Appeals and Grievances

Bright HealthCare offers a grievance and appeals process through which members can express dissatisfaction with plans and/or network provider services and appeal an adverse benefit determination. The process is designed to address and resolve member concerns in a manner that is timely, fair, and thorough. The process meets applicable state regulatory requirements.

Please keep in mind that most appeals must be submitted within 180 days of the claim denial. It is your right to attempt an appeal for any claim decision.

The member request for an appeal must include*:*

- The patient's name and their member ID (located on their member ID card)
- The date(s) of the medical service(s) and the provider's name
- A description of the adverse determination, including what was denied
- The reason the member disagrees with the adverse determination
- Any documentation, including medical records, or other written information to support the member's position
- If the adverse determination is based on a contractual exclusion, the member may want to submit evidence from a medical professional indicating that there is a reasonable medical basis for the exclusion not to apply

Submit Appeals and Grievances to:

IF enrolled in a policy through CA, GA, UT, or VA:

Fax #: (877) 471-0295

OR

Bright Health P.O. Box 1519 Portland, ME 04104

IF enrolled in a policy through AL, AZ, CO, FL, IL, OK, NC, NE, SC, or TN:

Fax #: (888) 965-1815

OR

Bright Health P.O. Box 16275 Reading, PA 19612

For general questions about a previously filed appeal or grievance you may call 844-202-2154 and leave a detailed message about your issue. We will return your call within 1 business day. Messages left about any other topic will not be returned.