

Introduction

Carrier Name: Bright Health Insurance Company

Network Name: Bright Health Plan EPO Network

Network ID Number: CON001

Network Description: Bright Health's EPO Network uses Colorado State access standards to ensure our members have access to a network of providers that will meet their health care needs. Our network includes physicians and other health care providers who are our Care Partners committed to delivering high value care to our members.

Bright Health's EPO Network is a statewide network of Facilities, Urgent Care, Skilled Nursing Facilities, Home Health Care, Durable Medical Equipment and professionals (primary care, specialty care, therapies).

Geographic Area: Bright Health Plan's EPO Network includes Broomfield, Jefferson, Douglas and Summit counties in full, and certain zip codes within Denver, Arapahoe, Boulder and El Paso counties.

Website: www.brighthouseplan.com

Contact: 1-855-8-BRIGHT, or at <http://www.brighthouseplan.com/contact-us>

Network Adequacy and Corrective Action Process

Bright Health has established standards for network adequacy and the availability of providers and facilities to ensure our provider network is sufficient to meet the needs of our members. Bright Health maintains a network that is sufficient in the number and types of providers to assure that all covered benefits to covered persons are accessible without unreasonable delay.

Criteria for Provider Availability

Criteria includes, but is not limited to:

- Number of Healthcare Professional(s) and facilities available per member
- Geographic Distribution of Providers
- Availability or timeliness in which a member can access a Participating Provider.

Bright Health Plan measures adequacy according to these standards on an annual basis. Each category must have a 90% for a pass status. If a category does not achieve a 90%, Bright Health Plan will implement a corrective action plan to remedy the gaps.

Geographic Availability

The geographic availability of providers is monitored by Bright Health's Network Development Team on an annual basis, at a minimum. We use GEO Access software and established standards to ensure there are a sufficient number of participating health care professionals in every member's immediate area. Results of calculations are compared against required standards and reported as appropriate. If standards are not met, we implement a corrective action plan to remedy any gaps in our network as quickly as possible.

Corrective Action

Bright Health shall review the reports measuring the performance of provider access against the our goals to assist with establishing priorities regarding the recruitment of providers into our Provider Network. Where reports indicate that we are not meeting our objectives in a particular area, we will immediately work to:

- Identify and contract a provider to fill the gap;
- Authorize medically necessary care with a Non-Participating Provider.

Bright Health strives to correct any network gaps within 90 days from the date that the gap is identified.

Network Adequacy Results

Bright Health meets 100% of network adequacy requirements of 1 provider per 1,000 members with access to Primary Care, Specialty Care, Pediatric Care and Behavioral Health/Mental Health/Substance Abuse providers.

Telehealth Services

If a Bright Health Participating Provider offers Telehealth services, Bright Health would allow members to use that service as if a Telehealth visit were a face-to-face visit with the Participating Provider. Benefits would be payable for Telehealth as they would be for a primary or specialty care visit, and the applicable cost-share would apply.

No Availability of a Network Provider for a Covered Benefit

In a case where Bright Health does not have a Participating Provider or specialist within the network to provide services for a covered benefit, we will issue Pre-authorization to see a non-network provider. Bright

Health members will not be denied necessary medical care or charged additional expenses because use of a non-network provider is required.

Assisting Non-Network Providers in a Network Facility

If a Bright Health member receives care from a Non-Participating Provider while accessing care at a Participating, or In-Network Facility, Bright Health will hold the member harmless for additional charges related to health care services received from the Non-Participating Provider(s). Most often these types of services include anesthesiology, radiology, pathology, laboratory services, or hospitalist care.

Procedures for Referrals

Provider Directories

Bright Health updates its online Provider Directory on a daily basis. A member may access our Provider Directory online at <https://brighthouseplan.com/provider-finder/ifp/co-chn>. A member may also download an English or Spanish Provider Directory from our website, or contact our Customer Service Department to request a paper copy of the directory.

Referrals to Specialists

Members are not required to obtain a Referral from their primary care physician before receiving care from an In-Network or Participating specialist.

Most health care specialty services are available within Bright Health's EPO Network. In some instances, Bright Health's network may not contain a certain type of specialist, or the specialists within the network may not be able to provide a certain type of care. If specific Covered Health Services are not available from a Network Provider, a Member may be eligible to receive In-Network benefits from a Non-Network Provider. In these situations Bright Health Plan will work with the Member and their In-Network Provider to pre-authorize and coordinate care with an Out-of-Network Provider that can give the necessary care.

Receiving Care From Non-Network Providers

This plan does not cover non-emergency services rendered by Non-Network Providers. However, emergency medical services or services received from a Non-Network Provider in a Network hospital or facility are covered at the In-Network benefit level. To ensure that the Providers are In-Network, visit our website at <https://brighthouseplan.com/provider-finder/ifp/co-chn>, or call Us at (855) 827-4448.

When receiving emergency care from a Non-Network Provider in a Non-Network facility, payment from the Plan will be limited to the Allowable Amount. The Allowable Amount is the amount determined by Us to be paid to a Provider for Covered Health Services.

Non-Network Providers are allowed to bill any amount they wish for health care services. The charges that they bill may be more than Our Allowable Amount. The member will be responsible for their Copayment, Deductible and Coinsurance amounts, and for charges that the Non-Network Provider bills above of the Allowable Amount.

Plan Disclosures and Notices

Bright Health Plan communicates with Members in a variety of ways, including: newsletters, emails, a welcome kit, and Bright Health Plan's Web site and Member Hub.

Welcome Kit

When a person enrolls with Bright Health, we will send a Welcome Kit from us that includes the plan ID card and a Summary of Benefits and Coverage. The Welcome Kit will also provide instruction on how a member create an account in our Member Hub, where they can find additional information regarding the plan.

Bright Health Member Hub

Bright Health's Member Hub offers an array of information about the Bright Health plan and benefits, as well as tools to assist in managing care.

Through the Member Hub a member can:

- Get the scoop on health plan benefits, including viewing the Summary of Benefits & Coverage, Schedule of Benefits and Insurance Policy
- Find an In-Network Provider in the neighborhood
- Update a Primary Care Provider (PCP)
- Track health care costs
- Print an ID Card
- Earn rewards!

Appeals and Complaints

If a member has a question about the plan, they can contact Customer Service at (855) 827-4448. If a member has a complaint, they can contact Customer Service or send the complaint in writing to:

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

Complete information about Appeals and Complaints is provided in the Insurance Policy located in the Member Hub. A member may also request a copy from Customer Service by calling (855) 827-4448.

Bright Health Insurance Policy

The Bright Health Insurance Policy includes important information that describes the plan. It explains the Benefits for health care services, as well as applicable plan terms, conditions, exclusions and limitations. Just to list a few, the Insurance Policy will help a member to understand:

- Plan Benefits, Exclusions and Limitations;
- Which Services Require Prior Authorization;
- Continuity of Care and Transition of Care
- How Bright Health contracts with providers and work with our providers to ensure delivery of top notch health care;
- How Emergency Care works within the plan;
- Rights and Responsibilities of a Bright Health Member;

- How to File a Claim;
- How to File a Complaint or an Appeal; and
- How the Prescription Drug Formulary works.

Members with Physical and Mental Disabilities

Bright Health Plan customer service representatives are available to assist members who have physical or mental disabilities, or other special needs. Special assistance is available for the hearing impaired with our TTY service. Information regarding this service is available in the Insurance Policy.

Non-English Speaking Members

Bright Health Plan is committed to addressing the needs of all covered persons. Our member service line provides direct support in both English and Spanish. Access for other languages is provided through a translation service. Our provider search website allows members to search by location, specialty and/or additional language spoken. This feature of our search functionality helps members to feel more comfortable with the physicians they select. Information regarding this service is available in the Insurance Policy.

Care Navigation

Bright Health Plan has a Care Navigation Unit to assist members requiring special health care services. Our Care Navigators can assist members in finding a primary care doctor or provide information regarding specialists and hospitals available to Bright Health Plan members. Members are nominated for Care Navigation based on clinical information received by Bright Health such as a recent hospital admission or Emergency Department usage.

Health Needs Assessment

Bright Health Plan continually collects and analyzes data from submitted member claims. This allows Bright Health Plan to assess the population health statistics pertaining to our members and, through internally developed procedures, determine the needs all of our members or view diverse populations. Bright Health Plan maintains a Quality Program to meet or exceed URAC Standards, state and federal regulations and statutes, loan agreement provisions, and policy provisions. The program consists of activities, policies and procedures to ensure the following:

- Maintaining the Quality Health Plan (QHP) status
- Achieving and maintaining URAC standards
- Ensuring compliance with Patient Protection and Affordable Care Act (PPACA) and State regulations, rules and legislation
- Ensuring quality of health plan services through ongoing assessment of performance monitored through Quality Assurance
- Identifying educational opportunities and process improvements to work towards reduction in medical errors
- Incorporating health and wellness initiatives to promote prevention, in addition to care for acute and chronic conditions
- Participating and integrating feedback from Quality programs and surveys in alignment with the PPACA, National Strategy for Quality Improvement in Health Care (NQS) and URAC

Bright Health Plan also provides oversight of delegated quality activities by performing the following:

- Annually review the Delegate's Quality program for:

- Behavioral healthcare aspects of the program
- Patient safety
- Serving a culturally and linguistically diverse membership
- Serving members with complex health needs (Complex Case Management, Disease Management)

Coordination and Continuity of Care

Coordination Activities

Contracts between Bright Health Plan and participating providers include provisions for continuity of care. The purpose of continuity of care is to ensure the coordination and continuity of health care during a member's transition between health care practitioners/providers, health care settings, or level of care. Continuity also applies to tests and procedures performed in the course of treatment.

Bright Health Plan's contracts also allows its members to receive services at network coverage levels for medical and behavioral conditions for a period of time in the event of Bright Health Plan's insolvency or other inabilities on its part or the part of its network partners to continue operations.

Primary care providers will assume the principal role of coordinating the care members receive in different settings, by different providers and through transitions in care. Primary care providers will request information from other treating providers as necessary to provide coordinated care for their patients.

Primary care providers will promote the diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care. Primary care providers should call or have the member call Member Services to determine if the facility or service requires prior authorization.

All providers will ensure that information is exchanged in an effective, timely and confidential manner between behavioral health care practitioners, medical/surgical specialists, community and social services and other relevant medical delivery systems. Exchange of information will occur in accordance with state and federal confidentiality laws. This requirement includes providers both internal and external to the network.

All providers will ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health and comply with prescribed treatments or regimens.

Bright Health Plan will share member information with other providers or insurers with which members may subsequently enroll or from which the member may seek care. Exchange of information will occur when requested by the member or employer and in accordance with state and federal confidentiality laws.

Continuity of Care

Continuity of Care allows members to receive services at Network coverage levels for specified medical and behavioral conditions for a defined period of time when their Network doctor, hospital, or Provider leaves our Network and there are strong clinical reasons preventing immediate transfer of care to another Network Provider. Members must apply for Continuity of Care within 30 days of their Network Provider leaving our Network. Requests will reviewed within 10 days of receipt; organ transplant requests will take longer.

If members are under the care of a Network Provider for one of the medical conditions below, and the Network Provider caring for them is terminated from the Network by us, we can arrange, at the member's request and subject to the Provider's agreement, for continuation of Covered Health Services rendered by the terminated Provider for the time periods shown below. Co-payments, Deductibles or other cost sharing components will be the same as the member would have paid for a Provider currently contracting with us.

Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Policy are:

- An Acute Condition or Serious Chronic Condition. Treatment by the terminated Provider may continue for up to 90 days.
- A high risk Pregnancy or a Pregnancy that has reached the second or third trimester. Treatment by the terminated Provider may continue until the postpartum services related to the delivery are completed.

This section does not apply to treatment by a Provider or Provider group whose contract with us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Changing Primary Care Providers

Bright Health members are able to choose a Primary Care Physician at the time of enrollment and change their Primary Care Physician once per calendar month. A Primary Care Physician can be changed by contacting Customer Service at (855) 827-4448, or a change can be made through the Member Hub.