



# Summary of Benefits 2022

**Bright Advantage Dual Access  
(HMO D-SNP) H7853-011**

## **Colorado**

Adams  
Arapahoe  
Boulder  
Broomfield  
Denver  
Douglas  
El Paso  
Elbert  
Jefferson  
Summit  
Teller

# 2022 Summary of Benefits

## BRIGHT ADVANTAGE DUAL ACCESS (HMO D-SNP)

H7853-011

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](https://BrightHealthCare.com/Medicare).

This plan is a **Dual Eligible Special Needs Plan (D-SNP)** for people who are eligible for both Medicare and Medicaid. As a dual eligible beneficiary, your services are paid first by Medicare and then by Medicaid. How much Medicaid covers depends on the type of Medicaid eligibility you have. To join **Bright Advantage Dual Access (HMO D-SNP)**, you must be in one of the following Medicaid eligibility categories:

- **Qualified Medicare Beneficiary (QMB):** Medicaid covers your Medicare Part A and B premiums, deductibles, coinsurance and copayment amounts. You are not otherwise eligible for any Medicaid benefits.
- **Qualified Medicare Beneficiary Plus (QMB+):** Medicaid covers your Medicare Part A and B premiums, deductibles, coinsurance and copayment amounts. You are also eligible for full Medicaid benefits, secondary to your Medicare coverage.
- **Full Benefit Dual Eligible – Medicaid Only:** You are eligible for full Medicaid benefits. Medicaid may provide some assistance with Medicare cost-sharing. Generally, your cost share is \$0 when the service is covered by both Medicare and Medicaid. There may be instances where you have to pay Medicare cost-sharing when the service or benefit is not covered by Medicaid.

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If your category of Medicaid eligibility changes, your cost-share may also increase or decrease. You must remain eligible for and enrolled in Medicaid to stay enrolled in this plan. You also 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 Colorado: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Jefferson, Summit, and Teller.

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 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 Brigh 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](https://BrightHealthCare.com/Medicare).

Bright HealthCare plans are HMOs and PPOs with a Medicare contract. Bright HealthCare's Colorado D-SNP is an HMO with a Medicare contract and a State Medicaid Agency Contract with the Colorado Department of Health Care Policy and Financing. 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
<b>Monthly Plan Premium</b>	<b>\$0</b>	<p>You must keep paying your Medicare Part B premium.</p> <p>Your premium may be more if you are not receiving Extra Help.</p>
<b>Deductible</b>	<b>No deductible</b>	
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	<b>No more than \$0 annually</b>	<p>Includes copays and other costs for medical services for the year.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Inpatient Hospital</b>	<b>\$0 per stay</b>	<p>Services may require authorization and a referral.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Outpatient Hospital</b>	<b>\$0 copay</b>	<p>Services may require authorization and a referral.</p> <p>Please reference Evidence of Coverage (EOC) for details on specific services.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Ambulatory Surgery Center</b>	<b>\$0 copay</b>	<p>Services may require authorization and a referral.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
<p><b>Doctor Visits</b></p> <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Specialists</li> </ul>	<p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p>	<p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p> <p>Services may require authorization and a referral.</p>
<p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>• Flu vaccine, diabetic screenings, etc.</li> <li>• Routine Annual Physical</li> </ul>	<p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p>	<p>Other preventive services are available. There are some covered services that may have a cost.</p> <p>Services may require authorization and a referral.</p> <p>Services do not require authorization or a referral.</p>
<p><b>Emergency Care</b></p>	<p><b>\$0 copay</b></p>	<p>Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<p><b>Worldwide Emergency Care</b></p> <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Emergency Room</li> <li>• Emergency Transportation</li> </ul>	<p><b>\$90 copay</b></p>	<p>Coverage is limited to \$50,000</p>
<p><b>Urgent Care</b></p>	<p><b>\$0 copay</b></p>	
<p><b>Diagnostic Services/Labs/Imaging</b></p> <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Lab services</li> <li>• MRI, CAT scan</li> <li>• X-rays</li> </ul>	<p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p>	<p>Services may require authorization and a referral.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
<p><b>Hearing Services</b></p> <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid fittings and evaluations</li> <li>• Hearing aid</li> </ul>	<p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$149 per hearing aid</b> for the advanced model</p>	<p>One routine hearing exam annually. One hearing aid fitting annually.</p> <p>You receive 2 hearing aids every 3 years.</p>
<p><b>Dental Services</b></p> <ul style="list-style-type: none"> <li>• Preventive dental (e.g., oral exam, x-rays, cleanings)</li> </ul> <p><b>Comprehensive Dental</b></p> <ul style="list-style-type: none"> <li>• Diagnostic services</li> <li>• Restorative services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Extractions</li> <li>• Implant Services, Prosthodontics, other oral/maxillofacial surgery, other services</li> </ul> <ul style="list-style-type: none"> <li>• Non-routine services</li> </ul>	<p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 - \$350 copay</b></p> <p><b>\$0 copay</b></p>	<p>Limitations may apply. See your EOC for details.</p> <p>Prosthodontics, other oral/maxillofacial surgery, and other services range from \$0 for surgical placement of implant body (endosteal implant) to \$350 for implant supported crowns.</p>
<p><b>Vision Services</b></p> <ul style="list-style-type: none"> <li>• Routine eye exam</li> <li>• Retinal imaging</li> <li>• Eyeglasses (frames)</li> <li>• Eyeglass lenses</li> </ul> <ul style="list-style-type: none"> <li>• Contact lenses</li> </ul> <ul style="list-style-type: none"> <li>• Upgrades</li> </ul>	<p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p> <p><b>\$0 copay</b></p>	<p>One exam per year.</p> <p>One exam per year.</p> <p>\$175 allowance for frames.</p> <p>For standard lenses (includes standard progressives).</p> <p>\$175 allowance in lieu of frames for contact lenses every year.</p> <p>\$70 allowance for polycarb lenses upgrade.</p> <p>\$89.50 allowance for premium progressives upgrade.</p>

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>• Outpatient individual therapy</li> <li>• Outpatient group therapy</li> </ul>	<b>\$0 copay</b>  <b>\$0 copay</b>	<p>Services may require authorization and a referral.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Skilled Nursing Facility (SNF)</b>	<b>\$0 per stay</b>	<p>Services may require authorization.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Physical Therapy</b>	<b>\$0 copay</b>	<p>Services may require authorization and a referral.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Ambulance (Ground)</b>	<b>\$0 copay per ride</b>	<p>Services may require authorization.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>
<b>Transportation</b>	<b>\$0 copay for unlimited round-trip trips to approved locations</b>	<p>Services may require authorization and a referral.</p>
<b>Medicare Part B Drugs</b> <ul style="list-style-type: none"> <li>• Chemotherapy drugs</li> <li>• Other Part B drugs</li> </ul>	<b>\$0 copay</b>  <b>\$0 copay</b>	<p>Services may require authorization.</p> <p>Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.</p>

## OUTPATIENT PRESCRIPTION DRUGS

<b>Part D Deductible</b>	<b>No deductible (your deductible may be more if you are not receiving Extra Help).</b>	
	<b>Retail Rx 30-day supply</b>	<b>Mail Order 100-day supply</b>
<p><b>Initial Coverage</b> You are in the Initial Coverage stage until you reach \$4,430 in drug costs (year to date)</p> <p><b>Tier 1 - Preferred Generic</b>      <b>\$0 copay</b></p> <p><b>Tiers 2 (Generic) to 5 (Specialty Tier)</b>      <b>\$0 or \$1.35 for generics. \$0 or \$4 for brands. (Depending on your level of Extra Help that you receive).</b></p> <p><b>Tier 6 - Select Care</b>      <b>\$0 copay</b></p>		
<p><b>Coverage Gap</b> You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$7,050</p> <p><b>Tier 1 - Preferred Generic</b>      <b>\$0 copay</b></p> <p><b>Tiers 2 (Generic) to 5 (Specialty Tier)</b>      <b>\$0 or \$1.35 for generics. \$0 or \$4 for brands. (Depending on your level of Extra Help that you receive).</b></p> <p><b>Tier 6 - Select Care</b>      <b>\$0 copay</b></p>		
<p><b>Catastrophic Coverage</b></p>	<p>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).</p> <p><b>Depending on your level of Extra Help that you receive, \$0 copay for all covered drugs or \$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.</b></p>	

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
<b>Over-The-Counter (OTC) Items</b>	<b>Up to \$700 each year</b>	\$175 credit every 3 months.
<b>Healthy Foods Allowance</b>	<b>Up to \$540 each year for healthy foods</b>	Receive a \$45 monthly allowance to buy healthy whole foods at approved grocery stores.
<b>Meals and Nutritional Counseling</b>	<b>Receive 14 meals each month, for 12 months in the calendar year (168 total meals)</b>	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.
<b>Acupuncture</b> <ul style="list-style-type: none"> <li>• Medicare-covered acupuncture</li> <li>• Routine acupuncture</li> </ul>	<b>\$0 copay</b>  <b>\$0 copay</b>	Services may require authorization and a referral.  For up to 12 visits every year combined with Routine Chiropractic services.
<b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>• Medicare-covered chiropractic care</li> <li>• Routine chiropractic care</li> </ul>	<b>\$0 copay</b>  <b>\$0 copay</b>	Services may require authorization and a referral.  For up to 12 visits every year combined with Routine Acupuncture services.

WELLNESS BENEFITS	YOU PAY / RECEIVE	WHAT YOU SHOULD KNOW
<b>Blood Pressure Cuffs</b>	<b>\$0 copay</b>	Blood pressure cuff is provided to qualifying members through our care management program.
<b>Scales</b>	<b>\$0 copay</b>	A scale is provided to qualifying members through our care management program.
<b>Gym Membership</b>	<b>\$0 copay</b>	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.
<b>24/7 Doctor Advice Line</b>	<b>\$0 copay</b>	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.
<b>Personal Emergency Response System (PERS)</b>	<b>\$0 copay</b>	Mobile PERS device with GPS and fall detection; 24/7/365 monitoring

# Summary of Medicaid covered benefits

## Services available through Health First Colorado

In addition to the Medicare services described in the Summary of Benefits, you may be eligible for the following Medicaid benefits based on the level of your Medicaid coverage. For eligibility rules, a complete list of services, and additional information about Medicaid benefits, please visit: <https://www.healthfirstcolorado.com/>.

Inpatient Hospital Care	Diagnostic Tests, Lab and Radiology Services, and X-Rays
Inpatient Mental Health Care	Outpatient Hospital Services
Skilled Nursing Facility (SNF)	Outpatient Substance Abuse Services
Emergency Care	Renal Dialysis
Urgently Needed Services	Ambulance Services
Home Health Care	Routine Transportation
Hospice	Diabetes Supplies and Services
Doctor Office Visits	Durable Medical Equipment (DME)
Preventive Care	Prosthetic Devices
Foot Care	Immunizations
Telemedicine	Dental Services
Speech Therapy	Vision Services
Physical Therapy/Occupational Therapy	Hearing Services
Mental Health Care	Prescription Drug Benefits

The categories above are subject to the coverage and limitation policies listed in your Medicaid contract.

**Have Questions?** What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to, please call: 1-800-221-3943



## **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.





