2019

Bright Health Summary of Benefits

Bright Advantage Choice (HMO-POS)
H8280-003

Bright Advantage Choice Plus (HMO-POS)
H8280-004

Y0127_H8280-MA-DIR-2450_M 11/6/2018

Welcome to Bright Health.

Enclosed you will find our summary of the health and drug services covered by Bright Health Medicare Advantage plans from January 1, 2019 to December 31, 2019 for Jefferson and Shelby counties.

Keep in mind, this is a *summary* of what's covered and what you would pay for those benefits and services. For a complete coverage list, including limitations and exclusions, please refer to our Evidence of Coverage ("EOC"). You can find an EOC online at www.brighthealthplan.com/medicare, or you can request a printed copy to be mailed to you by calling us at 844-667-5502, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

We designed our plans a little differently.

We believe that health insurance and healthcare work better together. So, that's why we built our health plans from the ground up, with carefully selected Care Partners like Brookwood Baptist Health. Our partnership with Brookwood Baptist Health means you benefit from a connected care system that puts your healthcare needs at the center. With a network of hand-picked doctors, working together on your behalf, you get to focus on living your best life.

This is healthcare that revolves around you.

When your health plan and your healthcare providers are working together, you're always at the center – but never caught in the middle.

We're proud of our Medicare Advantage plans, and we think you'll love them, too. But we also believe it's important that you enroll in the health plan that's right for you. So, take a look, and give us a call if you have any questions.

We look forward to helping you live your best life.

Some Frequently Asked Questions:

May I choose my providers?

Bright Health has carefully selected a network of doctors, hospitals, pharmacies, and other providers. **To keep your costs down, it's important that you receive care from an in-network provider.** In most cases, if you choose to get care outside of the plan's network, you will likely pay more for the service. However, if you need out-of-network emergency services, urgently needed services or dialysis services, then we've got you covered.

To find an in-network provider near you, visit our website at www.brighthealthplan.com/medicare or call Bright Health at 844-667-5502.

What is a prescription drug formulary?

A formulary is a list of drugs covered by a health plan. To make sure your drugs are included in the Bright Advantage Choice (HMO-POS) and Bright Advantage Choice Plus (HMO-POS) formulary, you can search and download our formulary online at www.brighthealthplan.com/medicare. Or you can call Bright Health at 844-667-5502 to discuss your drugs. Please note that the formulary is subject to change, and you can always find the most up-to-date list of drugs on our website.

For more information, or if you have any questions, just give us a call.

bright SM HEALTH | Brookwood Baptist Health™

844-667-5502, 8 am - 8 pm local time
7 days a week Oct. 1-Mar. 31
Monday-Friday Apr. 1-Sept. 30
TTY: 711
www.brighthealthplan.com/medicare

If you'd like to know more about the coverage and costs of Original Medicare, please look in your current *Medicare & You* handbook. You can view it online at 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.

Bright Health Premiums & Benefits

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Monthly Plan Premium	$0	$48
Annual Medical Deductible	$0	$0
Maximum Out-Of-Pocket Amount*	**In-Network:** $5,500	**In-Network:** $3,200
Point-of-Service (POS) Benefit Maximum	$25,000 Max plan will pay for POS services per year	$25,000 Max plan will pay for POS services per year

Bright Health Benefits

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Inpatient Hospital Coverage	**In-Network** $250 per day for days 1-6 $0 per day for days 7+ **Out-of-Network** Not Covered	**In-Network** $185 per day for days 1-5 $0 per day for days 6+ **Out-of-Network** Not Covered
Outpatient Hospital Services and Observation	**In-Network** $250 copay **Out-of-Network** Not Covered	**In-Network** $215 copay **Out-of-Network** Not Covered
Doctor Visits		
Primary Care Providers (PCP)	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 30% coinsurance
Specialists	**In-Network** $25 copay **Out-of-Network** 35% coinsurance	**In-Network** $20 copay **Out-of-Network** 30% coinsurance
Annual Routine Physical Exam	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 30% coinsurance

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
	Our plan covers many preventive services at no cost when you see an in-network provider, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual Wellness Visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screening (cholesterol, lipids, triglycerides) • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma test • Hepatitis C screening • HIV screening • Lung cancer screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infection screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time)	
Emergency Care	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.
Urgently Needed Services	$30 copay	$30 copay
Diagnostic Services/Labs/Imaging		
Diagnostic Tests and Procedures	**In-Network** 20% coinsurance **Out-of-Network** Not Covered	**In-Network** 20% coinsurance **Out-of-Network** Not Covered

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Lab Services	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 30% coinsurance
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	**In-Network** $75 copay **Out-of-Network** Not Covered	**In-Network** $50 copay **Out-of-Network** Not Covered
Outpatient X-rays	**In-Network** $15 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 30% coinsurance
Hearing Services		
Exam to Diagnose and Treat Hearing and Balance Issues	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
Routine Hearing Exam	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** Not Covered	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** Not Covered
Fitting-Evaluation(s) for Hearing Aids	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** Not Covered	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** Not Covered
Hearing Aids	Up to a $1,000 allowance for both ears combined every three years for hearing aids.	Up to a $2,000 allowance for both ears combined every three years for hearing aids.
Dental Services		
Medicare-covered dental services	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
Annual Dental Benefit Maximum	No benefit maximum for preventive dental services.	No benefit maximum for preventive dental services.

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Oral Exams	**In-Network** $0 copay Limited to 1 oral exam every year **Out-of-Network** Not Covered	**In-Network** $0 copay Limited to 1 oral exam every year **Out-of-Network** Not Covered
Prophylaxis (Cleaning)	**In-Network** $0 copay Limited to 1 cleaning every year **Out-of-Network** Not Covered	**In-Network** $0 copay Limited to 1 cleaning every year **Out-of-Network** Not Covered
Dental X-rays	**In-Network** $0 copay Limited to 2 x-rays every year **Out-of-Network** Not Covered	**In-Network** $0 copay Limited to 2 x-rays every year **Out-of-Network** Not Covered
Optional Comprehensive Dental Services	Available for an additional $21 monthly premium. Up to a $1,500 benefit maximum for all plan covered dental services not covered by Medicare every year. Please see Evidence of Coverage for details.	Available for an additional $21 monthly premium. Up to a $1,500 benefit maximum for all plan covered dental services not covered by Medicare every year. Please see Evidence of Coverage for details.
Vision Services		
Exam to Diagnose and Treat Diseases and Conditions of the Eye	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
Eyewear After Cataract Surgery	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
Routine Eye Exam	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** Not Covered	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** Not Covered

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Contact Lenses	Available for an additional $4 monthly premium. Up to $130 allowance towards eyeglasses (lenses and frames) or contact lenses. Please see Evidence of Coverage for details.	**In-Network** $0 - $60 copay Up to $130 allowance towards eyeglasses (lenses and frames) or contact lenses. **Out-of-Network** Not Covered
Eyeglasses (Lenses and Frames)		**In-Network** $25 copay Up to $130 allowance towards eyeglasses (lenses and frames) or contact lenses. **Out-of-Network** Not Covered
Mental Health Services		
Inpatient Visit	**In-Network** $250 copay per day for days 1-6 $0 copay per day for days 7-90 **Out-of-Network** Not Covered	**In-Network** $185 copay per day for days 1-5 $0 copay per day for days 6-90 **Out-of-Network** Not Covered
Outpatient Group Therapy Visit	**In-Network** $10 copay **Out-of-Network** Not Covered	**In-Network** $10 copay **Out-of-Network** Not Covered
Outpatient Individual Therapy Visit	**In-Network** $40 copay **Out-of-Network** Not Covered	**In-Network** $40 copay **Out-of-Network** Not Covered
Skilled Nursing Facility (SNF) Care	**In-Network** $0 copay per day for days 1-20 $172 copay per day for days 21-100 **Out-of-Network** Not Covered	**In-Network** $0 copay per day for days 1-20 $172 copay per day for days 21-100 **Out-of-Network** Not Covered
Physical Therapy, Occupational Therapy, or Speech Therapy Visit	**In-Network** $30 copay **Out-of-Network** Not Covered	**In-Network** $20 copay **Out-of-Network** Not Covered

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Ambulance Services		
Ground Ambulance	$200 copay	$200 copay
Air Ambulance	$205 copay	$205 copay
Transportation	Not Covered	$0 copay 24 one-way trips to plan approved locations every year
Medicare Part B Prescription Drugs		
Chemotherapy Drugs	**In-Network** 20% coinsurance **Out-of-Network** Not Covered	**In-Network** $50 copay **Out-of-Network** Not Covered
Other Part B Drugs	**In-Network** 20% coinsurance **Out-of-Network** Not Covered	**In-Network** 20% coinsurance **Out-of-Network** Not Covered
Foot Care (Podiatry Services)		
Medicare-covered Foot Exams & Treatment	**In-Network** $30 copay **Out-of-Network** Not Covered	**In-Network** $20 copay **Out-of-Network** Not Covered
Medical Equipment / Supplies		
Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-Network** 20% coinsurance **Out-of-Network** Not Covered	**In-Network** 20% coinsurance **Out-of-Network** Not Covered
Prosthetics (e.g., braces, artificial limbs)	**In-Network** 20% coinsurance **Out-of-Network** Not Covered	**In-Network** 20% coinsurance **Out-of-Network** Not Covered

	Bright Advantage Choice (HMO-POS)	Bright Advantage Choice Plus (HMO-POS)
Diabetic Monitoring Supplies	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
Therapeutic Shoes or Inserts	**In-Network** $0 copay **Out-of-Network** Not Covered	**In-Network** $0 copay **Out-of-Network** Not Covered
Outpatient Surgery		
Ambulatory Surgical Center	**In-Network** $200 copay **Out-of-Network** Not Covered	**In-Network** $145 copay **Out-of-Network** Not Covered
Outpatient Hospital Facility	**In-Network** $250 copay **Out-of-Network** Not Covered	**In-Network** $215 copay **Out-of-Network** Not Covered
Fitness Program	Not Covered	$0 copay at participating locations
Over-the-Counter (OTC) Debit Card	Not Covered	$0 copay $30 allowance every three months to be used toward the purchase of OTC health and wellness products.

*The annual out-of-pocket maximum does not apply to Part D prescription drugs or Bright Health Extra Benefits.

Some services may require prior authorization. Refer to your Evidence of Coverage for details.

Bright Health plans are HMOs and PPOs with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal.

To enroll in a Bright Health Medicare Advantage Plan, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in the plan's service area.

Bright Health Extra Benefits Information

To find network providers for the following services, call Bright Health Member Services at 844-202-4129, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

- Hearing
- Vision
- Dental

Fitness Membership: Offered through Silver&Fit® Fitness program. To find a participating facility near you, call Bright Member Services at 844-202-4129, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

Over-the-Counter (OTC): Offered through InComm. For more information, call Bright Member Services at 844-202-4129, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

Transportation: For more information, call Bright Member Services at 844-202-4129, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

Prescription Drug Benefits

The chart below outlines your costs. The tier your drugs are in will determine how much you will pay. Generally, the higher the tier, the higher the cost.

Prescription Drug Coverage	Bright Advantage Choice (HMO-POS)		Bright Advantage Choice Plus (HMO-POS)	
Stage 1: Annual Prescription Deductible				
Deductible	$50 for Tiers 3-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.		$0 This plan has no deductible for Part D drugs, this payment stage doesn't apply.	
Stage 2: Initial Coverage (after you pay your deductible, if applicable)				
	Standard retail cost-sharing (30-day / 90-day supply)	**Standard mail-order cost-sharing** (up to a 90-day supply)	**Standard retail cost-sharing** (30-day / 90-day supply)	**Standard mail-order cost-sharing** (up to a 90-day supply)
Tier 1 (Preferred Generic)	$0/$0 copay	$0 copay	$0/$0 copay	$0 copay
Tier 2 (Generic)	$8/$24 copay	$16 copay	$8/$24 copay	$0 copay
Tier 3 (Preferred Brand)	$45/$135 copay	$135 copay	$45/$135 copay	$135 copay
Tier 4 (Non-Preferred Drug)	$95/$285 copay	$285 copay	$95/$285 copay	$285 copay
Tier 5 (Specialty Tier)	32% coinsurance	32% coinsurance	33% coinsurance	33% coinsurance
Stage 3: Coverage Gap				
After your yearly total drug costs (including what our plan has paid and what you have paid) reach $3,820, you will enter the coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. Not everyone will enter the coverage gap. If you enter the coverage gap, you will pay no more than 37% coinsurance for covered generic drugs or 25% coinsurance for covered brand name drugs until your costs total $5,100, which is the end of the coverage gap.				
Stage 4: Catastrophic Coverage				
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% coinsurance, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copay for all other drugs.				

Long-term care facilities

If you reside in a long-term care facility, you pay the same copays and coinsurance for a 31-day supply as a 30-day supply at a retail pharmacy.

Out-of-network pharmacies

If you choose to get drugs from an out-of-network pharmacy, you will pay the full cost of the prescription. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Extra Help

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at http://www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Our plans are issued through Bright Health Insurance Company or one of its affiliates. Other providers and pharmacies are available in our network. Most network providers participate through our Care Partner.

Out-of-network/noncontracted providers are under no obligation to treat Bright Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 844-667-5502 (TTY: 711) for more information.

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 844-667-5502.

Understand the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.brighthealthplan.com/medicare or call 844-667-5502 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understand 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 copays/co-insurance may change on January 1 of each year.

- 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 situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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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 (844) 606-4633.

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 (844) 202-2154.

"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.

Updated 06/29/2018

Section 1557 / Multi Language Insert

This information is available in other formats like large print. To ask for another format, please call (844) 606-4633.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (844) 606-4633.
Spanish (US)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de ayuda con el idioma. Llame al (844) 606-4633.
Chinese (S)	注意：如果您讲中文，您可以获得免费的语言协助服务。请致电 (844) 606-4633。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, то услуги бесплатной языковой поддержки доступны Вам. Позвоните по телефону (844) 606-4633.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 606-4633 로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (844) 606-4633.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero (844) 606-4633.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט ייִדיש, שפּראך הילף סערוויסעס, פריי פון אָפּצאָל, זענען פאראן פאר אייך. רופט (844) 606-4633
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে, আপনার জন্য উপলব্ধ আছে। (844) 606-4633 নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متاحة لك من دون مقابل. اتصل على الرقم (844) 606-4633.
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić pod numer (844) 606-4633.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le (844) 606-4633.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyong pangwika. Tawagan ang (844) 606-4633.
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 (844) 606-4633.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí bee yáníłti'go Diné bizaad, saad bee áká'ánida'áwo'dęę', t'áá jiik'eh, ná hóló. Kojį' hódíílnih (844) 606-4633.
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، بلامعاوضہ دستیاب ہیں۔ 606-4633 (844) پر کال کریں۔
Japanese	ご注意：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。(844) 606-4633 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 (844) 606-4633.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter (844) 606-4633 an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات پشتیبانی زبانی به صورت رایگان در اختیار شماست. با 4633 -606 (844) تماس بگیرید.

For more information, call Bright Health: 844-667-5502

8 am - 8 pm local time

7 days a week Oct. 1-Mar. 31

Monday-Friday Apr. 1-Sept. 30

TTY: 711

or

Go online: www.brighthealthplan.com/medicare

Find Bright Health’s provider directory, pharmacy directory, and formulary (drug list) at www.brighthealthplan.com/medicare