Bright HealthCare™

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

Annual Notice of Changes for 2023

You are currently enrolled as a member of Bright Advantage Health Dollars Plan (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review 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.)

- **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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your Medicare & You 2023 handbook.

☐ 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, 2022, you will be enrolled in Bright Advantage Part B Savings Plan.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on January 1, 2023. This will end your enrollment with Bright Advantage Part B Savings Plan.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-844-926-4521 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. Enrollment in our plans depends on contract renewal.
- When this document says "we," "us," or "our", it means Bright HealthCare. When it says "plan" or "our plan," it means Bright Advantage Part B Savings Plan.

Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Bright Advantage Part B Savings Plan in several important areas. **Please note this is only a summary of costs**. 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	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 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 2.2 for details.)	From network providers: $4,400 From network and out-of-network providers combined: $10,000	From network providers: $4,900 From network and out-of-network providers combined: $8,950
Doctor office visits	**In-Network:** You pay $0 per visit for Primary Care Physician services. You pay $15 per visit for Physician Specialist services. **Out-of-Network:** You pay $0 per visit for Primary Care Physician services. You pay $25 per visit for Physician Specialist services.	**In-Network:** You pay $0 per visit for Primary Care Physician services. You pay $20 per visit for Physician Specialist services. **Out-of-Network:** You pay $30 per visit for Primary Care Physician services. You pay $60 per visit for Physician Specialist services.
Inpatient hospital stays	**In-Network:** You pay a $225 copay per day for days 1-5 You pay a $0 copay per day for days 6-90	**In-Network:** You pay a $235 copay per day for days 1-7 You pay a $0 copay per day for days 8-90

Cost	2022 (this year)	2023 (next year)
	Out-of-Network: You pay 40% of the total cost	**Out-of-Network:** You pay 40% of the total cost
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 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: 33% • 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

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Bright Advantage Part B Savings Plan in 2023

On January 1, 2023, Bright HealthCare will be combining Bright Advantage Health Dollars Plan with one of our plans, Bright Advantage Part B Savings Plan. The information in this document tells you about the differences between your current benefits in Bright Advantage Health Dollars Plan and the benefits you will have on January 1, 2023 as a member of Bright Advantage Part B Savings Plan.

If you do nothing by December 7, 2022, we will automatically enroll you in our Bright Advantage Part B Savings Plan. This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through Bright Advantage Part B Savings Plan. If you want to change plans or switch to Original Medicare, you must 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.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
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.	$0	$120

- 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.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,400	$4,900 Once you have paid $4,900 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 providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) 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	$8,950 Once you have paid $8,950 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 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at brighthealthcare.com/medicare. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making change to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Inpatient Hospital (Acute)	**In-Network:** You pay a $225 copay per day for days 1-5 You pay a $0 copay per day for days 6-90	**In-Network:** You pay a $235 copay per day for days 1-7 You pay a $0 copay per day for days 8-90
Inpatient Hospital (Psychiatric)	**In-Network:** You pay a $225 copay per day for days 1-5 You pay a $0 copay per day for days 6-90	**In-Network:** You pay a $235 copay per day for days 1-7 You pay a $0 copay per day for days 8-90
Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	**In-Network:** You pay a $25 copay per visit	**In-Network:** You pay a $30 copay per visit
Primary Care Physician Services	**Out-of-Network:** You pay a $0 copay per visit	**Out-of-Network:** You pay a $30 copay per visit
Occupational Therapy Services	**In-Network:** You pay a $25 copay per visit for Medicare-covered benefits	**In-Network:** You pay a $0 copay per visit for Medicare-covered benefits
Physician Specialist Services	**In-Network:** You pay a $15 copay per visit for Medicare-covered benefits **Out-of-Network:** You pay a $25 copay per visit	**In-Network:** You pay a $20 copay per visit for Medicare-covered benefits **Out-of-Network:** You pay a $60 copay per visit

Cost	2022 (this year)	2023 (next year)
Other Health Care Professional Services	**In-Network:** You pay a $15 copay per visit for Medicare-covered benefits	**In-Network:** You pay a $20 copay per visit for Medicare-covered benefits
Physical Therapy and Speech Language Therapy	**In-Network:** You pay a $25 copay per visit for Medicare-covered benefits	**In-Network:** You pay a $0 copay per visit for Medicare-covered benefits
Outpatient Diagnostic Procedures and Tests	**In-Network:** You pay a $0 copay for a diagnostic colonoscopy and a $125 copay for all other Medicare-covered diagnostic procedures/tests	**In-Network:** You pay a $0 copay for diagnostic colonoscopy and a $250 copay for all other Medicare-covered diagnostic procedures/tests
Outpatient Diagnostic Radiological Services (e.g. CT, MRI, and PET Scans)	**In-Network:** You pay a $0 copay for Ultrasound, other general imaging, diagnostic DEXA scans and diagnostic mammograms. You pay a $125 copay for MRI, CT, and PET scans	**In-Network:** You pay a $0 copay for Ultrasound, other general imaging, diagnostic DEXA scans and diagnostic mammograms. You pay a $150 copay for MRI, CT, and PET scans
Outpatient Hospital Services	**In-Network:** You pay a $0 copay for diagnostic mammograms, DEXA scans, and colonoscopies in an outpatient hospital, you pay a $250 copay for observation services, and a $260 copay for all other Medicare-covered outpatient hospital services	**In-Network:** You pay a $0 copay for diagnostic mammograms, DEXA scans, and colonoscopies in an outpatient hospital. You pay a $275 copay for Medicare-covered outpatient hospital services
Ambulatory Surgical Center (ASC) Services	**In-Network:** You pay $0 for diagnostic mammograms, DEXA scans	**In-Network:** You pay $0 for diagnostic mammograms, DEXA scans and colonoscopies in an ASC setting

Cost	2022 (this year)	2023 (next year)
	and colonoscopies in an ASC setting You pay a $150 copay for all other Medicare-covered ASC services	You pay a $200 copay for all other Medicare-covered ASC services
Outpatient Substance Abuse Services	**In-Network:** You pay a $30 copay for Medicare-covered group sessions	**In-Network:** You pay a $35 copay for Medicare-covered group sessions
Ambulance Services	**In-Network and Out-of-Network:** You pay a $0 copay per trip for Medicare-covered ground ambulance services for a transfer from an out-of-network hospital to an in-network hospital and a $200 copay per trip for all other Medicare-covered ground ambulance services. You pay a $0 copay per trip for Medicare-covered air ambulance services for a transfer from an out-of-network hospital to an in-network hospital and a $250 copay per trip for all other Medicare-covered air ambulance services.	**In-Network and Out-of-Network:** You pay a $0 copay per trip for Medicare-covered ground ambulance services for a transfer from an out-of-network hospital to an in-network hospital and a $250 copay per trip for all other Medicare-covered ground ambulance services. You pay a $250 copay per trip for all Medicare-covered air ambulance services
Transportation Services	**In-Network:** You pay a $0 copay for unlimited trips each year	**In-Network:** Not covered
Over-the-Counter (OTC) Items	OTC items are covered under your Health Dollars benefit	Not covered

Cost	2022 (this year)	2023 (next year)
Made Easy Meals	**In-Network:** You receive 15 meals each week for 6 weeks with a $0 copay (90 total meals), once per year, eligible to receive up to 30 additional meals per year for a $5 copay per meal.	**In-Network:** Not covered
Exercise Consultation	**In-Network:** Includes a one-on-one consultation with an exercise coach to develop an exercise plan either face-to- face or virtually once a year	Not covered
Dental Services (Preventive)	**In-Network:** Dental prophylaxis (cleaning) (up to 1 every year): You pay a $0 copay Dental x-ray(s) (up to 1 every year): You pay a $0 copay Fluoride treatment (up to 2 every 6 months): You pay a $0 copay Prior Authorization is not required There is no maximum benefit for dental services **In-Network and Out-of-Network** In addition to the benefits outlined above, you also	**In-Network:** Dental prophylaxis (cleaning) (up to 2 every year): You pay a $0 copay Dental x-ray(s) (up to 2 every year): You pay a $0 copay Fluoride treatment (Unlimited): You pay a $0 copay Prior Authorization may be required There is a $4,000 maximum benefit for preventive and comprehensive dental services **Out-of-Network:** You pay a $0 copay for covered preventive dental services

Cost	2022 (this year)	2023 (next year)
	have dental coverage through the Health Dollars benefit	**In-Network and Out-of-Network** Health Dollars is not covered
Dental Services (Comprehensive)	**In-Network:** Non-Routine services: You pay a $0-$300 copay Restorative services: You pay a $25-$400 copay Endodontic services: You pay a $25-$720 copay Periodontic services: You pay a $0-$780 copay Extractions: You pay a $70-$140 copay Prosthodontics, Other Oral/Maxillofacial Surgery: You pay a $0-$1,100 copay There is no maximum benefit for dental services **In-Network and Out-of-Network** In addition to the benefits outlined above, you also have dental coverage through the Health Dollars benefit	**In-Network:** Non-Routine services: You pay a $0 copay Restorative services: You pay a $0 Endodontic services: You pay a $0 copay Periodontic services: You pay a $0 copay Extractions: You pay a $0 copay Prosthodontics, Other Oral/Maxillofacial Surgery: You pay a $0 copay There is a $4,000 maximum benefit for preventive and comprehensive dental services **Out-of-Network** You pay 20% - 50% coinsurance for covered comprehensive dental services **In-Network and Out-of-Network** Health Dollars is not covered

Cost	2022 (this year)	2023 (next year)
Eye Exams (Routine)	**In-Network:** Prior Authorization is not required	**In-Network:** Prior Authorization may be required
Eyewear	Our plan pays up to $175 every year for routine eyeglass frames Routine eyeglass lenses are covered in full One pair of contact lenses in lieu of eyeglasses are covered in full Authorization is required There is a $70 limit for polycarbonate lenses upgrade and an $89.50 limit for premium progressives upgrade You are responsible for any routine eyeglass frame costs over the $175 plan limit	There is a $150 allowance every year for eyewear. Eyewear includes eyeglass lenses and frames (up to 1 per year), contacts in lieu of eyeglasses, and upgrades.
Health Dollars	You get $250 per quarter for a total of $1,000 for the year on a Health Dollars debit card. Health Dollars funds can be used towards OTC items and dental services.	Not covered

Section 2.5 – 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.

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, Please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

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. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this	The deductible is $110.

Stage	2022 (this year)	2023 (next year)
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.	payment stage does not apply to you.	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

Please see the following chart for the changes from 2022 to 2023.

Stage	2022 (this year)	2023 (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**. 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.	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 33% of the total 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 $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.

Stage	2022 (this year)	2023 (next year)
	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).	**Tier 6 - Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-share tier it's on, even if you haven't paid your deductible.

SECTION 3 Administrative Changes

Description	2022 (this year)	2023 (next year)
Pharmacy Benefits Manager	Your pharmacy benefits were managed by MedImpact.	Your pharmacy benefits are managed by Express Scripts.
Extended Day Supply	Allowed you to fill up to a 100-day supply of medication. Applicable to tiers 1-4 and 6.	Allows you to fill up to a 90-day supply of medication. Applicable to tiers 1-4. Tier 6 has a 100-day supply.
Diabetic Supplies	You could order from a network pharmacy.	You can order from a network pharmacy. The preferred diabetic products are Abbott brands (Freestyle and Precision).

Description	2022 (this year)	2023 (next year)
Telehealth	Your Telehealth benefits were provided by Doctors on Demand.	Your Telehealth benefits are provided by DocSquad.
Hearing Aid Provider	Your hearing aid benefits were provided by TruHearing.	Your hearing aid benefits are provided by Nations.
Dental Provider	Your dental benefits were provided by Delta	Your dental benefits will be provided by Liberty

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Bright Advantage Part B Savings 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 Part B Savings Plan.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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.
- 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.
- 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 so.
  - – *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 5 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, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage Plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage at any time. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Florida, the SHIP is called Serving Health Insurance Needs of Elders (SHINE).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Serving Health Insurance Needs of Elders (SHINE) 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 Serving Health Insurance Needs of Elders (SHINE) at 1-800-963-5337. You can learn more about Serving Health Insurance Needs of Elders (SHINE) by visiting their website (https://www.floridashine.org/).

SECTION 7 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. 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; 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 (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-850-245-4422.

SECTION 8 Questions?

Section 8.1 – Getting Help from Bright Advantage Part B Savings Plan

Questions? We're here to help. Please call Member Services at 1-844-926-4521. (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 *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Bright Advantage Part B Savings 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 8.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website

(https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.