2021 Summary of Benefits

Bright Advantage Choice (PPO)

H3281-003

Bright Advantage Part B Savings (PPO)

H3281-010

January 1, 2021 – December 31, 2021

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, https://brighthealthplan.com/medicare-advantage.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Bright Advantage Choice (PPO)** and **Bright Advantage Part B Savings (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Bright Advantage Choice (PPO)** and **Bright Advantage Part B Savings (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Bright Advantage Choice (PPO)** and **Bright Advantage Part B Savings (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Additional Benefits
- Prescription Drug Benefits

Things to Know About Bright Advantage Choice (PPO) and Bright Advantage Part B Savings (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. Local Time, 7 days a week, excluding Federal holidays.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. Local Time, Monday through Friday, excluding Federal holidays.
- If you are a member of this plan, call us at 1-844-221-7736, TTY: 711.
- If you are not a member of this plan, call us at 1-844-221-7736, TTY: 711.
- Our website: https://brighthealthplan.com/medicare-advantage.

Who can join?

To join **Bright Advantage Choice (PPO) and Bright Advantage Part B Savings (PPO)** , you must have both Medicare Part A and Part B, you must live in our service area, and be a United States citizen or lawfully present in the United States. The service area for **Bright Advantage Choice (PPO)** includes the following counties in Florida: Orange, Osceola, Pasco and Seminole.
The service area for **Bright Advantage Part B Savings (PPO)** includes the following counties in Florida: Orange, Osceola, Pasco and Seminole.

Which doctors, hospitals, and pharmacies can I use?

Bright Advantage Choice (PPO) and **Bright Advantage Part B Savings (PPO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (https://brighthealthplan.com/medicare-advantage).

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, https://brighthealthplan.com/medicare-advantage.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Bright Health

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
Monthly Plan Premium	$0	$0
Monthly Part B Premium Rebate	$0	$80
Deductible	Medical Deductible: $0.	Medical Deductible: $0.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $5,400 for services you receive from in-network providers. • $10,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • $10,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital	In-Network: Days 1-5: $250 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. Out-of-Network: 40% coinsurance each day for Medicare-covered hospital care.	In-Network: Days 1-6: $295 copay per day for each admission. Days 7-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. Out-of-Network: 30% coinsurance each day for Medicare-covered hospital care.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
	May require prior authorization.	May require prior authorization.
Ambulatory Surgical Center	In-Network: Ambulatory Surgical Center: $125 copay. Out-of-Network: Ambulatory Surgical Center: 40% coinsurance. May require prior authorization.	In-Network: Ambulatory Surgical Center: $150 copay. Out-of-Network: Ambulatory Surgical Center: 40% coinsurance. May require prior authorization.
Outpatient Hospital	In-Network: Outpatient hospital: $225 copay. Out-of-Network: Outpatient hospital: 40% coinsurance. May require prior authorization.	In-Network: Outpatient hospital: $270 copay. Out-of-Network: Outpatient hospital: 40% coinsurance. May require prior authorization.
Doctor's Office Visits	In-Network: Primary care physician visit: $0 copay. Specialist visit: $20 copay. Out-of-Network: Primary care physician visit: $0 copay. Specialist visit: $20 copay. May require prior authorization.	In-Network: Primary care physician visit: $0 copay. Specialist visit: $40 copay. Out-of-Network: Primary care physician visit: $0 copay. Specialist visit: $40 copay. May require prior authorization.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	In-Network: You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. Out-of-Network: 40% coinsurance for all preventive services covered under Original Medicare at zero cost sharing. May require prior authorization.	In-Network: You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. Out-of-Network: 30% coinsurance for all preventive services covered under Original Medicare at zero cost sharing.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
		May require prior authorization.
Emergency Care	$90 copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $90 copay.	$90 copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $90 copay.
Urgently Needed Services	$35 copay per visit.	$40 copay per visit.
Diagnostic Services / Labs/ Imaging	In-Network: Diagnostic tests and procedures: $0 - $100 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $25 - $100 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. Out-of-Network: Diagnostic tests and procedures: 40% coinsurance. Lab services: 40% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 40% coinsurance. X-rays: 40% coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance. May require prior authorization.	In-Network: Diagnostic tests and procedures: $0 - $250 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $25 - $250 copay. X-rays: $5 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. Out-of-Network: Diagnostic tests and procedures: 40% coinsurance. Lab services: 40% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 40% coinsurance. X-rays: 40% coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance. May require prior authorization.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
Hearing Services	In-Network: Exam to diagnose and treat hearing and balance issues: $0 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid: $0 copay. Hearing Aid Allowance: $750 per year. Out-of-Network: Exam to diagnose and treat hearing and balance issues: 40% coinsurance. Routine hearing exam (up to 1 visit(s) every year): 40% coinsurance. Hearing Aid: $0 copay. Hearing Aid Allowance: $750 per year. May require prior authorization.	In-Network: Exam to diagnose and treat hearing and balance issues: $0 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Out-of-Network: Exam to diagnose and treat hearing and balance issues: 40% coinsurance. Routine hearing exam (up to 1 visit(s) every year): 40% coinsurance.
Dental Services	In-Network: Medicare Covered: $0 copay. Preventive dental services: • Oral exam (up to 2 visit(s) every year): $0 copay. • Cleaning (up to 2 visit(s) every year): $0 copay. • Fluoride treatment (up to 1 visit(s) every year): $0 copay. • Dental X-rays (up to 2 visit(s)): $0 copay. • Annual Dental Benefit Maximum: $1,500 per year. Comprehensive dental is included. You pay $0 - 50% for comprehensive dental services.	In-Network: Medicare Covered: $0 copay. Preventive dental services: • Oral exam (up to 2 visit(s) every year): $0 copay. • Cleaning (up to 2 visit(s) every year): $0 copay. • Fluoride treatment (up to 1 visit(s) every year): $0 copay. • Dental X-rays (up to 2 visit(s)): $0 copay. • Annual Dental Benefit Maximum: $1,500 per year.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
	Out-of-Network: Medicare Covered : 40% coinsurance. Preventive dental services: • Oral Exams (up to 2 visit(s) every year): 30% coinsurance. • Cleaning (up to 2 visit(s) every year): 30% coinsurance. • Fluoride treatment (up to 1 visit(s) every year): 30% coinsurance. • Dental X-rays (up to 2 visit(s)): 30% coinsurance. Comprehensive dental is included. You pay 30% - 75% for comprehensive dental services. There is a $1,500 maximum benefit for all in-network and out-of-network services combined every year. May require prior authorization.	Out-of-Network: Medicare Covered : 40% coinsurance. Preventive dental services: • Oral Exams (up to 2 visit(s) every year): 30% coinsurance. • Cleaning (up to 2 visit(s) every year): 30% coinsurance. • Fluoride treatment (up to 1 visit(s) every year): 30% coinsurance. • Dental X-rays (up to 2 visit(s)): 30% coinsurance. We also offer optional supplemental benefits to enhance your dental benefit for an additional premium. For details please see the Optional Supplemental Benefit Section.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
Vision Services	In-Network: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Contact lenses: $0 - $60 copay. Eyeglasses (frames and lenses): $25 copay. Eyewear Allowance: $130 every two years. Out-of-Network: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 40% coinsurance. Routine eye exam (up to 1 visit(s) every year): 40% coinsurance. Eyeglasses or contact lenses after cataract surgery: 40% coinsurance. Contact lenses: $0 - $60 copay. Eyeglasses (frames and lenses): $25 copay. Eyewear Allowance: $130 every two years. May require prior authorization.	In-Network: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Out-of-Network: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 40% coinsurance. Routine eye exam (up to 1 visit(s) every year): 40% coinsurance. Eyeglasses or contact lenses after cataract surgery: 40% coinsurance. We also offer optional supplemental benefits to enhance your vision benefit for an additional premium. For details please see the Optional Supplemental Benefit Section. May require prior authorization.
Mental Health Care	In-Network: Outpatient group therapy visit: $35 copay. Individual therapy visit: $40 copay. Inpatient Mental Health Care: Days 1-5: $250 copay per day for each admission. Days 6-90: $0 copay per day.	In-Network: Outpatient group therapy visit: $35 copay. Individual therapy visit: $40 copay. Inpatient Mental Health Care: Days 1-6: $295 copay per day for each admission. Days 7-90: $0 copay per day.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
	Out-of-Network: Outpatient group therapy visit: 40% coinsurance. Individual therapy visit: 40% coinsurance. Inpatient Mental Health Care: 40% coinsurance each day for Medicare-covered hospital care. May require prior authorization.	Out-of-Network: Outpatient group therapy visit: 40% coinsurance. Individual therapy visit: 40% coinsurance. Inpatient Mental Health Care: 30% coinsurance each day for Medicare-covered hospital care. May require prior authorization.
Skilled Nursing Facility (SNF)	In-Network: Days 1-20: $0 copay per day. Days 21-100: $178 copay per day. Out-of-Network: 40% coinsurance each day for days 1-100. May require prior authorization.	In-Network: Days 1-20: $0 copay per day. Days 21-100: $178 copay per day. Out-of-Network: 40% coinsurance each day for days 1-100. May require prior authorization.
Outpatient Rehabilitation	In-Network: Occupational therapy visit: $30 copay. Physical therapy and speech and language therapy visit: $30 copay. Out-of-Network: Occupational therapy visit: 40% coinsurance. Physical therapy and speech and language therapy visit: 40% coinsurance. May require prior authorization.	In-Network: Occupational therapy visit: $0 copay. Physical therapy and speech and language therapy visit: $0 copay. Out-of-Network: Occupational therapy visit: 40% coinsurance. Physical therapy and speech and language therapy visit: 40% coinsurance. May require prior authorization.
Ambulance	In-Network: Ground Ambulance: $200 copay. Air Ambulance: $250 copay. Out-of-Network: Ground Ambulance: $200 copay.	In-Network: Ground Ambulance: $225 copay. Air Ambulance: $225 copay. Out-of-Network: Ground Ambulance: $225 copay.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
	Air Ambulance: $250 copay. May require prior authorization.	Air Ambulance: $225 copay. May require prior authorization.
Transportation	In-Network: $0 copay, unlimited trips. Out-of-Network: $0 copay. May require prior authorization.	In-Network: Not Covered. Out-of-Network: Not Covered.
Medicare Part B Drugs	In-Network: For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance. Out-of-Network: For Part B drugs such as chemotherapy drugs: 40% coinsurance. Other Part B drugs: 40% coinsurance. May require prior authorization.	In-Network: For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance. Out-of-Network: For Part B drugs such as chemotherapy drugs: 35% - 40% coinsurance. Other Part B drugs: 35% - 40% coinsurance. May require prior authorization.
ADDITIONAL BENEFITS		
Health Club & Fitness Membership	In-Network: $0 copay at participating locations. Out-of-Network: Not Covered.	In-Network: $0 copay at participating locations. Out-of-Network: Not Covered.
Medical Equipment and Supplies	In-Network: 20% coinsurance. Out-of-Network: 40% coinsurance. May require prior authorization.	In-Network: 20% coinsurance. Out-of-Network: 40% coinsurance. May require prior authorization.
Over-the-Counter (OTC) Allowance	In-Network: $0 copay, $75 credit every three months.	In-Network: Not Covered.

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
	Out-of-Network: Not Covered.	Out-of-Network: Not Covered.
Podiatry Services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care for members with certain medical conditions affecting the lower limbs.	In-Network: $35 copay. Out-of-Network: 40% coinsurance. May require prior authorization.	In-Network: $0 copay. Out-of-Network: 40% coinsurance. May require prior authorization.
Telehealth Services	In-Network: $0 copay. Out-of-Network: Not Covered.	In-Network: $0 copay. Out-of-Network: Not Covered.
Meal Benefit	In-Network: Not Covered. Out-of-Network: Not Covered.	In-Network: Not Covered. Out-of-Network: Not Covered.
PRESCRIPTION DRUG BENEFITS		
Deductible	Prescription Drug Deductible: $0	Prescription Drug Deductible: $400 for Tiers 2, 3, 4 and 5.

SECTION II - SUMMARY OF BENEFITS

	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
Initial Coverage	You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$8 copay
Tier 3 (Preferred Brand)	$47 copay
Tier 4 (Non-Preferred Drug)	$100 copay
Tier 5 (Specialty Tier)	33% coinsurance
Tier 6 (Select Care Drugs)	$0 copay

Tier	90-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$16 copay
Tier 3 (Preferred Brand)	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 copay

Standard Mail Order

Tier	30-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$8 copay

Standard Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	$47 copay
Tier 4 (Non-Preferred Drug)	$100 copay
Tier 5 (Specialty Tier)	25% coinsurance
Tier 6 (Select Care Drugs)	$0 copay

Tier	90-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$40 copay
Tier 3 (Preferred Brand)	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay
Tier 5 (Specialty Tier)	Not Applicable
Tier 6 (Select Care Drugs)	$0 copay

Standard Mail Order

Tier	30-day supply
Tier 1 (Preferred Generic)	$0 copay

SECTION II - SUMMARY OF BENEFITS	Bright Advantage Choice (PPO) H3281-003	Bright Advantage Part B Savings (PPO) H3281-010
	<table><tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td></tr></table> <table><tr><th>Tier</th><th>90-day supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$16 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$94 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$200 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td></tr></table> Cost-sharing may differ based on pharmacy type or status (mail-order, retail, long term care (LTC), home infusion), or whether the prescription is short-term (30-day supply) or long-term (90-day supply). Please call us or see the plan's **"Evidence of Coverage"** on our website (https://brighthealthplan.com/medicare-advantage) for complete information about your costs for covered drugs.	<table><tr><td>Tier 2 (Generic)</td><td>$20 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>25% coinsurance</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td></tr></table> <table><tr><th>Tier</th><th>90-day supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$40 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$94 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$200 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>Not Applicable</td></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td></tr></table> Cost-sharing may differ based on pharmacy type or status (mail-order, retail, long term care (LTC), home infusion), or whether the prescription is short-term (30-day supply) or long-term (90-day supply). Please call us or see the plan's **"Evidence of Coverage"** on our website (https://brighthealthplan.com/medicare-advantage) for complete information about your costs for covered drugs.
Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130.

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<tr><th colspan="3">SECTION II - SUMMARY OF BENEFITS</th></tr>
<tr><th></th><th>Bright Advantage Choice (PPO)
H3281-003</th><th>Bright Advantage Part B Savings (PPO)
H3281-010</th></tr>
<tr><td></td><td>25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap.

Our plan covers Tier 6 Select Care Drugs in the coverage gap.

Standard Retail Cost-Sharing
<table><tr><th>Tier</th><th>30-day supply</th></tr><tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td></tr></table></td><td>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap.

Our plan covers Tier 6 Select Care Drugs in the coverage gap.

Standard Retail Cost-Sharing
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<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of:
$3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs, or
5% of the cost.</td><td>After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of:
$3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs, or
5% of the cost.</td></tr>
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Optional Supplemental Benefits Bright Advantage Part B Savings (PPO) H3281-010		
Comprehensive Dental 002 for $19.00 per month.	**Dental**	In-network: You pay $0 copay to 50% coinsurance for all covered services. Out-of-network: You pay 30% to 75% coinsurance for all covered services. There is a $1,500 maximum benefit for all in-network and out-of-network covered services combined every year. May require prior authorization.

Optional Supplemental Benefits Bright Advantage Part B Savings (PPO) H3281-010		
Comprehensive Vision 002 for $3.50 per month.	**Vision**	You pay a $25 copay for basic lenses. You pay a $0 to $60 copay for contact lenses. You have a $130 allowance every other year for eyeglasses (lenses and frames) or contact lenses. May require prior authorization.

DISCLAIMERS

Bright Health plans are HMOs and PPOs with a Medicare contract. Bright Health's New York D-SNP plan is an HMO with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Bright Health Insurance Company is a Colorado Life and Health company that issues indemnity products, including EPOs offered through Medicare Advantage. An EPO is an exclusive provider organization plan that may be written on an HMO license in some states and on a Life and Health license in some states, including Colorado. Enrollment in our plans depends on contract renewal.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-221-7736 (TTY 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit https://brighthealthplan.com/medicare-advantage or 1-844-221-7736 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Out-of-network/non-contracted providers are under no obligation to treat **Bright Advantage Choice (PPO)** and **Bright Advantage Part B Savings (PPO)** members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

bright[SM] HEALTH

Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright Health plans and their affiliates.

Language assistance and alternate formats:

Assistance is available at *no cost* to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call **1-844-221-7736**.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
P.O. Box 853943
Richardson, TX 75085-3943
Phone: **1-844-202-2154**
Email: OAG@brighthealthplan.com

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone:** Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)
- **Mail:** U.S Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If you need help with your complaint, please call **1-844-202-2154**. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call **1-844-221-7736**.

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call (844) 221-7736.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 221-7736.
Chinese (S)	注意：如果您使用的语言并非英语，则可获得免费的语言协助服务请拨打电话 (844) 221-7736。
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. بالرقم 221-7736 (844).
Bengali	মনোযোগ দিন: আপনি যদি ইংরাজী ব্যতীত অন্য কোনও ভাষায় কথা বলেন তাহলে ভাষা সহায়তা সংক্রান্ত পরিষেবাগুলি নিখরচায় আপনার জন্য উপলব্ধ। (844) 221-7736 নম্বরে কল করুন।.
French	ATTENTION : Si vous parlez une autre langue que l’anglais, des services d’assistance linguistique sont mis gratuitement à votre disposition. Appelez (844) 221-7736.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die (844) 221-7736.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε το (844) 221-7736.
Italian	ATTENZIONE: se parla una lingua diversa dall’inglese, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero (844) 221-7736.
Japanese	ご注意：英語以外の言語を話される場合は、無料の言語支援サービスをご利用いただけます。(844) 221-7736 までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 연락하십시오(844) 221-7736으로
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług tłumaczeniowych. Zadzwoń pod numer (844) 221-7736.
Portuguese	ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de assistência de idioma para si. Contacte o número (844) 221-7736.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по телефону (844) 221-7736.
Tagalog	PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga serbisyong tulong sa wika nang walang bayad. Tumawag sa (844) 221-7736.
Urdu	دھیان دیں: اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات مفت دستیاب ہیں۔ 221-7736 (844) پر کال کریں۔

Vietnamese	CHÚ Ý: Nếu bạn nói một thứ tiếng nào khác ngoài tiếng Anh, bạn sẽ được cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi số (844) 221-7736.
Navajo	SHOOH: Biligáanaa bizaad doo dints’a’gó ata’ hane’ t’áájííkeh hóló̜. Béésh bee hodíilni (844) 221-7736.
Amharic	ማሳሰብያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ። በ (844) 221-7736 ይደውሉ።
Burmese	သင်သည် အင်္ဂလိပ်စကားမဟုတ်သော အခြားဘာသာစကားတစ်ခုအား ပြောဆိုသူဖြစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ်ပြားပေါ်ရှိ အဖွဲ့ဝင်များဝန်ဆောင်မှုဌာန (844) 221-7736 သို့ ဖုန်းခေါ်ဆိုပါ။
Cherokee	ᏧᎧᏎᏍᏓᏓ: ᏥᎢ ᏕᏣᏂᏍᎩ ᏍᏆᏂᏧ ᏏᏃ ᎩᎵᏏ, ᏕᏣᏂᏑᏍᏗ ᎠᏢᏍᏚᏢᏍᎩ ᎢᏗᏓᏅᏛᎢ, Ꮳ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏍᎩ ᎠᏎᏇᎢ, ᏂᏑ ᏒᏩᏛᏛᎢᏍᏓᏛᎩᎢ. ᎾᏍᎩᏃ (844) 221-7736.
Cushite-Oromo	XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta’e, tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Bilbili (844) 221-7736.
French Creole	ATANSYON: Si ou pale yon lang ki pa Anglè, sèvis asistans lengistik la gratis, epi li disponib pou ou. Rele (844) 221-7736.
Gujarti	ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા સહાય સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. (844) 221-7736 પર કૉલ કરો.
Hindi	ध्यान दें: यदि आप अंग्रेज़ी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ़्त में भाषा सहायता सेवाएं उपलब्ध हैं। (844) 221-7736 पर कॉल करें।
Hmong	UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Thov hu rau (844) 221-7736.
Karen	တၢ်သးစၢၢ်ဆၢ: နကတိၤအဲကလံးကျိာ်မ့ၢ်တဘၣ်ဘၣ်န့ၣ် နဒိးန့ၢ်ဘၣ်ကျိာ်အတၢ်မၤစၢၤတဖၣ်သ့ဝဲဒၣ် ဒီးနကလိၣ်ဟ့ၣ်အပ့ၤဘၣ်. ကိး (844) 221-7736 တက့ၢ်.
Kru / Bassa	YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ, ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i Mbon. Sébé ni njel singa ini nle (844) 221-7736.
Kurdish	اگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریە زمانەوانیەکان بەخۆڕایی بۆ تۆ بەدەستن. پەیوەندی بە ژمارەی (844) 221-7736 بکەن.
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ (844) 221-7736.
Mon-Khmer	សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយភាសា ដែលឥតគិតថ្លៃ គឺមានផ្តល់ជូនដល់អ្នក។ ទូរសព្ទ (844) 221-7736

Nepali

ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुनुहुन्छ भने तपाइँको लागि निःशुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। (844) 221-7736 मा कल गर्नुहोस्।

Persian Farsi

توجه: اگر به زبانی غیر از انگلیسی صحبت می‌کنید، خدمات تسهیلات زبانی، رایگان دردسترس شما قرار می‌گیرند.
با شماره 7736-221 (844) تماس بگیرید.

Serbo-Croatian

PAŽNJA: ako ne govorite engleski, nego neki drugi jezik, na raspolaganju su vam besplatne usluge jezične pomoći. Nazovite (844) 221-7736.

Syriac

[illegible] (844) 221 7736

Thai

ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษาจัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขโทรศัพท์ (844) 221-7736.

Turkish

DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak faydalanabilirsiniz. (844) 221-7736 numaralı hattı arayın.

Ukrainian

УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними послугами мовної підтримки. Зателефонуйте за телефоном (844) 221-7736.

Yiddish

אַכטונג: אויב איר רעדן אַן אַנדער שפּראַך ווי ענגליש, שפּראַך הילף באַדינען, פֿרייַ פֿון אָפּצאָל, זייַנען פֿאַראַנען פֿאַר איַיך.
אָנקלינגט 7736-221 (844)