Alabama

2019 Bright Extra Optional Benefits Enrollment Form

As a member of a Bright Health plan, you may add Bright Extra Optional Benefits during the first month of your coverage by completing this form and sending it back to Bright Health as indicated in this document. The premium for Bright Extra Optional Benefits is paid in addition to your monthly health plan premium (if applicable) and your Medicare Part B premium.

Choose Your Bright Extra Optional Benefits

☐ **Comprehensive Dental**	☐ **Comprehensive Vision**
$21 monthly premium if you are a member of one of the following plans: • Bright Advantage (HMO) • Bright Advantage Plus (HMO) • Bright Advantage Choice (HMO-POS) • Bright Advantage Choice Plus (HMO-POS)	**$4 monthly premium** if you are a member of one of the following plans: • Bright Advantage Choice (HMO-POS)

Personal Information

Bright Health Member ID:		
☐ Mr. ☐ Mrs. ☐ Ms.		
First Name:	Last Name:	MI:
Birthdate (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	Gender ☐ M ☐ F	
Primary Phone Number: (__ __ __) __ __ __ - __ __ __ __	Alternate Phone Number: (__ __ __) __ __ __ - __ __ __ __	
Email (By giving my email address, I agree to receive email about my benefits, health programs and other plan services):		

Permanent Residence Street Address (P.O. Box is not allowed):			Apt or Suite
City:	State:	ZIP Code:	County:

Please Read

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. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/ coinsurance may change on January 1 of each year.

If you have any questions, please call Members Services at: <phone number> (TTY: 711) from 8 a.m. to 8 p.m. local time 7 days a week Oct. 1 to March 31, Monday through Friday April 1 to Sept 30.

By completing this enrollment application, I understand that this is an extension of my original Bright Health plan application. All the same terms and conditions apply.

Bright Health serves a specific service area. If I move out of the area that Bright Health serves, I need to notify the plan, so I can disenroll and find a new plan in my new area. As a member of Bright Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Bright Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Bright Health coverage begins, I must get all my health care from Bright Health participating providers, except for emergency or out-of-area urgently needed services or out-of-area dialysis services. Services authorized by Bright Health and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BRIGHT HEALTH WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with, Bright Health, he/she may be paid based on my enrollment in Bright Health.

Conditions of Enrollment

I understand that Bright Extra Optional Benefits, also referred to as Optional Supplemental Benefits, are only available to members enrolled in a Bright Health plan.

I understand that by adding Optional Supplemental Benefits to my Medicare Advantage plan, coverage becomes effective on the first of the month following receipt of the enrollment application. Members can add Optional Supplemental Benefits within 90 days of enrollment effective date or can add Optional Supplemental Benefits with a valid Special Election Period. Benefits will become effective the first of the month following receipt of the enrollment form.

I understand that the Optional Supplemental Benefit plan that I have selected supplements my Bright Health coverage and is subject to the terms and conditions stated in the Bright Health Medicare Advantage Evidence of Coverage.

I understand that Bright Health will not allow members to disenroll from Optional Supplemental Benefits until the end of the benefit plan year unless a Special Election Period exists. In addition, Bright Health reserves the right to disenroll members from Optional Supplemental Benefits for failure to pay plan premium if payment is not received within 90 days. The member will receive a warning notice for reduction in coverage within 7 days of failure to pay premium and subsequent notices after 30 and 60 days. If payment is not received by the last day of the 3rd month, the member will be disenrolled effective the first day of the following month. (Example: Optional Supplemental Benefit premium not paid for May, letter is sent to member within 7 days of due date. Second Notice sent in June and third notice in July. If no response by end of July, member will be disenrolled for the effective date of August 1st.)

If I discontinue payment of the Optional Supplemental Benefits, my membership in the Optional Supplemental Benefits will be terminated, and my Medicare Advantage (medical) plan enrollment status will not be affected. My coverage will default to my standard Bright Health Medicare Advantage (medical) plan only.

Release of Information: By joining a supplemental benefit plan, I acknowledge that Bright Health will release my information to other parties for treatment, payment and health care operations, including without limitation to Medicare, other plans, providers, and Bright Health's Care Partner. I also acknowledge that Bright Health may release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Name:	Date:

Payment

Payment is not required at the time of enrollment. The additional premium for your Bright Extra Optional Benefits will be processed in the same manner (mailed invoice or automatic deduction) as your Bright Health Medicare Advantage plan premium.

Authorized Representative

If you are the authorized representative, you must sign below & provide the following information:

First Name	Last Name	
Mailing Address:		
City:	State:	ZIP Code:
Primary Phone Number (_ _ _) _ _ _ - _ _ _ _	Relationship to Applicant	

Please Read

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature of Applicant or Authorized Representative

Signature	Today's Date

Please return your completed application to:
Bright Health Plan, P.O. Box 853958, Richardson, TX 75085-3958
Fax: 1-800-208-7647

bright 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, which are listed below.

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 the Member Services number on your member ID card.

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
PO Box 853943, Richardson, TX 75085-3943
Phone: (844) 202-2154
Fax: (800) 894-7742

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, 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 the Member Services number on your member ID card. You must send the complaint within 60 days of discovering the issue.

"Bright Health” means Bright Health Insurance Company of Alabama, Inc; Bright Health Company of Arizona; Bright Health Insurance Company; Bright Health Insurance Company of Tennessee; Bright Health Insurance Company of Ohio, Inc.; Bright Health Insurance Company of New York.

MULTI-MA-LTR-2267_C Updated 06/29/2018

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Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call the Member Services number on your ID card.
Spanish (US)	ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación.
Chinese (S)	注意：如果您讲中文，我们可以为您提供免费的语言协助服务。请拨打您ID卡上的会员服务电话号码。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Службу работы с клиентами по телефону, указанному в Вашей идентификационной карте.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 있는 회원 서비스 번호로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm nan nimewo ki make sou kat ID ou an.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero dell'assistenza ai membri riportato sulla Sua scheda identificativa.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט ייִדיש, עס זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אָפּצאָל. רופט די מעמבער סערוויסעס נומער אויף אייערע אייִ־די קארטל.
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জন্য, ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে উপলব্ধ আছে। আপনার ID কার্ডে থাকা সদস্য পরিষেবাগুলির নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فيمكنك الاستعانة بخدمات المساعدة اللغوية بدون مقابل. اتصل برقم خدمات الأعضاء المدوّن على بطاقة التعريف الخاصة بك.
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić do Działu Usług dla Członków, którego numer jest podany na Pana/ Pani karcie identyfikacyjnej.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le numéro des services aux membres, qui figure sur votre carte d'identification.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo para sa wika. Tawagan ang numero ng Mga Serbisyo sa Miyembro na nasa inyong ID kard.
Vietnamese	LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số Dịch vụ Hội viên trên thẻ ID của quý vị.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí Diné bizaad be yáníłti'go, saad bee áká'ánida'áwo' dęę', t'áá jiik'eh, ná hóló. Kojį' hódíílnih Member Servicesjį éí binumber naaltsoos nitł'izgo bee nee hódólzin biniiyé nantinígíí bikáá'
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ پر موجود ممبر سروسز کے نمبر پر کال کریں۔
Japanese	注記：日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載のメンバーサービス電話番号までお電話ください。
Portuguese (BR)	ATENÇÃO: caso você fale português, há serviços gratuitos de assistência de idioma à sua disposição. Ligue para o número de Atendimento ao Associado, impresso no seu cartão de identificação.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter der auf Ihrer ID-Karte aufgeführten Telefonnummer für Mitgliederdienstleistungen an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات کمک زبانی به صورت رایگان در اختیار شماست. با «خدمات اعضا» که شماره آن روی کارت شناسایی شما درج شده است تماس بگیرید.