Bright HealthCare™

Bright Advantage Part B Savings Plan (PPO) offered by Bright HealthCare

Annual Notice of Changes for 2022

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

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 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 3.6 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, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Bright Advantage Part B Savings Plan.
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in 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 Part B Savings Plan

- Bright HealthCare plans are HMOs and PPOs with a Medicare contract. 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 Part B Savings Plan.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Bright Advantage Part B Savings 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 amounts 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.)	From network providers: $5,900 From network and out-of-network providers combined: $10,000	From network providers: $4,400 From network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network:** You pay $0 per visit for Primary Care Physician services. You pay $30 per visit for Physician Specialist services. **Out-of-Network:** You pay $0 per visit for Primary Care Physician services. You pay $30 per visit for Physician Specialist services.	**In-Network:** You pay $0 per visit for Primary Care Physician services. You pay $30 per visit for Physician Specialist services. **Out-of-Network:** You pay $0 per visit for Primary Care Physician services. You pay $40 per visit for Physician Specialist services.

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-Network:** You pay $250 per day for days 1-7. You pay $0 for days 8-90. **Out-of-Network:** You pay 40% of the total cost.	**In-Network:** You pay $235 per day for days 1-7. You pay $0 for days 8-90. **Out-of-Network:** You pay 40% of the total cost.
Part D prescription drug coverage (See Section 3.6 for details.)	Deductible: $400 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 25% • Drug Tier 6: $0	Deductible: $110 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 25% • Drug Tier 6: $0

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 We Are Changing the Plan's Name

On January 1, 2022, our plan name will change from Bright Advantage Part B Savings to Bright Advantage Part B Savings 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 Part B Savings Plan* in 2022

On January 1, 2022, Bright HealthCare will be combining Bright Advantage Part B Savings with one of our plans Bright Advantage Part B Savings Plan.

If you do nothing to change your Medicare coverage by December 7, 2021, we will automatically enroll you in our Bright Advantage Part B Savings Plan. This means starting January 1, 2022, you will be getting your medical and prescription drug coverage through Bright Advantage Part B Savings 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 Part B Savings and the benefits you will have on January 1, 2022, as a member of Bright Advantage Part B Savings 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
Optional Supplemental Comprehensive Dental 002	$19.00	Optional supplemental comprehensive dental is no longer offered at an additional premium.

Cost	2021 (this year)	2022 (next year)
Optional Supplemental Comprehensive Vision 002	$3.50	Optional supplemental comprehensive vision benefits are no longer offered at an additional premium.
Part B Premium Rebate One of the benefits our plan includes is a Part B Premium Rebate. This means that each month the amount displayed will be automatically applied to your Part B Premium, increasing your Social Security check each month.	$50	$110

- 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 Amounts

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

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket	$5,900	$4,400 Once you have paid $4,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered

Cost	2021 (this year)	2022 (next year)
amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 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	**In-Network:** You pay $250 per day for days 1-7. You pay $0 for days 8-90.	**In-Network:** You pay $235 per day for days 1-7. You pay $0 for days 8-90.

Cost	2021 (this year)	2022 (next year)
	You pay $0 per day for all additional days after day 90.	Additional days are not covered.
Psychiatric Inpatient Hospital	**In-Network:** You pay $250 per day for days 1-7. You pay $0 for days 8-90.	**In-Network:** You pay $235 per day for days 1-7. You pay $0 for days 8-90.
Cardiac and Pulmonary Rehabilitation Services	**In-Network:** You pay $10 per visit for Cardiac Rehabilitation services. You pay $10 per visit for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services.	**In-Network:** You pay $0 per visit for Cardiac Rehabilitation services. You pay $30 per visit for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services.
Emergency/Post-Stabilization Services	You pay $90 per visit. 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 prior emergency room discharge and $90 for all other emergency room services. This copay is waived if you are admitted to the hospital within 3 days.
Urgently Needed Services	You pay $65.	You pay $0.
Worldwide Emergency / Urgent Coverage	You pay $90 for each Worldwide Emergency service. Worldwide Urgent service is not covered.	You pay $90 for each Worldwide Emergency service. You pay $90 for each Worldwide Urgent service.

Cost	2021 (this year)	2022 (next year)
	Worldwide Emergency Transportation service is not covered. There is a maximum plan benefit coverage amount of $50,000.	You pay $90 per trip for Worldwide Emergency Transportation services. There is a maximum plan benefit coverage amount of $50,000 for worldwide emergency services, worldwide urgently needed services, and worldwide emergency transportation services combined.
Routine Chiropractic Services	Routine chiropractic services are not covered.	**In-Network** You pay $20 per visit for 12 visits per year. These visits are combined with routine acupuncture services. Services may require prior authorization.
Specialist Services	**Out-of-Network:** You pay $30 per visit.	**Out-of-Network:** You pay $40 per visit.
Mental Health Specialty Services	**In-Network** You pay $40 per visit for group sessions.	**In-Network** You pay $30 per visit for group sessions.
Medicare-Covered Podiatry Services	You pay $0 per visit.	You pay $20 per visit.
Other Health Care Professional Services	**In-Network:** You pay $0 per visit. Services do not require prior authorization.	**In-Network:** You pay $20 per visit for Medicare-covered acupuncture and $30 per visit for all other services. Services may require prior authorization.

Cost	2021 (this year)	2022 (next year)
Psychiatric Services	**In-Network:** You pay $40 per visit for group sessions.	**In-Network:** You pay $30 per visit for group sessions.
Additional Telehealth Services	**In-Network:** Services do not require prior authorization.	**In-Network:** Services may require prior authorization.
Outpatient Diagnostic Procedures, Tests and Lab Services	**In-Network:** You pay $5 for lab services. If you receive multiple services at the same location on the same day, you pay multiple copays.	**In-Network:** You pay $0 for lab services. If you receive multiple services at the same location on the same day, the highest amount applies.
Outpatient Diagnostic and Therapeutic Radiological Services	**In-Network:** You pay $35 for ultrasound and other general imaging and $250 for MRI, CT, and PET scans. You pay $35 for X-Ray services. If you receive multiple services at the same location on the same day, you pay multiple copays.	**In-Network:** You pay $0 for ultrasound, other general imaging, diagnostic DEXA scan and diagnostic mammogram and $250 for MRI, CT, and PET scans. You pay $15 for X-Ray services. If you receive multiple services at the same location on the same day, the highest amount applies.
Outpatient Hospital Services	**In-Network:** You pay $275.	**In-Network:** You pay $0 for diagnostic mammograms, DEXA scans, and colonoscopies in an outpatient hospital, $275 for observation services, and $285 for all other services.
Ambulatory Surgical Center (ASC) Services	**In-Network:** You pay $250.	**In-Network:** You pay $0 for diagnostic

Cost	2021 (this year)	2022 (next year)
		mammograms, DEXA scans, and colonoscopies in an ambulatory surgical center and $200 for all other services.
Outpatient Substance Abuse Services	**In-Network:** You pay $40 per visit for group sessions.	**In-Network:** You pay $35 per visit for group sessions.
Outpatient Blood Services	**In-Network:** 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 three (3) pints of blood furnished during the calendar year.	**In-Network:** You pay $0 for all blood services starting with the first pint.
Ambulance Services	**In-Network and Out-of-Network:** You pay $250 per trip for ground ambulance services and 20% of the total cost for air ambulance services.	**In-Network and Out-of-Network:** You pay $0 per trip for ground and air ambulance for transfer from an out-of-network hospital to an in-network hospital. You pay $250 per trip for all other ground and air ambulance services.
Durable Medical Equipment (DME)	**In-Network:** You pay 20% of the total cost.	**In-Network:** You pay $0 for items $100 or less and 20% of the total cost for items greater than $100.

Cost	2021 (this year)	2022 (next year)
Prosthetics/ Medical Supplies	**In-Network:** You pay 20% of the total cost.	**In-Network:** You pay $0 for items $100 or less and 20% of the total cost for items greater than $100.
Routine Acupuncture	Routine Acupuncture is not covered.	**In-Network:** You pay $20 per visit for 12 visits per year. These visits are combined with routine chiropractic visits. Services may require prior authorization.
Meal Benefit	Meal Benefit is not covered.	**In-Network:** You pay $0 for fifteen (15) meals per week for six (6) weeks (90 total meals). You pay $5 per meal for up to 30 additional meals. Meal delivery one (1) time per week. 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.

Cost	2021 (this year)	2022 (next year)
		Services may require prior authorization.
Fitness Benefit	You pay $0 for an annual fitness center membership or home fitness kits. Services do not require prior authorization.	**In-Network:** You pay $0 for an annual fitness center membership or home fitness kits. Also includes one-on-one consultation with an exercise coach to develop an exercise plan either face to face or virtually every year. Services may require prior authorization.
Health Education	Health Education is not covered.	**In-Network:** You pay $0 for Health Education classes in group settings and as in-home one-on-one trainings for homebound. Health education materials are provided at no cost, along with access to a website with live telephonic coaching, real-time interventions, feedback, and goal setting. Services may require prior authorization.
Nursing Hotline	Nursing Hotline is not covered.	**In-Network:** 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 prior authorization.
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) is not covered.	**In-Network:** You pay $0 for a mobile Personal Emergency Response System (PERS) device with GPS and fall detection that is monitored 24 hours a day seven (7) days a week. Services may require prior authorization.
Kidney Disease Education Services	Services do not require prior authorization.	Services may require prior authorization.
Glaucoma Screening	Services do not require prior authorization.	Services may require prior authorization.
Diabetes Self-Management Training	Services do not require prior authorization.	Services may require prior authorization.
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.

Cost	2021 (this year)	2022 (next year)
Dental Services	**In-Network** **Preventive Dental:** Dental prophylaxis (cleaning) (up to two (2) every year): You pay $0. Fluoride treatment (up to one (1) per year): You pay $0. Oral exam (up to 2 every year): You pay $0. Dental x-ray(s) includes one (1) set of bitewings every year and one (1) radiographic image every three (3) years): You pay $0. **Comprehensive Dental:** Medicare-covered services: You pay $0 Optional supplemental comprehensive dental is offered at an additional premium. Services do not require prior authorization.	**In-Network** **Preventive Dental:** Dental prophylaxis (cleaning) (up to one (1) every year): You pay $0. Fluoride treatment (up to two (2) every six (6) months): You pay $0. Oral exam (up to 2 every year): You pay $0. Dental x-ray(s) (1 annually, maximum of 1 per year): You pay $0. **Comprehensive Dental:** Medicare-covered services: You pay $0 Non-routine services: You pay $0 for non-routine regional anesthesia and $300 for a non-routine occlusal guard. Diagnostic Services: You pay $0. Restorative services: You pay $25 for a provisional crown and $400 for porcelain crowns. Endodontic services: You pay $25 for a pulp cap and $720 for retreatment of previous root canal. Periodontic services: You pay $0 for gingival irrigation and $780 for osseous surgery. Extractions: You pay $70 for the primary tooth and $140 for an erupted tooth.

Cost	2021 (this year)	2022 (next year)
		Prosthodontics and Other Oral/Maxillofacial Surgery: You pay $0 for surgical placement of an implant body (endosteal implant) and a $1,110 copay for an abutment supported retainer for a porcelain/ceramic crown. There is no benefit maximum for dental services. Services may require prior authorization. Dental benefits may be subject to exclusions and limitations per American Dental Association (ADA) code guidelines.
	Out-of-Network: You pay 30% of the total cost for preventive dental services and Medicare-covered comprehensive dental services.	**Out-of-Network:** Preventive dental and non-Medicare-covered comprehensive dental services are <u>not</u> covered. You pay 40% of the total cost for Medicare-covered dental services. Services may require prior authorization. Dental benefits may be subject to exclusions and limitations per American Dental Association (ADA) code guidelines.

Cost	2021 (this year)	2022 (next year)
Eye Exams	**In-Network:** You pay $30 for Medicare-covered retinal imaging. **Out-of-Network:** You pay $30 for Medicare-covered retinal imaging. You pay a 40% coinsurance for routine eye exams and other services.	**In-Network:** You pay $0 for one retinal imaging and $30 for each additional Medicare-covered imaging. **Out-of-Network:** You are reimbursed up to $45 for one (1) non-Medicare-covered eye exams and $5 for one (1) retinal imaging. You pay $40 for each additional Medicare-covered retinal imaging. You are responsible for all amounts above the reimbursement amounts for out-of-network eye services.
Eyewear	**In-Network:** Medicare-covered services: You pay $0 Optional supplemental comprehensive vision is offered at an additional premium.	**In-Network:** Medicare-covered services: You pay $0 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

Cost	2021 (this year)	2022 (next year)
		lens costs over the $175 plan limit. **Out-of-Network:** You are reimbursed up to $70 for frames, $30 for standard glasses lenses, $50 for bifocal lenses, $65 for trifocal lenses, and $105 for contacts. . You are responsible for all amounts above the reimbursement amounts for out-of-network eye services.
Routine Hearing Exams	**Out-of-Network:** You pay 40% of the total cost.	**Out-of-Network:** Routine hearing exams are not covered out-of-network.
Fitting/evaluation for hearing aids	**In-Network:** Fitting/evaluation for hearing aids is not covered.	**In-Network:** You pay $0 for one (1) fitting/evaluation for hearing aids every year.
Hearing Aids	Hearing Aids are not covered.	**In-Network:** You pay $699 copay per aid for an advanced model up to two (2) per year. You pay $999 per aid for a premium model up to two (2) per year. Services may require prior authorization.

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" and haven't received this insert by September 30, 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 During this stage, **you pay the full cost** of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $400. During this stage, you pay $0 cost sharing for drugs on Tier 1 and Tier 6, and the full cost of drugs on Tier 2, Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.	The deductible is $110. During this stage, you pay $0 cost sharing for drugs on Tier 1 and Tier 6, and the full cost of drugs on Tier 2, Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.

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 Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1: Preferred Generic:** You pay $0 per prescription. **Tier 2: Generic:** You pay $20 per prescription. **Tier 3: Preferred Brand:** You pay $47 per prescription. **Tier 4: Non-Preferred Drug:** You pay $100 per prescription. **Tier 5: Specialty Tier:** You pay 25% of the total cost. **Tier 6: Select Care Drugs:** You pay $0 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1: Preferred Generic:** You pay $0 per prescription. **Tier 2: Generic:** You pay $0 per prescription. **Tier 3: Preferred Brand:** You pay $47 per prescription. **Tier 4: Non-Preferred Drug:** You pay $100 per prescription. **Tier 5: Specialty Tier:** You pay 25% of the total cost. **Tier 6: Select Care Drugs:** You pay $0 per prescription.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued) 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 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.	Once your total drug costs have reached $4,130 you will move to the next stage (the Coverage Gap Stage).	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*.

SECTION 4 Administrative Changes

Description	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

Description	2021 (this year)	2022 (next year)
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
Geographic/Service Area	Service area consists of Lake, Sumter counties	Service area consists of Broward, Lake, Orange, Osceola, Palm Beach, Pasco, Sarasota, Seminole, Sumter, Volusia counties
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 for an exception to the copayment or coinsurance amount we require you to pay for the drug.	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 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.

Description	2021 (this year)	2022 (next year)
Dental Provider	Your dental benefits are provided by Liberty Dental.	Your dental benefits are provided by Delta Dental.
Fitness Provider	Your fitness benefits are provided by Silver&Fit.	Your fitness benefits are provided by SilverSneakers.

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in Bright Advantage Part B Savings Plan (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Bright Advantage Part B Savings Plan (PPO).

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 prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Bright Advantage Part B Savings Plan (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Bright Advantage Part B Savings Plan (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 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 Florida, the SHIP is called SHINE-Florida SHIP.

SHINE-Florida SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE-Florida SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE-Florida SHIP at 800-

963-5337. You can learn more about SHINE-Florida SHIP by visiting their website ((https://www.floridashine.org/).

SECTION 8 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 850-245-4422.

SECTION 9 Questions?

Section 9.1 – Getting Help from Bright Advantage Part B Savings Plan (PPO)

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 Part B Savings

Plan (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at 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.