bright HEALTH

Ohio

# Bright Extra Optional Benefits Enrollment Form

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

| Choose Your Bright Extra Optional Benefits | | |
|---|---|---|
| **Contract** | **Optional Benefit Package** | **Premium** |
| ☐ **H1142-002**<br>Bright Advantage Plus (HMO) | **Combined Benefits Package 5**<br>Transportation Services<br>Over-the-Counter (OTC)<br>Eyewear<br>Hearing Aids | **$26**<br>Unlimited rides<br>$30 credit every month<br>$130 allowance every 2 years<br>$750 allowance per year |
| ☐ **H9878-001**<br>Bright Advantage Choice (PPO) | **Combined Benefits Package 2**<br>Transportation Services<br>Comprehensive Dental<br>Eyewear<br>Hearing Aids | **$34**<br>Unlimited rides<br>$1,500 limit<br>$130 allowance every 2 years<br>$750 allowance per year |
| ☐ **H9878-002**<br>Bright Advantage Choice Plus (PPO) | **Combined Benefits Package 10**<br>Transportation Services<br>Over-the-Counter (OTC)<br>Comprehensive Dental<br>Eyewear<br>Hearing Aids | **$42**<br>Unlimited rides<br>$30 credit every month<br>$1,500 limit<br>$130 allowance every 2 years<br>$750 allowance per year |

| Choose Your Bright Extra Optional Benefits (Continued) | | |
|---|---|---|
| **Contract** | **Optional Benefit** | **Premium** |
| ☐ H1142-001 Bright Advantage (HMO) | Comprehensive Dental 001 | $17 |
| ☐ H1142-001 Bright Advantage (HMO) | Comprehensive Vision 001 | $3.75 |
| ☐ H9878-006 Bright Advantage Flex Choice (PPO) | Comprehensive Dental 002 | $21 |
| ☐ H9878-006 Bright Advantage Flex Choice (PPO) | Comprehensive Vision 002 | $3.50 |

| **Personal Information** | | | |
|---|---|---|---|
| Bright Health Member ID: | | | |
| FIRST Name: | LAST Name: | | MI: |
| Birthdate (MM/DD/YYYY):<br>__ / __ / _____ | Sex: ☐ Male ☐ Female | | |
| Primary Phone Number:<br>____ - ____ - _____ | Alternate Phone Number:<br>____ - ____ - _____ | | |
| Email Address: _____<br>By giving my email address, I agree to receive email about my benefits, health programs and other plan services. | | | |
| Permanent Residence Street Address: (Don't enter a P.O. Box) | | | Apt or Suite: |
| City: | State: | ZIP Code: | County: |

## Please Read

Bright Health plans are HMOs and PPOs with a Medicare contract. Bright Health's New York D-SNP plan is an HMO with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal.

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

Please contact our Member Services number at **1-844-221-7736** for additional information. (TTY users should call 711). Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, Oct. 1 - March 31; Monday - Friday, April 1 - Sept. 30, excluding Federal holidays.

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

Bright Health serves a specific service area. If I move out of the area that Bright Health serves, I need to notify the plan, so I can disenroll and find a new plan in my new area. As a member of Bright Health, I have the right to appeal plan decisions about payment or services if I disagree.

I will read the Evidence of Coverage document from Bright Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that by adding Optional Supplemental Benefits to my Medicare Advantage plan within 30 days of enrollment effective date or can add Optional Supplemental Benefits with a valid Special Election Period, coverage becomes effective on the first of the month following receipt of the enrollment application. Services authorized by Bright Health and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization or eligibility in the optional benefits, NEITHER MEDICARE NOR BRIGHT HEALTH WILL PAY FOR THE SERVICES.

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

## Conditions of Enrollment

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

I understand that by adding Optional Supplemental Benefits to my Medicare Advantage plan, coverage becomes effective on the first of the month following receipt of the enrollment application. Members can add Optional Supplemental Benefits within 30 days of enrollment effective date or can add Optional Supplemental Benefits with a valid Special Election Period. Benefits will become effective the first of the month following receipt of the enrollment form.

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

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

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

Release of Information: By joining a supplemental benefit plan, I acknowledge that Bright Health will release my information to other parties for treatment, payment and health care operations, including without limitation to Medicare, other plans, providers, and Bright Health's Care Partner. I also acknowledge that Bright Health may release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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

| Name: | Date: |
| --- | --- |
| | |

## Payment

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

## Authorized Representative

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

| First Name | Last Name |
|---|---|
| Mailing Address, City, State, ZIP Code | |
| Primary Phone Number | Relationship to Applicants |

## Please Read

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

## Signature of Applicant or Authorized Representative

| **Signature:** | **Today's Date:** |
|---|---|

**Please return your completed application to:**

**Bright Health Plan**
**P.O. Box 853958**
**Richardson, TX 75085-3958**

**Fax: 1-800-208-7647**