BayCarePlus®
Medicare Advantage

2021

SUMMARY OF BENEFITS

Medicare Advantage

BayCarePlus Complete (HMO)
BayCarePlus Rewards (HMO)
BayCarePlus Signature (HMO)

Serving
Hillsborough, Pasco
and Polk Counties

Summary of Benefits
January 1, 2021 – December 31, 2021

This booklet gives you a summary of what we cover and what you pay. It doesn't list every limitation, exclusion or covered service. To get a complete list of services we cover, call us and ask for the Evidence of Coverage. You can also view it on BayCarePlus.org.

This Summary of Benefits booklet gives you a summary of what **BayCare**Plus **Complete (HMO), BayCare**Plus **Rewards (HMO)** and **BayCare**Plus **Signature (HMO)** cover and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on 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 Medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call (877) 486-2048.

Sections in This Booklet

- Things to Know About **BayCare**Plus **Complete, BayCare**Plus **Rewards** and **BayCare**Plus **Signature**
- Table of Contents
- Monthly Premium, Deductibles and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Other Covered Benefits
- Optional Comprehensive Dental 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 Customer Service at (866) 509-5396 (TTY: 711).

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Things to Know About BayCarePlus Complete, BayCarePlus Rewards and BayCarePlus Signature

Hours of Operation

- From October 1 to March 31, you can call us seven days a week from 8am to 8pm.
- From April 1 to September 30, you can call us Monday through Friday from 8am to 8pm.

Phone Numbers and Website

- If you have questions, call toll free: (866) 947-5820 (TTY: 711).
- Our website: BayCarePlus.org

Who can join?

To join **BayCare**Plus **Complete, BayCare**Plus **Rewards** or **BayCare**Plus **Signature**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or are lawfully present in the United States and live in our service area. Our service area includes the following counties in Florida: Hillsborough, Pasco and Polk.

Which doctors, hospitals and pharmacies can I use?

BayCarePlus plans have a network of doctors, hospitals, pharmacies and other providers. If you use the providers that aren't 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. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's Provider Directory at BayCarePlus.org. Or, call us and we'll send you a copy.

What do we cover?

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

- **Our plan members get *all* 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's covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

What drugs do we cover?

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 at BayCarePlus.org.
- Or, call us and we'll send you a copy.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You'll need to use your formulary to locate what tier your drug is on to determine how much it'll cost you. The amount you pay depends on the drug's tier and what stage of the benefit you've reached. Later in this document, we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage. If you have questions about the different benefit stages, please contact the plan for more information or access the Evidence of Coverage on our website.

Monthly Premium, Deductibles and Limits on How Much You Pay for Covered Services

	BayCarePlus **Complete (HMO) H2235-001**	**BayCare**Plus **Rewards (HMO) H2235-002**	**BayCare**Plus **Signature (HMO) H2235-004**
Monthly Plan Premium	$0 Per month. You must continue to pay your Medicare Part B premium.	$0 Per month. You must continue to pay your Medicare Part B premium.	$28 Per month. You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	Not covered	$114 Per month	Not covered
Deductibles	This plan doesn't have a deductible.	This plan doesn't have a deductible.	This plan doesn't have a deductible.
Maximum Out-of Pocket Responsibility	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: • $3,500 For covered hospital and medical 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'll pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: • $4,500 For covered hospital and medical 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'll pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: • $2,800 For covered hospital and medical 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'll pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Covered Medical and Hospital Benefits

	BayCarePlus **Complete (HMO)**	**BayCare**Plus **Rewards (HMO)**	**BayCare**Plus **Signature (HMO)**
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • $175 Copay per day, per stay: days 1-5 • $0 Copay per day, per stay: days 6 and beyond Prior authorization is required.	Our plan covers an unlimited number of days for an inpatient hospital stay. • $250 Copay per day, per stay: days 1-6 • $0 Copay per day, per stay: days 7 and beyond Prior authorization is required.	Our plan covers an unlimited number of days for an inpatient hospital stay. • $150 Copay per day, per stay: days 1-5 • $0 Copay per day, per stay: days 6 and beyond Prior authorization is required.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Outpatient Hospital Coverage	Ambulatory surgical center: $75 copay Outpatient hospital: $125 copay Prior authorization is required. A referral is required for outpatient hospital services.	Ambulatory surgical center: $125 copay Outpatient hospital: $195 copay Prior authorization is required. A referral is required for outpatient hospital services.	Ambulatory surgical center: $50 copay Outpatient hospital: $95 copay Prior authorization is required. A referral is required for outpatient hospital services.
Doctor Visits *(primary care providers and specialists)*	Primary care provider (PCP) visit: $0 copay Specialist visit: $15 copay **BayCare**Anywhere® virtual visits: $20 copay, limited to four visits per calendar year A referral is required for specialist visits except for visits with an obstetrician/gynecologist, chiropractor, podiatrist or dermatologist.	Primary care provider (PCP) visit: $0 copay Specialist visit: $35 copay **BayCare**Anywhere® virtual visits: $20 copay, limited to four visits per calendar year A referral is required for specialist visits except for visits with an obstetrician/gynecologist, chiropractor, podiatrist or dermatologist.	Primary care provider (PCP) visit: $0 copay Specialist visit: $10 copay **BayCare**Anywhere® virtual visits: $20 copay, limited to four visits per calendar year A referral is required for specialist visits except for visits with an obstetrician/gynecologist, chiropractor, podiatrist or dermatologist.
Preventive Care	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Health and wellness education programs • HIV screening • Immunizations (pneumonia, hepatitis B and influenza) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP)	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Health and wellness education programs • HIV screening • Immunizations (pneumonia, hepatitis B and influenza) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP)	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Health and wellness education programs • HIV screening • Immunizations (pneumonia, hepatitis B and influenza) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP)

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Preventive Care *(continued)*	• Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low-dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit (one time) Any additional preventive services approved by Medicare during the contract year will be covered.	• Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low-dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit (one time) Any additional preventive services approved by Medicare during the contract year will be covered.	• Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low-dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit (one time) Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$90 Copay If you're admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. This coverage is worldwide.	$90 Copay If you're admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. This coverage is worldwide.	$120 Copay If you're admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. This coverage is worldwide.
Urgently Needed Services	$35 Copay within the United States $90 Copay outside the United States This coverage is worldwide.	$35 Copay within the United States $90 Copay outside the United States This coverage is worldwide.	$30 Copay within the United States $120 Copay outside the United States This coverage is worldwide.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Diagnostic Services/ Labs/ Imaging *(Costs for these services may vary based on place of service.)*	Lab services: $0 copay Diagnostic procedures and tests: $0 copay X-rays: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $0-$90 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% co-insurance Some services may require prior authorization or a referral. See Evidence of Coverage for more details and a complete listing. There is no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they're ordered as a preventive service.	Lab services: $0 copay Diagnostic procedures and tests: $100 copay* X-rays: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $0-$125 copay** Therapeutic radiology services (such as radiation treatment for cancer): 20% co-insurance Some services may require prior authorization or a referral. See Evidence of Coverage for more details and a complete listing. There is no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they're ordered as a preventive service. *Diagnostic colonoscopies are $0. **Diagnostic mammograms are $0.	Lab services: $0 copay Diagnostic procedures and tests: $0 copay X-rays: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $0-$90 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% co-insurance Some services may require prior authorization or a referral. See Evidence of Coverage for more details and a complete listing. There is no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they're ordered as a preventive service.
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $0 copay (one per calendar year) Hearing aids: up to two every two calendar years (one per ear) Hearing aid copays: $699 for TruHearing Advanced or $999 for TruHearing Premium (Copay is per hearing aid.)* Hearing aid fitting: $0 copay A referral is required for Medicare-covered exams. *Amounts you pay for these services don't count toward your maximum out-of-pocket amount.	Medicare-covered exam to diagnose and treat hearing and balance issues: $30 copay Routine hearing exam: $30 copay (one per calendar year) Hearing aids aren't covered. A referral is required for Medicare-covered exams.	Medicare-covered exam to diagnose and treat hearing and balance issues: $30 copay Routine hearing exam: $0 copay (one per calendar year) Hearing aids: up to two every two calendar years (one per ear) Hearing aid copays: $599 for TruHearing Advanced or $899 for TruHearing Premium (Copay is per hearing aid.)* Hearing aid fitting: $0 copay A referral is required for Medicare-covered exams. *Amounts you pay for these services don't count toward your maximum out-of-pocket amount.
Dental Services	**Preventive dental services:** $0 copay Preventive services include: • Periodic oral evaluation (one every six months) • Routine cleaning (one every six months) • Fluoride application (one every six months with routine cleaning)	**Preventive dental services:** $0 copay Preventive services include: • Periodic oral evaluation (one every six months) • Routine cleaning (one every six months) • Fluoride application (one every six months with routine cleaning)	**Preventive dental services:** $0 copay Preventive services include: • Periodic oral evaluation (one every six months) • Routine cleaning (one every six months) • Fluoride application (one every six months with routine cleaning)

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Dental Services *(continued)*	• Horizontal bitewing X-ray(s) (up to four, once every calendar year) • Intraoral X-ray image of the entire mouth (full-mouth series or panoramic image) (once every three calendar years) Comprehensive services include: • Full-mouth debridement (deep cleaning) (one every three calendar years) • Scaling and root planing—four or more teeth per quad (four quads every three calendar years) • Scaling and root planing—one to three teeth per quad (four quads every three calendar years) See page 17 for information on optional comprehensive dental coverage that can be purchased separately **Medicare-covered dental services:** $15 copay A referral is required to visit an oral surgeon for Medicare-covered services, and those services require a prior authorization.	• Horizontal bitewing X-ray(s) (up to four, once every calendar year) • Intraoral X-ray image of the entire mouth (full-mouth series or panoramic image) (once every three calendar years) Comprehensive services include: • Full-mouth debridement (deep cleaning) (one every three calendar years) • Scaling and root planing—four or more teeth per quad (four quads every three calendar years) • Scaling and root planing—one to three teeth per quad (four quads every three calendar years) See page 17 for information on optional comprehensive dental coverage that can be purchased separately. **Medicare-covered dental services:** $35 copay A referral is required to visit an oral surgeon for Medicare-covered services, and those services require a prior authorization.	• Horizontal bitewing X-ray(s) (up to four, once every calendar year) • Intraoral X-ray image of the entire mouth (full-mouth series or panoramic image) (once every three calendar years) Comprehensive services include: • Full-mouth debridement (deep cleaning) (one every three calendar years) • Scaling and root planing—four or more teeth per quad (four quads every three calendar years) • Scaling and root planing—one to three teeth per quad (four quads every three calendar years) • Fillings (two per calendar year) • Extractions (two per calendar year) See page 17 for information on optional comprehensive dental coverage that can be purchased separately. **Medicare-covered dental services:** $10 copay A referral is required to visit an oral surgeon for Medicare-covered services, and those services require a prior authorization.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Vision Services	**Routine vision services:** One routine eye exam every calendar year: $0 copay One pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses), frames or contact lenses (or two six-packs) per calendar year: $0 copay Our plan pays up to $100 per calendar year for eyeglasses (lenses and frames) or contact lenses. Upgrades may come at an additional cost. **Medicare-covered vision services:** Medicare-covered eye exams: $15 copay Diabetic eye exams performed by a specialist, such as an ophthalmologist or optometrist: $0 copay A referral is required for these Medicare-covered visits. One pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular) after cataract surgery: $0 copay One pair of Medicare-covered eyeglass frames or contact lenses (or two six packs) after each cataract surgery: $0 copay	**Routine vision services:** One routine eye exam every calendar year: $0 copay One pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses), frames or contact lenses (or two six-packs) per calendar year: $0 copay Our plan pays up to $100 per calendar year for eyeglasses (lenses and frames) or contact lenses. Upgrades may come at an additional cost. **Medicare-covered vision services:** Medicare-covered eye exams: $35 copay Diabetic eye exams performed by a specialist, such as an ophthalmologist or optometrist: $0 copay A referral is required for these Medicare-covered visits. One pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular) after cataract surgery: $0 copay One pair of Medicare-covered eyeglass frames or contact lenses (or two six packs) after each cataract surgery: $0 copay	**Routine vision services:** One routine eye exam every calendar year: $0 copay One pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses), frames or contact lenses (or two six-packs) per calendar year: $0 copay Our plan pays up to $200 per calendar year for eyeglasses (lenses and frames) or contact lenses. Upgrades may come at an additional cost. **Medicare-covered vision services:** Medicare-covered eye exams: $10 copay Diabetic eye exams performed by a specialist, such as an ophthalmologist or optometrist: $0 copay A referral is required for these Medicare-covered visits. One pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular) after cataract surgery: $0 copay One pair of Medicare-covered eyeglass frames or contact lenses (or two six packs) after each cataract surgery: $0 copay

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $175 Copay per day, per stay: days 1-5 • $0 Copay per day, per stay: days 6 and beyond Outpatient individual visit: $15 copay Outpatient group visit: $10 copay Opioid treatment programs: $15 copay per visit for Medicare-covered services Partial hospitalization: $55 copay per day for Medicare-covered partial hospitalization services Prior authorization is required.	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $250 Copay per day, per stay: days 1-6 • $0 Copay per day, per stay: days 7 and beyond Outpatient individual visit: $35 copay Outpatient group visit: $30 copay Opioid treatment programs: $35 copay per visit for Medicare-covered services Partial hospitalization: $55 copay per day for Medicare-covered partial hospitalization services Prior authorization is required.	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $150 Copay per day, per stay: days 1-5 • $0 Copay per day, per stay: days 6 and beyond Outpatient individual visit: $10 copay Outpatient group visit: $5 copay Opioid treatment programs: $10 copay per visit for Medicare-covered services Partial hospitalization: $55 copay per day for Medicare-covered partial hospitalization services Prior authoriziation is required.
Skilled Nursing Facility	The plan covers up to 100 days per admission. No prior hospital stay is required. • $0 Copay per day, per stay: days 1–20 • $150 Copay per day, per stay: days 21–100 Prior authorization is required.	The plan covers up to 100 days per admission. No prior hospital stay is required. • $0 Copay per day, per stay: days 1–20 • $172 Copay per day, per stay: days 21–100 Prior authorization is required.	The plan covers up to 100 days per admission. No prior hospital stay is required. • $0 Copay per day, per stay: days 1–20 • $150 Copay per day, per stay: days 21–100 Prior authorization is required.
Physical Therapy	$15 Copay A referral is required.	$35 Copay A referral is required.	$10 Copay A referral is required.
Ambulance	$200 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.	$250 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.	$200 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.
Transportation	$0 Copay Limited to 16 one-way trips to plan-approved locations every calendar year	Not covered	$0 Copay Limited to 24 one-way trips to plan-approved locations every calendar year

Prescription Drug Benefits

	BayCarePlus Complete (HMO)			BayCarePlus Rewards (HMO)			BayCarePlus Signature (HMO)		
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% co-insurance Other Part B drugs: 20% co-insurance Prior authorization is required.			For Part B drugs such as chemotherapy drugs: 20% co-insurance Other Part B drugs: 20% co-insurance Prior authorization is required.			For Part B drugs such as chemotherapy drugs: 20% co-insurance Other Part B drugs: 20% co-insurance Prior authorization is required.		
Deductible	This plan doesn't have a deductible.			This plan doesn't have a deductible.			This plan doesn't have a deductible.		
Initial Coverage	You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.		
	Standard Retail Cost-Sharing			**Standard Retail Cost-Sharing**			**Standard Retail Cost-Sharing**		
Tier	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 (preferred generic)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 2 (generic)	$4 Copay	$8 Copay	$12 Copay	$10 Copay	$20 Copay	$30 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 3 (preferred brand)	$35 Copay	$70 Copay	$105 Copay	$47 Copay	$94 Copay	$141 Copay	$35 Copay	$70 Copay	$105 Copay
Tier 4 (non-preferred brand)	$85 Copay	$170 Copay	$255 Copay	$100 Copay	$200 Copay	$300 Copay	$85 Copay	$170 Copay	$255 Copay
Tier 5 (specialty drug)	33% Co-insurance	Not offered	Not offered	33% Co-insurance	Not offered	Not offered	33% Co-insurance	Not offered	Not offered

	BayCarePlus Complete (HMO)			BayCarePlus Rewards (HMO)			BayCarePlus Signature (HMO)		
Initial Coverage *(continued)*	If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out of network.			If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out of network.			If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out of network.		
	Mail-Order Pharmacy			**Mail-Order Pharmacy**			**Mail-Order Pharmacy**		
Tier	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 (preferred generic)	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay
Tier 2 (generic)	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay
Tier 3 (preferred brand)	Not offered	Not offered	$95 Copay	Not offered	Not offered	$125 Copay	Not offered	Not offered	$95 Copay
Tier 4 (non-preferred brand)	Not offered	Not offered	$245 Copay	Not offered	Not offered	$275 Copay	Not offered	Not offered	$245 Copay
Tier 5 (specialty drug)	33% Co-insurance	Not offered	Not offered	33% Co-insurance	Not offered	Not offered	33% Co-insurance	Not offered	Not offered
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'll pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you've paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the 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'll pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you've paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the 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'll pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you've paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.		

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of: • 5% Co-insurance or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs	After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of: • 5% Co-insurance or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs	After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of: • 5% Co-insurance or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs

Other Covered Benefits

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Chiropractic Care	Manual manipulation of the spine to correct subluxation: $20 copay	Manual manipulation of the spine to correct subluxation: $20 copay	Manual manipulation of the spine to correct subluxation: $10 copay
Diabetes Supplies and Services	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 10% co-insurance When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Bayer/Ascensia products. Diabetic therapeutic custom-molded shoes or inserts: 20% co-insurance Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters and insulin pumps). *See Evidence of Coverage for a complete listing.	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 10% co-insurance When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Bayer/Ascensia products. Diabetic therapeutic custom-molded shoes or inserts: 20% co-insurance Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters and insulin pumps). *See Evidence of Coverage for a complete listing.	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 10% co-insurance When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Bayer/Ascensia products. Diabetic therapeutic custom-molded shoes or inserts: 20% co-insurance Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters and insulin pumps). *See Evidence of Coverage for a complete listing.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% Co-insurance for Medicare-covered items Prior authorization may be required.	20% Co-insurance for Medicare-covered items Prior authorization may be required.	20% Co-insurance for Medicare-covered items Prior authorization may be required.
Foot Care *(podiatry services)*	$15 Copay for each Medicare-covered podiatry visit	$35 Copay for each Medicare-covered podiatry visit	$10 Copay for each Medicare-covered podiatry visit
Home Health Care	$0 Copay A referral is required.	$0 Copay A referral is required.	$0 Copay A referral is required.
Hospice	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.
Outpatient Substance Abuse	Individual visit: $15 copay Group visit: $10 copay Prior authorization is required.	Individual visit: $35 copay Group visit: $30 copay Prior authorization is required.	Individual visit: $10 copay Group visit: $5 copay Prior authorization is required.
Over-the-Counter Coverage *(OTC)*	$70 Credit per quarter to use on approved health products that can be ordered online, by phone or by mail Leftover allowance doesn't roll over from quarter to quarter.	Not covered	$100 Credit per quarter to use on approved health products that can be ordered online, by phone or by mail Leftover allowance doesn't roll over from quarter to quarter.
Meals	28 Meals (two meals/day for 14 days) delivered directly to the home after each discharge from an inpatient acute hospital stay or skilled nursing facility stay Annual limit of two discharges for a total of 56 meals/ calendar year	Not covered	28 Meals (two meals/day for 14 days) delivered directly to the home after each discharge from an inpatient acute hospital stay or skilled nursing facility stay Annual limit of two discharges for a total of 56 meals/ calendar year

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Prosthetic Devices	Prosthetic devices: 20% co-insurance Related medical supplies: 20% co-insurance Prior authorization may be required.	Prosthetic devices: 20% co-insurance Related medical supplies: 20% co-insurance Prior authorization may be required.	Prosthetic devices: 20% co-insurance Related medical supplies: 20% co-insurance Prior authorization may be required.
Outpatient Rehabilitation Services	Cardiac rehabilitation services: $30 copay per day Occupational, speech and language therapy visits: $15 copay A separate copay for occupational therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.	Cardiac rehabilitation services: $30 copay per day Occupational, speech and language therapy visits: $35 copay A separate copay for occupational therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.	Cardiac rehabilitation services: $30 copay per day Occupational, speech and language therapy visits: $10 copay A separate copay for occupational therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.
Wellness Programs	Health club membership/ fitness classes through SilverSneakers®: $0 copay	Health club membership/ fitness classes through SilverSneakers®: $0 copay	Health club membership/ fitness classes through SilverSneakers®: $0 copay
Acupuncture	**Medicare-covered services (chronic low back pain):** $20 copay for up to 12 visits in 90 days* No more than 20 chronic low back pain visits per calendar year **Supplemental services:** $20 copay for up to 20 visits per calendar year through American Specialty Health *See Evidence of Coverage for more details	**Medicare-covered services (chronic low back pain):** $20 copay for up to 12 visits in 90 days* No more than 20 chronic low back pain visits per calendar year **Supplemental services:** $20 copay for up to 20 visits per calendar year through American Specialty Health *See Evidence of Coverage for more details	**Medicare-covered services (chronic low back pain):** $20 copay for up to 12 visits in 90 days* No more than 20 chronic low back pain visits per calendar year **Supplemental services:** $20 copay for up to 30 visits between acupuncture and therapeutic massage per calendar year through American Specialty Health *See Evidence of Coverage for more details
Therapeutic Massage	Not covered	Not covered	$20 Copay for up to 30 combined total visits between acupuncture and therapeutic massage per calendar year

Optional Comprehensive Dental Benefits

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)	BayCarePlus Signature (HMO)
Optional Supplemental Benefits	As a member of any **BayCare**Plus plan, you'll receive preventive and limited comprehensive dental benefits (see pages 8-9). For an additional monthly premium, you can also choose to add optional comprehensive coverage that provides more benefits. Monthly premium: $14 Yearly deductible: $0	As a member of any **BayCare**Plus plan, you'll receive preventive and limited comprehensive dental benefits (see pages 8-9). For an additional monthly premium, you can also choose to add optional comprehensive coverage that provides more benefits. Monthly premium: $14 Yearly deductible: $0	As a member of any **BayCare**Plus plan, you'll receive preventive and limited comprehensive dental benefits (see pages 8-9). For an additional monthly premium, you can also choose to add optional comprehensive coverage that provides more benefits. Monthly premium: $14 Yearly deductible: $0
	Comprehensive dental services: $0 copay We cover the following dental services when provided by an Argus contracted dental provider: Restorative: • Crown porcelain/ceramic substrate - one per calendar year • Crown porcelain fused to high noble metal - one per calendar year Endodontics: • Root canal - anterior - per tooth - one per calendar year • Root canal - bicuspid - per tooth - one per calendar year • Root canal - molar - per tooth - one per calendar year Prosthodontics (removable): One set of complete or partial dentures once per five years (upper and lower): • Complete denture upper • Complete denture lower • Immediate complete upper denture • Immediate complete lower denture • Partial upper - resin base (with clasps/rests and teeth) • Partial lower - resin base (with clasps/rests and teeth) • Upper partial - cast metal base with resin saddles (with clasps/rests and teeth) • Lower partial - cast metal base with resin saddles (with clasps/rests and teeth) Additional services available on a discounted fee schedule basis. Prior authorization may be required.		

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Pre-Enrollment Checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at (866) 509-5396 (TTY: 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit BayCarePlus.org or call (866) 509-5396 (TTY: 711) to view a copy of the EOC.

- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they aren't listed, it means you will likely have to select a new doctor.

- ☐ Review the Provider Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy isn't listed, you'll likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.

- ☐ Except in emergency or urgent situations, we don't cover services by out-of-network providers (doctors who aren't listed in the Provider Directory).

BayCare Select Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Select Health Plans depends on contract renewal.

This information is not a complete description of benefits. Call (866) 509-5396 (TTY: 711) for more information.

BayCare Select Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

BayCare Health Plans
300 Park Place Blvd.
Suite 170
Clearwater, FL 33759

BayCarePlus.org
Toll free: (877) 528-5821
(TTY: 711)
8am to 8pm,
Seven days a week

You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message, and your call will be returned the next business day.

BayCare Select Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Select Health Plans depends on contract renewal. All BayCare Select Health Plans plans include Part D drug coverage. To enroll, you must have both Medicare Parts A and B and reside in the Florida counties of Hillsborough, Pasco or Polk.

Members must use plan providers except in emergency or urgent care situations. If a member obtains routine care from an out-of-network provider without prior approval from BayCare Select Health Plans, neither Medicare nor BayCare Select Health Plans will be responsible for the costs. BayCare Select Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

BayCarePlus®
Medicare Advantage

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