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HEALTHCARE YOU CAN FEEL GOOD ABOUT

This is important information on changes in your Brand New Day Plan information.

Changes to your 2023 Annual Notice of Changes, Evidence of Coverage and Summary of Benefits:

Where you can find the change in your 2023 Materials:	**Original information:**	**Corrected information:**	**What does this mean to you?**
Annual Notice of Change – Changes to Benefits and Costs for Medical Services – Medicare Part B Prescription Drugs	Not included	**2022:** You pay 20% coinsurance **2023:** You pay up to 20% coinsurance. Certain rebatable drugs may be subject to a lower coinsurance. Part B insulin cost sharing is no more than a $35 copay for a one-month supply.	You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a $35 copay for a one-month supply of Medicare Part B insulin.
Evidence of Coverage – Chapter 4, Section 2.1 Your medical benefits and costs as a member of the plan – Medicare Part B Prescription Drugs	You pay 20% coinsurance	You pay up to 20% coinsurance. Certain rebatable drugs may be subject to a lower coinsurance. Part B insulin cost sharing is no more than a $35 copay for a one-month supply.	You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a $35 copay for a one-month supply of Medicare Part B insulin.

Summary of Benefits – Medicare Part B Drugs • Chemotherapy drugs •Other Part B drugs	• 20% coinsurance • 20% coinsurance	• Up to 20% coinsurance • Up to 20% coinsurance. Part B insulin cost sharing is no more than a $35 copay for a one-month supply	You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a $35 copay for a one-month supply of Medicare Part B insulin.

You are not required to take any action in response to this document, but we recommend you keep this information for future reference.

If you have any questions, please call us at 1-866-255-4795 (TTY users should call 711.). Hours are 8:00 am to 8:00 pm 7 days a week from October 1 – March 31 and 8:00 am to 8:00 pm Monday – Friday from April 1 – September 30.

Brand New Day is an HMO plan with a Medicare contract. Enrollment in this plan depends on contract renewal.

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A Bright HealthCare Company

Brand New Day Classic Care III Plan (HMO) offered by Brand New Day

Annual Notice of Changes for 2023

You are currently enrolled as a member of Brand New Day Classic Care III Plan. 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 www.bndhmo.com. 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 stay in Brand New Day Classic Care III 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 Brand New Day Classic Care III 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 1-866-255-4795 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m. 7 days a week from October 1 – March 31 and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30.
- This document may be available in other formats such as braille, large print or other alternate formats.
- **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 Brand New Day Classic Care III Plan

- Brand New Day is a Medicare Advantage Organization with a Medicare contract. Enrollment in this plan depends on contract renewal.
- When this document says "we," "us," or "our", it means Brand New Day. When it says "plan" or "our plan," it means Brand New Day Classic Care III Plan.

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Brand New Day Classic Care III Plan in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$55	$55
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$2,999	$2,999
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $10 per visit	Primary care visits: $0 per visit Specialist visits: $10 per visit
Inpatient hospital stays	You pay a $250 copay per day for days 1-5 You pay $0 copay per day for days 6-90	You pay a $250 copay per day for days 1-5 You pay a $0 copay per day for days 6-90
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $50 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $12 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 30% • Drug Tier 6: $0	Deductible: $50 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $12 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 30% • Drug Tier 6: $0

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – 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.)	$55	$55

- 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 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." 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)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$2,999	$2,999 Once you have paid $2,999 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. There is no change for the upcoming benefit year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.bndhmo.com. 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 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Ambulance Services	You pay a $0 per trip for air ambulance services for a transfer from an out-of-network hospital to an in-network hospital. You pay $200 copay per trip for all other air ambulance services.	You pay a $200 copay per trip for all air ambulance services
Transportation Services	You pay a $0 copay for unlimited one-way trips every year	You pay a $0 copay for 24 round-trips every year Routine transportation is limited to plan-approved locations (up to 50 miles) for member to receive healthcare services from network providers. Arrangement for transportation must be made through Member

Cost	2022 (this year)	2023 (next year)
		Services at least 2 business days in advance.
Supplemental Nutritional Consultation	Includes a nutritional consultation with a registered dietician to develop a healthy eating plan	Not covered
Exercise Consultation	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
Over-the-Counter (OTC) Items	You have a $40 OTC allowance every three months	You have a $60 OTC allowance every three months
Dental Services (Preventive)	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	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
Eye Exams	Prior Authorization is not required Referral is not required	Prior Authorization may be required Referral may be required

Cost	2022 (this year)	2023 (next year)
Eyewear	Our plan pays up to $175 every year for routine eyeglass frames One pair of contact lenses in lieu of eyeglasses are covered in full Routine eyeglass lenses are covered in full 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 Referral is not required	There is a $300 allowance every year for eyewear Eyewear includes eyeglass lenses and frames, contacts, and upgrades Referral may be required

Section 1.5 – 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.

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.**

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 have included 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 didn't receive this insert with this packet, 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 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 $50. 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 $50. 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	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 - Preferred Generic:**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 - Preferred Generic:**

Stage	2022 (this year)	2023 (next year)
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.	You pay $0 per prescription. **Tier 2 - Generic:** You pay $12 per prescription. **Tier 3 - Preferred Brand:** You pay $47 per prescription. **Tier 4 - Non-Preferred Drug:** You pay $100 per prescription. **Tier 5 - Specialty Drug:** You pay 30% of the total cost. **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).	You pay $0 per prescription. **Tier 2 - Generic:** You pay $12 per prescription. **Tier 3 - Preferred Brand:** You pay $47 per prescription. **Tier 4 - Non-Preferred Drug:** You pay $100 per prescription. **Tier 5 - Specialty Drug:** You pay 30% of the total cost. **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 2 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).
Hearing Aid Provider	Your hearing aid benefits were provided by TruHearing.	Your hearing aid benefits are provided by Nations.
Made Easy Meals	Eligible chronic conditions for this benefit include diabetes, CHF, cardiovascular disorders, dementia, chronic and disabling mental health conditions, kidney disease and hypertension.	Eligible chronic conditions for this benefit include diabetes, CHF, cardiovascular disorders, dementia, chronic and disabling mental health conditions and kidney disease.
Over-the-Counter Items (OTC)	Your benefits include using NationsOTC catalog	Your OTC benefit is administered exclusively through NationsOTC and retail pharmacies through a debit card
Conversio Compound Pharmacy	Your benefits include Conversio Compound Pharmacy as in-network for nebulizers and inhalers	Conversio is out-of-network. You can receive nebulizers or inhalers at any in-network retail pharmacy or Express Scripts mail order

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Brand New Day Classic Care III 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 Brand New Day Classic Care III Plan.

Section 3.2 – 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 1.1 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 5), or call Medicare (see Section 7.2).

As a reminder, Brand New Day offers other Medicare health 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 Brand New Day Classic Care III Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Brand New Day Classic Care III 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 4 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 5 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 California, the SHIP is called Health Insurance Counseling & Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Insurance Counseling & Advocacy Program (HICAP) 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 Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222. You can learn more about Health Insurance Counseling & Advocacy Program (HICAP) by visiting their website https://aging.ca.gov/Programs_and_Services/Medicare_Counseling/.

SECTION 6 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 California Department of Public Health, Center for Infectious Diseases, Office of AIDS. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050. Monday through Friday, 8:00 A.M. to 5:00 P.M. (excluding holidays).

SECTION 7 Questions?

Section 7.1 – Getting Help from Brand New Day Classic Care III Plan

Questions? We're here to help. Please call Member Services at 1-866-255-4795. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m. 7 days a week from October 1 – March 31 and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30. 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 Brand New Day Classic Care III 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 www.bndhmo.com. 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 www.bndhmo.com. 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 7.2 – 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.