2024 Summary of Benefits

Medicare Advantage

BayCarePlus **Rewards** (HMO)
BayCarePlus **Value** (HMO)
BayCarePlus **Complete** (HMO)
BayCarePlus **Premier** (HMO)
BayCarePlus **Freedom** (HMO-POS)

Serving Hillsborough, Pasco, Pinellas and Polk Counties

BayCarePlus®
Medicare Advantage

Summary of Benefits

January 1, 2024–December 31, 2024

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 **Value** (HMO), **BayCare**Plus **Complete** (HMO), **BayCare**Plus **Premier** (HMO) and **BayCare**Plus **Freedom** (HMO-POS) Plans 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 1-800-Medicare (1-800-633-4227), 24 hours a day, seven days a week. TTY users can call (877) 486-2048.

Sections in This Booklet

- Things to Know About **BayCare**Plus **Rewards** (HMO), **BayCare**Plus **Value** (HMO), **BayCare**Plus **Complete** (HMO), **BayCare**Plus **Premier** (HMO) and **BayCare**Plus **Freedom** (HMO-POS) Plans
- 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) 549-1741 (TTY: 711) to speak with a health care advisor.

Bernadette S.,
BayCarePlus Member

Things to Know About **BayCare**Plus Medicare Advantage (HMO)

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) 549-1741 (TTY: 711).
- Our website: BayCarePlus.org

Who can join?
To join **BayCare**Plus **Rewards**, **BayCare**Plus **Value**, **BayCare**Plus **Complete**, **BayCare**Plus **Premier** and **BayCare**Plus **Freedom** plans, 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 these Florida counties: Hillsborough, Pasco, Pinellas and Polk.

What's 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.

What's an HMO-POS?
An HMO-POS plan is a type of Medicare Advantage plan which is a health maintenance organization (HMO) plan with point of service (POS) benefits. The added POS benefits give you flexibility to see health care providers outside the plan's network for care or services at a higher out-of-pocket cost, if you choose.

Which doctors, hospitals and pharmacies can I use?
BayCarePlus has 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. The exception is the **BayCare**Plus **Freedom** (HMO-POS) plan which gives you the flexibility to use providers outside the plan's network for an additional cost. 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 of the formulary.

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, 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	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Monthly Plan Premium	$0 per month	$0 per month	$0 per month
	You must continue to pay your Medicare Part B premium.		
Part B Premium Reduction	$134 per month	$113 per month	Not covered
Deductibles	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 in this plan: **$4,500** for covered hospital and medical services you receive from in-network providers		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 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 pay the full cost for the rest of the year. You'll still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network*
$42 per month	$0 per month	
You must continue to pay your Medicare Part B premium.		
Not covered	Not covered	
A deductible isn't required for these plans.		
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 in this plan: **$2,500** for covered hospital and medical services you receive from in-network providers	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 in this plan: **$3,850** for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for combined in-network and out-of-network covered hospital and medical services. Your yearly limit in this plan: **$8,950** for covered hospital and medical services you receive from in-and out-of-network providers
If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we pay the full cost for the rest of the year. You'll still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.		

*Must see a provider who accepts Medicare and who agrees to see you. Out-of-network cost sharing applies. See the Evidence of Coverage.

Covered Medical and Hospital Benefits

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Inpatient Hospital Coverage	This plan covers an unlimited number of days for an inpatient hospital stay. $250 copay per day, per stay: days 1-5 $0 copay per day, per stay: day 6 and beyond Prior authorization is required.	This plan covers an unlimited number of days for an inpatient hospital stay. $250 copay per day, per stay: days 1-5 $0 copay per day, per stay: day 6 and beyond Prior authorization is required.	This plan covers an unlimited number of days for an inpatient hospital stay. $200 copay per day, per stay: days 1-5 $0 copay per day, per stay: day 6 and beyond Prior authorization is required.
Outpatient Hospital Coverage	$225 copay Prior authorization is required.	$225 copay Prior authorization is required.	$125 copay Prior authorization is required.
Ambulatory Surgical Center (ASC)	$125 copay Prior authorization is required.	$125 copay Prior authorization is required.	$75 copay Prior authorization is required.

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
This 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: day 6 and beyond Prior authorization is required.	This plan covers an unlimited number of days for an inpatient hospital stay. $250 copay per day, per stay: days 1-5 $0 copay per day, per stay: day 6 and beyond Prior authorization is required.	This plan covers an unlimited number of days for an inpatient hospital stay. 45% coinsurance per day, per stay: day 1 and beyond
$95 copay Prior authorization is required.	$125 copay Prior authorization is required.	45% coinsurance for all Medicare-covered outpatient hospital services
$50 copay Prior authorization is required.	$75 copay Prior authorization is required.	45% coinsurance

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Doctor Visits *(Primary care providers (PCPs) and specialists)*	PCP visit: $0 copay Specialist visit: $40 copay A referral is required for specialist visits except for an obstetrician/ gynecologist, chiropractor, podiatrist or dermatologist. Certain services may require prior authorization.	PCP visit: $0 copay Specialist visit: $40 copay A referral is required for specialist visits except for an obstetrician/ gynecologist, chiropractor, podiatrist or dermatologist. Certain services may require prior authorization.	PCP visit: $0 copay Specialist visit: $15 copay A referral is required for specialist visits except for an obstetrician/ gynecologist, chiropractor, podiatrist or dermatologist. Certain services may require prior authorization.
Virtual/Telehealth Visits	Telehealth visits are available with select primary care and specialist physicians as well as for therapy *(occupational, physical, speech)*, mental health, psychiatry and substance use 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 use 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.		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
PCP visit: $0 copay Specialist visit: $15 copay A referral isn't required to see specialists except for home health, occupational therapy, physical therapy and speech therapy. Certain services may require prior authorization.	PCP visit: $0 copay Specialist visit: $35 copay A referral is required for specialist visits except for an obstetrician/gynecologist, chiropractor, podiatrist or dermatologist. Certain services may require prior authorization.	PCP visit: $50 copay Specialist visit: $70 copay A referral isn't required for specialist visits. Certain services may require prior authorization.

Telehealth visits are available with select primary care and specialist physicians as well as for therapy *(occupational, physical, speech)*, mental health, psychiatry and substance use services.

Members pay the same copay as if the services were provided at an in-person visit.

BayCareAnywhere 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 use 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.

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Preventive Care	**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.		
Emergency Care	$100 copay	$100 copay	$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.		
Urgently Needed Services	$35 copay within the U.S. $100 copay outside the U.S.	$35 copay within the U.S. $100 copay outside the U.S.	$35 copay within the U.S. $90 copay outside the U.S.
	We provide worldwide coverage.		

<table>
<tr><th>BayCarePlus
Premier (HMO)
H2235-003</th><th colspan="2">NEW!
BayCarePlus
Freedom (HMO-POS)
H2235-006</th></tr>
<tr><td></td><td>In network</td><td>Out of network</td></tr>
<tr><td colspan="2">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.</td><td>45% coinsurance for all preventive care services</td></tr>
<tr><td>$120 copay</td><td colspan="2">$135 copay</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>$30 copay within the U.S.
$120 copay outside the U.S.</td><td colspan="2">$40 copay within the U.S.
$135 copay outside the U.S.</td></tr>
<tr><td colspan="3">We provide worldwide coverage.</td></tr>
</table>

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Diagnostic Services/Labs/ Imaging *Costs for these services may vary based on the 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% coinsurance Some services may require prior authorization. See the Evidence of Coverage for more details and a complete list. There's 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 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% coinsurance Some services may require prior authorization. See the Evidence of Coverage for more details and a complete list. There's 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% coinsurance Some services may require prior authorization. See the Evidence of Coverage for more details and a complete list. There's no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they're ordered as a preventive service.

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
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% coinsurance Some services may require prior authorization. See the Evidence of Coverage for more details and a complete list. There's 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% coinsurance Some services may require prior authorization. See the Evidence of Coverage for more details and a complete list. There's no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they're ordered as a preventive service.	Lab services: 45% coinsurance Diagnostic procedures and tests: 45% coinsurance X-rays: 45% coinsurance MRI, CT and PET scans: 45% coinsurance Diagnostic mammograms: 45% coinsurance Diagnostic colonoscopies: 45% coinsurance Therapeutic radiology services *(such as radiation treatment for cancer)*: 45% coinsurance Abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening ordered as a preventive service: 45% coinsurance

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: $40 copay A referral is required for Medicare-covered exams. Routine hearing exam: $30 copay *(one per calendar year)* Up to two hearing aids every calendar year *(one per ear)* Hearing aid copays: $599 for TruHearing Advanced or $899 for TruHearing Premium *(copay is per hearing aid*)* Rechargeable premium hearing aids are available for an additional $50 copay per aid. Hearing aid purchase includes post-purchase visits for one year following purchase for fitting, adjustment and education: $0 copay	Medicare-covered exam to diagnose and treat hearing and balance issues: $40 copay A referral is required for Medicare-covered exams. Routine hearing exam: $30 copay *(one per calendar year)* Up to two hearing aids every calendar year *(one per ear)* Hearing aid copays: $599 for TruHearing Advanced or $899 for TruHearing Premium *(copay is per hearing aid*)* Rechargeable premium hearing aids are available for an additional $50 copay per aid. Hearing aid purchase includes post-purchase visits for one year following purchase for fitting, adjustment and education: $0 copay	Medicare-covered exam to diagnose and treat hearing and balance issues: $15 copay A referral is required for Medicare-covered exams. Routine hearing exam: $0 copay *(one per calendar year)* Up to two hearing aids every calendar year *(one per ear)* Hearing aid copays: $699 for TruHearing Advanced or $999 for TruHearing Premium *(copay is per hearing aid*)* Rechargeable premium hearing aids are available for an additional $50 copay per aid. Hearing aid purchase includes post-purchase visits for one year following purchase for fitting, adjustment and education: $0 copay

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
Medicare-covered exam to diagnose and treat hearing and balance issues: $15 copay A referral isn't required for Medicare-covered exams. Routine hearing exam: $0 copay *(one per calendar year)* Up to two hearing aids every calendar year *(one per ear)* Hearing aid copays: $599 for TruHearing Advanced or $899 for TruHearing Premium *(copay is per hearing aid*)* Rechargeable premium hearing aids are available for an additional $50 copay per aid. Hearing aid purchase includes post-purchase visits for one year following purchase for fitting, adjustment and education: $0 copay	Medicare-covered exam to diagnose and treat hearing and balance issues: $35 copay A referral is required for Medicare-covered exams. Routine hearing exam: $0 copay *(one per calendar year)* Up to two hearing aids every calendar year *(one per ear)* Hearing aid copays: $699 for TruHearing Advanced or $999 for TruHearing Premium *(copay is per hearing aid*)* Rechargeable premium hearing aids are available for an additional $50 copay per aid. Hearing aid purchase includes post-purchase visits for one year following purchase for fitting, adjustment and education: $0 copay	Medicare-covered exam to diagnose and treat hearing and balance issues: $70 copay Routine hearing services and hearing aids are not covered out of network.

*Amount you pay for these services doesn't count toward your maximum out-of-pocket amount.

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Dental Services	Medicare-covered dental services: $40 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services require prior authorization.	Medicare-covered dental services: $40 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services require prior authorization.	Medicare-covered dental services: $15 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services require prior authorization.
	You pay $0 copay for covered preventive dental services including: One comprehensive oral exam every three years per provider or location Two periodic oral evaluations every calendar year Two routine cleanings every calendar year Two fluoride applications every calendar year One bitewing X-ray every calendar year One complete intra-oral series and panoramic film every two calendar years Limited oral evaluations **You pay $0 copay for covered comprehensive dental service including:** One root planing/scaling and planing per quadrant every two years Two fillings every calendar year One crown every calendar year Two root canals per calendar year Two extractions per calendar year One full mouth debridement every two calendar years One denture per arch every five calendar years Two relines per calendar year Annual maximum of $2,000 for comprehensive dental. The amounts you pay for preventive and comprehensive dental don't apply to your out-of-pocket maximum. Services for preventive and comprehensive dental are only covered when obtained through the Delta Dental Medicare Advantage network. See page 38 for information on optional comprehensive dental coverage that can be purchased separately.		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
Medicare-covered dental services: $15 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services require prior authorization.	Medicare-covered dental services: $35 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services require prior authorization.	Medicare-covered dental services: $70 copay
You pay $0 copay for covered preventive dental services including: One comprehensive oral exam every three years per provider or location Two periodic oral evaluations every calendar year Two routine cleanings every calendar year Two fluoride applications every calendar year One bitewing X-ray every calendar year One complete intra-oral series and panoramic film every two calendar years Limited oral evaluations **You pay $0 copay for covered comprehensive dental service including:** One root planing/scaling and planing per quadrant every two years Two fillings every calendar year One crown every calendar year Two root canals per calendar year Two extractions per calendar year One full mouth debridement every two calendar years One denture per arch every five calendar years Two relines per calendar year Annual maximum of $2,000 for comprehensive dental. The amounts you pay for preventive and comprehensive dental don't apply to your out-of-pocket maximum. Services for preventive and comprehensive dental are only covered when obtained through the Delta Dental Medicare Advantage network. See page 38 for information on optional comprehensive dental coverage that can be purchased separately.		

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Vision Services	Routine vision services are provided by EyeMed *(vision care provider)*: One routine eye exam every calendar year: $0 copay This plan pays up to $150 per calendar year for eyeglasses *(lenses and frames)* and upgrades or contact lenses. Medicare-covered vision services: Medicare-covered eye exams: $40 copay	Routine vision services are provided by EyeMed *(vision care provider)*: One routine eye exam every calendar year: $0 copay This plan pays up to $300 per calendar year for eyeglasses *(lenses and frames)* and upgrades or $350 for contact lenses. Medicare-covered vision services: Medicare-covered eye exams: $40 copay	Routine vision services are provided by EyeMed *(vision care provider)*: One routine eye exam every calendar year: $0 copay This plan pays up to $300 per calendar year for eyeglasses *(lenses and frames)* and upgrades or $350 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.		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
Routine vision services are provided by EyeMed *(vision care provider)*: One routine eye exam every calendar year: $0 copay This plan pays up to $300 per calendar year for eyeglasses *(lenses and frames)* and upgrades or $350 for contact lenses. Medicare-covered vision services: Medicare-covered eye exams: $15 copay	Routine vision services are provided by EyeMed *(vision care provider)*: One routine eye exam every calendar year: $0 copay This plan pays up to $300 per calendar year for eyeglasses *(lenses and frames)* and upgrades or $350 for contact lenses. Medicare-covered vision services: Medicare-covered eye exams: $35 copay	Medicare-covered vision services: Medicare-covered eye exams: $70 copay There's no out-of-network coverage for free diabetic eye exams, routine vision services or post-cataract surgery refractions, glasses or contact lenses.
Diabetic eye exams performed by a specialist such as an ophthalmologist or optometrist: $0 copay A referral isn't required for these Medicare-covered visits.		

Post-cataract coverage for all plans *(in network only)*:

Post-cataract eye exam: $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.

All eyeglasses and contact lenses, including eye refractions, must be obtained through an EyeMed vision care provider.

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
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 1–5 $0 copay per day, per stay: day 6 and beyond Outpatient individual visit: $40 copay Outpatient group visit: $35 copay Opioid treatment programs: $40 copay per visit for Medicare-covered services Partial hospitalization: $55 copay per day for Medicare-covered partial hospitalization services Prior authorization may be required.	$250 copay per day, per stay: days 1–5 $0 copay per day, per stay: day 6 and beyond Outpatient individual visit: $40 copay Outpatient group visit: $35 copay Opioid treatment programs: $40 copay per visit for Medicare-covered services Partial hospitalization: $55 copay per day for Medicare-covered partial hospitalization services Prior authorization may be required.	$200 copay per day, per stay: days 1–5 $0 copay per day, per stay: day 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 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.	$0 copay per day, per stay: days 1–20 $172 copay per day, per stay: days 21–100 Prior authorization is required.	$0 copay per day, per stay: days 1–20 $150 copay per day, per stay: days 21–100 Prior authorization is required.

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
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: day 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 may be required.	$250 copay per day, per stay: days 1–5 $0 copay per day, per stay: day 6 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 may be required.	45% coinsurance per day, per stay: day 1 and beyond Outpatient individual visit: $70 copay Outpatient group visit: $70 copay Opioid treatment programs: $70 copay per visit for Medicare-covered services Partial hospitalization: 45% coinsurance for Medicare-covered partial hospitalization services
The plan covers up to 100 days per admission. No prior hospital stay is required.		
$0 copay per day, per stay: days 1–20 $175 copay per day, per stay: days 21–100 Prior authorization is required.	$0 copay per day, per stay: days 1–20 $200 copay per day, per stay: days 21–100 Prior authorization is required.	45% coinsurance, days 1–100

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Physical Therapy	$40 copay A referral is required.		$15 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.	$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.
Transportation	Not covered		$0 copay Limited to 16 one-way trips to plan-approved locations every calendar year
Medicare Part B Drugs	Part B drugs such as chemotherapy drugs: 20% coinsurance Prior authorization is required for chemotherapy drugs. Insulin administered via a durable medical equipment insulin pump: 20% coinsurance up to a maximum copay of $35 for a one-month supply		
	If a Part B prescription drug's price has increased at a rate faster than the rate of inflation, we'll reduce your coinsurance for that drug by a certain amount as directed by the Centers for Medicare & Medicaid Services (CMS). CMS will tell **BayCare**Plus what your coinsurance should be for that drug. The amount you pay will never exceed your coinsurance, but it could be lower based on information we receive from CMS. Amounts you pay for Part B drugs count toward your MOOP; they don't count toward your Part D initial coverage limit or true out-of-pocket cost of $8,000.		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
$15 copay A referral is required.	$35 copay A referral is required.	$70 copay
$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.	45% coinsurance
$0 copay Limited to 24 one-way trips to plan-approved locations every calendar year	Not covered	Not covered
Part B drugs such as chemotherapy drugs: 20% coinsurance Prior authorization is required for chemotherapy drugs. Insulin administered via a durable medical equipment insulin pump: 20% coinsurance up to a maximum copay of $35 for a one-month supply		Part B drugs such as chemotherapy drugs: 45% coinsurance Prior authorization is required for chemotherapy drugs. Insulin administered via a durable medical equipment insulin pump: 45% coinsurance
If a Part B prescription drug's price has increased at a rate faster than the rate of inflation, we'll reduce your coinsurance for that drug by a certain amount as directed by the Centers for Medicare & Medicaid Services (CMS). CMS will tell **BayCare**Plus what your coinsurance should be for that drug. The amount you pay will never exceed your coinsurance, but it could be lower based on information we receive from CMS. Amounts you pay for Part B drugs count toward your MOOP; they don't count toward your Part D initial coverage limit or true out-of-pocket cost of $8,000.		

Part D Prescription Drug Benefits

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Deductible	A deductible isn't required for these plans.		
Initial Coverage	You pay the amounts listed in the tables on the following pages until your total yearly drug costs reach $5,030. For insulins, you won't pay more than $35 for a one-month supply of each insulin product covered by our plans 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 or your Extra Help status.		
Coverage Gap	Most Medicare drug plans have a coverage gap *(also called the "donut hole")*. This means 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 $5,030. 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 $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Important: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
A deductible isn't required for these plans.		
You pay the amounts listed in the tables on the following pages until your total yearly drug costs reach $5,030. For insulins, you won't pay more than $35 for a one-month supply of each insulin product covered by our plans 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.		
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 or your Extra Help status.		
Most Medicare drug plans have a coverage gap *(also called the "donut hole")*. This means 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 $5,030. 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 $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Important: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan.		
After your yearly out-of-pocket drug costs reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.		

Standard Retail Cost Sharing

*Co-insurance N/O–Not offered	**BayCare**Plus **Rewards (HMO)** H2235-002			**NEW! BayCare**Plus **Value (HMO)** H2235-005		
	30/60/90-Day Supply					
Tier	**30**	**60**	**90**	**30**	**60**	**90**
Tier 1 *(preferred generic)*	$0 copay					
Tier 2 *(generic)*	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay
Tier 3 *(preferred brand)*	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Insulins	$35 copay	$75 copay	$105 copay	$35 copay	$75 copay	$105 copay
Tier 4 *(non-preferred brand)*	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5 *(specialty drug)*	33%*	N/O	N/O	33%*	N/O	N/O
	Mail Order Pharmacy					
Tier	**30**	**60**	**90**	**30**	**60**	**90**
Tier 1 *(preferred generic)*	N/O	N/O	$0 copay	N/O	N/O	$0 copay
Tier 2 *(generic)*	N/O	N/O	$0 copay	N/O	N/O	$0 copay
Tier 3 *(preferred brand)*	N/O	N/O	$125 copay	N/O	N/O	$125 copay
Insulins	N/O	N/O	$105 copay	N/O	N/O	$105 copay
Tier 4 *(non-preferred brand)*	N/O	N/O	$275 copay	N/O	N/O	$275 copay
Tier 5 *(specialty drug)*	33%*	N/O	N/O	33%*	N/O	N/O

BayCarePlus **Complete (HMO)** H2235-001			**BayCare**Plus **Premier (HMO)** H2235-003			**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006		
30/60/90-Day Supply								
30	**60**	**90**	**30**	**60**	**90**	**30**	**60**	**90**
$0 copay								
$3 copay	$6 copay	$9 copay	$0 copay			$3 copay	$6 copay	$9 copay
$35 copay	$70 copay	$105 copay	$30 copay	$60 copay	$90 copay	$35 copay	$70 copay	$105 copay
$35 copay	$70 copay	$105 copay	$30 copay	$60 copay	$90 copay	$35 copay	$70 copay	$105 copay
$85 copay	$170 copay	$255 copay	$85 copay	$170 copay	$255 copay	$85 copay	$170 copay	$255 copay
33%*	N/O	N/O	33%*	N/O	N/O	33%*	N/O	N/O
Mail Order Pharmacy								
30	**60**	**90**	**30**	**60**	**90**	**30**	**60**	**90**
N/O	N/O	$0 copay	N/O	N/O	$0 copay	N/O	N/O	$0 copay
N/O	N/O	$0 copay	N/O	N/O	$0 copay	N/O	N/O	$0 copay
N/O	N/O	$95 copay	N/O	N/O	$80 copay	N/O	N/O	$95 copay
N/O	N/O	$95 copay	N/O	N/O	$80 copay	N/O	N/O	$95 copay
N/O	N/O	$245 copay	N/O	N/O	$245 copay	N/O	N/O	$245 copay
33%*	N/O	N/O	33%*	N/O	N/O	33%*	N/O	N/O

Other Covered Benefits

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Chiropractic Care	Manual manipulation of the spine to correct subluxation: $20 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% coinsurance* 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).*	Diabetes self-management training: $0 copay Diabetes monitoring supplies *(including blood glucose monitors, lancets and blood glucose test strips)*: 10% coinsurance* 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).*	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).*

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
Manual manipulation of the spine to correct subluxation: $15 copay	Manual manipulation of the spine to correct subluxation: $20 copay	Manual manipulation of the spine to correct subluxation: $70 copay
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)*.	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 Authorization is required for some items *(e.g., diabetic custom-molded shoes and inserts, continuous glucose meters and insulin pumps)*.	Diabetes self-management training: 45% coinsurance Diabetes monitoring supplies *(including blood glucose monitors, lancets and blood glucose test strips)*: 45% coinsurance* 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: 45% coinsurance

*See the Evidence of Coverage for a complete list.

**The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% coinsurance for Medicare-covered items Prior authorization is 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*
Home Health Care	$0 copay A referral is required.		
Hospice	You pay nothing for hospice care from any Medicare-certified hospice program. Contact us for more details.		
Outpatient Substance Abuse	Individual visit: $40 copay Group visit: $35 copay Prior authorization is required.		Individual visit: $15 copay Group visit: $10 copay Prior authorization is required.

<table>
<tr><th>BayCarePlus
Premier (HMO)
H2235-003</th><th colspan="2">NEW!
BayCarePlus
Freedom (HMO-POS)
H2235-006</th></tr>
<tr><td></td><td>In network</td><td>Out of network</td></tr>
<tr><td colspan="2">20% coinsurance
for Medicare-covered items

Prior authorization is required.</td><td>45% coinsurance for Medicare-covered items</td></tr>
<tr><td>$15 copay for each Medicare-covered podiatry visit

Members with diabetes:
$0 copay for six routine podiatry visits (including nail trimmings) per calendar year*</td><td>$35 copay
for each
Medicare-covered
podiatry visit</td><td>$70 copay
for each
Medicare-covered
podiatry visit</td></tr>
<tr><td colspan="2">$0 copay

A referral is required.</td><td>45% coinsurance for all Medicare-covered home health care.</td></tr>
<tr><td colspan="3">You pay nothing for hospice care from any Medicare-certified hospice program. Contact us for more details.</td></tr>
<tr><td>Individual visit:
$15 copay

Group visit: $10 copay

Prior authorization is required.</td><td>Individual visit:
$35 copay

Group visit: $30 copay

Prior authorization is required.</td><td>Individual visit:
$70 copay

Group visit: $70 copay</td></tr>
</table>

*The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Over-the-Counter (OTC) Coverage	Not covered	$50 credit per quarter to use on approved health products that can be ordered online, by phone or by mail Up to two orders per quarter are allowed and the leftover allowance doesn't roll over from quarter to quarter.	$107 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 the leftover allowance doesn't roll over from quarter to quarter.
Meals	Not covered	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
Grocery Allowance	Not covered	$50 per quarter*	

*The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
$135 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 the leftover allowance doesn't roll over from quarter to quarter.	$25 credit per quarter to use on approved health products that can be ordered online, by phone or by mail Up to two orders per quarter are allowed and the leftover allowance doesn't roll over from quarter to quarter.	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	Not covered	Not covered
$50 per quarter*	Not covered	Not covered

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
Prosthetic Devices	Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization is required.		
Outpatient Rehabilitation Services	Cardiac and pulmonary rehabilitation services: $15 copay per day Occupational, speech and language therapy visits: $40 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: $10 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.
Wellness Programs	Health club membership/fitness classes through Silver&Fit®: $0 copay Access to a network of more than 16,500 fitness centers and studios 13,000+ digital workout videos through the website and mobile app digital library including Silver&Fit Signature Series Classes® One home fitness kit per benefit year from a variety of fitness categories		

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization is required.		45% coinsurance
Cardiac and pulmonary 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 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: 45% coinsurance Occupational, speech and language therapy visits: $70 copay
Health club membership/fitness classes through Silver&Fit: $0 copay Access to a network of more than 16,500 fitness centers and studios 13,000+ digital workout videos through the website and mobile app digital library including Silver&Fit Signature Series Classes One home fitness kit per benefit year from a variety of fitness categories		

	BayCarePlus **Rewards (HMO)** H2235-002	**NEW! BayCare**Plus **Value (HMO)** H2235-005	**BayCare**Plus **Complete (HMO)** H2235-001
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.

Optional Comprehensive Dental Benefits

Optional Supplemental Benefits	As a member of any **BayCare**Plus plan, you'll receive select dental benefits for no additional cost (see page 18). For a low monthly premium, you can replace the comprehensive benefits on page 18 with these enhanced comprehensive dental benefits: Monthly premium: $49 Yearly deductible: $0 Maximum benefit: $4,000 per year* Services can be provided in network through the Delta Dental Medicare Advantage Network or out of network.** You pay $0 copay for covered comprehensive dental services including: One root planing/scaling and planing per quadrant every two years One filling per tooth every calendar year Two crowns every calendar year Three root canals per calendar year Two extractions per calendar year One full mouth debridement every two calendar years One denture per arch every five calendar years Two relines per calendar year Prior authorization may be required.

*The amounts you pay for comprehensive dental services don't apply to your maximum out-of-pocket amount.

BayCarePlus **Premier (HMO)** H2235-003	**NEW! BayCare**Plus **Freedom (HMO-POS)** H2235-006	
	In network	Out of network
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	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	Medicare-covered services *(chronic low back pain)*: $70 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.

As a member of any **BayCare**Plus plan, you'll receive select dental benefits for no additional cost (see page 19). For a low monthly premium, you can replace the comprehensive benefits on page 19 with these enhanced comprehensive dental benefits:

Monthly premium: $49

Yearly deductible: $0

Maximum benefit: $4,000 per year*

Services can be provided in network through the Delta Dental Medicare Advantage Network or out of network.**

You pay $0 copay for covered comprehensive dental services including:

One root planing/scaling and planing per quadrant every two years

One filling per tooth every calendar year

Two crowns every calendar year

Three root canals per calendar year

Two extractions per calendar year

One full mouth debridement every two calendar years

One denture per arch every five calendar years

Two relines per calendar year

Prior authorization may be required.

**The Delta Dental plan will pay benefits for covered services provided by a non-participating provider. However, a non-participating provider may charge you more than the maximum plan allowance payable under this Medicare Advantage plan and you'll be responsible for all charges above the maximum plan allowance. Any amount you pay doesn't count toward your maximum out-of-pocket amount.

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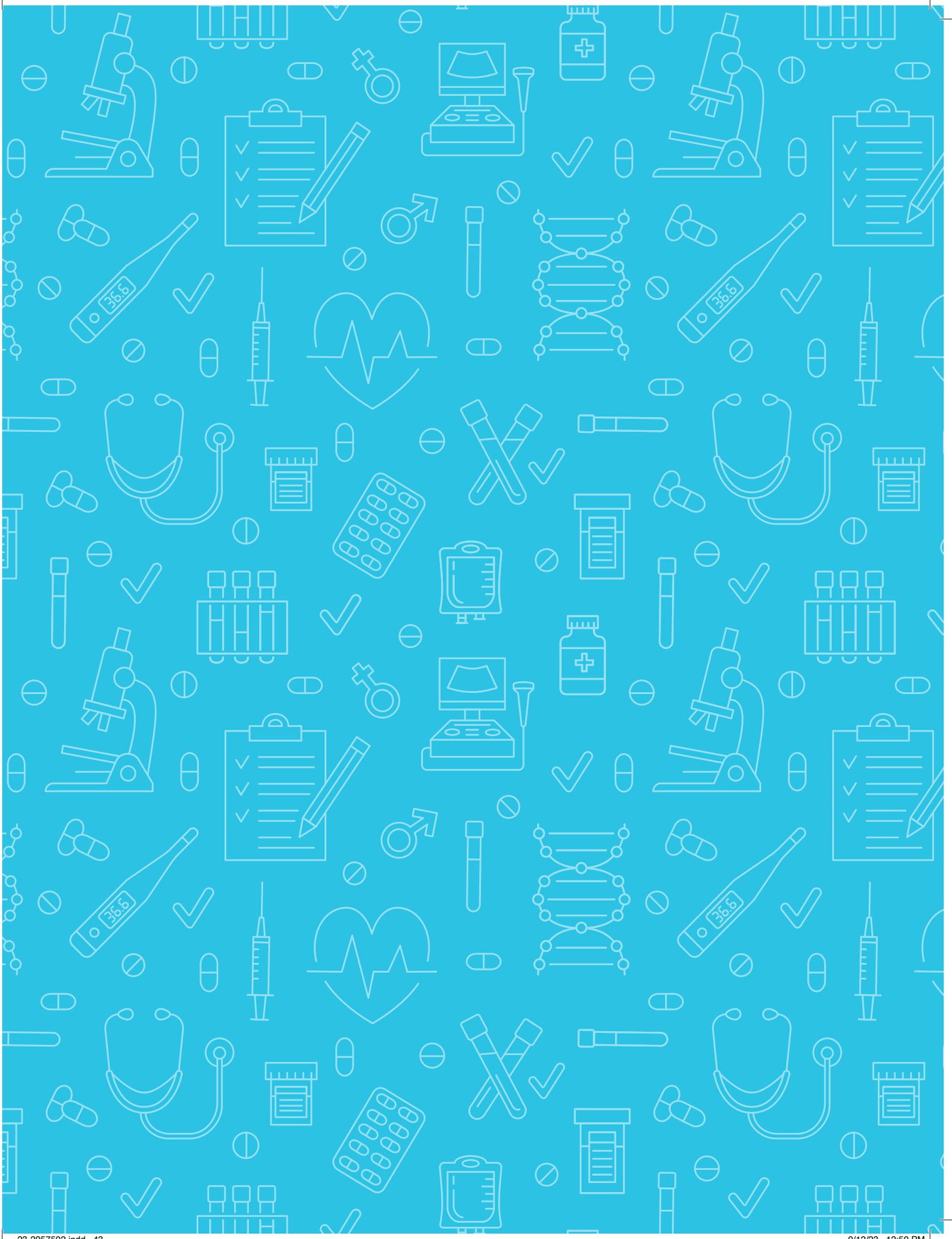
NOTES



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

BayCarePlus.org

Toll-free: (877) 549-1741 (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.

Members of the **BayCare**Plus **Freedom** (HMO-POS) plan may go to out-of-network doctors and hospitals for a higher cost share. Providers must accept Medicare.

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

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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