Bright HealthCare™

Summary of Benefits 2023

Bright Advantage Classic Care Plan
HMO H4709-035

Bright Advantage Part B Savings Plan
HMO H4709-036

Florida

Miami-Dade

2023 Summary of Benefits

Bright Advantage Classic Care Plan (HMO) H4709-035

Bright Advantage Part B Savings Plan (HMO) H4709-036

January 1, 2023 - December 31, 2023.

Bright HealthCare plans are HMOs and PPOs with a Medicare contract. Enrollment in our plans 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 Classic Care Plan (HMO)** or **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 county in Florida: Miami-Dade.

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 Bright HealthCare Member Services Department at 1-844-926-4521, TTY 711 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 or visit our website at brighthealthcare.com/medicare.

Premium & Benefits	Bright Advantage Classic Care Plan HMO	Bright Advantage Part B Savings Plan HMO
Monthly Plan Premium You must keep paying your Medicare Part B premium.	**$0**	**$0**
Part B Rebate	**$0 per month**	**$166.50 per month**
Deductible	**No deductible**	**No deductible**
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**No more than $999 annually**	**No more than $3,450 annually**
Inpatient Hospital*	**$0 per stay**	**$0 copay** per day for days 1-3 **$100 copay** per day for days 4-7 **$0 copay** per day for days 8-90
Outpatient Hospital*‡	**$0 - $60 copay**	**$0 - $210 copay**
Ambulatory Surgery Center*	**$0 copay**	**$0 - $50 copay**
Doctor Visits • Primary care providers • Specialists*	 **$0 copay** **$0 copay**	 **$0 copay** **$0 copay**

* Services may require authorization.
‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Premium & Benefits	Bright Advantage Classic Care Plan HMO	Bright Advantage Part B Savings Plan HMO
Preventive Care Other preventive services are available. • Flu vaccine, diabetic screenings, etc.* • Routine Annual Physical◊	**$0 copay** **$0 copay**	**$0 copay** **$0 copay**
Emergency Care Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours	**$0 - $90 copay**	**$0 - $90 copay**
Urgent Care	**$0 copay**	**$0 copay**
Diagnostic Services/Labs/ Imaging* • Diagnostic tests and procedures • Lab services • MRI, CAT scan • X-rays	 **$0 - $100 copay** **$0 copay** **$0 copay** **$0 copay**	 **$0 - $100 copay** **$0 copay** **$0 - $150 copay** **$0 copay**
Hearing Services* • Routine hearing exam One per year • Hearing aid fittings and evaluations One per year • Hearing aid	 **$0 copay** **$0 copay** **$149 per hearing aid** for the basic model You receive 2 hearing aids every 3 years	 **$0 copay** **$0 copay** **$699 per hearing aid** for the basic model You receive 2 hearing aids every year **$999 per hearing aid** for the prime model

* Services may require authorization.
◊ Services do not require authorization or a referral.

Premium & Benefits	Bright Advantage Classic Care Plan HMO	Bright Advantage Part B Savings Plan HMO
Dental Services*†		
• Preventive dental (e.g., oral exam, x-rays, cleanings)	**$0 copay**	**$0 copay**
Comprehensive Dental*		
• Diagnostic services	**$0 copay**	**$0 copay**
• Restorative services	**$0 copay**	**$0 copay**
• Endodontics	**$0 copay**	**$0 copay**
• Periodontics	**$0 copay**	**$0 copay**
• Extractions	**$0 copay**	**$0 copay**
• Implant Services, Prosthodontics, other oral/maxillofacial surgery, other services	**$0 copay**	**$0 copay**
• Non-routine services	**$0 copay**	**$0 copay**
Annual Dental Maximum	**$4,000 for preventive and comprehensive dental services each year**	**$4,000 for preventive and comprehensive dental services each year**
Vision Services*†		
• Routine eye exam	**$0 copay** One exam per year	**$0 copay** One exam per year
• Retinal imaging	**$0 copay** One exam per year	**$0 copay** One exam per year
• Eyewear allowance	**Up to $400 per year**	**Up to $150 per year**
Mental Health Services*		
• Outpatient individual therapy	**$0 copay**	**$25 copay**
• Outpatient group therapy	**$0 copay**	**$25 copay**
Skilled Nursing Facility (SNF)*	**$0 per stay**	**$0 copay** per day for days 1–20 **Up to $194.50 copay** per day for days 21–100 These amounts are for 2022 and may change in 2023

* Services may require authorization.
† Limitations may apply. See your EOC for details.

Premium & Benefits	Bright Advantage Classic Care Plan HMO	Bright Advantage Part B Savings Plan HMO
Physical Therapy*	**$0 copay**	**$35 copay**
Ambulance (Ground)*	**$0 - $100 copay per ride**	**$0 - $175 copay per ride**
Transportation*	**$0 for 24 one-way trips to plan approved locations (up to 50 mile limit)**	**Not covered**
Medicare Part B Drugs*		
• Chemotherapy drugs	**20% coinsurance**	**20% coinsurance**
• Other Part B drugs	**20% coinsurance**	**20% coinsurance**

* Services may require authorization.

Outpatient Prescription Drugs				
	Bright Advantage Classic Care Plan HMO		Bright Advantage Part B Savings Plan HMO	
Part D Deductible (Tiers 2 to 5)	**No deductible**		**No deductible**	
	Retail Rx 30-day supply	**Mail Order 90-day supply**	**Retail Rx 30-day supply**	**Mail Order 90-day supply**
Initial Coverage You are in the Initial Coverage stage until you reach $4,660 in drug costs (year to date)				
Tier 1 – Preferred Generic	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**
Tier 2 – Generic	**$0 copay**	**$0 copay**	**$4 copay**	**$8 copay**
Tier 3 – Preferred Brand	**$15 copay**	**$30 copay**	**$47 copay**	**$94 copay**
Tier 4 – Non-Preferred Brand	**$100 copay**	**$200 copay**	**$100 copay**	**$200 copay**
Tier 5 – Specialty Tier	**33% of the cost**	**Not available**	**33% of the cost**	**Not available**
Tier 6 – Select Care	**$0 copay**	**$0 copay**	**$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 $7,400				
Tier 1 – Preferred Generic	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**
Tier 2 – Generic	**$0 copay**	**$0 copay**	**25% of the cost**	**25% of the cost**
Tier 3 - Preferred Brand	**25% of the cost**	**25% of the cost**	**25% of the cost**	**25% of the cost**
Tier 4 - Non-preferred Drug	**25% of the cost**	**25% of the cost**	**25% of the cost**	**25% of the cost**
Tier 5 - Specialty	**25% of the cost**	**Not available**	**25% of the cost**	**Not available**

Outpatient Prescription Drugs				
	Bright Advantage Classic Care Plan HMO		Bright Advantage Part B Savings Plan HMO	
Tier 6 – Select Care	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**
Catastrophic Coverage You are in this stage after your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,400	**During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023).** **$4.15 copay or 5% (whichever costs more) for generic drugs or a preferred multi-source drug and $10.35 copay or 5% (whichever costs more) for all other drugs.**		During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023). **$4.15 copay or 5% (whichever costs more) for generic drugs or a preferred multi-source drug and $10.35 copay or 5% (whichever costs more) for all other drugs.**	

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 (if you have a deductible). Call Member Services for more information.

Important Message About What You Pay for Insulin

You won't pay more than $35 (or less, depending on your level of Extra Help or if your Tier 3 copay is less than $35) for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if you have a deductible).

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

Extra Benefits*	Bright Advantage Classic Care Plan HMO	Bright Advantage Part B Savings Plan HMO
Over-The-Counter (OTC) Items	**See 'Health Dollars' below**	**Up to $25 every month**
Bright Health Dollars Card 'Health Dollars' can be used for Over-The-Counter (OTC) items and dental services	**$250 'Health Dollars' per quarter**	**Not covered**
Meals and Nutritional Counseling (Made Easy Meals)‡	**Receive 15 meals each week, for 6 weeks (90 total meals). Meal delivery is included 1 time per week. Receive up to 30 additional meals for a $5 copay per meal.**	**Not covered**
Acupuncture* • Medicare-covered acupuncture • Routine acupuncture	**$0 copay** **$0 copay** **Up to 12 visits every year combined with Routine Chiropractic services.**	**$0 copay** **$0 copay** **Up to 12 visits every year combined with Routine Chiropractic services.**
Chiropractic Services* • Medicare-covered chiropractic care • Routine chiropractic care	**$0 copay** **$0 copay** **Up to 12 visits every year combined with Routine Acupuncture services.**	**$0 copay** **$0 copay** **Up to 12 visits every year combined with Routine Acupuncture services.**
Gym Membership	**$0 copay**	**$0 copay**
24/7 Telehealth	**$0 copay**	**$0 copay**

‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Extra Benefits*	Bright Advantage Classic Care Plan HMO	Bright Advantage Part B Savings Plan HMO
Personal Emergency Response System (PERS)	**$0 copay**	**$0 copay**
Durable Medical Equipment (DME)*	**$0 - 20% coinsurance**	**$0 - 20% coinsurance**
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	**$125 copay** **Coverage up to $50,000**	**$90 copay** **Coverage up to $50,000**

NOTICE OF NON-DISCRIMINATION

Bright HealthCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Bright HealthCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Bright HealthCare

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Bright HealthCare Member Services Department at: 1-844-926-4521 (TTY 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.

If you believe that Bright HealthCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling our Customer Service Department or mailing a letter to:

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

You can file a grievance in person or by mail. If you need help filing a grievance, our Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 1-800-537-7697
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-926-4521. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-926-4520. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何 疑 问。如果您需要此翻译服务，请致电 1-844-926-4521。我们的中文工作人员很乐意 帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的 翻譯 服務。如需翻譯服務，請致電 1-844-926-4521。我們講中文的人員將樂意為您提 供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-926-4521. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurancemédicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-926-4521. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-926-4521 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-926-4521. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-926-4521 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-926-4521. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المتر جم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-926-4521. سيقوم شخص ما يتدث العربية مساعدتك. هذه خدمة مجانية.

Hindi:
हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-926-4521. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-926-4521. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-926-4521. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-926-4521. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-926-4521. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、 1-844-926-4521 にお電話ください。日本語を話す人 者 が支援いたします。これは 無料のサー ビスです。