In Partnership

bright HEALTH | TriStar Health

Bright Advantage Flex Choice (PPO) offered by Bright Health

Annual Notice of Changes for 2020

You are currently enrolled as a member of Bright Advantage Flex (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.1 and 2.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 2.6 for information about changes to our drug coverage.

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(Expires: December 31, 2021)

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** Bright Advantage Flex (PPO), you don't need to do anything. You will stay in Bright Advantage Flex (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Bright Advantage Flex (PPO).
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- Please contact our Member Services number at (844) 202-4025 for additional information. (TTY users should call 711). Hours are October 1st through March 31st: Monday through Sunday, 8am - 8pm local time, excluding Federal holidays. April 1st through September 30th: Monday through Friday, 8am - 8pm local time, excluding Federal holidays.
- This document may be available in alternate formats such as Braille, large print or audio.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Bright Advantage Flex Choice (PPO)

- 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.
- When this booklet says "we," "us," or "our," it means Bright Health. When it says "plan" or "our plan," it means Bright Advantage Flex Choice (PPO).

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Bright Advantage Flex Choice (PPO) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at https://brighthealthplan.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: $5,900 From network and out-of-network providers combined: $10,000	From network providers: $5,900 From network and out-of-network providers combined: $10,000
Doctor office visits	Primary care visits: In-Network: $0 copay per visit Out-of-Network: 45% coinsurance per visit Specialist visits: In-Network: $35 copay per visit Out-of-Network: 45% coinsurance per visit	Primary care visits: In-Network: $0 copay per visit Out-of-Network: 35% coinsurance per visit Specialist visits: In-Network: $35 copay per visit Out-of-Network: 35% coinsurance per visit

Cost	2019 (this year)	2020 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In-Network: $275 copay each day for days 1 to 5 and $0 copay each day for days 6 to 90 for Medicare-covered hospital care. $0 copay for additional Medicare-covered days. Out-of-Network: 45% coinsurance per stay.	In-Network: $275 copay each day for days 1 to 5 and $0 copay each day for days 6 to 90 for Medicare-covered hospital care. $0 copay for additional Medicare-covered days. Out-of-Network: 35% coinsurance per stay.
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $100 for your Tier 3, Tier 4, and Tier 5 drugs Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 copay • Drug Tier 2: $8 copay • Drug Tier 3: $45 copay • Drug Tier 4: $95 copay • Drug Tier 5: 31% coinsurance	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $8 copay • Drug Tier 3: $39 copay • Drug Tier 4: $92 copay • Drug Tier 5: 33% coinsurance • Drug Tier 6: $0 copay

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2020, our plan name will change from Bright Advantage Flex (PPO) to Bright Advantage Flex Choice (PPO).

This name change will not impact any other communications you receive from us. You will receive a new member ID card through the mail in January 2020.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Optional benefits monthly premium Comprehensive dental Additional Eye Wear	$20 $4	$20 $4
One of the benefits of our plan includes is a Part B Premium Rebate. This means that each month $25 is automatically applied to your Part B Premium, increasing your Social Security check each month.	$25	$25

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 2.2 Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$5,900**	**$5,900** Once you have paid $5,900 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$10,000**	**$10,000** Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 2.3 Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at https://brighthealthplan.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please**

review the 2020 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

Our network has changed more than usual for 2020. An updated Pharmacy Directory is located on our website at https://brighthealthplan.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **We strongly suggest that you review our current Pharmacy Directory to see if your pharmacy is still in our network.**

Section 2.5 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Ambulance services - Ground transportation	You pay a $195 copay for each Medicare-covered service.	You pay a $200 copay for each Medicare-covered service.
Annual routine physical exam	**Out-of-Network** You pay a 45% coinsurance.	**Out-of-Network** You pay a 35% coinsurance.
Cardiac rehabilitation services - Intensive	**In-Network** You pay a $25 copay for each Medicare-covered service.	**In-Network** You pay a $50 copay for each Medicare-covered service.
Cardiac rehabilitation services - Intensive	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Cardiac rehabilitation services - Non-Intensive	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Chiropractic services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Colorectal cancer screening - Medicare-covered Barium Enema Preventive Services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Dental services - Comprehensive Dental Services	Up to a $1,000 allowance for all in-network and out-of-network covered services every year.	Up to a $1,500 allowance for all in-network and out-of-network covered services every year.
Diabetes self-management training, diabetic services and supplies - Diabetic monitoring supplies	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Diabetes self-management training, diabetic services and supplies - Diabetes self-management training	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.

Cost	2019 (this year)	2020 (next year)
Diabetes self-management training, diabetic services and supplies - Diabetic therapeutic shoes or inserts	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Durable medical equipment (DME) and related supplies - Durable medical equipment	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Hearing services - Medicare-covered hearing exam	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Hearing services - Additional routine hearing exams	**Out-of-Network** You pay a 45% coinsurance.	**Out-of-Network** You pay a 35% coinsurance.
Hearing services - Fitting-evaluation(s) for hearing aids	**In-Network** You pay a $0 copay.	**In-Network** Not covered
Hearing services - Fitting-evaluation(s) for hearing aids - Periodicity	Limited to 1 visit(s) every year.	Not covered
Hearing services - Hearing aids - All types - Periodicity	Unlimited hearing aids every year.	Not covered
Hearing services - Hearing aids	Up to a $1,000 allowance for both ears combined every three years for hearing aids.	Not covered
Home health agency care	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Inpatient hospital care	**Out-of-Network** You pay a 45% coinsurance per stay for Medicare-covered hospital care.	**Out-of-Network** You pay a 35% coinsurance per stay for Medicare-covered hospital care.

Cost	2019 (this year)	2020 (next year)
Inpatient mental health care	**Out-of-Network** You pay a 45% coinsurance each day for days 1 to 90 for Medicare-covered hospital care.	**Out-of-Network** You pay a 35% coinsurance each day for days 1 to 90 for Medicare-covered hospital care.
Medicare Part B prescription drugs - Chemotherapy drugs	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Medicare Part B prescription drugs - Part B drugs	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Opioid Treatment Program Services	**In-Network** Not covered	**In-Network** You pay a $0 copay for each Medicare-covered service.
Opioid Treatment Program Services	**Out-of-Network** Not covered	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Outpatient blood services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic procedures and tests	**In-Network** You pay a 20% coinsurance for each Medicare-covered service.	**In-Network** You pay a $200 copay for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic procedures and tests	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic radiological services	**In-Network** You pay a 20% coinsurance for each Medicare-covered service.	**In-Network** You pay a $35 - $200 copay depending on the Medicare-covered service.

Cost	2019 (this year)	2020 (next year)
Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic radiological services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Lab services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Medical supplies	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services	**In-Network** You pay a $15 copay for each Medicare-covered service.	**In-Network** You pay a $0 copay for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Therapeutic radiological services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient mental health care - Non-psychiatric services - Group sessions	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient mental health care - Non-psychiatric services - Individual sessions	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient mental health care - Psychiatric services - Group sessions	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.

Cost	2019 (this year)	2020 (next year)
Outpatient mental health care - Psychiatric services - Individual sessions	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient rehabilitation services - Occupational therapy	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient rehabilitation services - Physical therapy and speech-language pathology	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient substance abuse services - Group sessions	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient substance abuse services - Individual sessions	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Ambulatory surgical center	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital observation	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.

Cost	2019 (this year)	2020 (next year)
Partial hospitalization services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Physician/Practitioner services, including doctor's office visits - Medicare-covered comprehensive dental	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Physician/Practitioner services, including doctor's office visits - Primary care	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Physician/Practitioner services, including doctor's office visits - Specialist	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Physician/Practitioner services, including doctor's office visits - Other healthcare professionals	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Podiatry services - Medicare-covered	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Prostate cancer screening exams - Digital rectal exam	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Prosthetic devices and related supplies - Prosthetic devices	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Pulmonary rehabilitation services	**In-Network** You pay a $25 copay for each Medicare-covered service.	**In-Network** You pay a $0 copay for each Medicare-covered service.

Cost	2019 (this year)	2020 (next year)
Pulmonary rehabilitation services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Services to treat kidney disease and conditions - Kidney disease education services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Skilled nursing facility (SNF) care	**In-Network** You pay a $0 copay each day for days 1 to 20 and $172 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care.	**In-Network** You pay a $0 copay each day for days 1 to 20 and $178 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care.
Skilled nursing facility (SNF) care	**Out-of-Network** You pay a 45% coinsurance each day for days 1 to 100 for Medicare-covered skilled nursing facility care.	**Out-of-Network** You pay a 35% coinsurance each day for days 1 to 100 for Medicare-covered skilled nursing facility care.
Supervised Exercise Therapy (SET)	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Vision care - Glaucoma screening	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Vision care - Medicare-covered eye exam	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Vision care - Medicare-covered eyewear	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.

Cost	2019 (this year)	2020 (next year)
"Welcome to Medicare" Preventive Visit - Medicare-covered EKG following Welcome Visit Preventive Services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Other Medicare-covered preventive services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.
Preventive services	**Out-of-Network** You pay a 45% coinsurance for each Medicare-covered service.	**Out-of-Network** You pay a 35% coinsurance for each Medicare-covered service.

Section 2.6 Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy.

If you have received a formulary exception to a medication this year, the formulary exception request is approved through the date indicated in the approval letter. A new formulary exception request is only needed if the date indicated on the letter has passed.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30th, 2019, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the Evidence of Coverage, which is located on our website at https://brighthealthplan.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	The deductible is $100. During this stage, you pay $2 cost-sharing for drugs on Tier 1: Preferred Generic and $8 cost-sharing for drugs on Tier 2: Generic and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you have reached the yearly deductible.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:	Your cost for a one-month supply filled at a network pharmacy:
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy.	Tier 1: Preferred Generic: You pay $2 per prescription.	Tier 1: Preferred Generic: *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $0 per prescription at a preferred network pharmacy.

Stage	2019 (this year)	2020 (next year)
For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost-sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage.	Tier 2: Generic: *Standard cost-sharing:* You pay $8 per prescription.	Tier 2: Generic: *Standard cost-sharing:* You pay $16 per prescription. *Preferred cost-sharing:* You pay $8 per prescription at a preferred network pharmacy.
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Tier 3: Preferred Brand: *Standard cost-sharing:* You pay $45 per prescription.	Tier 3: Preferred Brand: *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $39 per prescription at a preferred network pharmacy.
	Tier 4: Non-Preferred Drug: *Standard cost-sharing:* You pay $95 per prescription.	Tier 4: Non-Preferred Drug: *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $92 per prescription at a preferred network pharmacy.
	Tier 5: Specialty Tier Drugs: *Standard cost-sharing:* You pay 31% of the total cost.	Tier 5: Specialty Tier Drugs: *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost at a preferred network pharmacy.

Stage	2019 (this year)	2020 (next year)
		Tier 6: Select Care Drugs: *Standard cost-sharing:* You pay $0 per prescription. *Preferred cost-sharing:* You pay $0 per prescription at a preferred network pharmacy.
	_____ Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in Bright Advantage Flex Choice (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 3.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,

- --*OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Bright Health offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Bright Advantage Flex Choice (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Bright Advantage Flex Choice (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage Plan for January 1, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug

coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Tennessee, the SHIP is called Tennessee State Health Insurance Assistance Program (SHIP).

Tennessee State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Tennessee State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Tennessee State Health Insurance Assistance Program (SHIP) at 1-877-801-0044. You can learn more about Tennessee State Health Insurance Assistance Program (SHIP) by visiting their website (http://tnmedicarehelp.com/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program (ADAP). For

information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800- 525-2437.

SECTION 7 Questions?

Section 7.1 Getting Help from Bright Advantage Flex Choice (PPO)

Questions? We're here to help. Please call Member Services at (844) 202-4025. (TTY only, call 711.) We are available for phone calls October 1st through March 31st: Monday through Sunday, 8am - 8pm local time, excluding Federal holidays. April 1st through September 30th: Monday through Friday, 8am - 8pm local time, excluding Federal holidays. Calls to these numbers are free.

Read your 2020 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for Bright Advantage Flex Choice (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at https://brighthealthplan.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at https://brighthealthplan.com/medicare. As a reminder our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.

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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.

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
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, 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.

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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 יידיש, עס זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אָפּצאָל. רופט די מעמבער סערוויסעס נומער אויף אייערע אייַ־די קאַרטל.
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.

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Amharic	ማሳሰቢያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ:: በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ::
Burmese	သင့်သည့် အဂၤလိပ်စကားမဟုတ်သော အျခားဘာသာစကားတစ်ခုအား ဂျဟာဆိုသျူဖစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မႈအား သင့်ရရွိနိုင်ပါသည့်။ သင့် ID (သက္သေခံ) ကတ္ျပားေပၚရွိ အဖ၇ြဝင်မ်ားဝန်ဆောင်မႈဌာနအား ဖုန်းခေၚဆိုပါ။
Cherokee	ᎣᏍᏓᎦᏍᏓᏓᏂ: ᏐᎢ ᎦᏬᏂᎯᏍᏗ ᎯᏬᏂᎯᏎ ᏏᏃ ᏯᎮᏏ, ᎦᏬᏂᎯᎯᏍᏓᏁ ᎠᎮᏍᎦᎮᏍᏗ ᎢᏁᏓᎾᏁᎯᎢ, ᏝᎪᎢᏍᏓᏁ ᏧᎬᎶᏁ ᎯᏯ D4ᏣᎢ, ᏂᎯ ᎡᏩᎾᏙᎢᏍᏓᏓᏁᏐᎢ. ᎾᏍᏗZ ᏯᎯᏍᎾ ᏈᏢ ᎠᎮᏍᎦᎮᏍᏗ Ꮑ4ᏍᏓᏁ ᎤᎾᎢ ᏣᏤᏢ ᎪᏣᏍᏓᏁᏁ ᏆᎾᏂᏍᏁ.
Cushite-Oromo	XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta’e, tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa keerra kan jiru lakkoofsa Tajaajilawwan Miseensaatti bilbili.
French Creole	ATANSYON : Si w pale yon lòt lang ke Angle, gen sèvis èd lengwistik ki disponib pou w gratis. Rele nimewo Sèvis pou manm yo nan kat idantite w la.
Gujarti	ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા સહાય સેવાઓ નિઃશુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્યની સેવાઓનાં નંબર પર કૉલ કરો.
Hindi	ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ़्त में भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबरों 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. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.
Karen	တိၢ်နိ၌ – နမ့ၢ်ကတိၤကျိာ်လၢတမ့ၢ်ဏဲကလံးကျိာ်ဘာ်နူာ်, ကျိာ်တၢ်တိစၢၤမၤစၢၤတၢ်မၤစၢၤတဖဉ်, လၢတလိာ်ဟ့ာ်ဇာပူၤတဖဉ်အိာ်လၢနဂီၢ်နူာ် လီၤ. ကိးကရၢဖိတၢ်မၤစၢၤတဖဉ် (နူနာ်ဘနမ့ာနမလၢခန္ဒ) ဇာနိဉ်ဂံၢ်ဖဲန တၢ်ဆုဉ်သးနိဉ်ဂံၢ်ခးက့ဇာဖိခိဉ်နူာ်တက့ၢ်.
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.
Kurdish	ئاگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریە زمانەوانیەکان بەخۆڕایی بۆ تۆ بەردەستن. پەیوەندی بە ژمارەی خزمەتگوزاری ئەندامانی سەر ناسنامەکەت بکە.
Laotian	ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID ຂອງທ່ານ.

Mon-Khmer
ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ សូមទូរស័ព្ទទៅលេខសេវាបម្រើសមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។

Nepali
ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाइँको लागि निःशुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। तपाइँको आइडी कार्डमा भएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।

Persian Farsi
توجه: در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد.
برای این منظور با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید

Serbo-Croatian
PAŽNJA: Ako govorite neki drugi jezik osim engleskog, dostupne su vam besplatne usluge za jezičnu pomoć. Pozovite broj službe za članove na vašoj ličnoj karti.

Syriac
ܐܙܕܗܪ: ܐܢ ܗܘ ܕܡܡܠܠܝܬܘܢ ܐܝܬܝܟ ܠܫܢܐ ܐܚܪܢܐ ܣܛܪ ܡܢ ܠܫܢܐ ܐܢܓܠܝܙܝܐ: ܗܒ ܠܐܠܘܟ ܚܘܕܡܬܐ ܕܡܥܕܪܢܘܬܐ ܕܠܫܢܐ
ܒܠܐ ܦܘܪܥܢܐ. ܘܠܐ ܩܪܝܬܐ ܠܟܘܢ ܡܢܝܢܐ ܕܡܫܡܫܢܘܬܐ ܕܗܕܡܐ (Member Services).

Thai
ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษาจัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขให้บริการสมาชิกที่บัตรประจำตัวของคุณ

Turkish
DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak faydalanabilirsiniz. Kimlik kartınızın üzerindeki numaradan Üye Hizmetlerini arayın.

Ukrainian
УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними послугами мовної підтримки. Зателефонуйте до Відділу обслуговування учасників програми за телефоном, вказаним на вашій ідентифікаційній картці.