brand new day

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.

2023

brand new day

A Bright HealthCare Company

SUMMARY OF BENEFITS

BRAND NEW DAY SELECT CARE I PLAN (HMO I-SNP)
BRAND NEW DAY SELECT CHOICE I PLAN (HMO I-SNP)

Los Angeles
Orange

Riverside
San Bernardino

Y0127_H0838042044_SB_2023_M

MA23_101914_01

2023 Summary of Benefits

Brand New Day Select Care I Plan (HMO I-SNP) H0838-042

Brand New Day Select Choice I Plan (HMO I-SNP) H0838-044

January 1, 2023 - December 31, 2023.

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

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please access the "Evidence of Coverage" at www.bndhmo.com.

To join **Brand New Day Select Care I Plan (HMO I-SNP)** or **Brand New Day Select Choice I Plan (HMO I-SNP)** 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 counties in California: Los Angeles, Orange, Riverside, San Bernardino.

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 Brand New Day Member Services Department at 1-866-255-4795, TTY 711 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 or visit our website at www.bndhmo.com.

Premium & Benefits	Brand New Day Select Care I Plan HMO I-SNP (42)	Brand New Day Select Choice I Plan HMO I-SNP (44)
Monthly Plan Premium You must keep paying your Medicare Part B premium.	**$0**	**$38.90** **Your premium may be less if you are receiving Extra Help.**
Part B Rebate	**$85 per month**	**$0 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 $7,550 annually**
Inpatient Hospital*	**$0 per stay**	**$1,600 deductible** **$0 copay** per day for days 1–60 **$400 copay** per day for days 61–90**
Outpatient Hospital*‡	**$0 - $100 copay**	**$0 - 20% coinsurance****
Ambulatory Surgery Center*	**$0 copay**	**$0 - 20% coinsurance****
Doctor Visits • Primary care providers • Specialists*	 **$0 copay** **$0 copay**	 **$0 copay** **20% coinsurance****

** Your costs for Brand New Day Select Choice I Plan (HMO I-SNP) may be less depending on your Medi-Cal status.
* Services may require authorization.
‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Premium & Benefits	Brand New Day Select Care I Plan HMO I-SNP (42)	Brand New Day Select Choice I Plan HMO I-SNP (44)
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 - $10 copay**	**$90 copay****
Urgent Care	**$0 copay**	**$0 copay**
Diagnostic Services/Labs/ Imaging* • Diagnostic tests and procedures • Lab services • MRI, CAT scan • X-rays	 **$0 copay** **$0 copay** **$0 copay** **$0 copay**	 **$0 - 20% coinsurance**** **$0 copay** **$0 - 20% coinsurance**** **20% coinsurance**
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** **$149 per hearing aid** for the basic model You receive 2 hearing aids every 3 years

* Services may require authorization.
◊ Services do not require authorization or a referral.
** Your costs for Brand New Day Select Choice I Plan (HMO I-SNP) may be less depending on your Medi-Cal status.

Premium & Benefits	Brand New Day Select Care I Plan HMO I-SNP (42)	Brand New Day Select Choice I Plan HMO I-SNP (44)
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	**$25 - $400 copay**	**$0 copay**
• Endodontics	**$25 - $720 copay**	**$0 copay**
• Periodontics	**$0 - $780 copay**	**$0 copay**
• Extractions	**$70 - $140 copay**	**$0 copay**
• Prosthodontics, other oral/maxillofacial surgery, other services	**$0 - $1,110 copay**	**$0 - $350 copay**
• Non-routine services	**$0 - $300 copay**	**$0 copay**
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 $300 per year**	**Up to $300 per year**
Mental Health Services*		
• Outpatient individual therapy	**$0 copay**	**$40 copay****
• Outpatient group therapy	**$0 copay**	**$40 copay****
Skilled Nursing Facility (SNF)*	**$0 per stay**	**$0 copay** per day for days 1–20 **Up to $200 copay** per day for days 21–100**
Physical Therapy*	**$0 copay**	**$40 copay****

* Services may require authorization.
† Limitations may apply. See your EOC for details.
** Your costs for Brand New Day Select Choice I Plan (HMO I-SNP) may be less depending on your Medi-Cal status.

Premium & Benefits	Brand New Day Select Care I Plan HMO I-SNP (42)	Brand New Day Select Choice I Plan HMO I-SNP (44)
Ambulance (Ground)*	**$0 - $75 copay per ride**	**$0 - 20% coinsurance per ride****
Transportation*	**$0 for 24 one-way trips to plan approved locations (up to 50 mile limit)**	**$0 for 48 one-way trips to plan approved locations (up to 50 mile limit)**
Medicare Part B Drugs*		
• Chemotherapy drugs	**$0 copay**	**20% coinsurance****
• Other Part B drugs	**$0 copay**	**20% coinsurance****

** Your costs for Brand New Day Select Choice I Plan (HMO I-SNP) may be less depending on your Medi-Cal status.
* Services may require authorization.

Outpatient Prescription Drugs				
	Brand New Day Select Care I Plan HMO I-SNP (42)		Brand New Day Select Choice I Plan HMO I-SNP (44)	
Part D Deductible (Tiers 2 to 5)	**No deductible**		**$0 or $104[1]** [1] Depending on the level of Extra Help that you receive	
	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**	**$0 copay**	**$0 copay**
Tier 3 – Preferred Brand	**$0 copay**	**$0 copay**	**$0, $1.45, $4.15 or 15% for generic drugs[1]**	
Tier 4 – Non-Preferred Brand	**$50 copay**	**$100 copay**		
Tier 5 – Specialty Tier	**25% of the cost**	**Not available**	**$0, $4.30, $10.35 or 15% for brand drugs[1]**	
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**

Outpatient Prescription Drugs			
	Brand New Day Select Care I Plan HMO I-SNP (42)		Brand New Day Select Choice I Plan HMO I-SNP (44)
Tier 2 – Generic	**25% of the cost**	**25% of the cost**	**$0, $1.45, $4.15 or 15%[1] for generic drugs**
Tier 3 - Preferred Brand	**25% of the cost**	**25% of the cost**	**$0, $4.30, $10.35 or 15%[1] for brand drugs**
Tier 4 - Non-preferred Drug	**25% of the cost**	**25% of the cost**	
Tier 5 - Specialty	**25% of the cost**	**Not available**	
Tier 6 – Select Care	**$0 copay**	**$0 copay**	**$0 copay[1] | $0 copay Depending on the level of Extra Help that you receive**
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*	Brand New Day Select Care I Plan HMO I-SNP (42)	Brand New Day Select Choice I Plan HMO I-SNP (44)
Over-The-Counter (OTC) Items	**Up to $65 every 6 months**	**Up to $465 every 3 months**
Acupuncture* • Medicare-covered acupuncture	**$0 copay**	**$0 copay**
Chiropractic Services* • Medicare-covered chiropractic care	**$0 copay**	**$0 copay**
24/7 Telehealth	**$0 copay**	**$0 copay**
Personal Emergency Response System (PERS)	**$0 copay**	**$0 copay**
Durable Medical Equipment (DME)*	**$0 - 20% coinsurance**	**20% coinsurance****
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	**$10 copay** **Coverage up to $50,000**	**$90 copay** **Coverage up to $50,000**

** Your costs for Brand New Day Select Choice I Plan (HMO I-SNP) may be less depending on your Medi-Cal status.

NOTICE OF NON-DISCRIMINATION

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

Brand New Day

- 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 Brand New Day Customer Service Department at: 1-866-255-4795 (TTY 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.

If you believe that Brand New Day 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:

Brand New Day
Attn: Appeals & Grievances Department
5455 Garden Grove Blvd, Suite 500
Westminster, California 92683
Fax: 657-400-1217
Email: Complaints@universalcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Customer Service 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 1-866-255-4795. 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 1-866-255-4795. 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 1-866-255-4795。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 1-866-255-4795。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 1-866-255-4795. 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 1-866-255-4795. 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 1-866-255-4795 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 1-866-255-4795. 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 1-866-255-4795 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 1-866-255-4795. 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 1-866-255-4795. 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 1-866-255-4795. 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 1-866-255-4795. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-866-255-4795. 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 1-866-255-4795. 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 1-866-255-4795. 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、 1-866-255-4795 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。