Bright HealthCare™

Policies and Procedures

Out of Network Payment Policy

EFFECTIVE DATE January 1, 2022 - December 31, 2022

This policy does not and is not intended to detail all covered benefits offered by Bright HealthCare. In addition to the information included in this policy, Bright HealthCare reserves the right to apply its other standard coding and claims adjustment methodology to claims submitted by providers pursuant to this policy, including, without limitation, changes required or contemplated by the unique benefit design; standards required by law, regulation, or accreditation; industry standard reimbursement guidelines; and Bright HealthCare's provider manual. Providers must submit claims accurately to Bright HealthCare and ensure that such claims are properly coded for the treatment provided.

DEFINITIONS

1. **Benefit Plan** means a plan of health care benefits issued or administered by Bright HealthCare under which Members receive coverage for Covered Services.
2. **Billed Charges** means the gross billed or retail price for services provided by a health care services provider.
3. **Claim** means a request to receive payment for Covered Services rendered to a Member.
4. **CMS** means the Centers for Medicare and Medicaid Services.
5. **Commercial Benefit Plans** means benefit plans issued or administered by Bright HealthCare that are designed for purchase by individuals or groups and are not intended for government health programs such as Medicare, Medicaid, or the Children's Health Insurance Program.
6. **Covered Services** means medically necessary health care services and supplies for which a Member is entitled to coverage under a Benefit Plan.
7. **CPT/Healthcare Common Procedure Coding System (HCPCS) Codes** means the set of five (5) character codes that are used to identify tests, surgeries, evaluations, and any other medical procedure supplies, products and services performed or rendered by a healthcare Provider on a Member. CPT Codes are copyrighted and licensed by the American Medical Association ("AMA").
8. **Delegate** means a person or entity to which Bright has through a contractual arrangement, given the authority to carry out a function which Bright would otherwise perform itself.
9. **Emergency Services** means a medical screening exam (including routine ancillary services needed to evaluate someone's condition), further treatment to stabilize the Member, and post-stabilization services with an emergency medical condition.[1]
10. **Exchange Benefit Plans** means subsidized and unsubsidized benefit plans sold on the state and federal health insurance marketplaces established under the Affordable Care Act ("ACA") or sold through other channels created by subsequent legislation at the state or federal level intended to replace the ACA marketplaces.
11. **Extraordinary Circumstance** means circumstances beyond the control of the Provider. Such circumstances may include (but are not limited to) natural disasters (such as severe hurricane

[1] *45 CFR* §149.110

or flood) or issues with data-collection system that directly affect the ability of facilities to process, store, document and/or managed data.

12. **Hold Harmless** within the context of this policy generally means that providers are prohibited from balance billing patients, and that providers can collect no more than the applicable in-network cost-sharing amount from patients. Bright will work on behalf of its members to ensure providers are educated on compliant billing practices and members are held harmless when required under law.
13. **IFP Emergency Medical Services ("Emergency")** means a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.[2]
14. **Individual and Family Plans ("IFP")** means individual and family plans offered as an Exchange Benefit Plans and Off-Exchange Benefit Plans.
15. **MA Emergency Medical Services ("Emergency")** means covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and required to evaluate or stabilize an emergency medical condition.[3]
16. **Medicare** means the United States federal government health insurance program that subsidizes healthcare services.
17. **Medicare Advantage** (sometimes called Medicare Part C or MA) means a type of health insurance plan in the United States that provides Medicare benefits through a private-sector health insurer.
18. **Medicare Advantage ("MA") Benefit Plans** means benefit plans issued or administered by Bright HealthCare pursuant to the MA program.
19. **Medicare Rates** means reimbursement established by the Centers of Medicare and Medicaid Services (CMS) for specific services and supplies.
20. **Member** means an individual who is enrolled in a Bright HealthCare plan and eligible to receive benefits for Covered Services under a Benefit Plan.
21. **Member Expenses** means any amounts that are the Member's responsibility to pay for Covered Services pursuant to the Member's Benefit Plan, including without limitation co-payments, coinsurance, deductibles, and other cost-share amounts.
22. **Network Laboratory** means a participating laboratory in plan's network of laboratories that has a participation agreement in effect (either directly or indirectly) with Bright HealthCare.
23. **Network Participation Agreement** means the written contract entered into by Bright HealthCare and the Provider to furnish efficient, cost-effective, high-quality health care services to Members.
24. **No Surprises Act ("NSA")** as defined by the Consolidated Appropriations Act of 2021 (Pub. L 116-260) and its implementing regulations, prohibits balance billing in the case of emergent case and surprise medical bills — those for non-emergency services furnished by out-of-network providers during a visit by the patient at an in-network facility — unless the law's notice and consent requirements are met.
25. **Notice and Consent** means that a member has been given notice from the out-of-network provider about the estimated cost of a procedure or services and has provided consent to receive a bill(s) from the out-of-network provider or facility in compliance with the NSA.

[2] 45 CFR § 147.138(b)(4)(ii)
[3] 42 CFR § 422.113(b)(i-ii)

Members are protected against receiving bills and do not need to consent to receive services when getting care outlined in Sections I, II, and III of this policy.

26. **Off-Exchange Benefit Plans** means Commercial Benefit Plans that are eligible for sale in commercial individual and group markets.
27. **Out of Network (OON)** means Covered Services performed by a health care service provider not participating in Bright HealthCare's provider network.
28. **Out of Network (OON) Payment** means reimbursement for Covered Services performed by an out of network health care service provider. Payment may be based on one or a combination of UCR, Medicare rates, Single Case Agreement, Qualified Payment Amount, or industry acceptable RBP. Some states have regulations that govern how a health care benefit plan must reimburse an OON Provider. Payment may vary based on the commercial versus government line of business.[4]
29. **Out of Network (OON) Provider** means a Provider who has not entered into a Network Participation Agreement contract with Bright or its Delegates, agreeing to provide Covered Services to Members with the expectation of receiving payments less Member Expenses, directly from Bright or its Delegates.
30. **Prior Authorization ("PA")** also referred to as "prospective" or "pre-service" review**,** means a process by which the treating physician or other health care provider requests provisional approval from Bright HealthCare before rendering healthcare Covered Services or furnishing items to a member. This includes submission of clinical information prior to certain procedures, diagnostic studies, medical equipment, or medications for review by Bright HealthCare to confirm that the requested Covered services meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness. The member is not responsible for obtaining prior authorization, unless otherwise specified by law. Prior authorization does not guarantee payment by Bright HealthCare.[5]
31. **Provider** means any a medical group, individual physician, or other healthcare service provider who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.
32. **The Qualifying Payment Amount (QPA)** means the in-network median rate, negotiated with in-network providers and Bright HealthCare for the emergency service furnished, excluding any ***in-network*** copayment or coinsurance in-network median rate for a particular medical item or service furnished in a particular geographic region as of Jan. 31, 2019, or date acceptable to the applicable regulatory agency.[6] If there is an insufficient number of in-network rates for the item or service being billed, Bright HealthCare may use a credible third-party database to calculate the QPA.
33. **Reference Based Pricing ("RBP")** means reimbursement generated by a pricing tool based upon claims data from health insurance companies/third party administrators and maintains a database of rates used by payers to benchmark average UCR or its in-network median in a defined geographic area including the QPA as defined in the NSA.[7]
34. **Reimbursement Policy ("Policy")** means payment policy that governs how a specific procedure or service will be reimbursed.

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[4] *45 CFR § 147.138(b)(3)(i)(A)–(C)*
[5] MED-038 *Bright HealthCare Part C Medicare Advantage Out of Network Processes* Policy
[6] *45 CFR* §149.30
[7] *45 CFR* §149.30

35. **Small Group Plans** means health insurance plans that are established under the ACA under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer that may be purchased through a broker directly or may be offered on the state or federal health insurance marketplaces. Group size is state-specific. Generally, a small group is defined as under 50 full-time employees, except for a few states whose requirements are under 99 full-time employees.[8]
36. **Single Case Agreement** means an agreement with a Provider for reimbursement for a specific, approved Covered Service(s) for a specific, Bright HealthCare Member(s).
37. **Usual, Customary and Reasonable ("UCR")** means reasonable and recognized reimbursement allowed amounts established by state or federal rules for a Covered and approved (if applicable) OON service(s) for the same services by providers or facilities within the same geographic areas or region.[9]

PURPOSE

To set forth and establish a policy for Covered Services performed by an OON Provider based on the Member's health care Benefit Plan.

SCOPE

This policy and procedure apply to all Bright HealthCare departments, staff, and delegates under contract with Bright HealthCare to support Bright HealthCare's Commercial Plans, Individual and Family Plans (IFP), Small Group Plans (SG), and Medicare Advantage Plans (MA). This policy further applies to Bright HealthCare and all its affiliates, Providers, all Benefit Plans, and Bright HealthCare members. This policy is a part of Bright HealthCare's Program Requirements.

Notwithstanding the foregoing, in the event that this policy conflicts with Centers for Medicare and Medicaid Services (CMS) Medicare Advantage Organization (MAO) guidance and requirements, CMS/MAO guidelines will prevail for the Medicare Advantage Plans only.

Before applying this policy, please refer to the Member Benefit Plan document and any federal or state mandates, if applicable. If there is a difference between this policy and the Member specific plan document, the Member benefit plan document will govern.

POLICY[10]

Bright HealthCare follows state and federal laws and regulation in remitting OON Payments.[11]

[8] 45 CFR § 149.30 Propose 45 CFR 146.145 Special rules related to group health plans
[9] *Health Insurance Marketplace,* https://www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/ (accessed 04 November 2020).
[10] NET-007 and NET-008 Bright Health Out of Network Services, Policy
[11] Please see sate specific regulations in References/Citations Section

OON Covered Services for Members are provided by certain health care Benefit Plans administered or insured by affiliates of Bright HealthCare. It is Bright HealthCare's policy to disallow payment for OON rendered services (other than Emergency Care) without Prior Authorization unless the Member is entitled to coverage for such services in accordance with the Benefit Plan or applicable law. Reimbursement is subject to the terms of the Member's Benefit Plan. The OON Provider will receive the lesser of the OON Payment or Billed Charges unless otherwise specified by state or federal law.

When a Benefit Plan does not have OON benefits, claims will be denied, with the exception of the following: i) emergency room visit and/or an appropriate emergency admission or observation at an OON facility; ii) an approved prior authorization for an OON Provider or facility; iii) execution of an OON Single Case Agreement for approved Covered Services, between Bright HealthCare and the health care services provider; or iv) as required by law.[12] Single Case Agreements are contingent upon an approved Prior Authorization.

PROCEDURES[13]

I. Emergency Services[14]

Members should not receive surprise medical bills for emergency services from the point of evaluation and treatment until they are stabilized and can consent to being transferred to an in-network facility.

Protections will apply whether the emergency services are received at an out-of-network facility (including any facility fees) or provided by an out-of-network emergency physician or other provider at either an in-network or out-of-network facility. These protections also apply to independent freestanding emergency departments and urgent care centers if that urgent care center is specifically licensed by the state to provide emergency care and appropriately renders and bills for such emergency services.

Bright HealthCare will provide benefits for OON emergency services in an amount at least equal to the following unless otherwise prescribed by state law:

- Qualified Payment Amount. In determining the median, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this paragraph is disregarded.
- The amount for the emergency service calculated according to Bright HealthCare's Usual, Customary, and Reasonable amount, excluding any ***in-network*** copayment or coinsurance.

Any cost-sharing requirement for OON emergency services will not exceed the cost-sharing requirement if the services were provided in-network. However, a Member may be required to

[12] 45 CFR 149.110
[13] NET-007 and NET-008 Bright Health Out of Network Services, Policy
[14] *45 CFR §149.30*

pay, in addition to the in-network cost-sharing, the excess of the amount the OON provider charges over the amount issuer is required to pay[15]. Deductible and/or out-of-pocket maximum amounts may be imposed with respect to emergency services provided OON if the cost-sharing requirement generally applies to OON benefits. A deductible may be imposed with respect to OON emergency services only as part of a deductible that generally applies to OON benefits. If an out-of-pocket maximum generally applies to OON benefits, that out-of-pocket maximum must apply to OON emergency services[16].

PLEASE NOTE: These minimum payment standards do not apply in cases where state or federal law prohibit a Member from being required to pay, in addition to the in-network cost sharing, the excess of the amount the OON provider charges over the amount the issuer provides in benefits[17]. Please reference state specific appendices to determine if state law supersedes.

II. Post Stabilization Services[18]

Post-stabilization services are considered emergency services subject to surprise billing protections, unless all certain conditions regarding member consent are met (see below section on consent). These services fall under the NSA regardless of where in a hospital such services are furnished; they may be provided as part of outpatient observation or an inpatient or outpatient stay if provided together with emergency services.

III. Non-Emergency Services[19]

Members cannot be balance billed for certain non-emergency services provided by an out-of-network provider at an in-network health care facility. Health care facilities include hospitals, hospital outpatient departments, and ambulatory surgical centers. Members cannot be billed for Ancillary services provided during a visit:

- Radiology, Anesthesiology, Pathology, Physician at an INN facility whether provided by physician or non-physician
- Items provided by nonparticipating provider if no participating provider is available at the facility
- Services furnished as the result of an unforeseen need

Out-of-network providers that perform nonemergency services at an in-network facility must inform insurers, as part of their submission of a claim, that the item or service that they provided was furnished during a visit to an in-network facility.

IV. Unauthorized Non-Emergent OON Laboratory Care

Generally, unauthorized non-emergent out of network laboratory services will be denied as non-participating unless otherwise required by state or federal law. The COVID-19 laboratory services

[15] *45 CFR § 147.138(b)(3)(i)*
[16] *45 CFR § 147.138(b)(3)(ii)*
[17] *45 CFR § 147.138(b)(3)(iii)(A)*
[18] 45 CFR 149.110
[19] 45 CFR 149.110

will be handled in accordance with Bright HealthCare's COVID-19 policy, which is consistent with the national public health emergency declaration guidance for these allowances.[20] Non-emergent laboratory testing outside of the in-office laboratory testing must be performed at a participating lab according to Bright HealthCare policies including the In-office Laboratory policy.[21] Participating labs are found in the BrightCare Health Provider Directory.[22]

V. Other Services

The prohibitions on balance billing do not apply if certain notice is provided to the patient and the patient waives the balance billing protections with respect to the particular out-of-network provider. Notwithstanding the foregoing, there are certain ancillary providers that are prohibited from securing member consent/waivers.[23]

OON Providers must inform plans and insurers when a patient consents to OON care (and thus a potential balance bill). We need this information to accurately calculate cost sharing, apply this cost sharing to deductibles and out-of-pocket limits, and make an appropriate payment to the provider or facility.

VI. Air Ambulance[24]

If Bright HealthCare provides or covers any benefits for air ambulance services, Bright HealthCare will cover such services from a nonparticipating air ambulance provider. The cost-sharing requirements must be the same requirements that would apply if the services were provided in-network and be calculated as if the total amount that would have been charged for the services by a participating air ambulance provider.

VII. Payment Policy for Individual and Family Plans and Small Group Plans[25]

Bright HealthCare has established OON Payment rates (except in cases where a Single Case Agreement or other OON agreement is entered into by and between Bright HealthCare and the OON Provider) for authorized or Emergency services performed by an OON Provider as defined in this Policy, including RBP for the specific services and geographical area or region where the servicers were performed. The OON Provider will receive the lesser of the OON Payment or Billed Charges.

A. Unless otherwise prescribed by state regulations[26], Claims submitted for Emergency OON services will be reimbursed at the appropriate OON Payment methodology less Member Expenses. Bright HealthCare will provide benefits for OON Emergency

[20] Net-020 COVID-19 Policy

[21] NET-021In-Office Laboratory Testing Payment Policy

[22] Bright Health Provider Directory https://brighthealthcare.com/search

[23] 45 C.F.R. § 149.420(b)

[24] 45 CFR §149.130

[25] NET-007 and NET-008 Bright Health Out of Network Services, Policy

[26] Please see sate specific regulations in References/Citations Section

Services, and OON provider will receive the lesser of the QPA or UCR of Billed Charges.[27]

B. Absent extraordinary circumstances, a Claim submitted for non-emergent OON services that lacks a PA for a Member lacking OON coverage will be denied for payment.

C. A non-emergent Claim submitted for a Member with appropriate coverage for non-emergent OON services will be reimbursed at the appropriate OON Payment Methodology. The OON Provider will receive the lesser of the OON Payment or Billed Charges.

D. Reimbursement for OON Urgent Care services shall not exceed a specific per visit dollar amount set by Bright Health annually, unless otherwise required by state or federal law.

E. In addition to the information included in this policy, Bright HealthCare reserves the right to apply its other standard coding and claims adjustment methodology to claims submitted by providers pursuant to this policy, including, without limitation, changes required or contemplated by the unique benefit design; standards required by state or federal law, regulation, or accreditation; industry standard reimbursement guidelines including CMS coding and billing guidelines; and Bright HealthCare's provider manual.

VIII. Payment Policy for Medicare Advantage

If a Member is covered by Bright HealthCare's Medicare Advantage health care benefits and receives care from an OON health care services provider, Bright HealthCare will reimburse Covered Services at 100% of the Original Medicare fee-for-service allowable rate for Emergency and authorized services. Claim payments will be in accordance with the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage Organization (MAO) guidance and requirements.[28] [29] [30]

REFERENCES/CITATIONS

45 CFR § 147.138(b)(4)(ii)
42 CFR § 422.113(b)(i-ii)
45 C.F.R. § 147.138(b)(3)(i)(A)–(C)
NET-007 *Bright HealthCare Out of Network Services*, Policy
NET-008 *Bright HealthCare Out of Network Services*, Policy
MED-024 *Bright HealthCare Out of Network Exceptions*, Policy

[27] 45 CFR §149.30
[28] Medicare Managed Care Manual, Chapter 4, section 110.1.3 – Service for Which MA Plans Must Non-Contracted Providers and suppliers
[29] Medicare Managed Care Manual, Chapter 6, section(s) 10 – Introduction and 100 – Special Rules for Service Furnished by Non-Contract Providers
[30] Medicare Managed Care Manual, Chapter 11, section100.2 – Other Provisions of the MA Contract

MED-035 *Bright HealthCare Part C Medicare Advantage Emergency, Urgent, and Post Stabilization Services policy*, Policy
MED-038 *Bright HealthCare Part C Medicare Advantage Out of Network Processes* Policy
MED-079 *Bright HealthCare Emergency Services and Post Stabilization Services Coverage*
Ariz. Admin. Code R20-6-1902.
Ariz. Rev. Stat. Ann. § 20-3115(K)
Ariz. Rev. Stat. Ann. § 20-3115(S)
Colo. Rev. Stat. Ann. § 10-16-704(5.5)(a)(V)
Colo. Rev. Stat. Ann. § 10-16-704(3)(d)(II) & (V)
Colo. Rev. Stat. Ann. § 10-16-704(5.5)(b)(I)
Colo. Rev. Stat. Ann. § 10-16-704(5.5)(b)(II)
Colo. Rev. Stat. Ann. § 10-16-704(5.5)(b)(III)
Colo. Rev. Stat. Ann. § 10-16-704(5.5)(c)
Colo. Rev. Stat. Ann. § 10-16-704(5.5)(d); Stat. Ann. § 10-16-704(15)
https://doi.colorado.gov/announcements/notice-of-adoption-of-emergency-regulation-21-e-11-concerning-coverage-and
https://doi.colorado.gov/announcements/notice-of-adoption-of-emergency-regulation-21-e-11-concerning-coverage-and
Fla. Stat. Ann. § 627.6472(9)
Fla. Stat. Ann. § 627.64194(2)
Fla. Stat. Ann. § 627.64194(3)
Fla. Stat. Ann. § 627.64194(4)
Stat. Ann. § 408.7057. Fla. Stat. Ann. §§ 627.64194(6)
IL- *215 Ill. Comp. Stat. Ann. § 5/356z.3a(b)-(d), (f)*
N.C. Gen. Stat. Ann. § 58-3-190(a)–(b), (d)
N.C. Gen. Stat. Ann. § 58-3-190(a)–(b), (d)
Neb. Rev. Stat. Ann. § 44-7105(1)(a)
https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerFactSheetBalanceBillingandOutofNetworkProviders.pdf
California State Regulations:
§1371.31(a)(3)(E)
1300.71.31(f)
§1371.9(a)(1-4)
§1371.9(b)
§1371.31(b)
§1371.31(d)(1)
§1371.31(f)
§1371.9(c)
§1371.9(e)
§1371.31(a)(1)
1300.71.31(b)
1300.71.31(c)(1-5)
1300.71.31.(e)
Rule 1300.71.31(c)(6-7)
§1371.31(a)(2)
Georgia State Regulations:
Rule 120-2-106-.03

Rule 120-2-106-.05
Rule 120-2-106-.06
Rule 120-2-106-.11
Rule 120-2-106-.07
Rule 120-2-106-.07
Rule 120-2-106-.10

Texas State Regulations:
Tex. Ins. Code § 1301.155(b)
Tex. Ins. Code § 1301.155(c)
Tex. Ins. Code § 1301.155(d)
Tex. Ins. Code § 1301.154
Tex. Ins. Code § 1301.153(c)
Tex. Ins. Code § 1301.005(b)
28 TAC § 3.3708(a)
28 TAC § 3.3708(b)
28 TAC § 3.3708(c)
28 TAC § 3.3708(d)
Tex. Ins. Code § 1301.164(b)
Tex. Ins. Code § 1301.164(c)
Tex. Ins. Code § 1301.165(b)
Tex. Ins. Code § 1301.165(c)
Tex. Ins. Code § 1301.0052(a)
Tex. Ins. Code § 1301.0053(a)
Tex. Ins. Code § 1301.0053(b)
28 TAC § 3.3725(a-f)

Utah State Regulations:
29 CFR Sec. 2590.715-719A8
Utah Code Ann. § 31A-22-627(1)
29 CFR §2590.715-719A(b)(3)(i)(A)-(B)
Utah Code Ann. § 31A-22-627(1)
29 CFR §2590.715-719A(b)(3)(i)
Utah Code Ann. § 31A-22-627(1)
29 CFR §2590.715-719A(b)(3)(ii)
Utah Code Ann. § 31A-45-401(2)
Utah Code Ann. § 31A-45-401(3)
Utah Code Ann. § 31A-45-501(2), (4)(a) and (5)(a)
Utah Code Ann. § 31A-45-501(3), (4)(b) and (5)(b)

Virginia State Regulations:
§ 38.2-3445.01
§ 38.2-3445.2
§ 38.2-3407.3
§ 6.2-301
§ 38.2-3445.02
§ 38.2-218
26 U.S.C. § 223(c)(2)

EXHIBITS/ATTACHMENTS
None

POLICY HISTORY
Initial Approval Date: November 20, 2020
Version 2, Approval Date: September 23, 2021
Version 3, Approval Date: February 24, 2022
Version 4, Approval Date: March 10, 2022

AUTHORIZATION
The following signatory is duly authorized to approve and sign this policy and supporting procedures on behalf of Bright HealthCare and its affiliates.