Bright HealthCare™

Bright Advantage Embrace Care Plan (HMO C-SNP) offered by Bright HealthCare

Annual Notice of Changes for 2022

You are currently enrolled as a member of Bright Advantage Senior Savings (HMO C-SNP). 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 3.2 and 3.5 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 2022 Drug List and look in Section 3.6 for information about changes to our drug coverage.

- 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 go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. 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 3.3 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 www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You 2022 handbook.
- Look in Section 5.2 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 don't join another plan by December 7, 2021, you will be enrolled in Bright HealthCare.
- 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**

- If you don't join another plan by **December 7,** 2021, you will be enrolled in Bright Advantage Embrace Care Plan.
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1**, You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Chinese and Spanish.
- Please contact our Member Services number at (844) 926-4521 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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Bright Advantage Embrace Care Plan

- Bright HealthCare plans are HMOs and PPOs with a Medicare contract. Bright HealthCare 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 HealthCare Insurance Company or one of its affiliates. Bright HealthCare 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 HealthCare. When it says "plan" or "our plan," it means Bright Advantage Embrace Care Plan.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Bright Advantage Embrace Care Plan 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 brighthealthcare.com/medicare. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 3.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 3.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: You pay $0 Specialist visits: You pay $0	Primary care visits: You pay $0 Specialist visits: You pay $0
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.	You pay $275 per day for days 1 - 5. You pay $0 for days 6 - 90.	You pay $275 per day for days 1 - 5. You pay $0 for days 6 - 90.

Part D prescription drug coverage (See Section 3.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $12 • Drug Tier 3: $47 • Drug Tier 4: $90 • Drug Tier 5: 33% • Drug Tier 6: $0	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $12 • Drug Tier 3: $47 • Drug Tier 4: $90 • Drug Tier 5: 33% • Drug Tier 6: $0 To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2022, our plan name will change from Bright Advantage Senior Savings to Bright Advantage Embrace Care Plan.

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 2022.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Bright Advantage Embrace Care Plan in 2022

If you do nothing to change your Medicare coverage by December 7, 2021, we will automatically enroll you in our Bright Advantage Embrace Care Plan. This means starting January 1, 2022, you will be getting your medical and prescription drug coverage through Bright Advantage Embrace Care Plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Bright Advantage Senior Savings and the benefits you will have on January 1, 2022 as a member of Bright Advantage Embrace Care Plan.

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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. Please see Section 8 regarding "Extra Help" from Medicare.

Section 3.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 3.3 – 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 brighthealthcare.com/madoctors. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2022 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 to manage your care.

Section 3.4 – 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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at brighthealthcare.com/madoctors. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2022 Pharmacy Directory to see which pharmacies are in our network.**

Section 3.5 – 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 2022 Evidence of Coverage.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Inpatient Hospital Services	You pay $0 for days after day 90.	Additional days after day 90 are not covered.

Cost	2021 (this year)	2022 (next year)
	Services do not require a referral.	Services may require a referral.
Psychiatric Inpatient Hospital	You pay $370 per day for days 1 - 5. Services do not require a referral.	You pay $325 per day for days 1 - 5. Services may require a referral.
Skilled Nursing Facility (SNF)	Services do not require a referral.	Services may require a referral.
Cardiac Rehabilitation **Cardiac and Pulmonary Rehabilitation Services**	You pay 20% of the total cost. Services do not require a referral.	You pay $0. Services may require a referral.
Emergency Services	You pay $90 per visit. Services do not require a referral. This copay is waived if you are admitted to the hospital within 24 hours.	You pay $0 if you are admitted to the emergency room within 72 hours of a previous emergency room discharge. You pay $90 per visit for all other emergency services. This copay is waived if you are admitted to the hospital within 3 days.
Urgently Needed Services	You pay $35 per visit.	You pay $0.
Worldwide Emergency/Urgent Coverage	You pay $90 for each Worldwide Emergency service. Worldwide Urgent service is not covered. Worldwide Emergency Transportation service is not covered. There is a maximum plan benefit coverage amount of $50,000.	You pay $90 for each Worldwide Emergency service. You pay $90 for each Worldwide Urgent service. You pay $90 for each Worldwide Emergency Transportation service. There is a maximum plan benefit coverage amount of $50,000 for worldwide emergency services, worldwide urgently needed

Cost	2021 (this year)	2022 (next year)
		services, and worldwide emergency transportation services combined.
Partial Hospitalization	Services do not require a referral.	Services may require a referral.
Home Health Services	Services do not require a referral.	Services may require a referral.
Medicare-Covered Chiropractic Services	You pay $20 per visit. Services do not require a referral.	You pay $0. Services may require a referral.
Routine Chiropractic Services	Routine chiropractic services are not covered.	You pay $0 for 30 visits per year. These visits are combined with routine acupuncture visits. Services may require a referral
Occupational Therapy Services	Services do not require a referral.	Services may require a referral.
Specialist Services	Services do not require a referral.	Services may require a referral.
Mental Health Specialty Services	You pay $20 per visit. Services do not require a referral.	You pay $25 per visit. Services may require a referral.
Medicare-Covered Podiatry Services	You pay 20% of the total cost per visit. Services do not require a referral.	You pay $20 per visit. Services may require a referral.
Other Health Care Professional Services	Services do not require a referral or prior authorization.	Services may require a referral and prior authorization
Psychiatric Services	Services do not require a referral.	Services may require a referral.
Physical Therapy and Speech Services	Services do not require a referral.	Services may require a referral.
Additional Telehealth Services	Services do not require prior authorization.	Services may require prior authorization.
Opioid Treatment Program Services	Services do not require prior authorization.	Services may require prior authorization.

Cost	2021 (this year)	2022 (next year)
Outpatient Diagnostic Procedures, Tests and Lab Services	You pay 20% of the total cost for diagnostic procedures and tests. You pay 20% of the total cost for lab services. Services do not require a referral.	You pay $0 for diagnostic colonoscopy and 20% of the total cost for all other services. You pay $0 for lab services. Services may require a referral. If you receive multiple services at the same location on the same day, the highest amount applies.
Outpatient Diagnostic and Therapeutic Radiological Services	You pay 20% of the total cost. Services do not require a referral.	You pay $0 for ultrasound, other general imaging, diagnostic DEXA scans and diagnostic mammograms and 20% of the total cost MRI, CT, and PET scans. Services may require a referral.
Outpatient Hospital Services	You pay 20% of the total cost. Services do not require a referral.	You pay $0 for diagnostic mammograms, DEXA scans, and colonoscopies in an outpatient hospital and 20% of the total cost for all other services. Services may require a referral.
Ambulatory Surgical Center (ASC) Services	You pay 20% of the total cost. Services do not require a referral.	You pay $0 for diagnostic mammograms, DEXA scans, and colonoscopies in an ambulatory surgical center and 20% of the total cost for all other services. Services may require a referral.
Outpatient Substance Abuse Services	Services do not require a referral.	Services may require a referral.

Cost	2021 (this year)	2022 (next year)
Outpatient Blood Services	If a provider has to buy blood for you from a blood bank, you are responsible to pay the cost or arrange to have the blood replaced (donated by you or someone else) for the first 3 pints of blood furnished during the calendar year.	You pay $0 for all blood services starting with the first pint.
Ambulance Services	You pay 20% of the total cost for ground ambulance services. You pay 20% of the total cost for air ambulance services.	You pay $0 for ground ambulance services for a transfer from an out-of-network hospital to an in-network hospital and 20% of the total cost for all other ground ambulance services. You pay $0 for air ambulance services for a transfer from an out-of-network hospital to an in-network hospital and 20% of the total cost for all other air ambulance services.
Durable Medical Equipment (DME)	You pay 20% of the total cost.	You pay $0 for Medicare-covered continuous glucose monitors and items $100 or less and 20% of the total cost for items greater than $100.
Prosthetics and Medical Supplies	You pay 20% of the total cost.	You pay $0 for items $100 or less and 20% of the total cost for items greater than $100.
Dialysis Services	Services do not require a referral.	Services may require a referral.
Routine Acupuncture	Routine acupuncture services are not covered.	You pay $0 for 30 visits per year. These visits are combined with routine chiropractic visits.

Cost	2021 (this year)	2022 (next year)
		Services may require a referral and prior authorization
Over-the-Counter (OTC) Items	You have a $100 allowance every three (3) months. Blood pressure cuff is not covered. Scale is not covered.	You have a $30 allowance every month. Blood pressure cuff will be provided at no cost to members with hypertension who do not meet Medicare guidelines for coverage and participate in a care management program. Scale is provided at no cost to members with kidney disease or chronic heart failure who do not meet Medicare guidelines for coverage and participate in a care management program.
Meal Benefit	You pay $0 for 3 meals per day as needed through the Bright HealthCare Care Coordinator's discretion. Prior authorization is not required.	You pay $0 for 14 meals per week, for 12 consecutive weeks (168 total meals). Nutritional consultation with a registered dietician is included to develop a healthy eating plan. Eligible chronic conditions for this benefit include diabetes, Congestive Heart Failure (CHF), cardiovascular disorders, dementia, chronic and disabling mental health conditions, kidney disease, and hypertension. Prior authorization may be required.

Cost	2021 (this year)	2022 (next year)
Continuous Glucose Monitor	Continuous glucose monitor is not covered.	A continuous glucose monitor will be provided at no cost for qualifying members who do not meet Medicare covered requirements for these devices.
Medicare-covered Zero Cost-Sharing Preventive Services	Services do not require a referral.	Services may require a referral.
Fitness Benefit	You pay $0 for an annual fitness center membership or home fitness kits. Services do not require a referral or prior authorization.	You pay $0 for an annual fitness center membership or home fitness kits. Also includes a one-on-one consultation with an exercise coach to develop an exercise plan either face to face or virtually once a year. Services may require a referral and prior authorization.
Health Education	Health education is not covered	You $0 For health education classes offered in group settings and as in-home 1-on-1 trainings for the homebound. Health Education materials are also provided at no cost, along with access to a website with live telephonic coaching, real time interventions, feedback, and goal setting. Services may require a referral and prior authorization.
Nurse Hotline	Nurse hotline is not covered.	You pay $0 for a 24/7 nurse advice line staffed by registered nurses. Nurses can triage conditions and forward calls to on-call physicians, psychiatrists, and other qualified providers as needed.

Cost	2021 (this year)	2022 (next year)
		Services may require a referral and prior authorization.
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) is not covered.	You pay $0 for a mobile PERS device with GPS and fall detection, 24/7/365 monitoring. Services may require a referral and prior authorization.
Kidney Disease Education Services	Services do not require a referral or prior authorization.	Services may require a referral and prior authorization.
Glaucoma Screening	Services do not require a referral or prior authorization.	Services may require referral and prior authorization.
Diabetes Self-Management Training	Services do not require a referral or prior authorization.	Services may require referral and prior authorization.
Barium Enemas	Services do not require a referral.	Services may require a referral.
Digital Rectal Exams	Services do not require a referral.	Services may require a referral.
EKG Following Welcome Visit	Services do not require a referral.	Services may require a referral.
Step therapy for Part B Drugs	There is no step therapy for Medicare Part B drugs.	Step therapy applies to Medicare Part B drugs. Step therapy means that you may be required to try a different, less expensive drug that treats the same condition before we will cover a more expensive drug. We cannot apply step therapy if you are already taking a Part B drug. We can only apply step therapy when you start a new Part B drug.
Dental Services	**Preventive Dental** Dental prophylaxis (cleaning) (up to 2 every year): You pay $0.	**Preventive Dental** Dental prophylaxis (cleaning) (up to 1 every year): You pay $0.

Cost	2021 (this year)	2022 (next year)
	Dental x-ray(s) (two set of bitewings every year and one radiographic image every three years): You pay $0. Oral exam (up to 2 every year): You pay $0. Fluoride treatment (up to one per year): You pay $0. **Comprehensive Dental** Medicare-covered services: You pay $0. Non-Routine services: You 50% coinsurance of the total cost. Diagnostic services: You pay $0. Restorative services: You pay 30% of the total cost for amalgam fillings and 50% of the total cost for post removal. Endodontic Services: You pay 50% of the total cost. Periodontic Services: You pay 50% of the total cost. Extractions: You pay 50% of the total cost. Prosthodontics, Other Oral/Maxillofacial Surgery: You pay 50% of the total cost. There is a maximum benefit of $1,500 for preventive and	Dental x-ray(s) (up to one set of bitewings every year and up to one radiographic image every three years): You pay $0. Oral exam (up to 2 every year): You pay $0. Fluoride treatment (1 every six months, maximum of 2 per year): You pay $0. **Comprehensive Dental** Medicare-covered services: You pay $0. Non-Routine services: You pay $0 to $300 copay. No limit per year. Diagnostic services: You pay $0. Restorative services: You pay $25 for amalgam fillings and $400 of the total cost for post removal. Endodontic Services: You pay $25 to $720 copay. Periodontic Services: You pay $0 to $780 copay. Extractions: You pay $70 to $140 copay. Prosthodontics, Other Oral/Maxillofacial Surgery: You pay $0 to $1110 copay. There is no allowance for dental services.

Cost	2021 (this year)	2022 (next year)
	comprehensive dental services combined.	Services may require a referral. Benefits may be subject to exclusions and limitations per the ADA code guidelines.
Retinal Imaging	You pay $20 for Medicare-covered retinal imaging.	You pay $0 for one retinal imaging and $0 for each additional Medicare-covered imaging.
Eyewear	Our plan pays up to $130 every two years for routine eyeglasses (frames and lenses) or one pair of elective contact lenses. You pay $25 for standard lenses Upgrades are not covered. You are responsible for any routine eyeglass or contact lens costs over the $130 plan limit.	Our plan pays up to $175 every year for eyeglass frames or one pair of contact lenses in lieu of frames. Standard lenses (including standard progressive lenses) are covered in full. There is a $70 allowance for an upgrade to polycarbonate lenses and an $89.50 allowance for an upgrade to premium progressive lenses. You are responsible for any eyeglass frame or contact lens costs over the $175 plan limit.
Hearing Aids	Our plan pays up to $750 every year for hearing aids for both ears combined	You pay $149 per aid, up to two (2) hearing aids every 3 years.

Section 3.6 – 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.

(To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

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.

Starting in 2022, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep

the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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. Because you receive "Extra Help" if you haven't received this insert by September 30th, 2021, please call Member Services and ask for the "LIS Rider."

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 brighthealthcare.com/medicare. You may also call Member Services to ask us to mail you an Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	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	2021 (this year)	2022 (next year)
Stage 2: 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.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. 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. 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.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1: Preferred Generic:** You pay $0 per prescription **Tier 2: Generic:** You pay $12 per prescription **Tier 3: Preferred Brand:** You pay $47 per prescription You pay $0 for select insulins. **Tier 4: Non-Preferred Drug:** You pay $90 per prescription **Tier 5: Specialty Tier:** You pay 33% of the total cost **Tier 6: Select Care Drugs:** You pay $0 per prescription Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy: **Tier 1: Preferred Generic:** You pay $0 per prescription **Tier 2: Generic:** You pay $12 per prescription You pay $0 for select insulins. **Tier 3: Preferred Brand:** You pay $47 per prescription You pay $35 for select insulins. **Tier 4: Non-Preferred Drug:** You pay $90 per prescription **Tier 5: Specialty Tier:** You pay 33% of the total cost **Tier 6: Select Care Drugs:** You pay $0 per prescription Once your total drug costs have reached $4,430, 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.

Bright Advantage Embrace Care Plan offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $0 - $35.

SECTION 4 Administrative Changes

Cost	2021 (this year)	2022 (next year)
Customer Service Phone Number	(844) 221-7736 This phone number should be used for questions about your 2021 benefits.	(844) 926-4521 Starting October 1, 2021, this phone number can be used for questions about 2022 benefits.
Premium Payments Address	**Old remittance address:** Bright Health Group, Inc. St. Louis, MO 63195	**New remittance address:** Bright Health Group, Inc. PO Box 772714 Detroit, MI 48277-2714
Plan Website	https://brighthealthplan.com/medicare-advantage	brighthealthcare.com/medicare
Participating Pharmacy Website	https://brighthealthplan.com/provider-finder/ma/	brighthealthcare.com/madoctors
Formulary Website	https://brighthealthplan.com/drug-search/ma/	brighthealthcare.com/drug-search/ma
Participating Provider Website	https://brighthealthplan.com/provider-finder/ma/	brighthealthcare.com/madoctors
Part D Out-of-Network Cost-Sharing Structure	You pay the standard retail copayment, plus the difference between the out-of-network billed charge and the allowed amount for a standard retail pharmacy.	You pay the standard retail copayment.
Formulary Exception Tier	If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4. You cannot ask	If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 5. You

Cost	2021 (this year)	2022 (next year)
	for an exception to the copayment or coinsurance amount we require you to pay for the drug.	cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
Pharmacy Benefits Manager	Your pharmacy benefits are managed by Elixir.	Your pharmacy benefits are managed by MedImpact.
Extended day supply	Allows you to fill up to a 90-day supply of medication	Allows you to fill up to a 100-day supply of medication.
Dental Provider	Your dental benefits are provided by Liberty Dental.	Your dental benefits are provided by Delta Dental.
Meal Benefit Provider	Your meal benefits are provided by GA Foods.	Your meal benefits are provided by Healthrageous.
Transportation Provider	Your transportation benefits are provided by Circulation	Your transportation benefits are provided by SafeRide.
Over-the-Counter (OTC) Provider	Over-the-Counter (OTC) items are provided by Incomm.	Over-the-Counter (OTC) items are provided by NationsOTC. Items are provided by mail order only.
Hearing Aid Provider	Nations administers the allowance you can use to purchase hearing aids.	Your hearing aid benefits are provided by TruHearing.

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in Bright Advantage Embrace Care Plan

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 be enrolled in our Bright Advantage Embrace Care Plan.

Section 5.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 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 the Medicare & You 2022 handbook, call your State Health Insurance Assistance Program (see Section 7), or call Medicare (see Section 9.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Bright HealthCare offers other Medicare health plans.

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 Embrace Care Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Bright Advantage Embrace Care Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 9.1 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 6 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, 2022.

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, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 7 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 New York, the SHIP is called New York Health Insurance Information, Counseling and Assistance (HIICAP).

New York Health Insurance Information, Counseling and Assistance (HIICAP) 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. New York Health Insurance Information, Counseling and Assistance (HIICAP) 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 New York Health Insurance Information, Counseling and Assistance (HIICAP) at 1-800-701-0501. You can learn more about New York Health Insurance Information, Counseling and Assistance (HIICAP) by visiting their website https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

SECTION 8 Programs That Help Pay for Prescription Drug

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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).

- **Help from your state's pharmaceutical assistance program.** New York has a program called New York State Elderly Pharmaceutical Insurance Coverage (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 7 of this booklet).

- **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 HIV Uninsured Care Programs. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437

SECTION 9 Questions?

Section 9.1 – Getting Help from Bright Advantage Embrace Care Plan

Questions? We're here to help. Please call Member Services at (844) 926-4521. (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 2022 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 2022. For details, look in the 2022 Evidence of Coverage for Bright Advantage Embrace Care Plan. 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 brighthealthcare.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 brighthealthcare.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 9.2 – 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 (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 www.medicare.gov/plan-compare).

Read Medicare & You 2022

You can read the Medicare & You 2022 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 (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.