brand new day

HEALTH MAINTENANCE ORGANIZATION

In Control Extra Care (HMO SNP) Summary of Benefits

January 1, 2015 - December 31, 2015

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

You have choices about how to get your Medicare benefits

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

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **In Control Extra Care** (**HMO SNP**) covers and what you pay.

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

View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

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

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

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

Este documente puede ser disponible en un idioma no ingles. Para obtener informacion adicional, llame a servicio al cliente en el numero de telefono (866-255-4795). Los usuarios de TTY deben llamar al 1-866-321-5955.

Things to Know About In Control Extra Care (HMO SNP)

Hours of Operation

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

In Control Extra Care (HMO SNP) Phone Numbers and Website

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

Who can join?

To join **In Control Extra Cares** (**HMO SNP**), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be diagnosed with Diabetes mellitus, and live in our service area.

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

Which doctors, hospitals, and pharmacies can I use?

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

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

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

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

What do we cover?

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

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

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

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

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

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

How will I determine my drug costs?

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

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

How much is the monthly premium?	$28.80 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$320 per year for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:
• SERVICES WITH A ❶ MAY REQUIRE PRIOR AUTHORIZATION.
• SERVICES WITH A ❷ MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

Benefit Category	In Control Extra Care (HMO SNP)
OUTPATIENT CARE AND SERVICES	
Acupuncture and Other Alternative Therapies ❶❷	For up to 6 visit(s) every year: You pay nothing
Ambulance ❶	20% of the cost
Chiropractic Care ❶❷	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing
Dental Services ❶❷	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing

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Benefit Category	In Control Extra Care (HMO SNP)
OUTPATIENT CARE AND SERVICES (continued)	
Dental Services ❶❷ (continued)	Preventive dental services: • Cleaning (for up to 1 every six months): You pay nothing • Dental x-ray(s) (for up to 1 every year): You pay nothing • Fluoride treatment (for up to 1 every year): You pay nothing • Oral exam (for up to 2 every year): You pay nothing Comprehensive Dental Services: • $1000 plan coverage limit annually for Comprehensive Dental services
Diabetes Supplies and Services ❶❷	Diabetes monitoring supplies. You pay nothing. Diabetes self-management training. You pay nothing. Therapeutic shoes or inserts: You pay nothing.
Diagnostic Tests, Lab and Radiology Services, and XRays ❶❷	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
Doctor's Office Visits ❶❷	Primary care physician visit: You pay nothing Specialist visit: You pay nothing
Durable Medical Equipment *(wheelchairs, oxygen, etc.)* ❶	20% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.
Emergency Care	$65 copay 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. Worldwide emergency care coverage: $65 copay

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Benefit Category	In Control Extra Care (HMO SNP)
OUTPATIENT CARE AND SERVICES (continued)	
Foot Care *(podiatry services)* ❶❷	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing
Hearing Services ❶❷	Exam to diagnose and treat hearing and balance issues: 20% of the cost
Home Health Care ❶❷	You pay nothing
Mental Health Care ❶❷	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. 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. 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. In 2014 the amounts for each benefit period were: • $1,216 deductible for days 1 through 60 • $304 copay per day for days 61 through 90 • $608 copay per day for 60 lifetime reserve days These amounts may change for 2015. Outpatient group therapy visit: You pay nothing Outpatient individual therapy visit: You pay nothing
Outpatient Rehabilitation ❶❷	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Occupational therapy visit: 20% of the cost Physical therapy and speech and language therapy visit: 20% of the cost

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Benefit Category	In Control Extra Care (HMO SNP)
OUTPATIENT CARE AND SERVICES (continued)	
Outpatient Substance Abuse ❶❷	Group therapy visit: You pay nothing Individual therapy visit: You pay nothing
Outpatient Surgery ❶❷	Ambulatory surgical center: 20% of the cost Outpatient hospital: 20% of the cost
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)* ❶	Prosthetic devices: You pay nothing Related medical supplies: You pay nothing
Renal Dialysis ❶❷	20% of the cost
Transportation ❶❷	You pay nothing
Urgent Care	You pay nothing
Vision Services ❶❷	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every year): You pay nothing Eyeglass frames (for up to 1 every two years): You pay nothing Eyeglass lenses (for up to 1 every year): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing
Preventive Care ❶❷	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy

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OUTPATIENT CARE AND SERVICES (continued)	
Preventive Care ❶❷ (continued)	• Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	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.
INPATIENT CARE	
Inpatient Hospital Care ❶❷	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. 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. In 2014 the amounts for each benefit period were: • $1,216 deductible for days 1 through 60 • $304 copay per day for days 61 through 90 • $608 copay per day for 60 lifetime reserve days

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INPATIENT CARE (continued)	
Inpatient Hospital Care ❶❷ (continued)	These amounts may change for 2015.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF) ❶❷	Our plan covers up to 100 days in a SNF. In 2014 the amounts for each benefit period were: • You pay nothing for days 1 through 20 • $152 copay per day for days 21 through 100 These amounts may change for 2015.
PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemotherapy drugs ❶: 20% of the cost Other Part B drugs ❶: 20% of the cost
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Non-Preferred Generic)	25% of the cost	25% of the cost
Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
Tier 4 (Non-Preferred Brand)	25% of the cost	25% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost
Tier 6 (Select Diabetic Drugs)	$0	$0

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Benefit Category	In Control Extra Care (HMO SNP)

PRESCRIPTION DRUG BENEFITS (continued)

Initial Coverage (continued)

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0
Tier 2 (Non-Preferred Generic)	25% of the cost
Tier 3 (Preferred Brand)	25% of the cost
Tier 4 (Non-Preferred Brand)	25% of the cost
Tier 5 (Specialty Tier)	25% of the cost
Tier 6 (Select Diabetic Drugs)	$0

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

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. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:
- 5% of the cost, or
- $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.