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Network Access Plan

Bright Health Plan 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 Plan providers must pass a URAC approved credentialing process. The provider must either be part of our Care Partner's network or they must fill a gap in that network.

1. Acces to Service/Waiting Time Standards

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care-Routine symptoms non- urgent, routine Behavioral Health care	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to afterhours care	Office number answered 24 hrs./ 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care-non urgent	Within 60 calendar days	Met ≥ 90% of the time

2. Availability Standards

Provider/Facility Type	Large Metro	Metro	Micro
Primary Care to members	1:1000	1:1000	1:1000
Pediatricians to members	1:1000	1:1000	1:1000
OB/GYN to members	1:1000	1:1000	1:1000

Behavioral Health Providers to members	1:1000	1:1000	1:1000

3. Geographic Access Standards

Speciality	Large Metro Maximum Distance (miles)	Metro Maximum Distance (miles)	Micro Maximum Distance (miles)	Rural Maximum Distance (miles)	CEAC Maximum Distance (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
29-Jan-16					
Cardiothoracic Surgery	15	40	75	90	130
Cardiovascular Disease	10	20	35	60	85
Chiropracty	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85

Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation/Radiation Oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physiatry, Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER	15	40	75	90	130

4. Referral Policy

Bright Health Plan does not require referrals for specialist care when a member is seeking care from an In-Network or Participating specialist.

Most health care specialty services are available within Bright Health Plan's network. In some instance, Brigth Health Plan'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 coordinate care with an out of network provider who or which can give the necessary care.

5. Ongoing Monitoring

Brigth Health Plan conducts regular audits of provider availability by state/market. These audits utilize available software such as GEO Access and use CMS established standards to ensure that there are consistently a sufficient number of participating health care professionals in every member's immediate area.

6. Needs of Special Populations

Members with Physical and Mental Disabilities
Brigth 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.

Non-English Speaking Members
Brigth 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.

7. Health Needs Assessment

Brigth Health Plan continually collects and analyzes data from submitted member claims. This allows Brigth 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. Brigth 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

Brigth 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)

8. Communication with Members

Brigth Health Plan communicates with Members in a variety of ways, including: newsletters, emails, a welcome kit, and Brigth Health Plan's Web site and member portal.

Customer Service
Brigth Health Plan customer service representatives are available to assist members in understanding their plan, finding a provider, and addressing any concerns that the member may have.

Care Navigation
Brigth Health Plan has also implemented 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 Brigth Health Plan members.

Member Concerns
Brigth Health Plan has processes through which members can express dissatisfaction with the Brigth Health Plan'sand/or network providers' services, and appeal adverse determinations. The processes are designed to address and resolve members' concerns in a manner that is timely, fair, thorough, and to meet all regulatory requirements. These processes are explained in the evidence/certificate of coverage document provided to members.

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Any member wishing to express or submit an inquiry, complaint, grievance, or appeal may do so at any time and Brigth Health Plan will handle them accordingly.

Plans Services and Features
Brigth Health Plan will provide all members with access to the appropriate Summaries of Benefits and Coverage (SBC) and the Colorado Supplement to the Summary of Benefits and Coverage (COSBC) in an electronic format. Upon request, members will be provided a hard copy of both documents.

In addition to making all SBCs and COSBCs available online, Brigth Health Plan will provide hard copies of the appropriate SBC and corresponding COSBC as described below:

- as part of every enrollment packet that is delivered in hard copy, which will be provided no later than the first date on which the employee is eligible to enroll for coverage for the employee or dependent;
- within seven (7) business days of a potential policyholder expressing interest in a particular plan or such plan being selected as a finalist from which the ultimate selection will be made;
- within seven (7) business days, of a oral or written request from any person who is interested in or covered by a Brigth Health Plan plan;
- within seven (7) business days of a oral or written request from any person who is interested in or covered by a Brigth Health Plan plan;
- within seven (7) business days of a oral or written request from a producer on behalf of any person, group, association, or health care cooperative who is interested or covered by a Brigth Health Plan plan;
- as part of the Company's renewal packet, no later than seven (7) business days after issuance of the new policy or the receipt of written confirmation of intent to renew, whichever is earlier;
- within seven (7) business days following receipt of the group application; and
- no later than the first day of coverage if there were any change in the information between the application for coverage and the first day of coverage.

9. Coordination Activities

Contracts between Brigth 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.

Brigth 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 Brigth 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.

Brigth 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.

10. 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.