



Summary of Benefits 2022

**Bright Advantage Part B Savings Plan
(HMO) H4709-032**

Florida

Broward
Palm Beach

2022 Summary of Benefits

BRIGHT ADVANTAGE PART B SAVINGS PLAN (HMO)

H4709-032

January 1, 2022 - December 31, 2022.

Bright HealthCare is a Medicare Advantage plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please access the "Evidence of Coverage" at BrightHealthCare.com/Medicare.

To join **Bright Advantage Part B Savings Plan (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: Broward and Palm Beach.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at [Medicare.gov](https://www.Medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227) available 24 hours, 7 days a week including some federal holidays. TTY/TDD users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

Have questions? Please call Bright HealthCare Member Services Department at 1-844-926-4521, TTY 711 Monday - Friday 8 am - 8 pm between April 1 and September 30 and 7 days a week between October 1 to March 31, 8 am - 8 pm or visit our website at BrightHealthCare.com/Medicare.

Bright HealthCare plans are HMOs and PPOs with a Medicare contract. Bright HealthCare's New York D-SNP plan is an HMO with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Our plans are issued through Bright 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.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Monthly Plan Premium	\$0	You must keep paying your Medicare Part B premium.
Part B Rebate	\$130 per month	
Deductible	No deductible	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	No more than \$3,200 annually	Includes copays and other costs for medical services for the year.
Inpatient Hospital	\$195 copay per day for days 1-5 \$0 copay per day for days 6-90	Services may require authorization.
Outpatient Hospital	\$0 - \$160 copay	Services may require authorization. Please reference Evidence of Coverage (EOC) for details on specific services. Minimum amount for diagnostic mammograms, DEXA scans, and colonoscopies. Maximum amount for all other services.
Ambulatory Surgery Center	\$0 - \$75 copay	Services may require authorization. Minimum amount for diagnostic mammograms, DEXA scans, and colonoscopies. Maximum amount for all other services.
Doctor Visits • Primary care providers • Specialists	\$0 copay \$20 copay	Services may require authorization.
Preventive Care • Flu vaccine, diabetic screenings, etc. • Routine Annual Physical	\$0 copay \$0 copay	Other preventive services are available. There are some covered services that may have a cost. Services may require authorization. Services do not require authorization or a referral.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Emergency Care	\$0 - \$120 copay	Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours.
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	\$120 copay	Coverage is limited to \$50,000.
Urgent Care	\$0 copay	
Diagnostic Services/Labs/Imaging • Diagnostic tests and procedures • Lab services • MRI, CAT scan • X-rays	\$0 - \$75 copay \$0 copay \$0 - \$150 copay \$0 copay	Services may require authorization. Minimum copay for diagnostic colonoscopy, maximum copay for all other diagnostic procedures/ tests. Maximum copay for MRI, CT, and PET scans. Minimum copay for Ultrasound, other general imaging, diagnostic DEXA scans and mammograms.
Hearing Services • Routine hearing exam • Hearing aid fittings and evaluations • Hearing aid	\$0 copay \$0 copay \$699 per hearing aid for the advanced model \$999 per hearing aid for the premium model	One routine hearing exam annually. One hearing aid fitting annually. You receive 2 hearing aids every year.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Dental Services • Preventive dental (e.g., oral exam, x-rays, cleanings) Comprehensive Dental • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Implant Services, Prosthodontics, other oral/maxillofacial surgery, other services • Non-routine services	\$0 copay \$0 copay \$25 - \$400 copay \$25 - \$720 copay \$0 - \$780 copay \$70 - \$140 copay \$0 - \$1,110 copay \$0 - \$300 copay	Limitations may apply. See your EOC for details. Restorative services range from \$25 for provisional crown to \$400 for porcelain crowns. Endodontics range from \$25 for pulp cap to \$720 for retreatment of previous root canal. Periodontics range from \$0 for gingival irrigation to \$780 for osseous surgery. Extractions range from \$70 for primary tooth to \$140 for erupted tooth. Prosthodontics and other services range from \$0 for surgical placement of implant body (endosteal implant) to \$1,110 for abutment supported retainer for porcelain/ceramic crown. Non-routine services range from \$0 for regional anesthesia to \$300 for an occlusal guard.
Vision Services • Routine eye exam • Retinal imaging • Eyeglasses (frames) • Eyeglass lenses • Contact lenses • Upgrades	\$0 copay \$0 copay \$0 copay \$0 copay \$0 copay	One exam per year. One exam per year. \$175 allowance for frames. For standard lenses (includes standard progressives). \$175 allowance in lieu of frames for contact lenses every year. \$70 allowance for polycarb lenses upgrade. \$89.50 allowance for premium progressives upgrade.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Mental Health Services • Outpatient individual therapy • Outpatient group therapy	\$35 copay \$35 copay	Services may require authorization.
Skilled Nursing Facility (SNF)	\$0 copay per day for days 1-20 \$178 copay per day for days 21-100	Services may require authorization.
Physical Therapy	\$35 copay	Services may require authorization.
Ambulance (Ground)	\$0 - \$200 copay per ride	Services may require authorization. Minimum copay for transfer from out-of-network hospital to an in-network hospital, maximum copay for all other ambulance services.
Transportation	\$0 copay for 12 round trip trips every year to approved locations	Services may require authorization.
Medicare Part B Drugs • Chemotherapy drugs • Other Part B drugs	20% of the cost 20% of the cost	Services may require authorization.

OUTPATIENT PRESCRIPTION DRUGS

Part D Deductible	No deductible	
	Retail Rx 30-day supply	Mail Order 100-day supply
Initial Coverage You are in the Initial Coverage stage until you reach \$4,430 in drug costs (year to date)		
Tier 1 - Preferred Generic	\$0 copay	\$0 copay
Tier 2 - Generic	\$5 copay	\$10 copay
Tier 3 - Preferred Brand	\$47 copay	\$94 copay
Tier 4 - Non-Preferred Brand	\$100 copay	\$200 copay
Tier 5 - Specialty Tier	33% of the cost	Not available
Tier 6 - Select Care	\$0 copay	\$0 copay
Coverage Gap You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$7,050		
Tier 1 - Preferred Generic	\$0 copay	
Tier 2 - Generic	25% of the cost	
Tier 3 - Preferred Brand	25% of the cost	
Tier 4 - Non-Preferred Brand	25% of the cost	
Tier 5 - Specialty Tier	25% of the cost	
Tier 6 - Select Care	\$0 copay	
Catastrophic Coverage	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2022). \$3.95 copay or 5% (whichever costs more) for generic drugs or a preferred multi-source drug and \$9.85 copay or 5% (whichever costs more) for all other drugs.	

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.

WELLNESS BENEFITS	YOU PAY / RECEIVE	WHAT YOU SHOULD KNOW
Over-The-Counter (OTC) Items	Up to \$400 each year	\$100 credit every 3 months.
Meals and Nutritional Counseling	Receive 15 meals each week for 6 weeks with a \$0 copay (90 total meals). Meal delivery is included 1 time per week. Receive up to 30 additional meals for a \$5 copay per meal	Meal programs include: Diabetes, congestive heart failure (CHF), cardiovascular disorders, dementia, chronic and disabling mental health conditions, kidney disease, and hypertension. Also includes a nutritional consultation with a registered dietician to develop a healthy eating plan.
Acupuncture • Medicare-covered acupuncture • Routine acupuncture	\$0 copay \$0 copay	Services may require authorization. For up to 12 visits every year combined with Routine Chiropractic services.
Chiropractic Services • Medicare-covered chiropractic care • Routine chiropractic care	\$0 copay \$0 copay	Services may require authorization. For up to 12 visits every year combined with Routine Acupuncture services.
Gym Membership	\$0 copay	SilverSneakers gym membership is available to you at no cost with access to fitness facilities, or SilverSneakers Steps at-home kits for members who are unable to exercise in a fitness facility or prefer to work out at home.
24/7 Doctor Advice Line	\$0 copay	A Doctor is available at no cost to you 24 hours a day, 7 days a week by web, mobile app, or phone at: 1-800-835-2362. Doctors can diagnose and prescribe medications if medically necessary.
Personal Emergency Response System (PERS)	\$0 copay	Mobile PERS device with GPS and fall detection; 24/7/365 monitoring.



Nondiscrimination Notice and Assistance with Communication

Bright HealthCare does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright HealthCare plans and their affiliates.

Language assistance and alternate formats:

Assistance is available at no cost to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright HealthCare websites.

To ask for help with these services, please call **1-844-926-4521**.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright HealthCare Civil Rights Coordinator
P.O. Box 1868
Portland, ME 04104
Phone: **1-844-926-4521**

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
- **Phone:** Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)
- **Mail:** U.S Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If you need help with your complaint, please call **1-844-926-4521**. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call **1-844-926-4521**.

English	ATTENTION: If you speak a language other than English, language assistance services including interpretation and written translation, free of charge, are available to you. Call (844)-926-4521.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística, incluidos servicios de interpretación y traducción. Llame al (844) 926-4520.
Chinese (S)	注意：如果您使用的语言并非英语，则可获得免费的语言协助服务（包括口译和笔译）。请拨打电话 (844)-926-4521。
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية، ومن بينها الترجمة الشفوية والترجمة التحريرية، متاحة من أجلك، دون تكلفة. اتصل بالرقم (844)-926-4521.
Bengali	মনোযোগ: আপনি যদি ইংরেজী ব্যতীত অন্য কোনও ভাষায় কথা বলেন তবে বিনা মূল্যে ব্যাখ্যামূলক এবং লিখিত অনুবাদ সহ ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য উপলভ্য। (844)-926-4521 নম্বরে কল করুন।
French	ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique, notamment d'interprétation et de traduction écrite, sont mis gratuitement à votre disposition. Appelez le (844)-926-4521.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung einschließlich Dolmetschen und schriftlicher Übersetzung zur Verfügung. Wählen Sie die (844)-926-4521.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας συμπεριλαμβανομένης της διερμηνείας και της γραπτής μετάφρασης. Καλέστε το (844)-926-4521.
Italian	ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti, inclusi di interpretariato e traduzione scritta. Chiami il numero (844)-926-4521.
Japanese	ご注意: 英語以外の言語を話される場合は、通訳および書面による翻訳を含めて無料の言語支援サービスをご利用いただけます。(844)-926-4521 までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 번역 및 통역과 같은 무료 언어 지원 서비스를 이용하실 수 있습니다. (844)-926-4521번으로 연락하십시오.
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowej usługi tłumaczenia ustnego i pismnego. Zadzwoń pod numer (844)-926-4521.
Portuguese	ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de assistência de idioma, incluindo interpretação e tradução escrita. Entre em contato no número (844)-926-4521.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки, включая устный и письменный перевод. Позвоните по телефону (844)-926-4521.

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