

Embrace Choice for Medi-Medi (HMO C-SNP) - Plan 36

| Premiums and Benefits | Brand New Day (HMO) | What You Should Know |
|--|---|---|
| Monthly Plan Premium | \$35.50 | In addition, you must keep paying your Medicare Part B premium. |
| Deductible | <p>In 2017, the inpatient hospital deductible is \$1,316.</p> <p>In 2017, the inpatient hospital psychiatric services deductible is \$1,316.</p> <p>These amounts may change in 2018.</p> | |
| Maximum Out-Of-Pocket Responsibility (Does not include prescription drugs) | \$6,700 | <p>In this plan, you might pay nothing for Medicare-covered services, depending on your level of Medi-Cal eligibility. In this Plan, the amount you can pay out of pocket for services you receive from in-network providers is limited to \$6,700.</p> <p>If you reach the limit on out-of-pocket costs, you will continue to have hospital and medical services and the Plan will pay the full cost for the rest of the year.</p> |

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| <p>Inpatient Hospital Care</p> | <p>In 2017, the amounts for each benefit period were: \$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 These amounts may change in 2018.</p> | <p>This plan covers 90 days per benefit period for an inpatient hospital stay.</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>Doctor's Office Visits</p> <ul style="list-style-type: none"> • Primary • Specialist | <p>\$35 Copay \$50 Copay</p> | <p>Prior authorization is required for specialist visits.</p> |
| <p>Preventive Care</p> | <p>You pay nothing</p> | <p>This plan covers many preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>Services require prior authorization and a referral.</p> |

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| Emergency Care Worldwide emergency | \$80 Copay \$80 Copay | If you are admitted to the hospital within 3 days of an ER visit, you do not have to pay your share of the emergency care visit. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| Urgent Care | You pay nothing | If you are admitted to the hospital within 3 days of an Urgent Care visit, you do not have to pay your share of the cost for urgently needed services. |
| Diagnostic Tests, Lab, Radiology Services, and X-Rays <ul style="list-style-type: none"> • Diagnostic radiology services • Lab services • Diagnostic tests and procedures • Outpatient x-rays | 20% of the cost You pay nothing 20% of the cost 20% of the cost | Costs for these Services be different if received in an outpatient surgery setting. Services require prior authorization and a referral. |
| Hearing Services <ul style="list-style-type: none"> • Hearing Exam • Hearing Aid | You pay nothing Not a covered benefit | This plan covers the exam to diagnose and treat hearing and balance issues. Services require prior authorization and a referral. Hearing aids are not a covered benefit. |
| Dental Services <ul style="list-style-type: none"> • Oral Exam • X-rays | You pay nothing You pay nothing | This plan provides enhanced dental coverage. Limitations and exclusions on services may apply. |

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| <p>Vision Services</p> <ul style="list-style-type: none"> • Routine eye exam • Eyeglasses (frames and lenses) | <p>You pay nothing</p> <p>This plan pays up to \$500 every two years for contacts or eyeglasses (frames and lenses)</p> | <p>This plan pays up to \$500 every two years for contacts or eyeglasses (frames and lenses).</p> |
| <p>Mental Health</p> <ul style="list-style-type: none"> • Inpatient Mental Health • Outpatient Mental Health | <p>In 2017 you pay \$1,316 deductible for days 1-60 \$329 Copay per day for days 61-90 \$658 Copay per day for 60 lifetime reserve days These amounts may change in 2018.</p> <p>Group Therapy: \$0</p> <p>Individual Therapy: \$0</p> | <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 in a general hospital.</p> <p>This plan covers 90 days for an inpatient hospital stay.</p> <p>This 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>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>Services require authorization and a referral.</p> |

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| Skilled Nursing Facility (SNF) | <p>In 2017, the amounts for each benefit period were: You pay nothing for days 1-20 You pay \$164.50 for days 21-100 These amounts may change in 2018.</p> | <p>This plan covers up to 100 days in a SNF. Services require authorization and a referral.</p> |
| <p>Rehabilitation Services</p> <ul style="list-style-type: none"> • Cardiac Rehabilitation • Occupational therapy visit • Physical therapy • Speech language therapy visit • Pulmonary Rehab services | <p>20% of the cost \$40 Copay \$40 Copay \$40 Copay 20% of the cost</p> | <p>Services require authorization and a referral.</p> |
| Ambulance | 20% of the cost | |
| Transportation | You pay nothing | <p>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.</p> |
| <p>Foot Care (Podiatry Services)</p> <ul style="list-style-type: none"> • Foot exams and treatment | 20% of the cost | <p>This plan covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. Services require authorization and a referral.</p> |

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| <p>Medical Equipment/Supplies</p> <ul style="list-style-type: none"> • Durable Medical Equipment(e.g.: wheelchairs, oxygen) • Prosthetics (e.g.: braces, artificial limbs) | <p>20% of the cost</p> <p>20% of the cost</p> | <p>Services require authorization and a referral.</p> |
| <p>Diabetes Supplies & Services</p> <ul style="list-style-type: none"> • Diabetes Monitoring supplies • Diabetes self-management training • Therapeutic shoes or inserts | <p>You pay nothing</p> <p>20% of the cost</p> <p>You pay nothing</p> | <p>Services require authorization and a referral.</p> |
| <p>Wellness Programs</p> <ul style="list-style-type: none"> • Health club benefit • Diabetic health coach • Nutrition counseling • 24 hour nurse advice line • 24 hour doctor advice line | <p>You pay nothing</p> | <p>Services require authorization and a referral.</p> |
| <p>Medicare Part B Drugs</p> | <p>You pay nothing</p> | <p>Services require authorization and a referral.</p> |
| <p>Acupuncture</p> | <p>You pay nothing</p> | <p>This plan covers up to 24 visits every year. Subject to medical necessity.</p> |

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| Chiropractic Care | You pay nothing | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). Services require authorization and a referral. This does not include routine chiropractic care. |
| Outpatient Surgery <ul style="list-style-type: none"> • Ambulatory Surgical Center (ASC) • Outpatient Hospital | 20% of the cost 20% of the cost | Services require authorization and a referral. |
| Over-the-Counter | \$70 allowance | This plan covers \$70 per quarter for approved OTC items. Instructions about how to obtain benefit can be found on www.bndhmo.com or in the member handbook. |
| Renal Dialysis | 20% of the cost | Services require authorization and a referral. |
| Hospice | \$0 | 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. |

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| Deductible | \$405 | Deductible does not apply to Tier 1 (Preferred generic) and Tier 6 (Select Diabetic Drugs). |
| Initial Coverage Stage (30-day supply) | <p>Tier 1 Preferred Generic: You pay nothing</p> <p>Tier 2 Generic: 25% of cost</p> <p>Tier 3 Preferred Brand: 25% of cost</p> <p>Tier 4 Non-Preferred Brand: 25% of cost</p> <p>Tier 5 Specialty Tier: 25% of cost</p> <p>Tier 6 Select Care Drugs: Generic covered medications to help you control blood pressure, cholesterol, and/or diabetes are covered with no copayment. You pay nothing</p> | <p>You stay in this stage until your year to date total drug costs reaches \$3,750.</p> <p>Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. To 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.</p> |

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| Coverage Gap (30-day supply) | <p>35% of the plan's cost for covered brand name drugs</p> <p>44% of the plan's cost for covered generic drugs</p> | <p>Except for Tier 1, 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.</p> <p>You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$5,000</p> |
| Catastrophic Coverage (30-day supply) | <p>You pay whichever amount is the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.35 Copay for generic (including brand drugs treated as generic) and a \$8.35 copayment for all other drugs | |

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This Summary of Benefits booklet gives you a summary of what Embrace Choice for Medi-Medi (HMO C-SNP) Plan 36 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 the plan for further details.

Medicare beneficiaries may also enroll in Brand New Day, **"Embrace Choice for Medi-Medi (HMO C-SNP),"** 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 from 8 a.m. to 8 p.m. Monday through Friday and weekends between October 1st and 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.