BayCarePlus®
Medicare Advantage

2021

ANNUAL NOTICE OF CHANGE

Medicare Advantage

BayCarePlus Rewards (HMO)

Serving
Hillsborough, Pasco,
Pinellas and Polk Counties

BayCarePlus Rewards (HMO) offered by BayCare Select Health Plans

Annual Notice of Changes for 2021

You are currently enrolled as a member of **BayCare**Plus Rewards (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 1.5 and 1.6 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 1.6 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 1.3 for information about our Provider/Pharmacy 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 Medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 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 **BayCare**Plus Rewards.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in **BayCare**Plus Rewards.
- If you join another plan by **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 Customer Service number at (866) 509-5396 (TTY: 711) for additional information. Hours are 8 am to 8 pm, 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.

- Contacte a nuestro servicio de atención al cliente al (866) 509-5396 (TTY: 711) para más información. El horario de atención es los 7 días de la semana, de 8am a 8pm. Puede dejar un mensaje los fines de semana desde el 1 de abril hasta el 30 de septiembre y los dias feriados. Si lo hace, se le devolverá la llamada el siguiente día hábil.

- This document may be available in other formats such as braille, large print or other alternate formats.

- **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 IRS.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About BayCare Plus Rewards

- **BayCare**Plus Rewards is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.
- BayCare Select Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Select Health Plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means BayCare Select Health Plans. When it says "plan" or "our plan," it means **BayCare**Plus Rewards.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for **BayCare**Plus Rewards 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 Member.BayCarePlus.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0 **BayCare**Plus will pay up to $100 of your Medicare Part B premium.	$0 **BayCare**Plus will pay up to $114 of your Medicare Part B premium.
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 1.2 for details.)	$5,300	$4,500
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $45 per visit	Primary care visits: $0 per visit Specialist visits: $35 per visit
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.	$250 copay per day: Days 1-6 for each stay. $0 copay per day: Days 7 and beyond for each stay.	$250 copay per day: Days 1-6 for each stay. $0 copay per day: Days 7 and beyond for each stay.

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: **Retail Pharmacy 30-day Supply** • Drug Tier 1: $0 copay • Drug Tier 2: $10 copay • Drug Tier 3: $47 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% co-insurance	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: **Retail Pharmacy 30-day Supply** • Drug Tier 1: $0 copay • Drug Tier 2: $10 copay • Drug Tier 3: $47 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% co-insurance

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0 **BayCare**Plus will pay up to $100 of your Medicare Part B premium.	$0 **BayCare**Plus will pay up to $114 of your Medicare Part B premium.
Monthly optional supplemental benefits premium For more information, see Chapter 4, Section 2.2, Extra "optional supplemental" benefits you can buy in your *2021 Evidence of Coverage*.	Not offered	$14

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – 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 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.	$5,300	$4,500 Once you have paid $4,500 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider/Pharmacy Directory is located on our website at Member.BayCarePlus.org. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2021 Provider/Pharmacy 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 1.4 – 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 Provider/Pharmacy Directory is located on our website at Member.BayCarePlus.org. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2021 Provider/Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

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, *Medical Benefits Chart (what is covered and what you pay),* in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Acupuncture for chronic low back pain	You pay a $45 copay for each Medicare-covered acupuncture treatment. A referral from your PCP is required for acupuncture.	You pay a $20 copay for each Medicare-covered acupuncture treatment through an American Specialty Health (ASH) provider. A referral from your PCP is required for a visit with a doctor or other health care professional but is not required for acupuncture treatments.
Acupuncture - supplemental	Acupuncture - supplemental is not covered.	You pay a $20 copay for up to 20 visits through an American Specialty Health (ASH) provider.

Cost	2020 (this year)	2021 (next year)
Dental services - comprehensive	You pay a $45 copay for Medicare-covered dental services. Other comprehensive dental is not covered.	You pay a $35 copay for Medicare-covered dental services. You pay a $0 copay for coverage of some periodontics provided by an Argus contracted dental provider. Optional supplemental benefits for comprehensive dental services are available for an extra premium. See the Dental services – comprehensive (optional supplemental benefit) section at the end of this chart.
Dental services - preventive	You pay a $0 copay for preventive dental services provided by a DentaQuest contracted dental provider. Your plan covers periodic oral evaluations and routine cleaning twice every calendar year. It covers fluoride treatments and horizontal bitewing images once every calendar year.	You pay a $0 copay for preventive dental services provided by an Argus contracted dental provider. Your plan covers a periodic oral exam and prophylaxis every six months, bitewing x-rays every year, panoramic x-rays every three years, and full-mouth debridement every three years.

Cost	2020 (this year)	2021 (next year)
Diabetes self-management training, diabetic services and supplies	Prior authorization is required for therapeutic custom-molded shoes and inserts.	Prior authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, insulin pumps, continuous glucose monitors and their associated supplies such as sensors, transmitters, receivers, and readers).
Doctor's office visit	You pay a $45 copay for each Medicare-covered specialist visit. You pay a $45 copay for each Medicare-covered visit with other health care professionals. You pay a $45 copay for virtual doctor visits through BayCareAnywhere®, limited to 4 visits per year.	You pay a $35 copay for each Medicare-covered specialist visit. You pay a $35 copay for each Medicare-covered visit with other health care professionals. You pay a $20 copay for virtual doctor visits through BayCareAnywhere®, limited to 4 visits per year.
Excluded drugs	Erectile dysfunction drugs are not covered.	Limited quantities of certain oral generic drugs used for treatment of erectile dysfunction are covered at tier-2 cost sharing level.

Cost	2020 (this year)	2021 (next year)
Help with certain chronic conditions	You pay a $0 copay for diabetic eye exams and a $45 copay for all other Medicare-covered eye exams (performed by a specialist such as an ophthalmologist or optometrist).	You pay a $0 copay for diabetic eye exams and a $35 copay for all other Medicare-covered eye exams (performed by a specialist such as an ophthalmologist or optometrist). We made additional changes to how we report this benefit to Medicare. However, the only changes to what you pay are those listed above.
Opioid Treatment Program Services	You pay a $40 copay per visit for Medicare-covered opioid treatment program services.	You pay a $35 copay per visit for Medicare-covered opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies	You pay a $6 copay for Medicare-covered lab services. If you receive multiple services at the same location on the same day, individual service level copays may apply.	You pay a $0 copay for Medicare-covered lab services. If you receive multiple services at the same location on the same day, only the maximum copay applies.
Outpatient mental health care	You pay a $40 copay for each Medicare-covered individual visit. You pay a $35 copay for each Medicare-covered group visit.	You pay a $35 copay for each Medicare-covered individual visit. You pay a $30 copay for each Medicare-covered group visit.

Cost	2020 (this year)	2021 (next year)
Outpatient rehabilitation services	You pay a $40 copay for each Medicare-covered occupational therapy, physical therapy and/or speech and language pathology visit.	You pay a $35 copay for each Medicare-covered occupational therapy, physical therapy and/or speech and language pathology visit.
Outpatient substance abuse services	You pay a $40 copay for each Medicare-covered individual visit. You pay a $35 copay for each Medicare-covered group visit.	You pay a $35 copay for each Medicare-covered individual visit. You pay a $30 copay for each Medicare-covered group visit.
Podiatry services	You pay a $45 copay for each Medicare-covered podiatry service.	You pay a $35 copay for each Medicare-covered podiatry service.
Vision care	You pay a $45 copay for each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits. You pay a $0 copay for up to 1 pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) after each cataract surgery. You pay a $15 copay for 1 pair of Medicare-covered eyeglass frames or 1 pair of Medicare-covered contact lenses (or 2 six packs) after each cataract	You pay a $35 copay for each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits. You pay a $0 copay for 1 pair of Medicare-covered eyeglasses, which includes frame and plastic lens, or Medicare-covered contact lenses (after each cataract surgery).

Cost	2020 (this year)	2021 (next year)
Vision care **(continued)**	surgery. Your plan pays up to $100 for eyeglass frames or contact lenses after each cataract surgery.	
	You pay a $0 copay for up to 1 routine eye exam every calendar year.	You pay a $0 copay for up to 1 routine eye exam every calendar year.
	You pay a $0 copay for up to 1 pair of eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) per calendar year. You pay a $15 copay for up to 1 pair of eyeglass frames or 1 pair of contact lenses (or 2 six packs) every calendar year.	You pay a $0 copay for up to 1 pair of eyeglasses (lenses and frames), with CR-39 clear plastic single vision, lined bifocal, trifocal, or contact lenses per calendar year.
	Your plan pays up to $100 per calendar year for eyeglass frames or contact lenses.	Your plan pays up to $100 per calendar year for eyeglasses (lenses and frames) or contact lenses.
	For upgrades to eyeglass lenses and contact lenses, which apply to routine eyewear only: • You pay a $15 copay which applies to UV treatment, tint, or standard plastic scratch coating. • You pay a $65 copay which applies to standard progressive lenses and standard anti-reflective coating. • You pay 80% of the total cost for premium progressive lenses and	For upgrades to eyeglass lenses and contact lenses, which apply to routine eyewear only: • You pay a $40 copay for photochromic lenses. • You pay a $50 copay for standard progressive lenses. • You pay 85% of the total cost for lens treatment upgrades. • You pay 100% of the total cost for contact lenses fitting and follow-up.

Cost	2020 (this year)	2021 (next year)
Vision care **(continued)**	other coatings, oversized lenses, prism and other lens options. • You pay 90% of the total cost for contact lenses fitting and follow-up. Routine vision care must be obtained from an EyeQuest provider.	Routine vision care must be obtained from an Argus provider.
Dental services - comprehensive (optional supplemental benefit)*	Optional supplemental dental services are not covered.	You pay a $0 copay for covered dental services when provided by an Argus contracted dental provider. Refer to Chapter 4, Section 2.2, Extra "optional supplemental" benefits you can buy in your *2021 Evidence of Coverage*, for specific details.

*** Optional supplemental benefits are available for an extra premium.** For more information about optional supplemental benefits see Chapter 4, Section 2.2 of your *Evidence of Coverage*.

Section 1.6 – 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. **You can get the *complete* Drug List** by calling Customer Service (see the back cover) or visiting our website Member.BayCarePlus.org.

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 Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service 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 exception approvals are typically valid for 12 months.

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 sent you 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 haven't received this insert by September 28, 2020, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 6.1, 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 at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*,

which is located on our website at Member.BayCarePlus.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copays 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 During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Preferred Generic:** *Standard cost-sharing:* You pay $0 per prescription. **Generic:** *Standard cost-sharing:* You pay $10 per prescription. **Preferred Brand:** *Standard cost-sharing:* You pay $47 per prescription. **Non-Preferred Brand:** *Standard cost-sharing:* You pay $100 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Preferred Generic:** *Standard cost-sharing:* You pay $0 per prescription. **Generic:** *Standard cost-sharing:* You pay $10 per prescription. **Preferred Brand:** *Standard cost-sharing:* You pay $47 per prescription. **Non-Preferred Brand:** *Standard cost-sharing:* You pay $100 per prescription.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued)	**Specialty Tier:** *Standard cost-sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	**Specialty Tier:** *Standard cost-sharing:* You pay 33% of the total cost. _____ 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 other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in **BayCare**Plus Rewards

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 **BayCare**Plus Rewards.

Section 2.2 – 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 timely,
- *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 do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

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 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.Medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from **BayCare**Plus Rewards.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from **BayCare**Plus Rewards.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 6.1 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.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until 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. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

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 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Florida the SHIP is called Serving Health Insurance Needs of Elders (SHINE).

SHINE 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.

SHINE 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 SHINE at (800) 963-5337. You can learn more about SHINE by visiting their website FloridaSHINE.org.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, 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 the AIDS Drugs Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please contact:

  AIDS Drugs Assistance Program
  HIV/AIDS Section
  4052 Bald Cypress Way
  Tallahassee, FL 32399

Phone: (850) 245-4422

Florida HIV/AIDS Hotline:
English: (800) 352-AIDS (2437)
Spanish: (800) 545-7432
Haitian Creole: (800) 243-7101
TTY: (888) 503-7118

FloridaHealth.gov/Diseases-and-Conditions/AIDS/ADAP/
Email: DiseaseControl@flhealth.gov

SECTION 6 Questions?

Section 6.1 – Getting Help from BayCarePlus Rewards

Questions? We're here to help. Please call Customer Service at (866) 509-5396 (TTY 711). We are available from 8 am to 8 pm, 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. 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 **BayCare**Plus Rewards. 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 Member.BayCarePlus.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at Member.BayCarePlus.org. As a reminder, our website has the most up-to-date information about our provider network (Provider/Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – 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 (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 Medicare.gov/plan-compare).

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* 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 (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.

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

Member.BayCarePlus.org

Toll free: (866) 509-5396
(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.

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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