brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

Brand New Day Dual Access Plan (HMO D-SNP) offered by Brand New Day

Annual Notice of Changes for 2024

You are currently enrolled as a member of Brand New Day Dual Access Plan (HMO D-SNP). Next year, there will be some changes to the plan's costs and benefits*.* ***Please see page 4 for a Summary of Important Costs, included 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*.

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 2024 "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 2024* 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, 2023, you will be enrolled in Brand New Day Dual Access Plan (HMO D-SNP).
   - To **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Your new coverage will start on January 1, 2024. This will end your enrollment with Brand New Day Dual Access Plan (HMO D-SNP).
   - Look in section 3.2, page 18 to learn more about your choices.
   - 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 (866) 255-4795 for additional information. (TTY users should call 711.) Hours are 8:00 A.M. to 8:00 P.M. (PT), 7 days a week. This call is free.
- 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 Dual Access Plan (HMO D-SNP)

- Brand New Day is an HMO SNP with a Medicare contract. Enrollment in Brand New Day depends on contract renewal. The plan also has a written agreement with the CA Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means Brand New Day. When it says "plan" or "our plan," it means Brand New Day Dual Access Plan (HMO D-SNP).

Annual Notice of Changes for 2024
Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Brand New Day Dual Access Plan (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$38.90	$41
Doctor office visits	Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.	Primary care visits: 40% of the total cost per visit Specialist visits: 40% of the total cost per visit If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.
Inpatient hospital stays	You pay a $1,600 deductible per benefit period. You pay a $0 copay per day for days 1–60 You pay a $400 copay per day for days 61–90 You pay a $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). If you are eligible for Medicare cost-sharing assistance under	You pay a $1,600 deductible per benefit period. You pay a $0 copay per day for days 1–60 You pay a $400 copay per day for days 61–90 You pay a $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). These are 2023 cost-sharing amounts and may change for 2024. Brand New Day

Cost	2023 (this year)	2024 (next year)
	Medi-Cal (Medicaid), you pay $0.	Dual Access Plan (HMO D-SNP) will provide updated rates as soon as they are released. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $505 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0. • Drug Tier 2: You pay 25% of the total cost. • Drug Tier 3: You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: You pay 25% of the total cost. • Drug Tier 5: You pay 25% of the total cost. • Drug Tier 6: You pay $0. Catastrophic Coverage:	Deductible: $545 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0. • Drug Tier 2: You pay 25% of the total cost. • Drug Tier 3: You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: You pay 25% of the total cost. • Drug Tier 5: You pay 25% of the total cost. • Drug Tier 6: You pay $0. Catastrophic Coverage:

Cost	2023 (this year)	2024 (next year)
	• During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	• During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.
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.)	$8,300 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,850 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medi-Cal (Medicaid).)	$38.90	$41

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	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount	$8,300	$8,850
Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. If you are eligible for Medi-Cal (Medicaid) assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) 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.		Once you have paid $8,850 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.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are 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, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 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 2024 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 a 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

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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

Cost	2023 (this year)	2024 (next year)
Skilled Nursing Facility (SNF)	A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	For each Medicare-covered SNF stay, you are required to pay the applicable cost sharing, starting with Day 1 each time you are admitted. The copays for skilled nursing facility (SNF) benefits are based on benefit. A SNF where your spouse is living at the time you leave the hospital periods. A benefit period begins the day you're admitted as an inpatient and ends when you are discharged from the SNF. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. For each SNF stay, you are required to pay the applicable cost sharing, starting with Day 1 each time you are admitted. There's no limit to the number of benefit periods. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2023 (this year)	2024 (next year)
Cardiac Rehabilitation Services	You pay 20% coinsurance per visit for cardiac rehabilitation. You pay 20% coinsurance per visit for intensive cardiac rehabilitation. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $30 copay per visit for cardiac rehabilitation. You pay a $55 copay per visit for intensive cardiac rehabilitation. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Pulmonary Rehabilitation Services	You pay a $20 copay per visit for pulmonary rehabilitation services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $15 copay per visit for pulmonary rehabilitation services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	You pay 20% coinsurance per visit for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $25 copay per visit for supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2023 (this year)	2024 (next year)
Emergency Care	You pay a $90 copay per visit for all emergency services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $100 copay per visit for all emergency services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Worldwide Emergency Coverage	You pay a $90 copay per visit for Worldwide Emergency services. You pay a $90 copay per visit for Worldwide Urgently Needed services. You pay a $90 copay per visit for Worldwide Emergency Transportation services. There is a maximum plan benefit coverage amount of $50,000 for worldwide emergency services, worldwide urgently needed services and worldwide emergency transportation services combined.	You pay a $100 copay per visit for Worldwide Emergency services. You pay a $100 copay per visit for Worldwide Urgently Needed services. You pay a $100 copay per visit for Worldwide Emergency Transportation services. There is a maximum plan benefit coverage amount of $50,000 for worldwide emergency services, worldwide urgently needed services and worldwide emergency transportation services combined.
Partial Hospitalization Services	You pay a $55 copay per day. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $70 copay per day. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2023 (this year)	2024 (next year)
Primary Care Physician (PCP) Visits	You pay 20% coinsurance for each PCP visit. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 40% coinsurance for each PCP visit. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Specialist Visits	You pay 20% coinsurance for office visits with a specialist. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 40% coinsurance for office visits with a specialist. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Outpatient Mental Health Care	You pay a $40 copay per visit for individual sessions. You pay a $40 copay per visit for group sessions. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $45 copay per visit for individual sessions. You pay a $45 copay per visit for group sessions. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Other Health Care Professional Services	You pay 20% coinsurance per visit for other health care professional services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 40% coinsurance per visit for other health care professional services. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.

Cost	2023 (this year)	2024 (next year)
Psychiatric Services	You pay a $40 copay per visit for individual sessions. You pay a $40 copay per visit for group sessions. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $45 copay per visit for individual sessions. You pay a $45 copay per visit for group sessions. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Outpatient Rehabilitation Services	You pay a $40 copay for each therapy visit (physical therapy, or speech language therapy). If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay a $50 copay for each therapy visit (physical therapy, or speech language therapy). If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Telehealth	Prior Authorization may be required. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	Prior Authorization is not required. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Opioid Treatment Program Services	You pay 20% coinsurance per visit. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 50% coinsurance per visit. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Transportation	You pay a $0 copay for 48 one-way non emergency transportation trips.	You pay a $0 copay for 12 one-way non emergency transportation trips.

Cost	2023 (this year)	2024 (next year)
Over-the-counter (OTC) items	You have a $180 allowance per quarter for over-the-counter (OTC) items.	You have a $33 allowance every month for over-the-counter (OTC) items.
Medicare Part B Prescription Drugs	You pay 20% coinsurance. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.	You pay 20% coinsurance on all Part B drugs unless capped by Inflation Reduction Act (IRA) rules. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copayment amount.
Dental Services		
• **Preventive Dental**	You pay a $0 copay	You pay a $0 - $17 copay
• **Non-Routine Services**	You pay a $0 copay.	You pay a $20 copay.
• **Diagnostic Services**	You pay a $0 copay.	You pay a $2 - $3 copay.
• **Extractions**	You pay a $0 copay.	You pay $0 - $350 copay.
Special Supplemental Benefits for the Chronically Ill (SSBCI) SSBCI benefits are available only for members with a qualifying chronic condition. Please see your EOC for more details.		
• **Blood Pressure Cuffs**	You pay a $0 copay for plan approved blood pressure cuffs	Not covered

Summary of Medi-Cal covered dental benefits

Services available through *Brand New Day Dual Access Plan (HMO D-SNP)*

In addition to the Medicare-covered dental services described in the Annual Notice of Change, you may be eligible for additional Medi-Cal dental benefits based on the level of your Medi-Cal coverage.

For a full list of services covered by the Medi-Cal Dental Program, call 1-800-322-6384 (TTY 1-800-735-2922) or visit: www.smilecalifornia.org. These resources can also help you locate a Medi-Cal dental provider and file a grievance or complaint.

To view the Medi-Cal Provider Directory, visit: www.smilecalifornia.org/partners-and-providers/

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," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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 your 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

If you receive “Extra Help” to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **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	2023 (this year)	2024 (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 doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $505. Your deductible amount is either $0 or $104, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) 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 $545. 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 2023 to 2024.

Stage	2023 (this year)	2024 (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**. Most adult Part D vaccines are covered at no cost to you.	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 25% 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 25% of the total cost.

Stage	2023 (this year)	2024 (next year)
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.	**Tier 3 - Preferred Brand:** You pay 25% of the total cost. **Tier 4 - Non-Preferred Drug:** You pay 25% of the total cost. **Tier 5 - Specialty:** You pay 25% 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).	**Tier 3 - Preferred Brand:** You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 - Non-Preferred Drug:** You pay 25% of the total cost. **Tier 5 - Specialty:** You pay 25% of the total cost. **Tier 6 - Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Extended Day Supply	Allows you to fill up to a 90-day supply of medication. Applicable to tiers 1-4. Tier 6 has a 100-day supply.	Allows you to fill up to a 100-day supply of medication. Applicable to tiers 1-4 and 6.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Brand New Day Dual Access Plan (HMO D-SNP)

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 Dual Access Plan (HMO D-SNP).

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 2024 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.

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 2024* 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 Dual Access Plan (HMO D-SNP).

- 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 Dual Access Plan (HMO D-SNP).
- 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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 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, 2024.

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 Medi-Cal (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.

Because you have Medi-Cal (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods:**

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

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 and Medi-Cal (Medicaid)

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 http://www.aging.ca.gov/hicap.

For questions about your Medi-Cal benefits, contact Medi-Cal at 1-800-541-5555 (TTY 1-800-896-2512). Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medi-Cal (Medicaid), you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", 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 Medi-Cal (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 am - 5 pm; COVID-19 Hotline: Monday through Friday 8 am - 8 pm; Saturday, Sunday 8 am - 5 pm.

SECTION 7 Questions?

Section 7.1 – Getting Help from Brand New Day Dual Access Plan (HMO D-SNP)

Questions? We're here to help. Please call Member Services at (866) 255-4795. (TTY only, call 711.) We are available for phone calls 8:00 A.M. to 8:00 P.M. (PT), 7 days a week. Calls to these numbers are free.

Read your *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for Brand New Day Dual Access Plan (HMO D-SNP). 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 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document 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.

Section 7.3 – Getting Help from Medi-Cal (Medicaid)

To get information from Medi-Cal (Medicaid) you can call Medi-Cal at 1-800-541-5555. TTY users should call 1-800-896-2512.