

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

2024

Summary of Benefits

Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)

Los Angeles
Orange

Riverside
San Bernardino

San Diego

2024 Summary of Benefits

Brand New Day Embrace Choice Plan (HMO C-SNP) H0838-040-001

January 1, 2024 - December 31, 2024.

Brand New Day is an HMO SNP with a Medicare contract. Enrollment in Brand New Day 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 Embrace Choice Plan (HMO C-SNP)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area, and must have Diabetes, Chronic Heart Failure (CHF), or Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder). Our service area includes the following counties in California: Los Angeles, Orange, Riverside, San Bernardino and San Diego.

Except in emergency or urgent 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 (866) 255-4795, TTY 711 8:00 A.M. to 8:00 P.M. (PT), 7 days a week or visit our website at www.bndhmo.com.

Premium & Benefits	Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)	Your Cost w/ Medicare+full Medi-Cal
Monthly Plan Premium You must keep paying your Medicare Part B premium.	\$41 Your premium may be less if you are receiving Extra Help.	\$0
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	No more than \$8,850 annually	\$0
Inpatient Hospital*	\$1,600 deductible \$0 copay per day for days 1–60 \$400 copay per day for days 61–90 These are 2023 cost-sharing amounts and may change for 2024. We will provide updated rates at www.bndhmo.com as soon as they are released.	\$0 copay
Outpatient Hospital*‡	20% coinsurance	\$0 copay
Ambulatory Surgery Center*	20% coinsurance	\$0 copay
Doctor Visits <ul style="list-style-type: none"> • Primary care providers • Specialists* 	\$0 copay 40% coinsurance	\$0 copay \$0 copay

* Services may require authorization.

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

Premium & Benefits	Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)	Your Cost w/ Medicare+full Medi-Cal
<p>Preventive Care</p> <p>Other preventive services are available.</p> <ul style="list-style-type: none"> • Flu vaccine, diabetic screenings, etc.* • Routine Annual Physical 	<p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay</p> <p>Refer to Medi-Cal handbook for details about your Medi-Cal benefits.</p>
<p>Emergency Care</p> <p>Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours</p>	<p>\$100 copay</p>	<p>\$0 copay</p>
<p>Urgent Care</p>	<p>\$0 copay</p>	<p>\$0 copay</p>
<p>Diagnostic Services/Labs/Imaging*</p> <ul style="list-style-type: none"> • Diagnostic tests and procedures • Lab services • MRI, CAT scan • X-rays 	<p>20% coinsurance</p> <p>\$0 copay</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>
<p>Hearing Services</p> <ul style="list-style-type: none"> • Medicare-covered hearing exam • Routine hearing exam One per year • Hearing aid fittings and evaluations One per year • Hearing aid* 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$149 per hearing aid for the basic model You receive 2 hearing aids every 3 years</p>	<p>\$0 copay</p> <p>Refer to Medi-Cal handbook for details about your Medi-Cal benefits.</p>

* Services may require authorization.

Premium & Benefits	Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)	Your Cost w/ Medicare+full Medi-Cal
<p>Dental Services†</p> <ul style="list-style-type: none"> • Medicare-covered dental services* • Preventive dental (e.g., oral exam, x-rays, cleanings) <p>Comprehensive Dental*</p> <ul style="list-style-type: none"> • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics, other oral/ maxillofacial surgery, other services • Non-routine services 	<p>\$0 copay</p> <p>\$0 - \$17 copay</p> <p>\$2 - \$3 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 - \$350 copay</p> <p>\$0 - \$350 copay</p> <p>\$20 copay</p>	<p>\$0 copay</p> <p>Refer to Medi-Cal handbook for details about your Medi-Cal benefits.</p> <p>Refer to Medi-Cal handbook for details about your Medi-Cal benefits.</p>
<p>Vision Services*†</p> <ul style="list-style-type: none"> • Medicare-covered eye exams • Medicare-covered eyewear • Routine eye exam • Retinal imaging • Eyewear allowance 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>One exam per year \$0 copay</p> <p>One exam per year Up to \$300 per year</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>Refer to Medi-Cal handbook for details about your Medi-Cal benefits.</p>
<p>Mental Health Services*</p> <ul style="list-style-type: none"> • Outpatient individual therapy • Outpatient group therapy 	<p>\$45 copay</p> <p>\$45 copay</p>	<p>\$0 copay</p> <p>\$0 copay</p>

† Limitations may apply. See your EOC for details.

* Services may require authorization.

Premium & Benefits	Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)	Your Cost w/ Medicare+full Medi-Cal
Skilled Nursing Facility (SNF)*	<p>\$0 copay per day for days 1–20</p> <p>Up to \$200 copay per day for days 21–100</p> <p>These are 2023 cost-sharing amounts and may change for 2024. We will provide updated rates at www.bndhmo.com as soon as they are released.</p>	\$0 copay
Physical Therapy*	\$0 copay	\$0 copay
Ambulance (Ground)*	20% coinsurance per ride	\$0 copay
Ambulance (Air)*	20% coinsurance	\$0 copay
Transportation*	\$0 for 12 one-way trips to plan approved locations (up to 50 mile limit)	Refer to Medi-Cal handbook for details about your Medi-Cal benefits.
Medicare Part B Drugs* <ul style="list-style-type: none"> • Chemotherapy drugs • Other Part B drugs • Part B insulin drugs 	<p>20% coinsurance unless capped by Inflation Reduction Act (IRA) rules</p> <p>20% coinsurance unless capped by Inflation Reduction Act (IRA) rules</p> <p>\$35 copay</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>

* Services may require authorization.

Outpatient Prescription Drugs

Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)

**Part D Deductible
(Tiers 2 to 5)**

\$0*

***For Full Benefit Dual Eligible (FBDE) members**

Retail Rx 30-day supply

Mail Order 100-day supply

**Part D Insulins
Tier 3 – Preferred Brand**

\$0 copay*

\$0 copay*

***For Full Benefit Dual Eligible (FBDE) members**

Initial Coverage

You are in the Initial Coverage stage until you reach \$5,030 in drug costs (year to date)

Tier 1 – Preferred Generic

\$0 copay

\$0 copay

Tier 2 – Generic

\$0 copay*

\$0 copay*

Tier 3 – Preferred Brand

\$0 copay*

\$0 copay*

Tier 4 – Non-Preferred Brand

\$0 copay*

\$0 copay*

Tier 5 – Specialty Tier

\$0 copay*

Not available

Tier 6 – Select Care

\$0 copay

\$0 copay

***For Full Benefit Dual Eligible (FBDE) members**

Coverage Gap

You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$8,000

Tier 1 – Preferred Generic

\$0 copay

\$0 copay

Tier 2 – Generic

\$0 copay*

\$0 copay*

Tier 3 - Preferred Brand

\$0 copay*

\$0 copay*

Tier 4 - Non-preferred Drug

\$0 copay*

\$0 copay*

Outpatient Prescription Drugs

Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)

Tier 5 - Specialty
Tier 6 – Select Care

\$0 copay*

\$0 copay*

\$0 copay

\$0 copay

***For Full Benefit Dual Eligible (FBDE) members**

Catastrophic Coverage

You are in this stage after your year-to-date "out-of-pocket costs" (your payments) reach a total of \$8,000

During this stage, the plan will pay for the full cost of your covered Part D drugs.

Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year (through December 31, 2024).

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 Embrace Choice Plan (HMO C-SNP) (40-1)
24/7 Telehealth	\$0 copay
Acupuncture* <ul style="list-style-type: none"> • Medicare-covered acupuncture • Routine acupuncture 	\$0 copay \$0 copay Up to 30 visits every year combined with Routine Chiropractic services.
Chiropractic Services* <ul style="list-style-type: none"> • Medicare-covered chiropractic care • Routine chiropractic care 	\$0 copay \$0 copay Up to 30 visits every year combined with Routine Acupuncture services.
Durable Medical Equipment (DME)*	20% coinsurance
Flex Card You will have one card to use at retail locations for all of your individual benefits listed below: <ul style="list-style-type: none"> • Over-The-Counter (OTC) Items 	Up to \$60 every month
Gym Membership*	\$0 copay
Healthy Foods Allowance‡ These are Special Supplemental Benefits for Chronic Illnesses. Certain qualifying conditions are required for members to access these benefits.	Up to \$50 each month for healthy foods for members with a qualifying chronic condition
In-Home Support Services*	\$0 copay for up to 20 hours per calendar year. Not all members will qualify, please see your EOC for more details.

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

Extra Benefits	Brand New Day Embrace Choice Plan (HMO C-SNP) (40-1)
Meals (Made Easy Meals)*‡	Receive 14 meals each month, for 12 months (168 total meals). Meal delivery is included 1 time per month.
Personal Emergency Response System (PERS)*	\$0 copay
Scales These are Special Supplemental Benefits for Chronic Illnesses. Certain qualifying conditions are required for members to access these benefits.	\$0 copay
Worldwide Emergency Care <ul style="list-style-type: none"> • Urgent Care • Emergency Room • Emergency Transportation 	\$100 copay Coverage up to \$50,000

* Services may require authorization.

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