brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

<PROCESSED_DATE>

Dear <MEM_FIRST_NAME> <MEM_LAST_NAME>,

This is a notice to let you know that some of your health plan materials will be available in electronic format. We hope this will be easier for you than saving stacks of paper. It also allows us to put more funds towards other benefits that are important to our members. **The plan materials will be available to you starting October 1st, 2018 in electronic format or you may call the Member Services Department and request them to be sent by email or postal mail.**

For your convenience, the following plan materials will be posted on our website.
Use the links below to access them.

> **Evidence of Coverage:** www.bndhmo.com/members/plan-details
> These plan materials are related to detailed information about your coverage and how it works.
>
> **Provider and Pharmacy Directories:** www.bndvpc.com/provider_search/
> This is a list of doctors and pharmacies in your area.
>
> **Formularies:** www.bndhmo.com/members/covered-medication-list-formulary
> This is a list of the Part D drugs that are covered by your plan.
>
> **Member Handbook:** www.bndhmo.com/members/member-handbook
> Your guide to using your benefits.

Remember, you can visit our website 24 hours a day, 7 days a week. These documents will remain posted there until year 2020. If you decide at any time that you want all documents going forward to be sent by regular mail, please call Brand New Day Member Services Department and tell them you want to "opt out of electronic notices".
Tell them you always want your copies mailed and we will always mail them to you instead.

Member Services can be reached by telephone at 1-866-255-4795; TTY is 1-866-321-5955. They are open Monday through Friday from 8 a.m. to 8 p.m. between April 1 and September 30 and 7 days a week between October 1 to March 31, from 8 a.m. to 8 p.m. We are here to help you.

Sincerely,
Enrollment Department
Brand New Day

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

Annual Notice of Changes for 2019

You are currently enrolled as a member of Brand New Day Classic Care Drug Savings. Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 3 and 3.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 3.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

H0838_550.2019.ANOC.025.180823.v2_M

OMB Approval 0938-1051 (Pending OMB Approval)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 3.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 5.2 to learn more about your choices.

☐ 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 want to **keep** our plan, you don't need to do anything. You will stay in Brand New Day Classic.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2018**

- If you **don't join another plan by December 7, 2018**, you will be enrolled in Brand New Day Classic Care I Plan.
- If you **join by another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-866-255-4795 for additional information. (TTY users should call 1-866-321-5955.) Hours are 8:00 a.m. to 8:00 p.m. 7 days a week from October 1 – March 31 and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30.
- This information may be available in a different format or language.
- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Brand New Day Classic Care I Plan

- Brand New Day is a Medicare Advantage Organization with a Medicare contract. Enrollment in this plan depends on contract renewal.
- 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 Classic Care I Plan.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Brand New Day Classic Care I Plan in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this Annual Notice of Changes** and review the enclosed Evidence of Coverage to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 3.1 for details.	$0	$0
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 3.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: You pay $0 per visit Specialist visits: You pay $0 per visit	Primary care visits: You pay $0 per visit Specialist visits: You pay $0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay $0	You pay $0

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 3.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay a $8 copay • Drug Tier 3: You pay a $45 copay • Drug Tier 4: You pay a $75 copay • Drug Tier 5: You pay 33% of the total cost • Drug Tier 6: You pay $0	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay an $8 copay • Drug Tier 3: You pay a $45 copay • Drug Tier 4: You pay a $85 copay • Drug Tier 5: You pay 33% of the total cost • Drug Tier 6: You pay $0

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from Brand New Day Classic Care Drug Savings to Brand New Day Classic Care I Plan.

You will receive your Brand New Day ID card by or before January 1, 2019.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Brand New Day Classic Care I Plan in 2019

If you do nothing to change your Medicare coverage by December 7, 2018, we will automatically enroll you in our Brand New Day Classic Care I Plan. This means starting January 1, 2019, you will be getting your medical and prescription drug coverage through Brand New Day Classic Care I Plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you can do so between January 1 and March 31. You can also change plans between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Brand New Day Classic Care Drug Savings and the benefits you will have on January 1, 2019 as a member of Brand New Day Classic Care I Plan.

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 3.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400 Once you have paid $3,400 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year	There is no change for the upcoming benefit year

Section 3.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.bndhmo.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 3.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.bndhmo.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 3.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2019 Evidence of Coverage.

Cost	2018 (this year)	2019 (next year)
Emergency Care	You pay a $100 copay per visit	You pay a $120 copay per visit

Cost	2018 (this year)	2019 (next year)
Worldwide Emergency /Urgent Coverage	You pay a $100 copay per visit for worldwide emergency services You pay a $125 copay for worldwide emergency transportation services You pay $0 for worldwide urgently needed services	You pay 20% of the total cost for worldwide emergency services You pay 20% of the total cost for worldwide emergency transportation services You pay 20% of the total cost for worldwide urgently needed services The maximum benefit per year for all worldwide services combined is $50,000.
Ambulance services	You pay a $125 copay per trip Covered ambulance services include fixed wing, rotary wing, and ground ambulance services	You pay a $125 copay per trip Covered ambulance services include fixed wing, rotary wing, ground ambulance services, and air ambulance services
Routine hearing exam	Routine hearing exams are not covered	You pay $0 for up to one routine hearing exam per year
Hearing aids	Hearing aids are not covered	You pay a $699 copay per aid Advanced aids You pay a $999 copay per aid for Premium aids Up to 2 hearing aids every year

Cost	2018 (this year)	2019 (next year)
Dental prophylaxis (cleaning)	You pay a $15 copay per visit one every 6 months	You pay a $0 copay per visit once every 6 months You pay a $55 copay per visit if more frequent
Dental oral exam	You pay $0 for an oral exam up to one every 6 months	You pay $0 for oral exams
Dental fluoride treatment	You pay $0 for fluoride treatment without varnish and a $12 copay for fluoride treatment with varnish up to one per year	You pay $0 for fluoride treatment without varnish and a $12 copay for fluoride treatment with varnish
Dental x-ray(s)	You pay $0 for dental x-ray(s) up to one per year	You pay $0 for dental x-ray(s)
Inpatient mental health	You pay $0 for days 1-90	You pay $0 for days 1-60 You pay a $329 copay per day for days 61-90 You pay a $658 copay per day for up to 60 lifetime reserve days
Outpatient mental health services	You pay $0 per visit for individual therapy visits You pay $0 per visit for group therapy visits	You pay a $20 copay per visit for individual therapy visits You pay a $20 copay per visit for group therapy visits

Cost	2018 (this year)	2019 (next year)
Outpatient substance abuse services	You pay $0 per visit for individual therapy visits You pay $0 per visit for group therapy visits	You pay 20% of the total cost for individual therapy visits You pay 20% of the total cost for group therapy visits
Physical therapy	You pay a $5 copay per visit	You pay a $10 copay per visit
Occupational therapy	You pay a $5 copay per visit	You pay a $20 copay per visit
Speech and language therapy	You pay a $5 copay per visit	You pay a $10 copay per visit
Durable Medical Equipment (DME)	You pay 20% of the total cost	You pay $0 for DME that costs less than $100 You pay 20% of the total cost for DME that costs more than $100
Prosthetic devices and related medical supplies	You pay 20% of the total cost for prosthetic devices You pay $0 for related medical supplies	You pay $0 for prosthetic devices that cost less than $100 You pay 20% of the total cost for prosthetic devices that cost more than $100 You pay 20% of the total cost for related medical supplies

Cost	2018 (this year)	2019 (next year)
Cardiac rehabilitation	You pay $0 for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks	You pay $0 for cardiac rehabilitation services Supervised Exercise Therapy is covered for qualified individuals up to 36 sessions for individuals with peripheral artery disease (PAD).
Pulmonary rehabilitation	You pay $0	You pay $0 for pulmonary rehabilitation services Supervised Exercise Therapy is covered for qualified individuals up to 36 sessions for individuals with peripheral artery disease (PAD).
Medicare Part B prescription drugs	You pay $0	You pay 20% of the total cost
Vial of Life Program The Vial of Life Program is a national program that allows individuals to have their complete medical information readily available to first responders in a universally recognized format when the individual is not able to speak or remember.	Vial of Life Program is not covered	You pay $0

Cost	2018 (this year)	2019 (next year)
Health education group classes	You pay $0 Health Education Group classes are offered to all members and one-to-one training in homes for the homebound. Educators consist of trained health professionals, nurses, nutritionist, certified addiction counselors, licensed clinical social workers with other behavioral health specialists appropriate to the type of class being taught.	You pay $0 Health Education Group classes are offered to all members and 1 on 1 training in homes for the homebound. Educators consist of trained health professionals, nurses, nutritionist, certified addiction counselors, licensed clinical social workers with other behavioral health specialists. All members have unlimited access to scheduled weekly classes on various topics which take place in Brand New Day sponsored Wellness Centers. Topics include prevention and management of Diabetes, Dementia, HIV / AIDS, Asthma, Chronic Bronchitis, other COPD, Artery Diseases, Cardiac Diseases, Cellulitis, MRSA, preventing and overcoming addictions to Smoking, Alcohol and Other Substances, Eating Disorders, and other classes as needed. One on one health education and healthcare delivery support is also provided. Health educational materials on specific diseases, nutrition, healthy aging, etc. are provided at no cost to the member.

Cost	2018 (this year)	2019 (next year)
Fitness benefit	You pay $0 Brand New Day offers a Gym and Fitness benefit for members. Members receive a membership at a local professional gym at no cost to the member for unlimited authorized visits. The first visit includes an orientation to the gym / fitness program, facilities, and equipment led by a qualified health professional. Brand New Day has contracts with professional gyms in each community. Additionally, Brand New Day has fitness classes (which may include yoga, walking clubs, and exercise classes) for all members led by local experts at Brand New Day sponsored Wellness Centers. These are scheduled group classes with unlimited interactive opportunity to meet with the local health educator, licensed vocational nurse, and / or fitness leader to discuss fitness goals.	You pay $0 Brand New Day offers a Gym and Fitness benefit for members. Members receive a membership at a local professional gym at no cost for unlimited authorized visits. The first visit includes an orientation to the gym / fitness program, facilities, and equipment led by a qualified health professional. Brand New Day has contracts with professional gyms in each community. Additionally, Brand New Day has fitness classes (which may include yoga, walking clubs, and exercise classes) for all members led by local experts at Brand New Day sponsored Wellness Centers. These are scheduled group classes with unlimited interactive opportunity to meet with the local health educator, licensed vocational nurse, and / or fitness leader to discuss fitness goals. Exercise Coach Consultant: One annual face to face or telephonic consultation with a personal trainer to help the member develop an exercise plan is included.

Cost	2018 (this year)	2019 (next year)
Weight Management benefit Members with a BMI of 30 or greater can join one of the Brand New Day weight loss programs to support a healthy weight loss plan, which includes medical management and educational sessions on nutrition, physical activity, and behavior changes.	Weight management is not covered	You pay $0

Section 3.6 – 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. The Drug List we provided electronically includes many –but not all– of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the complete Drug List** by calling Member Services (see the back cover) or visiting our website www.bndhmo.com.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
  - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary

supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions that have been approved for 2019 will be covered to the expiration date in 2019. You do not need to ask for another one. Some formulary exceptions may change in 2019, and you will not need to ask for an exception. Before the end of the expiration date stated in the approval letter, call member services for assistance.

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.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and didn’t receive this insert with this packet, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are in Section 9.1 of this booklet.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2018 to 2019.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.

Stage	2018 (this year)	2019 (next year)
Stage 2: 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.** 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.**	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 a $8 copay per prescription **Tier 3 – Preferred Brand:** You pay a $45 copay per prescription **Tier 4 – Non-Preferred Drug:** You pay a $75 copay per prescription **Tier 5 – Specialty Tier:** You pay 33% of the total cost. **Tier :6 – Select Care Drugs:** You pay an $11 copay per prescription ______________ Once your total drug costs have reached $3,750 you will move to the next stage (the Coverage Gap Stage).	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 an $8 copay per prescription **Tier 3 – Preferred Brand:** You pay a $45 copay per prescription **Tier 4 – Non-Preferred Drug:** You pay a $85 copay per prescription **Tier 5 – Specialty Tier:** You pay 33% of the total cost. **Tier :6 – Select Care Drugs:** You pay $0 per prescription _______________ Once your total drug costs have reached $3,820 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. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

SECTION 4 Administrative Changes

	2018 (this year)	2019 (next year)
Enhanced drug coverage	Enhanced drug coverage is not covered	Your plan includes coverage for excluded drugs

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in Brand New Day Classic Care I Plan

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 5.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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, read Medicare & You 2019, call your State Health Insurance Assistance Program (see Section 7), or call Medicare (see Section 9.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Brand New Day offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Brand New Day Classic Care I Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Brand New Day Classic Care I Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 9.1 of this booklet).
  - – or – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 6 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

Note: If you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 7 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. 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 HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website: www.aging.ca.gov/hicap/

SECTION 8 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or pate enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through Magellan Rx Management, contractor for Pharmacy/Medication Benefits for ADAP (telephone number: 1-800-424-5906). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the California Department of Public Health (CDPH), ADAP Toll Free, Phone Number: 1-844-421-7050.

SECTION 9 Questions?

Section 9.1 – Getting Help from Brand New Day Classic Care I Plan

Questions? We're here to help. Please call Member Services at 1-866-255-4795. (TTY only, call 1-866-321-5955. We are available for phone calls:

- October 1 – March 31: 7 days a week, 8:00 a.m. – 8:00 p.m.
- April 1 – September 30: Monday – Friday, 8:00 a.m. – 8:00 p.m.

Calls to these numbers are free.

Read your 2019 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 2019. For details, look in the 2019 Evidence of Coverage for Brand New Day Classic Care I Plan. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is included in this envelope.

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 9.2 – 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

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on “Find health & drug plans”).

Read Medicare & You 2019

You can read the Medicare & You 2019 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) 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.

Brand New Day Classic Care I Plan Member Services

Method	Member Services – Contact Information
CALL	1-866-255-4795 Calls to this number are free. October 1 – March 31: 7 days a week, 8:00 a.m. – 8:00 p.m. April 1 – September 30: Monday – Friday, 8:00 a.m. – 8:00 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-866-321-5955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 – March 31: 7 days a week, 8:00 a.m. – 8:00 p.m. April 1 – September 30: Monday – Friday, 8:00 a.m. – 8:00 p.m.
FAX	1-657-400-1217
WRITE	Brand New Day Attn: Member Services 5455 Garden Grove Blvd., Suite 500 Westminster, CA 92683
WEBSITE	www.bndhmo.com

Health Insurance Counseling and Advocacy Program (HICAP): California's SHIP

HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	HICAP (California SHIP)
CALL	1-800-434-0222
WEBSITE	https://www.aging.ca.gov/hicap/

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MULTI-LANGUAGE INTERPRETER SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-255-4795 (TTY: 1-866-321-5955).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-255-4795 (TTY: 1-866-321-5955).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-255-4795（TTY：1-866-321-5955）

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-255-4795 (TTY: 1-866-321-5955).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-255-4795 (TTY: 1-866-321-5955).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-255-4795 (ATS : 1-866-321-5955).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-255-4795 (TTY: 1-866-321-5955).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-255-4795 (TTY: 1-866-321-5955) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-255-4795 (телетайп: (TTY: 1-866-321-5955).

Arabic: مقرب ةظوحلم: اذإ تنك ثدحتت ركذا ةغللا، فإن تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب .
مقر فتاه مصلا مكبلاو4795-255-866-1لصتا(: (TTY: 1-866-321-5955).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-255-4795 (TTY: 1-866-321-5955).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-255-4795 (TTY: 1-866-321-5955).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-255-4795 (TTY: 1-866-321-5955).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-255-4795 (TTY: 1-866-321-5955).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-255-4795 (TTY: 1-866-321-5955) まで、お電話にてご連絡ください。

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-866-255-4795 (TTY (հեռատիպ)՝ 1-866-321-5955):

Farsi: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-255-4795 (TTY: 1-866-321-5955) تماس بگیرید.

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-866-255-4795 (TTY: 1-866-321-5955) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-255-4795 (TTY: 1-866-321-5955) ។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-255-4795 (TTY: 1-866-321-5955).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-255-4795 (TTY: 1-866-321-5955).

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 1-866-321-5955). Hours are: October 1 – March 31: 7 days a week, 8 a.m. – 8 p.m., April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

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
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html