2020 Summary of Benefits

Bright Advantage Flex Choice (PPO)
H8364-001

Bright Advantage Flex Plus (PPO)
H8364-002

Bright Advantage Assist (PPO)
H8364-003

Welcome to Bright Health.

Enclosed you will find our summary of the health and drug services covered by Bright Advantage Flex Choice (PPO), Bright Advantage Flex Plus (PPO), and Bright Advantage Assist (PPO) plans from January 1, 2020 to December 31, 2020, for Chilton, Jefferson, Shelby, and Walker 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 844-679-2027, 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, out-of-area urgently needed services or out-of-area 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 844-679-2027.

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 Flex Choice (PPO), Bright Advantage Flex Plus (PPO), and Bright Advantage Assist (PPO) formulary, you can search and download our formulary online at www.brighthealthplan.com/medicare. Or you can call Bright Health at 844-679-2027 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.

844-679-2027, TTY: 711
8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30
www.brighthealthplan.com/medicare

If you'd like to know more about the coverage and costs of Original Medicare, please look in the 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.

This is a summary of drug and health services covered by Bright Advantage Flex Choice (PPO), Bright Advantage Flex Plus (PPO), and Bright Advantage Assist (PPO) , January 1, 2020 - December 31, 2020.

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.

Please contact us at 844-679-2027 for additional information. (TTY users should call 711.) Hours are 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30. You may also visit the website at www.brighthealthplan.com/medicare.

To join Bright Advantage Flex Choice (PPO), you must have both Medicare Part A and Medicare Part B, and live in our service area.

Bright Advantage Flex Choice (PPO) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.brighthealthplan.com/medicare. If you use providers that are not in our network, the plan may not pay for these services.

Premiums & Benefits

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Monthly Plan Premium	$0	$65	$28.70 As low as $0 based on your level of "Extra Help."
Deductible	$0	$0	$0
Maximum Out-Of-Pocket Amount	From network providers: $4,900* From network and out-of-network providers combined: $10,000*	From network providers: $3,200* From network and out-of-network providers combined: $5,100*	From network providers: $6,700* From network and out-of-network providers combined: $10,000*
Part B Premium Reduction	One of the benefits 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.	Not covered	Not covered

Benefits

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Inpatient Hospital Coverage	**In-Network** $250 copay each day for days 1 to 6 and $0 copay each day for days 7 to 90 $0 copay for additional Medicare-covered days. **Out-of-Network** 35% coinsurance each day	**In-Network** $150 copay each day for days 1 to 6 and $0 copay each day for days 7 to 90 $0 copay for additional Medicare-covered days. **Out-of-Network** 35% coinsurance each day	**In-Network** $200 copay each day for days 1 to 6 and $0 copay each day for days 7 to 90 $0 copay for additional Medicare-covered days. **Out-of-Network** 35% coinsurance each day
Outpatient Hospital Coverage			
Outpatient hospital services	**In-Network** $300 copay **Out-of-Network** 35% coinsurance	**In-Network** $215 copay **Out-of-Network** 35% coinsurance	**In-Network** $215 copay **Out-of-Network** 35% coinsurance
Outpatient hospital observation services	**In-Network** $300 copay **Out-of-Network** 35% coinsurance	**In-Network** $215 copay **Out-of-Network** 35% coinsurance	**In-Network** $215 copay **Out-of-Network** 35% coinsurance
Services provided at an ambulatory surgical center	**In-Network** $200 copay **Out-of-Network** 35% coinsurance	**In-Network** $145 copay **Out-of-Network** 35% coinsurance	**In-Network** $175 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Doctor Visits			
Primary Care Providers	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Specialists	**In-Network** $35 copay **Out-of-Network** 35% coinsurance	**In-Network** $20 copay **Out-of-Network** 35% coinsurance	**In-Network** $25 copay **Out-of-Network** 35% coinsurance
Annual Routine Physical Exam	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Any additional preventive services approved by Medicare during the contract year will be covered.	• Abdominal aortic aneurysm screening • Alcohol misuse counseling • 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		

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
	• HIV screening • Lung cancer screening • Medical nutrition therapy services • Medicare Diabetes Prevention Program • 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) • Annual Wellness Visit		
Emergency Care	$90 copay Copayment is waived if you are admitted to a hospital within 24 hours.	$90 copay Copayment is waived if you are admitted to a hospital within 24 hours.	$90 copay Copayment is waived if you are admitted to a hospital within 24 hours.
Urgently Needed Services	$35 copay Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	$30 copay Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	$35 copay Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.
Diagnostic Services/Labs/Imaging Diagnostic tests and procedures	**In-Network** $200 copay **Out-of-Network** 35% coinsurance	**In-Network** $50 copay **Out-of-Network** 35% coinsurance	**In-Network** $125 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Lab services	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $15 copay **Out-of-Network** 35% coinsurance
Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $35 - $200 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 - $50 copay **Out-of-Network** 35% coinsurance	**In-Network** $25 - $125 copay **Out-of-Network** 35% coinsurance
Outpatient X-rays	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Hearing Services			
Exam to diagnose and treat hearing and balance issues	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Routine hearing exam	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Fitting-evaluation(s) for hearing aids	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *Limited to 1 visit(s) every year*	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *Limited to 1 visit(s) every year*

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Hearing aids	Not covered	Up to a $750 allowance for every year for hearing aids.	Up to a $750 allowance for every year for hearing aids.
Dental Services			
Medicare-covered dental services	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 35% coinsurance for each Medicare-covered service.	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 35% coinsurance for each Medicare-covered service.	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 35% coinsurance for each Medicare-covered service.
Annual dental benefit maximum	Up to a $1,500 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.	Up to a $1,500 allowance for all in-network and out-of-network covered services every year.
• Oral Exams	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 oral exam(s) every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 oral exam(s) every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 oral exam(s) every year*

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
• Prophylaxis (Cleaning)	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 cleaning(s) every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 cleaning(s) every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 cleaning(s) every year*
• Fluoride Treatment	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 1 fluoride treatment(s) every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 1 fluoride treatment(s) every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 1 fluoride treatment(s) every year*
• Dental X-Rays	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 x-ray(s)*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 x-ray(s)*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 x-ray(s)*
• Non-Routine Services	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies
• Diagnostic Services	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** $0 copay **Out-of-Network** Coinsurance varies	**In-Network** $0 copay **Out-of-Network** 30% - 75% coinsurance

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
• Restorative Services	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Coinsurance varies **Out-of-Network** Coinsurance varies	**In-Network** Coinsurance varies **Out-of-Network** Coinsurance varies
• Periodontics	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies
• Endodontics	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies
• Extractions	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies
• Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies	**In-Network** 50% coinsurance **Out-of-Network** Coinsurance varies

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Comprehensive Dental Services	$22 monthly premium Copayments vary by service. Please refer to your Evidence of Coverage for details.	Included in your plan monthly premium Copayments vary by service. Please refer to your Evidence of Coverage for details.	Already included in your plan monthly premium Copayments vary by service. Please refer to your 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** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Routine eye exam	**In-Network** $0 copay **Out-of-Network** $0 copay *Limited to 1 visit(s) every year*	**In-Network** $0 copay **Out-of-Network** $0 copay *Limited to 1 visit(s) every year*	**In-Network** $0 copay **Out-of-Network** $0 copay *Limited to 1 visit(s) every year*
Eyewear after cataract surgery	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Contact lenses	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Available once every other calendar year. Contacts are in lieu of glasses. Contact lens exam (fitting and evaluation) $60 maximum copay $130 allowance towards prescription contact lenses. **Out-of-Network** Available once every other calendar year. Contacts are in lieu of glasses. Contact lens exam (fitting and evaluation) $60 maximum copay $130 allowance towards prescription contact lenses.	**In-Network** Available once every other calendar year. Contacts are in lieu of glasses. Contact lens exam (fitting and evaluation) $60 maximum copay $130 allowance towards prescription contact lenses. **Out-of-Network** Available once every other calendar year. Contacts are in lieu of glasses. Contact lens exam (fitting and evaluation) $60 maximum copay $130 allowance towards prescription contact lenses.

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Eyeglasses (lenses and frames)	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Available once every other calendar year. $25 copay Coverage includes single vision, lined bifocals, lined trifocals, lenticular lenses and a $130 allowance towards a frame. **Out-of-Network** Available once every other calendar year. $25 copay Coverage includes single vision, lined bifocals, lined trifocals, lenticular lenses and a $130 allowance towards a frame.	**In-Network** Available once every other calendar year. $25 copay Coverage includes single vision, lined bifocals, lined trifocals, lenticular lenses and a $130 allowance towards a frame. **Out-of-Network** Available once every other calendar year. $25 copay Coverage includes single vision, lined bifocals, lined trifocals, lenticular lenses and a $130 allowance towards a frame.
Optional Vision Care - Additional Eye Wear	$4 monthly premium Up to a $130 allowance towards eyeglasses (lenses and frames) or contact lenses.	These benefits are already included in your plan.	These benefits are already included in your plan.

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Mental Health Services			
Outpatient group therapy visit	**In-Network** $10 copay **Out-of-Network** 35% coinsurance	**In-Network** $10 copay **Out-of-Network** 35% coinsurance	**In-Network** $10 copay **Out-of-Network** 35% coinsurance
Outpatient individual therapy visit	**In-Network** $40 copay **Out-of-Network** 35% coinsurance	**In-Network** $40 copay **Out-of-Network** 35% coinsurance	**In-Network** $25 copay **Out-of-Network** 35% coinsurance
Inpatient visit	**In-Network** $250 copay each day for days 1 to 6 and $0 copay each day for days 7 to 90 $0 copay for an additional 60 lifetime reserve days. **Out-of-Network** 35% coinsurance each day for days 1 to 90	**In-Network** $150 copay each day for days 1 to 6 and $0 copay each day for days 7 to 90 $0 copay for an additional 60 lifetime reserve days. **Out-of-Network** 35% coinsurance each day for days 1 to 90	**In-Network** $200 copay each day for days 1 to 6 and $0 copay each day for days 7 to 90 $0 copay for an additional 60 lifetime reserve days. **Out-of-Network** 35% coinsurance each day for days 1 to 90
Skilled Nursing Facility (SNF) Care	**In-Network** $0 copay each day for days 1 to 20 and $178 copay each day for days 21 to 100 **Out-of-Network** 35% coinsurance each day for days 1 to 100	**In-Network** $20 copay each day for days 1 to 20 and $178 copay each day for days 21 to 100 **Out-of-Network** 35% coinsurance each day for days 1 to 100	**In-Network** $0 copay each day for days 1 to 20 and $178 copay each day for days 21 to 100 **Out-of-Network** 35% coinsurance each day for days 1 to 100

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Physical Therapy	**In-Network** $30 copay **Out-of-Network** 35% coinsurance	**In-Network** $20 copay **Out-of-Network** 35% coinsurance	**In-Network** $30 copay **Out-of-Network** 35% coinsurance
Ambulance Services Ground Ambulance Air Ambulance	$200 copay $250 copay	$200 copay $225 copay	$200 copay $225 copay
Transportation (Additional Routine)	Not covered	$0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by taxi, van, or rideshare services to a plan approved health-related location.	$0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by taxi, van, or rideshare services to a plan approved health-related location.
Medicare Part B Prescription Drugs Chemotherapy drugs	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Other Part B drugs	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance

Additional Benefits

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Health Club & Fitness Membership	$0 copay at participating locations	$0 copay at participating locations	$0 copay at participating locations
Medical Equipment and Supplies			
Diabetic monitoring supplies	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Durable medical equipment	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance
Prosthetics	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance

	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Therapeutic shoes or inserts	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Over-the-Counter (OTC) Debit Card	Not covered	$20 allowance every month to be used toward the purchase of OTC health and wellness products.	$30 allowance every month to be used toward the purchase of OTC health and wellness products.
Podiatry Services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**In-Network** $30 copay **Out-of-Network** 35% coinsurance	**In-Network** $20 copay **Out-of-Network** 35% coinsurance	**In-Network** $20 copay **Out-of-Network** 35% coinsurance

*Part B prescription drugs and optional supplemental benefits do not apply to the annual out-of-pocket maximum.

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

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 Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Stage 1: Annual Prescription Deductible			
Deductible	$50 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.	This plan has no deductible for Part D drugs, this payment stage doesn't apply.	For drugs in Tiers 2-5 your deductible amount is either $0 or $89 depending on the level of "Extra Help" you receive (look at the separate insert, the "LIS Rider" for your deductible amount). If you do not qualify for "Extra Help" from Medicare to pay for your prescription drug costs, your deductible is $435.
Stage 2: Initial Coverage (after you pay your deductible, if applicable)			
Preferred retail cost-sharing (30-day/90-day supply)			
Tier 1 (Preferred Generic)	$0/$0 copay	$0/$0 copay	Depending on your level of "Extra Help," you only have to pay the following cost-sharing amounts for your prescription drugs:
Tier 2 (Generic)	$8/$16 copay	$8/$16 copay	

Prescription Drug Coverage	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Tier 3 (Preferred Brand)	$39/$78 copay	$39/$78 copay	for generic drugs (including brand drugs treated as generic) you pay either $0, $1.30, $3.60 copay, or 15% of the total cost; for all other covered drugs you pay either $0, $3.90, $8.95 copay, or 15% of the total cost. If you do not receive "Extra Help" please refer to your Evidence of Coverage (EOC) for your cost-sharing amounts for prescription drugs.
Tier 4 (Non-Preferred Drug)	$92/$184 copay	$92/$184 copay	
Tier 5 (Specialty Tier)	32% coinsurance / Not Available	33% coinsurance / Not Available	
Tier 6 (Select Care Drugs)	$0/$0 copay	$0/$0 copay	

Prescription Drug Coverage	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Standard retail cost-sharing (30-day/90-day supply)			
Tier 1 (Preferred Generic)	$8/$16 copay	$8/$16 copay	Depending on your level of "Extra Help," you only have to pay the following cost-sharing amounts for your prescription drugs: for generic drugs (including brand drugs treated as generic) you pay either $0, $1.30, $3.60 copay, or 15% of the total cost; for all other covered drugs you pay either $0, $3.90, $8.95 copay, or 15% of the total cost. If you do not receive "Extra Help" please refer to your Evidence of Coverage (EOC) for your cost-sharing amounts for prescription drugs.
Tier 2 (Generic)	$16/$32 copay	$16/$32 copay	
Tier 3 (Preferred Brand)	$47/$94 copay	$47/$94 copay	
Tier 4 (Non-Preferred Drug)	$100/$200 copay	$100/$200 copay	
Tier 5 (Specialty Tier)	32% coinsurance / Not Available	33% coinsurance / Not Available	
Tier 6 (Select Care Drugs)	$0/$0 copay	$0/$0 copay	
Standard mail-order cost-sharing (up to 90 day supply)			
Tier 1 (Preferred Generic)	$0 copay	$0 copay	Depending on your level of "Extra Help," you only have to pay the following cost-sharing amounts for your prescription drugs:
Tier 2 (Generic)	$16 copay	$16 copay	

Prescription Drug Coverage	Bright Advantage Flex Choice (PPO)	Bright Advantage Flex Plus (PPO)	Bright Advantage Assist (PPO)
Tier 3 (Preferred Brand)	$78 copay	$78 copay	for generic drugs (including brand drugs treated as generic) you pay either $0, $1.30, $3.60 copay, or 15% of the total cost; for all other covered drugs you pay either $0, $3.90, $8.95 copay, or 15% of the total cost. If you do not receive "Extra Help" please refer to your Evidence of Coverage (EOC) for your cost-sharing amounts for prescription drugs.
Tier 4 (Non-Preferred Drug)	$184 copay	$184 copay	
Tier 5 (Specialty Tier)	Not Available	Not Available	
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	
Stage 3: Coverage Gap			
After your total drug costs (including what our plan has paid and what you have paid) reach $4,020, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during 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 $6,350, you pay the greater of: • 5% coinsurance, or • $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs.			

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).

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.

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.

Bright Extra Benefits Information

To get more information on any of your benefits, please call us at 844-679-2027, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

Other providers are available in our network.

Out-of-network/non-contracted providers are under no obligation to treat Bright Advantage Flex Choice (PPO) members, except in emergency situations. Please call our member services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network providers.

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 844-679-2027.

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 844-679-2027 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 copayments/co-insurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ 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.

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
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 (844) 202-2154.

bright HEALTH

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 יידיש, שפראך 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.

Summary of Benefits

Kru/Bassa

YI LE: I balè u mpot Ngissi, bot ba ñhola ni kobol mahop, ngui nsaa wogui wo, bayé ha i nyuu yoñ. Sebel nsinga. Sebel nsinga (844) 606-4633

Serbo-Croatian

PAŽNJA: Ako govorite engleski, dostupne su vam besplatne usluge za jezičnu pomoć. Pozovite (844) 606-4633

Cherokee

ᏣᎧᏎᏍᏓ: ᎩᎵᏏ ᎯᎧᏂᏍᎧᎩ ᎠᎩ, ᎦᎧᏂᎯᎧᏍᏓ ᎠᎵᏍᎧᎦᏍᎧᎩ ᎢᏗᏓᎵᏁᏗᏗT, Ꮭ ᎪᎵᏍᏓ ᏧEᏩᎶᏗ ᎠᎩ D4ᏣTᏂᎯ ᏒᏣᎵᎤᏔᏍᏓᏓᏁᎢT. ᎤᏣᎾ (844) 606-4633

Burmese

သတိပြုရန်- အကယ်၍ သင်သည် အင်္ဂလိပ်ဘာသာစကားပြောသူ ဖြစ်ပါက အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ ရရှိနိုင်ပါသည်။ (844) 606-4633 သို့ ခေါ်ဆိုပါ

Gujarati

ધ્ય રરેજ , તો તમારા માટે ભાષા સહાય સેવાઓ ન્મિ શુલ્ક છે. (844) 606-4633 પર કૉલ કરો.

Hindi

ध्यान दें: यदि आप अंरि्। भाषा बोलते ग्रतो आपके लिए मु ्त में भाषा सहायता सेवाएं उपलब्ध ग्र (844) 606-4633 पर कॉल करें

Hmong

LUS TSEEM CEEB: Yog koj hais lus As Kiv, muaj kev pab cuam fab lus pab dawb rau koj. Hu rau tus xov tooj (844) 606-4633

Karen

တိၢ်နိၣ် – နမ့ၢ်ကတိၤဒဲကလံးကျိာ်နှၣ်, ကျိာ်တၢ်တိစၢၤမၤစၢၤတၢ်မၤစၢၤတဖဉ်အိဉ်လၢနဂိၢ်, လၢနမၤန့ၢ်အိၤသ့လၢအကလိနှၣ်လိၤ. ကိး (844) 606-4633

Khmer-Combodian

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាអង់គ្លេស យើងមានសេវាជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នក។ សូមទូរស័ព្ទមក (844) 606-4633

Nepali

ध्यान दिनुहोस्: तपाईं अङ्ग्रेजी भाषा बोल्नुहुन्छ भने, तपाईंको लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। (844) 606-4633 मा कल गर्नुहोस्

Turkish
DİKKAT: İngilizce konuşuyorsanız dil destek hizmetleri ücretsiz olarak sağlanacaktır. (844) 606-4633 numaralı hattı arayın.

Ukrainian
УВАГА! Якщо ви розмовляєте українською, то вам доступні безплатні послуги перекладу. Телефонуйте за номером (844) 606-4633.

Haitian-Creole
ATANSYON: Si w pale angle, gen sèvis èd lengwistik ki disponib pou w gratis. Rele nan (844) 606-4633

Lao
ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອັງກິດ, ການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ເສຍຄ່າແມ່ນມີໃຫ້ທ່ານ. ໂທ (844) 606-4633.

Cushite/Oromo
XIYYEEFFANNOO: Afaan Ingilizii kan dubbattu yoo ta'e, tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Bilbili (844) 606-4633

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (844) 606-4633

Kurdish
ئاگاداری: ئەگەر زمانی ئینگلیزی دەزانیت، خزمەتگوزاریەکانی زمان بە خۆڕایی بۆ تۆ بەردەستن. پەیوەندی بە (844)6064633 بکە.

Persian
ت‌وجه:گ‌ربنان انگلیسی صحبت میکنید خدمات کمکی زبانی به طور رایگان برای شما وجود داردب‌اش‌م‌اه 606-4633 (844)ت‌م‌اس بگیرید

Syriac
ܡܚܫܒܢܘܬܐ: ܐ ܗܘ ܒܡܫܟܚ ܐܝܠܐ ܟܐ ܐܢ ܐܝܟ ܡܐ ܐܢ ܐܬ ܡܬܟܠܡ ܒܠܫܢ ܐܢܓܠܝܐ ܫܝܪܘܬ ܕܥܙܪܐ ܠܠܫܢ ܕܡܬܐ ܠܟ ܒܚܢܡ. ܩܪܝ ܠ (844) 606-4633

Summary of Benefits

For more information, call Bright Health:

844-679-2027

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.