

Brand New Day Dual Coverage (HMO SNP) Summary of Benefits

January 1, 2015 - December 31, 2015

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Dual Coverage (HMO SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Dual Coverage (HMO SNP)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook.

View it online at <http://www.medicare.gov> or get a copy 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.

Sections in this booklet

- Things to Know About **Dual Coverage (HMO SNP)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at (866-255-4795). TTY users should call 1-866-321-5955.

Este documento puede ser disponible en un idioma no ingles. Para obtener informacion adicional, llame a servicio

al cliente en el numero de telefono (866-255-4795). Los usuarios de TTY deben llamar al 1-866-321-5955.

Things to Know About Dual Coverage (HMO SNP)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time.

Dual Coverage (HMO SNP) Phone Numbers and Website

- If you are a member of this plan, call toll-free (866-255-4795). TTY: 1-866-321-5955
- If you are not a member of this plan, call toll-free (866-255-4795). TTY: 1-866-321-5955
- Our website: <http://www.brandnewdayhmo.com>

Who can join?

To join **Dual Coverages (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Medi-Cal, and live in our service area.

Our service area includes the following counties in California: Kern, Los Angeles, Orange, Riverside, and San Bernardino.

Which doctors, hospitals, and pharmacies can I use?

Dual Coverage (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (<http://www.brandnewdayhmo.com>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.

- **Our plan members also get *more than what is covered by Original Medicare*.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, <http://www.brandnewdayhmo.com>

- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Dual Coverage (HMO SNP) Summary of Benefits

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

How much is the monthly premium?	\$0 per month.
How much is the deductible?	<p>This plan does not have a deductible.</p> <p>This plan does not have a deductible for chemotherapy and other drugs administered in your doctor's office (Part B drugs).</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>
Is there any limit on how much I will pay for my covered services?	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medi-Cal eligibility.</p> <p>Refer to the "Medicare & You" handbook for Medicare-covered services. For Medi-Cal-covered services, refer to the Medicaid Coverage section in this document.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$6,700 for services you receive from in-network providers. <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:

- SERVICES WITH A ❶ MAY REQUIRE PRIOR AUTHORIZATION.
- SERVICES WITH A ❷ MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

Benefit Category	Dual Coverage (HMO SNP)
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OUTPATIENT CARE AND SERVICES

Acupuncture and Other Alternative Therapies ❶❷	For up to 6 visit(s) every year: You pay nothing
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Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
OUTPATIENT CARE AND SERVICES (continued)	
Ambulance ①	You pay nothing
Chiropractic Care ①②	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing
Dental Services ①②	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing</p> <p>Preventive dental services:</p> <ul style="list-style-type: none"> • Cleaning (for up to 1 every six months): You pay nothing • Dental x-ray(s) (for up to 1 every year): You pay nothing • Fluoride treatment (for up to 1 every year): You pay nothing • Oral exam (for up to 2 every year): You pay nothing <p>Comprehensive Dental Services:</p> <ul style="list-style-type: none"> • \$1000 plan coverage limit annually for Comprehensive Dental services
Diabetes Supplies and Services ①②	<p>Diabetes monitoring supplies. You pay nothing.</p> <p>Diabetes self-management training. You pay nothing.</p> <p>Therapeutic shoes or inserts: You pay nothing.</p>
Diagnostic Tests, Lab and Radiology Services, and XRays ①②	<p>Diagnostic radiology services (such as MRIs, CT scans): You pay nothing</p> <p>Diagnostic tests and procedures: You pay nothing</p> <p>Lab services: You pay nothing</p> <p>Outpatient x-rays: You pay nothing</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing</p>
Doctor's Office Visits ①②	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p>
Durable Medical Equipment (wheelchairs, oxygen, etc.) ①	You pay nothing

Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
OUTPATIENT CARE AND SERVICES (continued)	
Emergency Care	<p>You pay nothing</p> <p>Worldwide emergency care is covered.</p>
Foot Care (podiatry services) ①②	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing
Hearing Services ①②	Exam to diagnose and treat hearing and balance issues: You pay nothing
Home Health Care ①②	You pay nothing
Mental Health Care ①②	<p>Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient 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. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay nothing</p> <p>Outpatient group therapy visit: You pay nothing</p> <p>Outpatient individual therapy visit: You pay nothing</p>
Outpatient Rehabilitation ①②	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: You pay nothing</p> <p>Physical therapy and speech and language therapy visit: You pay nothing</p>

Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
OUTPATIENT CARE AND SERVICES (continued)	
Outpatient Substance Abuse ①②	Group therapy visit: You pay nothing Individual therapy visit: You pay nothing
Outpatient Surgery ①②	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing
Over-the-Counter Items	Not Covered
Prosthetic Devices (braces, artificial limbs, etc.) ①	Prosthetic devices: You pay nothing Related medical supplies: You pay nothing
Renal Dialysis ①②	You pay nothing
Transportation ①②	You pay nothing 36 one way trips to plan approved locations is covered annually
Urgent Care	You pay nothing
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every year): You pay nothing Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to \$150 every two years for eyeglasses (frames and lenses).
Preventive Care ①②	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings

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Benefit Category	Dual Coverage (HMO SNP)
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OUTPATIENT CARE AND SERVICES (continued)

Preventive Care ①② (continued)	<ul style="list-style-type: none"> • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Hospice	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p>

INPATIENT CARE

Inpatient Hospital Care ①②	<p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient 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. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay nothing</p>
Inpatient Mental Health Care	<p>For inpatient mental health care, see the "Mental Health Care" section of this booklet.</p>

Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
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INPATIENT CARE (continued)

Skilled Nursing Facility (SNF) ①②	Our plan covers up to 100 days in a SNF. You pay nothing
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PRESCRIPTION DRUG BENEFITS

How much do I pay?	For Part B drugs such as chemotherapy drugs ①: You pay nothing Other Part B drugs ①: You pay nothing
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Initial Coverage	Our plan does not have a deductible for Part D prescription drugs. You pay the following: You may get your drugs at network retail pharmacies and mail order pharmacies.
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Standard Retail Cost-Sharing
Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$0	\$0
Tier 2 (Non-Preferred Generic)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay. 	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
Tier 3 (Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay. 	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.

Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
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PRESCRIPTION DRUG BENEFITS (continued)

Initial Coverage (continued)	<u>Standard Retail Cost-Sharing (continued)</u>		
	Tier	One-month supply	Three-month supply
	Tier 4 (Non-Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay. 	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
	Tier 5 (Specialty Tier)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay. 	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
	Tier 6 (Select Diabetic Drugs)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay. 	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.

Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
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PRESCRIPTION DRUG BENEFITS (continued)

Initial Coverage (continued)	Standard Mail Order Cost-Sharing	
	Tier	Three-month supply
	Tier 1 (Preferred Generic)	\$0
	Tier 2 (Non-Preferred Generic)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
	Tier 3 (Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
	Tier 4 (Non-Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.

Dual Coverage (HMO SNP) Summary of Benefits

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Benefit Category	Dual Coverage (HMO SNP)
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PRESCRIPTION DRUG BENEFITS (continued)

Initial Coverage (continued)	<u>Standard Mail Order Cost-Sharing (continued)</u>	
	Tier	Three-month supply
	Tier 5 (Specialty Tier)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
	Tier 6 (Select Diabetic Drugs)	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$2.65 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.60 copay; or • \$6.60 copay.
If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.		

Catastrophic Coverage	You pay nothing
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SUMMARY OF MEDI-CAL COVERED BENEFITS

The benefits described below are covered by Medi-Cal. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what Medi-Cal covers and what our plan covers. What you pay for covered services may depend on your level of Medi-Cal eligibility.

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
1. Inpatient hospital services	\$0 copay for Medicaid-covered services	<p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient 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. You must pay the inpatient hospital deductible for each benefit period.</p> <p>There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>You pay nothing</p>
2. Outpatient hospital services	\$0 copay for Medicaid-covered services	<p>Ambulatory surgical center: You pay nothing</p> <p>Outpatient hospital: You pay nothing</p>
3. Rural health clinic services	\$0 copay for Medicaid-covered services	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p>
4. Federally qualified health center services	\$0 copay for Medicaid-covered services	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p>
5. Laboratory services	\$0 copay for Medicaid-covered services	<p>Lab services: You pay nothing</p>

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
6. X-rays	\$0 copay for Medicaid-covered services	<p>Diagnostic radiology services (such as MRIs, CT scans): You pay nothing</p> <p>Outpatient x-rays: You pay nothing</p> <p>Therapeutic radiology (such as radiation treatment for cancer): You pay nothing</p>
7. Skilled nursing facility care for over 21 years of age - Subacute care	\$0 copay for Medicaid-covered services	<p>You pay nothing.</p> <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient 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. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>A per admission deductible is applied once during the defined benefit period.</p>
8. Pediatric nursing facility care for under 21 years of age - Subacute services <i>(Early & periodic screening, diagnosis, and treatment supplemental services)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit.
9. Family planning services & supplies	\$0 copay for Medicaid-covered services	Some contraceptives are covered under the Part D benefit. Refer to the prescription drug benefit for details.
10. Physician services	\$0 copay for Medicaid-covered services	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: You pay nothing</p>
11. Medical & surgical dental services	\$0 copay for Medicaid-covered services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):

**STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM
COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES**

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
12. Ophthalmologist services	\$0 copay for Medicaid-covered services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing
13. Podiatry services*	\$0 copay for Medicaid-covered services	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing.
14. Optometry services	\$0 copay for Medicaid-covered services	<p>Routine eye exam (for up to 1 every year): You pay nothing</p> <p>Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing</p> <p>Eyeglasses or contacts after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$150 every two years for eyeglasses (frames and lenses)</p>
15. Chiropractic services*	\$0 copay for Medicaid-covered services	<p>We cover only manual manipulation of the spine to correct subluxation (when 1 or more of the bones of your spine move out of position)</p> <p>You pay nothing.</p>
16. Psychology services*	\$0 copay for Medicaid-covered services	<p>Outpatient group therapy visit: You pay nothing</p> <p>Outpatient individual therapy visit: You pay nothing</p>
17. Nurse anesthetist services	\$0 copay for Medicaid-covered services	\$0 co-pay for Medicare-covered Nurse Anesthetist services.
18. Optician and optical fabricating lab services*	\$0 copay for Medicaid-covered services	Not a covered benefit
19. Medical supplies (does not include incontinence creams and washes)	\$0 copay for Medicaid-covered services	General Authorization rules may apply.

**STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM
COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES**

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
19. Medical supplies (continued))		<p>In-Network</p> <p>Diabetic supplies \$0 co-pay for Medicare-covered diabetes monitoring supplies (Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors, Therapeutic shoes).</p> <p>Durable Medical Equipment Supplies such as wheelchairs, crutches and hospital bed are covered under the Durable medical equipment benefit: \$0 co-pay for Medicare-covered durable medical equipment.</p> <p>Prosthetic related supplies (such as colostomy supplies) \$0 co-pay for Medicare-covered prosthetic devices.</p> <p>Surgical supplies Surgical supplies, such as dressings, supplies such as splints and casts covered under the Outpatient diagnostic tests and therapeutic services and supplies benefit: \$0 co-pay for Medicare-covered outpatient diagnostic tests and therapeutic services and supplies</p>
20. Incontinence creams and washes*	\$0 copay for Medicaid-covered services	Not a covered benefit
21. Durable medical equipment	\$0 copay for Medicaid-covered services	You pay nothing
22. Hearing aids	\$0 copay for Medicaid-covered services	Not a covered benefit
23. Enteral formulae	\$0 copay for Medicaid-covered services	\$0 co-pay for Medicare covered services
24. Acupuncture services*	\$0 copay for Medicaid-covered services	For up to 6 visit(s) every year: You pay nothing

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
25. Licensed midwife services	\$0 copay for Medicaid-covered services	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare covered Licensed midwife services</p>
26. Home health services through a home health agency <i>(including home health nursing and aide services, physical and occupational therapy, speech pathology and audiology services, intermittent nursing, home health aid care, medical supplies, equipment and appliances)</i>	\$0 copay for Medicaid-covered services	You pay nothing.
27. Physical therapy and related services	\$0 copay for Medicaid-covered services	Physical therapy visit: You pay nothing
28. Rehabilitation facilities	\$0 copay for Medicaid-covered services	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare covered rehabilitation facility.</p>
29. Private duty nursing <i>(Waiver only)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit
30. Clinic <i>(Organized outpatient clinic, Indian Health Services, alternate birthing centers, ambulatory surgical centers)</i>	\$0 copay for Medicaid-covered services	<p>Ambulatory surgical center: You pay nothing</p> <p>Outpatient hospital: You pay nothing</p>
31. Dental services	\$0 copay for Medicaid-covered services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing

**STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM
COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES**

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
31. Dental services (continued)		<p>Preventive dental services:</p> <ul style="list-style-type: none"> •Cleaning (for up to 1 every six months): You pay nothing •Dental x-ray(s) (for up to 1 every year): You pay nothing •Fluoride treatment (for up to 1 every year): You pay nothing •Oral exam (for up to 2 every year): You pay nothing <p>\$1,000 plan coverage limit for comprehensive dental benefits every year</p>
32. Occupational therapy	\$0 copay for Medicaid-covered services	Occupational therapy visit: You pay nothing
33. Speech pathology/ Speech therapy*	\$0 copay for Medicaid-covered services	Speech and language therapy visit: You pay nothing
34. Audiology services*	\$0 copay for Medicaid-covered services	Exams to diagnose and treat hearing and balance issues: You pay nothing
35. Pharmaceutical services and prescribed drugs	\$0 copay for drugs excluded from Medicare Part D coverage	<p>For Part B drugs such as chemotherapy drugs: You pay nothing</p> <p>Other Part B drugs: You pay nothing</p> <p>Services may require prior authorization</p> <p>Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.brandnewdayhmo.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers.

**STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM
COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES**

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
35. Pharmaceutical services and prescribed drugs (continued)		<p>Your in-network prescription coverage may be limited to the plan's service area.</p> <p>In-Network You pay a \$0 annual deductible.</p> <p>Initial Coverage Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either: - \$0 copay; or - \$1.20 copay; or - \$2.65 copay</p> <p>For all other drugs, either: - \$0 copay; or - \$3.60 copay; or - \$6.60 copay.</p> <p>Catastrophic Coverage You pay a \$0 copay.</p>
36. Dentures*	\$0 copay for Medicaid-covered services	<p>General Authorization rules may apply</p> <p>\$0 co-pay</p>
37. Prosthetic appliances (Orthotic appliances) prosthetic eyes	\$0 copay for Medicaid-covered services	<p>Prosthetic devices: You pay nothing</p> <p>Related medical supplies: You pay nothing</p>
38. Eyeglasses, other eye appliances*	\$0 copay for Medicaid-covered services	<p>Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$150 every two years for eyeglasses (frames and lenses).</p>

**STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM
COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES**

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
39. Comprehensive Perinatal Services Program <i>(Preventive services)</i>	\$0 copay for Medicaid-covered services	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare covered perinatal services (Preventive services)</p>
40. Community-Based Adult Services (CBAS) <i>(waiver only)**</i>	\$0 copay for Medicaid-covered services	Not a covered benefit
41. Chronic dialysis services		You pay nothing
42. Rehabilitation services <i>(chronic dialysis, outpatient heroin detoxification, rehabilitative mental health, drug Medi-Cal, independent rehabilitation centers)</i>	<p>\$0 copay for Medicaid-covered services</p> <p>\$0 copay for Medicaid-covered services</p> <p>\$0 copay for Medicaid-covered services</p>	<p>General Authorization rules may apply.</p> <p>In-Network Dialysis (Kidney) \$0 co-pay for Medicare-covered renal dialysis.</p> <p>Outpatient substance abuse services \$0 co-pay for Medicare-covered individual substance abuse outpatient treatment visit</p> <p>\$0 co-pay for Medicare covered group substance abuse outpatient treatment visit</p> <p>Outpatient Mental Health Care In-Network \$0 copay for each Medicare-covered individual therapy visit</p> <p>\$0 copay for: - each Medicare-covered individual therapy visit with a psychiatrist - each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$0 copay for Medicare-covered partial hospitalization program services</p>

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
43. Institutes for Mental Diseases <i>(for under 21 years of age and over 65 years of age, including inpatient psychiatric care).</i>	\$0 copay for Medicaid-covered services	<p>Covered services include mental health care services that require a hospital stay. 190 day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</p> <p>\$0 co-pay</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
44. Intermediate Care Facility	\$0 copay for Medicaid-covered services	Custodial care received in an Intermediate or Long Term Care Facility is not covered by Brand New Day.
45. Nurse midwife	\$0 copay for Medicaid-covered services	<p>\$0 co-pay for Medicare covered Nurse midwife services</p> <p>Authorization rules may apply</p>
46. Hospice	\$0 copay for Medicaid-covered services	<p>General You must get care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program your hospice services and your Original Medicare services are paid for by Original Medicare not Brand New Day.</p>
47. TB-related services	\$0 copay for Medicaid-covered services	\$0 co-pay for Medicare covered TB related services
48. Respiratory care for ventilator-dependent patients	\$0 copay for Medicaid-covered services	\$0 co-pay for Medicare covered respiratory care for ventilator-dependent patients. Authorization rules may apply.
49. Family nurse practitioner	\$0 copay for Medicaid-covered services	<p>General Authorization rules may apply</p> <p>In Network \$0 co-pay for Medicare covered family nurse practitioner services</p>

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
50. Home and community care for functionally disabled elderly <i>(Waiver only)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit
51. Community-supported living arrangements <i>(Waiver only)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit
52. Personal care services	\$0 copay for Medicaid-covered services	Not a covered benefit
53. Rural primary care hospital	\$0 copay for Medicaid-covered services	<p>General Authorization rules may apply</p> <p>In Network \$0 co-pay for Medicare covered Rural primary care hospital services.</p> <p>Authorization rules may apply.</p>
54. Nonmedical health facilities	\$0 copay for Medicaid-covered services	<p>If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, our plan will provide coverage for care in a religious non- medical health care institution. Only Part A inpatient services (non-medical health care services) are covered. Must get approval from our plan in advance of care being provided or the stay is not covered. Medicare Inpatient hospital coverage limits apply to care received in a Religious non-medical care institution.</p> <p>Plan covers 90 days each benefit period.</p>
55. Emergency hospital services	\$0 copay for Medicaid-covered services	<p>General \$0 co-pay for Medicare-covered emergency room visits.</p> <p>Worldwide emergency care is covered by the plan.</p>

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM

COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
<p>56. Transportation <i>(State provides emergency and non-emergency medical transportation. Meets federal requirement for assurance of transportation to medically necessary services)</i></p>	<p>\$0 copay for Medicaid-covered services</p>	<p>Ambulance Services General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered ambulance benefits.</p> <p>Transportation (Routine) General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for up to 36 one-way trips to plan approved location every year.</p>
<p>57. Services for pregnant women that treat a condition that may impact the woman and/or the fetus <i>(Not specifically stated as a benefit but is a mandated provision under federal regulations)</i></p>	<p>\$0 copay for Medicaid-covered services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare covered services.</p>
<p>58. Marriage and family counselor services <i>(Early & periodic screening, diagnosis, and treatment services & waiver only)</i></p>	<p>\$0 copay for Medicaid-covered services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare covered marriage and family counselor services</p>
<p>59. Licensed clinical social worker services <i>(Early & periodic screening, diagnosis, and treatment services & waiver only)</i></p>	<p>\$0 copay for Medicaid-covered services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare covered Licensed clinical social worker services.</p>
<p>60. Case management <i>(Early & periodic screening, diagnosis, and treatment services & waiver only)</i></p>	<p>\$0 copay for Medicaid-covered services</p>	<p>\$0 copay for Medicare covered case management services.</p>

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
61. Private duty nursing agency services <i>(Early & periodic screening, diagnosis, and treatment services & waiver only)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit
62. Individual nurse provider services <i>(Early & periodic screening, diagnosis, and treatment services & waiver only)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit
63. Nonmedical services <i>(Waiver only)</i>	\$0 copay for Medicaid-covered services	Not a covered benefit

***Optional Benefit Exclusion:**

The benefits noted above with * are only available to this beneficiary population: 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a skilled nursing facility (Nursing Facilities Level A and Level B, including sub-acute care facilities); 3) beneficiaries who are pregnant (pregnancy-related benefits and services; other benefits and services to treat conditions that, if left untreated, might cause difficulties for the pregnancy); 4) California Children's Services beneficiaries; and 5) beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly.

****Community-Based Adult Services (CBAS)** has replaced Adult Day Health Care services. Adult Day Health Care services were eliminated on March 31, 2012. CBAS became effective April 1, 2012