BayCarePlus™
Medicare Advantage

2019

SUMMARY OF BENEFITS

Medicare Advantage

BayCarePlus Complete (HMO)
BayCarePlus Rewards (HMO)

Serving:
Hillsborough, Pasco,
Pinellas & Polk counties

Summary of Benefits
January 1, 2019 – December 31, 2019

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

This Summary of Benefits booklet gives you a summary of what **BayCarePlus Complete (HMO)** and **BayCarePlus Rewards (HMO)** covers and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on Medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call (877) 486-2048.

Sections in this booklet

- Things to Know About **BayCarePlus Complete** and **BayCarePlus Rewards**
- Table of Contents
- Monthly Premium, Deductibles and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Other Covered Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call customer service at (866) 509-5396 (TTY: 711).

H2235_18-051_M CMS Approved 09/16/2018

Things to Know About BayCarePlus Complete and BayCarePlus Rewards

Hours of Operation

- From October 1 to March 31, you can call us seven days a week from 8:00am to 8:00pm.
- From April 1 to September 30, you can call us Monday through Friday from 8:00am to 8:00pm.

BayCarePlus Complete/BayCarePlus Rewards Phone Numbers and Website

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

Who can join?

To join **BayCarePlus Complete or BayCarePlus Rewards**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or are lawfully present in the United States, live in our service area and can't have end-stage renal disease (ESRD). Our service area includes the following counties in Florida: Hillsborough, Pasco, Pinellas and Polk.

Which doctors, hospitals and pharmacies can I use?

BayCarePlus Complete and BayCarePlus Rewards have a network of doctors, hospitals, pharmacies and other providers. If you use the providers that aren't in our network, the plan may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost sharing. You may pay less if you use these pharmacies. You can see our plan's provider directory at BayCarePlus.org. Or, call us and we'll send you a copy of the provider directory.

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, please contact the Plan for more information or access the Evidence of Coverage on our website.

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

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
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.
Part B Premium Buy-Down	Not covered	$100 per month
Deductibles	This plan doesn't have a deductible.	This plan doesn't have a deductible.
Maximum Out-of-Pocket Responsibility *(doesn't include 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: • $3,900 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: • $5,900 for covered hospital and medical services you receive from in-network providers If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we'll pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Covered Medical and Hospital Benefits

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • $195 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. • $250 copay per day, per stay: Days 1–6 • $0 copay per day, per stay: Days 7 and beyond Prior authorization is required.
Outpatient Hospital Coverage	Ambulatory surgical center: $75 copay Outpatient hospital: $125 copay Prior authorization is required. A referral is required for outpatient hospital services.	Ambulatory surgical center: $125 copay Outpatient hospital: $195 copay Prior authorization is required. A referral is required for outpatient hospital services.
Doctor Visits *(Primary Care Providers and Specialists)*	Primary care physician (PCP) visit: $0 copay Specialist visit: $35 copay A referral is required for specialist visits.	Primary care physician (PCP) visit: $0 copay Specialist visit: $45 copay A referral is required for specialist visits.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • HIV screening • Immunizations (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) • Vision care • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • HIV screening • Immunizations (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) • Vision care • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Emergency Care	$90 copay If you're admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. This coverage is worldwide.	$90 copay If you're admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. This coverage is worldwide.
Urgently Needed Services	$35 copay within the United States $90 copay outside the United States This coverage is worldwide.	$35 copay within the United States $90 copay outside the United States This coverage is worldwide.
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service)*	Lab services: $0 copay Diagnostic procedures and tests: $0 copay X-rays: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $90 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance Prior authorization and a referral are required. There is no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they are ordered as a preventive service.	Lab services: $6 copay Diagnostic procedures and tests: $100 copay X-rays: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $125 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance Prior authorization and a referral are required. There is no copay for abdominal aortic aneurysm screening, diabetes screening or prostate cancer screening when they are ordered as a preventive service.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 copay Hearing aids: $750 allowance/max benefit per year (both ears total) Hearing aid fitting: $0 copay	Exam to diagnose and treat hearing and balance issues: $30 copay Routine hearing exam: $30 copay Hearing aids are not covered.
Dental Services	Covered diagnostic and preventive dental services: $0 copay Preventive services include: • Periodic oral evaluation (two every calendar year) • Routine cleaning (two every calendar year) • Fluoride treatment (two every calendar year) • Horizontal bitewing X-ray(s) (once every calendar year)	Preventive dental services: $0 copay Preventive services include: • Periodic oral evaluation (two every calendar year) • Routine cleaning (two every calendar year) • Fluoride treatment (one every calendar year) • Horizontal bitewing X-ray(s) (up to four, once every calendar year)

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Dental Services *(continued)*	Medicare-covered dental services: $35 copay A referral is required for Medicare-covered dental services. *Comprehensive services include (but are not limited to): Yearly deductible: $100 (must be met before benefits for comprehensive dental services are available) Basic restorative (includes services such as fillings, inlays/onlays and protective restorations): 20% coinsurance after deductible Oral surgery: • Simple and surgical extractions: 20% coinsurance after deductible • Other surgical procedures: 50% coinsurance after deductible Periodontics (includes services such as periodontal surgery, scaling, root planing and full mouth debridement): 50% coinsurance after deductible Endodontics (includes services such as root canal treatment, retreatment root canal therapy, apicoectomy and pulpotomy): 50% coinsurance after deductible Prosthetic maintenance (includes services such as bridges, dentures, crowns and tissue conditioning): 20% coinsurance after deductible Adjunct general services (includes services such as general anesthesia): 50% coinsurance after deductible Major restorative (includes services such as bridges, dentures and crowns): 50% coinsurance after deductible Yearly maximum benefit for preventive and comprehensive services: $1,000 A referral is required for comprehensive services. *See Evidence of Coverage for a more details and a complete listing.	Medicare-covered dental services: $45 copay A referral is required for Medicare-covered dental services. Services such as fillings, extractions, crowns and dentures are not covered under this routine preventive benefit.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Vision Services	Each visit to a specialist, such as an Ophthalmologist or Optometrist, for Medicare-covered benefits: $35 copay One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery: $35 copay Our plan pays up to $100 per calendar year for eyeglass frames or contact lenses after cataract surgery. A referral is required for Medicare-covered vision care. One routine eye exam every calendar year: $15 copay One pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) per calendar year: $0 copay One pair of eyeglass frames or one pair of contact lenses (or two six packs) per calendar year. Our plan pays up to $100 per calendar year for eyeglass frames or contact lenses: $35 copay Upgrades may come at an additional cost.	Each visit to a specialist, such as an Ophthalmologist or Optometrist, for Medicare-covered benefits: $45 copay One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery: $35 copay Our plan pays up to $100 per calendar year for eyeglass frames or contact lenses after cataract surgery. A referral is required for Medicare-covered vision care. One routine eye exam every calendar year: $15 copay One pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) per calendar year: $0 copay One pair of eyeglass frames or one pair of contact lenses (or two six packs) per calendar year. Our plan pays up to $100 per calendar year for eyeglass frames or contact lenses: $35 copay Upgrades may come at an additional cost.
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay: • $195 copay per day, per stay: Days 1–6 • $0 copay per day, per stay: Days 7 and beyond Outpatient individual therapy visit: $35 copay Outpatient group therapy visit: $30 copay Prior authorization is required.	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay: • $250 copay per day, per stay: Days 1–6 • $0 copay per day, per stay: Days 7 and beyond Outpatient individual therapy visit: $40 copay Outpatient group therapy visit: $35 copay Prior authorization is required.
Skilled Nursing Facility	The plan covers up to 100 days each benefit period. 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 each benefit period. 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.
Physical Therapy	$35 copay A referral is required.	$40 copay A referral is required.

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Ambulance	$200 copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.	$250 copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.
Transportation	$0 copay Limited to 16 one-way trips to plan-approved locations every year.	Not covered

Prescription Drug Benefits

	BayCarePlus Complete (HMO)				BayCarePlus Rewards (HMO)			
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% coinsurance Other Part B drugs: 20% coinsurance Prior authorization is required.				For Part B drugs such as chemotherapy drugs: 20% coinsurance Other Part B drugs: 20% coinsurance Prior authorization is required.			
Deductible	This plan doesn't have a deductible.				This plan doesn't have a deductible.			
Initial Coverage	You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.				You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			
	Standard Retail Cost-Sharing				**Standard Retail Cost-Sharing**			
	Tier	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**Tier**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
	Tier 1 (preferred generic)	$0 copay	$0 copay	$0 copay	Tier 1 (preferred generic)	$0 copay	$0 copay	$0 copay
	Tier 2 (generic)	$4 copay	$8 copay	$12 copay	Tier 2 (generic)	$10 copay	$20 copay	$30 copay
	Tier 3 (preferred brand)	$35 copay	$70 copay	$105 copay	Tier 3 (preferred brand)	$47 copay	$94 copay	$141 copay
	Tier 4 (non-preferred brand)	$85 copay	$170 copay	$255 copay	Tier 4 (non-preferred brand)	$100 copay	$200 copay	$300 copay
	Tier 5 (specialty drug)	33% co-insuance	Not offered	Not offered	Tier 5 (specialty drug)	33% co-insuance	Not offered	Not offered

<table>
<tr><th></th><th colspan="4">BayCarePlus Complete (HMO)</th><th colspan="4">BayCarePlus Rewards (HMO)</th></tr>
<tr><td rowspan="8">Initial Coverage
(continued)</td><td colspan="4">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.</td><td colspan="4">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.</td></tr>
<tr><td colspan="4">Standard Mail Order Cost-Sharing</td><td colspan="4">Standard Mail Order Cost-Sharing</td></tr>
<tr><td>Tier</td><td>30-Day Supply</td><td>60-Day Supply</td><td>90-Day Supply</td><td>Tier</td><td>30-Day Supply</td><td>60-Day Supply</td><td>90-Day Supply</td></tr>
<tr><td>Tier 1 (preferred generic)</td><td>Not offered</td><td>Not offered</td><td>$0 copay</td><td>Tier 1 (preferred generic)</td><td>Not offered</td><td>Not offered</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (generic)</td><td>Not offered</td><td>Not offered</td><td>$0 copay</td><td>Tier 2 (generic)</td><td>Not offered</td><td>Not offered</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (preferred brand)</td><td>Not offered</td><td>Not offered</td><td>$95 copay</td><td>Tier 3 (preferred brand)</td><td>Not offered</td><td>Not offered</td><td>$125 copay</td></tr>
<tr><td>Tier 4 (non-preferred brand)</td><td>Not offered</td><td>Not offered</td><td>$245 copay</td><td>Tier 4 (non-preferred brand)</td><td>Not offered</td><td>Not offered</td><td>$275 copay</td></tr>
<tr><td>Tier 5 (specialty drug)</td><td>33% co-insuance</td><td>Not offered</td><td>Not offered</td><td>Tier 5 (specialty drug)</td><td>33% co-insuance</td><td>Not offered</td><td>Not offered</td></tr>
<tr><td>Coverage Gap</td><td colspan="4">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 $3,820.

After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand-name drugs and 37% of the plan’s cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.</td><td colspan="4">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 $3,820.

After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand-name drugs and 37% of the plan’s cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.</td></tr>
<tr><td>Catastrophic Coverage</td><td colspan="4">After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of:
5% coinsurance, or
$3.40 copay for generic(including brand drugs treated as generic) and a $8.50 copay for all other drugs.</td><td colspan="4">After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of:
5% coinsurance, or
$3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copay for all other drugs.</td></tr>
</table>

Other Covered Benefits

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Chiropractic Care	Manual manipulation of the spine to correct subluxation: $20 copay	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 Prior authorization is required for diabetic therapeutic custom-molded shoes and inserts only. *See Evidence of Coverage for a complete listing.	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 10% 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 Prior authorization is required for diabetic therapeutic custom-molded shoes and inserts only. *See Evidence of Coverage for a complete listing.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% coinsurance Prior authorization may be required.	20% coinsurance Prior authorization may be required.
Foot Care *(podiatry services)*	$35 copay A referral is required.	$45 copay A referral is required.
Home Health Care	$0 copay A referral is required.	$0 copay A referral is required.
Hospice	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.	You pay nothing for hospice care from any Medicare-certified hospice program. Please contact us for more details.
Outpatient Substance Abuse	Individual therapy visit: $35 copay Group therapy visit: $30 copay Prior authorization is required.	Individual therapy visit: $40 copay Group therapy visit: $35 copay Prior authorization is required.
Over-the-Counter Coverage *(OTC)*	$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 is allowed and left over allowance does not roll over from quarter to quarter.	Not covered

	BayCarePlus Complete (HMO)	BayCarePlus Rewards (HMO)
Prosthetic Devices	Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization may be required.	Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization may be required.
Outpatient Rehabilitation Services	Cardiac rehabilitation services: $30 copay per day Occupational, speech and language therapy visits: $35 copay A referral is required.	Cardiac rehabilitation services: $30 copay per day Occupational, speech and language therapy visits: $40 copay A referral is required.
Wellness Programs	Health club membership/Fitness classes through SilverSneakers: $0 copay	Health club membership/Fitness classes through SilverSneakers: $0 copay

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BayCare Plus™
Medicare Advantage

Notice of Non-Discriminatory Practices

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

BayCare Health Plans:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreter services
- Written information in other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreter services
- Information written in other languages

If you need these services, contact Customer Service at (866) 509-5396 (TTY: 711).

If you believe that BayCare Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Section 1557 Compliance Coordinator
ATTN: Discrimination Grievance
BayCare Health Plans
P.O. Box 17500
Clearwater, FL 33762

Email: BCPlus1557@BayCare.org

You must file a grievance using the prescribed form in writing by mail, fax, or email. You may request a form and instruction on how to file a grievance from the Coordinator at the contact information above.

If you need help filing a grievance, the Compliance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

H2235_18-049_C

BayCarePlus Medicare Advantage

Multi-Language Interpreter Services

ENGLISH: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call (866) 509-5396 (TTY: 711).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (866) 509-5396 (TTY: 711).

FRENCH CREOLE: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 509-5396 (TTY: 711).

VIETAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (866) 509-5396 (TTY: 711).

PORTUGUESE: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (866) 509-5396 (TTY: 711).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(866) 509-5396 (TTY: 711)。

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (866) 509-5396 (ATS : 711).

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga libreng serbisyo para sa tulong sa wika na maaari mong gamitin. Tumawag sa (866) 509-5396 (TTY: 711).

RUSSIAN: ВНИМАНИЕ! Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по номеру (866) 509-5396 (телетайп: 711).

ARABIC: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم (866) 509-5396 (711 :هاتف الصم والبكم)

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (866) 509-5396 (TTY: 711).

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie uns an unter (866) 509-5396 (TTY: 711).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (866) 509-5396 번 (TTY: 711 번)으로 전화하십시오.

POLISH: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (866) 509-5396 (TTY: 711).

GUJARATI: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (866) 509-5396 (TTY: 711).

THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (866) 509-5396 (TTY: 711).

Pre-Enrollment Checklist

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

Understanding the Benefits

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

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the provider directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

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

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.

☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

BayCare Health Plans
P.O. Box 3710
Troy, MI 48007

BayCarePlus.org

Toll-free: (866) 509-5396
TTY users call: 711
8am to 8pm,
seven days a week

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

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

BayCare 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.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al (866) 509-5396 (TTY: 711). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 509-5396 (TTY: 711).

BayCarePlus™
Medicare Advantage