2021

ANNUAL NOTICE OF CHANGE (ANOC)

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

Brand New Day Dual Access Plan (HMO D-SNP) offered by Brand New Day

Annual Notice of Changes for 2021

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

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 2 and 2.5 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 2021 Drug List and look in Section 2.6 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 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.

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

- Are your doctors, including specialists you see regularly in our network?
- What about the hospitals or other providers you use?

- Look in Section 2.3 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 www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 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 don't join another plan by December 7, 2020, you will be enrolled in Brand New Day.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 2, page 6 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between now and **December 31, 2020**

- If you don't join another plan by **December 31, 2020**, you will be enrolled in Brand New Day.
- If you join another plan between **October 15 and December 7, 2020**, your new coverage will start on **January 1, 2021.** You will be automatically disenrolled from your current plan**.**

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 711.) 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 Dual Access 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 Dual Access Plan.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Brand New Day Dual Access Plan in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.bndhmo.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$32	$31.50
Doctor office visits	Primary care visits: You pay 20% of the total cost per visit Specialist visits: You pay 20% of the total cost per visit	Primary care visits: You pay 20% of the total cost per visit Specialist visits: You pay $0 per visit for surgery and 20% of the total cost per visit for all other specialist services

Cost	2020 (this year)	2021 (next year)
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 a $1408 deductible per benefit period You pay $0 per day for days 1-60 You pay a $352 copay per day for days 61-90; You pay a $704 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) You pay 100% of all costs beyond the lifetime reserve days	You pay a $1408 deductible per benefit period You pay $0 per day for days 1-60 You pay a $352 copay per day for days 61-90; You pay a $704 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) You pay 100% of all costs beyond the lifetime reserve days These are 2020 cost sharing amounts and may change for 2021. Brand New Day will provide updated rates as soon as they are released.

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $435 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay 25% of the total cost • Drug Tier 3: You pay 25% of the total cost • Drug Tier 4: You pay 25% of the total cost • Drug Tier 5: You pay 25% of the total cost • Drug Tier 6: You pay $0	Deductible: $445 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay 25% of the total cost • Drug Tier 3: You pay 25% of the total cost • Drug Tier 4: You pay 25% of the total cost • Drug Tier 5: You pay 25% of the total cost • Drug Tier 6: You pay $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 2.2 for details.)	$6,700 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$7,550 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Annual Notice of Changes for 2021
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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Brand New Day Dual Access Plan in 2021

If you do nothing to change your Medicare coverage in 2020, we will automatically enroll you in our Brand New Day Dual Access Plan. This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through Brand New Day Dual Access Plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you want to change, you can do so between now and December 7. The change will take effect on January 1, 2021.

The information in this document tells you about the differences between your current benefits in Brand New Day Dual Access Plan and the benefits you will have on January 1, 2021, as a member of Brand New Day Dual Access Plan.

SECTION 2 Changes to Medicare Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$32	$31.50

Section 2.2 – 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 Part A and Part B services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year	$7,550 Once you have paid $7,550 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year

Section 2.3 – 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 2021 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, we must 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 to manage your care.

Section 2.4 – 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 2021 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

Please note that the Annual Notice of Changes only tells you about changes to your Medicare benefits and costs.

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, Benefits Chart (what is covered and what you pay), in your 2021 Evidence of Coverage. A copy of the Evidence of Coverage is located on our website at www.bndhmo.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Cost	2020 (this year)	2021 (next year)
Routine chiropractic services	Routine chiropractic services are not covered.	You pay $0 for up to 30 routine chiropractic visits per year. These 30 visits are combined with acupuncture visits.

Cost	2020 (this year)	2021 (next year)
Routine acupuncture services	You pay $0 for up to 24 acupuncture visits per year	You pay $0 for up to 30 acupuncture visits per year. These 30 visits are combined with routine chiropractic visits.
Acupuncture for chronic low back pain Chronic low back pain is defined as: • Lasting 12 weeks or longer • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease) • not associated with surgery and • not associated with pregnancy	Acupuncture for chronic low back pain is not covered.	You pay $0 per visit up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Referral and prior authorization is required for the Medicare-covered acupuncture benefit.
Over-the-Counter items and services	Maximum benefit of $125 every 3 months Scale and/or blood pressure cuff will be provided at no cost to members with chronic heart failure or liver disease.	Maximum benefit of $325 every 6 months Scale and/or blood pressure cuff will be provided at no cost to members with chronic heart failure or liver disease.

Cost	2020 (this year)	2021 (next year)
Health education group classes	No website access	The health plan offers access to a website with live telephonic coaching, real time interventions, feedback, and goal setting.
Medical Nutrition Therapy	Diabetic education is provided by certified diabetic educators.	No longer covered
Dental prophylaxis (cleaning)	You pay $0 for up to two (2) cleanings per year	You pay $0 for up to one (1) cleaning per year
Dental fluoride treatment	You pay $0 for up to one (1) fluoride treatment per year	Dental fluoride treatment is not covered
Eyewear	Upgrades not included Retinal Imaging you pay up to $39 copay	$70 limit for polycarbonate lenses upgrade and $89.50 limit for premium progressives' upgrade. Retinal Imaging you pay $0

Section 2.6 – 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 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 2021will be covered to the expiration date in 2021. You do not need to ask for another one. Some formulary exceptions may change in 2021, 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.

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 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 in your Summary of Benefits or at Chapter 6, Sections 6 and 7, in the Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage **During this stage,** you pay the full cost **of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible.**	The deductible is $435. (does not apply to Tier 1 and Tier 6) During this stage, you pay $0 cost-sharing for drugs on Tier 1, Tier 2 and Tier 6 and the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.	The deductible is $445. (does not apply to Tier 1 and Tier 6) During this stage, you pay $0 cost-sharing for drugs on Tier 1 and Tier 6 and the full cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

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	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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.**	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 25% of the total cost **Tier 3 - Preferred Brand:** You pay 25% of the total cost **Tier 4 - Non-Preferred Drug:** You pay 25% of the total cost **Tier 5 - Specialty Tier:** You pay 25% of the total cost **Tier 6 - Select Care Drugs:** You pay $0 per prescription _____	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 25% of the total cost **Tier 3 - Preferred Brand:** You pay 25% of the total cost **Tier 4 - Non-Preferred Drug:** You pay 25% of the total cost **Tier 5 - Specialty Tier:** You pay 25% of the total cost **Tier 6 - Select Care Drugs:** You pay $0 per prescription _____

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued) 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.	Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your Summary of Benefits or at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

SECTION 3 Administrative Changes

Cost	2020 (this year)	2021 (next year)
Service area	Our service area includes these counties in California: Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, and Tulare.	Our service area includes these counties in California: Fresno, Imperial, Kern, Kings, Los Angeles, **Madera,** Orange, Riverside, **Sacramento,** San Bernardino**, San Francisco, San Joaquin,** and Tulare
Dental benefits administrator	Your dental benefits are administered by DeltaCare USA and Western Dental.	Your dental benefits are administered by Liberty Dental and Western Dental.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Brand New Day Dual Access 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 be enrolled in our plan.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 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.

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 2021, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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.**

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. **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 Dual Access 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 Dual Access 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 8.1 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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to December 7. The change will take effect on January 1, 2021.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2021, 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, 2021. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

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 and 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: https://www.aging.ca.gov/hicap/.

For questions about your Medi-Cal (Medicaid) benefits, contact Medi-Cal at 1-916-449-5000. TTY users should dial 711. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, 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 (CDHP), ADAP Toll Free, Phone number: 1-844-421-7050.

SECTION 8 Questions?

Section 8.1 – Getting Help from Brand New Day Dual Access Plan

Questions? We're here to help. Please call Member Services at 1-866-255-4795. (TTY only, call 711. We are available for phone calls October 1 – March 31: 7 days a week, 8:00 a.m. – 8:00 p.m. and April 1 – September 30: Monday – Friday, 8:00 a.m. – 8:00 p.m. Calls to these numbers are free.

Read your 2021 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 2021. For details, look in the 2021 Evidence of Coverage for Brand New Day Dual Access 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 located on our website at www.bndhmo.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.

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 8.2 – 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 (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 www.medicare.gov/plan-compare).

Read Medicare & You 2021

You can read Medicare & You 2020 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 (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.

Section 8.3 – Getting Help from Medicaid

To get information from Medi-Cal (Medicaid) you can call the California Department of Health Care Services at 1-916-449-5000. TTY users should dial 711.

Brand New Day Dual Access 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	711 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/