

Dual Coverage for Medi-Medi (HMO D-SNP) Plan 24

Introduction to Summary of Benefits

THINGS TO KNOW:

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.

Brand New Day Dual Coverage for Medi-Medi (HMO D-SNP) Plan 24 phone number and website

- You can call toll-free 1-866-255-4795 or for TTY users, 1-866-321-5955.
- Our website: www.bndhmo.com
- 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://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.

Who can join?

To join Brand New Day Dual Coverage for Medi-Medi (HMO D-SNP) Plan 24, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and have Medi-Cal coverage. Dual Coverage for Medi-Medi (HMO D-SNP) Plan 24 is available to anyone who lives in our service area: Kings and Kern Counties.

Which doctors, hospitals, and pharmacies can I use?

Brand New Day Dual Coverage for Medi-Medi (HMO D-SNP) Plan 24 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 on our website (www.bndhmo.com). Or, call us and we will send you a copy of the provider and pharmacy directories.

How will I determine my drug costs?

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, www.bndhmo.com.
- Or, call us we will send you a copy of the formulary.

Brand New Day Health Plan is an HMO with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Brand New Day Health Plan depends on contract renewal.

Dual Coverage for Medi-Medi (HMO D-SNP) - Plan 24

Premiums and Benefits	Brand New Day (HMO)	What You Should Know
<p>Inpatient Hospital Care</p>	<p>\$0 Copay</p>	<p>This plan also covers 60 "Lifetime Reserve Days." These are "extra" days that the Plan covers. 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>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>Services require authorization and a referral.</p>
<p>Doctor's Office Visits</p> <ul style="list-style-type: none"> • Primary • Specialist 	<p>\$0 Copay \$0 Copay</p>	<p>Prior authorization is required per specialist visit.</p>

Dual Coverage for Medi-Medi (HMO D-SNP) - Plan 24

Premiums and Benefits	Brand New Day (HMO)	What You Should Know
Preventive Care	\$0 Copay	This plan covers many preventive services. Any additional preventive services approved by Medicare during the contract year will be covered. Services require authorization and a referral.
Emergency Care Worldwide emergency	\$0 Copay \$80 Copay	
Urgent Care	\$0 Copay	\$0 Copay for Medicaid-covered services.
Diagnostic Tests, Lab and Radiology Services, and X-Rays <ul style="list-style-type: none"> • Diagnostic radiology services • Lab services • Diagnostic tests and procedures • Outpatient x-rays 	\$0 Copay \$0 Copay \$0 Copay \$0 Copay	Services require authorization and a referral.
Hearing Services <ul style="list-style-type: none"> • Hearing Exam • Hearing Aid 	\$0 Copay Hearing aids are not covered.	This plan covers the exam to diagnose and treat hearing and balance issues. Services require authorization and a referral. Hearing aids are not a covered benefit.
Dental Services <ul style="list-style-type: none"> • Oral Exam • Dental x-rays 	\$0 Copay \$0 Copay	This plan provides enhanced dental coverage. Limitations and exclusions on services may apply.

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Premiums and Benefits	Brand New Day (HMO)	What You Should Know
<p>Vision Services</p> <ul style="list-style-type: none"> • Exam & Diagnose • Routine eye exam • Eyeglasses (frames and lenses) 	<p>\$0 Copay</p> <p>\$0 Copay</p> <p>Plan pays up to \$500</p>	<p>This plan covers up to \$500 every two years for contacts or eyeglasses (frames and lenses for up to 1 every two years).</p>
<p>Mental Health</p>	<p>Inpatient Mental Health</p> <p>Outpatient Mental Health:</p> <p>\$0 Copay</p> <p>Outpatient group therapy visit:</p> <p>\$0 Copay</p> <p>Outpatient individual therapy visit:</p> <p>\$0 Copay</p>	<p>This plan covers up to 190 days in a lifetime for inpatient mental healthcare in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>This plan covers 90 days for an inpatient hospital stay. This plan also covers 60 "lifetime reserve days." These are extra days that we cover.</p> <p>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>Services require authorization and a referral.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>\$0 Copay</p>	<p>This plan covers up to 100 days in a SNF. Services require authorization and a referral.</p>

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Premiums and Benefits	Brand New Day (HMO)	What You Should Know
Rehabilitation Services <ul style="list-style-type: none"> • Cardiac Therapy • Occupational Therapy Visit • Physical Therapy 	\$0 Copay \$0 Copay \$0 Copay	Services require authorization and a referral.
Ambulance	\$0 Copay	
Transportation	\$0 Copay	This plan covers unlimited transportation to and from plan approved doctor visits. Services require authorization and a referral. You are entitled to a monthly bus pass at no cost.
Foot Care (Podiatry Services) <ul style="list-style-type: none"> • Foot exams and treatment 	\$0 Copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/Supplies <ul style="list-style-type: none"> • Durable Medical Equipment (e.g.; wheelchairs, oxygen) • Prosthetics (e.g; braces, artificial limbs) • Diabetes monitoring supplies • Diabetic therapeutic shoes or inserts 	\$0 Copay \$0 Copay \$0 Copay \$0 Copay	Services require authorization and a referral.
Wellness Programs <ul style="list-style-type: none"> • Health club membership • Access to Brand New Day care management programs 	\$0 Copay	This plan has special programs for COPD, CKD, Fall Prevention, Smoking Cessation, Addiction Treatment, Incontinence, and more.
Medicare Part B Drugs <ul style="list-style-type: none"> • Part B Chemotherapy Drugs • Other Part B Drugs 	\$0 Copay \$0 Copay	Services require prior authorization and a referral.

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Premiums and Benefits	Brand New Day (HMO)	What You Should Know
Acupuncture	\$0 Copay	This plan covers up to 24 visits every year. Subject to medical necessity.
Chiropractic Care	\$0 Copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). Services may require prior authorization and a referral. Routine chiropractic care is not a covered benefit.
Outpatient Surgery <ul style="list-style-type: none"> • Ambulatory Surgical Center (ASC) • Outpatient Hospital 	\$0 Copay \$0 Copay	Services require prior authorization and a referral.
Over-the-Counter (OTC)	\$125 allowance	This plan covers \$125 per quarter for approved OTC items. Instructions about how to obtain this benefit can be found on www.bndhmo.com and in the member handbook.
Renal Dialysis	\$0 Copay	Services require prior authorization and a referral.
Hospice	\$0 Copay	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.

Dual Coverage for Medi-Medi (HMO D-SNP) - Plan 24

Prescription Drug Coverage		
Premiums and Benefits	Brand New Day (HMO)	What You Should Know
Outpatient Prescription Drugs		Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Initial Coverage Stage (30-day supply)	<p>Tier 1 Preferred Generic: \$0 Copay</p> <p>Tier 2: \$0 Copay</p> <p>Tier 3 Preferred Brand: \$3.30</p> <p>Tier 4 Non-Preferred Brand: \$3.30</p> <p>Tier 5 Specialty Tier: \$3.30</p> <p>Tier 6: Generic medications for Blood Pressure, Cholesterol and Diabetes are covered for \$0 Copay. This does not include Insulin.</p>	You stay in this stage until your year to date total drug costs reaches \$3,750.

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Prescription Drug Coverage		
Premiums and Benefits	Brand New Day (HMO)	What You Should Know
Coverage Gap (30-day supply)	\$0 Copay for drugs	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$5,000.
Catastrophic Coverage (30-day supply)	\$0 Copay for drugs	

Dual Coverage for Medi-Medi (HMO D-SNP) - Plan 24

This Summary of Benefits booklet gives you a summary of what the Dual Coverage covers and what you pay.

- If you want to compare this plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets, or use the Medicare Plan Finder at <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.

Copays and coinsurance, may vary based on the level of **extra help** you receive. Please contact **Brand New Day** for further details.

Medicare beneficiaries may also enroll in Brand New Day **Dual Coverage** through the CMS Medicare Online Enrollment Center located at <http://www.medicare.gov>.

This information is available for free in other languages. Please call the **Brand New Day customer service** number at **1-866-255-4795** or for TTY users, 1-866-321-5955. Customer Service Representatives are available to help you from 8 a.m. to 8 p.m. Monday through Friday and weekends from October 1st through February 14th.

Esta informacion esta disponible gratis en otros idiomas. Por favor llame al departamento de servicio al miembro at **1-866-255-4795** o para usuarios de TTY, 1-866-321-5955. Los representates del servicio al miembro estan disponibles para asistirle de 8:00am a 8:00pm, de Lunes a Viernes y fines de semana de Octubre 1 a Febrero 14.

COORDINATION OF BENEFITS

MEDICARE AND MEDI-CAL

“The benefits described in the following tables 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.”

Note:

- Services with a “1” require prior authorization.
- Services with a “2” require a referral from your doctor.

SUMMARY OF MEDI-CAL COVERED BENEFITS

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 ^{1,2}	You pay nothing 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. There's no limit to the number of benefit periods. 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>In 2017 the amounts for each benefit period are \$0 or:</p> <ul style="list-style-type: none"> • \$1,316 deductible for days 1 through 60 • \$329 copay per day for days 61 through 90 • \$658 copay per day for 60 lifetime reserve days. <p>These amounts may change in 2018.</p>
2. Outpatient hospital services ^{1,2}	You pay nothing for Medicaid-covered services	Outpatient hospital: 20% of the cost
3. Rural health clinic services ^{1,2}	You pay nothing for Medicaid-covered services	Primary care physician visit: \$35.00 co-pay Specialist visit: \$50.00
4. Federally qualified health center services ^{1,2}	You pay nothing for Medicaid-covered services	Primary care physician visit: \$50.00 Specialist visit: \$35.00

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
5. Laboratory services ^{1,2}	You pay nothing for Medicaid-covered services	Lab services: You pay nothing Diagnostic Procedures/Tests: 20% of the cost
6. X-rays ^{1,2}	You pay nothing for Medicaid-covered services	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost Outpatient x-rays: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
7. Skilled nursing facility care for over 21 years of age - Subacute care ^{1,2}	You pay nothing 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. 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> <p>Our plan covers up to 100 days in a SNF.</p> <p>In 2017 the amounts for each benefit period are: You pay nothing for days 1 through 20 \$164.50 copay per day for days 21 through 100 These amounts may change in 2018.</p>
8. Pediatric nursing facility care for under 21 years of age - Subacute services (Early & periodic screening, diagnosis, and treatment supplemental services)	You pay nothing for Medicaid-covered services	Not a covered benefit.

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
9. Family planning services & supplies	You pay nothing for Medicaid-covered services	Some contraceptives are covered under the Part D benefit. For more details about contraceptives covered by the plan refer to the Brand New Day formulary and refer to the prescription drug benefit description in this booklet.
10. Physician services ^{1,2}	You pay nothing for Medicaid-covered services	Primary care physician visit: \$35.00 co-pay Specialist visit: \$50.00 co-pay
11. Medical & surgical dental services ^{1,2}	You pay nothing 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 for Medicare-covered benefits
12. Ophthalmologist services ^{1,2}	You pay nothing for Medicaid-covered services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% of the cost for Medicare-covered benefits
13. Podiatry services ^{1,2}	You pay nothing for Medicaid-covered services	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: 20% of the cost for Medicare-covered benefits
14. Optometry services ^{1,2}	You pay nothing for Medicaid-covered services	Routine eye exam (for up to 1 every year): You pay nothing Eyeglasses (frames and lenses) (for up to 1 every two years): Our plan pays up to \$500 every two years for eyeglasses (frames and lenses)

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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)
15. Chiropractic services*	You pay nothing for Medicaid-covered services	Covers 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 for Medicare-covered benefits
16. Psychology services* 1,2	You pay nothing for Medicaid-covered services	Outpatient group therapy visit: You pay nothing Outpatient individual therapy visit: You pay nothing
17. Nurse anesthetist services ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare-covered services.
18. Optician and optical fabricating lab services*	You pay nothing for Medicaid-covered services	Not a covered benefit
19. Medical supplies (does not include incontinence creams and washes) ^{1,2}	You pay nothing for Medicaid-covered services	Medicare-covered Medical Supplies: 20% of the cost
20. Incontinence creams and washes*	You pay nothing for Medicaid-covered services	Not a covered benefit
21. Durable medical equipment ^{1,2}	You pay nothing for Medicaid-covered services	20% of the cost.
22. Hearing aids	You pay nothing for Medicaid-covered services	Not a covered benefit
23. Enteral formulae ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
24. Acupuncture services*1,2	You pay nothing for Medicaid-covered services	For up to 24 visit(s) every year: You pay nothing
25. Licensed midwife services ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
26. Home health services through a home health agency (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) ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services.
27. Physical therapy and related services ^{1,2}	You pay nothing for Medicaid-covered services	\$40 co-pay per visit
28. Rehabilitation facilities ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
29. Private duty nursing (Waiver only)	You pay nothing for Medicaid-covered services	Not a covered benefit

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
30. Clinic (Organized outpatient clinic, Indian Health Services, alternate birthing centers, ambulatory surgical centers) ^{1,2}	You pay nothing for Medicaid-covered services	Ambulatory surgical center: 20% of the cost Outpatient hospital: 20% of the cost
31. Dental services*	You pay nothing 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 Preventive dental services: Dental x-ray(s) (for up to 1 every year): You pay nothing Oral exam (for up to 2 every year): You pay nothing
32. Occupational therapy ^{1,2}	You pay nothing for Medicaid-covered services	Occupational therapy per visit: 20% of the cost
33. Speech pathology/ Speech therapy* ^{1,2}	You pay nothing for Medicaid-covered services	Physical therapy and speech and language therapy per visit: \$40 copay
34. Audiology services* ^{1,2}	You pay nothing for Medicaid-covered services	Exam to diagnose and treat hearing and balance issues: You pay nothing for Medicare covered services

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

SUMMARY OF MEDI-CAL COVERED BENEFITS

Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
<p>35. Pharmaceutical services and prescribed drugs</p>	<p>You pay nothing for drugs excluded from Medicare Part D coverage</p>	<p>For Part B drugs such as chemotherapy drugs¹: 20% of the cost Other Part B drugs¹: 20% of the cost Drugs covered under Medicare Part D \$405 deductible (does not apply to Tier 1, Tier 2 and Tier 6)</p> <p>Initial Coverage For generic drugs (including brand drugs treated as generic), either:</p> <p>1 month supply Tier 1-\$0 co-pay Tier 2-\$0 co-pay Tier 3-25% of the cost Tier 4-25% of the cost Tier 5-25% of the cost Tier 6-\$0 co-pay</p> <p>90 day supply Tier 1-\$0 co-pay Tier 2-\$0 co-pay Tier 3-25% of the cost Tier 4-25% of the cost Tier 5-Not available Tier 6-\$0 co-pay</p> <p>Mail order (3 month supply) Tier 1-\$0 co-pay Tier 2-\$0 co-pay Tier 3-25% of the cost Tier 4-25% of the cost Tier 5-Not available Tier 6-\$0 co-pay</p>
<p>36. Dentures*</p>	<p>You pay nothing for Medicaid-covered services</p>	<p>You pay nothing for Medicare covered services</p>

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
37. Prosthetic appliances (Orthotic appliances) prosthetic eyes ^{1,2}	You pay nothing for Medicaid-covered services	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
38. Eyeglasses, other eye appliances*	You pay nothing for Medicaid-covered services	Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing (as long as the cost for the eyeglasses doesn't exceed the \$500 plan benefit limit) Our plan pays up to \$500 once every two years for eyeglasses (frames and lenses).
39. Comprehensive Perinatal Services Program (Preventive services) ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
40. Community-Based Adult Services (CBAS) (waiver only)**	You pay nothing for Medicaid-covered services	Not a covered benefit
41. Chronic dialysis services ^{1,2}	You pay nothing for Medicaid-covered services	20% of the cost
42. Rehabilitation services (chronic dialysis, outpatient heroin detoxification, rehabilitative mental health, drug Medi-Cal, independent rehabilitation centers) ^{1,2}	You pay nothing for Medicaid-covered services	Renal Dialysis 20% of the cost Outpatient substance abuse: Individual therapy visit: You pay nothing Group therapy visit: You pay nothing Outpatient Mental Health Care Individual therapy visit: You pay nothing Group therapy visit: You pay nothing

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
<p>43. Institutes for Mental Diseases (for under 21 years of age and over 65 years of age, including inpatient psychiatric care).^{1,2}</p>	<p>You pay nothing for Medicaid-covered services</p>	<p>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. 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. 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>In 2017, the amounts for each benefit period were: \$1316 deductible for days 1 through 60 \$329 copay per day for days 61 through 90 \$658 copay per day for 60 lifetime reserve days These amounts may change in 2018.</p> <p>Outpatient individual therapy visit: You pay nothing Outpatient group therapy visit: You pay nothing</p>
<p>44. Intermediate Care Facility</p>	<p>You pay nothing for Medicaid-covered services</p>	<p>Custodial care received in an Intermediate or Long Term Care Facility is not covered by Brand New Day.</p>

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
45. Nurse midwife ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for hospice care from a Medicare-certified hospice.
46. Hospice	You pay nothing for Medicaid-covered services	You pay nothing for hospice care from a Medicare-certified hospice.
47. TB-related services ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
48. Respiratory care for ventilator-dependent patients ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
49. Family nurse practitioner ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
50. Home and community care for functionally disabled elderly (Waiver only)	You pay nothing for Medicaid-covered services	Not a covered benefit
51. Community-supported living arrangements (Waiver only)	You pay nothing for Medicaid-covered services	Not a covered benefit

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
52. Personal care services	You pay nothing for Medicaid-covered services	Not a covered benefit
53. Rural primary care hospital ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
54. Nonmedical health facilities ^{1,2}	You pay nothing 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	You pay nothing for Medicaid-covered services	<p>\$80 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p>
56. Transportation (State provides emergency and non-emergency medical transportation. Meets federal requirement for assurance of transportation to medically necessary services) ^{1,2}	You pay nothing for Medicaid-covered services	<p>Ambulance Services 20% of the cost</p> <p>Transportation (Routine): We cover unlimited round trip transports to plan-approved locations. The mode of transportation may be Taxi, Bus/Subway or Van as determined by the plan.</p> <p>You pay nothing</p>

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Benefit Category	Medicaid (Medi-Cal)	Brand New Day Dual Coverage (HMO SNP)
57. Services for pregnant women that treat a condition that may impact the woman and/or the fetus (Not specifically stated as a benefit but is a mandated provision under federal regulations) ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
58. Marriage and family counselor services (Early & periodic screening, diagnosis, and treatment services & waiver only) ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
59. Licensed clinical social worker services (Early & periodic screening, diagnosis, and treatment services & waiver only) ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered
60. Case management (Early & periodic screening, diagnosis, and treatment services & waiver only) ^{1,2}	You pay nothing for Medicaid-covered services	You pay nothing for Medicare covered services
61. Private duty nursing agency services (Early & periodic screening, diagnosis, and treatment services & waiver only)	You pay nothing for Medicaid-covered services	Not a covered benefit
62. Individual nurse provider services (Early & periodic screening, diagnosis, and treatment services & waiver only)	You pay nothing for Medicaid-covered services	Not a covered benefit
63. Nonmedical services (Waiver only)	You pay nothing 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.