Bright HealthCare™ 2022 Provider Manual

Individual & Family Plans and Small Group

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Welcome to Bright HealthCare!

This manual outlines key program requirements for Bright HealthCare's commercial (Individual & Family) and Small Group plans. Program requirements are protocols, payment policies, and other administrative regulations that define Bright HealthCare's business requirements for network providers. For a more specific definition of program requirements, please refer to your Network Participation Agreement. Additional program requirements can be found in other Bright HealthCare policy documents provided separately from this manual. For information on Bright HealthCare's commercial plans, please refer to **Availity.com**. Log in using your credentials provided when you completed registration for Availity.

We're building partnerships

Bright HealthCare strives to partner with providers who share our passion of elevating primary care.

We help your patients improve their health

Our plans encourage preventive care, which leads to healthier, more highly-engaged patients.

We're here to support your community

We know that every community has different needs. That's why we're committed to working with you to develop community-specific healthcare solutions.

We tailor our partnership to fit your needs

Our vision

Collaborating with Care Partners to make healthcare simpler, personal, and more affordable.

Our mission

Making healthcare right. Together.

Our values

Be: Purposeful, Respectful, Authentic, Brave and Positive

Updates and revisions

This provider manual is a dynamic tool and will evolve with Bright HealthCare. Written communication will accompany any material changes made to this manual.

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Section One:
Provider Roles and Expectations

Provider rights

Providers have the right to freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Provider roles and responsibilities

- Confirm member eligibility and benefits prior to rendering services
- Confirm any limitations, exceptions, and/or benefit exclusions applicable to Bright HealthCare members
- Cooperate with Bright HealthCare's Case Management and Utilization Management Programs
- Where applicable, obtain prior authorization before rendering services
- Communicate member information to Bright HealthCare, as appropriate under HIPAA
- Maintain confidentiality of medical information in compliance with all state and federal regulatory agencies, including HIPAA
- Maintain legible and comprehensive medical records for each member encounter that conform to documentation standards for at least ten years or applicable federal or state law, whichever is longer
- Provide Bright HealthCare with advance notice of providers joining or leaving their practice, as described in the applicable Network Participation Agreement
- Cooperate with Bright HealthCare to achieve effective and efficient discharge, post-discharge, and follow up procedures for members
- Cooperate with Bright HealthCare in investigating and resolving member grievances and appeals
- Comply with Bright HealthCare credentialing requirements, including state credentialing application with CAQH
- Follow the billing guidelines provided in the Claims & Provider Reimbursement section or risk delayed or denied payments
- Follow rules for requesting reconsideration of claims payment decisions and for resolution of overpayments and underpayments
- Refer members to Bright HealthCare in-network providers
- Adhere to the applicable standards of care, professional code of conduct, and facility accreditation and quality standards
- Report any potential fraud, waste, and abuse
- Update Bright HealthCare when there are changes to provider demographic and billing information
- Conduct an audit of provider demographic and billing information in accordance with your Network Participation Agreement

- Comply with all state laws, rules, and regulations as well as all other applicable laws and regulations

Rights in the case of disruptive member behavior

If, after reasonable effort, the member's primary care provider (PCP) or any other contracted provider is unable to establish and maintain a satisfactory relationship with a patient and member of Bright HealthCare, the provider may request that the member be discharged from care and transferred to an alternate network provider. The PCP must submit the request in writing to Bright HealthCare Member Services. Please refer to Appendix 1 for contact information. Reasons for discharge may include but are not limited to:

- Disruptive behavior
- Physical threats
- Physical abuse and verbal abuse
- Gross non-compliance with the treatment plan

Note: Physical abuse and other behavior that is a danger to the physician or the member warrants immediate action, which must be documented. Please notify the proper law enforcement authorities immediately and notify Bright HealthCare Member Services.

Note: The PCP must provide adequate documentation in the member's medical record of the verbal and written warnings. In the absence of an emergency created by abusive member behavior, the provider is obligated to provide care to the member until it is determined that the member is under the care of another physician.

Using Availity.com

Bright HealthCare uses **Availity.com**, a secure multi-payer platform, to facilitate key electronic transactions and share information. Providers can register for an account directly from Availity.

Once registered, log into your account to:

- Verify member eligibility and benefits
- File claims electronically
- Check claims status and electronic remittance
- Submit and track prior authorizations
- Access key information and documents from the **Bright HealthCare Payer Spaces** tab
- Locate prior authorization lists, forms, and instructions
- View Certificates of Coverage (COCs) and Summaries of Benefits and Coverage (SBCs)
- Locate the Quick Reference Guide
- Find a copy of this Provider Manual
- Access Bright HealthCare news, tools, and resources

Using InstaMed

(For providers in California, Georgia, Texas, Utah, and Virginia or for providers who see patients in both the Medicare and Individual & Family Plan line of business, this should only be used for Medicare patients).

Bright Healthcare will offer electronic payment to its provider network. Bright is working with InstaMed to deliver claim payments via electronic remittance advice (ERA) and EFT. ERA/EFT is a convenient, paperless, and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN Reassociate Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

Additional benefits of ERA/EFT include:

- Accelerated access to funds with direct deposit into your existing bank account
- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow- there is an option to have ERAs routed to your existing clearinghouse

To expediate payment, you can sign up for InstaMed Payer Payments today. Just visit **instamed.com/eraeft**. Even if you are already enrolled with InstaMed, make sure InstaMed has added Bright to your profile (Payor ID BRGHT)

Credentialing process

Bright HealthCare is dedicated to providing our members with access to high-quality, affordable healthcare. Credentialing ensures that our members have access to providers who demonstrate consistent delivery of high-quality care. Credentialing for Bright HealthCare's provider networks is performed by Bright HealthCare personnel or is delegated, as applicable.

Bright HealthCare utilizes the state-mandated Professional Credentials Application for gathering data about providers for initial credentialing and every 36 months thereafter for recredentialing purposes. Providers should file applications with the Council for Affordable Quality Healthcare (CAQH) to streamline the credentialing process. Bright HealthCare utilizes a Credentialing Verification Organization (CVO) vendor, Aperture Credentialing, LLC, to access CAQH application information and conduct primary source verification of provider credentials. Providers may be contacted by Aperture on behalf of Bright HealthCare.

For more information about Bright HealthCare's credentialing process, please visit **BrightHealthCare.com/provider/resource/credentialing.**

Provider credentialing

Providers should ensure that their CAQH profile has a current attestation within the last 180 days and that they have authorized Bright HealthCare to access their application. Providers can go to **CAQH.org/solutions/caqh-proview-faqs** for detailed information on how to obtain a CAQH number and how to create or edit their application.

Bright HealthCare credentials providers who are licensed, certified or registered by the state to practice independently without direction or supervision. Per our policy these are **examples** of Providers to be credentialed and re-credentialed under the scope of our policies and URAC requirements.

Medical:

- Allopathic Physician of Medicine and Surgery (MD)
- Osteopathic Physician of Medicine and Surgery (DO)
- Doctor of Dentistry (DDS)
- Doctor of Medical Dentistry (DMD)
- Doctor of Optometry (OD)

Allied Health Professionals:

- Physician Assistant
- Clinical Psychologist (Ph.D.)
- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Midwife (CNM)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage Family Therapist (LMFT)
- Physical/Occupational Therapist (PT/OT)

Facility credentialing

We do not require facilities applying for participation with Bright HealthCare to use CAQH. Instead, facilities should complete and submit Bright HealthCare's Facility Credentialing Application. Please contact Bright HealthCare to obtain the application, which also includes a detailed list of the specific types of facilities that Bright HealthCare credentials. Bright HealthCare collects Facility Credentialing Applications on an individual Tax Identification Number (TIN) level. As part of the application, the facility entity is required to submit copies of the following items:

- Current and valid state license
- Certifications and Accreditation Certificates

  Note: If unaccredited, include a copy of the most recent CMS Survey or State Survey indicating the facility is in substantial compliance (include the Corrective Action Plan and Approval Letter, if applicable)
- Declaration sheet and certificate of insurance
- Current professional malpractice
- Comprehensive general liability insurance policies
- Copy of Medicare Participation Number/CMS Certification Number (CCN)
- Signed and dated complete attestation

A facility only needs to submit one copy of each required attachment for all locations that use the associated TIN, unless one of the locations differs (i.e., one location has separate insurance from other locations). For each separate location, include additional state license(s), accreditation(s) and certificates of insurance for each Group NPI associated with the TIN.

If you have any further questions, please contact us at **FacilityCredentialing@BrightHealthGroup.com**

Post-application collection

For both professional and facility applicants, following successful application collection and primary source verification, Bright HealthCare's Credentialing Committee makes the final determination on whether a provider will be added to Bright HealthCare's network.

Bright HealthCare retains the right to approve, suspend, or terminate individual physicians, healthcare professionals, or where it has delegated credentialing decision making. Submission of a credentialing application and required documentation does not guarantee inclusion in Bright HealthCare's network(s). Each applicant will receive a written response regarding the Credentialing Committee's decision, sent within 10 business days of the Committee review date.

Bright HealthCare conducts regular reviews to verify the credentials of network providers. This process includes, but is not limited to, monthly monitoring of the Medicare and Medicaid sanctions, state sanctions and limitations on licensure, and complaints. We use the Office of Inspector General (OIG) published sanction lists and National Practitioner Data Bank (NPDB), among other sources.

Bright HealthCare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or any other identifier protected by state or federal law, the types of procedures the applicant performs, or the patients for whom the provider renders services. This does not preclude Bright HealthCare from including providers in our network who meet certain demographic or specialty needs to fulfill the cultural needs of our members.

For more information

If you are unsure of your credentialing status or have questions about the credentialing process, please contact Bright HealthCare Credentialing at **Credentialing@BrightHealthPlan.com** or **FacilityCredentialing@BrightHealthGroup.com,** or refer to Appendix 1 for additional contact information.

For more information about Bright HealthCare's credentialing process, please visit **BrightHealthCare.com/provider/resource/credentialing.**

Credentialing requirements

Bright HealthCare requires all providers being directly credentialed to submit a fully completed credentialing application. Submit the required documentation listed below to CAQH.

Note: Providers delegated for credentialing by Bright HealthCare will be directly credentialed by their respective delegated entity and should submit applications through that entity's preferred process.

Professional application requirements

Professional credentialing applications, whether directly credentialed or delegated by Bright HealthCare, must contain the following elements:

- **State license:** A current, valid, and unrestricted license to practice in the state in which the provider will treat Bright HealthCare members
- **DEA/CDS:** For prescribing providers, a current and unrestricted Drug Enforcement Administration (DEA) registration and/or CDS certification from each state in which the provider treats Bright HealthCare members, if applicable.
  A copy of the DEA/CDS certificate must include effective and expiration dates
- **Education and training:** Graduation from an accredited medical school or accredited profession training program, internship, residency training program, and any applicable fellowships
- **Board certification:** Board certification is recommended for all physicians to participate in Bright HealthCare's provider network
    - Individual exceptions may apply, if explained and approved
- **Certificate of current malpractice insurance:** Malpractice insurance must be current with acceptable minimum amounts. Providers must provide a cover sheet with the effective dates, covered amounts indicated, and their name
- **Malpractice history:** A list of all liability claims history, including details for any claims within the last ten years

- **Hospital affiliations:** A listing of hospital affiliations and privileges, if applicable
- **Work history (N/A for recredentialing):** A chronological, relevant work history for at least the past five years, including month and year
    - All gaps of six months or more must be explained by the provider in writing
    - If the provider has practiced for fewer than five years, professional work history starts at the time of initial licensure
- **History of state and federal sanctions:** A listing of all sanctions or penalties imposed by licensing boards, government entities, and managed care organizations, along with a written explanation for each
- **Additional disclosures:** Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the provider's ability to provide care according to accepted standards of professional performance or that poses a threat to the health or safety of patients
- **Attestations:** Providers must sign and date a statement attesting that the information submitted within the credentialing application is complete and accurate to the provider's knowledge. The provider must additionally sign and authorize Bright HealthCare to collect any information necessary to verify the information within the credentialing or recredentialing application

The application is required for both initial credentialing and recredentialing. It also contains questions regarding:

- Reasons for inability to perform the essential functions of the position
- Lack of present illegal drug use
- History of loss of license
- License sanctions
- Disciplinary actions or felony convictions
- History of loss or limitation of clinical privileges
- Current malpractice insurance

Recredentialing requirements

The recredentialing process takes place at least every 36 months for both professionals and facilities. For professionals, the provider credentialing application is required each time. A previously completed copy may be submitted with any updates or changes noted but must include an updated attestation. The credentialing requirements listed above are reviewed and verified with each application submission. The Credentialing Committee may also incorporate the following information into the recredentialing decision making process:

- Member grievances
- Provider complaints
- Quality of care concerns
- Monthly monitoring activities
- Provider office site quality issues
- Medical malpractice actions

Ongoing provider monitoring

Bright HealthCare monitors, identifies, and when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing and recredentialing.

For providers that Bright HealthCare directly credentials, Bright HealthCare will review reports monthly including:

- Medicare/Medicaid sanctions
- Monitoring of Medicare opt-out
- Sanctions or limitations on licensure
- Provider adverse events
- Member complaints
- Access and Availability

Substantiated complaints or identified issues will be incorporated in the provider's credentialing file and will be considered at the time of recredentialing.

When Bright HealthCare identifies such issues, we will make a determination if there is evidence of poor quality that could affect the health and safety of members, and depending on the nature of the event, implement appropriate interventions.

If a provider is suspended or terminated due to reasons that qualify as reportable under state and federal regulations, Bright HealthCare will report such actions to the appropriate regulatory bodies. Bright HealthCare does not report administrative terminations based on failure to meet contractual obligations for participation in the network.

As required in their Network Participation Agreements, network providers must report any of the adverse events described above to Bright HealthCare as soon as reasonably possible, and in any event within the time limits outlined in the Network Participation Agreement.

For provider entities to which credentialing and recredentialing activities are delegated on Bright HealthCare's behalf, the provider entity will provide ongoing monitoring and reporting of such monitoring to Bright HealthCare. Monitoring under this section shall include monitoring of any adverse or formal actions against a provider, including actions by CMS, any state agency, or any licensing or accreditation body. Monitoring under this section shall additionally include monitoring for complaints against a provider, even to the extent that such complaint does not result in formal action against the provider. Monitoring procedures must ensure that any complaint or action against a provider is reviewed within 30 days of its release.

Provider rights regarding credentialing

Each applicant seeking credentialing through Bright HealthCare has the right to:

- Receive the status of their credentialing or recredentialing application upon request
- Request to review information submitted to support their credentialing application
- Correct erroneous information provided for credentialing by phone or in writing (refer to Appendix 1 for contact information)

If any information obtained through the credentialing verification process is found to be significantly disparate from the information provided by the provider, the applicant will be contacted by the Bright HealthCare credentialing team to provide an opportunity to explain the discrepancy prior to making a negative credentialing decision. The provider may not review references, recommendations, or other information that is protected under the law or through peer review privilege, and Bright HealthCare is not required to reveal the source of information or other details if the law prohibits disclosure. Upon request, the provider can contact the Credentialing Department to inquire about the status of their application, including the date Bright HealthCare received the application, the date the application went into process, or the date that we mailed the determination letter.

Provider rights regarding credentialing are detailed fully in the Bright HealthCare Policy and Procedure Provider Credentialing Guidelines.

Provider appeal rights and fair hearing plan

Bright HealthCare makes every effort to ensure providers are treated fairly. Bright HealthCare has a well-defined appeal process regarding provider appeal rights for negative credentialing or recredentialing decisions and provider appeal rights in the case of suspensions, terminations, or other change in participation in the Bright HealthCare network.

- For initial credentialing determination appeals, send a formal appeal letter in writing to:

  Bright HealthCare Credentialing
  777 NW Blue Pkwy Suite 3350
  Lee's Summit, MO 64086

- All written requests must be received within 30 days of the date the notification letters were sent
- Notification of appeal should include additional supporting documentation in favor of the applicant's reconsideration for network participation
- Reconsideration/appeal with additional information will be reviewed by Bright HealthCare's Senior Medical Director (or independent participating provider designee) at a Credentialing Committee within 60 calendar days of receipt of written appeal
- Bright HealthCare will inform the provider of a specific date when the hearing is scheduled
- We will notify the provider of the decision within 10 days of the reconsideration/appeal decision
- If the initial decision of denial of participation is upheld, then the provider may not apply for participation in Bright HealthCare's network earlier than 12 months from the final reconsideration/appeal decision date. These rights are fully detailed in the Bright HealthCare's Policy and Procedure for Fair Hearing Plan. You may request a copy of this document by contacting Bright HealthCare Provider Services. Refer to Appendix 1 for contact information.

Disputes Concerning Professional Competence or Conduct

Bright HealthCare implements a mechanism to resolve disputes with participating providers that relate to the participating provider's status within the provider network and any action by Bright HealthCare related to a provider's professional competency or conduct.

a. Disputes are referred to a first-level panel consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute

b. As a provider, you have the right to consideration by a second-level panel and the methods to request such consideration

c. The second-level panel consists of at least three individuals that comply with (a.) above

Participating Provider Suspension Mechanism for Patient Safety

Bright HealthCare implements a mechanism to immediately suspend, pending investigation, the participation status of a participating provider who, in the opinion of the medical director, is engaged in behavior or is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of patients. Bright HealthCare investigates such instances on an expedited basis and makes the dispute resolution process available to any participating provider subject to suspension of participation status.

Provider Directory

The provider directory is available on Bright HealthCare's website, **BrightHealthCare.com.** Bright HealthCare makes every effort to ensure information available through the provider directory is current, accurate, and consistent with information obtained during the credentialing process as well as through ongoing audits and provider data quality initiatives. Bright HealthCare makes timely updates to the directory as new information is received and validates the information on a regular basis.

Providers are required to supply to Bright HealthCare or its delegate, accurate, complete, and up-to-date information in a format requested by Bright HealthCare to populate the provider directory. Providers are also required to notify Bright HealthCare of changes in demographic data that affect the provider directory. Additionally, Bright HealthCare expects that each provider assists in assuring the accuracy of the information provided by reviewing what is being displayed for themselves and providing notification of any discrepancies or erroneous information as soon as possible. Refer to Appendix 1 for contact information.

Effective Date

Bright HealthCare will confirm the information provided in member materials and the provider directory is consistent with the information obtained during the independent direct credentialing process, or through the data provided by Bright HealthCare's delegated entities with credentialing authority, and through ongoing audits and provider data quality initiatives. Providers will enter the provider directory after credentialing is complete and Bright HealthCare has received the minimum roster data requirements. Bright HealthCare will not pay claims from or add a provider to the directory prior to their effective date of passing credentialing. Bright HealthCare will provide providers with formal notification of the effective date of passing credentialing.

Covering Physicians

Bright HealthCare's participating providers must arrange for coverage of their practice **24 hours a day, 7 days a week**. The covering physician must be a Bright HealthCare participating provider. If the covering physician is **not** in your group practice, you must notify Bright HealthCare to prevent claims payment issues.

Closed Panels

If a participating provider wishes to close their panel, the request must be made to Bright HealthCare in writing in advance in accordance with your Network Participation Agreement. The participating provider's panel must be closed to all new patients, not only to Bright HealthCare members. Once a panel is closed, it may not be opened to allow only select members to enter.

National Provider Identifier requirements

As required by the Health Insurance Portability and Accountability Act (HIPAA), rendering, referring, attending, and supervising providers must be identified on electronic claims by their National Provider Identifier (NPI). These providers must be enrolled and their NPI must be on record with the fiscal agent for the billing provider to be paid. Atypical Providers, as defined under federal law, are not required to have an NPI.

Regulatory requirements addendums

One or more regulatory appendices may be attached to this Provider Manual, setting forth additional provisions included into the Network Participation Agreements, to satisfy regulatory requirements related to specific types of benefit plans. Such additional provisions are incorporated by reference into this Provider Manual and into the applicable Network Participation Agreement. The parties agree to comply with all such regulatory requirements for those types of benefit plans to which the regulatory requirements apply and to ensure that their employees, subcontractors, affiliates, and network providers understand and adhere to the regulatory provisions. To the extent that the regulatory requirements are inconsistent with other provisions of the Network Participation Agreement, including those provisions found in other exhibits, appendices, and attachments, the regulatory requirements will prevail for those benefit plans to which the regulatory requirements apply.

Section Two: Enrollment and Eligibility

Member enrollment

Individuals are enrolled either directly through Bright HealthCare or through the public marketplace after completing an application and being approved by Bright HealthCare.

Newborns are generally covered under the mother's policy for the first 31 days of life, or as defined by state law. If the member wishes to continue coverage for the newborn beyond the 31st day, they must submit a completed enrollment form to Bright HealthCare within 60 days of the newborn's date of birth.

A member is not eligible until Bright HealthCare receives their first premium payment. Please contact Bright HealthCare to confirm eligibility. Refer to Appendix 1 for contact information.

For more details about this process, please refer to the member's Certificate of Coverage (COC).

Eligibility verification process

Member eligibility may change frequently. It is important to verify eligibility prior to rendering services to a member. Bright HealthCare will not pay claims for members who are not eligible on the date of service. The provider is responsible for verifying eligibility prior to rendering services. Bright HealthCare strongly recommends that providers verify eligibility on an ongoing basis, as eligibility status is subject to change.

To verify if a member is currently eligible to receive services through Bright HealthCare, follow these steps:

- Request that the member present their Bright HealthCare member ID card at each encounter
- Contact Bright HealthCare Provider Services for assistance with eligibility determinations. Refer to Appendix 1 for contact information
- Check **Availity.com** each time the member appears at the office for care or referrals

Eligibility discrepancy: If there is a discrepancy between Bright HealthCare and the member who believes that they are covered, a review of the application and any documentation from on-exchange or off-exchange will be conducted. The decision will be made by Bright HealthCare based on the supporting data.

Member disenrollment

Voluntary disenrollment: subscriber or group chooses to terminate coverage for any reason.

Involuntary disenrollment: subscriber or group stops paying required premium or Bright HealthCare discontinues benefit plans, only as permitted by law.

Termination due to non-payment of premium following grace period is eligible for reinstatement of coverage within 30 days of policy termination at the request of the policy holder or as required by law. The policy holder is required to bring all premiums current and set up recurring payments for future premiums.

After 31 or more days have elapsed from date of termination, an individual terminated for non-payment of premium may have to wait for a qualifying life event to create a Special Enrollment Period (SEP), or until the next annual Open Enrollment Period (OEP) to be eligible to re-enroll.

Grace Period

Non-Subsidized Members

Alabama, Arizona, California, Florida, Illinois, Nebraska, North Carolina, Oklahoma, Tennessee, Texas, Utah, Virginia

Members have a 31-day grace period. Premiums are due on the 20th day of each month. If a member does not pay their premium by that date, Bright HealthCare will send a grace period notice to the member on the 1st day of the following month. If we still do not receive payment by the expiration of the 31-day grace period, we will terminate coverage for nonpayment of premium. Bright HealthCare will not cover any claims incurred after the paid-through date.

> **Example:** Bright HealthCare bills the April premium on 3/5. The premium payment is due on 3/20. The member does not pay the premium; therefore, Bright HealthCare automatically issues a grace period notice on 4/1. The member does not pay the premium by 5/1, Bright HealthCare terminates coverage for nonpayment of premium, effective 3/31, which is the paid-through date. Bright HealthCare will not pay claims incurred for dates of service after 3/31.

Colorado, Georgia, South Carolina

Members have a 31-day grace period. Premiums are due on the 20th day of each month. If a member does not pay their premium by that date, Bright HealthCare will send a grace period notice to the member on the 1st day of the following month. If we still do not receive payment by the expiration of the 31-day grace period, we will terminate coverage for nonpayment of premium. However, we will honor any claims incurred for dates of service until the expiration of the grace period.

> **Example:** Bright HealthCare bills the April premium on 3/5. The premium payment is due on 3/20. The member does not pay the premium; therefore, Bright HealthCare automatically issues a grace period notice on 4/1. The member does not pay the premium by 5/1. Bright HealthCare terminates

coverage for nonpayment of premium on 5/2. Bright HealthCare will pay for claims incurred for dates of service 4/1-4/30.

Subsidized Members

Alabama, Arizona, California, Colorado, Florida, Georgia, Illinois, Nebraska, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia

Members have a three-month grace period. Premiums are due on the 20th day of each month. If a member does not pay their premium by that date, Bright HealthCare issues an automatic grace period notice to the member on the 1st day of the following month. Bright HealthCare will honor any claims incurred for dates of service during the first month of the grace period. However, claims incurred during the second and third months of the grace period until the member pays the premium, or the grace period ends, will be pended. Pharmacy claims will be denied in the second and third months of the grace period. If a premium payment is not received by the expiration of the three-month grace period, Bright HealthCare will terminate coverage for nonpayment of premium, back to the end of the first month of the grace period and claims denied.

Example: Bright HealthCare Invoices the April premium on 3/5. The premium payment is due on 3/20. The member does not pay the premium, so Bright HealthCare issues a grace period notice on 4/1. We will cover claims incurred for dates of service 4/1-4/30. Any services incurred 5/1-6/30 will be pended. If the member does not pay the premium by 6/30, Bright HealthCare terminates coverage for nonpayment of premium, effective 4/30. Bright HealthCare will deny all claims incurred for dates of service after 4/30.

Section Three:
Member Benefits and Services

Health plan benefit summary

Benefits are limited to covered health services included in the group's Certificate of Coverage (COC) document. All covered health services are subject to the limitations and exclusions contained in the Limitations/Exclusions section of the COC. The COC and Summary of Benefits for each plan are located on **Availity.com.**

Coverage is only available when the following are true:

- Unless otherwise specified, services or supplies are medically necessary as defined in the COC and in Bright HealthCare's medical policies and coverage guidelines
- Covered health services are received while the policy is in effect
- The person who receives covered health services is a covered person and meets all eligibility requirements specified in the policy

Additionally, to help keep member out-of-pocket expenses low, most health services should be provided by a network provider. Exceptions, which include without limitation emergency services and out of area urgently needed services, are outlined in the COC.

Bright HealthCare Individual & Family Plans

Bright HealthCare offers Gold, Silver, Bronze, and Catastrophic Qualified Health Plans to consumers in our markets across the United States. We partner with health systems to deliver a higher quality experience that makes dealing with health insurance simpler for our members, at a lower cost.
Our 2022 markets include the areas surrounding:

ALABAMA: Birmingham

ARIZONA: Phoenix & Tucson

CALIFORNIA: Contra Costa

COLORADO: Denver, Fort Collins & Durango

FLORIDA: Daytona Beach, Fort Lauderdale, Jacksonville, Miami, Orlando, Palm Beach, Pensacola, Sarasota, Tampa & Treasure Coast

GEORGIA: Atlanta & Savannah

ILLINOIS: Chicago

NEBRASKA: Omaha, Lincoln & statewide

NEW MEXICO: Statewide

NORTH CAROLINA: Asheville, Charlotte, Greensboro, Greenville, Raleigh-Durham, Winston-Salem

OKLAHOMA: Oklahoma City

SOUTH CAROLINA: Anderson, Charleston, Greenville, Myrtle Beach & Spartanburg

TENNESSEE: Chattanooga, Columbia, Cookeville, Dickson, Knoxville, Livingston, Memphis & Nashville

TEXAS: Austin, Dallas & Houston

UTAH: Salt Lake City

VIRGINIA: Northern Virginia & Richmond

Bright HealthCare Small Group Plans

Bright HealthCare offers Platinum, Gold, Silver, and Bronze Health Plans to groups in our markets across the United States. We partner with health systems to deliver a higher quality experience that makes dealing with health insurance simpler for our members, at a lower cost. Our 2022 markets include the areas surrounding:

ARIZONA: Phoenix & Tucson

COLORADO: Denver, Fort Collins, Peak, Peak SHA

NEBRASKA: Omaha, Lincoln & statewide

NORTH CAROLINA: Raleigh-Durham, Greensboro, Greenville

TENNESSEE: Chattanooga, Dixon, Memphis, Nashville

Section Four: Member Appeals

Member appeals

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.

Appeal of an adverse determination

If the member disagrees with an adverse determination and wishes to appeal, the member may request a review. Bright HealthCare offers an internal review process. The number of internal appeal levels that the process includes depends on the applicable state regulatory requirements in which Bright HealthCare offers the benefit plan.

Appeal submission

The member must submit the appeal request orally or in writing to Bright HealthCare within 180 days of the date of receipt of an adverse determination notice, unless the state regulations allow for a longer filing time.

Bright HealthCare may expedite an appeal if it involves a case of urgently needed care. If the deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Internal review process

To begin the internal review process, the member must send a written request to Bright HealthCare at the address provided within their COC.

The member request for an appeal must include:

- The patient's name and their member ID (located on their member ID card)
- If post-service, 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

Notice of appeal determination

Bright HealthCare will notify the appellant member of the determination in compliance with state laws, and in all cases, will mail a written notice of determination to the appellant. State regulation determines the time frames in which we are required to notify the appellant of our decision. They are provided to the member within their COC.

If the initial adverse determination was upheld, we will inform the member of the process for requesting an external review.

Bright Healthcare Payment Integrity

Bright HealthCare Payment Integrity focuses on ensuring claims are paid accurately. Claim controls focus on optimization of claim payment efficiencies; including payment accuracy and shared liability for all business segments and claims platforms. Payment Integrity will request refunds on claims when overpayments are identified.

Reasons for overpayments include, but are not limited to:

- Duplicate payments
- An issue regarding the coordination of member benefits
- Subrogation
- Member plan termination
- Medical record/coding reviews
- Fraud, Waste and Abuse Detection
- Incorrect provider reimbursement
- Industry Standard Practices

Bright HealthCare, or one of its designees, utilizes but is not limited to, the resources below to conduct its reviews. These are widely acknowledged national guidelines for billing practices and support the concept of uniform billing for all payers. A healthcare provider's order must be present to support all charges, along with clinical documentation to support the diagnosis and services or supplies that were billed:

- Centers for Medicare & Medicaid Services (CMS) guidelines as stated in Medicare manuals
- Medicare Local Coverage Determinations and National Coverage Determinations
- All Bright HealthCare policies, including medical coverage policies, Bright HealthCare provider manuals, and claims payment policies
- National Uniform Billing Guidelines from the National Uniform Billing Committee
- American Medical Association Current Procedural Terminology (CPT®) guidelines
- Healthcare Common Procedure Coding System (HCPCS) rules
- ICD-10-CM Official Guidelines for Coding and Reporting

- American Association of Medical Audit Specialists National Health Care Billing Audit Guidelines
- Industry-standard utilization management criteria and/or care guidelines, including MCG care guidelines (formerly Milliman Care Guidelines): current edition on date of service
- UB-04 Data Specifications Manual
- American Hospital Association Coding Clinic Guidelines
- Social Security Act
- National professional medical societies' guidelines and consensus statements
- Department of Health and Human Services final rules, regulations and instructions published in the Federal Register

Medical Records Review

- Bright, or one of our designees, has the right to request and review records related to services rendered to its members. We may request records and/or other billing documents to conduct reviews
- The Treatment, Payment and Health Care Operations (TPO) exception under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.506) allows the release of medical records containing protected health information between covered entities without additional authorization for the payment of health care claims. All billed charges must be supported by the clinical documentation to support the diagnosis and services/supplies that are billed
- In the event Bright HealthCare requests medical records from a participating provider, such provider must honor the request within 30 calendar days (unless the request is otherwise stated or separately defined within the network agreement)
- Under no circumstances will Bright HealthCare reimburse participating providers for the cost of collecting, copying, or delivering requested medical records, except when required by law or separately defined within the network agreement
- Participating providers, and any subcontractors or third parties who may collect, copy and/or deliver records for such providers, may not bill Bright HealthCare or any Bright HealthCare member for expenses related to a records request from Bright unless otherwise stated in the network agreement
- Types of records Bright HealthCare or its designee may request include, but are not limited to the following:
    - Activities of daily living (ADL) sheet, including flow sheets and/or logs
    - Admission assessments
    - Anesthesia records (including time of anesthesia administration)
    - Case management notes
    - Change of therapy (COT) assessment
    - Chat logs
    - Chemotherapy orders
    - Clinical trial information, including consents and treatment plans

- Consultation notes
- Diagnosis notes, including past medical history
- Discharge/transfer summaries
- Drawings and photos, when applicable
- Emergency department reports
- Evaluations: any evaluation related to the service provided
- Face sheets
- Face-to-face encounter documentation
- For durable medical equipment/home infusion/home health: delivery receipts for supplies or drugs/proof of delivery
- Hospice/end-of-life-care documentation
- Implant detail: sticker sheet and copies of invoices for implants or high-cost drugs; implant logs with additional information on implants, screws, and plates
- Itemized bills
- Laboratory and pathology reviews: Clinical reviews of pathology claims often require additional information to make determinations. Medical records from the ordering physician, as well as the requisition form and lab results, are necessary to complete a full and fair review of the pathology claim.
- Laboratory reports and X-rays from ordering provider, along with written interpretations of X-rays, tests and/or laboratory results
- Letter/certificate of medical necessity (CMN) for services
- Medication records/medication administration records (MAR), including strength, National Drug Code (NDC) and waste, mixing logs, infusion medication sheet and transfusion/infusion logs
- Nurse or any other healthcare provider's progress, treatment, SOAP (subjective, objective, assessment, plan) notes, dietary notes and daily notes
- Obstetric/newborn services
- Operative reports
- Patient history
- Physical exam
- Provider office records: complete records, including office visit documentation, demographic/face sheet, patient history, laboratory and procedure results and all correspondence with healthcare providers, including consultation requests and reports
- Provider orders

- Plans of care (POC), treatment plans (tried and failed conservative treatments) and any related evaluations and updates or recertifications for the time period during which the patient was treated. The POC and recertifications should be signed by a qualified healthcare provider.
- Preanesthetic evaluation
- Preoperative and postoperative notes
- Prescriptions
- Progress notes
- Psychiatric evaluation notes
- Test orders/results/reports including, but not limited to, pathology, radiology and laboratory (include results, when applicable)
- Toxicology reports
- Treatment notes
- Uniform billing form (UB-04)/Health Care Finance Administration Form (HCFA 1500)
- Wound care assessment

Hospital Bill Validation

Bright, or one of our designees, may perform focused audits verifying the accuracy of the site of service billed for specific claims based on the level of care acuity, documented clinical information and severity of illness. We will consider reimbursement for services at an outpatient level when hospital services were appropriate but reimbursement at the inpatient level is not appropriate. Discrepancies may result in reimbursement reduction or payment recoupment.

Hospital Charge Audits

Bright, or one of our designees, may audit either onsite or perform a desk audit of a facility's claim(s) to assess the accuracy of the inpatient or outpatient facility charges by such provider. Bright HealthCare may sometimes review an itemized bill for an inpatient admission to determine whether supplies, items and services specified on the itemized bill are separately billable. If an itemized bill is not provided when requested or if improper billing is identified during the review of the itemized bill, one of the following outcomes may result:

- Reimbursement reduction
- Payment recoupment
- Denial of specific charges

DRG Audits

Bright HealthCare, or one of our designees, may audit claims to ensure the diagnosis and procedure codes which generate the DRG, and hospital invoice are accurate, valid and sequenced in accordance with nationally correct coding rules and standards.

- A Diagnosis-Related Group (DRG) audit focuses on payment of a claim related to an inpatient hospital stay
- The intent of a post-payment DRG audit is to ensure that the hospital has applied appropriate care, utilization, and billing practices to code the claim correctly
- The post-payment DRG audit process requires obtaining the patient's medical record in order to review the underlying and supporting documentation

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and coordination of benefits rules. Bright HealthCare or one of its designees will review claims data to identify where Bright HealthCare paid as primary but another plan or party should have. We will identify other responsible payers, verify results, and determine primacy.

- **Subrogation** – Bright HealthCare reserves the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan
- **Coordination of Benefits (COB)** – COB is administered according to the member's benefit plan and in accordance with law
- **Workers' Compensation** – In cases where an illness or injury is employment-related, workers' compensation is primary. If you receive notification that the workers' compensation carrier has denied a claim for services, submit the claim to us. It is also helpful to send us the workers' compensation denial statement with the claim
- **Medicare** – If the care provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary. Other coverage is primary over Medicare in the following instances:
    - Aged employees: For members who are entitled to Medicare due to age, commercial is primary over Medicare if the employer group has 20 or more employees
    - Disabled employees (large group health plan): For members who are entitled to Medicare due to disability, commercial is primary to Medicare if the employer group has 100 or more employees
    - End-Stage Renal Disease (ESRD) If a member has or develops ESRD while covered under an employer's group benefit plan, the member must use the benefits of the employer's group plan for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer

Pre-Payment Reviews

- Bright, or its designee, conducts pre-payment reviews related to the services billed to its members and facilitates accurate claims payments.
- Payment Integrity Prepayment reviews look for overutilization of services or practices that directly or indirectly result in unnecessary costs to the healthcare industry. Examples include, but are not limited to:
    - Excessive billed charges or selection of the wrong code(s) for services or supplies
    - Billing for items or services that should not have been or were not provided based on documentation supplied
    - Unit errors, duplicate charges, and redundant charges
    - Insufficient documentation in the medical record to support the charges billed
    - Experimental and investigational items billed
    - Lack of medical necessity to support services or days billed
    - Uncovered services per the member's benefit plan, Bright HealthCare or CMS policies
    - Lack of objective clinical information in the medical record to support condition for which services were billed
    - Items not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.
    - Consolidated Billing
- These reviews also confirm that:
    - The most appropriate and cost-effective supplies were provided
    - The records and/or documentation substantiate the setting or level of service that was provided to the patient
- Bright, or one of its designees, will review records to determine if the services billed are substantiated by the submitted clinical and medical documentation. If the findings do not support the services billed, Bright HealthCare will process the claim accordingly. If there is a dispute of the findings, there is an opportunity to appeal
- If the requested records are not returned in the timeframe requested, the claim(s) may result in a technical denial

Post-Payment Reviews

Bright's Payment Integrity Team, or one of its designees, will review claims and claims data on a post-payment basis to detect, prevent and mitigate fraud, waste, abuse, and error.

Bright HealthCare may conduct reviews within 12 months of date of claim's payment (or as otherwise designated by state or federal statute(s)).

Health care professionals are asked to send complete copies of medical records within 30 days of receipt of the request (unless otherwise designated). If the requested records are not returned in the timeframe requested, the claim(s) may result in a technical denial and validated overpayment.

If an overpayment is identified, the health care professional will be notified of the findings via an overpayment letter with an explanation of findings. If there is a dispute of the findings, there is an opportunity to appeal.

Technical Denial

A denial of the entire claim amount will occur when services cannot be substantiated due to the health care provider's non-response to Bright's request for records.

- **Initial Request** – An initial request for medical records will be made with a due date listed in the letter. The due date is 30 days from the date the letter was sent by Bright
- **Second Request** – If records are not received by the initial due date, a second request for records will be sent, allowing an additional 14 days for records submission
- **Request for Overpayment Refund** – If the records are not received after the second request due date, a technical denial letter will be sent with an overpayment request. The health care provider will have 60 days from the date on the refund letter to submit a refund check before the paid amount of the claims is set to offset future funds owed. If an immediate offset is desired, please include the overpayment notification letter with that instruction. Funds can be offset immediately to satisfy the overpayment amount.

Overpayments

Offsets/Recoupments/Takebacks are various names used for an adjustment made by the carrier when excess/wrong payments are made by offsetting the debt by withholding payments of future claims of same patient or other beneficiaries. If we inform you of an overpaid claim that you do not contest, send us your refund check or recoupment request within 60 calendar days (or as required by law or your Agreement), from the date of notification. We may apply/offset/recoup the overpayment against future claim payments unless your Agreement states otherwise or as required by law. If you find we overpaid a claim, please use the Overpayment Refund/Notification Form. Bright HealthCare follows state regulations, provider contract requirements and CMS provisions when processing overpayments and recoupments.

For states: AL, AZ, CO, FL, IL, OK, NC, NE, SC and TN

Call: **866-239-7191** with questions related to overpayments

- **Send Refunds to:**

  Bright Healthcare

  PO Box 16275

  Reading PA 19612-6275

- **Send Overnight Mail to:**

  Bright Healthcare
  Attention: Refunds
  850 N. Park Road
  Wyomissing, PA 19610

For states: CA, GA, TX, UT and VA

- Call: **844-926-4525** with questions related to overpayments
- **Send Refunds to:**

  Bright HealthCare
  PO Box 23004
  New York, NY 10087-3004

- **Send Overnight Mail to:**

  JPMorgan Chase – Lockbox Processing
  Attn: Bright HealthCare Lockbox 23004
  4 Chase Metrotech Center
  7th Floor East
  Brooklyn, NY 11245

Please include documentation that shows the overpayment, including member's name, member ID number, date of service and amount paid. If possible, also include a copy of the Explanation of Payment (EOP) that corresponds with our payment. If the refund is owed because of COB with another carrier, please provide a copy of the other carrier's EOB/remittance advice with the refund. If we find a claim was paid incorrectly, we may make a claim adjustment which will be detailed on the EOP.

Post-audit Procedures

Refund Remittance – Following an overpayment request, the provider/hospital should remit the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by state or federal law.

Audit Findings – If the provider/hospital disagrees with the findings, they can submit notification of the disagreement/dispute/appeal within 30 calendar days of receipt of the audit findings per the terms outlined in the overpayment notification letter. The notification must clearly identify the items in which you disagree and include any relevant documentation to support your position.

Disagreement/Dispute/Appeal Resolution – Bright's Appeals and Grievance (A&G) Team or one of Bright's designees will respond to audit findings. Time frame may vary by state. (Refer to Section 5 that provides an overview of the A&G process).

Offsets – When we issue a refund request in connection with an audit, we recoup or offset the identified overpayment, and/or disallowed charge amounts after 60 calendar days from the date of the refund request, except when the hospital/provider:

- Has refunded the amount due within the requested timeframe
- Has provided written notification of its disagreement with the audit findings within the required timeframe
- Your Agreement/Contractual obligations or state law states otherwise

Cultural and linguistic handling of denials and appeals

As an insurer offering Qualified Health Plans (QHP), we are required to provide timely, culturally and linguistically appropriate notices at no cost to the enrollee, including the following:

- Oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language at all points of contact
- Assistance with filing claims and appeals (including external review) in any applicable non-English language
- Upon request, a non-English version of any notice

We will provide the notice of the appeals process in a culturally and linguistically appropriate manner, in any county within our service area that has attained the threshold of 10% or more of the population being literate in the same non-English language as determined by the Department of Health and Human Services (HHS).

In California, we will translate any vital document (A&G letters) if 5% of the enrollee population or 3,000 or more prefer a specific language.

More information regarding this language is available on **Availity.com**

Section Five: Claims and Provider Reimbursement

Timely Filing

Bright HealthCare requests that providers submit claims within 90 days from the date of service. Providers must submit claims within the contractual time limit, regardless of any event.

Bright HealthCare responsibilities regarding claims

Definition of "clean" claim: A claim in which all required fields have been completed, that has no defect, impropriety, or lack of any required substantiating documentation or circumstance requiring special treatment that would prevent timely payment.

When all necessary information to process a claim is initially provided in the appropriate claim form or format, including all essential and supplementary fields, the claim will be considered a clean claim. Bright HealthCare has the following responsibilities with respect to the provider:

- Provide information about requirements for filing claims
- Notify providers of changes in standard forms, instructions, or requirements in advance of change
- Determine whether provider submitted sufficient information to allow proper consideration of a claim and notify provider if we need additional information
- Provide appropriate explanations for denied claims
- Approve, deny, or settle all clean paper, electronic, or all other (except fraudulent claims) within state and federal required turnaround times, or the time period specified in the provider's Network Participation Agreement
- Apply interest and/or penalties to clean claims paid outside of the applicable regulatory time limit under state and federal law

Provider billing responsibilities

Providers rendering services to Bright HealthCare members have the following responsibilities in relation to billing:

- Verify member eligibility prior to rendering services (except in the case of emergencies)
- Verify that the service is covered under the member's benefit plan
- Ensure provider met all appropriate authorization requirements
- Ensure they file claims using appropriate coding standards as established by CMS
- Verify place of service codes are correct
- Verify diagnosis and/or procedure codes match the service(s) provided

When completing a claim form:

- Complete all required data elements
- Leave non-required data fields blank (do not enter N/A)
- Use only black or dark red ink on any handwritten paper claim
- Use only high-quality toner, typewriter, or printer ribbons/cartridges for paper claims
- Do not use highlighters to mark claims or attachments
- Attach all required documentation to the claim
- If several claims require the same attachment, a provider must submit a photocopy of the attachment with each claim
- Submit initial claims within 90 days or as specified by in the Network Participation Agreement
- Bill Medicare when they are the primary payer prior to submitting claims to Bright HealthCare
- Providers are responsible for following national billing guidelines
- Providers are responsible for maintaining the relationship between their organization and their clearinghouse

Providers are required to submit clean claims to Bright HealthCare for all services rendered to Bright HealthCare members. Bright HealthCare will accept paper claims in current CMS-1500 or UB04/CMS 1450 formats. To process claims in a timely and accurate manner, providers must follow standard billing requirements and use the form consistent with the method in which they contracted and with the requirements listed above.

Providers may also reference the following resources when completing claims submissions:

- CMS 1500 Physician's Manual

  Medicare Billing: Form CMS-1500 and the 837 Professional

- UB04 Billing Manual

  Medicare Billing: Form CMS-1450 and the 837 Institutional

- ICD-10-CM Code Book

  Medicare Learning Network – Information and Resources for Submitting Correct ICD-10 Codes to Medicare

- Physicians' "Current Procedural Terminology" (CPT)

  AMA – Finding coding resources

- Health Care Financing Administration Common Procedure Coding System (HCPCS)

Bright HealthCare accepts claims electronically through EDI Clearinghouses or through direct batch file submissions in the HIPAA5010 version of the 837-file format.

EDI Clearinghouses: Electronic Data Interface (EDI) for Bright HealthCare is Payer ID BRGHT. Providers can submit a paper claim or use another clearinghouse. Providers can submit through Availity, Emdeon, Gateway, Relay Health, and other EDI clearinghouses if they so desire. If your practice is contracted through any network other than Bright HealthCare, please confirm the appropriate procedure for claims submission with the contracting entity.

Overpayments and underpayments

Overpayments and underpayments may be identified by the provider or by Bright HealthCare and will follow the time period and other terms defined in the provider's Network Participation Agreement and state defined regulations.

For purposes of this manual, a provider's request for a claim adjustment or a claim reconsideration, as described in more detail below, will be defined as a "payment dispute." To initiate a provider payment dispute, providers should follow the steps in this section. While the provider's Network Participation Agreement may contain varying time limits, Bright HealthCare asks that the provider payment dispute be submitted within 180 days of the original explanation of payment (with the contractual time limit ultimately controlling). Correspondence related to overpayments/underpayments should be sent to the mailing address located in the contact information in Appendix 1.

If Bright HealthCare notifies the provider of an overpayment, the provider has 60 days (or such longer time limit granted under the Network Participation Agreement) to dispute or reimburse Bright HealthCare for the amount of the overpayment. If the provider does not reimburse or dispute the overpayment amount within the required time limit, Bright HealthCare will reconcile overpayments through electronic adjustments in future payment cycles, using industry standard procedures identifying the claim overpayment for which the adjustment will be made, and subject to any applicable regulatory limitations or any restrictions in the provider's Network Participation Agreement.

Provider payment dispute process

Bright HealthCare has established procedures to resolve provider payment disputes.

Definition of a payment dispute: A written request for a review, submitted by the provider, when they want to dispute the amount that Bright HealthCare paid for a service, including issues related to administrative denials, bundling, and downcoding of services.

The written request (only 1 member per request) must include the following:

- Each applicable date of service
- Subscriber or member name
- Patient name
- Subscriber or member ID number
- Claim number(s)
- Provider name
- Provider tax identification number

- Dollar amount in dispute, if applicable
- Provider's position statement explaining the nature of the dispute
- Supporting documentation where necessary, e.g., medical records, proof of timely filing, etc

Send Disputes to:

For states: AL, AZ, CO, FL, IL, OK, NE, NE, SC and TN

Bright HealthCare
P.O. Box 16275
Reading, PA 19612-6275

For states: CA, GA, TX, UT and VA

Bright HealthCare
P.O. Box 836
Portland, ME 04104

Requirements of the written request

When all necessary information is provided

For provider payment dispute requests, where all necessary information was provided to the address on the member's ID card, Bright HealthCare will send written confirmation of receipt within 15 days of the dispute resolution request (or shorter time period if required by the Network Participation Agreement or law). The written confirmation must contain:

- A description of Bright HealthCare's dispute resolution procedures and time frames
- The procedures and time frames for the provider to present the rationale for the dispute resolution request
- The date by which Bright HealthCare must resolve the dispute resolution request

Note: In the instance where Bright HealthCare resolves the payment dispute resolution request in accordance with this section within 30 days, the notice required under the Notice of Determination section below will constitute the notice required by this section.

When all necessary information is not provided

In cases where Bright HealthCare does not receive all necessary information, Bright HealthCare will send a written request for additional information within 30 days of receipt of the request (or shorter time period if required by the Network Participation Agreement or law). The request will include:

- A description of the additional necessary information required to process the request
- The date that additional information must be supplied by the provider
- A statement that failure to provide the requested information within the time limit noted in the request will result in the closure of the request with no further review

If additional necessary information is requested but not provided

If Bright HealthCare does not receive the additional information within the 30-day time frame, we will close the request without further review. The request will be re-opened upon receipt of the additional information and a formal written request for reconsideration.

Notice of determination

Bright HealthCare will make a determination of a provider dispute resolution request within 45 calendar days (or shorter, if required by state law) of receipt of all necessary information. The parties may mutually agree in writing to extend the time frames beyond the 45 days.

Bright HealthCare will send written notification of the determination to the provider. In the event the determination is not in favor of the provider, the written notification will include the principal reasons for the determination.

The written notice of determination notification will include:

- The names and titles of the parties evaluating the payment dispute resolution request, and where the decision was based on a review of medical documentation, and the qualifying credentials of the parties evaluating the payment dispute
- A statement of the reviewers' understanding of the basis for the payment dispute
- The reviewers' decision and the rationale for the decision in clear terms
- A reference to the evidence or documentation used as the basis for the decision

Coordination of Benefits

If Bright HealthCare is the "secondary payer," we are only legally obligated to pay claims subject to the primary payer's payment responsibilities. Coordination of benefits occurs during claims adjudication to ensure payment is made for only that portion of the claim for which Bright HealthCare is responsible. Bright HealthCare actively pursues any identified overpayments resulting from circumstances where a member has other primary healthcare coverage.

Bright HealthCare is not liable for any claims for which the member is entitled to benefits under state or federal workers' compensation law or plan, any no-fault insurance, or any liability insurance policy or plan. Bright HealthCare will identify claims for which a third party may be liable and make recoveries for those claims. All recovery activities will be made in accordance with the COC, applicable laws, and CMS instructions.

Bright HealthCare will ask a network provider to cooperate with our coordination of benefits procedures, as required in their Network Participation Agreement.

Patient Billing

Balance billing

Balance billing is the practice of billing a Bright HealthCare member for the difference between the provider's billed charges and the amount reimbursed by Bright HealthCare under the Network Participation Agreement. It can also be defined as billing a Bright HealthCare member for denied charges when the denial rationale is due to billing issues. Therefore, except for member cost sharing, providers may not bill Bright HealthCare members for outstanding amounts owed on claims.

Member self-payment for non-covered services

Where a Bright HealthCare member wishes to receive and self-pay for a non-covered service, the member (or the provider on the member's behalf) must first obtain an organization determination from Bright HealthCare denying coverage for the service, subject to the exceptions described below.

Member cost sharing

Bright HealthCare asks that providers submit claims first and obtain a remittance advice with the cost sharing indicated, permitting the provider to bill the member accurately for the cost sharing. This will reduce member overpayments. The member will also receive an Explanation of Benefits (EOB) referencing their cost sharing responsibility. If member cost sharing is taken at the time of service, Bright HealthCare asks that providers use consumer-friendly procedures and do not demand up-front cost sharing as a condition of providing services. If the member has overpaid for cost sharing, a refund of the difference must be provided to the member.

General Compliance and Fraud, Waste, and Abuse Requirements

Bright HealthCare's contracted providers are responsible for implementing a compliance program, which includes but is not limited to:

- Be familiar with Bright HealthCare's general compliance and fraud, waste, and abuse (FWA) requirements
- Comply with all applicable federal and state laws, regulations, and sub regulatory guidance
- Monitor the compliance of your workforce and address non-compliance issues in a timely manner
- Monitor and audit the compliance of subcontractors that provide services to you in support of Bright HealthCare's plans, as applicable
- Obtain approval from Bright HealthCare when seeking relationships with downstream entities (subcontractors)
- Notify Bright HealthCare of any contractor that is located outside of the United States or a territory of the United States that receives, processes, transfers, stores, or accesses member protected health information (PHI) verbally, written, or in electronic form
- Report instances of non-compliance or suspected or actual FWA to Bright HealthCare immediately upon discovery

Develop and implement policies and procedures that describe how to prevent, detect, correct, and report FWA that include, but are not limited to:

- Requiring employees and downstream entities to report FWA
- Screening all individuals and entities against federal and state government exclusion lists prior to hire or contract execution, including the Office of Inspector General's List of Excluded Individuals and Entities and the General Service Administration (GSA) Excluded Parties List System (EPLS)
- Anyone listed on an exclusion list is not eligible to provide services for Bright HealthCare's plans. Providers must notify Bright HealthCare immediately if a person or entity is identified as being excluded from either of these lists. Your procedure must include ongoing monthly monitoring of the OIG LEIE and the GSA EPLS lists
- Procedures for conducting general compliance and FWA training for all employees and any individuals or entities that will be providing services to support Bright HealthCare's members within 90 days of hire or contracting, including collecting and retaining training records for a period of at least 10 years. The training is to be administered upon new hire or contract execution and annually thereafter
- Publicizing disciplinary standards and taking appropriate action upon discovery on non-compliance or FWA
- Safeguarding Bright HealthCare's confidential and proprietary information
- Protecting member health information in accordance with HIPAA Privacy and Security Rules

Fraud, waste, and abuse

Bright HealthCare is committed to detecting, preventing, investigating, and reporting potential fraud, waste, and abuse in accordance with federal and state statutory, regulatory, and contractual requirements. Preventing and correcting FWA helps to keep healthcare affordable. Bright HealthCare requires members, providers, employees, and other parties to report suspected unethical or illegal conduct or suspected FWA.

Fraud, waste, and abuse are defined as:

Abuse includes actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by, or under the custody or control of, any healthcare benefit program. 18 U.S.C. § 1347.

Waste is the overutilization of services or other practices that directly or indirectly result in unnecessary costs. Waste is generally not considered to be criminally negligent actions but rather the misuse of resources.

Examples of provider fraud, waste, and abuse could include:

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can prevent FWA by ensuring the services rendered are medically necessary, accurately documented in the medical records, and billed according to American Medical Association guidelines.

Examples of member fraud, waste, and abuse could include:

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent FWA, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is reviewing the member's ID card. It is the first line of defense against fraud.

Important FWA laws

Anti-Kickback Statute

The Anti-Kickback Statute imposes penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce or reward business payable (or reimbursable) under the Medicare or other federal healthcare programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other federal healthcare programs and subject to civil monetary penalties. Civil penalties for violating the Anti-Kickback Statute may include penalties of up to $50,000 per kickback plus three times the amount of kickback. Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment, or both. Additionally, many states have anti-kickback statutes with which providers are required to comply.

Health Insurance Portability and Accountability Act
The Health Insurance Portability and Accountability Act protects the privacy of an individual's identity and medical records. Providers are responsible for implementing procedures to protect member health information in accordance with HIPAA Privacy and Security Rules. Additionally, some states have state medical record privacy laws with which providers are required to comply.

False Claims Act
The False Claims Act (FCA) prohibits knowingly presenting, or causing to be presented, to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly using, or causing to be used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents. The FCA protects individuals from retaliation (ex., demotion, dismissal, suspension, harassment, etc.) for reporting suspected FWA. The FCA provides civil penalties of no less than $5,000 but no more than $10,000, plus three times the government's damages, with respect to each false claim. Additionally, many states have local false claims act laws with which providers are required to comply.

Physician Self-Referral Law (Stark Law)
The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from making a referral for certain designated health services payable by Medicare or Medicaid to an entity in which the physician or an immediate family member has an ownership/investment interest or with which they have a compensation arrangement, unless an exception applies. Penalties for violation of the Stark Law can include overpayment or refund obligation, FCA liability, civil money penalties (CMPs), and program exclusion for knowing violations, potential $15,000 CMP for each service, and civil assessment of up to three times the amount claimed.

Reporting potential FWA or suspicious activity

Contracted providers, their employees and related entities are required to notify Bright HealthCare of suspected or actual FWA. Federal and state regulatory agencies, law enforcement, and Bright HealthCare investigate all incidents of suspected or actual FWA.

If you think that FWA or other suspicious activity has occurred, may be occurring, or is going to occur, you must report it to Bright HealthCare immediately, by calling or emailing Bright HealthCare Compliance. Refer to Appendix 1 for contact information.

When reporting suspicious or fraudulent activity, be sure to include as much detail as possible in the report for thorough investigation of the issue. Reports can be made anonymously. All reports are treated as confidential to the extent required under the law and in order to properly investigate. Bright HealthCare will not release personal information unless required to do so, for example, under court rule or subpoena. Bright HealthCare may refer the activity to law enforcement or other appropriate regulatory bodies. Members or providers that are found to be engaging in suspicious activity or FWA are subject to termination from the Bright HealthCare network and recovery of any overpayments.

The time limits in this manual and in the Network Participation Agreements that apply to the resolution and collection of overpayments in the normal course of business do not apply in the instance of an investigation and settlement of fraud, waste, and abuse against a network provider. Such investigations and settlement matters are instead subject to statutory or regulatory statute of limitations provisions.

Corrective action plans

Bright HealthCare evaluates the appropriateness of paid claims as part of our payment integrity process. We may initiate corrective action if a provider does not comply with our fraud, waste, and abuse requirements.

Gag Clause Prohibition

No provision of this Provider Manual or any provider agreement shall be construed to directly or indirectly conflict with the requirements of 2799A-9(a)(2) of the Public Health Service Act and restrict Bright HealthCare or issuers of benefit plans from (1) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, members, or prospective members; (2) sharing, for plan design, plan administration, and plan, financial, legal and quality improvement activities, data described in item (1) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of Health Insurance Portability and Accountability Act of 1996 (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Americans with Disabilities Act of 1990 (ADA); (3) electronically accessing de-identified claims and encounter information or data about members upon request, including but not limited to, on a per claim basis, financial information, provider information, service codes, and any other data element included in claim or encounter transactions; and (4) sharing information or data described in subparagraph (1), (2) or (3), or directing that such data be shared, with a business associate (as defined by HIPAA regulations).

Section Six:
Prescription Drug Coverage

Formulary

Bright HealthCare's formulary is designed to provide access to clinically supported therapies used to aid the delivery of high-quality, cost-effective healthcare for members in conformance with Bright HealthCare's values, covered benefits, and applicable health plan requirements. The formulary is also designed to aid members and providers in the identification of low-cost therapy options, validate that medications are used in accordance with health plan benefit restrictions, and support clinical best practices. Members will typically experience a lower out-of-pocket cost when using medications covered on a lower formulary tier, as compared to comparable medications on a higher tier. Medications that are not listed on Bright HealthCare's formulary are not covered unless the member is granted a formulary exception. Bright HealthCare's formulary aligns with the minimum coverage requirements as set forth in the applicable state Essential Health Benefits benchmark plan formulary.

For coverage, cost sharing, and Utilization Management (UM) protocols, please view the formulary. The formulary is available on **Availity.com**.

Drug Utilization Management and pharmacy coverage determinations

Certain drugs may be subject to Utilization Management requirements, such as prior authorization, step therapy, or quantity limits.

Medications subject to prior authorization require the prescriber to provide additional clinical information to the plan before Bright HealthCare will cover the medication. These reviews are considered coverage determinations and may include a review of approved formulary clinical criteria, coverage guidance, and the member's benefits.

Medications subject to step therapy will not be covered unless the member has first attempted treatment with other drugs that are considered first line therapy according to approved formulary criteria. Coverage of medications subject to step therapy will be granted when members have pharmacy claim history of first line drug use. When prior use cannot be confirmed via pharmacy claims, providers will need to seek an exception for the medication to be covered.

Quantity limits may be instituted to prevent the overuse of medications. Quantity limits may be based on a maximum daily dose, the maximum amount of drug allowed over a period of time, and/or the maximum number of dosage units covered over a period of time.

Formulary exceptions for a drug that is not included on Bright HealthCare's formulary will require the provider to submit additional clinical information before the medication will be covered. These exceptions may include review of appropriate clinical criteria, previous use of formulary alternatives, and appropriate use.

Providers may request access to a formulary drug without being subject to applicable formulary utilization management criteria (e.g., step therapy, prior authorization, quantity limit). Coverage may be granted if the provider submits a supporting statement indicating that a non-formulary or restricted drug is necessary for treating a member's condition and other formulary coverage options would either be less effective and/or may not be tolerated by the member.

As required in the Network Participation Agreements, providers will be expected to comply with the above Bright HealthCare or any other applicable drug utilization management procedures.

Providers may request a coverage determination by contacting the Pharmacy Prior Authorizations Department at **833-726-0670**.

Section Seven: Utilization Management Program

Introduction to the Utilization Management program

Bright HealthCare's Utilization Management (UM) program is designed to ensure the delivery of high-quality, cost-efficient healthcare for members in conformance with our values, covered benefits, and applicable state requirements. The Utilization Management program is dynamic through the care setting, acuity, and product and services continuums, in order to achieve the desired outcomes of the program.

Provider obligations and disclaimers

Bright HealthCare validates that healthcare service coverage is in accordance with state laws and regulations, plan benefits, and established clinical guidelines which support the safe and effective use of healthcare services.

Bright HealthCare will not approve services that do not meet these conditions. Subject to limitations set forth in a provider's Network Participation Agreement, denials for failure to seek a prior authorization review will result in the provider being held financially responsible for the claims and providers may not balance bill Bright HealthCare members for such claims. An approved authorization is not a guarantee of payment. Billed services are subject to additional review for billing and coding issues, plan limits, eligibility at the time of service, and other limitations on coverage.

Bright HealthCare requires prior authorizations on select inpatient, outpatient, and ancillary services. The complete lists of services requiring prior authorization can be found on **Availity.com** or **BrightHealthCare.com** > For Providers > Access Provider Resources. **Services requiring prior authorization are subject to change. Please make sure to review the most current list**.

Objectives of the Utilization Management program

The objectives of the Utilization Management program are to promote evidence-based care and cost-effective use of healthcare resources, and to proactively identify and connect members to care management programs. To that end, the program is grounded in applicable federal and state regulations and coverage guidelines, published clinical evidence, and well-established third-party clinical guidelines. Prior authorizations seek to confirm that:

- Providers and facilities are in network
- The member is eligible under the line of business
- The requested product or service is a covered benefit
- The requested product or service is medically necessary based on evidence-based clinical criteria as discussed in more detail below
- The requested product or service is provided in the least-costly method, manner, or supplies, as required by the member's condition

Some procedures/services may ONLY require a network validation authorization and other procedures/services will require a network validation AND medical necessity review. Please review the prior authorization list carefully as to the level of authorization review, if required.

Bright HealthCare prior authorization and Utilization Management determinations

This section outlines how Bright HealthCare makes Utilization Management (UM) decisions for specific services subject to UM protocols and for those that require the application of clinical criteria to determine coverage.

A member's Certificate of Coverage (COC), applicable federal and state rules, and coverage guidelines ultimately control the determination of whether a specific health service is covered under that member's benefit plan. *Most plan limit out of network care to emergencies.* The member's COC states that covered services must meet the standard for medical necessity, along with meeting other conditions for coverage, including eligibility. Bright HealthCare's medical policies define whether a health service is proven to be effective and medically necessary. Services that are not medically necessary, or that are unproven, investigational, or experimental, are not covered under Bright HealthCare's commercial benefit plans.

Bright HealthCare's clinical criteria determines whether a service falls within a covered benefit category, is an excluded service, or has a limitation. Examples of services determined by coverage guidelines include but are not limited to whether a service is skilled or custodial, whether a service is reconstructive or cosmetic, and whether a service involves a limited number of visits to a provider.

Medical necessity and other medical coverage determinations based on clinical criteria

Benefits that require medical necessity coverage determinations must meet all criteria. The benefit is subject to:

- Member eligibility
- A medical necessity determination
- A determination that the service is not unproven, investigational, or experimental

To make these determinations, Bright HealthCare uses:

- Bright HealthCare's clinical criteria and coverage guidelines
- Third party, nationally recognized clinical care guidelines, including but not limited to MCG Health (MCG), American Society of Addiction Medicine (ASAM) Criteria, or other criteria as mandated by the member's state
- Other clinical criteria in order to determine coverage

To interpret the terms of a COC, Bright HealthCare uses:

- State and federal statutory and regulatory requirements
- Corresponding state coverage requirements as defined by the applicable benchmark health plan as found on the CMS.gov website **cms.gov/CCIIO/Resources/Data-Resources/ehb**

- The terms of the COC prevail in instances where there is a conflict between the COC and Bright HealthCare's medical policies, or third-party guidelines.

Authorization requirements vary based on provider network status. Here are the three key types with details in the following paragraphs:

- An in-network provider providing services in a setting listed in the contract with Bright Health. Example: A provider treating a member at the office listed in the contract.
- An in-network provider providing services in a setting contracted separately. Example: in-network provider performing surgery at an out-of-network ambulatory surgical center, admitting a member to an out of network acute or sub-acute facility, or treating at an out-of-network office location.
- An Out-of-Network provider or facility.

In-network provider/contracted location or facility

- Certain treatments and procedures require prior authorization regardless of the place of service or network status. An up-to-date list can be found at **Availity.com** or **BrightHealthCare.com/provider/utilization-management**. As this list changes periodically, please verify authorization requirements prior to service.
- In-network providers do not need to submit an authorization for services that require only a network validation review, provided the service is rendered in the location listed in the contract.
- For medications, refer to the formulary available on **Availity.com** to understand which medications are covered under the pharmacy benefit and subject to utilization management review.

In-network provider/location separately contracted

- Certain treatments and procedures require prior authorization regardless of the place of service or network status. An up-to-date list can be found at **Availity.com** or **BrightHealthCare.com/provider/utilization-management.** As this list changes periodically, please verify authorization requirements prior to service.
- In-network providers are required to obtain prior authorization when rendering services at an out-of-network facility, unless the member's policy is a Preferred Provider Organization (PPO)
- Network providers are responsible for validating the network status of the facility where services will be rendered. When the authorization requirement is listed only as "Network Validation", clinical review is not necessary if both the provider and the place of service are in-network. Validation of network status is typically done within 24 hours.
- All Partial Hospital services require prior authorizations.

Planned inpatient admissions

- All admissions require prior authorizations (except as noted in sections below).
- Network providers must admit members to Bright HealthCare contracted facilities.
- **Network providers must obtain prior authorization for non-emergent inpatient admissions,** including but not limited to admissions to:
    - Acute and sub-acute facilities including behavioral health

- Inpatient habilitation or rehabilitation facilities
- Skilled nursing facilities (SNF) and Residential Treatment Centers (RTC)
    - In-network SNFs and RTCs are automatically approved for the first seven days of the member's stay. Any stays longer than seven days require a prior authorization and a review for medical necessity.
- Long-term acute care (LTAC) facilities

In the case of a request to maintain a specific level of care, or to transfer a member to a different level of care, the provider must submit the request with sufficient notice and supporting information for Bright HealthCare to make a determination.

In-network inpatient admissions – facility responsibility

In-network facility admitting members for emergent and planned inpatient services must notify Bright HealthCare within 24 hours of admission, or as soon as reasonably possible (unless timing differs based on state regulations).

In-network labor and delivery

Authorization is required for inpatient hospital stays in excess of 48 hours for the mother and newborn child following a normal vaginal delivery or inpatient hospital stays in excess of 96 hours for the mother and child following a cesarean delivery.

All admissions will be reviewed for medical necessity and follow normal concurrent review process.

Home health services

In-network providers are required to submit a prior authorization request for medical necessity review after a total of six visits per episode of continuous home health services.

Transplant services

- Transplant services are subject to prior authorization procedures, beginning with the transplant evaluation. Submit an authorization request at the point that a transplant is considered to avoid delays.
- Please refer to the Transplant Page for more information and specific instruction, as well as FAQs.
- Bright HealthCare reserves the right to direct members to receive inpatient care and other medically necessary services related to the transplant at particular facilities identified as meeting the required quality standards of our transplant management programs.

Out-of-network inpatient medical and behavioral admissions

- **Out-of-network providers must notify Bright HealthCare of an admission within 48 hours of the admission.**
    - Bright HealthCare may work with the admitting physician to move the member to the nearest appropriate in-network facility after the member is stabilized.

Out-of-network outpatient services

- Bright HealthCare programs provide a spectrum of benefit options, so out-of-network coverage varies based on the plan specifics. In general, out-of-network services require prior approval and may require a significantly higher share of the payment to come from the member. Out-of-network providers should Bright HealthCare Provider Services as soon as possible for authorizations and further details.

Concurrent review

As part of our UM program, Bright HealthCare conducts concurrent reviews of inpatient admissions and certain outpatient services for duration of stay, level of care reviews, and other medical necessity reviews. Providers are required to cooperate with UM program and concurrent reviews, as stated in their Network Participation Agreements.

Submitting Requests for Prior Authorization and Accessing UM Program Staff

Refer to Appendix 1 and 2 for a list of procedures and conditions that require prior authorization. A defined list of procedures that require prior authorization can be found on **Availity.com.**

Requests for authorization may be submitted electronically through Availity for some states and service types. For specific prior authorization resources, go to **BrightHealthCare.com/provider/utilization-management.**

For electronic submission, log in to your account, then click on **Patient Registration > Authorizations and Referrals**.

A user guide with instructions for submitting electronic prior authorizations is available from **Availity.com > Payer Spaces tab > Bright HealthCare > Resources**.

Bright HealthCare also accepts prior authorization requests via fax for certain states and service types. However, we encourage providers to use Availity to submit prior authorizations when possible. Electronic prior authorization requests are faster, easier, and offer many useful features not available through fax, such as the ability to track requests.

If you are unsure where or how to submit a prior authorization, utilize Bright HealthCare's Authorization Navigator at **careteam.BrightHealthCare.com/auth-check**. The Authorization Navigator is an online tool to help determine if an authorization is needed and where/how to submit the authorization depending on the location or specialty.

Availability of criteria

Upon request or in accordance with state requirements, Bright HealthCare will provide the criteria that was used to make a coverage decision in the UM program in writing. Bright HealthCare has established policies and procedures for registering and responding to member grievances and appeals if a member or authorized representative is not satisfied with a coverage decision. Refer to the **Member Appeals and Grievances** section for more information.

Quality assurance and improvement

Where applicable, Bright HealthCare follows state Utilization Management licensure requirements and URAC accreditation standards. To the extent that Utilization Management functions are delegated to a third party, Bright HealthCare performs appropriate oversight of the quality of the vendor's performance, including monitoring the consistency of approvals, denials and inpatient admission decisions, turnaround time of Utilization Management decisions, and oversight of physician review activities performed by medical directors. Telephone services are tracked based on the percentage of calls that go into the hold queue, abandonment rate, and average speed of answer.

The UM program is under the administrative and clinical direction of Bright HealthCare's senior clinical staff, Utilization Management Subcommittee and Quality Management Committee. The Quality Management Committee evaluates and approves the Utilization Management program annually. Updates occur, as required, based on feedback from providers and in consideration of the needs of members. Bright HealthCare and its delegated Utilization Management partners receive no financial incentives for issuing denials of coverage.

Case Management

The purpose of Case Management programs at Bright HealthCare is to identify and engage with members who are at high risk for complex, costly, or long-term healthcare needs. Through logical process and utilizing the member's network, the case manager will coordinate medically appropriate services in a supportive and cost-effective manner. All case management activities will maintain the member's privacy, confidentiality and safety. The case manager will advocate for the member and adhere to ethical, legal, and accreditation/regulatory standards while reinforcing the member's rights and responsibilities as noted in the EOC. The desired outcomes of the program are to:

- Improve self-management knowledge and skills regarding disease/condition
- Return the member's health to the maximum potential
- Promote positive health outcomes
- Increase member satisfaction
- Support the primary care physician
- Utilize in-network providers
- Reduce the cost of care
- Reduce unplanned hospital admissions and inappropriate emergency room use

Identifying and recommending members to Case Management

Members may be identified by Care Partners, individual care providers, Health Risk Assessment (HRA) responses, administrative data (prior authorization and processed claims data), member services, and utilization review staff. Members may also self-refer to our programs by calling Member Services. Refer to the contact information in Appendix 1. As required in their Network Participation "Agreements, network providers will be asked to cooperate with such Case Management programs offered by Bright HealthCare.

If you feel that a Bright HealthCare member would benefit from our Case Management program, please contact Bright HealthCare Provider Services. Refer to the contact information in Appendix 1.

Disease Management

The purpose of Disease Management programs at Bright HealthCare is to identify and engage members who have been diagnosed with a specific condition and are at risk for costly, or chronic healthcare needs. Members may be identified for disease management programs by Health Risk Assessment (HRA) responses, administrative data (prior authorization and processed claims data), and case management staff.

Disease management provides supports for the following conditions:

- Diabetes
- Depression
- Heart Disease
- Asthma/COPD
- High Cholesterol/High Blood Pressure
- Low Back Pain
- High Risk Pregnancy

All disease management activities will maintain the member's privacy, confidentiality and safety. The disease manager will advocate for the member and adhere to ethical, legal, and accreditation/regulatory standards while reinforcing the member's rights and responsibilities as noted in the COC.

Section Eight: Quality Management and Improvement

Quality Management Program

Bright HealthCare's Quality Management Program is based on a philosophy that emphasizes a systematic, data-driven effort to measure and continuously improve healthcare services and outcomes for members while exceeding customer expectations. It applies to all member demographic groups, care settings, and types of services (medical and behavioral health). We maintain a quality program that aims to meet or exceed accreditation requirements, state and federal regulations, and statutes and policies.

The overall goal of the Quality Management Program is to improve the quality and safety of clinical care and services provided to the members in Bright HealthCare's network of providers. All goals are reviewed annually and revised as needed. All goals will operate in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators, and appropriate accrediting bodies.

As part of its Health Plan Quality Management Program, Bright HealthCare measures and analyzes data to improve performance, process, satisfaction, and outcome in the areas of consumer satisfaction, access and availability, surveys, HEDIS measures calculated from claims, medical records and supplemental data, outcome reports of targeted quality improvement activities, and claims data.

Key areas of focus include, but are not limited to:

- Quantitative member and organizational outcomes
- Patient safety
- Confidentiality
- Network adequacy
- Preventive health
- Service utilization
- Disease and case management
- Coordination/continuity of care
- Cultural competency
- Credentialing
- Quality of care/service, including critical incidents
- Appeals and grievances
- Member, provider, and client satisfaction
- Components of operational services
- Reporting requirements

Provider Support

Bright HealthCare's provider network is a key partner in achieving the goals of our Quality Management Program. Key areas of support include, but are not limited to:

- **Gaps in Care Closure**
    - A gap in care is defined as a discrepancy between recommended best practices and care that is provided. Bright HealthCare obtains health information on our members and shares potential gaps with our provider partners. Opportunities to close gaps in care include, but are not limited to:
        - ***Complete and accurate coding and documentation*** is the first step to closing care gaps. By following, documenting, and coding the recommended care, Bright HealthCare will receive the necessary information via claims submissions which automatically closes the gap in care for the member
        - ***Direct EMR Access*** allows Bright HealthCare to efficiently close quality gaps and gather required medical records without having to put undue burden on your staff (Bright HealthCare adheres to all HIPAA regulations and only obtains the minimum information necessary to close the care gap)
        - ***Supplemental Data*** refers to additional clinical information about a member, beyond administrative claims, received by a health plan. A health system or provider group can submit reports directly from their EMR to Bright HealthCare as an acceptable way to close gaps in care
        - ***Chart Chase*** is the final way to close quality gaps in care. During specific times of year, Bright HealthCare will submit bulk requests for medical records to be abstracted to prove that required care was delivered. This usually takes place as part of HEDIS or Risk Adjustment audits (see below)
- **Chart Retrieval**
    - Providing ***contact information for your Medical Records Department or Third-Party Record Retrieval Vendors*** allows Bright HealthCare to more accurately direct chart requests within your organization, reducing administrative burden to your team. Please provide the following information to our Medical Record Retrieval Team (**medicalrecords@BrightHealthPlan.com**):
        - Internal Medical Records Department
            - Contact Name
            - Phone Number
            - Fax Number
            - Mailing Address

    - Third Party Vendor
        - Name of the organization
        - Established organization workflow for records
        - Escalation contact
- ***Health Effectiveness Data and Information Set (HEDIS)*** is a comprehensive set of standardized performance measures designed to ensure that the public has information to compare different health insurance organizations' performance on important dimensions of care and service. A portion of HEDIS reporting relies on providers submitting necessary medical records to prove that certain aspects of care were provided
    - Timeline – Annually February through May
    - Your office will receive requests directly from Bright HealthCare or through our third-party record retrieval vendor. Specific instructions for the type of information needed will be provided along with directions on where to send the information. Timely submission of records is key to ensuring the care provided is accurately reflected in the published HEDIS rates
- **Risk**
    - Risk adjustment is a statistical process developed by the Centers for Medicare and Medicaid Services (CMS) that helps predict healthcare utilization and patient care needs for Medicare Advantage and Affordable Care Act patients. Riskadjustable medical conditions are captured by providers and submitted on claims in order to determine the patient's health status. Risk adjustment chart review is necessary in order to ensure that the risk adjustable conditions documented and submitted are complete and accurate
    - Timeline
        - RADV Audits (IFP) - annually May through December
        - Risk Adjustment Chart Reviews
            - Medicare Advantage – annually May to December
            - Individual and Family Plans (IFP) – annually September to April
    - Your office will receive requests directly from Bright HealthCare or through our third-party record retrieval vendor. Specific instructions for the type of information needed will be provided along with directions on where to send the information. Timely submission of records is key to ensuring the care provided is accurately reflected in the member's risk score

- **Quality of Care and Patient Safety**
    - Care Partners, clinically integrated networks, health systems, facilities, and medical groups are responsible for monitoring the quality of services provided by providers to members, without limitation to ensure patient safety
    - In addition to any regulatory reporting requirements, providers must provide prompt notice to Bright HealthCare of any member quality issues or other adverse events. Such reporting requirements must include Hospital-Acquired Conditions ("HAC") and Serious Reportable Events (as defined by the National Quality Forum) related to services rendered to a Bright HealthCare member.
    - Such notifications should be submitted in a HIPAA-compliant communication to one or more of the following:
        - Certified mail or courier:
          Bright HealthCare
          ATTN: Quality
          8000 Norman Center Drive, Suite 1200
          Minneapolis, MN 55437
        - Fax: **877-825-2725**
        - Email: **Quality@BrightHealthPlan.com**
    - Bright HealthCare may also receive Quality of Care Concerns (QOCC) directly from Members or from our internal clinical staff. If that occurs, requests for medical records will be submitted to your office or facility (or third-party vendor identified). CMS requires that Member-initiated concerns be addressed within 30 days, making timely submission of medical records vitally important. We ask that you submit any records requested through our QOCC process as soon as possible but no later than 7 days after the request
- **Quality Improvement Projects (QIPs) – *IFP ONLY***
    - At any given time, Bright HealthCare has a minimum of three ongoing quality improvement projects (QIPs) in compliance with accreditation standards. QIPs focus on activities that address opportunities for error reduction or performance improvement
    - All three QIPs at any given time focus on clinical quality, with at least one designed to address consumer safety for the population served.
    - Projects relate to key indicators of quality, are member focused, and designed to improve performance
    - Bright HealthCare, clinical leadership staff members and at least one participating provider will provide input for all clinical QIPs. If you would like to take a more active role in Bright HealthCare's Quality Improvement Projects, please reach out to our Quality Team **(Quality@BrightHealthPlan.com)**

Section Nine: Delegation Oversight

Delegation Oversight

Broad Definition of what it means to be a delegated group

Physician organizations, commonly referred to as medical groups or Independent Physicians Organizations (IPA), are paid under a population-based payment model (commonly referred to as capitation). In this model, the Centers for Medicare & Medicaid Services (CMS) makes a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrolled patient for services over a span of time, which is typically a per member, per month payment. When a health plan (Sponsor) contracts with an IPA or medical group and delegates them to perform administrative or healthcare services for enrollees on behalf of the Plan, the entity is considered a delegated (contracted) medical group. Bright HealthCare's Delegation Agreement (Division of Delegated Responsibilities) will specify in detail what functions have been delegated to the Delegated Group.

Responsibilities of being delegated

The Sponsor maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with federal CMS or state requirements. Therefore, state and federal regulators may hold the Sponsor accountable for the failure of its First Tier, Downstream, and Related Entities (FDRs) to comply with state and federal requirements. Providers contracted directly with Bright HealthCare shall be monitored to ensure compliance with federal and state regulations, accreditation standards (e.g. NCQA or URAC) standards, and Bright HealthCare policies. If the Delegated Group is delegated to perform Utilization Management (UM), Claims, Credentialing, Provider Network Operations (PNO), or any of these specific functions, the delegate is to ensure that their Policy and Procedures (P&Ps) for each area are in alignment with Bright HealthCare policies and requirements.

Ongoing Auditing/Monitoring

Annually, Bright HealthCare will conduct an audit of delegated functions performed by the Delegated Group. If the Delegated Group sub-contracts with a Management Services Organization (MSO) to perform the delegated functions, the MSO performing the functions on behalf of the delegated group is audited. Bright HealthCare's annual audit is a comprehensive review of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote the organization's overall goals and objectives for the delegated function. Annual audits will include a comprehensive review of **UM, Claims, Credentialing, and PNO.** The UM review shall include an extensive review of UM P&Ps, SOD/EOD files, and denials. The Claims review shall include non-contracted paid/denied claims and denied reports. Credentialing will review the delegate's Credentialing P&Ps and credentialing files to ensure all providers are credentialed and recredentialed. The review of PNO shall include a request for a full network roster to ensure CMS network adequacy requirements are met. Provider contracts are also reviewed to ensure all required state and federal terms are in contracts. In the event problems or deficiencies are identified, a corrective action may be issued and may include procedures for assuring that the corrective action is implemented.

Required Reporting

Delegated Groups shall provide Bright HealthCare with periodic written reports regarding all delegated activities in the formats specified by each business unit. Delegated Groups are to submit complete and accurate ongoing reports for all delegated activities according to the reporting frequencies specified in the Required Reporting Agreement.

Sub-Delegation

All Providers delivering service to Bright HealthCare members will adhere to the guidelines listed below. Delegated Groups shall not further sub-delegate any delegated activities to any other entity or organization without the prior written consent of the Plan.

Revocation

Bright HealthCare may in its sole discretion or at the discretion of CMS revoke any or all delegated activities at any time, for any reason.

Appendix 1: Individual and Family Plans & Small Group Contact Information

Provider Services

- Phone: **1-866-239-7191** for states: **AL**, **AZ**, **CO**, **FL**, **IL**, **OK**, **NC**, **NE**, **SC** and **TN**
- Phone: **1-844-926-4525** for states: **CA**, **GA**, **TX**, **UT** and **VA**
- 8 a.m. to 5 p.m. local time, Monday – Friday; closed (Holidays)

Specific Care Services

Pharmacy Services

- Phone: **1-833-661-1988**
- 24 hours a day, seven days a week, 365 days a year, no holidays
- For medical UM prior authorization, refer to information on **BrightHealthCare.com/provider/utilization-management.**

Prior Authorization

- The prior authorization process varies by state and service type. For authorization resources and contact information, go to **BrightHealthCare.com/provider/utilization-management** or **Availity.com**.

Care Management

(AL, AZ, CO, FL, IL, NE, NC, OK, SC, TN)

- Phone: **1-888-658-6818**

(CA, GA, TX, UT, VA)

- Phone: **844-926-4525**

8 a.m. to 5 p.m. CT, Monday – Friday

Closed Holidays

Claims Submission Addresses

For states: AL, AZ, CO, FL, IL, OK, NC, NE, SC and TN

- Bright HealthCare
  P.O. Box 16275
  Reading, PA 19612-6275

  EDI Payer ID: BRGHT

Statewide NE

- Midlands Choice
  P.O. Box 5809
  Troy, MI 48007-5809

  EDI Payer ID: 47080

For states: CA, GA, TX, UT and VA

- Bright HealthCare
  P.O. Box 211502
  Eagan, MN 55121

  EDI Payer ID: BRGHT

Appeals, grievances, and complaints

For states: AL, AZ, CO, FL, IL, OK, NC, NE, SC and TN

- Bright HealthCare
  ATTN: IFP Appeals and Grievances
  PO Box 16275
  Reading, PA 19612-6275

For states: CA, GA, TX, UT and VA

- Bright HealthCare
  ATTN: IFP Appeals and Grievances
  PO Box 1519
  Portland, ME 04104

Reporting fraud, waste, and abuse or suspicious activity

- Phone: **1-855-208-3766**

Appendix 2:
State Regulatory Appendices

Alabama Regulatory Requirements Appendix

This Alabama Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Alabama law, provided that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Care Partner each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement, unless otherwise defined. For example, "Benefit Plans," as used in this Appendix, has the same meaning as "benefit contracts." "Member," as used in this Appendix, has the same meaning as "customer," "enrollee," or "covered person." "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer." "Provider" as used in this Appendix, will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Professional," or other type of provider entity.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Non-discrimination

Bright HealthCare will not require as a condition of insurability that a person take a genetic test to determine if the person has a predisposition for cancer. Neither Bright HealthCare nor Care Partner will use the results of a genetic test which may show a predisposition of a person for cancer to determine insurability or to otherwise discriminate against the person in rates or benefits based on the genetic test.

Payment of claims

Bright HealthCare and Care Partner will develop and use standard health insurance claim forms required by, and that otherwise comply with, Alabama Code 27-1-16.

A "clean electronic claim" and a "clean written claim" (collectively "clean claim") means a claim for payment of covered healthcare expenses as defined under Section 27-1-17 of the Code of Alabama that is submitted to Bright HealthCare on a claim form adopted pursuant to Sections 27-1-16 of the Code of Alabama and related regulations with all required fields completed with correct and complete information in accordance with uniform elements specified under Alabama law. Bright HealthCare shall not require Care Partner to submit data elements in excess of those required under Alabama Code 27-1-16 as a condition to the acceptance and processing of an initial claim as a clean claim.

Clean claims will be paid, denied, pended, or settled within 30 calendar days after receipt by Bright HealthCare of a clean electronic claim and within 45 calendar days after receipt by Bright HealthCare or a clean written claim or a claim submitted by any other means. Any undisputed portion of a claim shall be paid within 30 calendar days after receipt by Bright HealthCare of a clean electronic claim and within 45 calendar days after receipt by Bright HealthCare or a clean written claim or a claim submitted by any other means.

If a claim is denied or pended, Bright HealthCare will notify Care Partner or Member, as appropriate, of the reason for denying or pending the claim and, if resolution of a claim requires additional information, Bright HealthCare will give Care Partner or Member, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim. Such notice will be given within 30 calendar days after receipt by Bright HealthCare of a clean electronic claim and within 45 calendar days after receipt by Bright HealthCare of a clean written claim or a claim submitted by any other means. Upon receipt of the necessary information, Bright HealthCare will pay, deny, or otherwise adjudicate the claim within 21 calendar days from the receipt of the requested information.

If Bright HealthCare fails to pay a clean claim, fails to provide notice of denying or pending a claim, or fails to provide notice of the reason for denying or pending the claim within the time frames set forth in this section, then such claim, if and when determined to be payable, shall accrue interest at the rate of 1.5 percent per month prorated daily from the date such claim became overdue or notice of the reason for denying or pending the claim should have been given.

The time frames set forth in this section do not apply when (1) Bright HealthCare's failure to comply is caused by a directive from a court or a federal or state agency, (2) Bright HealthCare's compliance is rendered impossible due to matters beyond its control which were not caused by Bright HealthCare or by a third party vendor, agent, or contracting party furnishing service to Bright HealthCare which are related directly or indirectly to the processing of claims, (3) the claim is pended due to a fraud investigation that has been reported to a state or federal agency or an external review process, or (4) Bright HealthCare is in liquidation or rehabilitation or is operating in compliance with a court ordered plan of rehabilitation. The failure of Bright HealthCare to comply with the time limits set forth in this paragraph shall not have the effect of requiring coverage for an otherwise uncovered claim.

To the extent that a claim is made under a Medicare Supplemental Insurance Policy, Bright HealthCare and Care Partner shall comply with the Medicare Supplemental Insurance Minimum Standards Regulation, Alabama Code Chapter 19-2 and Alabama Administrative Code Ch. 482-1-071, including standards for claims payment set forth in Alabama Administrative Code 482-1-071-.13.

Retroactive denial, adjustment, recoupment or refund of paid claims

Bright HealthCare shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for healthcare expenses submitted to Care Partner after the expiration 180 days from the date that the initial claim was paid, except that Bright HealthCare may retroactively deny, adjust, or seek recoupment or refund of a paid claim for healthcare expenses to Care Partner for reasons related to coordination of benefits after the expiration of 18 months from the date the original claim was paid. The limitation set forth in this section does not apply in cases of fraud or for duplicate payments for the same service.

Bright HealthCare will provide Care Partner with notice specifying the reason for retroactively denying, adjusting, or seeking recoupment or refund the paid claim. If the denial, adjustment, or request for recoupment or refund is for reasons related to coordination of benefits, Bright HealthCare shall, upon the request of Care Partner, provide Care Partner with any available information concerning the name and address of the entity determined to be responsible for payment of the claim. Further, any retroactive denials, adjustments, or requests for recoupment or refund of previous payments which are based on medical necessity determinations, level of service determinations, coding errors, or billing irregularities shall be reconciled to specific claims.

If Care Partner disputes or contests the basis for the retroactive denial, adjustment, or request for recoupment or refund on all or any portion of a claim, Care Partner must notify Bright HealthCare within 30 days after Care Partner receives notice of the retroactive denial, adjustment, or request for recoupment or refund. In addition, Care Partner shall have an additional period of six months from the date that Bright HealthCare provided Care Partner with notice of the reason for denying, adjusting, or seeking recoupment of the paid claim within which to file either a revised claim or a request for reconsideration with additional medical records or information. Bright HealthCare will process such revised claim or request for reconsideration in accordance with the time frames and requirements set forth in Paragraph 6 or, if applicable, in accordance with U.S. Department of Labor regulations governing the resolution of claims disputes and times for appeals.

Safeguarding consumer information

Care Partner shall cooperate with Bright HealthCare to protect the security, confidentiality, and integrity of nonpublic personal Member information and ensure compliance with Alabama Administrative Code Chapter 482-1-126. Such cooperation shall include implementation by Care Partner of appropriate measures designed to protect the security, confidentiality, and integrity of nonpublic personal Member information subject to review and confirmation of such measures by Bright HealthCare. "Nonpublic personal Member information" has the same meaning as "Customer Information" defined in Alabama Administrative Code 382-1-126.03(b).

Care Partner shall cooperate with Bright HealthCare to ensure compliance with the Privacy of Nonpublic Personal Financial Information Regulations, Alabama Administrative Code Chapter 482-1-122. Care Partner shall not disclose or use any nonpublic personal financial information related to a Member other than for the purposes for which Bright HealthCare shared the information, including, but not limited to, the provision of covered healthcare services or other services authorized by this agreement to a Member or to otherwise fulfill Care Partners' obligations under this agreement. "Nonpublic personal financial information" has the same meaning as "Nonpublic Personal Financial Information" defined in Alabama Administrative Code 482-1-122-.04 (T).

Marketing

The comprehensive sales and marketing plan set forth in Section 4(l) of the Agreement is subject to the provisions of this paragraph. All advertising by Bright HealthCare and Care Partner shall comply with Alabama Administrative Code Chapter 482-1-013. To the extent Bright HealthCare offers a Medicare Supplemental Insurance Policy, Bright HealthCare and Care Partner shall comply with the Medicare Supplemental Insurance Minimum Standards Regulation, Alabama Administrative Code Ch. 482-1-071, including filing standards for advertising set forth in Alabama Administrative Code 482-1-071-.19.

Fraud warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Post-partum care

Bright HealthCare will not terminate the services, reduce capitation payment, or otherwise penalize Care Partner, or its employees and agents, if Care Provider, or its employees or agents: (1) orders medically necessary inpatient care for a mother and her newborn child as determined by the woman's prenatal care physician, obstetrician gynecologist, certified nurse midwife, or the child's attending pediatrician and when such care is consistent with the standards for admission and discharge of a mother and the newborn child set forth in Alabama Code 27-48-2, (2) allows the mother and newborn child a hospital stay of no less than 48 hours in connection with childbirth for the mother or newborn child following a normal vaginal delivery or a hospital stay of no less than 96 hours in connection with childbirth for the mother or newborn child following a cesarean section. Bright HealthCare is not providing, and will not provide, Care Partner, directly or indirectly, any financial incentive or disincentive or grant or deny any special favor of any kind or nature to any person to encourage or cause early discharge of a hospital patient from postpartum care, excluding capitation or global fee arrangements.

Domestic Abuse Insurance Protection Act

Bright HealthCare and Care Partner will comply with the Domestic Abuse Insurance

Protection Act, Alabama Code Title 27, Chapter 55. Bright HealthCare will not disclose to Care Partner any Confidential Abuse Information as defined in Alabama Code 27-55-2(6) except as necessary (1) for the direct provision of healthcare services, (2) if a licensed physician employed or contracted by Care Partner is identified and designated to receive the information by the subject of abuse, (3) for a valid business purpose to transfer information that includes confidential abuse information as set forth in Alabama Code 27-55-3(b)(5), or (4) as otherwise allowed under the Domestic Abuse Insurance Protection Act.

Access to Eye Care Act

To the extent Bright HealthCare covers, and Care Partner provides, eye care under the terms of this agreement, Bright HealthCare will pay a licensed optometrist for each service which falls within the scope of the optometrist's license to the same extent it pays for the same service when provided by any other provider of such services. Bright HealthCare and Care Partner will ensure compliance with the Access to Eye Care Act, Alabama Code Title 27, Chapter 56, as required by the law, including providing each Member direct access to any eye care provider to provide covered services without any referral or preapproval requirement. To the extent Bright HealthCare covers, and Care Partner provides, eye care under the terms of this agreement, Bright HealthCare and Care Partners will cooperate to make reasonable efforts to include a sufficient number of qualified providers, including optometrists, to ensure reasonable access to eye care services. Nothing in this paragraph limits the authority of Bright HealthCare, in coordination with Care Partners, to be able to establish and apply selection criteria and utilization protocols for healthcare providers as well as credentialing criteria used in the selection of providers to the extent such activities and authority are allowed under the Access to Eye Care Act.

Breast cancer screening

Care Partner agrees to cooperate with Bright HealthCare to ensure that the Care Partner network has accessible to Members a healthcare professional with expertise in screening mammography. Bright HealthCare shall not terminate services, reduce capitation payment, or otherwise penalize Care Partner if it orders for a Member a mammogram in accordance with the time frames set forth in Alabama Code 27-50-4.

Prostate cancer screening

Care Partner agrees to cooperate with Bright HealthCare to ensure that the Care Partner network has accessible to Members a certified, registered, or licensed health care professional with expertise in screening for the early detection of prostate cancer. Bright HealthCare shall not terminate services, reduce capitation payment, or otherwise penalize Care Partner if it orders for a Member an annual screening for the early detection of prostate cancer in men over age 40 including, at a minimum, a prostate-specific antigen blood test and a digital rectal examination.

Arizona Regulatory Requirements Appendix

This Arizona Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Arizona law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts";

"Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Member Hold Harmless

If Bright HealthCare fails to pay for any Covered Services as provided in a Member's Benefit Plan, the Member is not liable to Provider or Participating Provider for any amounts owed by Bright HealthCare and Provider or Participating Provider shall not bill or otherwise attempt to collect from the Member the amount owed by Bright HealthCare in accordance with Ariz. Rev. Stat. § 20-1072. Provider or Participating Provider shall not maintain an action at law against a Member to collect any amounts owed by Bright HealthCare for which the Member is not liable to Provider or Participating Provider pursuant to Ariz. Rev. Stat. § 20-1072. Neither Provider nor Participating Providers may charge a Member more than the amount Provider has contracted with
Bright HealthCare to charge Members.

Freedom of Choice

Bright HealthCare and Provider will adhere to "Freedom of Choice" statutes requiring that Bright HealthCare reimburse health services covered by Benefit Plans without designating the specific type of licensed health professional to perform the service. In accordance with Ariz. Rev. Stat. § 20-461, Bright HealthCare will reimburse charges for reasonable and necessary Covered Services provided by any Provider licensed pursuant to Ariz. Rev. Stat. Title 32, chapter 8 (chiropractors), chapter 9 (physicians), or chapter 17 (osteopathic physicians), if the services are within the lawful scope of practice of the Provider, regardless of the nomenclature used to describe the condition, complaint or service.

Treatment Discussions

Neither Bright HealthCare nor Provider shall restrict or prohibit a Participating Provider's good faith communications with the Participating Provider's Members concerning any such Member's health care or medical needs, treatment options, health care risks or benefits.

Neither Bright HealthCare nor Provider shall terminate or refuse to renew a Participating Provider's participation in Bright HealthCare's network, solely because the Participating Provider in good faith does any of the following: (a) advocates in private or in public on behalf of a Member; (b) assists a Member in seeking reconsideration of a decision made by Bright HealthCare to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority, in accordance with Ariz. Rev. Stat. § 20-118; § 20-1061.

Provider Directories and Demographic Reports

Provider will furnish Bright HealthCare with the necessary information for Bright HealthCare to maintain a provider directory that includes a list of network Participating Providers available to Members and to provide demographic information reports in accordance with Ariz. Admin. Code R20-6-1912 and R20-6-1913.

Uniform Billing

To the extent Provider operates a hospital which is subject to the uniform billing requirements of Ariz. Rev. Stat. § 36-125.05, Bright HealthCare shall accept such billing as its principal billing format, in accordance with Ariz. Rev. Stat. 36-125.07. To the extent Provider is a hospital and Bright HealthCare requires the submission of supplemental information in order to substantiate billing for emergency services, Bright HealthCare shall pay the reasonable cost to the hospital of reproducing such supplemental information that shall be related solely to emergency services.

Prompt Claim Payments.

Bright HealthCare and Provider will adhere to Arizona's prompt claim payment statutes, Ariz. Rev. Stat. Title 20, Chapter 20. A "clean claim" means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from Provider, another health care provider, the Member or a third party, except in cases of fraud. The term "adjudicate" for purposes of this section means Bright HealthCare's decision to deny or pay a claim, in whole or in part, including the decision as to how much to pay.

Unless otherwise agreed, Bright HealthCare will adjudicate clean claims within thirty (30) days after Bright HealthCare receives a clean claim, in accordance with Ariz. Rev. Stat. § 20-3102. Unless otherwise agreed, Bright HealthCare shall pay the approved portion of any clean claim within thirty (30) days after the claim is adjudicated. If the claim is not paid within thirty (30) days from the date of adjudication or within the time period agreed to by the parties, Bright HealthCare shall pay interest on the claim at a rate that is allowed under Arizona law. Arizona Revised Statutes 20-3102(A). Interest shall be calculated beginning on the date that the payment to the health care provider is due.

If a claim is not a clean claim and Bright HealthCare requires additional information to adjudicate the claim, Bright HealthCare will send a written request for additional information to Provider within thirty days after Bright HealthCare receives the claim. Bright HealthCare will notify Provider of all of the specific reasons for the delay in adjudicating the claim. Bright HealthCare will not request information from Provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim. Bright HealthCare may only request that Provider resubmit claim information that Provider previously provided to Bright HealthCare if Bright HealthCare has a reasonable justification to request the resubmission and the purpose of the request is not to delay the payment of the claim. Bright HealthCare will record the date it receives additional information and shall adjudicate the claim within thirty (30) days of receiving the additional information. Bright HealthCare will pay the approved portion of the adjudicated claim within thirty (30) days from the date of adjudication or within the time frame agreed to by the parties. If the claim, supplemented by the additional information, is not paid within thirty (30) days from the date of adjudication, Bright HealthCare shall pay interest on the claim at a rate that is equal to the legal rate specified in Arizona Revised Statutes 20-3102(A).

Retroactive Adjustment of Claims

Unless otherwise agreed, neither Bright HealthCare or Provider shall adjust or request adjustment of the payment or denial of a claim more than one year after Bright HealthCare has paid or denied that claim. If the parties agree on a different length of time to adjust or request adjustment of the payment of a claim, both parties shall have the same length of time to do so. If the claim is adjusted, neither Bright HealthCare nor Provider shall owe interest on the overpayment or the underpayment resulting from the adjustment, as long as the adjusted payment is made or recoupment taken within thirty (30) days of the date of the adjudication of the claim adjustment. The time limitations set forth in this paragraph do not apply in cases of fraud.

Claims Grievance Reporting

Bright HealthCare and Provider shall resolve payment disputes and other contractual grievances as set forth in the Agreement. The parties acknowledge that the process set forth in the Agreement constitutes the internal system of resolving payment disputes and other contractual grievances required by Arizona Revised Statutes 20-3102(F).

Bright HealthCare and Provider agree that, in accordance with Arizona Revised Statutes 20-3102(F), Bright HealthCare may disclose to the Arizona Department of Insurance Director a summary of any grievances submitted by Provider on a semiannual basis, including the name and identification number(s) of Provider, the type of grievance, the date Bright HealthCare received the grievance, and the date the grievance was resolved.

This paragraph does not apply to a decision by Bright HealthCare to terminate Provider from Bright HealthCare's network or otherwise terminate this Agreement. This paragraph does not apply to any Bright HealthCare decision that is subject to Bright HealthCare's utilization review plan and adopted in accordance with Arizona Revised Statutes Title 20, Chapter 15, Article 2.

Provider Incentives

Bright HealthCare will not offer any type financial incentive plan which provides a specific payment made to or withheld from Provider or Participating Providers as an inducement to deny, reduce, limit, or delay medically necessary care that is a Covered Service in accordance with Ariz. Rev. Stat. 20-1061.

Utilization Review

In accordance with Ariz. Rev. Stat. Title 20, Chapter 15, to the extent Bright HealthCare has adopted a utilization review plan including written utilization review standards and criteria to assess requested medical or health care services or claims for medical and health care services, as well as processes for the review, reconsideration and appeal of denials of requested medical or health care services or claims for medical and health care services. Bright HealthCare and Provider agree that decisions regarding approval or denial of medical or health care services or claims for medical and health care services will be governed by the most recent utilization review system plan filed with the Director of the Arizona Department of Insurance in accordance with Ariz. Rev. Stat. § 20-2532. The most current utilization review plan will be made available upon request. Bright HealthCare and Provider acknowledge that the utilization review plan may be changed subject to the requirements of Ariz. Rev. Stat. Title 20, Chapter 15. Provider agrees to fully cooperate and provide information to Bright HealthCare or its designated utilization review agent in a complete and timely a manner to allow Bright HealthCare or its authorized utilization review agent to investigate, evaluate and form a reasonable basis for utilization decisions concerning requested medical or health care services or claims for medical and health care services of Members. To the extent Bright HealthCare provides a Member's treating provider who is Participating Provider a form statement concerning the Member's right to appeal a denial, Provider will ensure that Participating Provider will notify the Member of the Member's right to appeal, in accordance with Ariz. Rev. Stat. 20-2533.

Prior Authorization

To the extent Bright HealthCare establishes a prior authorization requirement for any of its Benefit Plans pursuant to Ariz. Rev. Stat. Title 20, Chapter 15, Provider and Participating Providers will fully cooperate and provide information to Bright HealthCare or its designated utilization review agent in a complete and timely manner to allow Bright HealthCare or its authorized review agent to investigate, evaluate and form a reasonable basis for prior authorization decisions.

Network Access Standards

Provider agrees to cooperate with Bright HealthCare to maintain the following standards to provide Members access to Covered Services, in accordance with Ariz. Admin. Code R20-1914:

a. For preventive care services from a contracted primary care Participating Provider, an appointment date within 60 days of the Member's request, or sooner if necessary, for the Member to be immunized on schedule.

b. For routine-care services from a contracted primary care Participating Provider, an appointment date within 15 days of the Member's request to the Participating Provider or sooner if medically necessary.

c. For specialty care services from a contracted specialty care Participating Provider, an appointment date within 60 days of the Member's request or sooner if medically necessary.

d. In-area urgent care services from a contracted Participating Provider seven days per week.

e. Timely non-emergency inpatient care services from a contracted facility.

f. Timely services from a contracted Participating Provider physician or practitioner in a contracted facility including inpatient emergency care.

g. Services from a contracted ancillary Participating Provider during normal business hours, or sooner if medically necessary.

Geographic Availability

Provider agrees to cooperate with Bright HealthCare to satisfy the following geographic availability standards, in accordance with Ariz. Admin. Code R20-1917; R20-1918; and R20-1919:

For Urban Areas:

a. Primary care services from a contracted Participating Provider located within 10 miles or

b. 30 minutes of a Member's home;

c. High profile specialty care services from a contracted Specialty Participating Provider located within 15 miles or 45 minutes of a Member's home; and

d. Inpatient care in a contracted general hospital or contracted special hospital, within 25 miles or 75 minutes of the Member's home.

For Suburban Areas:

a. Primary care services from a contracted Participating Provider located within 15 miles or
b. 45 minutes of a Member's home;
c. High profile specialty care services from a contracted Specialty Participating Provider located within 20 miles or 60 minutes of a Member's home; and
d. Inpatient care in a contracted general hospital or contracted special hospital, within 30 miles or 90 minutes of the Member's home.

For Rural Areas:

a. Primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.

Provider Credentialing

Bright HealthCare shall credential Participating Providers in accordance with the procedures and timelines provided in Ariz. Rev. Stat. Title 20, Chapter 27.

Member Continuity of Care After Provider Termination

Bright HealthCare shall allow any Member receiving healthcare from a Participating Provider who is terminated from Bright HealthCare's network (except for reasons of the Participating Provider's medical incompetence or unprofessional conduct), on written request of the Member to Bright HealthCare, to continue an active course of treatment with that Participating Provider during a transitional period if the conditions provided by Ariz. Rev. Stat. § 20-1057.04 are satisfied.

Member Continuity of Care After Insolvency

Provider and each Participating Provider shall provide Covered Services to Members at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after Bright HealthCare is declared insolvent, until the earliest of the following: (a) a determination by the court that the insolvent Bright HealthCare cannot provide adequate assurance it will be able to pay Provider or Participating Provider's claims for Covered Services that were rendered after Bright HealthCare is declared insolvent; (b) a determination by the court that the insolvent Bright HealthCare is unable to pay Provider's or Participating Provider's claims for Covered Services that were rendered after Bright HealthCare is declared insolvent; (c) a determination by the court that continuation of the Agreement would constitute undue hardship to Provider or Participating Provider; or (d) a determination by the court that Bright HealthCare has satisfied its obligations to all Members under the applicable Benefit Plans, in accordance with Ariz. Rev. Stat. § 20-1074(B)).

Maternity and Post-delivery Care

Bright HealthCare will not penalize or reduce or limit reimbursement to Provider, or its employees and agents, because Provider, or its employee or agents: (1) allows a mother and newly born baby a hospital stay of not less than forty-eight (48) hours in connection with childbirth for the mother or newborn child following a normal vaginal delivery or a hospital stay of not less than ninety-six (96) hours in connection with childbirth for the mother or newborn child following a cesarean section. Bright HealthCare is not providing, and will not provide, Provider, or its employees or agents, monetary or other incentives to induce Provider, or its employees or agents, to cause early discharge of a Member as set forth in this paragraph or otherwise provide care inconsistent with Ariz. Rev. Stat. 20-1342(12)(B). Nothing in this paragraph prevents Bright HealthCare from negotiating the level and type of reimbursement with Provider for post-partum care.

Dental Services

To the extent that Bright HealthCare offers reimbursement or coverage to Members for dental services and Provider or Participating Providers provide dental services to a Member under this Agreement. Bright HealthCare will not limit the fee or reimbursement that Provider may charge to a Member for dental services unless those dental services are Covered Services, in accordance with Ariz. Rev. Stat. 20-1057.12.

Limitations on Disclosure of HIV Information

Bright HealthCare will not disclose to Provider any confidential HIV-related information unless such disclosure is authorized in writing pursuant to a release as set forth in Arizona Revised Statutes 20-448.01 and Ariz. Admin. Code R20-6-1204 or as otherwise required by law. Provider shall not disclose, and shall take all reasonable measures to avoid disclosure of, any confidential HIV-related information provided to Provider by Bright HealthCare to any other person except as allowed under Arizona Revised Statutes 20-448.01. "Confidential HIV-related information" means information concerning whether a person has had an HIV-related test or has HIV infection, HIV-related illness or acquired immune deficiency syndrome and includes information which identifies or reasonably permits identification of that person or the person's contacts.

Telemedicine Services

To the extent that Provider provides any telemedicine services to Members within the scope of Ariz. Rev. Stat. § 20-1057.13, Provider will ensure that all such services provided through telemedicine or resulting from a telemedicine consultation will comply with Arizona licensure requirements, accreditation standards and any practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care, in accordance with Ariz. Rev. Stat. § 20-1057.13.

Familial Relationships

Bright HealthCare will provide coverage for lawful health care services that are provided by a Participating Provider to a Member regardless of the familial relationship of the Participating Provider to the Member if the health care service would be covered were it provided to a Member who was not related to the Participating Provider. Nothing in this Section of the Appendix limits the right or authority of Bright HealthCare to limit coverage to Participating Providers who are contracted with Providers or otherwise part of the Bright HealthCare network, in accordance with Ariz. Rev. Stat. 20-1057.17.

California Regulatory Requirements Appendix

Continuity of Care

Provider and Bright HealthCare acknowledge that, in accordance with Cal. Code Regs. tit. 28, § 1300.67.1(a) and (c), within each service area of a Benefit Plan, basic health care services must be provided in a manner which provides continuity of care, including but not limited to (i) the ability of primary care physicians, who will be responsible for coordinating the provision of health care services to each Member; and (ii) the maintenance and prompt availability of medical records, including for purposes of sharing within the Benefit Plan of all pertinent information relating to the health care of each Member.

Accessibility of Services

Provider and Bright HealthCare acknowledge that, in accordance with Cal. Code Regs. tit. 28, §§ 1300.67.2(b), (c) and (f) and 1300.67.2.2(c), within each service area of a Benefit Plan, basic health care services and specialized health care services must be readily available and accessible to each Member. As such, Provider acknowledges that: (i) hours of operation and provision for after-hour services must be reasonable; (ii) emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week; and (iii) Benefit Plans will have a documented system for monitoring and evaluating accessibility of care, including but not limited to a system for addressing problems regarding wait time and appointments.

Regulatory Requirements Applicable to Benefit Plan

Pursuant to Cal. Code Regs. tit. 28, § 1300.67.4(a)(9), Bright HealthCare acknowledges that it is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code (Health Care Service Plans) and of Chapter 1 of Title 28 of the California Code of Regulations (Department Administration), and any provision required to be in the Benefit Plan pursuant to the aforementioned shall bind Bright HealthCare whether or not provided in the Benefit Plan.

Effect of Termination on Care

a. Pursuant to Cal. Code Regs. tit. 28, § 1300.67.4(a)(10), upon termination of the Agreement, Bright HealthCare shall be liable, subject to the same terms and conditions in effect prior to the termination, for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Cal. Health & Safety Code § 1345) to a Member who retains eligibility under the applicable Benefit Plan or by operation of law under the care of Provider at the time of such termination until the services being rendered to the Member by Provider are completed, unless Bright HealthCare makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

b. In addition, and pursuant to Cal. Health & Safety Code § 1373.96, upon termination of the Agreement for reasons other than a medical disciplinary cause or reason (as defined in Cal. Bus & Prof. Code § 805(a)(6)), fraud, or other criminal activity, Provider and Participating Providers shall, upon request, continue to provide Covered Services to a Member who at the time of the Agreement's termination was receiving Covered Services from a Provider or a Participating Provider for one of the following conditions, as those terms are defined in Cal. Health & Safety Code § 1373.96:

    a. An acute condition;

    b. A serious chronic condition;

    c. A pregnancy;

    d. A terminal illness;

    e. The care of a newborn child between birth and thirty-six (36) months; or

    f. A procedure that is authorized by Bright HealthCare as part of a documented course of treatment to occur within one hundred eighty (180) days of the termination date of the Agreement.

To the extent that Provider continues to render Covered Services to a Member after the termination date of the Agreement, Provider agrees to be subject to the same contractual terms and conditions that were in effect under the Agreement prior to such termination, including but not limited to credentialing, utilization management, quality assurance, and reimbursement rates and payment terms. Bright HealthCare shall not be required to continue to reimburse for the services of Provider after the termination date of the Agreement if Provider does not agree to comply with such contractual terms and conditions, and to accept the reimbursement rates and payment terms required by this Section 4(b). Nothing in this section shall require Bright HealthCare to cover services or provide benefits that are not otherwise covered under the terms and conditions of the Member's Benefit Plan.

Certain Regulatory Requirements

Bright HealthCare and Provider acknowledge and agree that, pursuant to Cal. Code Regs. tit. 28, § 1300.67.8, the Agreement shall be subject to the following requirements:

a. The Agreement shall permit confidential treatment by the Director of the California Department of Managed Health Care (the "Director") of payment rendered or to be rendered to Provider without concealment or misunderstanding of other terms and provisions of the Agreement.

b. Provider shall maintain such records and provide such information to Bright HealthCare or to the Director as may be necessary for compliance by Bright HealthCare with the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the rules thereunder, that such records will be retained by Provider for at least two years, and that such obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise.

c. Bright HealthCare shall have access at reasonable times upon demand to the books, records and papers of Provider relating to the health care services provided to Members, to the cost thereof, to payments received by Provider from Members of any of the Benefit Plans (or from others on their behalf), and, unless Provider is compensated on a fee-for-service basis, to the financial condition of Provider.

d. Provider shall not collect surcharges for Covered Services. If Bright HealthCare receives notice of any such surcharge, Bright HealthCare shall take appropriate action pursuant to the Agreement.

e. In the event that Bright HealthCare fails to pay for Covered Services as set forth in a Member's Benefit Plan, the Member shall not be liable to Provider for any sums owed by Bright HealthCare, in accordance with Cal. Health & Safety Code § 1379(a). Provider and Participating Provider shall not collect or attempt to collect from the Member any sums owed by Bright HealthCare. Neither Provider, Participating Provider, nor any agent, trustee, or assignee of Provider or Participating Provider shall maintain any action at law against a Member to collect sums owed by Bright HealthCare. Upon termination of the Agreement for any cause, Provider shall comply with the provisions of Cal. Code Regs. tit. 28, § 1300.67.4(a)(10) (as described in Section 4 herein).

Invoice or Billing of Members

Except for applicable co-payments and deductibles, Provider and Participating Providers shall not invoice or balance bill a Member for the difference between Provider's or a Participating Provider's billed charges and the reimbursement paid by Bright HealthCare for any Covered Service, in accordance with Cal. Code Regs. tit. 28, § 1300.71(g)(4).

Moneys Paid by Members to Provider

Provider shall report to Bright HealthCare in writing all surcharge and co-payment moneys paid by Members directly to Provider or Participating Providers, in accordance with Cal. Health & Safety Code § 1385.

Quality Assurance Program

Provider agrees to participate in, and ensure Participating Providers will participate in, all quality assurance programs implemented by Bright HealthCare pursuant to California law, and agrees to cooperate with Bright HealthCare in providing or arranging for such quality assurance programs, in accordance with Cal. Code Regs tit. 28, § 1300.70.

Insolvency

In the event of insolvency of Bright HealthCare, and in accordance with Cal. Health & Safety Code § 1394.7(e), Provider and Participating Providers shall continue to provide Covered Services to Members until the effective date of a Member's coverage in a successor plan pursuant to open enrollment or the allocation process conducted by the Director, but in no event (i) for a period exceeding that required by the Agreement or forty-five (45) days in the event of allocation, whichever is greater, or (ii) for a period exceeding that required by the Agreement or thirty (30) days in the case of open enrollment, whichever is greater.

Acts and Omissions

Notwithstanding any provision of the Agreement to the contrary, and in accordance with Cal. Health & Safety Code § 1371.25, Bright HealthCare, Provider and Participating Providers are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, each other. Nothing in this section shall preclude a finding of liability on the part of Bright HealthCare, Provider or Participating Provider based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.

Dispute Resolution

In accordance with Cal. Health & Safety Code § 1367(h)(1) Bright HealthCare shall maintain a fast, fair, and cost-effective dispute resolution mechanism under which Provider may submit disputes according to the procedures for processing and resolving disputes as described in the Agreement and the Provider Manual. Bright HealthCare will inform Provider upon a change in the dispute resolution process, including the location and telephone number where information regarding disputes may be submitted.

Language Assistance Program

Provider shall cooperate and comply with, as applicable, Bright HealthCare's language assistance program standards for Members pursuant to California laws and regulations, including Cal. Health & Safety Code § 1367.04(f) and Cal. Code Regs tit. 28, 1300.67.04(c)(1)(E). Provider shall provide Bright HealthCare with any and all information necessary to assess or confirm compliance with this paragraph. Such standards and mechanisms for providing language assistance services at no charge to Members will be communicated to Provider from time to time, and Limited English Proficient language needs information collected by Bright HealthCare will be made available to Participating Providers.

Informational notices explaining how Members may contact their plan, file a complaint with their plan, obtain assistance from the California Department of Managed Health Care (the "Department"), and seek an independent medical review are available in non-English languages through the Department's website. The notice and translations can be obtained online at **www.hmohelp.ca.gov** for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, California 95814.

Material Changes to the Agreement or Other Documents

Amendments or Modifications of the Agreement are governed by Section 9(i) of the Agreement. To the extent required by applicable law, including Cal. Health & Safety Code § 1375.7(b)(1)(A), if a material change is made to the Agreement by amending a manual, policy, or procedure document referenced in the Agreement, Bright HealthCare shall give Provider at least forty-five (45) business days' notice of the material change, unless the change is a result of a change in State or federal law or regulations or any accreditation requirements of a private sector accreditation organization which requires a shorter timeframe for compliance. If Provider does not agree to the change, Provider shall have the right to terminate the Agreement prior to the implementation of the change, in which case Provider shall give Bright HealthCare written notice of the termination at least fifteen (15) days prior to the expiration of such forty-five (45) business day period. The parties may mutually agree to waive the forty-five (45) business day notice requirement.

To the extent required by applicable law, including Cal. Health & Safety Code 1375.7(b)(3), Provider will be given advance notice of a material change to the quality improvement or utilization management programs or procedures. Such change will be made pursuant to the requirements of this Section 13; provided that, a change to such quality improvement or utilization management programs or procedures may be made at any time if the change is necessary to comply with State or federal law or regulations or any accreditation requirements of a private sector accreditation organization.

Acceptance of Patients

Provider and Participating Providers are not obligated to accept additional Members as patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of Provider, accepting additional patients would endanger patient's access to, or continuity of, care, in accordance with Cal. Health & Safety Code § 1375.7(b)(2).

Disclosure of Certain Information

To the extent that information relating to claims processing and payment is required by applicable laws or regulations, including Cal. Code Regs. tit. 28, § 1300.71(l)–(o), to be disclosed to Provider, such information shall be provided by Bright HealthCare to Provider, and shall include the following:

a. In a paper or electronic format (which may include a website):
    - Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information and documentation, instructions for confirming the receipt of claims, and a phone number for claims inquiries and filing information.
    - The identity of the office responsible for receiving and resolving provider disputes.
    - Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of provider disputes and all claim dispute requirements, the timeframe for the acknowledgement of the receipt of a provider dispute and a phone number for provider dispute inquiries and filing information.
    - Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled notice.
b. In an electronic format (which may include a website, provided that Bright HealthCare must provide written notice to Provider at least forty-five (45) days prior to implementing a website transmission format or posting any changes to the mandatory information on the website):
    - Information as to the amount of payment for each and every service to be provided under the Agreement, including any fee schedules or other factors or units used in determining the fees for each service.
    - Detailed payment policies and rules and, if applicable, non-standard coding methodologies used to adjudicate claims.

d. Such information shall be disclosed to Provider upon initial contracting and annually thereafter on or before the contract anniversary date, and upon Provider's written request.

e. Bright HealthCare shall provide at least forty-five (45) days prior written notice to Provider before instituting any changes, amendments, or modifications to the disclosures required pursuant to this Section 15.

Relationship with Insurance Code and Knox-Keene Health Care Service Plan Act of 1975

In accordance with Cal. Health & Safety Code § 1375.7(b)(4), no provision in the Agreement shall waive or conflict with any applicable provision in the Knox-Keene Health Care Service Plan Act of 1975.

Notice Upon Cancellation or Amendment

Immediately upon cancellation or amendment of the Agreement, Provider shall notify the California Attorney General of such cancellation or amendment, the text thereof, and the effective date thereof, at the following address: Health Plan Registrar, Office of the Attorney General, 3580 Wilshire Boulevard, Los Angeles, California 90010, or such other address as may be set forth in regulation, in accordance with Cal. Code Regs. tit. 11, §§ 501 and 536.

Quality of Care Review System

To the extent any quality of care review system is administered by Provider, the parties must enter into a contractual arrangement to enable Bright HealthCare to monitor and require compliance with quality of care review system requirements in accordance with Cal. Code Regs. Tit. 28, § 1300.51.

Books and Records

All records, books, and papers between Bright HealthCare and Provider, shall be open to inspection during normal business hours by the Director. To the extent possible, all such records shall be located in California. In the event such records are located outside of California, the Director shall consider the cost to plan, and may, upon reasonable notice require that such records, books, and papers be made available for examination in California. Any records related to this Agreement shall not be removed from the state of California without the prior consent of the Director. The Director is permitted to conduct an examination of the fiscal and administration affairs of Bright HealthCare and this Agreement with Provider, as often as deemed necessary to protect the interest of Members, but not less frequently than once every five years. Cal. Health & Safety Code § 1381 and 1382(a); Cal. Code Regs. Tit. 28, §§ 1300.81.

Confidentiality of Member Medical Information

Bright HealthCare agrees to permit Members, and shall accommodate requests for, communication in the form and format requested by the Member, if it is readily producible in the requested form and format, or at alternative locations, if the Member clearly states either that the communication discloses medical information or provider name and address relating to receipt of sensitive services or that disclosure of all or part of the medical information or provider name and address could endanger the Member. Cal. Civ. Code § 56.107; Cal. Health & Safety Code § 1348.5.

Prohibition of Payment to Providers to Deny, Limit, or Deny Services

Bright HealthCare and Provider agree that no provision of this Agreement includes specific payments, whether directly or indirectly, in any type or form, to Provider or Participating Providers as an inducement to deny, reduce, limit, or delay specific, medically necessary and appropriate services to a specific Member or group of Members with similar medical conditions. Further, Bright HealthCare and Provider agree to not restrict maternity benefits to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. Cal. Health & Safety Code §§ 1348.6 and 1367.62.

Provider Disputes

a. In the event that Bright HealthCare, or Bright HealthCare's capitated Provider or Participating Provider, contests, adjusts, or denies a claim, Bright HealthCare or the Provider or Participating Provider, as the case may be, shall inform the provider of the availability of the provider dispute resolution mechanism and procedures for obtaining forms and instructions, including the mailing address, for filing a dispute. Cal. Code Regs. Tit. 28, § 1300.71.38(b).

b. Providers or Participating Providers that are reimbursed on a capitated basis under this Agreement shall make available to Bright HealthCare and the Department all records, notes, and documents regarding Provider or Participating Provider's provider dispute resolution process and the resolution of provider disputes. If a provider's dispute involves an issue of medical necessity or utilization review, provider shall have an unconditional right of appeal for the claim to Bright HealthCare's dispute resolution process for a new review and resolution for a period of 60 days from the Provider or Participating Provider's date of denial. In the event that Provider or Participating Provider fails to timely resolve provider disputes under this paragraph, Bright HealthCare shall assume responsibility for the administration of Provider's dispute resolution process. Cal. Code Regs. Tit. 28, §§ 1300.71(e)(4), (5), (7).

c. If the Provider dispute involves a claim and is determined in whole or in part in favor of the Provider, Bright HealthCare or a capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Section 23(a), within five (5) working days of the written determination. Cal. Code Regs. Tit. 28, § 1300.71.38(g).

Claims

a. Prompt Payment.

- Clean Claims. Bright HealthCare, or a capitated provider, shall pay uncontested portions of claims as soon as practicable, but no later than 45 working days after receipt of the claim from Provider. Late payments shall be subject to interest at a rate of (x) for complete claims for emergency services and care, the greater of $15 for each 12-month period or portion thereof, or 15% per year for the period of time that the payment is late or (y) for all other complete claims, 15% per year for the period of time that the payment is late. Cal. Health & Safety Code §§ 1371 and 1371.35; Cal. Code Regs. Tit. 28, §1300.71(i).
- Contested Claims. Bright HealthCare, or a capitated provider, will give Provider written notice within 45 working days following receipt of a contested claim and shall identify the portion of the claim that is contested and the specific reason(s) for contesting the claim. If Bright HealthCare contested a claim on the basis that it had not received all information necessary to determine Bright HealthCare's responsibility, and Bright HealthCare subsequently receives adequate information to determine payment responsibility, Bright HealthCare shall reimburse the claim in accordance with the timeframe in Section 23(a)(i). Cal. Health & Safety Code § 1371 and Cal. Code Regs. Tit. 28, §§ 1300.71(g) and (h).
- In the event that Bright HealthCare, or a capitated provider, fails to provide Provider with written notice of contestation in the timeframe in Section 23(a)(ii), or requests information from Provider that is not reasonably relevant or is in excess of the information necessary to determine Bright HealthCare's liability, but ultimately pay the claim in whole or in part, the claim shall be subject the accrual of interest as provided for in Section 23(a)(i). Cal. Code Regs. Tit. 28, § 1300.71(k).

f. Capitated Payments. Capitated providers shall accept and adjudicate claims for health care services provided to Members in accordance with this Agreement and applicable law. Cal. Code Regs. Tit. 28, § 1300.71(e)(1). In the event that Bright HealthCare or a capitated Provider denies a claim because it was field beyond the claim filing deadline, and upon provider's submission of a provider dispute and the demonstration of good cause for the delay, shall accept and adjudicate the claim according to this Agreement and applicable law. Cal. Code Regs. Tit. 28, § 1300.71(b)(4).

g. Telehealth Claims. Reimbursement of the Provider for telehealth services shall be made in accordance with this Agreement and Cal. Health & Safety Code § 1374.14.

Covered California

Bright HealthCare and Provider shall coordinate and cooperate to the extent necessary, and as applicable, to promote compliance by Participating Providers with the terms set forth in Agreement between Bright HealthCare and Covered California, California Health Benefit Exchange (the "Exchange"), which agreement is hereafter referred to as the "Covered California Agreement". Covered California Agreement § 1.7

Compliance

Bright HealthCare and Provider shall comply with all applicable Federal, State, and local laws, regulations, executive orders, ordinances and guidance, including without limitation, the Affordable Care Act, the California Affordable Care Act, the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, the Knox-Keene Health Care Service Plan Act of 1975, the California Insurance Code, as applicable. Covered California Agreement § 1.2(c)

Nondiscrimination

a. Services and Benefits. Bright HealthCare, Provider and Participating Providers, as well as their agents and employees, shall not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), or Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), or subject to any other applicable State and Federal laws, including without limitation Cal. Health & Safety Code § 1365.5, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through the Department and/or the Exchange. Covered California Agreement § 1.11(a)

b. Employment and Workplace. Bright HealthCare, Provider and Participating Providers, as well as their agents and employees, shall not unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Bright HealthCare, Provider and Participating Providers, as well as their agents and employees, shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Bright HealthCare, Provider and Participating Providers, as well as their agents and Employees, shall comply with the provisions of the Fair Employment and Housing Act (Government Code § 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR § 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code §12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2 CCR § 8103 et seq., are incorporated into the Agreement by reference and made a part hereof as if set forth in full. Bright HealthCare, Provider and Participating Providers shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Covered California Agreement § 1.11(b)

Conflict of Interest

Bright HealthCare, Provider and Participating Providers shall be free from any conflicts of interest with respect to services provided under the Covered California Agreement. Provider shall immediately notify Bright HealthCare of any conflicts of interest of Provider or any Participating Provider or any basis for potential violations of Provider or Participating Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered Services, including Federal and State anti-kickback and anti-self-referral laws, rules and regulations. Covered California Agreement § 1.12

Fraud, Waste and Abuse Programs

Provider acknowledges that the Department and/or the Exchange may request a description of Bright HealthCare's, Provider's, other subcontractors' and their authorized agents fraud, waste and abuse detection and prevention programs. In such case, Provider shall provide Bright HealthCare with a description of its fraud, waste and abuse detection and prevention programs, including a summary of key findings and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs. Covered California Agreement § 1.16

Participating Provider Stability

Bright HealthCare shall maintain, and Provider shall cooperate with, policies and procedures that are designed to preserve and enhance Bright HealthCare's network development by facilitating the recruitment and retention of Participating Providers necessary to provide access to Covered Services. Such policies and procedures shall be consistent with applicable laws, rules and regulations, and will include an ongoing assessment of turnover rates of its Participating Providers to ensure that the turnover rates do not disrupt the delivery of quality care. Covered California Agreement § 3.3.2(b)

Notice of Material Network Changes

Provider acknowledges and shall cooperate with Bright HealthCare in fulfilling Bright HealthCare's obligation to notify the Exchange of any pending material change in the composition of its provider network within any of the regions it covers, or its participating provider contracts, of and through the term of the Covered California Agreement at least 60 days prior to any change or immediately upon Bright HealthCare's knowledge of the change if knowledge is acquired less than 60 days prior to the change, and cooperate with the Department and/or the Exchange in planning for the orderly transfer of Members. Covered California Agreement 3.3.2(c)(i)

Network Stability

Provider acknowledges that Bright HealthCare will implement policies and practices designed (i) to reduce the potential for disruptions in Contractor's provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Enrollees in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption; and that Bright HealthCare must maintain adequate records, reasonably satisfactory to the Department and/or the Exchange, documenting its policies and its compliance with these requirements by Contractor and Participating Providers. As such, Provider agrees to cooperate with Bright HealthCare to comply with such policies and requirements. Covered California Agreement § 3.3.5(a)

Enrollee Transfers

In the event of a change in Participating Providers or QHPs related to network disruption, block transfers (as defined in Cal. Health and Safety Code § 1373.65 and Cal. Code Regs. tit. 28, § 1300.67.1.3), or other similar circumstances, Bright HealthCare must, and Provider and Participating Providers shall, cooperate with the Department and/or the Exchange in planning for the orderly transfer of Members as necessary and as required under applicable laws, rules and regulations including, those relating to continuity of care. Bright HealthCare shall file with the Department at least seventy-five (75) days prior to the termination of a Medical Group or Hospital in the event of a proposed block transfer of Members. Cal. Code Regs. tit. 28, § 1300.67.1.3.

Licensing, Certification, and/or Accreditation

All Covered Services must be provided by duly licensed, certified or accredited Participating Providers consistent with the scope of their license, certification or accreditation and in accordance with applicable laws, rules, regulations, the standards of medical practice in the community or a respective board or agency, and the terms set forth in the Agreement. Further, any equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law. Cal. Health & Safety Code §§ 1367(b) and (c), and Covered California Agreement § 3.4.1(a)

Credentialing

Bright HealthCare will establish criteria for credentialing and re-credentialing new and existing providers. Covered California Agreement 3.4.2

Member Costs

Bright HealthCare, Provider and Participating Provider shall comply with applicable laws, rules and regulations governing liability of Members for Covered Services provided to Members, including, those related to holding a Member harmless from liability in the event Bright HealthCare fails to pay an amount owning by Bright HealthCare to Provider or Participating Provider as required by Federal and State laws, rules and regulations. Covered California Agreement § 3.4.3

Disclosure to Members

Participating Providers shall inform every Member in a manner that allows the Member the opportunity to act upon a Participating Provider's proposal or recommendation regarding (i) the use of a non-network provider or facility, or (ii) the referral of a Member to a non-network provider or facility for proposed non-emergency Covered Services. Participating Providers shall disclose to a Member considering accessing non-emergency services from a network provider if a non-network provider or facility will be used as part of the network provider's plan of care. Participating Providers may rely on Bright HealthCare's provider directory in fulfilling their obligation under this provision. Covered California Agreement § 3.4.3

Provider Directory

Providers will provide Bright HealthCare with the necessary information to maintain a provider directory that includes a list of network Participating Providers available to Members. Further, Provider agrees to inform Bright HealthCare, within 5 business days, if the Provider is not accepting new patients or is accepting new patients if the Provider previously informed Bright HealthCare that it was not accepting new patients. If Provider is no longer accepting new patients, Provider agrees to direct Members seeking care to Bright HealthCare for assistance in finding a provider, and to report to the Department any inaccuracy with Bright HealthCare's provider directory. Cal. Health & Safety Code § 1367.27(j) and Covered California Agreement § 3.4.4

Provider Rates

To the extent permitted by law and by the Agreement, information to be provided to the Exchange under the Covered California Agreement may include information relating to contracted rates between Bright HealthCare and Provider that is treated as confidential information by Health Insurance Regulators pursuant to Cal. Ins. Code § 10181.7(b) and Cal. Health & Safety Code § 1385.07(b). Covered California Agreement § 3.5.4

Customer Service Standards

Bright HealthCare and Provider acknowledge that superior customer service is a priority of the Department and the Exchange. As such, Provider and Participating Providers shall cooperate with Bright HealthCare in an effort to ensure that the needs of Members are met. Covered California Agreement § 3.6

Member Appeals and Grievances

Bright HealthCare will maintain an internal review process to resolve a Member's written or oral expression of dissatisfaction regarding Bright HealthCare and Participating Providers, including appeals of claim and benefit determinations, and complaints relating to the scope of Covered Services, which process shall comply with all applicable State and Federal laws, rules and regulations relating to Member rights and appeals processes including Cal. Health and Safety Code § 1368. Provider agrees to make grievance forms and filing assistance available to Members. Bright HealthCare will comply with applicable State and Federal laws, rules and regulations regarding the external review process, including independent medical review, available to Members for Covered Services. Cal. Code Regs. Tit. 28, § 1300.68(b)(6) and (7), and Covered California Agreement § 3.6.2

Quality Management Program

Provider agrees to participate in, and ensure Participating Providers will participate in, all quality management programs implemented by Bright HealthCare to review the quality of Covered Services provided by Participating Providers, and will cooperate with Bright HealthCare in providing or arranging for such quality management programs. Covered California Agreement § 4.2. Provider will be given advance notice of a material change to the quality management programs or procedures, pursuant to Cal. Health & Safety Code 1375.7(b)(3), as further described in Section 13.

Utilization Management

Provider agrees to participate in, and ensure Participating Providers will participate in, all utilization management programs implemented by Bright HealthCare pursuant to applicable laws, rules and regulations including Cal. Health and Safety Code § 1367.01. Covered California Agreement 4.3

Clinical Records

Provider and Participating Providers shall maintain a medical record documentation system adequate to fully disclose and document the medical condition of each Member and the extent of Covered Services provided to Member. Clinical records shall be retained for at least seven (7) years following the year of the final claims payment. Except as otherwise required by State and Federal laws, rules, and regulations, if an audit, litigation, research, evaluation, claim, or other action involving the records has not been concluded before the end of the seven (7) year minimum retention period, the clinical records must be retained until all issues arising out of the action have been resolved. Covered California Agreement § 10.1

Storage and Retention of Books and Records

Books and records of Bright HealthCare, Provider and Participating Providers related to the Agreement shall be accurately maintained in accordance with applicable State and Federal law, including, without limitation Cal. Code Regs. Tit. 28, § 1300.85, rules and regulations and the Covered California Agreement. Covered California Agreement § 10.3. Such books and records subject to this Section shall be retained for a period not less than five years, the last two of which shall be in an easily accessible place. Cal. Code Regs. Tit. 28, § 1300.85.1

Notice of Certain Events

Provider shall promptly notify Bright HealthCare in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Provider or Participating Providers that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability of Bright HealthCare to perform in accordance with the Covered California Agreement. This section shall not be required with respect to disputes relating to claims and other matters noticed to the Exchange in the ordinary course of business pursuant to the Covered California Agreement or as required by law. Covered California Agreement § 10.

Colorado Regulatory Requirements Appendix

This Colorado Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Colorado law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider" as used in this Appendix, will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Professional," or other type of provider entity.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Non-discrimination

Provider will provide Covered Services to all Members as Provider's patient load and appointment calendar permit and will accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age, physical or mental health status, health insurance status, or on any other basis deemed unlawful under federal, state or local law. Provider also will not discriminate, with respect to the provision of medically necessary covered benefits, against Members that are participants in a publicly financed program.

Standing Referral

Bright HealthCare and Provider agree that if a Member needs ongoing care from a specialist or a specialized treatment center, Bright HealthCare or Payor will authorize for the Member a standing referral to such specialist or specialized treatment center for such specialty care. A standing referral will be authorized by Bright HealthCare or Payor if the Member's primary physician, in consultation with the specialist or a specialized treatment center and the Member, determines that the Member needs ongoing care from the specialist or the specialized treatment center. In no event will Bright HealthCare or Payor be required to permit a Member to elect to have a provider that does not participate in Bright HealthCare's Network as a specialist or specialized treatment center. The standing referral will be for a time period of up to one (1) year. A standing referral for a time period of more than one (1) year will be authorized by Bright HealthCare or Payor if the primary physician, in consultation with the specialist or the specialized treatment center, determines a period of time longer than one (1) year is warranted. During the period of the standing referral, the specialist or specialized treatment center must refer the Member back to the primary physician for primary care. In order for the specialist or the specialized treatment center to be reimbursed by the Payor, the specialty care must be services and supplies covered by the Member's Benefit Plan and provided in a manner consistent with that Benefit Plan. The primary physician will record the reason, diagnosis, or treatment plan necessitating the standing referral.

Bright HealthCare or an entity that contracts with Bright HealthCare will not penalize a primary physician who makes a standing referral of a Member to a specialist, nor will the specialist treating the Member be penalized, with actions that include but are not limited to disincentives or disaffiliation, except for violations of Colorado Revised Statutes, Section 10-1-128.

Continuity of Care

Provider agrees that in the event this Agreement is terminated by Bright HealthCare without cause and proper notice has not been provided to Members, Provider will continue the provision of Covered Services to Members for sixty (60) days from the date Provider is terminated by Bright HealthCare.

Provider agrees that in the event a Member's Benefit Plan is terminated for any reason other than nonpayment of premium, fraud or abuse, Provider will continue the provision of Covered Services to a Member who remains confined in an inpatient facility on and after the effective date of such termination until the Member is discharged. Provider will be reimbursed in accordance with this Agreement for all such Covered Services rendered subsequent to the termination of the Member's Benefit Plan.

Communication

Bright HealthCare encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with Bright HealthCare's ability to administer its Quality Improvement, Utilization Management, and credentialing programs.

Provider will not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Bright HealthCare or an entity representing or working for Bright HealthCare (e.g., a utilization review company).

Bright HealthCare or an entity representing or working for Bright HealthCare, will not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of any provider covered by this Agreement.

Bright HealthCare will not terminate this Agreement because Provider expresses disagreement with a decision by Bright HealthCare or an entity representing or working for Bright HealthCare to deny or limit benefits to a Member, or because Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Member's Benefit Plan or not, policy provisions of a Member's Benefit Plan, or Provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

Bright HealthCare will not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by Bright HealthCare that jeopardizes patient health or welfare, or because Provider discusses the financial incentives or financial arrangements between Provider and Bright HealthCare.

Notwithstanding subsections (a) through (c) above, Bright HealthCare prohibits Provider from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of Bright HealthCare and calculated to injure Bright HealthCare.

Hold Harmless

Provider agrees that in no event, including but not limited to nonpayment by Payor, insolvency of Bright HealthCare or breach of this Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than Bright HealthCare or Payor) acting on the Member's behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting supplemental charges or co-payments or fees for uncovered services delivered on a 'fee-for-service' basis to a Member.

Provider agrees that this provision will survive the termination of this Agreement for Covered Services rendered prior to the termination of this Agreement regardless of the cause giving rise to termination and will be construed to be for the benefit of the Member. This provision is not intended to apply to services provided after this Agreement has been terminated.

Provider agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between Provider and the Member or persons acting on his/her behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this Agreement.

Any modification, addition, or deletion to this provision will become effective on a date no earlier than thirty (30) days after the Colorado Commissioner of Insurance has received written notification of proposed changes.

Prompt Payment of Claims

A "clean claim" means a claim for payment of health care expenses that is submitted to Bright HealthCare on a uniform claim form (CMS-1500 and CMS1450, otherwise known as Form UB-04) adopted pursuant to Section 10-16-106.3 of the Colorado Revised Statutes with all required fields completed with correct and complete information in accordance with uniform elements specified under Colorado law. A claim requiring additional information will not be considered a "clean claim" and will be paid, denied, or settled as set forth below. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

Clean claims will be paid, denied, or settled within thirty (30) calendar days after receipt by Bright HealthCare if submitted electronically and within forty-five (45) calendar days after receipt by Bright HealthCare if submitted by any other means.

If the resolution of a claim requires additional information, Bright HealthCare will, within thirty (30) calendar days after receipt of the claim, give Provider or Member, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information will submit all additional information requested by Bright HealthCare within thirty (30) calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, Bright HealthCare or Payor may deny a claim if Provider receives a request for additional information and fails to timely submit the additional information requested, subject to resubmission of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim will be paid, denied or settled by Bright HealthCare or Payor within the applicable time period set forth in the following paragraph.

Absent fraud, all claims except those described in the second paragraph of this Section will be paid, denied, or settled within ninety (90) calendar days after receipt by Bright HealthCare.

Assignment

The rights and responsibilities under this Agreement will not be assigned or delegated by Provider without the prior written consent of Bright HealthCare.

Termination

This Agreement may be terminated as follows:

By Bright HealthCare upon thirty (30) days prior written notice in the event Provider materially misrepresents the provisions, terms, or requirements of Bright HealthCare's products.

By Bright HealthCare or Provider, if the Agreement permits a without cause termination, upon advance written notice in the form and for the length of time provided in the Agreement, but in no case upon less than ninety (90) days written notice. In such an event, Bright HealthCare will make a good faith effort to provide, within fifteen (15) business days after receipt of or issuance of a notice of termination, written notice of such termination to all Members that are patients seen on a regular basis by a Provider whose contract is terminating, regardless of whether the termination was for cause or without cause.

Where a termination involves a primary care physician, all Members who are patients of that primary care physician will also be notified. Within five (5) business days after the date that Provider either gives or receives notice of termination, Provider will supply Bright HealthCare with a list of those patients of Provider who are covered by a plan of Bright HealthCare.

If Provider is a "Health care provider" as defined by C.R.S. § 25-37-102 and if the Agreement has a duration of less than two (2) years, Bright HealthCare or Provider may terminate the Agreement without cause upon advanced written notice in the form and for the length of time provided in the Agreement, but in no case upon less than ninety (90) days written notice. If Provider is a "Health care provider" as defined by C.R.S. § 25-37-102, in accordance with Section 13 of this Appendix.

Claims Processing Functions

Any contract providing for the performance of claims processing functions by an entity with which Bright HealthCare contracts will require such entity to comply with Colorado Revised Statutes, Section 10-16-106.5 (3), (4), and (5).

Intermediaries

For each and every contract which an intermediary negotiates and executes with Bright HealthCare, on behalf of the providers covered by the intermediary: (a) No individual or group of providers covered by the contract will be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Bright HealthCare or an entity representing or working for Bright HealthCare (e.g., a utilization review company); (b) Bright HealthCare or an entity representing or working for Bright HealthCare will not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group of providers covered by the contract; and (c) Bright HealthCare will not terminate any contract executed by an intermediary because any individual or group of providers covered by the contract (i) expresses disagreement with a decision by Bright HealthCare or an entity representing or working for Bright HealthCare to deny or limit benefits to a Member, or (ii) assists the Member to seek reconsideration of Bright HealthCare's decision, or (iii) discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by Bright HealthCare or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

As required by C.R.S. 10-16-705, an intermediary must comply with the same standards, guidelines, medical policies, and benefit terms of Bright HealthCare and Payors. Furthermore, an intermediary must indicate the name of the intermediary and Bright HealthCare or Payor when making any payment to Provider on behalf of Bright HealthCare or a Payor.

Adjustments to Claims

Provider, Payor and Bright HealthCare will comply with the requirements set forth in Colorado Revised Statutes 10-16-704 (4.5) with regard to making adjustments to claims. Such requirements will include, but not be limited to, (a) the requirement that such adjustments be made within the time period set forth in the contract between Provider and Bright HealthCare; provided, however, that such time period will be the same for Provider and Bright HealthCare and (b) will not exceed twelve (12) months after the date of the original explanation of benefits, except as otherwise set forth in Colorado Revised Statutes 10-16-704 (4.5).

Fee Schedule Maintenance

Bright HealthCare will implement routine and non-routine fee schedule changes in accordance with the Agreement. Routine updates to a fee schedule or compensation consistent with the methodology described in the Agreement will be made after the date of publication of the source which causes a change in payment methodology; such changes are generally made within 90 days from the date of such publication. Bright HealthCare will comply with the requirements of C.R.S. § 25-37-104 for fee schedule changes that are "Material Changes" as defined by C.R.S. § 25-37-102.

Material Change to Contract

This section is applicable to "Health care providers" and "Material Changes" as those terms are defined by C.R.S. § 25-37-102. Bright HealthCare will give a Provider ninety (90) days' notice of a Material Change to the Agreement in accordance with C.R.S. § 25-37-104. Provider may object to the Material Change within fifteen (15) days, and if there is no resolution of the objection, either party may terminate this Agreement upon written notice of termination provided to the other party no later than sixty (60) days before the effective date of the Material Change. If a Material Change is the addition of a new Category of Coverage, as defined by C.R.S. §25-37-102, the Provider may object to the Material Change, and such change will not take effect as it pertains to Provider; the objection will not be a basis by which either party may terminate this Agreement.

Waiver

This section is applicable to "Health care providers" as defined by C.R.S. § 25-37-102. Bright HealthCare will not require a Provider, as a condition of contracting, to waive or forego any rights or benefits to which they may be entitled under state or federal law or regulation that provides legal protections to a person solely based on the person's status as a health care provider providing health care services.

Enforcement of Article 37-Contract with Health Care Providers

This section is applicable to "Health care providers" as defined by C.R.S § 25-37-102. With respect to the enforcement of C.R.S. § 25-37-101 and pursuant to C.R.S. § 25-37-114, the parties will have available: (1) binding arbitration; private rights of action at law and in equity; (3) equitable relief, including injunctive relief; (4) reasonable attorney fees when a Provider is the prevailing parting in an action to enforce C.R.S. § 25-37- 101, except to the extent that the violation consists of a mere failure to make payment to Provider pursuant to this Agreement; (5) the option to introduce as persuasive authority prior arbitration awards regarding a violation of C.R.S. § 25-37-101.

This Agreement does not preclude its use or disclosure to a third party for the purpose of enforcing C.R.S. § 25-37-101. The third party will be bound by the confidentiality requirements set forth in the Agreement. Any arbitration awards related to the enforcement of C.R.S. § 25-37-101 may be disclosed to those who have a bona fide interest in the arbitration.

Dispute Resolution

Bright HealthCare and Provider, as applicable, will comply with the resolution of disputes procedures as required by C.R.S. § 10-16-705 and 3 CCR 702-4 (4-2-23, as amended).

Confidentiality

Any data or information pertaining to the diagnosis, treatment, or health of any Member or applicant obtained from such person or from any Provider by Bright HealthCare will be held in confidence and will not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of any applicable law; or upon the express consent of the Member or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and Bright HealthCare wherein such data or information is pertinent. Bright HealthCare will be entitled to claim any statutory privileges against such disclosure which Provider, who furnished such information to Bright HealthCare, is entitled to claim.

Florida Regulatory Requirements Appendix

This Florida Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Florida law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts";

"Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Freedom of Choice

Bright HealthCare and Provider will comply with "Freedom of Choice" statutes requiring that Bright HealthCare reimburse health services covered by Benefit Plans without designating the specific type of licensed health professional to perform the service. Bright HealthCare will reimburse such services covered by Benefit Plans so long as the services are performed by a physician, chiropractor, dentist in consultation with a licensed physician, optometrist, or podiatrist, who may perform such services within the scope of his or her license. The level of reimbursement may change depending on the type of provider performing the service.

Psychotherapeutic Services

To the extent Bright HealthCare covers and Provider provides psychotherapeutic services, Bright HealthCare and Provider agree to cooperate to ensure against unauthorized or inadvertent disclosure of confidential information to persons inside or outside Bright HealthCare's organization in accordance with Fl. Stat. § 627.4195. As support for a claim submission, Bright HealthCare will accept a report instead of a copy of such Member's records. The report must include (a) clear statements summarizing the Member's presenting symptoms, (b) what transpired in any provided therapy, (c) what progress, if any, was made by the Member and (d) results obtained. Bright HealthCare may request copies of the Member's records if the report does not contain sufficient information. Upon such request, the Provider may redact portions of the Member's record in accordance with Fl. Stat. § 627.4195. Bright HealthCare may provide aggregate Member de-identified data to entities such as payors, sponsors, researchers, and accreditation bodies in accordance with Fl. Stat. § 627.4195.

Prior Authorization Form

If Bright HealthCare does not provide Provider or Participating Provider with an electronic prior authorization process for use, Bright HealthCare will only use the Prior Authorization Form for Medical Procedures, Courses of Treatment, or Prescription Drug Benefits (OIR Form OIR-B2-2180) (12/16) approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit in accordance with Fl. Stat. § 627.42392 and 69O-161.011, F.A.C.

Uniform Health Insurance Claim Form

Bright HealthCare will accept the Uniform Health Insurance Claim Form (Form HCFA-1500) (12/90) referenced in 69O-161.004, F.A.C. for the submission of claims by the Provider, in addition to its standard claim form.

Cancer Treatment Parity/Orally Administered Cancer Treatment Medications

Bright HealthCare will not apply cost-sharing requirements for orally administered cancer treatment medications that are less favorable to the Member than cost-sharing requirements for intravenous or injected cancer treatment medications in accordance with Fl. Stat. § 627.42391. Neither Bright HealthCare nor Provider may (a) vary the terms of policies in effect on July 1, 2014 to avoid compliance with Fl. Stat. § 627.42391; (b) provide any incentive, including, but not limited to, a monetary incentive, to induce a health care practitioner to provide care or services that do not comply with Fl. Stat. § 627.42391; (c) impose treatment limitations to encourage a Member to accept less than the minimum protections required by Fl. Stat. § 627.42391; (d) penalize a Participating Provider or reduce or limit the compensation of a Participating Provider for recommending or providing Covered Services to a Member as required under the law; or (e) change the classification of any intravenous or injected cancer treatment medication or increase the amount of cost sharing applicable to any intravenous or injected cancer treatment medication in effect on July 1, 2014 in order to achieve compliance with Fl. Stat. § 627.42391.

Prompt Payment

All claims for payment must be submitted to Bright HealthCare, when Bright HealthCare is the primary insurer, within 6 months of a Member's discharge for inpatient services or the date of service for outpatient services and Provider or Participating Provider has been furnished with the correct name and address of the patient's health insurer in accordance with

Fl. Stat. § 627.6131. All claims for payment must be submitted to Bright HealthCare, when Bright HealthCare is the secondary insurer, within 90 days after final determination by the primary insurer. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim.

For electronic claims only:

Bright HealthCare will provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim within 24 hours of the next business day after receipt of the claim. Bright HealthCare will pay the claim or notify Provider that the claim or a portion of the claim is denied or contested within 20 days of receipt of the claim. The date of notice of Bright HealthCare's action on a claim, or of payment is determined by the date the notice or payment was mailed or electronically transferred. Bright HealthCare's notification to Provider or Participating Provider of a contested claim will be accompanied by an itemized list of additional information or documents that Bright HealthCare has determined are necessary to process the claim. Provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Bright HealthCare will pay or deny a claim within 90 days after receipt of the claim, and will consider its own failure to pay or deny a claim within 120 days of receipt an uncontestable obligation to pay the claim.

For non-electronic claims only:

Bright HealthCare will provide to Provider acknowledgement of receipt of the claim or electronic access to the status of the claim within 15 days after receipt of such claim. Bright HealthCare will pay the claim, or notify Provider if the claim is denied or contested within 40 days. The date of notice of Bright HealthCare's action on a claim, or of payment is determined by the date the notice or payment was mailed or electronically transferred. Bright HealthCare's notification to Provider or Participating Provider of a contested claim will be accompanied by an itemized list of additional information or documents that Bright HealthCare has determined are necessary to process the claim. Provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Bright HealthCare will pay or deny a claim within 120 days after receipt of the claim, and will consider its own failure to pay or deny a claim within 140 days of receipt an uncontestable obligation to pay the claim.

Overpayments

If Bright HealthCare determines that it has made an overpayment to Provider or a Participating Provider for services rendered to a Member, Bright HealthCare will make a claim for the overpayment to Provider's or the Participating Provider's designated location in accordance with Fl. Stat. § 627.6131 within 30 months from the date of Bright HealthCare's payment of an initial claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, Bright HealthCare will adhere to the following procedures:

a. Provider or Participating Provider must pay, deny, or contest Bright HealthCare's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment of a claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

b. If Provider denies or contests Bright HealthCare's claim for overpayment or any portion thereof, Provider will notify Bright HealthCare, in writing of such denial or contest, within 35 days after Provider receives notice of such overpayment. Provider's notice of denial or contest must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If Bright HealthCare submits additional information, then Bright HealthCare must, within 35 days after receipt of the request, mail or electronically transfer the information to Provider. Provider will pay or deny the claim for overpayment within 45 days after receipt of the additional information. The notice is considered made on the date the notice is mailed or electronically transferred by Provider.

c. Bright HealthCare may not reduce payment to Provider or Participating Provider for other services unless Provider or Participating Provider agrees to the reduction in writing or fails to respond to Bright HealthCare's overpayment claim as required by this paragraph

d. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment begins to accrue when the claim should have been paid, denied, or contested.

Notwithstanding the foregoing, Bright HealthCare must submit all claims for overpayment to a Provider that is a licensed physician, osteopathic physician, chiropractor, podiatrist or dentist, within 12 months of Bright HealthCare's payment of the claim in accordance with Fl. Stat. § 627.6131, unless that claim is related to conviction of fraud. A claim from a licensed physician, osteopathic physician, chiropractor, podiatrist or dentist to Bright HealthCare alleging underpayment must be submitted to Bright HealthCare within 12 months of Bright HealthCare's payment of a claim.

Disputes

Bright HealthCare will ensure that its internal dispute resolution process relating to denied claims not under active review by a mediator, arbitrator, or third-party dispute entity will be finalized within 60 days after receipt of Provider or Participating Provider's request for review or appeal in accordance with Fl. Stat. § 627.6131.

Member Protection

Provider or Participating Provider will not bill or otherwise seek reimbursement or recourse against Members, other than supplemental charges or coinsurance amounts in accordance with Fl. Stat. § 627.6472. Provider or Participating Provider will not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a Member for payment of covered services which Bright HealthCare contested or denied Provider's or Participating Provider's claim for in accordance with Fl. Stat. § 627.6131.

Denial of Claims

Bright HealthCare will provide Provider or Participating Provider the opportunity for an appeal to Bright HealthCare's licensed physician responsible for medical necessity reviews in accordance with Fl. Stat. § 627.6141. Bright HealthCare's licensed physician must respond within a reasonable time, not to exceed 15 business days.

Improper Billing

Upon the request of a Member, Bright HealthCare will investigate any claim of improper billing by Provider or Participating Provider in accordance with Fl. Stat. § 627.613. Provider or Participating Provider agrees to cooperate with such investigation.

Decreasing Inappropriate Utilization of Emergency Care

Bright HealthCare will provide information on its website concerning information regarding appropriate utilization of emergency care services, including a list of alternative urgent care contracted Participating Providers and the types of services offered by these providers in accordance with Fl. Stat. § 627.6405. Provider agrees to provide Bright HealthCare with the necessary information to comply with such requirements.

Community Emergency Department Diversion Programs

To the extent Bright HealthCare implements a Community Emergency Department Diversion program pursuant to Fl. Stat. § 627.6405, Provider agrees to cooperate in establishing such a program.

Dermatological Services

To the extent Bright HealthCare covers and Provider provides dermatological services, Provider agrees to cooperate with Bright HealthCare to ensure that Member has access to licensed dermatologists for office visits and minor procedures and testing must be direct, and neither Bright HealthCare nor Provider will require that Member receive a referral or authorization before receiving such services. Bright HealthCare and Provider will develop criteria for compliance with these requirements, which may include a maximum of five office visits to a dermatologist without prior authorization for a dermatologic problem within a 12-month period.

Provider Contracts

Bright HealthCare will not require Provider or Participating Provider to accept the terms of other health care practitioner contracts with Bright HealthCare as a condition of continuation or renewal of a contract in accordance with Fl. Stat. § 627.6474, except to the extent Provider or Participating Provider is part of a group practice who must accept the terms of a contract negotiated by the group.

Dental Services

Bright HealthCare shall not require, directly or indirectly, that a dentist who is a Participating Provider provide services to a Member at a fee set by, or at a fee subject to, the approval of Bright HealthCare unless the dental services are Covered Services in accordance with Fl. Stat. § 627.6474.

Vision Services

To the extent Bright HealthCare covers and Provider provides vision services, Bright HealthCare will not restrict a Participating Provider that is a licensed ophthalmologist or optician to specific suppliers of material or optical laboratories in accordance with Fl. Stat. § 627.6474. Provider will notify Bright HealthCare within 30 days of a change in the number of its vision care Participating Providers, to permit Bright HealthCare to update its online vision care network provider directory to comply with Fl. Stat. § 627.6474.

List of Providers

Provider will provide Bright HealthCare with a list of Participating Providers, including specialty, to assist Bright HealthCare in complying with the requirements of Fl. Stat. § 627.6472.

Quality Assurance Plan

Provider will cooperate with Bright HealthCare in developing a quality assurance program, including written criteria for selection, retention and removal of Participating Providers, procedures for evaluating quality of care provided by exclusive providers, and a process to initiate corrective action as requested by Bright HealthCare to assist in Bright HealthCare's compliance with Fl. Stat. § 627.6472.

Covered Services

Provider will cooperate with Bright HealthCare to ensure that all Covered Services are provided with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care will reflect usual practice in the local area, and geographic availability will reflect the usual travel times within the community in accordance with Fl. Stat. § 627.6472. Provider will cooperate with Bright HealthCare to ensure that the number of Participating Providers in the service area is sufficient to adequately deliver all Covered Services or to make referrals and that emergency care is available 24/7. Bright HealthCare and Provider will cooperate to ensure that there are written agreements describing Provider's specific responsibilities to assist Bright HealthCare in maintaining compliance with Fl. Stat. § 627.6474.

Georgia Regulatory Requirements Appendix

Financial Incentive Programs Prohibited

Bright HealthCare may not use a financial incentive or disincentive program that directly or indirectly compensates Provider for ordering or providing less than medically necessary and appropriate care, as defined in O.C.G.A. § 33-20A-40, to a Member or for denying, reducing, limiting, or delaying such care. O.C.G.A. § 33-20A-6

Penalties Prohibited

A Participating Provider shall not be penalized for considering, studying, or discussing medically necessary or appropriate care, as defined in O.C.G.A. § 33-20A-40, with or on behalf of a Member. Provider shall not be penalized by Bright HealthCare for providing testimony, evidence, records, or any other assistance to a Member who is disputing a denial, in whole or in part, of a health care treatment or service or claim. O.C.G.A. § 33-20A-7

Availability of Personnel for Precertification Procedure

When Provider calls Bright HealthCare during regular business hours to request verification of benefits from Bright HealthCare, Provider shall have the clear and immediate option to speak to an employee or agent of Bright HealthCare who shall advise Provider that:

a. Such verification is only a determination of whether given Covered Services are a covered benefit under the Benefit Plan and is not a guarantee of payment for those services; and

b. If the Covered Services so verified are a covered benefit, whether precertification is required and the phone number to request precertification.

To the extent that Provider requests verification of benefits after regular business hours or by electronic or recorded means, Provider shall be provided by either electronic or recorded means or, at the option of Bright HealthCare, by a live person the information required in paragraphs (a) and (b) this section.

To the extent that Bright HealthCare requires precertification, Bright HealthCare shall have sufficient personnel available 24 hours a day, seven days a week, to provide such precertification for all procedures, other than non-urgent procedures; to advise of acceptance or rejection of such request for precertification; and to provide reasons for any such rejection. Such acceptance or rejection of a precertification request may be provided through a recorded or computer-generated communication, provided that the individual requesting precertification has the clear and immediate option to speak to an employee or representative of Bright HealthCare capable of providing information about the precertification request. O.C.G.A. § 33-20A-7.1

Physician Contracts

a. To the extent that Provider is a physician, the following shall apply. Should Bright HealthCare terminate a physician's contract and thereby affect any Member's opportunity to continue receiving Covered Services from Provider under the plan, any such Member who is suffering from and receiving active Covered Services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive Covered Services from Provider for a period of up to 60 days from the date of the termination of the Provider's contract. Any Member who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that Member's physician's contract shall have the right to continue receiving Covered Services from Provider throughout the remainder of that pregnancy, including six weeks' post-delivery care. During such continuation of coverage period, Provider shall continue providing such services in accordance with the Agreement, and Bright HealthCare shall continue to meet all obligations of the Agreement. The Member shall not have the right to the continuation provisions provided in this section if the Agreement is terminated because of the suspension or revocation of Provider's license or if Bright HealthCare determines that Provider poses a threat to the health, safety, or welfare of Members.

b. To the extent that Provider is a physician, the following shall apply. Should Provider terminate his or her contract with Bright HealthCare and thereby affect any Member's opportunity to continue receiving Covered Services from that under the Benefit Plan, any such Member who is suffering from and receiving active Covered Services for a chronic or terminal illness or who is an inpatient shall have the right to receive Covered Services from Provider for a period of up to 60 days from the date of the termination of Provider's contract. Any Member who is pregnant and receiving Covered Services in connection with that pregnancy at the time of the termination of that Member's physician's contract shall have the right to continue receiving Covered Services from Provider throughout the remainder of that pregnancy, including six weeks' post-delivery care. During such continuation of coverage period, Provider shall continue providing such services in accordance with the terms of the Agreement, and Bright HealthCare shall continue to meet all obligations of the Agreement. The Member shall not have the right to the continuation provisions provided in this section if Provider terminates the Agreement because of the suspension or revocation of Provider's license or for reasons related to the quality of Covered Services rendered or issues related to the health, safety, or welfare of Members. O.C.G.A. § 33-20A-61

Complaint System; Maintenance of Complaint Records

Bright HealthCare shall establish and maintain a complaint system that provides reasonable procedures for the resolution of written complaints initiated by Provider concerning Covered Services. Bright HealthCare shall maintain records of written complaints concerning Covered Services for five years from the time the complaints are filed and shall submit to the Georgia Commissioner of Insurance a summary report at such times and in such format as the Georgia Commissioner of Insurance may require. O.C.G.A. § 33-21-9

Maintenance of Records

The parties will maintain their respective medical, eligibility, enrollment/disenrollment, financial and other administrative records related to Covered Services rendered by Participating Providers to Members under this Agreement, in such form and such time periods as required by applicable state and federal laws, regulations, licensing, and accreditation requirements to which each individual party is respectively subject. Ga. Comp. R. & Regs. r. 120-5-37-.05

Confidentiality of Medical Information

Any data or information pertaining to the diagnosis, treatment, or health of any Member or applicant obtained from the Member or from Provider by Bright HealthCare shall be held in confidence and shall only disclosed as permitted for health care operations under HIPAA or as permitted under state law. O.C.G.A. § 33-21-23

Payments sent directly to Provider by Bright HealthCare

If a Member provides in writing to Provider that payment for Covered Services shall be made solely to Provider and be sent directly to Provider by Bright HealthCare, and Provider certifies to same upon filing a claim for the delivery of Covered Services, Bright HealthCare shall make payment solely to Provider and shall send said payment directly to Provider. This section shall not be construed to extend coverages or to require payment for services not otherwise covered. O.C.G.A. § 33-24-59.3

Standard Claim Form

Provider shall use and accept the most current editions of the HCFA Form 1450, HCFA Form 1500, or J512 Form and most current instructions for these forms in the billing of Members or their representatives and filing claims with Bright HealthCare. Bright HealthCare shall provide, upon request, to Provider, and accept the most current editions of the HCFA Form 1450, HCFA Form 1500, or J512 Form for the processing of claims. Ga. Comp. R. & Regs. r. 120-2-59-.05

Prompt Pay

All benefits under a Benefit Plan will be payable by Bright HealthCare upon Bright HealthCare's receipt of written or electronic claim. Bright HealthCare shall, within 15 working days for electronic claims and 30 calendar days for paper claims after such receipt, mail or send electronically to Provider payment for such benefits or a letter or electronic notice which states the reasons Bright HealthCare has for failing to pay the claim, either in whole or in part, and which also gives Provider so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where Bright HealthCare disputes a portion of the claim, any undisputed portion of the claim shall be paid by Bright HealthCare in accordance with this Section. When all of the listed documents or other information needed to process the claim has been received by Bright HealthCare, Bright HealthCare shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving Provider Bright HealthCare's reasons for such denial. Bright HealthCare shall pay to Provider interest equal to 12 percent per annum on the proceeds or benefits due under the terms of the Benefit Plan for failure to comply with this section. O.C.G.A. § 33-24-59.14

Payment

a. Bright HealthCare may not conduct a post-payment audit or impose a retroactive denial of payment on any claim by Provider relating to the provision of healthcare services that was submitted within 90 days of the last date of service or discharge covered by such claim unless:
    - Bright HealthCare has provided to Provider in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;
    - Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and
    - Any such audit or retroactive denial of payment must be completed and notice provided to Provider of any payment or refund due within 18 months of the last date of service or discharge covered by such claim.

b. Bright HealthCare may not conduct a post-payment audit or impose a retroactive denial of payment on any claim by Provider relating to the provision of healthcare services that was submitted more than 90 days after the last date of service or discharge covered by such claim unless:
    - Bright HealthCare has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;
    - Not more than 12 months have elapsed since such claim was initially submitted by Provider prior to the delivery to Provider of such written notice; and
    - Any such audit or retroactive denial of payment must be completed, and notice provided to Provider of any payment or refund due within the sooner of 18 months after Provider's initial submission of such a claim or 24 months after the date of service.

c. Bright HealthCare shall not be required to respond to Provider's request for additional payment or to adjust any previously paid Provider claim or any part thereof following a final payment unless:
    - Provider makes a request in writing to Bright HealthCare specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and
    - If Provider's claim was submitted within 90 days of the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within the earlier of 12 months of the date both Provider and Bright HealthCare agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by Provider or 24 months have elapsed from the date of service or discharge. O.C.G.A. § 33-20A-62

Termination of Rural Health Care Provider

To the extent that Provider is an essential rural health care provider, as defined in O.C.G.A. § 33-20B-2(1), the following shall apply:

a. To deny, reject, or terminate Provider from serving as a Provider in Bright's Network, Bright HealthCare shall:
    - Inform Provider in writing of the basis for such rejection or termination, including a reference to any specific qualification or standard which the provider failed to meet; and
    - Where possible, afford Provider a reasonable opportunity to cure the deficiency which is the basis for such rejection or termination. O.C.G.A. § 33-20B-4.

Complaint System

Bright HealthCare shall work with Provider to promote the operation of peer review mechanisms internal to Provider groups. Ga. Comp. R. & Regs. r. 120-2-33-.09

Prohibition on Most Favored Nation Clause

Bright HealthCare shall not:

a. Prohibit Provider from contracting with another party to provide Covered Services at a lower rate than the payment or reimbursement rate specified in the Agreement;

b. Require Provider to accept a lower payment or reimbursement rate if Provider agrees to provide Covered Services to another party at a lower rate than the payment or reimbursement rate specified in the Agreement;

c. Require Provider, or have an option, to terminate or renegotiate the Agreement in the event Provider agrees to provide Covered Services to any other party at a lower rate; or

d. Require Provider to disclose to Bright HealthCare Provider's contractual payment or reimbursement rates with other parties. Ga. Comp. R. & Regs. r. 120-2-20-.03

Emergency Services Requirements

In the event a Member seeks emergency services and if necessary in the opinion of Provider, to the extent Provider is responsible for the Member's emergency care and treatment, Provider may initiate necessary intervention necessary to stabilize the condition of the Member without seeking or receiving prospective authorization by Bright HealthCare. If in the opinion of Provider, a Member's condition has stabilized, and Provider certifies that the Member can be transported to another facility without suffering detrimental consequences or aggravating the Member's condition, the Member may be relocated to another facility which will provide continued care and treatment as necessary. O.C.G.A. § 33-21-18.1

a. **Breast Reconstruction**. Bright HealthCare shall not deselect, terminate the services of, require additional utilization review, reduce capitation payment, or otherwise penalize Provider for ordering care consistent with the provisions of O.C.G.A. § 33-24-72. [Note: Does not apply to Limited Benefit Plans.]

Women's Access to Health Care

To the extent Bright HealthCare covers obstetrical and gynecological services, Provider shall permit Members direct access to obstetrical and gynecological services for maternity and gynecological care, for diagnostic testing related to maternity and gynecological care, without prior approval from a primary care provider; provided, however, that the services covered by this section shall be limited to those services defined by the published recommendations of the Accreditation Council For Graduate Medical Education for training as an obstetrician or gynecologist, including but not limited to diagnosis, treatment, and referral. O.C.G.A. § 33-24-59

Registered Nurse First Assistants

To the extent that a Benefit Plan provides that any of its benefits are payable to a surgical first assistant for services rendered, and to the extent that Provider is a physician, Bright HealthCare shall be required to directly reimburse any registered nurse first assistant who has rendered such services at the request of Provider and within the scope of a registered nurse first assistant's professional license. This section shall not apply to a registered nurse first assistant who is employed by Provider. O.C.G.A. § 33-24-59.9

Member access to eye care

To the extent that Bright HealthCare covers vision services and Provider provides such vision services, Bright HealthCare shall:

a. Not set professional fees or reimbursement for the same eye care services as defined by established current procedural terminology codes in a manner that discriminates against an individual eye care provider or a class of eye care providers;

b. Not promote or recommend any class of providers to the detriment of any other class of providers for the same eye care service;

c. Ensure that all eye care providers on the Benefit Plan are included on any publicly accessible list of participating providers for the Benefit Plan;

d. Allow each eye care provider on the Benefit Plan, without discrimination between classes of eye care providers, to furnish covered eye care services to covered persons to the extent permitted by such provider's licensure;

e. Not require Provider to hold hospital privileges or impose any other condition or restriction for initial admittance to the Benefit Plan not necessary for the delivery of eye care upon such providers which would have the effect of precluding Provider from participation on the Benefit Plan. O.C.G.A. § 33-24-59.12

Coverage for Certain Dental Care Claims

a. Bright HealthCare may require prior authorization for general anesthesia and associated hospital or ambulatory surgical facility charges for dental care in the same manner that prior authorization is required for such benefits in connection with other covered medical care.

b. Bright HealthCare may restrict coverage under O.C.G.A. § 33-24-28.4 to include only procedures performed by:

- A fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which hospital or ambulatory surgical facility privileges are granted;
- A dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted hospital or ambulatory surgical facility privileges; or
- A dentist who has not yet satisfied certification requirements but has been granted hospital or ambulatory surgical facility privileges. O.C.G.A. § 33-24-28.4

Dermatologist Referrals

Neither Bright HealthCare nor Provider shall require as a condition to the coverage of dermatological services that a Member first obtain a referral from a primary care physician. O.C.G.A. § 33-24-56

Telemedicine Services

Bright HealthCare shall include payment for services that are covered under a Benefit Plan to the extent that such services are appropriately provided through telemedicine in accordance with O.C.G.A. § 43-34-31 and generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section shall be subject to all other applicable terms and conditions included in the applicable Benefit Plan and the Agreement. O.C.G.A. § 33-24-56.4

Coverage for Orally-administered Chemotherapy

Bright HealthCare shall not:

a. Penalize Provider or reduce or limit the compensation of Provider for recommending or providing services or care to a Member as required under O.C.G.A. § 33-24-56.5; or

b. Provide any incentive, including, but not limited to, a monetary incentive, to induce Provider to provide care or services that do not comply with O.C.G.A. § 33-24-56.5. [Note: Does not apply to Limited Benefit Plans.]

Illinois Regulatory Requirements Appendix

This Illinois Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Illinois law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts";

"Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Uniform Claim Forms

Provider agrees to submit all claims to Bright HealthCare on the following forms, in accordance with 215 ILCS 5/143.31: HCFA Form 1500, UB92/HCFA Form 1450, J510/J511/J512 Form, (provided in 50 Ill. Adm. Code 2017.10 et seq.). Bright HealthCare and Provider will adhere to the claims requirements provided in 50 Ill. Adm. Code 2017.10 et seq.

Freedom of Choice

Whenever Bright HealthCare's Benefit Plans use the term "physician" or "doctor," such terms will include within their meaning persons licensed to practice dentistry under the Illinois Dental Practice Act (225 ILCS 25/1 et seq) with regard to benefits payable for services performed by a person so licensed, when such services are within the coverage provided by the Benefit Plan in accordance with 215 ILCS 5/364. **[HMO and Insurance]**. To the extent Bright HealthCare's Benefit Plans provide for reimbursement for any service provided by persons licensed under the Medical Practice Act of 1987 (225 ILCS 60/1 et seq) or the Podiatric Medical Practice Act of 1987 (225 ILCS 100/1 et seq), Bright HealthCare will reimburse such services whether the services are performed by a Participating Provider licensed under the Medical Practice Act or the Podiatric Medical Practice Act in accordance with 215 ILCS 5/370b. **[Insurance only – NOTE: does not apply to preferred provider arrangements]**. Bright HealthCare will pay for services rendered by a registered surgical assistant (subject to 225 ILCS 130/1 et seq) who is neither an employee of an ambulatory surgical treatment center (as defined in 210 ILCS 5/1 et seq), nor an employee of a hospital, at the appropriate non-physician modifier rate if Bright HealthCare would have made payment had the same services been provided by a physician in accordance with 215 ILCS 5/350b.1.

[Insurance only] Member Hold Harmless

To the extent Bright HealthCare pays Provider on a capitated basis, the Provider and Participating Providers agree to the following, as provided by 50 Ill. Adm. Code 4521.50: "The provider agrees that in no event, including but not limited to nonpayment by the HMO of amounts due the provider under this contract, insolvency of the HMO or any breach of this contract by the HMO, shall the provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the enrollee, persons acting on the enrollee's behalf (other than the HMO), the employer or group contract holder for services provided pursuant to this contract; except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by the HMO. The requirements of this clause shall survive any termination of this contract for services rendered prior to such termination, regardless of the cause of such termination. The HMO's enrollees, the persons acting on the enrollee's behalf (other than the HMO), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the provider and the enrollee, persons acting on the enrollee's behalf (other than the HMO) and the employer or group contract holder." **[HMO only]**

Professional Liability Insurance

Provider agrees to ensure that all Participating Providers have professional liability insurance, and will give at least 15 days advance notice of cancellation of such insurance to Bright HealthCare, in accordance with 50 Ill. Ann. Code 4521.50. **[HMO only]**

Provider Credentialing/Uniform Credentialing Form

Bright HealthCare will, for the purposes of collecting credentials data, only require 1) the uniform health care credentials form; 2) the uniform health care recredentials form; and 3) the uniform updating forms; and any additional credentials data it requests in accordance with 410 ILCS 517/15. Bright HealthCare will complete the process of verifying credentials data in a timely fashion and will complete the process of credentialing or recredentialing within 60 days of submission of all credentials data and completion of verification of the credentials data. Participating Providers shall provide any corrections, updates, and modifications to credentials data to ensure that all credentials remains current. Such corrections, updates, and modifications shall be provided within 5 business days for state health care professional license revocation, federal Drug Enforcement Agency license revocation, Medicare or Medicaid sanctions, revocation of hospital privileges, any lapse in professional liability coverage required by a health care entity, health care plan, or hospital, or conviction of a felony, and within 45 days for any other change in the information from the date the health care professional knew of the change. All updates shall be made on the uniform updating form. Bright HealthCare will ensure all credentialing data it collects remains confidential as provided by 410 ILCS 517/15. Bright HealthCare will obtain credentials data on all Participating Providers on a single credentialing cycle, as provided by 410 ILCS 517/20. To the extent Bright HealthCare conducts site surveys, Bright HealthCare and Provider will utilize a single site survey and the uniform site survey instrument in accordance with 410 ILCS 5117/25. The credentialing forms may be found at:
http://dph.illinois.gov/topics-services/health-care-regulation/facilities/hospitals/
[Insurance and HMO]

Provider Contracting

Bright HealthCare will provide Provider with the information provided for in 215 ILCS 5/368b. Provider agrees that all information provided in accordance with 215 ILCS 5/368b is confidential, proprietary, and trade secret information and is subject to the provisions of the Illinois Trade Secrets Act (765 ILCS 1065/1 et seq). Provider may disclose the information on a need to know basis and only to individuals and entities that provide services directly related to Provider's decision to enter into the contract or keep the contract in force. Upon termination of its Network Participation Agreement with Bright HealthCare and at the request of a Member, Provider will transfer copies of the Member's medical records. **[Insurance and HMO]**

Participating Provider Non-Discrimination

Bright HealthCare will not discriminate against Participating Providers wishing to enter into an agreement with Bright HealthCare in accordance with 215 ILCS 5/370h. **[Insurance only] Claims Practice**

Bright HealthCare will not require Provider or Participating Provider to submit a preliminary claim report and a subsequent formal proof of loss forms in violation of 215 ILCS 5/154.6. Bright HealthCare will provide necessary forms to submit a claim within 14 working days of a request for such form. **[Insurance and HMO]**

Timely Payment

Bright HealthCare will ensure that all claims and indemnities concerning Covered Services, other than for any periodic payment, shall be paid within 30 days after receipt of due written proof of such loss in accordance with 215 ILCS 5/368a. Bright HealthCare will notify a Member, Provider, or Participating Provider of any failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Bright HealthCare's failure to pay within 30 days of receipt of a claim will result in an interest rate of 9% per year from the 30th day after receipt of due proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. Bright HealthCare will make any required interest payments within 30 days after the payment. To the extent Bright HealthCare pays Provider or Participating Provider on a periodic payment basis (such as prospective capitation payments), Bright HealthCare will ensure such payments are made in accordance with 215 ILCS 5/368a. **[Insurance and HMO]**

Remittance Advice and Recoupments

Bright HealthCare will furnish a remittance advice to Provider or Participating Provider that identifies the disposition of each claim, in accordance with 215 ILCS 5/368c. This remittance advice will identify services billed, the Member responsibility, if any, the actual payment, if any, for the services billed, and the reason for any reduction to the amount for which the claim was submitted. The remittance advice will identify any withholds and the reason for any denial or reduction. The remittance advice must include an explanation of a recoupment or offset taken by Bright HealthCare in accordance with 215 ILCS 5/368d. This explanation shall, at a minimum, include the name of the Member, the date of service, the service code or if no service code is available a service description, the recoupment amount, and the reason for the recoupment or offset. Bright HealthCare will provide a telephone number or mailing address for Provider to initiate an appeal of the recoupment or offset together with the deadline for initiating an appeal, prominently displayed on the remittance advice or document containing a demand for recoupment or offset. Provider or Participating Provider must initiate such appeal within 60 days after receipt of the remittance advice. To the extent

Bright HealthCare pays Provider or Participating Provider on a prospective or concurrent basis, it is not a recoupment when Bright HealthCare requires a retrospective reconciliation based upon specific conditions outlined in the Network Participation Agreement. No recoupment or offset may be requested or withheld from future payments 18 months or more after the original payment is made, except under the exceptions outlined in 215 ILCS 5/368d.

[Insurance and HMO]

Capitation Payments to Managed Care Organizations

To the extent Bright HealthCare pays Provider on a capitated basis, and Provider is determined to be a Managed Care Organization, defined as an organization "that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services," Provider will submit financial statements to Bright HealthCare quarterly and annual, in accordance with 50 Ill. Adm. Code 4521.50. Provider agrees to fully cooperate with, and disclose all relevant information requested by Bright HealthCare's actuaries for the preparation of their opinion as provided by Adm. Code 4521.50. Provider and Bright HealthCare acknowledge that, in the event of Provider's insolvency, Bright HealthCare is secondarily liable as the ultimate risk bearer for unpaid healthcare services rendered to its Members. **[HMO only]**

Dispute Resolution

In accordance with 215 ILCS 125/4-10, Bright HealthCare will provide a mechanism for the timely review by a physician holding the same class of license as a Participating Provider serving as a Member's primary care physician, who is unaffiliated with Bright HealthCare, jointly selected by the Member, the primary care Participating Provider, and Bright HealthCare in the event of a dispute between the Participating Provider and Bright HealthCare regarding the medical necessity of a covered service proposed by the Participating Provider.

Bright HealthCare will not base any future contractual or employment action concerning a Participating Provider based solely on such Participating Provider's participation in this procedure. **[HMO only]**

External Review

At the time it sends written notice of a Member's right to appeal a coverage decision upon an adverse determination or a final adverse determination, Bright HealthCare will notify, along with the Member, the Member's treating Participating Provider, in accordance with 215 ILCS 180/20. The notice will include specific a copy of the Illinois Department of Insurance's External Review Form. Bright HealthCare will also include an authorization form which authorizes Bright HealthCare and the Member's treating Participating Provider to disclose protected health information pertinent to the external review, as provided by 215 ILCS 5/1 et seq. **[Insurance and HMO]**

Quality Assurance Programs

Provider agrees to participate in, and ensure Participating Providers will participate in, all quality assurance programs implemented by Bright HealthCare pursuant to Illinois law, and agrees to cooperate with Bright HealthCare in providing or arranging for such quality assurance programs, in accordance with 215 ILCS 125/2-8 and 50 Ill. Adm. Code 4521.50. **[HMO only]**

Network Adequacy

Provider will cooperate with Bright HealthCare to ensure that Bright HealthCare will provide 24-hour, 7 day per week access to network-affiliated primary care, emergency services, and woman's principal health care providers in accordance with 215 ILCS 124/10. **[HMO and Insurance]**

Network Directory

Provider will assist Bright HealthCare in complying with the provider directory requirements set forth in 215 124/25. **[Insurance and HMO]**

Provision of Information

Provider will cooperate with Bright HealthCare by providing all necessary information to assist Bright HealthCare in complying with the requirements of 215 ILCS 124/10. **[HMO and Insurance]** Provider will assist Bright HealthCare in complying with the provision of information requirements set forth in 215 ILCS 134/15. Provider or Participating Provider shall, upon request of a Member, provide the Member information specified in 215 ILCS 134/15 concerning the Participating Provider's background, training and experience, privileges, and participation in continuing education. **[HMO only]**

Treatment Discussions

Bright HealthCare will not prohibit Provider or Participating Provider from discussing any specific or all treatment options with Members, or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes establish Bright HealthCare, in accordance with 215 ILCS 124/10. **[HMO and Insurance]** Bright HealthCare will not prohibit or discourage Provider or Participating Providers from discussing any health care services or providers, utilization review and quality assurance policies, terms and conditions of plans and plan policy with Members, prospective Members, other providers, or the public in accordance with 215 ILCS 134/30. **[HMO only]**

Patient Rights

Provider will comply with the requirements of 215 ILCS 134/5, providing for healthcare patient rights. **[HMO only]**

Medically Appropriate Healthcare Protection

Bright HealthCare will not prohibit Provider or Participating Providers for advocating for appropriate healthcare services for Members, in accordance with 215 ILCS 134/35. **[HMO only]**

Notice of Nonrenewal

Bright HealthCare will give a Participating Provider at least 60 days' notice of nonrenewal or termination of a Participating Provider from Bright HealthCare's network. Bright HealthCare will also provide notice to the Members served by the Participating Provider. This notice shall include a name and address to which a Member or Participating Provider may direct comments and concerns, and the telephone number maintained by the Department of Insurance for consumer complaints, pursuant to 215 ILCS 124/15 **[**215 ILCS 134/20 **(HMO)]**. Immediate written notice may be provided without 60 days' notice when a provider's license has been disciplined by a State licensing board or when the network plan reasonably believes direct imminent physical harm to Members under the Participating Providers' care may occur. Participating Providers acting as primary care providers must notify active Members of their nonrenewal or termination. **[HMO and Insurance]** This notice shall inform a Member of the availability of transitional services and that the Member must request transitional services within 30 days from receipt of this notice. 50 Ill. Adm. Code 4520.50. **[HMO only]** Participating Provider shall provide Bright HealthCare with at least 60 days notice for Participating Provider terminating its participation in Bright HealthCare's network for cause, and at least 90 days notice for termination without cause, in accordance with 50 Ill. Adm. Code 4520.50 and 50 Ill. Admin Code 4520.50. Bright HealthCare will give notice to affected members pursuant to 50 Ill. Adm. Code 4520. **[HMO only]**

Continuity of Care

If a Member's treating Participating Provider leaves Bright HealthCare's network for reasons other than termination of a contract in situations involving imminent harm or disciplinary action and the Participating Provider remains within Bright HealthCare's service area, Bright HealthCare will permit the Member to continue an ongoing court of treatment during a 90 day transitional period, or if the Member has entered the third trimester of pregnancy at the time of the Participating Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery in accordance with 215 ILCS 124/20 **[**215 ILCS 134/25 **(HMO)]**. Such care will be provided so long as Participating Provider receives reimbursement at the rates and terms applicable under the terminated contract, adheres to Bright HealthCare's quality assurance requirements, and otherwise adheres to the Bright HealthCare's other policies and procedures. This section does not apply if the Member has successfully transitioned to another Participating Provider, has already met or exceeded the benefit limitations of his or her plan, or if the care provided is not medically necessary. Bright HealthCare will provide notification to Members concerning transitional services in accordance with 50 Ill. Adm. Code 4520.60. **[HMO only]**

Access to Specialists

Bright HealthCare will establish a procedure for a Member who has a condition requiring ongoing care from a specialist physician or other health care provider to apply for a standing referral if a referral is required for coverage, in accordance with 215 ILCS 134/40. Provider and Participating Providers will cooperate with Bright HealthCare in implementing this procedure. Participating Providers serving as primary care physicians will assist Members as necessary in selecting a health care provider and coordinating care in the scenarios outlined by 215 ILCS 134/40, and will notify Bright HealthCare when any referral is made outside of Bright HealthCare's network. **[HMO only]**

Appeals

Bright HealthCare will provide Provider and Participating Providers serving as a Member's primary care physician, and any Participating Provider recommending a health care service involved in an appeal notice of an appeal relating to healthcare services as provided by 215 ILCS 134/45. Participating Providers may file appeals on behalf of Members, in accordance with 215 ILCS 134/45 and 50 Ill. Adm. Code 4520.80 A Participating Provider involved in an appeal pursuant to 215 ILCS 134/45 may request an external review following a denial as provided by the Illinois Health Carrier External Review Act. Bright HealthCare will not base any future contractual or employment action concerning a Participating Provider based on participation in appeals, complaints, or external independent reviews. **[HMO only]**

Medical Exceptions Procedures

Bright HealthCare will provide a Member's treating Participating Provider with notice of a denial under Bright HealthCare's medical exceptions procedures, including a reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal in accordance with 215 ILCS 134/45.1. **[HMO only]**

Prior Authorization

To the extent Bright HealthCare covers prescription benefits, Bright HealthCare will approve or deny a prior authorization request received in paper or electronic form from a Participating Provider within 72 hours, in accordance with 215 ILCS 134/45.2. The denial notice shall include the reason for the denial, an alternative covered medication, if applicable, and information regarding the denial. In the case of an expedited coverage determination, Bright HealthCare will approve or deny the prior authorization with 24 hours. A denial notification will include the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for appealing the denial. **[HMO only]**

Emergency Services Prior to Stabilization

Provider and Participating Providers will ensure that a determination of whether a Member needs emergency services shall be made for the purposes of treatment by a physician licensed to practice medicine in all its branches or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a licensed physician, in accordance with 215 ILCS 134/65. The evaluating Participating Provider shall indicate in the Member's chart the results of the emergency medical screening examination. **[HMO only]**

Definition of Emergency Services

"Emergency medical condition" shall be defined, in accordance with 50 Ill. Adm. Code 4520.20 and 215 ILCS 134/10, as "a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such 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: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part." **[Insurance and HMO]**

Post-stabilization Medical Services

Provider and Participating Providers will comply with the requirements for post-stabilization medical services set forth in 215 ILCS 134/70, including communicating with Bright HealthCare concerning the Member's condition and the documentation of the Member's condition and communications with Bright HealthCare. **[HMO only]**

Notice Upon Formulary Removal

Bright HealthCare will notify Provider at least 60 days before removing a drug from a formulary or negatively changing such drug's cost sharing through first class mail and electronic transmission, if available. This notice will include a one-page form by which a prescribing Participating Provider may notify Bright HealthCare, by first class mail or electronically, that coverage of the drug for a particular Member is medically necessary, as provided by 215 ILCS 134/25. **[HMO only]**

Preferred Provider Program Requirements (50 Ill. Adm. Code 2051.330/2051.290)

Note: 215 ILCS 5/370i authorizes insurers to enter into agreements with healthcare providers. 50 Ill. Adm. Code 2051.330 provides that an insurer must file copies of provider agreements as required by 2051.290. Appendix C of 2051.290 outlines these requirements. This section is applicable to the extent Bright HealthCare is offering a preferred provider insurance plan.

50 Ill. Adm. Code 2051.220 defines an administrator or preferred provider program administrator as an organization that "arranges, contracts with, or administers contracts with a provider under which insureds or beneficiaries are provided an incentive to use the services of the provider." To the extent that the Illinois Department of Insurance may consider Provider to be a PPO administrator, those requirements are outlined below. A checklist for preferred provider administrator arrangements can be found here: **https://www2.illinois.gov/sites/Insurance/Companies/Documents/2051AppendixCForm.pdf**

Specified Covered Health Care Services

Bright HealthCare and Provider's agreement must identify the specific covered healthcare services for which Provider will be responsible, including any discount services, copayments, benefit maximums, limitations and exclusions, as well as any discount amount or discounted fee schedule reflecting discounted rates will be enumerated, in accordance with 50 Ill. Adm. Code 2051.290 Bright HealthCare's covered health care services for which provider will be responsible and all other benefit plan details will be as described in the Member certificate of coverage, which will be supplied to providers.

Administrative Responsibilities

Provider will comply with all administrative policies and procedures of the Bright HealthCare including, but not limited to credentialing or recredentialing requirements, utilization review requirements, and referral procedures, in accordance with 50 Ill. Adm. Code 2051.290.

Medical Records

When payments are due to Provider for services rendered to a Member, Provider must maintain and make medical records available to the administrator and/or the Bright HealthCare for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Members, in accordance with 50 Ill. Adm. Code 2051.290. Such medical records must also be made available to appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints and to comply with the applicable State and federal laws related to privacy and confidentiality of medical records.

Licensure Requirements

Provider will ensure Participating Providers are licensed by the State, and will notify Bright HealthCare immediately whenever there is a change in licensure or certification status, in accordance with 50 Ill. Adm. Code 2051.290.

Hospital Admitting Privileges

Provider shall ensure that all physician Participation Providers licensed to practice medicine in all its branches to have admitting privileges in at least one hospital with which the Bright HealthCare has a written provider contract. The Bright HealthCare shall be notified immediately of any changes in privileges at any hospital or admitting facility. Reasonable exceptions shall be made for physicians who, because of the type of clinical specialty, or location or type of practice, do not customarily have admitting privileges, in accordance with 50 Ill. Adm. Code 2051.290.

Provider Contract Termination

Provider and Participating Provider agree that (1) they will give each other not less than 30 days prior written notice to terminate the Network Participation Agreement/individual provider agreements without cause; (2) Bright HealthCare may terminate the either agreement for cause immediately; and (3) that a Participating Provider acting as primary care physician under a Benefit Plan requiring a gatekeeper option must provide the Bright HealthCare with a list of all Members using that provider as a gatekeeper within 5 working days after the date that the provider either gives or receives notice of termination, in accordance with 50 Ill. Adm. Code 2051.290.

Continuation of Services

In the event of a termination of the Network Participation Agreement, Provider agrees to cooperate with Bright HealthCare in providing continuation of covered services, to the extent that an extension of benefits is required by law or regulation, or that such continuation is voluntarily provided by Bright HealthCare, in accordance with 50 Ill. Adm. Code 2051.290.

Delegation of Rights

The parties agree that the rights and responsibilities under the Network Participation

Agreement cannot be sold, leased, assigned, assumed or otherwise delegated by either party without the prior written consent of the other party. The Provider's written consent must be obtained for any assignment or assumption of the Agreement whenever Bright HealthCare is bought by another insurer. An assignment in accordance with the terms of the Network Participation Agreement will be deemed consent so long as the assignment is in accordance with the terms of the contract. The assignee must comply with all the terms and conditions of the Network Participation Agreement, including all appendices, policies and fee schedules, in accordance with 50 Ill. Adm. Code 2051.290.

Liability and Malpractice Coverage

Provider has and will maintain, and will ensure that Participating Providers maintain, adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to the Bright HealthCare. The Bright HealthCare must be notified within no less than ten days of the preferred provider's receipt of notice of any reduction or cancellation of such coverage, in accordance with 50 Ill. Adm. Code 2051.290.

Nondiscrimination Against Members

Provider will provide health care services without discrimination against any Member on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability, in accordance with 50 Ill. Adm. Code 2051.290.

Provider Collection of Out-of-Pocket Amounts

Provider may collect applicable copayments, coinsurance and/or deductibles from Members as provided by the Network Participation Agreement, pursuant to the fee schedules set forth in the Network Participation Agreement and agreed to by the parties, in accordance with 50 Ill. Adm. Code 2051.290.

24/7 Emergency Services

Provider will cooperate with Bright HealthCare to ensure that Bright HealthCare will provide 24-hour, 7 day per week access to network-affiliated primary care, emergency services, and woman's principal health care providers in accordance with 215 ILCS 124/10, in accordance with 50 Ill. Adm. Code 2051.290.

Payment Obligations

Bright HealthCare will pay Provider in as set forth in the Network Participation Agreement, in accordance with 50 Ill. Adm. Code 2051.290.

Administrative Services

Bright HealthCare will perform the administrative services as set forth in the Network Participation Agreement, and will submit information to Provider and give Provider access to such information as outlined in the Network Participation agreement, in accordance with 50 Ill. Adm. Code 2051.290.

Payor Access

Bright HealthCare will establish a mechanism for Provider and Participating Providers to obtain initial enrollment information and adequate notice of change in benefits and copayments. Bright HealthCare will provide Provider with all of Bright HealthCare's operational policies.

Arbitration Procedures

Provider and Bright HealthCare will participate in the internal appeal or arbitration procedures for settling contractual disputes between the parties, as outlined in the Network Provider Agreement, in accordance with 50 Ill. Adm. Code 2051.290.

Preferred Provider Administrator Requirements

To the extent Provider qualifies as an administrator of Bright HealthCare's preferred provider plan, as defined by 50 Ill. Adm. Code 2051.220, Provider and Bright HealthCare agree to adhere to the Department of Insurance's preferred provider administrator requirements as outlined in 50 Ill. Adm. Code Part 2051, including that Provider will incorporate the provider agreement requirements provided by 50 Ill. Adm. Code 2051.290 in its agreements with Participating Providers. Provider will not assume any underwriting risk through the arrangement, in accordance with 50 Ill. Adm. Code 2051.280. Bright HealthCare will ensure that both Bright HealthCare's and Provider's name and telephone number be included on Member identification cards, in accordance with 50 Ill. Adm. Code 2051.280. Whenever a Participating Provider or Provider finds it medically necessary to refer a Member to a non-Participation Provider, Bright HealthCare shall ensure that the Member so referred shall incur no greater out of pocket liability than had the Member received services from a Participating. This requirement does not apply to a Member who willfully chooses to access a non-Participating Provider for health care services available through the administrator's panel of participating providers.

End of Preferred Provider Requirements

Markup of Anatomic Pathology Services

To the extent Provider or Participating Provider orders, but does not supervise or perform, an anatomic pathology service as defined in 410 ILCS 50/3.3, Participating Provider shall not markup, or directly or indirectly increase the actual amount to be paid by Bright HealthCare in accordance with 410 ILCS 50/3.3. Participating Provider is not prohibited from charging a specimen acquisition or processing charge if the charge is limited to actual costs incurred for specimen collection and transportation and the charge is separately coded or denoted as a service distinct from the performance of the anatomic pathology service, in conformance with American Medical Association coding policies. Bright HealthCare will not be required to reimburse any charges or claims submitted in violation of 410 ILCS 50/3.3. Note: this provision does not apply to facilities licensed under the Hospital Licensing Act or clinical laboratories owned, operated by, or operated within facilities licensed under the Act. **[Insurance and HMO]**

HIV/AIDS Testing

To the extent Bright HealthCare requires any Member or prospective Member to be tested for infection with HIV or any other identified causative agent of acquired immunodeficiency syndrome (AIDS) for new or continued coverage, and Provider or Participating Provider is designated by a Member to receive the results of such testing, Participating Provider will keep the results of such testing confidential in accordance with 410 ILCS 50/3. **[Insurance and HMO] Clinical Breast Exams**

Bright HealthCare will reimburse clinical breast examinations, regardless of whether the exam is performed by a licensed physician, a licensed advanced practice registered nurse, or a licensed physician assistant, in accordance with 215 ILCS 5/356g.5. **[Insurance and HMO]**

Woman's Principal Health Care Provider

Bright HealthCare and Provider will allow each female Member to designate an individual Participating Provider, who is a physician specializing in obstetrics, gynecology, or family practice, to be the Member's woman's principal health care provider in accordance with 215 ILCS 5/356r. Such Member will be permitted access to their designated woman's principal health care provider without a referral. The Member may be required to designate a provider who has a referral arrangement with the Member's individual primary care provider if such referral arrangement exists or to select a new primary care provider who has a referral arrangement with the woman's principal health care provider chosen by the Member. If Bright HealthCare or Provider requires a Member to select a new physician subject to the foregoing, the Member must be provided with both options to select a new physician. Bright HealthCare or Provider will provide such Member with a list that identifies the referral arrangements that exist between primary care physicians and the woman's principal health care provider in order to assist the female insured or enrollee to make a selection within Bright HealthCare's requirements.
[Insurance and HMO]

Maternity and Post-delivery Care

To the extent Bright HealthCare covers and Provider provides maternity care, Bright HealthCare and Provider will ensure that a Member, after giving birth, will be provided a minimum 48 hours of inpatient stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient stay following a cesarean section in accordance with 215 ILCS 5/356s 215 ILCS 125/4-6.4 (HMO). A shorter length of inpatient stay may be provided if the Member's attending Participating Provider is a licensed physician and determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn and the coverage and availability of a post-discharge physician office visit or in-home nurse to verify the condition of the infant in the first 48 hours after discharge. **[Insurance and HMO]**

Post-Mastectomy Inpatient Care

To the extent Bright HealthCare covers and Provider provides mastectomy surgery, Bright HealthCare and Provider will ensure that the decision to discharge a Member following a mastectomy is made by the Member's attending physician and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the Member and the coverage for and availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the Member in the first 48 hours after discharge in accordance with 215 ILCS 5/356t **[**215 ILCS 125/4-6.5 **(HMO)]**. **[Insurance and HMO]**

Colorectal Cancer Examination and Screening

To the extent Bright HealthCare covers and Provider provides coverage for colorectal cancer examination and screening, Bright HealthCare will provide reimbursement for such colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by Participating Provider in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology, in accordance with 215 ILCS 5/356x. **[Insurance and HMO]**

Prenatal HIV Testing

To the extent Bright HealthCare covers maternity services, Bright HealthCare will reimburse prenatal HIV testing regardless of whether the test is ordered by a licensed physician, an advanced practice registered nurse, or a physician assistant in accordance with 215 ILCS 5/356z.1 and regardless of whether the order is consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. **[Insurance and HMO]**

Coverage for Cancer, HIV, or Acquired Immunodeficiency Syndrome Treatment

In accordance with 215 ILCS/4-6.3 to the extent Bright HealthCare provides reimbursement for prescription drugs for the treatment of a specific type of cancer approved by the federal Food and Drug Administration (FDA), it will not exclude coverage for any drug on the basis that the drug has not been approved by the FDA for the treatment of another specific type of cancer if the drug has been recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

the American Hospital Formulary Service Drug Information;

National Comprehensive Cancer Network's Drugs & Biologics Compendium;

Thomson Micromedex's Drug Dex;

Elsevier Gold Standard's Clinical Pharmacology;

or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services;

or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain. To the extent Bright HealthCare provides coverage in accordance with the above, it will also cover medically necessary services associated with the administration of the drugs described above. **[HMO only]**

Multiple Sclerosis Preventative Physical Therapy

To the extent Bright HealthCare covers and Provider provides, preventative physical therapy for Members diagnosed with multiple sclerosis, Bright HealthCare need only provide coverage for such therapy where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals in accordance with 215 ILCS 5/356z.8. **[Insurance and HMO]**

Autism Spectrum Disorders

To the extent Bright HealthCare covers and Provider provides, treatment for the diagnosis and treatment of autism spectrum disorders, upon request of Bright HealthCare, Provider or a Participating Provider treating autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status in accordance with 215 ILCS 5/356z.14. When treatment is anticipated to require continued services to achieve demonstrable progress, Bright HealthCare may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated. When making a determination of medical necessity for a treatment modality for autism spectrum disorders, Bright HealthCare must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders. To the extent a Member is receiving medically necessary early intervention services, such services must be delivered by certified early intervention specialists, as provided by 89 Ill. Admin. Code 500. **[Insurance and HMO]**

Habilitative Services for Children

To the extent Bright HealthCare covers and Provider provides, treatment for the diagnosis and treatment of habilitative services for Members that are children, as provided by 215 ILCS 5/356z.15, Bright HealthCare will reimburse such services so long as: 1) a physician licensed to practice medicine in all its branches has diagnosed the child Member's congenital, genetic, or early acquired disorder; 2) the treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches; 3) the initial or continued treatment must be medically necessary and therapeutic and not experimental or investigational. Any denial of care for habilitative services shall be subject to appeal and external independent review procedures as provided by Section 45 of the Managed Care Reform and Patient Rights Act (215 ILCS 134/45). Upon request of Bright HealthCare, Provider or Participating Provider under whose supervision the habilitative services are being provided shall furnish medical records, clinical notes, or other necessary data to allow the insurer to substantiate that initial or continued medical treatment is medically necessary and that the Member's condition is clinically improving. When Provider or Participating Provider anticipates that continued treatment is or will be required to permit the Member to achieve demonstrable progress, the Bright HealthCare may request that Provider or Participating Provider furnish a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Prosthetic and Customized Orthotic Devices

To the extent Bright HealthCare covers and Provider provides, orthotic and prosthetic devices, Provider will ensure that such devices are prescribed by a licensed prosthetist, licensed orthoptist, or licensed pedorthist in accordance with 215 ILCS 5/356z.18. **[Insurance and HMO]**

Cancer Treatment Parity/Orally Administered Cancer Treatment Medications

Bright HealthCare will provide coverage for orally administered cancer treatment medications on a basis that is no less favorable to the Members than coverage for intravenous or injected cancer treatment medications in accordance with 215 ILCS 5/356z.20. Increasing financial requirements or imposing more restrictive treatment limitations on prescribed orally-administered cancer medications or intravenously administered or injected cancer medications shall not be sufficient to obtain compliance with 215 ILCS 5/356z.20. **[Insurance and HMO]**

Ophthalmic Goods and Services

To the extent Bright HealthCare covers and Provider provides optometric or ophthalmic goods or services, Bright HealthCare will not require Provider to purchase ophthalmic goods or services, including but not limited to eyeglass frames, in a quantity or dollar amount in excess of the quantity or dollar amount a Member purchases under the terms of the policy in accordance with 215 ILCS 5/364.2 215 ILCS 125/4-19 (HMO). **[Insurance and HMO]**

Mental Health Services and Substance Use Services

Bright HealthCare, Provider, and Participating Providers will permit a Member to select the Participating Provider of the Member's choice in accordance with 215 ILCS 5/370c for treatment for mental, emotional, nervous, or substance use disorders or conditions as defined by 215 ILCS 5/370c. To the extent a Participating Provider is a licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Illinois Alcoholism and Other Drug Abuse and Dependency Act, such Participating Provider will, before providing services to a Member, inform the Member of the desirability of the Member conferring with the Member's primary care physician. Bright HealthCare and Provider will furnish medical records or other necessary data to substantiate that initial or continued treatment is at all times medically necessary. Bright HealthCare will provide a mechanism for timely review of medical necessity by a provider holding the same license and practicing in the same specialty as the Member's treating Participating Provider, who is unaffiliated with Bright HealthCare, jointly selected by the Member, the Member's treating Participating Provider and Bright HealthCare in the event of a dispute between Bright HealthCare and Member's treating Participating Provider. If the reviewing provider determines the treatment to be medically necessary, Bright HealthCare will provide reimbursement for the treatment. Nothing herein prevents a Member from agreeing in writing to continue treatment at his or her own expense.

A Participating Provider shall base all treatment recommendations for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. A Participating Provider shall base all treatment recommendations for medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

Bright HealthCare will not require prior authorization for treatment provided under 215 ILCS 5/370c. Provider and Participating Providers agree to adhere to the notice of discharge requirements set forth in 215 ILCS 5/370c. **[Insurance and HMO] Emergency Transportation by Ambulance**

To the extent Provider provides emergency transportation by ambulance to a Member, Bright HealthCare agrees to promptly pay Provider the charges for such emergency transportation that the Member is covered for, in accordance with 215 ILCS 125/4-15. Provider agrees not to seek any payment from Member for emergency transportation services provided pursuant to 215 ILCS 125/4-15. **[HMO only]**

Retirement Facility Residents

In accordance with 215 ILCS 125/4-18, with respect to a Member who is a resident of a retirement facility, as defined in 210 ILCS 45/1-101 et seq., and residential apartments, such Member's primary care Participating Provider must refer the Member to the retirement facility's long-term care facility for Medicare covered skilled nursing services pursuant to the requirements set forth in 215 ILCS 125/4-18. **[HMO only]**

Nebraska Regulatory Requirements Appendix

This Nebraska Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Nebraska law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts";

"Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Freedom of Choice

Bright HealthCare and Provider will comply with "Freedom of Choice" statutes requiring that Bright HealthCare reimburse health services covered by Benefit Plans without designating the specific type of licensed health professional to perform the service. Bright HealthCare will reimburse such services covered by Benefit Plans so long as the services are legally performed by a person licensed for the practice of osteopathic medicine and surgery, chiropractic, optometry, psychology, dentistry, podiatry or mental health practice. Neb. Rev. Stat. § 44-513.

Network Adequacy

Provider will cooperate with Bright HealthCare to ensure that Members have 24/7 access to emergency services in accordance with Neb. Rev. Stat. § 44-7105. Provider will provide Bright HealthCare with a list of Participating Providers, including specialty, to assist Bright HealthCare in complying with the requirements of Neb. Rev. Stat. § 44-7105.

Confidential Information

Provider will hold any data or information pertaining to the diagnosis, treatment, or health of any Member or applicant obtained from any Member or Participating Provider in confidence except (1) upon express consent of the Member or applicant, (2) pursuant to statute or court order for the production of evidence or the discovery thereof, or (3) in the event of a claim or litigation between such person and the preferred provider organization in which such data or information is pertinent in accordance with Neb. Rev. Stat. § 44-4110.01.

External Review

All requests for an external review by the Nebraska director of insurance of an adverse decision by Bright HealthCare shall be made by a Member or a Member's authorized representative using the form provided in Appendix B of Neb. Admin. Code. 210, Ch. 87 (may be found at: **http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Insurance_Dept_of/Title-210/ Chapter-87.pdf)**.

Cost Disclosure

Participating Providers will provide, within three working days of a request from a Member, information concerning the allowed amount of a nonemergency admission, procedure, or service, including the amount for any facility fees required, to a patient Member or a prospective patient Member in accordance with Neb. Rev. Stat. § 44-1404. If Participating Providers are unable to quote a specific amount, Participating Providers will disclose what is known concerning the estimated amount and will inform the Member about the incomplete nature of the estimate. Participating Providers will provide sufficient information regarding a Member's proposed nonemergency admission, procedure, or service for Bright HealthCare to provide a cost estimate to a Member to identify out-of-pocket costs for a proposed nonemergency admission, procedure or service. Participating Providers may assist a Member in using Bright HealthCare's toll-free telephone number or web site to obtain such estimate, to the extent Bright HealthCare maintains such service.

Provider Committee

Provider and Bright HealthCare will establish a mechanism by which a committee of Participating Providers will be involved in reviewing and advising Bright HealthCare about medical policy, including coverage of new technology and procedures, quality and credentialing criteria, and medical management procedures in accordance with Neb. Rev. Stat. § 44-4109.01.

Refusal to Contract

If Bright HealthCare refuses to contract with a potential Participating Provider, the provider shall be permitted to appeal the adverse decision pursuant to the procedure set forth in Neb. Rev. Stat. § 44-4109.01.

Credentialing and Exclusion of Participating Providers

Bright HealthCare's process for credentialing providers will be based solely on quality, accessibility, or economic considerations and will be applied in accordance with reasonable business judgment, in accordance with Neb. Rev. Stat. § 44-4109.01. Bright HealthCare will permit all health care providers within its geographic service area that meet the business criteria for participation in the Bright HealthCare Network to apply for credentials at least annually. Bright HealthCare will not exclude a potential provider from participation based on the fact that the provider's practice contains a substantial number of patients having severe or expensive medical conditions, except Bright HealthCare may exclude providers who fail to meet Bright HealthCare's criteria for quality, accessibility, or economic considerations.

Credentialing Verification

Bright HealthCare will establish written policies and procedures for credentialing verification of all providers to verify the credentials of providers before entering into a contract with such providers in accordance with Neb. Rev. Stat. § 44-7006. Bright HealthCare's medical director or another designated health care professional will have responsibility for, and will participate in, credentialing verification. Bright HealthCare will establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification. Bright HealthCare will make available for review by providers upon written request all application and credentialing verification policies and procedures, retain all records and documents relating to a health care professional's credentialing verification process for at least five years, and keep confidential all information obtained in the credentialing verification process except as otherwise provided by law. Bright HealthCare will obtain primary verification of the information listed in Neb. Rev. Stat. § 44-7007. Bright HealthCare will ensure that providers have the opportunity to review and correct information submitted in support of a credentialing verification application, in accordance with Neb. Rev. Stat. § 44-7008. To the extent Bright HealthCare delegates its credentialing functions to Provider, Provider will perform these functions in accordance with Neb. Rev. Stat. § 44-7001 et seq and Bright HealthCare will remain responsible for monitoring Provider's compliance with these requirements.

Termination of a Participating Provider's Participation

Before initiating a proceeding to terminate a Provider or Participating Provider's participation in Bright HealthCare's network, Bright HealthCare will give Provider or Participating Provider an opportunity to enter into and complete a corrective action plan, except in cases of fraud or imminent harm to patient health, or when the provider's ability to provide services has been restricted by an action such as probation or compliance agreements by any governmental agency in accordance with Neb. Rev. Stat. § 44-4109.01. Bright HealthCare will ensure that the appeal process set forth in Neb. Rev. Stat. § 44-4109.01 will be available should Bright HealthCare exclude or fail to retain Provider, or a Participating Provider previously contracted, to provide health care services. Should Provider or Participating Provider disagree with the appeal decision, Bright HealthCare will permit a further appeal to an appeals committee consisting of one person selected by each party to the appeal and one person mutually agreeable to both parties. The parties will be responsible for paying to the appeal committee any costs incurred by an appeal committee member, and the parties will share equally in reimbursing the costs of the appeal committee members mutually agreeable to both parties.

Provider Licensure and Certification

Participating Providers will ensure they have met all licensure and certification requirements necessary to practice a specific profession or to operate a specific health care facility in accordance with Neb. Rev. Stat. § 44-4110.

Obstetricians/Gynecologists as Primary Care Physicians

Bright HealthCare will permit Participating Providers who are obstetricians/gynecologists to serve as primary care physicians if they otherwise qualify as a primary care physician pursuant to Bright HealthCare's credentialing standards in accordance with Neb. Rev. Stat. § 44-786.

Diabetes Self-Management Training and Patient Management

To the extent Bright HealthCare covers and Provider provides diabetes self-management training and patient management, Provider will ensure that such training and management will be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or a health care professional that is a diabetes educator certified by the National Certification Board for Diabetes Educators in accordance with Neb. Rev. Stat. § 44-790.

Dental Services

Bright HealthCare shall not require, directly or indirectly, that a dentist who is a Participating Provider limit fees charged for dental services that are not covered by Bright HealthCare in accordance with Neb. Rev. Stat. § 44-7,105.

Autism Spectrum Disorder

To the extent Bright HealthCare covers and Provider provides treatment of autism spectrum disorder, Bright HealthCare has the right to request a review of a Member's treatment for such disorder once every six months except in the case of inpatient service in accordance with Neb. Rev. Stat. § 44-7, 106. Bright HealthCare and a Participating Provider treating a particular Member may sign an agreement that a more frequent review is necessary. Bright HealthCare will bear the cost of this review.

Medical Services Provided to Jails

Bright HealthCare will not refuse to credential a Participating Provider who is an employee or a contractor of a political subdivision on the basis that the Participating Provider provides medical services in a jail, in accordance with Neb. Rev. Stat. § 44-713.

Responsibility for Covered Health Services

Bright HealthCare and Provider will establish a mechanism to notify Participating Providers on an ongoing basis of the specific Covered Services for which a Participating Provider will be responsible, including any limitations or conditions of such Covered Services in accordance with Neb. Rev. Stat. § 44-7106.

Member Protection

Participating Providers agree that in no event, including, but not limited to, nonpayment by Bright HealthCare, insolvency of Bright HealthCare or Provider, or breach of this Agreement, shall a Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person, other than Bright HealthCare or Provider, acting on behalf of the Member for Covered Services provided pursuant to Bright HealthCare's Benefit Plans in accordance with Neb. Rev. Stat. § 44-7106. Participating Providers are not prohibited from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to Members. Participating Providers are not prohibited from agreeing with a Member to continue health care services solely at the expense of the Member, as long as the Provider or Participating Provider has clearly informed the Member that Bright HealthCare may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this Agreement does not prohibit Provider or Participating Providers from pursuing any available legal remedy. In no event shall Provider or Participating Provider collect or attempt to collect from a Member any money owed to Provider or Participating Provider by Bright HealthCare.

Continuity of Care

In the event of Bright HealthCare's insolvency, or other cessation of operations, covered benefits to Members will continue through the period for which a premium has been paid to Bright HealthCare on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater in accordance with Neb. Rev. Stat. § 44-7106. Covered benefits to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. This requirement will survive the termination of any contract between Bright HealthCare and Provider.

Medically Necessary Services

Bright HealthCare will not provide inducements to Provider or Participating Providers to deny or limit medically necessary Covered Services to a Member in accordance with Neb. Rev. Stat. § 44-7106. Nor shall Bright HealthCare prohibit Provider or Participating Providers from discussing treatment options with a Member or from advocating on behalf of Members under Bright HealthCare's utilization review or grievance processes.

Health Records

Provider agrees to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members, and to comply with all applicable state and federal laws related to the confidentiality of medical or health records in accordance with Neb. Rev. Stat. § 44-7106.

Contract Termination

Provider and Bright HealthCare will provide each other at least 60 days written notice prior to terminating the contract with each other without cause in accordance with Neb. Rev. Stat. § 44-7106. Bright HealthCare will make a good faith effort to provide written notice of termination within fifteen working days of receipt of a notice of termination to all Members who are patients seen on a regular basis by affected Participating Providers, irrespective of whether the termination was for cause or without cause. Where such contract termination involves a primary care professional, all Members who are patients of that primary care professional shall be notified.

Contract Assignment

Provider's duties and obligations under the Agreement shall not be assigned, delegated, or transferred without the prior written consent of Bright HealthCare in accordance with Neb. Rev. Stat. § 44-7106.

Coverage Determinations

Bright HealthCare will provide a mechanism that allows Provider to verify Member eligibility in accordance with Neb. Rev. Stat. § 44-7106.

Dispute Resolution

Bright HealthCare will establish procedures for resolution of administrative, payment, or other disputes between Provider and Bright HealthCare in accordance with Neb. Rev. Stat. § 44-7106.

Non-Discrimination

Provider will not discriminate in providing Covered Services to Members with regard to a Member's enrollment with Bright HealthCare as a private purchaser or as a participant in publicly financed programs of health care services in accordance with Neb. Rev. Stat. § 44-7106.

Provider as Intermediary

To the extent Provider is an intermediary, defined as a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network, Provider will ensure that all of its contracts with Participating Providers will comply with the provisions of Neb. Rev. Stat. § 44-7106 (outlined above) in accordance with Neb. Rev. Stat. § 44-7107.
Bright HealthCare will retain responsibility to monitor and oversee the offering of services to Members and its financial responsibility to Members. Bright HealthCare will maintain its right to approve or disapprove participation status of a Participating Provider for the purpose of delivering covered benefits to its Members. Provider will provide Bright HealthCare with copies of all of its health care subcontracts to the extent such subcontracts relate to its dealing with Bright HealthCare or ensure that Bright HealthCare has access to all such contracts upon twenty days prior written notice. This requirement may be satisfied by Provider providing a copy of its subcontract forms, and a copy of all subcontracts that substantially differ from such form in areas other than reimbursement. Provider will maintain the books, records, financial information, and documentation of health care services provided to Members at its principal place of business in the state and preserve them for five years in a manner that facilitates regulatory review. Provider will allow the Director of Insurance access to its books, records, financial information, and any documentation of health care services provided to Members, as necessary to determine compliance with the Managed Care Plan Network Adequacy Act, Neb. Rev. Stat. § 44-7101 et seq. Bright HealthCare will have the right, upon Provider's insolvency, to require assignment to Bright HealthCare of the provisions of Provider's contract addressing Provider's obligation to furnish covered services.

Contract Definitions and Provisions

To the extent any definitions or other provisions in the Agreement conflict with the definitions or provisions contained in Bright HealthCare's benefit plan or the Managed Care Plan Network Adequacy Act, Neb. Rev. Stat. § 44-7101 et seq, the definitions and provisions of the benefit plan and the Managed Care Plan Network Adequacy Act control in accordance with Neb. Rev. Stat. § 44-7106.

Quality Improvement

Provider agrees to cooperate with Bright HealthCare to support Bright HealthCare in meeting its obligation to continuously improve the health care services delivered to Members in accordance with Neb. Rev. Stat. § 44-7207. To the extent Bright HealthCare delegates any quality assessment or quality improvement functions to Provider, Provider agrees to ensure such functions are performed in accordance with Neb. Rev. Stat. § 44-7201 et seq and Bright HealthCare will remain responsible for monitoring compliance with such provisions.

Grievance Procedures

If Bright HealthCare denies a Member's request for a health care service, Bright HealthCare will inform the attending or ordering Participating Provider of the right to submit a grievance or a request for an expedited review and will explain such review procedures to the Participating Provider upon request in accordance with Neb. Rev. Stat. § 44-7308. A Participating Provider may submit a grievance on behalf of a Member, unless prohibited by federal or state law. Bright HealthCare will submit a written copy of a grievance decision to such Participating Provider. Such decision will contain the elements set forth in Neb. Rev. Stat. § 44-7308, subdivision 3. Bright HealthCare will make available to a Participating Provider acting on behalf of a Member its written procedures for a standard review of an adverse determination in accordance with Neb. Rev. Stat. § 44-7310. A Participating Provider may also submit a request for an expedited review on behalf of a Member in accordance with Neb. Rev. Stat. § 44-7311. If the standard review or expedited review process does not resolve a difference of opinion between Bright HealthCare and a Participating Provider acting on behalf of a Member, the Participating Provider may submit a written grievance, unless prohibited by federal or other state law. Bright HealthCare will ensure its grievance and review procedures meet the requirements set forth in Neb. Rev. Stat. § 44-7301 et seq.

Prompt Payment Act

Bright HealthCare will pay, deny, or settle clean claims submitted by Provider or Participating Provider within 30 calendar days after receipt if submitted electronically, and within 45 days of receipt if submitted nonelectronically in accordance with Neb. Rev. Stat. § 44-8004. To the extent Bright HealthCare provides a standard printed or electronic transaction form, Bright HealthCare will ensure that its form complies with standards issued by the Secretary of the United States Department of Health and Human Services in accordance with Neb. Rev. Stat. § 44-8002. If Bright HealthCare does not provide a standard form, Provider or Participating Provider will submit claim forms complying with such standards. An electronic claim is presumed to have been received on the date of the electronic verification of receipt by Bright HealthCare pursuant to Neb. Rev. Stat. § 44-8003. A claim submitted by mail is presumed to have been received five business days after the claim has been placed in the mail with first-class postage prepaid. If a claim requires additional information, Bright HealthCare will give Provider or Participating provider an explanation in writing of the additional information needed, and the applicable time period of 30 or 45 days will be tolled until such additional information is received in accordance with Neb. Rev. Stat. § 44-8004. Provider and Participating Providers will furnish all additional requested information within 30 days of receiving such request. Bright HealthCare may deny a claim if Provider or Participating Providers fail to submit additional information as requested, but a claim may not be invalidated or reduced if it was not reasonably possible to provide additional requested information within 30 days. A clean claim does not include a claim for which additional information is needed to resolve issues concerning coverage, eligibility, coordination of benefits, investigation of preexisting conditions, subrogation, determination of medical necessity, or the use of unlisted procedural codes or for which Bright HealthCare has a reasonable belief supported by specific information that the claim is fraudulent. To the extent a claim is submitted to a repricer, the time period for payment of a claim set forth in Neb. Rev. Stat. § 44-8004 will commence upon the repricer's receipt of the claim. If Bright HealthCare fails to settle a clean claim in accordance with the time periods provided by Neb. Rev. Stat. § 44-8004, it will pay Provider or Participating Providers interest at the rate of 12% per annum on the total amount ultimately

allowed in the claim, accruing from the date payment was due in accordance Neb. Rev. Stat. § 44-8005. Bright HealthCare may be exempt from the interest rate requirements in § 44-8005 during a calendar year in which Bright HealthCare has a prompt payment act compliance statement on file with the director of insurance in accordance with § 44-8006.

Coverage for Cancer, HIV, or Acquired Immunodeficiency Syndrome Treatment

To the extent Bright HealthCare provides reimbursement for prescription drugs for the treatment of a specific type of cancer approved by the federal Food and Drug Administration (FDA), it will not exclude coverage for any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the FDA for the treatment of another specific type of cancer if (a) the drug or combination of drugs is recognized for treatment of the other specific type of cancer in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the FDA or (b) the drug or combination of drugs is recognized for treatment of the other specific type of cancer in medical literature (as defined by Neb. Rev. Stat. § 44-788, subd. 5) and the drug or combination of drugs is approved for sale by the FDA in accordance with Neb. Rev. Stat. § 44-788, subd. 1. To the extent Bright HealthCare provides reimbursement for prescription drugs approved by the FDA for the treatment of HIV or acquired immunodeficiency syndrome, it will not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the FDA for the treatment of HIV or acquired immunodeficiency syndrome if (a) the drug or combination of drugs is recognized for treatment of HIV or acquired immunodeficiency syndrome in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the FDA or (b) the drug or combination of drugs is recognized for treatment of HIV or acquired immunodeficiency syndrome in medical literature (as defined by Neb. Rev. Stat. § 44-788(5)) and the drug or combination of drugs is approved for sale by the FDA in accordance with Neb. Rev. Stat. § 44-788(2).

To the extent Bright HealthCare provides coverage in accordance with the above, it will also cover medically necessary services associated with the administration of the cancer, HIV, or acquired immunodeficiency syndrome drugs described above.

Cancer Treatment Parity/Orally Administered Cancer Treatment Medications

Bright HealthCare will provide coverage for orally administered cancer treatment medications on a basis that is no less favorable to the Members than coverage for intravenous or injected cancer treatment medications in accordance with Neb. Rev. Stat. § 44-7,104. Bright HealthCare will not reclassify any anticancer medication or increase a coinsurance, copayment, deductible or other out-of-pocket expense imposed on any anticancer medication to achieve compliance with Neb. Rev. Stat. § 44-7,104.

North Carolina Regulatory Requirements Appendix

This North Carolina Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under North Carolina law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Uniform Claim Forms

Provider agrees to submit all claims to Bright HealthCare on a form approved by the North Carolina Department of Insurance in accordance with N.C. Gen. Stat. §58-3-171. Bright HealthCare and Provider agree to utilize the uniform claim forms, as applicable, provided in 11 N.C.A.C. 12.1500.

Treatment Discussions

Bright HealthCare will not limit Provider's or Participating Provider's ability to discuss with a Member the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment in accordance with N.C. Gen. Stat. §58-3-176. Bright HealthCare will not limit Provider's professional obligations to patients as such obligations are specified by the Provider's professional license.

Evaluation/Provider Credentials/Quality Management/Utilization Review Program

Bright HealthCare will develop programs to evaluate whether its provider network is sufficient, in numbers and types of providers, to ensure that all health care services will be accessible without unreasonable delay; to verify provider credentials; to assure quality of care and health care services managed and provided through Bright HealthCare's health care plan; and for utilization review in accordance with N.C. Gen. Stat. §58-67-11. Provider will cooperate with Bright HealthCare as necessary in developing these programs, and by providing all necessary information to assist Bright HealthCare in meeting its statutory obligations.

Provider Directories

Provider will furnish Bright HealthCare with the necessary information for Bright HealthCare to maintain a provider directory that includes a list of network Participating Providers available to Members to be updated no less than once a year and a telephone system through which insureds can access accurate, current, and up-to-date network information in accordance with N.C. Gen. Stat. §58-3-245. At Provider's request, Bright HealthCare will list any allied health professional providing primary care services under Provider's supervision whose services to Members are covered by virtue of the Agreement as part of Provider's directory listing.

Prompt Claim Payments

Within 30 days of receipt of a claim from Provider or Participating Provider, Bright HealthCare will send to Provider or Participating Provider payment of the claim, notice of denial of the claim, notice that proof of loss is inadequate or incomplete, notice that the claim is not submitted on the required form, notice that coordination of benefits information is needed in order to pay the claim, or notice that the claim is pending based on nonpayment of fees or premiums in accordance with N.C. Gen Stat. §58-3-225. Bright HealthCare will be presumed to have received a written claim five business days after Provider or Participating Provider has mailed the claim, and on the day a claim is electronically transmitted.

If Bright HealthCare denies a claim, the denial notice will include all of the specific good faith reasons for the denial. If the claim is contested or cannot be paid, the notice will include the specific good faith reasons why it has not been paid, and a description of information needed by Bright HealthCare to complete the processing of the claim. If the claim is contested or cannot be paid due to a utilization management or a medical necessity reason, the notice will contain the specific clinical rationale for that decision or will refer to specific provisions in documents which provide the specific clinical rationale for the decision. If a notice of noncertification has already been provided to Provider or Participating Provider in accordance with §58-50-61(h), then the specific clinical rationale is not required. If a claim is contested or cannot be paid because of the nonpayment of premiums or is pending receipt of requested coordination of benefits information, the notice will contain a statement advising Provider or Participating Provider of such situation. If a claim is contested because the claim was not submitted on the required form, the notice will contain the required form, if the form is not a UB or HCFA form.

If a claim is denied or contested in part, Bright HealthCare will pay the undisputed portion within 30 calendar days of the receipt of the claim.

Upon receipt of additional information requested from Provider or Participating Provider, Bright HealthCare will continue processing the claim and pay or deny the claim within 30 days after such receipt. If Bright HealthCare requests additional information, and does not receive the additional information within 90 days after the request was made, Bright HealthCare will deny the claim. Bright HealthCare will send notice of the denial, and include the specific reason or reasons for the denial in the notice, including the fact that information requested was not provided. Bright HealthCare will inform Provider or Participating Provider that the claim will be reopened if the previously requested information is submitted to Bright HealthCare within one year of the denial notice.

Payments that are not made in accordance with N.C. Gen Stat. §58-3-225 will bear interest at the annual percentage rate of eighteen percent (18%), beginning on the date following the day on which the claim should have been paid. If Bright HealthCare requested additional information, the interest will begin to accrue on the 31st day after Bright HealthCare received additional information.

Payment is considered made on the date upon which a check, draft, or other instrument is placed in the mail or on the date of the electronic transfer or other delivery of the payment to Provider or Participating Provider.

Unless otherwise agreed to by the parties, all claims must be submitted to Bright HealthCare within 180 days of service or discharge. Unless otherwise agreed, failure to submit a claim within the time required does not invalidate or reduce a claim if it was not reasonably possible for the Provider or Participating Provider to file the claim within that time, provided the claim is submitted as soon as reasonably possible and not less than one year from the time submittal of the claim is otherwise required, except in the absence of legal capacity of the Member. If Bright HealthCare has not paid or denied a claim within 60 days after receipt, Bright HealthCare will send a claim status report to the affected Member, but such report is not required if Bright HealthCare is waiting for information requested from Provider or Participating Provider. A claim status report will be sent to the Member every 30 days thereafter, with a copy sent to Provider or Participating Provider.

Overpayments

Bright HealthCare may recover overpayments made to Provider or Participating Provider by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments made in accordance with N.C. Gen Stat. §58-3-225. Bright HealthCare will provide notice to Provider or Participating Provider not less than 30 calendar days before Bright HealthCare seeks overpayment recovery or to offset future payments. This notice will be accompanied by adequate specific information to identify the specific claim and reason for recovery. This recovery or offsetting of future payments will occur within two years after the original claim payment date, unless Bright HealthCare suspects fraud or other misconduct. Bright HealthCare may make recovery by demanding refunds and may include applicable interest, this demand will be made within two years after the original claim adjudication, unless the claim involves Provider or Participating Provider receiving payment for the same service from a government payor.

Fee Schedules

Bright HealthCare will make available to Provider its schedule of fees associated with the top 30 services or procedures most commonly billed by a particular class of provider, and, upon request, the full schedule of fees for services or procedures billed by that class of provider in accordance with N.C. Gen Stat. §58-3-227. To the extent the Agreement incorporates multiple classes of providers, Bright HealthCare will provide its schedule of fees associated with the top 30 services or procedures most commonly billed for each class of provider, and upon request, the full schedule of fees for services or procedures billed for each class of provider. If Provider requests fees for more than 30 services and procedures, Bright HealthCare may limit Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by Provider. Bright HealthCare may limit the frequency of requests for the additional codes by each provider, provided that such additional codes will be made available upon request at least annually and any time there are changes for which notification is required pursuant to N.C. Gen Stat. §58-3-227. Bright HealthCare will provide Provider with advance notice of changes to its schedule of fees, reimbursement policies, or submission of claims policies no later than 30 days before a change in such policies. Such notice is not required if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in these cases, notification may be made concurrent with implementation of the changes. Bright HealthCare will inform Provider of the method of communication it will use to provide such notification. If Bright HealthCare references source information that is the basis for a schedule of fees, reimbursement policy, or claim submission policy, and the source of the information is developed independently of Bright HealthCare, Bright HealthCare will provide Provider with clear instructions concerning how Provider may access such information. Bright HealthCare will make available to Provider a description of its claim submission and reimbursement policies. Bright HealthCare will notify Provider of the availability of information required or authorized to be provided pursuant to N.C. Gen Stat. §58-3-227.

Post-Mastectomy Inpatient Care

To the extent Bright HealthCare covers and Provider provides mastectomy surgery, Bright HealthCare and Provider will ensure that the decision to discharge a Member following a mastectomy is made by the Member's attending physician in consultation with the Member, and will ensure that the length of the postmastectomy hospital stay is based on the Member's unique needs in accordance with N.C. Gen. Stat. §58-3-168.

Maternity and Post-delivery Care

To the extent Bright HealthCare covers and Provider provides maternity care, Bright HealthCare and Provider will ensure that a Member, after giving birth, will be provided a minimum 48 hours of inpatient stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient stay following a cesarean section, without prior authorization from Bright HealthCare in accordance with N.C. Gen. Stat. §58-3-169. However, Bright HealthCare is not required to provide coverage for such length of stay if a decision to discharge the Member is made by the Member's attending health care provider in consultation with the Member so long as Bright HealthCare covers post-delivery care as provided by N.C.

Gen. Stat. §58-3-169. Bright HealthCare will not penalize or otherwise reduce or limit the reimbursement of Provider because Provider provided treatment in accordance with N.C. Gen. Stat. §58-3-169.

Bright HealthCare will not provide incentives for a Member to receive, or Provider to provide, care inconsistent with N.C. Gen. Stat. §58-3-169.

Managed Care Provider Incentives

Bright HealthCare will not offer any type of material inducement, bonus, or other financial incentive to Provider to deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered by Bright HealthCare in accordance with N.C. Gen. Stat. §58-3-265.

Contraceptive Services

To the extent Bright HealthCare covers and Provider provides outpatient contraceptive services, Bright HealthCare will not penalize or otherwise reduce or limit its reimbursement of Provider because Provider provided contraceptive services in accordance with N.C. Gen. Stat. §58-3-178. Bright HealthCare will not provide incentives to Provider or Participating Provider or any Member to encourage care inconsistent with N.C. Gen. Stat. §58-3-178.

Emergency Services

Bright HealthCare will reimburse Provider for emergency services provided to Members to the extent necessary to screen and to stabilize the Member without prior authorization, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed in accordance with N.C. Gen. Stat. §58-3-190. Payment of claims for emergency services will be based on the retrospective review of the presenting history and symptoms of the covered person. If Bright HealthCare gives prior authorization for emergency services, it will cover the services and not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by Provider or the Member. Bright HealthCare and Provider will make a good faith effort to communicate with each other in a timely fashion to expedite the post-evaluation or post-stabilization services in order to avoid material deterioration of the Member's condition within a reasonable clinical confidence, or of a pregnant Member to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence. "Emergency medical condition" means a medical 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: placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

Access to Nonformulary and Restricted Access Prescription Drugs

To the extent Bright HealthCare maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, it will do so in accordance with N.C. Gen Stat. §58-3-221. This includes providing Provider the complete list of drugs or devices formulary or formularies maintained by Bright HealthCare.

Mammogram and Cervical Cancer Screening

Provider agrees to cooperate with Bright HealthCare to ensure that Bright HealthCare's network has accessible to Members certified, registered, or licensed health care professionals with expertise in providing examinations and laboratory tests for the screening and early detection of cervical cancer, following the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control; and low-dose screening mammograms, following mammography accreditation standards established by the North Carolina Medical Care Commission; in accordance with N.C. Gen Stat. §58-67-76.

Dental Services

To the extent Bright HealthCare covers and Provider provides dental services, Bright HealthCare will not require that a dentist who is a Participating Provider provide services at a fee limited or set by Bright HealthCare unless the services are reimbursed as Covered Services in accordance with N.C. Gen. Stat. §58-50-290.

Vision Services

To the extent Bright HealthCare covers and Provider provides vision services, Bright HealthCare will not require that an optometrist who is a Participating Provider provide services or materials at a fee limited or set by Bright HealthCare unless the services or materials are reimbursed as Covered Services in accordance with N.C. Gen. Stat. §58-50-300.

Freedom of Choice

Bright HealthCare and Provider will adhere to "Freedom of Choice" statutes requiring that Bright HealthCare reimburse health services covered by Benefit Plans without designating the specific type of licensed health professional to perform the service. Bright HealthCare will reimburse such services covered by Benefit Plans so long as the services are performed by a physician or other health professional (e.g. a licensed optometrist, licensed dentist, licensed podiatrist, licensed chiropractor, advanced practice registered nurse (subject to N.C. Gen. Stat. §58-50-30), licensed psychologist or psychological associate, licensed clinical social worker, licensed pharmacist (subject to N.C. Gen. Stat. §58-50-30), fee-based certified practicing pastoral counselor, certified substance abuse professional, physician assistant (subject to N.C. Gen. Stat. §58-50-30), licensed professional counselor, marriage and family therapist, physical therapist, hearing aid specialist, or occupational therapist) who may perform such services within the scope of his or her license in accordance with N.C. Gen. Stat. §58-50-30. Bright HealthCare will not exclude an individual health services professional from participation in its network based on the type of license/certification held by the professional.

Utilization Review

Bright HealthCare's utilization program will adhere to the requirements N.C. Gen. Stat. §58-50-61, including providing Provider or Participating Provider with access to its review staff by a toll-free or collect call telephone number whenever Provider or any Participating Provider is required to be available to provide services which may require prior certification to any Member. Bright HealthCare will have a written procedure to address the failure or inability of Provider or Participating Provider to provide all necessary information for review. Prospective and concurrent determinations shall be communicated to Provider or Participating Provider within three business days after Bright HealthCare obtains all necessary information about the admission, procedure, or health care service. If Bright HealthCare certifies a health care service, it will notify Provider or Participating Provider. For a noncertification, Bright HealthCare will notify the Member and Provider or Participating Provider.

Bright HealthCare will make retrospective review determinations within 30 days after receiving all necessary information. Bright HealthCare will notify Provider or Participating Provider of a certification, and notify Member and Provider or Participating Provider of a noncertification within five business days of making the noncertification. Any notices of noncertification will include all reasons for the noncertification, instructions for initiating a voluntary appeal or reconsideration, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification.

To the extent that Bright HealthCare establishes procedures for informal reconsideration of noncertifications, the reconsideration will be conducted between Provider or Participating Provider and a medical doctor licensed in North Carolina designated by Bright HealthCare.

Bright HealthCare will establish procedures for appeals of noncertifications by Members, Provider, or Participating Provider. For a nonexpedited appeal, Bright HealthCare will provide its decision to Member and Provider or Participating Provider within 30 days after Bright HealthCare received the request for appeal. If the decision is not in favor of the Member, the decision will contain the elements set forth in N.C. Gen. Stat. §58-50-61. In the case of an expedited appeal, Bright HealthCare will provide its decision to Member and Provider or Participating Provider no later than four days after receiving the information justifying expedited review. A decision following an expedited review must contain the elements specified in N.C. Gen. Stat. §58-50-61. If Bright HealthCare or its authorized representative determines that services, supplies, or other items are Covered Services, the determination shall not subsequently be retracted after the services, supplies, or other items have been provided, and payments shall not be reduced for a service, supply, or other item furnished in reliance on such a determination, unless that determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the insured or the provider of the service, supply, or other item in accordance with N.C. Gen. Stat. § 58-3-200.

Insurer Grievance Procedures

Bright HealthCare will establish a grievance process where a Member, or Provider acting on the Member's behalf, may request a review of any decision, policy, or action of Bright HealthCare that affects Members in accordance with N.C. Gen. Stat. §58-50-62 and Provider shall cooperate with Members in such process. A Member may use the grievance procedure to submit a grievance concerning the quality of care delivered by Provider.

Direct Access to Obstetrician-Gynecologist

Bright HealthCare and Provider will allow each female Member aged 13 or older direct access, without prior referral, to the health care services of an obstetrician-gynecologist participating in the health benefit plan in accordance with N.C. Gen. Stat. § 58-51-38.

Amendment of Provider Contracts in Accordance with N.C. Gen. §58-50-280

Bright HealthCare will send any proposed Agreement amendment to the notice contact of Provider, and the proposed amendment shall be dated, labeled "Amendment," signed by Bright HealthCare, and include an effective date for the proposed amendment in accordance with N.C. Gen. Stat. §58-50-280. Bright HealthCare will give Provider at least 60 days to object to a proposed amendment. Such amendment will be effective upon Provider's failing to object in writing within 60 days. If Provider objects to an amendment, then the amendment is not effective and Bright HealthCare may terminate the Agreement within 60 days written notice. Bright HealthCare will provide Provider with a copy of its policies and procedures prior to execution of a new or amended Agreement and annually in accordance with N.C. Gen. Stat. §58-50-285.

Provider Availability Standards

Bright HealthCare will develop a methodology to determine the size and adequacy of the network necessary to serve its Members in accordance with 11 N.C.A.C. 20.0301 and to establish performance targets for Member accessibility to primary and specialty care physician services and hospital-based services, in addition to health care services provided by non-physician providers, in accordance with 11 N.C.A.C. 20.0302. Provider agrees to cooperate with Bright HealthCare in developing this methodology as requested and provide Bright HealthCare with all necessary information to promote Bright HealthCare's compliance with 11 N.C.A.C. 20.0301 and 11 N.C.A.C. 20.0302. A Provider's obligation to arrange for call coverage or other back-up, and the Services rendered thereunder shall be in accordance with Bright HealthCare's performance targets developed in accordance with 11 N.C.A.C. 20.0302.

Entire Contract

The Agreement and all appendices and exhibits constitute the entire contract between the parties.

Definitions of Terms/Definition of Medical Necessity

The definitions provided in the Agreement and this Appendix are consistent with definitions included in the evidence of coverage issued in conjunction with the Bright HealthCare network plan. In accordance with N.C. Gen. Stat. § 58-3-200(b), "medically necessary services or supplies" are those covered services or supplies that are:

1. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
2. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
3. Within generally accepted standards of medical care in the community.
4. Not solely for the convenience of the insured, the insured's family, or the provider.

Provider's Continuing Obligation Upon Termination.

Continuation of Benefits. To the extent Bright HealthCare establishes a plan to handle its insolvency resulting in a discontinuance of operations in accordance with N.C. Gen Stat. §58-67-120, Provider agrees to comply with this plan. Such plan will allow for the continuation of benefits for the duration of a Member's contract period for which premiums have been paid, and for continuation of benefits to enrollees who are confined in an inpatient facility until patient is ready for discharge or expiration of benefits. Provider agrees that, in the event of

Bright HealthCare's or Provider's insolvency, it is obligated to provide covered services for the duration of the Member's contract period for which premiums have been paid, and continuation of benefits to Members who are confined in an inpatient facility until their discharge.

Continuity of Care. If the Agreement is terminated by either party, or benefits or coverage provided by Bright HealthCare is terminated because of a change in the terms of Provider's participation in Bright HealthCare's plan and a Member covered by the plan is undergoing treatment from Provider or Participating Provider for an ongoing special condition on the date of the termination, Bright HealthCare will notify the Member of the termination and of the right to elect continuation of coverage from Provider or Participating Provider if the Member has filed a claim with Bright HealthCare for services provided by the terminated provider, or Member is otherwise known by Bright HealthCare to be a patient of Provider or Participating Provider. Bright HealthCare will also permit the individual to elect to continue to be treated by Provider or Participating Provider for treatment of the ongoing special condition during a transitional period, as provided by N.C. Gen Stat. §58-67-88. An ongoing special condition is: a) in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; b) in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; c) in the case of a pregnancy, pregnancy from the start of the second trimester; d) in the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less. "Termination" includes the expiration or nonrenewal of the Agreement, but does not include a termination of the Agreement by Bright HealthCare for failure to meet applicable quality standards or fraud.

When transitional care is provided subject to the above, Provider or Participating Provider agrees to accept reimbursement from Bright HealthCare and the Member, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full. Provider or Participating Provider agrees to comply with Bright HealthCare's quality assurance programs, and to provide Bright HealthCare with necessary medical information related to the care provided. Provider or Participating Provider will adhere to Bright HealthCare's established policies and procedures for providers. Provider or Participating Provider will discontinue providing services at the end of the transition period and assist the Member in an orderly transition to a Bright HealthCare network provider.

Transition of Administrative Duties and Records. In the event the Agreement is terminated, or Bright HealthCare or Provider becomes insolvent, Bright HealthCare will establish a plan to ensure the orderly transition of administrative duties and records, to the extent applicable to the parties' relationship. Provider agrees to comply with such plan, and will ensure the compliance of Participating Providers.

Provider and Participating Providers will maintain licensure, accreditation, and credentials that meet Bright HealthCare's credential verification program requirements, and notify Bright HealthCare of any subsequent changes in status of Provider or Participating Provider's professional credentials. Bright HealthCare will establish a credential verification program to verify that its network providers are credentialed in accordance with 11 N.C.A.C. 20.0401. To the extent that Bright HealthCare delegates credential verification activities to Provider, Bright HealthCare will review Provider's credential verification program to ensure that Provider's program complies with all applicable requirements in 11 N.C.A.C. 20.0400. Bright HealthCare will implement oversight mechanisms, including reviewing Provider's credential verification plans, policies, procedures, forms, and adherence to verification procedures; requiring Provider to submit an updated list of providers quarterly; and conducting an evaluation of Provider's credential verification program every three years. Such credential verification program will meet the requirements of N.C. Gen. Stat. §58-3-230, including timeline and issuance of temporary credential requirements. Bright HealthCare will have a mechanism in place to reduce, suspend or terminate the participation of any network provider.

Professional Liability Insurance

Provider and Participating Provider will maintain professional liability insurance in an amount acceptable to Bright HealthCare, and will notify Bright HealthCare of any subsequent changes in status of professional liability insurance.

Member Billing

Provider shall be responsible for collecting from Members applicable Member deductibles, copayments, coinsurance, and fees for non-covered services. To the extent Bright HealthCare arranges for delivery of health care services on a prepaid basis, Provider or Participating Provider will not bill any Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. In the event Bright HealthCare fails to pay for health care services as set forth in the Agreement, Member shall not be liable to the provider for any sums owed by Bright HealthCare in accordance with N.C. Gen Stat. §58-67-115. Provider will not maintain any action at law against a Member to collect sums owed by Bright HealthCare.

Member Eligibility Mechanism

Bright HealthCare will provide a mechanism that allows Provider to verify Member eligibility, based on Bright HealthCare's current information, before Provider or Participating Provider renders health care services.

Patient Records

Provider will maintain confidentiality of Member medical records, personal information and other health records as required by N.C. Gen. Stat. §58-39 and other applicable law. Provider will maintain Member medical and health records in accordance with industry and Bright HealthCare standards. Provider will make copies of these records available to Bright HealthCare and the Department of Insurance.

Non-discrimination

Provider will not discriminate against Members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.

Information Provision

Bright HealthCare will provide information to Provider concerning its benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies as applicable to Provider. To the extent Provider's compensation is related to efficiency criteria, Bright HealthCare will provide performance feedback reports or information to Provider. Bright HealthCare will also provide notification of changes in the foregoing information, and permit Provider time to comply with such changes.

Utilization Management Compliance

Provider agrees to comply with Bright HealthCare's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs as applicable. Provider and Bright HealthCare acknowledge that none of the requirements of these programs shall override Provider or Participating Provider's professional or ethical responsibility toward Members, or interfere with Provider or Participating Provider's ability to provide information or assistance to Members.

Contract Assignment

Provider's duties and obligations under the Agreement shall not be shall not be assigned, delegated, or transferred without the prior written consent of Bright HealthCare.

Bright HealthCare shall notify Provider in writing, of any duties or obligations that are to be assigned, delegated, or transferred, before the assignment, delegation or transfer.

Provider as Intermediary

To the extent Provider is an intermediary, defined as an entity that employs or contracts with individual health care providers for the provision of health care services, and that also contracts with a network plan carrier, Provider will ensure that all of its contracts with Participating Providers will comply with the provisions of 11 N.C.A.C. 20.0202 (outlined above) in accordance with 11 N.C.A.C. 20.0204. Bright HealthCare will retain its legal responsibly to monitor and oversee the offering of services to Members and financial responsibility to Members. Provider may not subcontract for its services without Bright HealthCare's written consent. Bright HealthCare may approve or disapprove participation of individual providers contracting with Provider for inclusion in or removal from Bright HealthCare's network plan. Bright HealthCare will retain copies of, or Provider will make available, all Participating Provider contracts and subcontracts held by Provider for review by the Department of Insurance. To the extent Provider assumes risk from Bright HealthCare, or pays its Participating Providers on a risk basis or is responsible for claims payment to its providers: Bright HealthCare shall receive documentation of utilization and claims payment and maintain accounting systems and records; Bright HealthCare shall arrange for financial protection of itself and its members through such approaches as member hold harmless language and to the extent provided by law, the Department of Insurance shall have access to the books, records, and financial information to examine activities performed by Provider on behalf of Bright HealthCare. Such books and records shall be maintained in North Carolina.

To the extent Bright HealthCare delegates functions to Provider, Provider will comply with all statutory and regulatory requirements that apply to the functions delegated and assumed by Provider. To the extent Bright HealthCare pays Provider directly for health care services provided, Bright HealthCare will monitor the financial condition of Provider to ensure that Participating Providers are paid for services, or maintain hold harmless agreements with Participating Providers.

Non-Covered Service

If Provider furnishes services to Members that are not covered services under a Benefit Plan, either because the service was provided after the individual ceased to be a Member or on some other basis, Bright HealthCare is under no obligation to reimburse the services. Provider may continue providing non-covered services to a Member and bill such Member for such services, provided that Provider has notified the Member in advance of providing such non-covered services that Bright HealthCare may not cover or continue to cover such services, and Member agrees to continue receiving such non-covered services at Member's own expense. Provider shall follow Bright HealthCare's Program Requirements related to the provision of non-covered services. Provider will not arrange for a Member to self-pay for a non-covered service unless Provider has first obtained a denial under the Benefit Plan from Bright HealthCare for such service or unless the service is listed as explicitly excluded in the Member's benefit document.

Oklahoma Regulatory Requirements Appendix

This Oklahoma Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Oklahoma law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Prompt Pay

Provider shall submit claims to Bright HealthCare in accordance with O.A.C. § 365:10-1-32, which requires the use of the HCFA Form 1500. To the extent Provider furnishes dental or hospital services, Provider shall submit the claim forms specified in O.A.C. § 365:10-1-33 and O.A.C. § 365:10-1-34. Provider shall use the most current edition of such forms. O.A.C. § 365:10-1-36. Bright HealthCare shall reimburse all clean claims within forty-five (45) calendar days after receipt of such claim by Bright HealthCare. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, Member and Provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by Bright HealthCare. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of Bright HealthCare to provide Member and Provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the Agreement. Upon receipt of the additional

information or corrections which led to the claim's being delayed and a determination that the information is accurate, Bright HealthCare shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days. Payment shall be considered made on: 1) the date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or 2) if not so posted, the date of delivery. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney fee to be set by the court and taxed as costs against the party or parties who do not prevail. 36 Okl. Stat. § 1219.

Prohibition on Restrictions on Methods of Payment

Bright HealthCare shall not restrict its methods of payment to Provider where the only acceptable payment method is a credit card payment. If initiating or changing payments to Provider using electronic funds transfer payments, including virtual credit card payments, Bright HealthCare shall: 1) notify Provider if any fees are associated with a particular payment method; and 2) advise Provider of the available methods of payment and provide clear instructions to Provider as to how to select an alternative payment method. Should Bright HealthCare initiate or change payments to Provider through the Automated Clearing House Network, as codified in 45 C.F.R. § 162.1601 and 162.1602, Bright HealthCare shall not charge a fee solely to transmit the payment to Provider unless Provider has consented to the fee. 36 Okl. Stat. § 1219.6

Payments for Emergency Services

Bright HealthCare shall compensate Provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of Member requires emergency service. If Provider determines that Member does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the Agreement. 36 Okl. Stat. § 6055.

Unfair Claim Settlement

Bright HealthCare shall not deny payment to Provider on the grounds that services, procedures, or supplies provided by a treating physician or a hospital were not medically necessary unless Bright HealthCare first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of Provider, the opinion shall be set forth in a written report, prepared and signed by the reviewing physician. The report shall detail which specific services, procedures, or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by Bright HealthCare, postage prepaid, to Provider within fifteen (15) days after receipt of the written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes.

Bright HealthCare shall not request a refund of all or a portion of a payment of a claim made to Provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply if the payment was made because of fraud committed by Provider or if Provider has otherwise agreed to make a refund to Bright HealthCare for overpayment of a claim. 36 Okl. Stat. § 1250.5.

Credentialing

Bright HealthCare shall provide for credentialing and recredentialing of Participating Providers based on criteria provided in the uniform credentialing application required by 63 Okl. Stat. § 1-106.2 and O.A.C. § 310:2-15-3. Bright HealthCare shall make information on such criteria available to providers and shall provide providers with a checklist of materials required in the application process. Bright HealthCare shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, Bright HealthCare shall notify the provider in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed. In reviewing the application, Bright HealthCare shall evaluate each application according to Bright HealthCare's checklist of required materials that accompanies the application. When an application is deemed complete, Bright HealthCare shall initiate requests for primary source verification and malpractice history within seven (7) calendar days. Upon receipt of primary source verification and malpractice history by Bright HealthCare, Bright HealthCare shall determine if the application is a clean application. If the application is deemed clean, Bright HealthCare shall have forty-five (45) calendar days within which to credential or recredential provider as a Participating Provider. As used in this paragraph, a "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing. If Bright HealthCare is unable to credential or recredential the provider due to an application's not being clean, Bright HealthCare may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if Bright HealthCare is awaiting documentation to complete the application, the provider shall be notified of the reason for the delay by certified mail. The provider may extend the sixty-day period upon written notice to Bright HealthCare within ten (10) calendar days; otherwise the application shall be deemed withdrawn. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days. Bright HealthCare shall not solely base a denial of an application for credentialing or recredentialing on a lack of board certification or board eligibility and shall not add new requirements solely for the purpose of delaying an application. Within thirty-one (31) days after the Participating Provider has been credentialed by Bright HealthCare following the completion of the credentialing or recredentialing process pursuant to this section, Bright HealthCare shall consider the Participating Provider in-network for purposes of reimbursement. 36 Okl. Stat. § 4405.1.

Freedom of Choice

Bright Shall not discriminate against Participating Providers in regard to participation in Bright HealthCare's network or in regard to reimbursement of a Provider or a Participating Provider for the provision of Covered Services provided within the scope of a Participating Provider's license, solely on the basis of such license. 36 Okl. Stat. § 6055.

Determination of Charges

Upon the request of Provider, Bright HealthCare shall furnish, for a reasonable charge, information used to determine the average area charges or customary and reasonable charges for the services, procedures or supplies provided by Provider and authorized for payment pursuant to 36 Okl. Stat. § 6571. The information shall include the rationale and documentation of sources used in the determination of the average area charges or customary and reasonable charges for the services, procedures or supplies in question, including names, mailing addresses and telephone numbers of sources if available. Such information shall be furnished to Provider no later than ten (10) working days after the request for information by Provider. 36 Okl. Stat. § 6571.

Duty of Care

Bright HealthCare may not remove Provider from its plan or refuse to renew Provider from its plan for advocating on behalf of a Member for appropriate and medically necessary health care for the Member. Bright HealthCare shall not seek indemnification from Provider, whether contractual or equitable, for liability imposed by 36 Okl. Stat. § 6593.

Maternity Coverage

Bright HealthCare shall not terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a Participating Provider for ordering maternity care consistent with the provisions of 36 Okl. Stat. § 6060.3.

Diabetes Self-Management Training

To the extent diabetes self-management training is offered as a Covered Service, such training shall be supervised by a licensed physician or other licensed health care provider legally authorized to prescribe under the laws of Oklahoma. 36 Okl. Stat. § 6060.2.

South Carolina Regulatory Requirements Appendix

This South Carolina Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under South Carolina law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix and Provider agrees to assure that individual Participating Providers will be bound by the terms and conditions in this Appendix as well. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix. If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider," as used in this Appendix, refers to the entity with whom the network agreement is entered and will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," or other type of provider entity. "Participating Provider" shall mean the individual provider participating in the Bright HealthCare Network and furnishing Covered Services to Members and will have the same meaning as "Physician," Professional," or other individual providers.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Hold Harmless

Neither Provider nor any Participating Provider may bill Member directly or otherwise hold Member financially liable for services rendered by such Provider or Participating Provider. S.C. Code Ann. § 38-33-130

Confidentiality of Health Records

Any data or information pertaining to the diagnosis, treatment, or health of any Member obtained from Provider by Bright HealthCare is confidential and may only be disclosed for purposes outlined in Chapter 38 of the South Carolina statutes, or by express consent of the Member. S.C. Code Ann. § 38-33-260

Obstetrician-Gynecologist Services

Provider shall allow a female Member thirteen years of age or older to have direct access to the health-care services of an obstetrician-gynecologist participating in the plan without requiring prior referral from a primary care provider. S.C. Code Ann. § 38-33-325.

Fee Schedule

Bright HealthCare shall, upon written request from a physician who is a Participating Provider, provide, by CD-ROM, or electronically at Bright HealthCare's option, the fee schedule that is contracted with such Participating Provider for up to 100 CPT(r) Codes customarily and routinely used by the specialty type of such Participating Provider. Each Participating Provider may request from Bright HealthCare an updated fee schedule no more than two times annually. A Participating Provider requesting a fee schedule may elect to receive a hard copy of the fee schedule in lieu of the foregoing; however, Bright HealthCare may charge the Participating Provider a reasonable fee to cover the increased administrative costs of providing the hard copy. S.C. Code Ann. § 38-59-220.

Payment of Clean Claims

Bright HealthCare shall direct the issuance of a check or an electronic funds transfer to Provider in payment for a clean claim, as defined in S.C. Code Ann.§ 38-59-210, that is submitted via paper within forty (40) business days, or for a clean claim that is submitted electronically within twenty (20) business days. The date a clean claim is deemed submitted shall be the later of Bright HealthCare's receipt of the claim or the date on which Bright HealthCare is in receipt of all information needed, and in a format required, for the claim to constitute a clean claim and is in receipt of all documentation which is reasonably needed by Bright HealthCare to determine that such claim does not contain any material defect, error, or impropriety; or to make a payment determination.

Bright HealthCare shall maintain a system for determining the date claims are received by Bright HealthCare. Bright HealthCare shall send an electronic acknowledgement of claims submitted electronically either to Provider or Provider's designated vendor for the exchange of electronic health care transactions. The acknowledgement shall identify the date claims are received by Bright HealthCare. If Bright HealthCare determines that there is any defect, error, or impropriety in a claim that prevents the claim from entering Bright HealthCare's adjudication system, Bright HealthCare shall provide notice of the defect or error either to Provider or Provider's designated vendor for the exchange of electronic health care transactions within twenty (20) business days of the submission of the claim if it was submitted electronically or within forty (40) business days of the claim if it was submitted via paper. S.C. Code Ann. § 38-59-230.

Interest on Payments

For each clean claim with respect to which Bright HealthCare has directed the issuance of a check or the electronic funds transfer to Provider later than the applicable period specified in Section 6 of this Appendix, Bright HealthCare shall pay interest in the same manner and at the same rate set forth in S.C. Code Ann. § 34-31-20 on the balance due on each claim computed from the twenty-first or the forty-first business day, as appropriate, up to the date on which Bright HealthCare directs the issuance of the check or the electronic funds transfer for payment of the clean claim. At Bright HealthCare's election, interest paid pursuant to this section shall be included either in the claim payment check or wire transfer, or shall be remitted periodically, but at least quarterly, in a separate check or wire transfer along with a report detailing the claims for which interest is being paid. S.C. Code Ann. § 38-59-240.

Overpayment Recovery Efforts

Bright HealthCare shall initiate any overpayment recovery efforts by sending a written notice to Provider at least thirty business days prior to engaging in the overpayment recovery efforts, other than for recovery of duplicate payments or other similar adjustments relating to claims where Provider has received payment for the same services from another payor whose obligation is primary; or timing or sequence of claims for the same Member that are received by Bright HealthCare out of chronological order in which the services were performed. The written notice required by this Section 8 shall include the patient's name; the service date; the payment amount received by Provider; a reasonably specific explanation of the change in payment; and the telephone number or a mailing address through which Provider may initiate an appeal, and the deadline by which an appeal must be received. Bright HealthCare shall not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by Provider; however, this time limit does not apply to the initiation of overpayment recovery efforts based upon a reasonable belief of fraud or other intentional misconduct or required by a state or federal government program. S.C. Code Ann. § 38-59-250.

Freedom of Choice

To the extent Bright HealthCare covers and Provider provides a service which is within the scope of practice of a licensed podiatrist, licensed oral surgeon, licensed optometrist, or licensed doctoral psychologist, Member is entitled to payment or reimbursement in accordance with the usual and customary fee for the services whether the services are performed by a licensed physician or a licensed podiatrist, a licensed oral surgeon, a licensed optometrist, or a licensed doctoral psychologist, notwithstanding a provision in the Benefit Plan, and the Member may choose the provider of the services. S.C. Code Ann. § 38-71-200.

Emergency Medical Care

Bright HealthCare may not retrospectively deny or reduce payments to Provider for emergency medical care of a Member even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in these cases: (1) material misrepresentation, fraud, omission, or clerical error; (2) a payment reduction due to applicable co-payments, coinsurance, or deductibles which may be the responsibility of the Member; (3) cases in which the Member does not meet the emergency medical condition definition, as defined in S.C. Code Ann. § 38-71-1520, unless the Member has been referred to the emergency department by Member's primary care physician or other agent acting on behalf of the Bright HealthCare. S.C. Code Ann. § 38-71-1530. It is Bright HealthCare's obligation to inform Provider about all policies related to emergency medical care access coverage, payment, and grievance procedures. S.C. Code Ann. § 38-71-1530.

This Section shall be considered notice to Provider that the emergency medical care provisions contained in S.C. Code Ann. § 38-71-1530 are applicable to Provider and to Bright HealthCare.

Limitations on Discussion of Treatments, Risks, and Legal Obligations

Bright HealthCare shall not limit Provider's ability to discuss with a Member, the treatment options available to the Member, risks associated with treatments, utilization management decisions, and recommended course of treatment. Bright HealthCare shall not limit Provider's ability to discuss Provider's legal obligations to a Member as specified under Provider's professional license. S.C. Code Ann. § 38-71-1740.

Application of Negotiated Rates to Copayments and Deductibles

Bright HealthCare shall apply the percentage copayments and deductibles paid by Member to the negotiated rates or lesser charge of Provider. Nothing in this section precludes Bright HealthCare from issuing a Benefit Plan which contains fixed dollar copayments and deductibles. S.C. Code Ann. § 38-71-241.

Continuation of Care

If this Contract is terminated or nonrenewed, Bright HealthCare and Provider shall comply with the following requirements:

1. Bright HealthCare is liable for covered benefits rendered in the continuation of care by
2. Provider to a Member for a serious medical condition, as defined in S.C. Code Ann. § 38-71-243, for up to 90 days or the term of the Member's coverage with Bright HealthCare, whichever is greater. Except as required by this section, the benefits payable for services rendered during the continuation of care are subject to the Benefit Plan's regular benefit limits.
3. Bright HealthCare shall not require a Member to pay a deductible or copayment which is greater than the in-network rate for services rendered during the continuation of care.
4. Bright HealthCare shall not require a Member, as a condition of continued coverage, to pay a premium or contribution which is greater than the premium or contribution that the Member would have paid if the contract had not been terminated and continuation of care hadn't occurred.
5. Provider shall accept the negotiated rate under this Contract as payment in full for services rendered within the continuation of care.
6. Except for an applicable deductible or a copayment, Provider shall not bill or otherwise hold a Member financially responsible for services rendered in the continuation of care and furnished by Provider.
7. Upon receipt of the Member's request accompanied by a physician's attestation identifying the serious medical condition, Bright HealthCare shall notify Provider and the Member of Provider's date of termination from the network and of the continuation of care provisions as provided for in this section.
8. Bright HealthCare is responsible for determining if a Member qualifies for continuation of care and may request additional information in reaching such determination. S.C. Code Ann. § 38-71-246

Medical Eye and Vision Care

To the extent Bright HealthCare covers and Provider provides medical eye care or vision care benefits, or both, Bright HealthCare shall not discriminate against optometry, as a class, or ophthalmology, as a class, with respect to the terms, conditions, privileges, and opportunity of participation or compensation for the same eye care services provided in this Section 15. Bright HealthCare shall not impose on optometry, as a class, any condition or restriction which is not necessary for the delivery of services or materials, or both. S.C. Code Ann. § 38-71-440

Dermatology Referrals

Subject to medical necessity and other coverage limitations, if a primary care Participating Provider makes a referral to a dermatologist, Member may see the in-network dermatologist to whom the Member is referred, without further referral, for a minimum of six months or four visits, whichever first occurs, for diagnosis, medical treatment, or surgical procedures for the referral problem or related complications. S.C. Code Ann. § 38-71-215

Each Party Liable for Own Acts and Omissions

Each party to a managed care network agreement is responsible for the legal consequences and costs of his own acts or omissions and is not responsible for the acts or omissions of the other party. A provision in the managed care network agreement to the contrary is null and void. S.C. Code Ann. § 38-71-1740

Tennessee Regulatory Requirements Appendix

This Tennessee Regulatory Requirements Appendix (the "Appendix") applies to Benefit Plans to the extent such products are regulated under Tennessee law; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Bright HealthCare and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control, except with regard to Benefit Plans outside the scope of this Appendix.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "customer," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "HMO" or "insurer"; "Provider" as used in this Appendix, will have the same meaning as "Care Partner," "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Professional," or other type of provider entity.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix will be defined as set forth in the Agreement.

Credentialing

Bright HealthCare will notify a new Participating Provider applicant in writing of the status of a credentialing application no later than five (5) business days of receipt of the application. The notice shall indicate if the application is complete or incomplete, and, if the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application. Bright HealthCare will accept credentialing and re-credentialing application forms from the Council on Affordable Quality Healthcare addition to its own credentialing and re-credentialing applications forms.

Prompt Payment

Within thirty (30) calendar days after the date that Bright HealthCare receives a claim submitted on paper or within twenty-one (21) calendar days after receiving a claim by electronic submission from Provider or Participating Provider, Bright HealthCare will:

1. If the claim is clean, pay the total covered amount of the claim;
2. Pay the portion of the claim that is clean and not in dispute and notify Provider in writing why the remaining portion of the claim will not be paid; or

3. Notify Provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean.

To the extent Bright fails to comply with the payment provisions above, it agrees to pay one percent (1%) interest per month, accruing from the day after the payment was due, on that amount of the claim that remains unpaid.

Bright HealthCare will not deny a paper claim upon resubmission for lack of substantiating documentation or information that has been previously provided by Provider who submitted the resubmission.

Bright will timely provide Provider with all necessary information to properly submit a claim.

Payment Changes

Any change to a payment appendix by Bright HealthCare shall be made available to Provider at least thirty (30) days prior to the effective date of the amendment; provided, that this provision does not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

Prostate Screening

Provider agrees to cooperate with Bright HealthCare to ensure that the Provider network has accessible to Members a certified, registered, or licensed health care professional with expertise in screening for the early detection of prostate cancer and Bright HealthCare will, upon the recommendation of a physician, provide coverage for the early detection of prostate cancer for men fifty (50) years of age and older and other men if a physician determines that early detection for prostate cancer is medically necessary as set forth in Tenn. Code § 56-7-2354.

Breast Cancer Screening

To the extent Bright HealthCare covers and Provider provides surgical services for a mastectomy, Provider agrees to cooperate with Bright HealthCare to ensure that the Provider network has accessible to Members a health care professional with expertise in screening mammography. Bright HealthCare shall not terminate services, reduce capitation payment, or otherwise penalize Provider if it orders for a Member a mammogram in accordance with the guidelines set forth in Tenn. Code § 56-7-2502.

Breast Reconstruction

To the extent Bright HealthCare covers and Provider provides mastectomy surgery, Provider agrees to cooperate with Bright HealthCare to ensure that the Provider network has accessible to Members a health care professional with expertise in performing all stages of reconstructive breast surgery on the diseased breast as a result of a mastectomy, but not including a lumpectomy, as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two (2) breasts in the manner chosen by the patient and her physician to the extent provided for in Tenn. Code § 56-7-2507.

Infant Hearing Screening

Provider agrees to cooperate with Bright HealthCare to ensure that the Provider network has accessible to Members a certified, registered, or licensed health care professional with expertise in infant hearing screening tests as provided in Tenn. Code § 68-5-904.

Hospital Charge Reporting

Provider shall cooperate with Bright HealthCare to facilitate Bright HealthCare's compliance with the hospital charge reporting requirements contained in Tenn. Comp. R. & Regs. 0780-01-44-.04

Tennessee Health Freedom Act

Bright HealthCare and Provider agree to comply with Tenn. Code § 56-7-1016.

Dental Services

Bright HealthCare shall not require, directly or indirectly, that a dentist who is a Participating Provider provide services to a Member at a fee set by, or at a fee subject to, the approval of Bright HealthCare unless the dental services are Covered Services.

Freedom of Choice

Bright HealthCare and Provider will comply with "Freedom of Choice" statutes requiring that Bright HealthCare reimburse health services covered by Benefit Plans without designating the specific type of licensed health professional to perform the service. Bright HealthCare will reimburse such services covered by Benefit Plans so long as the services are performed by a physician or other health professional (e.g., an optometrist, a licensed psychologist, chiropractor, or advance practice nurse) who may perform such services within the scope of his or her license. The level of reimbursement may change depending on the type of provider performing the service.

(E.g., Tenn. Code § 63-8-102; § 63-3-101; § 63-23-105; § 63-22-115; § 63-22-150; § 56-7-2408.)

Texas Regulatory Requirements Appendix

Claim Submission; Prompt Pay

Provider shall submit a claim no later than the ninety-fifth (95th) day after the date of service. A claim not submitted within such time frame may be denied for payment, unless the failure to submit the claim in compliance with this section is a result of a catastrophic event that substantially interferes with the normal business operations of Provider. Provider (or any delegate) shall not submit a duplicate claim for payment before the forty-sixth (46th) day after the date the original claim was submitted. Tex. Ins. Code §§ 843.337, 1301.102.

Bright HealthCare shall determine whether a clean claim submitted by Provider for Covered Services is payable not later than the forty-fifth (45th) day after the date on which a clean claim in a nonelectronic format is received, or not later than the thirtieth (30th) day after the date on which a clean claim in an electronic format is received. Bright HealthCare shall pay clean claims submitted by Provider for Covered Services on or before the later of (i) the forty-fifth (45th) day after the date on which the claim for payment is received with the documentation reasonably necessary to process the claim, or (ii) the last day in the time period specified in the Agreement for payment of claims. Tex. Ins. Code §§ 843.336-843.354; 1301.064, and 1301.101-109

Communications

Bright HealthCare shall not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict Provider from communicating with a Member about the availability of out-of-network providers for the provision of Member's medical or health care services.

Bright HealthCare shall not terminate the contract of or otherwise penalize Provider solely because Provider's patients use out-of-network providers for medical or health care services. Tex. Ins. Code §1301.058

Batched Claims

Bright HealthCare shall not refuse to process or pay an electronically submitted clean claim, as that term is defined in Tex. Ins. Code § 843.336, as may be amended, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim. Tex. Ins. Code §§ 843.323; 1301.0641

Gag Clause

Bright HealthCare shall not limit, prohibit, or attempt to prohibit Provider from discussing with or communicating in good faith with Members or a person designated by a Member with respect to: (a) information or opinions regarding the Member's health care, including the patient's medical condition or treatment options; (b) information or opinions regarding the terms, requirements, or services of the Agreement as they relate to the medical needs of the Member; or (c) the termination of the Agreement or the fact that Provider will otherwise no longer be providing medical care, dental care, or health care services under the Agreement. Bright HealthCare shall not in any manner penalize, terminate, or refuse to compensate for Covered Services a Provider for communicating in a manner protected by this section with a current, prospective, or former patient that is a Member. Tex. Ins. Code §§ 843.363, 1301.067

Overpayments

Bright HealthCare may not recover an overpayment to Provider unless, not later than the one hundred eightieth (180th) day after the date Provider receives the payment, Bright HealthCare or one of its delegates provides written notice of the overpayment to Provider that includes the basis and specific reasons for the request for recovery of funds, and Provider does not make arrangements for repayment of the requested funds on or before the forty-fifth (45th) day after the date the notice is received. Tex. Ins. Code §§ 843.350, 1301.132

Contracting with Others

This Agreement does not restrict Provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs. 28 Tex. Admin. Code §3.3703(a)(1)

Referrals to Other Providers

This Agreement does not impose restrictions on the classes of physicians and providers who may refer a member to another physician or provider. This Agreement does not require a referring physician or provider to bear the expenses of a referral for specialty care in or out of the participating provider network. 28 Tex. Admin. Code §3.3703(a)(6)

Financial Incentives

Bright HealthCare will not provide financial incentives to Provider that act directly or indirectly as an inducement to limit medically necessary services. 28 Tex. Admin. Code §3.3703(a)(7); Tex. Ins. Code § 1301.068

Hold Harmless

Provider will not be required to execute a hold harmless clause that shifts the tort liability resulting from acts or omissions of Bright HealthCare to Provider. 28 Tex. Admin. Code §3.3703(a)(9); Tex. Ins. Code 843.310

Continuity of Care

Bright HealthCare and Provider will comply with Tex. Ins. Code §§1301.152 - 1301.154, relating to continuity of care. 28 Tex. Admin. Code §3.3703(a)(12)

Member Communications

Bright HealthCare will not, as a condition of this Agreement or in any other manner, prohibit, attempt to prohibit, or discourage Provider from discussing with or communicating to a current, prospective, or former Member, or a person designated by a Member, information or an opinion: (a) regarding Member's health care, including Member's medical condition or treatment options; or (2) in good faith regarding the provisions, terms, requirements, or services of the health insurance coverage as they relate to Member's medical needs. Bright HealthCare may not in any way penalize, terminate the participation of, or refuse to compensate for Covered Services, Provider for discussing or communicating with a current, prospective, or former Member, or a person designated by a Member. 28 Tex. Admin. Code §3.3703(a)(13)

Member Notice Upon Termination

If Provider voluntarily terminates this Agreement, Provider must provide reasonable notice to Members, and Bright HealthCare will provide assistance to Provider in assuring that such notice is provided. 28 Tex. Admin. Code §3.3703(a)(18)

Termination Review

Bright HealthCare will provide written notice to Provider on termination of this Agreement by Bright HealthCare, and such notice will include Provider's right to request a review. 28 Tex. Admin. Code §3.3703(a)(19)

Information on Compensation

Provider is entitled, upon request, to all information necessary to determine that Provider is being compensated in accordance with the terms of this Agreement. Provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made for covered services that are rendered to members. Bright HealthCare may provide the required information by any reasonable method through which Provider can access the information, including e-mail, website, computer disks, paper, or access to an electronic database. Bright HealthCare will provide the fee schedules and other required information by the 30th day after receipt of the request.

a. This information will include a specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by Provider, including the information required in 28 Tex. Admin. Code § 3.3703(a)(20).

b. In the case of a reference to source information as the basis for fee computation that is outside the control of Bright HealthCare, such as state Medicaid or federal Medicare fee schedules, the information will clearly identify the source and explain the procedure by which Provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

c. Nothing herein may be construed to require Bright HealthCare to provide specific information that would violate any applicable copyright law or licensing agreement. However, Bright HealthCare will supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made for covered services that are rendered to members.

d. No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided will be effective as to Provider, unless Bright HealthCare provides at least 90 calendar days written notice to Provider identifying with specificity the amendment, revision or substitution. Bright HealthCare will not make retroactive changes to claims payment procedures or to any of the information required to be provided as described above.

e. A Provider that receives the information described above (i) may not use or disclose the information for any purpose other than for practice management, billing activities, other business operations, or communications with a governmental agency involved in the regulation of health care or insurance; (ii) may not use the information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to a Member or to misrepresent any aspect of the services; and (iii) may not rely upon the information as a representation that a member is covered for that service under the terms of Member's policy or certificate.

f. A Provider that receives the information described above may terminate this Agreement on or before the 30th day after the date Provider receives the information without penalty or discrimination with respect to the participation in other health care products or plans of Bright HealthCare. If Provider chooses to terminate the Agreement, Bright HealthCare is required to assist Provider in providing the notice required by this section. 28 Tex. Admin Code § 3.3703(a)(20)

Claim Submission

Upon request by Provider, Bright HealthCare agrees that it and its clearinghouse will not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this paragraph, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. 28 Tex. Admin Code § 3.3703(a)(22)

Overpayments

A Provider who receives an overpayment from a Member must refund the amount of the overpayment to Member not later than the 30th day after the date Provider determines that an overpayment has been made. 28 Tex. Admin Code § 3.3703(a)(25)

Explanation of Benefits

Bright HealthCare shall provide written notice in accordance with this section in an explanation of benefits provided to Provider in connection with Covered Services. The notice must include:

1. a statement of the billing prohibition under Tex. Ins. Code § 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;
2. the total amount Provider may bill Member under Member's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and
3. for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Tex. Ins. Code §§ 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable. Tex. Ins. Code §1301.010.

Termination Review Process

Before terminating the Agreement, Bright HealthCare shall (1) provide written reasons for the termination; and (2) if the affected Provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving: (a) imminent harm to a patient's health; (b) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine; or (c) fraud or malfeasance. The review mechanism must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days. Bright HealthCare shall provide to the affected practitioner (1) the panel's recommendation, if any; and (2) on request, a written explanation of Bright HealthCare's determination, if that determination is contrary to the panel's recommendation. On request, Bright HealthCare shall provide to a Provider whose participation in a preferred provider benefit plan is being terminated: (1) an expedited review conducted in accordance with a process that complies with rules established by the commissioner; and (2) all information on which Bright HealthCare wholly or partly based the termination, including the economic profile of Provider, the standards by which Provider is measured, and the statistics underlying the profile and standards. Tex. Ins. Code §1301.057 and Tex. Ins. Code §843.306-307

Retaliation Against Provider Prohibited

Bright HealthCare shall not engage in any retaliatory action against Provider, including terminating Provider's participation in the Benefits Plan or refusing to renew Provider's contract, because Provider has (1) on behalf of a Member, reasonably filed a complaint against Bright HealthCare; or (2) appealed a decision of Bright HealthCare. Tex. Ins. Code §1301.066

Podiatrists

If Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners, the provisions set forth in this Section apply. Provider may request, and Bright HealthCare shall provide not later than the thirtieth (30th) day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that Provider receives or will receive under the Agreement. Bright HealthCare may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules. \ Provider may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the Agreement. Tex. Ins. Code §§ 843.311, 1301.062

Utah Regulatory Requirements Appendix

Member Protection

Provider or Participating Providers will accept the payment specified in the Agreement as payment in full, and do not have the right to collect amounts other than Member Expenses, in accordance with. If Bright Healthcare fails to pay for health care services as set forth in the Agreement, the Member is not liable to Provider or Participating Providers for any sums owed by Bright HealthCare.

Neither Provider, nor any Participating Provider, will bill or maintain any action at law against a Member to collect sums owed by Bright HealthCare or, in the event of Bright HealthCare's insolvency, the amount of the regular fee reduction authorized under Utah Code § 31A-45-301(1)(b)(ii). Provider further agrees that if the parties are unable to resolve any such payment dispute, then the matter shall be subject to binding arbitration by a jointly selected arbitrator. Utah Code §§ 31A-45-301 & 31A-45-303.

Continuity of Care

Provider and Bright HealthCare will comply with the requirements of Utah Code § 31A-45-301 in the event of Bright HealthCare's insolvency. If Bright HealthCare becomes insolvent, the rehabilitator or liquidator may require Provider to: (i) continue to provide health care services under the Agreement until the earlier of: (a) ninety (90) days after the date of the filing of a petition for rehabilitation or a petition for liquidation; or (b) the date the term of the Agreement ends; and (ii) reduce the fees Provider is otherwise entitled to receive from Bright HealthCare under the Agreement during such period.

Provider Payment Information

Bright HealthCare will grant Provider access to information necessary to determine (i) the effect of procedure codes on payment or compensation before a claim is submitted for a procedure, (ii) the plans and networks in which Provider is participating under the Agreement, and (iii) the specific rate and terms under which the Provider will be paid for Covered Services. The information requested by the Provider may be provided through a website and, if requested by the Provider, notice of the updated website shall be provided by Bright HealthCare. Utah Code §§ 31A-45-302 & 31A-22-637(2).

Notification of Hospital Inpatient Emergency Admission

Bright HealthCare may not require Provider to notify Bright HealthCare of a hospital inpatient emergency admission within a period of time that is less than one (1) business day of the hospital inpatient admission if compliance with the notification requirement would result in notification by the Provider on a weekend or federal holiday. The foregoing does not prohibit the applicability or administration of other contract provisions between Bright HealthCare and Provider that require preauthorization for scheduled inpatient admissions. Utah Code §§ 31A-45-302(2) & 31A-22-637(3).

Provider Directories

Provider will provide Bright HealthCare with the necessary information to maintain a provider directory that includes a list of network Participating Providers available to Members in accordance with Utah Statutes 31A-45-303(4)(a).

Quality Assurance Plan

Provider agrees to participate in, and ensure Participating Providers will participate in, all quality assurance programs implemented by Bright HealthCare pursuant to Utah law and agrees to cooperate with Bright HealthCare in providing or arranging for such quality assurance programs, in accordance with Utah Code 31A-45-303(4)(c) and 31A-45-303(5)(a). In the event that the Commissioner of the Utah Insurance Department ("Commissioner") performs an audit of such quality assurance programs, Bright HealthCare and Provider agree to provide the Commissioner with full access to all records of Bright HealthCare and Provider, including medical records of individual patients. Bright HealthCare and Provider will keep the information contained in the medical records of Members confidential. All information, interviews, reports, statements, memoranda or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceedings except hearings before the Commissioner concerning alleged violations of Utah Code 31A-45-303(5)(c).

Credentialing

Bright HealthCare will establish and/or maintain criteria for credentialing new and existing providers including training, certification, and hospital privileges. Bright HealthCare will provide credentialing criteria to providers upon request. Upon receipt of the provider's application and necessary documents, Bright HealthCare with make a decision on the provider's application for participation within one hundred twenty (120) days. Bright HealthCare may not reject a provider applicant based solely on: (i) the provider's staff privileges at a general acute care hospital not under contract with Bright HealthCare; or (ii) the provider's referral patterns for patients who are not covered by Bright HealthCare. If the provider is rejected, Bright HealthCare will inform the provider of the reason for the rejection relative to the criteria. The credentialing process and criteria may be modified or changed from time to time by Bright HealthCare to meet the business needs of the market. Utah Code 31A-45-304(1).

Termination

During the first two (2) years of the term of the Agreement, Bright HealthCare may terminate the Agreement, with or without cause, by giving the requisite amount of notice provided in the Agreement, but in no case shall it be less than sixty (60) days. In the event of a termination for cause, Bright HealthCare shall, at the request of the Provider, meet with the Provider to discuss the reasons for termination. Bright HealthCare will establish an internal appeal process for actions that may result in terminated participation with cause and will make known to the Provider the procedure for appealing such termination. Bright HealthCare and the terminated Provider or Participating Provider may mutually agree to submit the matters in dispute to mediation. If such matters are not mediated or mediation is unsuccessful, then the dispute shall be subject to binding arbitration by a jointly selected arbitrator. Termination for cause may not be based on: (i) the Provider or Participating Provider's staff privileges

at a general acute care hospital not under contract with Bright HealthCare; or (ii) the Provider or Participating Provider's referral patterns for patients who are not covered by Bright HealthCare. In addition, Bright HealthCare will not take adverse action against or reduce reimbursement to a Participating Provider who is not under a capitated reimbursement arrangement because of the decision of a Member to access health care services from a non-network provider in a manner permitted by the Member's Benefit Plan, regardless of how the plan is designated. Utah Code § 31A-45-304(2)(a).

Member Overpayment

Provider or Participating Providers will return to a Member any amount the Member overpaid, including interest that begins accruing ninety (90) days after the date of the overpayment, in accordance with Utah Code § 31A-26-301.5, if: (i) the Member has multiple insurers with whom the Provider or Participating Provider has contracts that cover the Member; and (ii) Provider or Participating Provider becomes aware that it has received, for any reason, payment for a claim in an amount greater than the contracted rate allows.

Timely Payment

Bright HealthCare will timely pay every valid claim submitted by Provider or a Participating Provider. Within thirty (30) days of the day on which Bright HealthCare receives a written claim, Bright HealthCare will pay the claim or deny the claim and provide a written explanation for any denial. Such period may be extended by fifteen (15) days if Bright HealthCare determines that the extension is necessary due to matters beyond its control, and before the end of the 30-day period Bright HealthCare notifies Provider or Participating Provider and Member in writing of: (i) the circumstances requiring the extension, and (ii) the date by which Bright HealthCare expects to pay or deny the claim.

If an extension is necessary due to a failure of the Provider or Participating Provider to submit the necessary information, the notice of extension will specifically describe the required information and Bright HealthCare will give the Provider or Participating Provider at least forty-five (45) days from the day on which the Provider or Participating Provider receives the notice before denying the claim for failure to provide the information requested. If a period of time is extended due to the Provider or Participating Provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Provider or Participating Provider until the date on which the Provider or Participating Provider responds to the request for additional information. If Bright HealthCare requests such information, Bright HealthCare will pay all sums to the Provider or Participating Provider that Bright HealthCare is obligated to pay on the claim and will provide a written explanation of its decision regarding any part of the claim that is denied within twenty (20) days of receiving the requested information. Utah Code § 31A-26-301.6.

Late Fees

Bright HealthCare and Provider agree that a late fee will be imposed on Bright HealthCare if Bright HealthCare fails to timely pay a claim, and on Provider or Participating Providers if Provider or Participating Providers fail to timely provide information on a claim. For the first ninety (90) days that a claim payment or a provider response is late, the late fee shall be determined by multiplying (i) the total amount of the claim; by (ii) the total number of days the response or payment is late; by (iii) .1%. For a claim payment or provider response that is ninety-one (91) or more days late, the late fee shall be determined by (i) multiplying (a) the total amount of the claim; by (b) the total number of days the response or payment was late beyond the initial 90-day period; by (c) the applicable rate of interest; and (ii) adding the applicable late fee for the 90-day period. Unless the parties specify a different rate of interest, the rate of interest is 10% per annum. Bright HealthCare will separately identify any late fee paid or collected on the documentation used to pay the claim. A late fee does not include an amount that is less than $1. Utah Code § 31A-26-301.6 & § 15-1-1

Claims Resolution Process

Bright HealthCare will establish a review process to resolve claims-related disputes between Bright HealthCare and Provider or Participating Providers. Utah Code § 31A-26-301.6(9).

Recovery of Improper Payments

Bright HealthCare and Provider or Participating Providers may recover any amount improperly paid. Any amount improperly paid may be recovered: (i) in accordance with state or federal law; (ii) within twenty-four (24) months of the amount improperly paid for a coordination of benefits error; (iii) within twelve (12) months of the amount improperly paid for any other reason not identified in subsection (i) or (ii) of this Section 13; or (iv) within thirty-six (36) months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program. Utah Code § 31A-26-301.6

Health Care Preauthorization

Bright HealthCare will not modify an existing requirement for authorization unless, at least thirty (30) days before the day on which the modification takes effect, Bright HealthCare, if requested by Provider or a Participating Provider, provides by mail or email a written notice of modification to a particular requirement for authorization described in the request from the Provider or Network Provider; however, such requirement does not apply if compliance would create a danger to the Member's health or safety, or the modification is for a newly covered drug or device.

Bright HealthCare will provide written disclosure of sufficient information to allow a Participating Provider to submit all of the information to Bright HealthCare necessary to meet each requirement for authorization. Bright HealthCare will post such information on its provider portal, and if requested by a Participating Provider for a specific drug, device, or covered service, will provide the Participating Provider with such information.

Bright HealthCare will not revoke an authorization for a drug, device, or covered service if: (i) the Provider or Participating Provider submits a request for authorization for the drug, device, or Covered Service to Bright HealthCare; (ii) Bright HealthCare grants the authorization requested; (iii) the Provider or Participating Provider renders the drug, device, or Covered Service to the Member in accordance with the authorization and any terms and conditions of the Agreement; (iv) on the day on which the Provider or Participating Provider renders the drug, device, or Covered Service to the Member, the Member is eligible for coverage and the condition or circumstances related to the Member's care have not changed; (v) the Provider or Participating Provider submits an accurate claim that matches the information in the request for authorization; and (vi) the authorization was not based on fraudulent or materially incorrect information from the Provider or Participating Provider.

If the Provider or a Participating Provider submits a claim to Bright HealthCare that includes an unintentional error that results in a denial of the claim, Bright HealthCare will permit the Provider or Participating Provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time. Utah Code § 31A-22-613.5 & § 31A-22-650.

Removal of Drug from Formulary

In the event that Bright HealthCare removes a drug from the formulary, Bright HealthCare will permit a Participating Provider to request an exemption from the change to the formulary for purpose of providing the Member with continuity of care and will have a process to review and make a decision regarding such a request. Utah Code § 31A-22-650(4).

Participating Provider Nondiscrimination

Bright HealthCare will not discriminate against Participating Providers. Utah Code §§ 31A-45-303 & 31A-22-618.

Dental Services

Bright HealthCare shall not require, directly or indirectly, that a dentist who is a Participating Provider provide dental services to a Member at a fee set by or subject to the approval of Bright HealthCare unless the dental services are Covered Services, or: (i) the dental services are not reimbursed by Bright HealthCare; (ii) the dental services are discounted for individuals who are part of a discount dental rates plan; and (iii) the dentist who provided the dental services has elected to participate in the discount dental rates plan. Bright HealthCare will not prohibit a dentist from offering or providing noncovered dental services to a Member at a fee determined by the dentist and the Member who will receive the noncovered services. Utah Code § 31A-22-646.

Vision Services

To the extent Bright HealthCare covers and Provider provides vision services, Bright HealthCare will not (i) prohibit a Participating Provider from offering or providing a vision service that is not a covered service to a Member at a fee determined by the Participating Provider or the Participating Provider and the Member; or (ii) require a Participating Provider to use one or more specific vendors to replenish the Participating Provider's inventory of spectacle lenses after the Participating Provider dispenses the Participating Provider's inventory to Members as a Covered Service. Utah Code § 31A-22-648.

Autism Spectrum Disorders

To the extent Bright HealthCare covers and Provider provides treatment for the diagnosis and treatment of autism spectrum disorders, upon the request of Bright HealthCare, Provider agrees to submit a treatment plan to Bright HealthCare within fourteen (14) days of starting treatment for autism spectrum disorder for a Member. If a Member is receiving treatment for an autism spectrum disorder, Bright HealthCare may request a review of that treatment not more than once every three (3) months. A review of treatment for autism spectrum disorder may include a review of treatment goals and progress toward the treatment goals. Utah Code § 31A-22-642

Uniform Claim Forms

Bright HealthCare will accept the uniform claim forms as designated by the Commissioner in accordance with Utah Code § 31A-22-614.5 and Utah Admin. Code r. 590-164-4 for the submission of claims by the Provider, in addition to its standard claim form. Bright HealthCare and Provider will adhere to the claims requirements provided in Utah Admin. Code r. 590-164-1 et seq.

Virginia Regulatory Requirements Appendix

Standardized Claim Form

Bright HealthCare will accept the following standardized claim forms: HCFA-1500, UB-82, and the standardized ADA form prepared by the American Dental Association in accordance with Va Code § 38.2-322.

Claims Reimbursement

Bright HealthCare will pay any clean claim within 40 days of receipt of the claim. Bright HealthCare will request, within 30 days of receipt of a claim, any information and documentation reasonably believed to be necessary to process and pay the claim if the claim is a clean claim. Bright HealthCare may not refuse to pay a claim if it fails to timely notify or attempt to notify the person submitted the claim of any deficiencies or discrepancies in the claim, unless such failure was caused by the person submitting the claim. Va Code § 38.2-3407.15 (B)(1).

Bright HealthCare may retroactively deny a claim if the claim was fraudulent, incorrect because the provider was already paid or the services were not provided, or the time elapsed since the date of the payment is the lesser of 12 months or the number of days within which Bright HealthCare requires under its contract that a claim be submitted by the provider following the date on which a service is provided. Va Code § 38.2-3407.15 (B)(1) and (2). Bright HealthCare must inform providers in writing which claims it is denying and why. Va Code § 38.2-3407.15 (B)(8). Any interest owing or accruing on a claim under applicable law will be paid withing 60 days of payment of the claim without necessity of demand, if not required to be paid sooner. Va Code § 38.2-3407.15 (B)(3).

Bright HealthCare will establish and implement reasonable policies to permit a participating provider (i) to confirm in advance during business hours by telephone or electronic means whether services are medically necessary and covered; and (ii) to determine Bright HealthCare's requirements as applicable to the provider or the service for (a) a pre-certification authorization, (b) retroactive reconsideration of a certification or authorization of coverage or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. Va Code § 38.2-3407.15 (B)(4)(a).

Bright HealthCare will disclose policies related to downing or bundling of claims submitted by a provider in its provider contract will also, as applicable, (1) disclose on its website the specific bundling and downcoding policies it reasonable expects to apply or (2) disclose in each provider contract a telephone or facsimile number or email address that a provider can use to request the specific bundling and downcoding policies that Bright HealthCare reasonable expects to be applied to provider's services, where Bright HealthCare will reply to such a request within 10 business days from receipt. Va Code § 38.2-3407.15 (B)(4(a) and (b). Bright HealthCare will make available a copy of these policies as applicable to the provider within 10 days. Va Code § 38.2-3407.15 (B)(4)(b).

Bright HealthCare will pay all claims pre-authorized by it and any claims it has advised the provider or Member in advance of the provision of the service that the service is medically necessary and covered, unless (1) the submitted documentation for the claim fails to support the claim as originally authorized; (2) Bright HealthCare's refusal is (i) because another payor is responsible for payment, (ii) the provider has already been paid for the service, (iii) the claim was submitted fraudulently or the authorization was based in whole or in part on erroneous information provided to the carrier by the provider, Member, or other person not related to Bright HealthCare, or (iv) the person receiving the health care services was not eligible to receive them on the date of the service and Bright HealthCare did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status, or (3) during the post-service claims process, Bright HealthCare determined that the claim was submitted fraudulently, Va Code § 38.2-3407.15 (B)(5).

Amendments

No amendment to a provider contract will by applicable to a provider unless the provider has been given the applicable portion of the proposed amendment at least 60 calendar days before the effective date of the amendment and the provider has failed to notify Bright HealthCare within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. Va Code § 38.2-3407.15 (B)(10).

Coordination of Benefits

Bright HealthCare will advise Participating Providers of their responsibility to share specific information with Member concerning their illness, condition or treatment, required for the Member to follow their plan of care and receive follow-up care when needed. Bright HealthCare will monitor the continuity and coordination of care a Member receives, facilitate transitions through the system of care, and provide the information necessary to support the provisions of care from one plan component to another and ensure the information is provided in a timely manner to Members, Providers, and Participating Providers to support the continuity of care in accordance with 12 Va. Admin. Code § 5-408-250.

Prior Authorization

Any provider contract between Bright HealthCare and a participating health care provider will require: (1) Bright HealthCare, in a method of its choosing, to accept telephone, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic medical record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards; (2) Bright HealthCare to communicate to the prescriber or their designee within 24 hours, including weekend hours, of submission of an urgent prior authorization request, if submitted in a method directed by Bright HealthCare, whether the request was approved; (3) Bright HealthCare to communicate to the prescriber or their designee within two business days of submission of a fully completed prior authorization request, whether the request is approved; (4) Bright HealthCare to communicate to the prescriber or their designee withing two business days of properly completed supplementation whether the request was approved; (5) Any denial of a request include the reasons for such a denial; (6) Bright HealthCare to honor prior authorization by another insurance carrier within the first 30 days of the Member's coverage under a new health care plan;

(7) Bright HealthCare to use a tracking system for all prior authorization requests and for identifying information to be provided electronically, telephonically, or by facsimile to the prescriber or their designee; (8) that all of Bright HealthCare's drug formularies, drug benefits and procedures subject to prior authorization, and prior authorization request forms be made available in one central location on Bright HealthCare's website and be updated within seven days of any changes; (9) that Bright HealthCare honor a prior authorization issued by it for a drug other than an opioid, regardless of changes in dosage, as long as the drug is being prescribed consistent with FDA standards; (10) that Bright HealthCare honor a prior authorization issued by it for a drug if a Member changes between Bright HealthCare plans and the drug is a covered benefit with the current health plan; (11) Bright HealthCare to specify the information needed when requesting supplemental information from a prescriber; and (12) that no prior authorization is required for at least one drug prescribed for substance abuse medication-assisted treatment if the drug is covered benefit and the prescription is consistent with FDA and Board of Medicine standards. Va Code § 38.2-3407.15:2 (B).

Treatment Discussion

Bright HealthCare will not restrict or prohibit a Participating Provider's communications with the Participating Provider's Member concerning any such Member's health care or medical needs, treatment options, health care risks or benefits in accordance with 12 Va. Admin. Code § 5-408-250 3.

Quality Assurance Program

Providers agree to participate in, and ensure Participating Providers will participate in, all quality assurance programs implemented by Bright HealthCare, and agree to cooperate with Bright HealthCare in providing or arranging for such quality assurance programs, in accordance with 12 Va. Admin. Code § 5-408-220 through 12 Va. Admin. Code § 5-408-240 and Va Code § 32.1-137.1-.6.

Utilization Management

Bright HealthCare will have a utilization review and management process that complies with the requirements of Va Code § 32.1-137.7 through § 32.1-137.16 and 12 Va. Admin. Code § 5-408-360. Provider agrees to fully cooperate and provide information to Bright HealthCare or its designated utilization review agent in a complete and timely a manner to allow Bright HealthCare or its authorized utilization review agent to investigate, evaluate, and form a reasonable basis for utilization decisions concerning requested medical or health care services or claims for medical and health care services of Members.

Provider Directories

Providers will furnish Bright HealthCare with the necessary information for Bright HealthCare to maintain a provider directory that includes a list of network Participating Providers, including the names and localities of the providers Va Code § 38.2-5805 and Title 32.1 of the Virginia Code.

Urgent Care and Emergency Services

Bright HealthCare requires Participating Providers to allow its Members, on a 24-hour basis, (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with the appropriate medical training who can refer or direct a Member for prompt medical care in accordance with 12 Va. Admin. Code § 5-408-280 A.

Bright HealthCare requires Participating Providers to clearly notify Members of provisions for urgent care or emergency services when the physician is not available after hours in accordance with 12 Va. Admin. Code § 5-408-280 C and recognizes primary care practitioners' authority to facilitate and authorize emergency services for Members. 12 Va. Admin. Code § 5-408-280 D.

Referrals to Specialists

Bright HealthCare will have a procedure in place for and permit a standing referral to health care services of a participating specialist authorized to provide services under the policy and selected by a Member with an ongoing special condition as defined by Va Code § 38.2-3407.11:1B . An initial referral by the Member's primary care physician is required; no further referral is required from the primary care physician for ongoing care by the specialist or other specialists to which the first specialist refers the Member. Va Code § 38.2-3407.11:1.

Clinical Performance Evaluation

Bright HealthCare will maintain a system for the evaluation of outcomes and processes of clinical care services delivered to its Members as required by 12 Va. Admin. Code § 5-408-300. Provider agrees to provide any information necessary for the evaluation of clinical care services delivered to Bright HealthCare Members.

Termination of Provider

Bright HealthCare will notify Members about the termination of a Participating Provider as soon as it becomes aware of the termination. Bright HealthCare will provide information regarding the affected Members of other Participating Providers available to assume their care. Members undergoing an active course of treatment will have continued access to care during the transition period. 12 Va. Admin. Code § 5-408-260 E.

Provider Credentialing and Recredentialing

Provider and Participating Providers will maintain licensure, accreditation, and credential that meet Bright HealthCare's credential verification program requirements and notify Bright HealthCare of any subsequent changes in status of Provider or Participating Provider's professional credentials. Bright HealthCare will establish a credential verification program to verify that its network providers are credentialed in accordance with the procedures and timelines provided in 12 Va. Admin. Code § 5-408-170.

Complaint System; Maintenance of Complaint Records

Bright HealthCare will establish and maintain a complaint system that provides reasonable procedures for the resolution of written complaints initiated by Participating Providers acting on the behalf of a Member concerning Covered Services in accordance with 12 Va. Admin. Code § 5-408-180 and Va Code § 38.2-5804.

Medical Records

Provider and Participating Providers shall maintain an organized medical record system that assures the availability of information required for effective and continuous care of Members. All medical records will be confidential and will only be disclosed as permitted for health care operations under HIPAA or as permitted under Va Code § 32.1-127.1:03 in accordance with 12 Va. Admin. Code § 5-408-210.

Health Promotion

Bright will develop and implement at least one health guideline for the prevention and early detection of illness and disease and distribute this guideline to Providers, in accordance with 12 Va. Admin. Code § 5-408-290.

Hospitals and Certified Nursing Facilities

If Provider is a hospital or certified nursing facility as defined by Va Code § 32.1-123, Provider will maintain compliance with the regulation requirements codified in Va Code § 32.1-123-137.07, including but not limited to abiding by inspection requirements, complaint procedures, anti-discrimination and anti-retaliation provisions, criminal records checks for employees, fire and asbestos inspections, and health records privacy provisions.

Critical Access Hospitals

If Provider is a critical access hospital, Provider agrees to maintain its certification and requisite bed capacity in accordance with Va Code § 32.1-125.3 (2006).

Balance Billing Prohibited

Provider shall not balance bill a Member for (i) emergency services provided to the Member or (ii) non-emergency services provided to a Member at an in-network facility if the services involve surgical or ancillary services provided by an out of network provider. Bright HealthCare and the Provider shall ensure that the Member incurs no greater cost than the amount determined for the in-network cost-sharing requirement specified in the Member's health plan. If the Member pays the out-of-network provider an amount over the Member's in-network cost-sharing requirement, that provider will refund the excess amount to the Member within 30 business of receipt. Va Code § 38.2-3445.01 (2020).

Dental Benefits and Oral Surgery

No contract between Bright HealthCare and a dentist or oral surgeon will establish the fee or rate that such dentist or oral surgeon is required to accept for the provision of services or require that a dentist or oral surgeon accept the reimbursement paid as payment in full unless the services are covered services under the applicable dental plan. Reimbursement will be reasonable and not nominal. Va Code § 38.2-3407.01 (2016). Bright HealthCare will not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a Member. Va Code § 38.2-3407.13 (1999). *See also* Va Code § 38.2-3407.17 (2010).