BayCarePlus®
Medicare Advantage

2023

SUMMARY OF BENEFITS

Medicare Advantage

BayCarePlus Rewards (HMO)
BayCarePlus Complete (HMO)
BayCarePlus Premier (HMO)

Serving
Hillsborough, Pasco,
Pinellas and Polk Counties

Summary of Benefits
January 1, 2023 – December 31, 2023

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® **Rewards (HMO)**, **BayCare**Plus **Complete (HMO)** and **BayCare**Plus **Premier (HMO)** plans 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 800-MEDICARE (800-633-4227), 24 hours a day/7 days a week. TTY users should call (877) 486-2048.

Sections in This Booklet

- Things to Know About **BayCare**Plus **Rewards**, **BayCare**Plus **Complete** and **BayCare**Plus **Premier**

- 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 (877) 528-5821 (TTY: 711) to speak with a customer service representative.

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

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: (877) 528-5821 (TTY: 711).
- Our website: BayCarePlus.org

Who can join?

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

What is an HMO?

An HMO, or Health Maintenance Organization, is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage.

Which doctors, hospitals and pharmacies can I use?

BayCarePlus plans have a network of doctors, hospitals, pharmacies and other providers. If you use 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. 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 **Rewards (HMO) H2235-002**	**BayCare**Plus **Complete (HMO) H2235-001**	**BayCare**Plus **Premier (HMO) H2235-003**
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.	$34 Per month. You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	$123 Per month	Not covered	Not covered
Deductibles	**All Plans** A deductible isn't required for these plans.		
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: • $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: • $3,100 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: • $2,500 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.

Covered Medical and Hospital Benefits

	BayCarePlus **Rewards (HMO)**	**BayCare**Plus **Complete (HMO)**	**BayCare**Plus **Premier (HMO)**
Inpatient Hospital Coverage	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. • $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. • $150 Copay per day, per stay: days 1-5 • $0 Copay per day, per stay: days 6 and beyond Prior authorization is required.

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Outpatient Hospital Coverage	$225 copay Prior authorization may be required.	$125 Copay Prior authorization may be required.	$95 copay Prior authorization may be required.
Ambulatory Surgical Center (ASC)	$125 copay Prior authorization may be required.	$75 copay Prior authorization may be required.	$50 copay Prior authorization may be required.
Doctor Visits (primary care providers and specialists)	Primary care provider (PCP) visit: $0 copay Specialist visit: $40 copay A referral is required for specialist visits except for visits with an obstetrician/ gynecologist, chiropractor, podiatrist or dermatologist. Certain services may require prior authorization.	Primary care provider (PCP) visit: $0 copay Specialist visit: $15 copay A referral is required for specialist visits except for visits with an obstetrician/ gynecologist, chiropractor, podiatrist or dermatologist. Certain services may require prior authorization.	Primary care provider (PCP) visit: $0 copay Specialist visit: $15 copay A referral is not required to see specialists on this plan, except for home health, occupational therapy, physical therapy and speech therapy. Certain services may require prior authorization.
Virtual/ Telehealth Visits	**All Plans** Telehealth visits are available with select primary care and specialist physicians as well as for therapy (occupational, physical, speech), mental health, psychiatry and substance abuse services. Members pay the same copay as if the services were provided at an in-person visit. **BayCare**Anywhere® virtual visits ($20 copay, up to four per calendar year): For urgent care needs—doctor visits through a smartphone, tablet or computer using the **BayCare**Anywhere app. For non-urgent care needs—doctor visits through a kiosk (located in a private room) via teleconferencing and medical diagnostic equipment. Available through Walk-In Care Provided by BayCare locations at select Publix Pharmacies. Prior authorization may be required for mental health, psychiatry and substance abuse services. A referral is required for therapy (occupational, physical, speech) or other health care professional services. The same prior authorization requirements and referral requirements for in-person visits apply to virtual/telehealth visits.		
Preventive Care	**All Plans** You pay nothing. Our plans cover 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 (COVID-19, pneumonia, hepatitis B and influenza) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • 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.		

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Emergency Care	$100 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. We provide worldwide coverage.	$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. We provide worldwide coverage.	$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. We provide worldwide coverage.
Urgently Needed Services	$35 Copay within the United States $100 Copay outside the United States We provide worldwide coverage.	$35 Copay within the United States $90 Copay outside the United States We provide worldwide coverage.	$30 Copay within the United States $120 Copay outside the United States We provide worldwide coverage.
Diagnostic Services/ Labs/Imaging (costs for these services may vary based on place of service)	Lab services: $0 copay Diagnostic procedures and tests: $100 copay X-rays: $0 copay MRI, CT and PET scans: $125 copay Diagnostic mammograms: $0 copay Diagnostic colonoscopies: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% co-insurance Some services may require prior authorization. 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: $0 copay X-rays: $0 copay MRI, CT and PET scans: $90 copay Diagnostic mammograms: $0 copay Diagnostic colonoscopies: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% co-insurance Some services may require prior authorization. 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: $0 copay X-rays: $0 copay MRI, CT and PET scans: $90 copay Diagnostic mammograms: $0 copay Diagnostic colonoscopies: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% co-insurance Some services may require prior authorization. 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.

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: $30 copay Routine hearing exam: $30 copay (one per calendar year) A referral is required for Medicare-covered exams. Hearing aids aren't covered.	Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $0 copay (one per calendar year) A referral is required for Medicare-covered exams. Up to two hearing aids 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 purchase includes fitting and two follow-up visits within the first year of hearing aid purchase: $0 copay *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: $0 copay (one per calendar year) Up to two hearing aids 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 purchase includes fitting and two follow-up visits within the first year of hearing aid purchase: $0 copay *Amounts you pay for these services don't count toward your maximum out-of-pocket amount.
Dental Services	**Dental services:** $0 copay Included dental services cover the following: • Comprehensive oral exam (once every three calendar years) • Periodic oral evaluation (two per calendar year) • Routine cleaning (two every calendar year) • Fluoride application (two every calendar year) • 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) • Full-mouth debridement (deep cleaning) (one every three calendar years)	**Dental services:** $0 copay Included dental services cover the following: • Comprehensive oral exam (once every three calendar years) • Periodic oral evaluation (two per calendar year) • Routine cleaning (two every calendar year) • Fluoride application (two every calendar year) • 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) • Full-mouth debridement (deep cleaning) (one every three calendar years)	**Dental services:** $0 copay Included dental services cover the following: • Comprehensive oral exam (once every three calendar years) • Periodic oral evaluation (two per calendar year) • Routine cleaning (two every calendar year) • Fluoride application (two every calendar year) • 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) • Full-mouth debridement (deep cleaning) (one every three calendar years)

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Dental Services (continued)	• Perio scaling and root planing—four or more teeth per quad (one per quad every three calendar years) • Perio scaling and root planing—one to three teeth per quad (one per quad every three calendar years) **Medicare-covered dental services:** $40 copay A referral is required to visit an oral surgeon for Medicare-covered services, and those services may require prior authorization. See page 17 for information on optional comprehensive dental coverage that can be purchased separately.	• Perio scaling and root planing—four or more teeth per quad (one per quad every three calendar years) • Perio scaling and root planing—one to three teeth per quad (one per quad every three calendar years) • Filling (one per calendar year) **Medicare-covered dental services:** $20 copay A referral is required to visit an oral surgeon for Medicare-covered services, and those services may require prior authorization. See page 17 for information on optional comprehensive dental coverage that can be purchased separately.	• Perio scaling and root planing—four or more teeth per quad (one per quad every three calendar years) • Perio scaling and root planing—one to three teeth per quad (one per quad every three calendar years) • Fillings (two per calendar year) • Extractions (two per calendar year) **Medicare-covered dental services:** $15 copay Medicare-covered services provided by an oral surgeon may require prior authorization. See page 17 for information on optional comprehensive dental coverage that can be purchased separately.
Vision Services	**Routine vision services:** One routine eye exam every calendar year: $0 copay Post-cataract eye exam: $0 copay Up to one pair of eyeglasses (frames, lens, and lens options) or contact lenses per calendar year: $0 copay Our plan pays up to $100 per calendar year for eyeglasses (lenses and frames) or contact lenses. Lens upgrades are included within the above material allowance.	**Routine vision services:** One routine eye exam every calendar year: $0 copay Post-cataract eye exam: $0 copay Up to one pair of eyeglasses (frames, lens, and lens options) or contact lenses per calendar year: $0 copay Our plan pays up to $150 per calendar year for eyeglasses (lenses and frames) or contact lenses. Lens upgrades are included within the above material allowance.	**Routine vision services:** One routine eye exam every calendar year: $0 copay Post-cataract eye exam: $0 copay Up to one pair of eyeglasses (frames, lens, and lens options) or contact lenses per calendar year: $0 copay Our plan pays up to $200 per calendar year for eyeglasses (lenses and frames) or contact lenses. Lens upgrades are included within the above material allowance.

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Vision Services (continued)	**Medicare-covered vision services:** Medicare-covered eye exams: $40 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, frames or contact lenses) after cataract surgery: $0 copay After each cataract surgery, our plan pays up to $150 per calendar year for eyeglasses (lenses and frames) or $200 per calendar year for contact lenses.	**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, frames or contact lenses) after cataract surgery: $0 copay After each cataract surgery, our plan pays up to $150 per calendar year for eyeglasses (lenses and frames) or $200 per calendar year for contact lenses.	**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 One pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular, frames or contact lenses) after cataract surgery: $0 copay After each cataract surgery, our plan pays up to $150 per calendar year for eyeglasses (lenses and frames) or $200 per calendar year for contact lenses.
Mental Health Services	**Inpatient stay:** 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	**Inpatient stay:** 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	**Inpatient stay:** 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

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Mental Health Services (continued)	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 may be required.	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 may be required.	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 authorization may be 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 • $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.	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	$35 Copay A referral is required.	$15 Copay A referral is required.	$10 Copay A referral is required.
Ambulance	$250 Copay This copay applies to each one-way trip. Prior authorization is required for non-emergent transportation by ambulance.	$200 Copay This copay applies to each one-way trip. Prior authorization is required for non-emergent transportation by ambulance.	$200 Copay This copay applies to each one-way trip. Prior authorization is required for non-emergent transportation by ambulance.
Transportation	Not covered	$0 Copay Limited to 16 one-way trips to plan-approved locations every calendar year	$0 Copay Limited to 24 one-way trips to plan-approved locations every calendar year
Medicare Part B Drugs	**All Plans** For Part B drugs such as chemotherapy drugs: 20% coinsurance Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 20% coinsurance Prior authorization is required. Amounts you pay for Part B drugs count toward your MOOP; they do not count toward your Part D initial coverage limit or true out-of-pocket cost of $7,400.		

Part D Prescription Drug Benefits

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Deductible	**All Plans** A deductible isn't required for these plans.		
Initial Coverage	**All Plans** You pay the amounts listed in the following tables until your total yearly drug costs reach $4,660. For insulins, you won't pay more than $35 for a one-month supply of each insulin product covered by our plan for all cost-sharing tiers. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. 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.		
Insulin Coverage	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing tier, the coverage phase, your Extra Help status or whether the insulin product is considered a Select Insulin under the plan's Prescription Drug Formulary.*		

	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)	$10 Copay	$20 Copay	$30 Copay	$3 Copay	$6 Copay	$9 Copay	$0 Copay	$0 Copay	$0 Copay
Select Insulins	Not applicable**	Not applicable**	Not applicable**	$3 Copay	$6 Copay	$9 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 3 (preferred brand)	$47 Copay	$94 Copay	$141 Copay	$35 Copay	$70 Copay	$105 Copay	$30 Copay	$60 Copay	$90 Copay
Select Insulins	Not applicable**	Not applicable**	Not applicable**	$35 Copay	$70 Copay	$105 Copay	$30 Copay	$60 Copay	$90 Copay
Tier 4 (non-preferred brand)	$100 Copay	$200 Copay	$300 Copay	$85 Copay	$170 Copay	$255 Copay	$85 Copay	$170 Copay	$255 Copay
Tier 5 (specialty drug)	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered

	BayCarePlus Rewards (HMO)			BayCarePlus Complete (HMO)			BayCarePlus Premier (HMO)		
	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
Select Insulins	Not offered	Not offered	Not applicable**	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay
Tier 3 (preferred brand)	Not offered	Not offered	$125 Copay	Not offered	Not offered	$95 Copay	Not offered	Not offered	$80 Copay
Select Insulins	Not offered	Not offered	Not applicable**	Not offered	Not offered	$95 Copay	Not offered	Not offered	$80 Copay
Tier 4 (non-preferred brand)	Not offered	Not offered	$275 Copay	Not offered	Not offered	$245 Copay	Not offered	Not offered	$245 Copay
Tier 5 (specialty drug)	33% Coinsurance	Not offered	Not offered	33% Co-insurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered
Coverage Gap	**All Plans** 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 $4,660. 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 out-of-pocket costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap. If you're eligible for the Insulin Savings Program and are a member of the **BayCare**Plus **Complete** or **Premier** plan, your cost-share for Select Insulins won't increase during the coverage gap.* **Important**—You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, even if the insulin product isn't considered a Select Insulin under the plan's Prescription Drug Formulary or you're not eligible for the Insulin Savings Program.								
Catastrophic Coverage	**All Plans** After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: 5% coinsurance or $4.15 copay for generic drugs (including brand drugs treated as generic) and a $10.35 copay for all other drugs. **Important**—You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, for all cost-sharing tiers.								

*Select Insulins are those that are part of the Insulin Savings Program and incur low, consistent copays through the coverage gap. Insulins administered via a durable medical equipment insulin pump are not included in the program. For information regarding which insulins are Select Insulins under the plan's benefit, refer to the plan's Prescription Drug Formulary. See the Evidence of Coverage for more information regarding Select Insulins, including full cost-sharing information. The program doesn't apply during the catastrophic coverage stage, if you're a a **BayCare**Plus **Rewards** member or if you receive Extra Help.

If you're a member of the **Rewards plan, insulins on this tier are covered at the regular tier cost-share and won't exceed $35 for a one-month supply of each insulin product covered by the plan.

Cost-sharing may change depending on the pharmacy you choose.

Other Covered Benefits

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (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% coinsurance 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): $0 copay* 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% coinsurance An additional $25 credit per quarter to spend on over-the-counter items** Four routine podiatry visits, which include nail trimmings, per calendar year: $0 copay** Four additional hours of nutrition counseling per calendar year: $0 copay** 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. **The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips): $0 copay* 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% coinsurance An additional $50 credit per quarter to spend on over-the-counter items** Six routine podiatry visits, which include nail trimmings, per calendar year: $0 copay** Six additional hours of nutrition counseling per calendar year: $0 copay** 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. **The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Durable Medical Equipment (wheelchairs, oxygen, etc.)	**All Plans** 20% Coinsurance for Medicare-covered items Prior authorization may be required.		
Foot Care (podiatry services)	$40 Copay for each Medicare-covered podiatry visit	$15 Copay for each Medicare-covered podiatry visit Members with diabetes: $0 copay for four routine podiatry visits (including nail trimmings) per calendar year* *The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.	$15 Copay for each Medicare-covered podiatry visit Members with diabetes: $0 copay for six routine podiatry visits (including nail trimmings) per calendar year* *The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.
Home Health Care	**All Plans** $0 Copay A referral is required.		
Hospice	**All Plans** You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.		
Outpatient Substance Abuse	Individual visit: $35 copay Group visit: $30 copay Prior authorization may be required.	Individual visit: $15 copay Group visit: $10 copay Prior authorization may be required.	Individual visit: $10 copay Group visit: $5 copay Prior authorization may be required.
Over-the-Counter Coverage (OTC)	Not covered	$85 Credit per quarter to use on approved health products that can be ordered online, by phone or by mail Members with diabetes will receive an additional $25 credit per quarter* Up to two orders per quarter are allowed and leftover allowance doesn't roll over from quarter to quarter. *The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.	$115 Credit per quarter to use on approved health products that can be ordered online, by phone or by mail Members with diabetes will receive an additional $50 credit per quarter* Up to two orders per quarter are allowed and leftover allowance doesn't roll over from quarter to quarter. *The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Meals	Not covered	Twenty-eight 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	Twenty-eight 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
Prosthetic Devices	**All Plans** Prosthetic devices: 20% coinsurance | Related medical supplies: 20% coinsurance Prior authorization may be required.		
Outpatient Rehabilitation Services	Cardiac and pulmonary rehabilitation services: $20–$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 and pulmonary rehabilitation services: $20–$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 and pulmonary rehabilitation services: $20–$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	**All Plans** Health club membership/fitness classes through Silver&Fit®: $0 copay • Access to a network of more than 15,500 fitness centers and studios • 8,000+ Digital workout videos through the website and mobile app digital library including the Silver&Fit Signature Series Classes® • One Home Fitness Kit per benefit year from a variety of fitness categories		
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 *See your Evidence of Coverage booklet 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 *See your Evidence of Coverage booklet 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 *See your Evidence of Coverage booklet for more details.

Optional Comprehensive Dental Benefits

	BayCarePlus Rewards (HMO)	BayCarePlus Complete (HMO)	BayCarePlus Premier (HMO)
Optional Supplemental Benefits	**All Plans** As a member of any **BayCare**Plus plan, you'll receive select dental benefits for no additional cost (see pages 8-9). For a low monthly premium, you can also choose to add optional comprehensive coverage that provides more benefits. Monthly premium: $30 Yearly deductible: $0 Comprehensive dental services: $0 copay Maximum benefit: $1,000 per calendar year We cover the following dental services when provided by a Delta Dental contracted dental provider: **Restorative:** Two crowns per calendar year **Endodontics:** Three root canals per calendar year **Prosthodontics (dentures):** One set of complete or partial dentures once per five years (upper and lower) **Extractions** An unlimited number of extractions are covered only when getting complete or partial dentures. Prior authorization is 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 (877) 528-5821 (TTY: 711).

Understanding the Benefits

☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It's important to review plan coverage, costs and benefits before you enroll. Visit BayCarePlus.org or call (877) 528-5821 (TTY: 711) to view a copy of the EOC.

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

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

☐ Review the formulary to make sure your drugs are covered.

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. (Please note: Some plans may have a $0 monthly plan premium).

☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2024.

☐ 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. 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.

Information on our utilization management processes, including prior authorization, concurrent review, postservice review and appeals can be found online at Member.BayCarePlus.org/s/Utilization.

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 plan service area.

Members must use plan providers except in emergency or urgent care situations. If a member obtains 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.

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