2024

KelseyCare Advantage

SECURE (HMO)
SIGNATURE (HMO)
FREEDOM (HMO-POS)
THRIVE (HMO-POS)

SUMMARY OF BENEFITS

1-866-535-8343 (TTY: 711)

KelseyCareAdvantage.com

H0332_49011SB24_M

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 713-442-CARE (2273) or toll-free at 1-866-535-8343 (TTY users can call 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 www.KelseyCareAdvantage.com or call 1-866-535-8343 (TTY users can call 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 *Pharmacy 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 (if applicable), 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/coinsurance may change on January 1, 2025.
	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), unless you are enrolled in the KelseyCare Advantage Freedom or KelseyCare Advantage Thrive plan.
	The KelseyCare Advantage Freedom and KelseyCare Advantage Thrive plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher cost-share for services received by non-contracted providers.

GENERAL PLAN INFORMATION

Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Signature (HMO), KelseyCare Advantage Freedom (HMO-POS), KelseyCare Advantage Secure (HMO), and KelseyCare Advantage Thrive (HMO-POS), cover and what you pay. It does not 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*." Tips for comparing your Medicare choices: • If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.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 http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
Sections in this book	• Things to know about KelseyCare Advantage Signature, KelseyCare Advantage Freedom, KelseyCare Advantage Secure and KelseyCare Advantage Thrive • Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits
Hours of Operation	• Hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 – March 31. From April 1 – September 30, Monday through Friday, hours are 8:00 a.m. to 8:00 p.m. local time. Messaging service used on weekends, after hours, and on federal holidays.
Phone numbers and Website	• If you are a member of this plan, call toll-free 1-866-535-8343 (TTY users can call 711). • If you are not a member of this plan, call toll-free 1-800-663-7146 (TTY users can call 711). • Our website: www.KelseyCareAdvantage.com
Who Can Join?	To join KelseyCare Advantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes the following counties in Texas:** Brazoria, Fort Bend, Harris, Montgomery, and Galveston (excluding the island). The service area for **KelseyCare Advantage Freedom** also includes the following counties: Austin, Chambers, Grimes, Liberty, San Jacinto, Walker, Waller, and Wharton.

Which doctors and hospitals can I use?	**KelseyCare Advantage Signature and KelseyCare Advantage Secure:** Has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.	**KelseyCare Advantage Freedom and KelseyCare Advantage Thrive:** Has a network of doctors, hospitals, and other providers. *For some services you can use providers that are not in our network.*
Out-of-Network/non-contracted providers are under no obligation to treat KelseyCare Advantage members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to Out-of-Network services.		
Which pharmacies can I use?	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 and pharmacy directory at our website (www.KelseyCareAdvantage.com). Or, call us at the phone numbers above, and we will send you a copy of the provider and pharmacy directories.	
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers – and more. **Our plan members get all of 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 is covered by Original Medicare. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. 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 on our website, (www.KelseyCareAdvantage.com). Or, call us and we will send you a copy of the formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.	
How will I determine my drug costs?	Our plan groups each medication into one of 6 "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.	

Summary of Benefits

January 1, 2024 – December 31, 2024

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

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
How much is the monthly premium?	$0 per month.	$0 per month.	$0 per month.	$0 per month.
	In addition, you must continue to keep paying your Medicare Part B premium.			
How much is the deductible?	These plans do not have a medical deductible.			

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on the out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. **Please note that you will still need to pay your monthly Part B premiums and cost-sharing for your Part D prescription drugs.**			
(Maximum Out-of-Pocket Responsibility)	Your yearly limit(s) in this plan: • $4,000 for services you receive from In-Network providers.	Your yearly limit(s) in this plan: • $3,450 for services you receive from In-Network providers. <u>Out of Network</u>: • $10,000 for services you receive from Out-of-Network providers.	Your yearly limit(s) in this plan: • $3,850 for services you receive from In-Network providers.	Your yearly limit(s) in this plan: • $6,000 for services you receive from In-Network providers. <u>Out of Network</u>: • $10,000 for services you receive from Out-of-Network providers.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain In-Network benefits. Contact us for the services that apply.			
Inpatient Hospital Coverage[1,2]	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days, per benefit period			

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Inpatient Hospital Coverage[1,2] (continued)	In-Network: • $300 copay per stay • $0 copay per day for lifetime reserve days (if available)	In-Network: • $325 copay per stay • $0 copay per day for lifetime reserve days (if available) Out-of-Network: • 40% coinsurance per stay	In-Network: • $245 copay per stay • $0 copay for each lifetime reserve day for lifetime reserve days (if available)	In-Network: • $375 copay per day for days 1-5, $0 for days 6-90 • $0 copay for each lifetime reserve day for lifetime reserve days (if available) Out-of-Network: • 40% coinsurance per stay
Outpatient Hospital Coverage[1,2]	In-Network: • $300 copay	In-Network: • $300 copay Out-of-Network: • 20% coinsurance	In-Network: • $150 copay	In-Network: • $325 copay Out-of-Network: • 40% coinsurance
Ambulatory Surgery Center (ASC)[1,2]	In-Network: • $225 copay	In-Network: • $225 copay Out-of-Network: • 20% coinsurance	In-Network: • $125 copay	In-Network: • $175 copay Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Doctor Visits (Primary Care Providers and Specialists)[1,2]	In-Network office visit: • Primary care: $0 copay • Specialist: $20 copay	In-Network office visit: • Primary care: $0 copay • Specialist: $25 copay Out-of-Network office visit: • Primary care: $10 copay • Specialist: $35 copay for each Medicare-covered specialist visit. *40% coinsurance for each MD Anderson provider visit	In-Network office visit: • Primary care: $0 copay • Specialist: $10 copay	In-Network office visit: • Primary care: $0 copay • Specialist: $40 copay Out-of-Network office visit: • Primary care: $10 copay • Specialist: $60 copay for each Medicare-covered specialist visit. *40% coinsurance for MD Anderson providers office visits

<table>
<tr><th></th><th>KelseyCare Advantage Signature (HMO)</th><th>KelseyCare Advantage Freedom (HMO-POS)</th><th>KelseyCare Advantage Secure (HMO)</th><th>KelseyCare Advantage Thrive (HMO-POS)</th></tr>
<tr><td rowspan="2">Preventive Care</td><td><u>In-Network:</u>
• $0 copay</td><td><u>In-Network:</u>
• $0 copay
<u>Out-of-Network:</u>
• 50% coinsurance</td><td><u>In-Network:</u>
• $0 copay</td><td><u>In-Network:</u>
• $0 copay
<u>Out-of-Network:</u>
• 40% coinsurance</td></tr>
<tr><td colspan="4">Preventive services include:
• Abdominal aortic aneurysm screening
• Alcohol misuse counseling
• Bone mass measurement
• Breast cancer screening (mammogram)
• Cardiovascular disease (behavioral therapy)
• Cervical and vaginal cancer screening
• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
• Depression Screening
• Diabetes screening
• HIV screening
• Medical nutrition therapy services
• Obesity screening and counseling
• Prostate cancer screenings (PSA
• Sexually transmitted infections screening and counseling
• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
• Vaccines, including Flu shots, hepatitis B shots, pneumococcal shots
• “Welcome to Medicare” preventive visit (one-time)
• Yearly “Wellness” visit

Any additional preventive services approved by Medicare during the contract year will be covered.</td></tr>
</table>

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Emergency Care	$120 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$120 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$120 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$100 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	$25 copay	$25 copay	$5 copay	$25 copay

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Diagnostic Services, Labs, Imaging[1,2]	Diagnostic radiology services (such as MRIs, CT scans): In-Network: • $0 to $150 copay, depending on the service. Diagnostic tests and procedures: In-Network: • $0 to $25 copay, depending on the service	Diagnostic radiology services (such as MRIs, CT scans): In-Network: • $0 to $150 copay, depending on the service. Out-of-Network: • 20% coinsurance Diagnostic tests and procedures: In-Network: • $0 to $25 copay, depending on the service Out-of-Network: • 20% coinsurance	Diagnostic radiology services (such as MRIs, CT scans): In-Network: • $0 to $150 copay, depending on the service. Diagnostic tests and procedures: In-Network: • $0 to $25 copay, depending on the service	Diagnostic radiology services (such as MRIs, CT scans): In-Network: • $0 to $150 copay, depending on the service. Out-of-Network: • 40% coinsurance Diagnostic tests and procedures: In-Network: • $0 to $25 copay, depending on the service Out-of-Network: 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Diagnostic Services, Labs, Imaging[1,2] **(continued)**	Lab services: In-Network: • $0 copay Outpatient X-Rays: In-Network: • $0 copay Therapeutic radiology services (such as radiation treatment for cancer): In-Network: • $50 copay	Lab services: In-Network: • $0 copay Out-of-Network: • 50% coinsurance at any other provider Outpatient X-Rays: In-Network: • $0 copay Out-of-Network: • $20 copay Therapeutic radiology services (such as radiation treatment for cancer): In-Network: • $50 copay Out-of-Network: • 20% coinsurance	Lab services: In-Network: • $0 copay Outpatient X-Rays: In-Network: • $0 copay Therapeutic radiology services (such as radiation treatment for cancer): In-Network: • $50 copay	Lab services: In-Network: • $0 copay Out-of-Network: • 40% coinsurance Outpatient X-Rays: In-Network: • $0 copay Out-of-Network: • 40% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): In-Network: • $50 copay Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: In-Network: • $20 copay Routine hearing exam: In-Network: $0 copay. You are covered for up to 1 routine hearing exam every year. Hearing aid allowance: Our plan pays up to $750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan allowed amount. Replacement batteries are not covered.	Exam to diagnose and treat hearing and balance issues: In-Network: • $25 copay Out-of-Network: • 20% coinsurance Routine hearing exam: In-Network: $0 copay. You are covered for up to 1 routine hearing exam every year Hearing aid allowance: Our plan pays up to $750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan allowed amount. Replacement batteries are not covered.	Exam to diagnose and treat hearing and balance issues: In-Network: • $0 copay Routine hearing exam: In-Network: $0 copay. You are covered for up to 1 routine hearing exam every year. Hearing aid allowance: Our plan pays up to $750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan allowed amount. Replacement batteries are not covered.	Exam to diagnose and treat hearing and balance issues: In-Network: • $40 copay Out-of-Network: • 40% coinsurance Routine hearing exam: In-Network: $0 copay. You are covered for up to 1 routine hearing exam every year. Hearing aid allowance: Our plan pays up to $750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan allowed amount. Replacement batteries are not covered.

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Medicare-covered Dental Services[1,2] *(see the additional benefits section for other dental services available)*	Medicare-covered Dental Services: (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-Network: • $20 copay	Medicare-covered Dental Services: (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-Network: • $25 copay Out-of-Network: • Not covered	Medicare-covered Dental Services: (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-Network: • $0 copay	Medicare-covered Dental Services: (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-Network: • $40 copay Out-of-Network: • Not covered
Vision Services	Routine eye exam and eyewear: In-Network only: • $0 copay for 1 routine vision exam every year $125 plan coverage limit for eyewear, glasses and/or contact lenses every year unrelated to post-cataract surgery. Allowance can only be used on one date of service.	Routine eye exam and eyewear: In-Network only: • $0 copay for 1 routine vision exam every year $125 plan coverage limit for eyewear, glasses and/or contact lenses every year unrelated to post-cataract surgery. Allowance can only be used on one date of service.	Routine eye exam and eyewear: In-Network only: • $0 copay for 1 routine vision exam every year $125 plan coverage limit for eyewear, glasses and/or contact lenses every year unrelated to post-cataract surgery. Allowance can only be used on one date of service.	Routine eye exam and eyewear: In-Network only: • $0 copay for 1 routine vision exam every year $175 plan coverage limit for eyewear, glasses and/or contact lenses every year unrelated to post-cataract surgery. Allowance can only be used on one date of service.

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Vision Services (continued)	In-Network: • $0 to $20 copay for each exam to diagnose and treat conditions of the eye • $0 copay for each annual glaucoma screening Eyeglasses or contact lenses after cataract surgery: In-Network: • $0 copay	In-Network: • $0 to $25 copay for each exam to diagnose and treat conditions of the eye • $0 copay for each annual glaucoma screening Out-of-Network: • 20% coinsurance for each exam to diagnose and treat conditions of the eye • 50% coinsurance for each annual glaucoma screening Eyeglasses or contact lenses after cataract surgery: In-Network: • $0 copay Out-of-Network: • 50% coinsurance up to the Medicare allowed rate.	In-Network: • $0 copay for each exam to diagnose and treat conditions of the eye • $0 copay for each annual glaucoma screening Eyeglasses or contact lenses after cataract surgery: In-Network: • $0 copay	In-Network: • $0 to $40 copay for each exam to diagnose and treat conditions of the eye • $0 copay for each annual glaucoma screening Out-of-Network: • 40% coinsurance for each exam to diagnose and treat conditions of the eye • 40% coinsurance for each annual glaucoma screening Eyeglasses or contact lenses after cataract surgery: In-Network: • $0 copay Out-of-Network: • 40% coinsurance up to the Medicare allowed rate.

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Mental Health Services (including inpatient)[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.			
	In-Network: • $300 copay per stay • $0 copay per day for lifetime reserve days (if available)	In-Network: • $325 copay per stay • $0 copay per day for lifetime reserve days (if available) Out-of-Network: • 40% coinsurance per stay	In-Network: • $245 copay per stay • $0 copay for each lifetime reserve day for lifetime reserve days (if available)	In-Network: • $375 copay per day for days 1-5, $0 for days 6-90 • $0 copay for each lifetime reserve day for lifetime reserve days (if available) Out-of-Network: • 40% coinsurance per stay
	Outpatient individual or group therapy visit: In-Network: • $20 copay	Outpatient individual or group therapy visit: In-Network: • $20 copay Out-of-Network: • $35 copay	Outpatient individual or group therapy visit: In-Network: • $20 copay	Outpatient individual or group therapy visit: In-Network: • $20 copay Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF per benefit period. In-Network: • $0 copay per day for days 1-20 $125 copay per day for days 21-100	Our plan covers up to 100 days in a SNF per benefit period. In-Network: • $0 copay per day for days 1-20 $125 copay per day for days 21-100 Out-of-Network: • 50% coinsurance per stay	Our plan covers up to 100 days in a SNF per benefit period. In-Network: • $0 copay per day for days 1-20; $125 copay per day for days 21-100	Our plan covers up to 100 days in a SNF per benefit period. In-Network: • $0 copay per day for days 1-20 $125 copay per day for days 21-100 Out-of-Network: • 40% coinsurance per stay
Physical Therapy[1,2]	In-network: • $10 copay	In-Network: • $10 copay Out-of-Network: • $40 copay	In-Network: • $10 copay	In-Network: • $10 copay Out-of-Network: • 40% coinsurance
Ambulance (*Medicare-covered ground and air transportation services)*	In-Network: • $100 copay for each one-way trip.	In-Network: • $225 copay for each one-way trip. Out-of-Network: • $250 copay for each one-way ground ambulance trip • 50% coinsurance for each one-way air ambulance trip.	In-Network: • $100 copay for each one-way trip.	In-Network: • $100 copay for each one-way trip. Out-of-Network: • $225 copay for each one-way ground ambulance trip • $225 copay for each one-way air ambulance trip.

Services with a ¹ may require prior authorization.
Services with a ² may require a referral from your doctor.

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Transportation	• $0 copay This plan covers unlimited trips to plan-approved locations. • Transportation is limited to medical appointments and medical facilities within KelseyCare Advantage plan service area • Wheelchair-accessible vehicles need to be requested at least 24 hours in advance • This benefit does not cover transportation by stretcher or ambulance (ALS or BLS)	• $0 copay This plan covers unlimited trips to plan-approved locations. • Transportation is limited to medical appointments and medical facilities within KelseyCare Advantage plan service area • Wheelchair-accessible vehicles need to be requested at least 24 hours in advance • This benefit does not cover transportation by stretcher or ambulance (ALS or BLS)	• $0 copay This plan covers unlimited trips to plan-approved locations. • Transportation is limited to medical appointments and medical facilities within KelseyCare Advantage plan service area • Wheelchair-accessible vehicles need to be requested at least 24 hours in advance • This benefit does not cover transportation by stretcher or ambulance (ALS or BLS)	• Not Available
Medicare Part B Drugs[1]	Part B chemotherapy drugs, insulin, and other Part B drugs: In-Network: • 0% to 20% coinsurance	Part B chemotherapy drugs, insulin, and other Part B drugs: In-Network: • 0% to 20% coinsurance Out-of-Network: • 0% to 20% coinsurance	Part B chemotherapy drugs, insulin, and other Part B drugs: In-Network: • 0% to 20% coinsurance	Part B chemotherapy drugs, insulin and other Part B drugs: In-Network: • 0% to 20% coinsurance Out-of-Network: • 0% to 40% coinsurance

Prescription Drug Benefits – Part D

Initial Coverage Limit				
	KelseyCare Advantage Signature (HMO)	**KelseyCare Advantage Freedom (HMO-POS)**	**KelseyCare Advantage Secure (HMO)**	**KelseyCare Advantage Thrive (HMO-POS)**
Pharmacy (Part D) Deductible	No Deductible	You will pay a yearly deductible of $100 on Tiers 3, 4, and 5 drugs. You must pay the full cost of your Tiers 3, 4, and 5 drugs until you reach the plan's deductible amount. There is no deductible for Insulin	No Deductible	You will pay a yearly deductible of $100 on Tier 3, Tier 4, and Tier 5 drugs. You must pay the full cost of your Tiers 3, 4, and 5 drugs until you reach the plan's deductible amount. There is no deductible for Insulin

You pay the following until your yearly out-of-pocket drug costs reach $8,000. Total yearly out-of-pocket costs are the total drug costs paid by both you and other qualified payers.

You may get your drugs at network retail and mail-order pharmacies

Standard Retail and Mail Order Cost-Sharing (Initial Coverage Limit)

KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Tier 1 ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***
$7 copay for a one-month supply.	$3 copay for a one-month supply.	$7 copay for a one-month supply.	$7 copay for a one-month supply.
$21 copay for a three-month supply.	$9 copay for a three-month supply.	$21 copay for a three-month supply.	$21 copay for a three-month supply.

KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Tier 2 *(Generic)*	**Tier 2 *(Generic)***	**Tier 2 *(Generic)***	**Tier 2 *(Generic)***
$15 copay for a one-month supply.	$15 copay for a one-month supply.	$15 copay for a one-month supply.	$15 copay for a one-month supply.
$45 copay for a three-month supply.	$45 copay for a three-month supply.	$45 copay for a three-month supply.	$45 copay for a three-month supply.
Tier 3 *(Preferred Brand)*	**Tier 3 *(Preferred Brand)***	**Tier 3 *(Preferred Brand)***	**Tier 3 *(Preferred Brand)***
$47 copay for a one-month supply of other drugs	$45 copay for a one-month supply of other drugs	$47 copay for a one-month supply of other drugs	$47 copay for a one-month supply of other drugs
$141 copay for a three-month supply of other drugs.	$135 copay for a three-month supply of other drugs.	$141 copay for a three-month supply of other drugs.	$141 copay for a three-month supply of other drugs.
Tier 4 *(Non-Preferred Drug)*	**Tier 4 *(Non-Preferred Drug)***	**Tier 4 *(Non-Preferred Drug)***	**Tier 4 *(Non-Preferred Drug)***
$100 copay for a one-month supply of other drugs.	$90 copay for a one-month supply of other drugs.	$100 copay for a one-month supply of other drugs.	$100 copay for a one-month supply of other drugs.
$300 copay for a three-month supply of other drugs.	$270 copay for a three-month supply of other drugs.	$300 copay for a three-month supply of other drugs.	$300 copay for a three-month supply of other drugs.
Tier 5 *(Specialty Tier)*	**Tier 5 *(Specialty Tier)***	**Tier 5 *(Specialty Tier)***	**Tier 5 *(Specialty Tier)***
33% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)	31% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)	33% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)	31% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)
Tier 6 *(Select Care Drugs)*	**Tier 6 *(Select Care Drugs)***	**Tier 6 *(Select Care Drugs)***	**Tier 6 *(Select Care Drugs)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Preferred Retail and Mail Order Cost-Sharing (initial Coverage Limit)

KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Tier 1 ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.
Tier 2 ***(Generic)***	**Tier 2** ***(Generic)***	**Tier 2** ***(Generic)***	**Tier 2** ***(Generic)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$5 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$13 copay for a three-month supply.
Tier 3 ***(Preferred Brand)***	**Tier 3** ***(Preferred Brand)***	**Tier 3** ***(Preferred Brand)***	**Tier 3** ***(Preferred Brand)***
$40 copay for a one-month supply of other drugs.	$40 copay for a one-month supply of other drugs.	$40 copay for a one-month supply of other drugs.	$45 copay for a one-month supply of other drugs.
$100 copay for a three-month supply of other drugs.	$100 copay for a three-month supply of other drugs.	$100 copay for a three-month supply of other drugs.	$113 copay for a three-month supply of other drugs.
Tier 4 ***(Non-Preferred Drug)***	**Tier 4** ***(Non-Preferred Drug)***	**Tier 4** ***(Non-Preferred Drug)***	**Tier 4** ***(Non-Preferred Drug)***
$80 copay for a one-month supply of other drugs.	$80 copay for a one-month supply of other drugs.	$80 copay for a one-month supply of other drugs.	$90 copay for a one-month supply of other drugs.
$200 copay for a three-month supply of other drugs.	$200 copay for a three-month supply of other drugs.	$200 copay for a three-month supply of other drugs.	$225 copay for a three-month supply of other drugs.

KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Tier 5 *(Specialty Tier)* 33% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)	**Tier 5 *(Specialty Tier)*** 31% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)	**Tier 5 *(Specialty Tier)*** 33% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)	**Tier 5 *(Specialty Tier)*** 31% coinsurance for a one-month supply of other drugs (long-term supply is not available for other drugs)
Tier 6 *(Select Care Drugs)* $0 copay for a one-month supply. $0 copay for a three-month supply.	**Tier 6 *(Select Care Drugs)*** $0 copay for a one-month supply. $0 copay for a three-month supply.	**Tier 6 *(Select Care Drugs)*** $0 copay for a one-month supply. $0 copay for a three-month supply.	**Tier 6 *(Select Care Drugs)*** $0 copay for a one-month supply. $0 copay for a three-month supply.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out of network pharmacy but may pay more than you pay at an In-Network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.

After you enter the coverage gap, you pay 25% of the plan's negotiated price for covered brand name drugs and 25% of the plan's negotiated price for covered generic drugs until your out-of-pocket costs total $8,000, which is the end of the coverage gap. KelseyCare Advantage offers additional gap coverage for Tier 1, Tier 2, and Tier 6 drugs. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Standard Retail and Mail Order Cost-Sharing (Coverage Gap)

KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Tier 1 ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***
$7 copay for a one-month supply.	$3 copay for a one-month supply.	$7 copay for a one-month supply.	$7 copay for a one-month supply.
$21 copay for a three-month supply.	$9 copay for a three-month supply.	$21 copay for a three-month supply.	$21 copay for a three-month supply.
Tier 2 ***(Generic)***	**Tier 2** ***(Generic)***	**Tier 2** ***(Generic)***	**Tier 2** ***(Generic)***
$15 copay for a one-month supply.	$15 copay for a one-month supply.	$15 copay for a one-month supply.	$15 copay for a one-month supply.
$45 copay for a three-month supply.	$45 copay for a three-month supply.	$45 copay for a three-month supply.	$45 copay for a three-month supply.
Tier 6 ***(Select Care Drugs)***	**Tier 6** ***(Select Care Drugs)***	**Tier 6** ***(Select Care Drugs)***	**Tier 6** ***(Select Care Drugs)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.

Preferred Retail and Mail Order Cost-Sharing (Coverage Gap)

KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Tier 1 ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***	**Tier 1** ***(Preferred Generic)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.
Tier 2 ***(Generic)***	**Tier 2** ***(Generic)***	**Tier 2** ***(Generic)***	**Tier 2** ***(Generic)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$5 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$13 copay for a three-month supply.
Tier 6 ***(Select Care Drugs)***	**Tier 6** ***(Select Care Drugs)***	**Tier 6** ***(Select Care Drugs)***	**Tier 6** ***(Select Care Drugs)***
$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.	$0 copay for a one-month supply.
$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.	$0 copay for a three-month supply.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Catastrophic Coverage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Additional Prescription Drug Benefits

As part of the plan's enhanced drug coverage for Calendar Year 2024, the plan covers the following Tier 2 excluded drugs: Sildenafil (generic Viagra), Vitamin D2, Folic Acid, and Vitamin B12. Payments you make for excluded drugs are not included in your out-of-pocket costs.

Additional Medical Benefits

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Acupuncture[1,2]	Annually the plan covers up to 12 acupuncture visits within 90 days for chronic low back pain, 8 additional sessions if improvement shown. No more than 20 acupuncture treatments can be given yearly.			
	In network: • $20 copay	In network: • $20 copay Out-of-Network: • $35 copay	In network: • $20 copay	In network: • $15 copay Out-of-Network: • 40% coinsurance
Foot Care (podiatry services)[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.			
	In-Network: • $20 copay	In-Network: • $25 copay Out-of-Network: • $35 copay	In-Network: • $20 copay	In-Network: • $40 copay Out-of-Network: • 40% coinsurance
Medical Equipment/ Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies)[1]	Durable medical equipment: In-Network: • 20% coinsurance	Durable medical equipment In-Network: • 20% coinsurance Out-of-Network: • 50% coinsurance	Durable medical equipment In-Network: • 20% coinsurance	Durable medical equipment In-Network: • 20% coinsurance Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Medical Equipment/ Supplies (continued)	Diabetes monitoring supplies: In-Network: • You pay 0% coinsurance for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay 0% coinsurance for lancets, lancet devices and control solutions. Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.	Diabetes monitoring supplies: In-Network: • You pay 0% coinsurance for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay 0% coinsurance for lancets, lancet devices and control solutions. Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered. Out-of-Network: • 50% coinsurance (even if preferred brands are used)	Diabetes monitoring supplies: In-Network: • You pay $0 copay for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay $0 copay for lancets, lancet devices and control solutions. Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.	Diabetes monitoring supplies: In-Network: • You pay $0 copay for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay $0 copay for lancets, lancet devices and control solutions. Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered. Out-of-Network: • 40% coinsurance (even if preferred brands are used)

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Medical Equipment/ Supplies (continued)	Therapeutic shoes or inserts and Prosthetic devices: In-Network: • 20% coinsurance Continuous Glucose Monitors – Preferred Brands: Dexcom G6 and G7: In-Network: • Continuous blood glucose monitors 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGMs are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy. All other DME is 20% coinsurance.	Therapeutic shoes or inserts and Prosthetic devices: In-Network: • 20% coinsurance Out-of-Network: • 50% coinsurance Continuous Glucose Monitors – Preferred Brands: Dexcom G6 and G7: In-Network: • Continuous blood glucose monitors 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGMs are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy. All other DME is 20% coinsurance. Out-of-Network: • 50% coinsurance	Therapeutic shoes or inserts and Prosthetic devices: In-Network: • 20% coinsurance Continuous Glucose Monitors – Preferred Brands: Dexcom G6 and G7: In-Network: • Continuous blood glucose monitors 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGMs are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy. All other DME is 20% coinsurance.	Therapeutic shoes or inserts and Prosthetic devices: In-Network: • 20% coinsurance Out-of-Network: • 40% coinsurance Continuous Glucose Monitors – Preferred Brands: Dexcom G6 and G7: In-Network: • Continuous blood glucose monitors 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGMs are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy. All other DME is 20% coinsurance. Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Wellness Programs (e.g., fitness)	You pay a $0 copay for OnePass – Access to a participating gym network, on-demand and livestreaming digital content and a comprehensive cognitive program called BrainHQ.	You pay a $0 copay for OnePass – Access to a participating gym network, on-demand and livestreaming digital content and a comprehensive cognitive program called BrainHQ.	Not Covered	You pay a $0 copay for OnePass – Access to a participating gym network, on-demand and livestreaming digital content and a comprehensive cognitive program called BrainHQ.
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-Network: • $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-Network: • $20 copay Out-of-Network: • $35 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-Network: • $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-Network: • $15 copay Out-of-Network: • 40% coinsurance
Diabetes Self-Management Training[1,2]	In-Network: • $0 copay	In-Network: • $0 copay Out-of-Network: • 50% coinsurance	In-Network: • $0 copay	In-Network: • $0 copay Out-of-Network: • 40% coinsurance
Home Health Care[1,2]	In-Network: • $0 copay	In-Network: • $10 copay Out-of-Network: • 50% coinsurance	In-Network: • $10 copay	In-Network: • $0 copay Out-of-Network: • 40% coinsurance

Services with a ¹ may require prior authorization.
Services with a ² may require a referral from your doctor.

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.			
Outpatient Substance Abuse[1,2]	Individual or group therapy visit: In-Network: • $20 copay	Individual or group therapy visit: In-Network: • $20 copay Out-of-Network: • $35 copay	Individual or group therapy visit: In-Network: • $20 copay	Individual or group therapy visit: In-Network: • $20 copay Out-of-Network: • 40% coinsurance
Surgery[1,2]	In-Network: • $300 copay at outpatient hospital • $225 copay at ambulatory surgery center	In-Network: • $300 copay at outpatient hospital • $225 copay at ambulatory surgery center Out-of- network: • 20% coinsurance	In-Network: • $150 copay at outpatient hospital • $125 copay at ambulatory surgery center	In-Network: • $325 copay at outpatient hospital • $175 copay at ambulatory surgery center Out-of- network: • 40% coinsurance
Over-the-Counter Items (OTC)	You receive a $125 allowance every 3 months for OTC items.	You receive a $95 allowance every 3 months for OTC items.	You receive a $90 allowance every 3 months for OTC items.	You receive a $150 allowance every 3 months for OTC items.
Renal Dialysis[1,2]	In-Network: • 20% coinsurance	In-Network: • 20% coinsurance Out-of-Network: • 50% coinsurance	In-Network: • 20% coinsurance	In-Network: • 20% coinsurance Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Telemedicine visits	E-Visits and Video Visits are a covered benefit for Kelsey-Seybold primary care and specialty physicians.			
	In-Network: • PCP: Phone, E-Visits and Video Visits with a PCP: $0 copay • Specialist: Specialty, Mental Health and other providers — Phone, E-Visits and Video Visits: $15 copay	In-Network: • PCP: Phone, E-Visits and Video Visits with a PCP: $0 copay • Specialist: Specialty, Mental Health and other providers — Phone, E-Visits and Video Visits: $15 copay Out-of-Network: • Not covered	In-Network: • PCP: Phone, E-Visits and Video Visits with a PCP: $0 copay • Specialist: Specialty, Mental Health and other providers — Phone, E-Visits and Video Visits: $15 copay	In-Network: • PCP: Phone, E-Visits and Video Visits with a PCP: $0 copay • Specialist: Specialty, Mental Health and other providers - Phone, E-Visits and Video Visits: $15 copay Out-of-Network: • Not covered
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):			
	In-Network: • $20 copay Occupational therapy: In-Network: • $35 copay	In-Network: • $25 copay Out-of-Network: • 50% coinsurance Occupational therapy: In-Network: • $10 copay Out-of-Network: • 50% coinsurance	In-Network: • $20 copay Occupational therapy: In-Network: • $20 copay	In-Network: • $35 copay Out-of-Network: • 40% coinsurance Occupational therapy: In-Network: • $35 copay Out-of-Network: • 40% coinsurance

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Preventive Dental Services	In-Network: • 0% coinsurance • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehen-sive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) Services are only covered if provided by an in-network dentist.	In-Network: • 0% coinsurance • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehen-sive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) Services are only covered if provided by an in-network dentist.	In-Network: • 0% coinsurance • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehen-sive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) Services are only covered if provided by an in-network dentist.	In-Network: • 0% coinsurance • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehen-sive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) Services are only covered if provided by an in-network dentist.

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Comprehensive Dental Services	In-Network: $3,000 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details. • 0% coinsurance for each service. Periodontic Services Prosthodontic Services Restorative Services Oral and Maxillofacial Surgery Services	In-Network: $2,500 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details. • 0% coinsurance for each service. Periodontic Services Prosthodontic Services Restorative Services Oral and Maxillofacial Surgery Services	In-Network: $2,500 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details. • 0% coinsurance for each service Periodontic Services Prosthodontic Services Restorative Services Oral and Maxillofacial Surgery Services	In-Network: $3,500 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details. • 0% coinsurance for each service Periodontic Services Prosthodontic Services Restorative Services Oral and Maxillofacial Surgery Services

	KelseyCare Advantage Signature (HMO)	KelseyCare Advantage Freedom (HMO-POS)	KelseyCare Advantage Secure (HMO)	KelseyCare Advantage Thrive (HMO-POS)
Flex Wallet Card	Your coverage includes a $750 annual flex wallet card benefit for dental, vision, and hearing services. You can use this allowance to pay for out-of-pocket amounts due to these providers. You will have access to these funds using an issued debit card. Unused allowances do not carry over to the next calendar year.	Your coverage includes a $750 annual flex wallet card benefit for dental, vision, and hearing services. You can use this allowance to pay for out-of-pocket amounts due to these providers. You will have access to these funds using an issued debit card. Unused allowances do not carry over to the next calendar year.	Your coverage includes a $250 annual flex wallet card benefit for dental, vision, and hearing services. You can use this allowance to pay for out-of-pocket amounts due to these providers. You will have access to these funds using an issued debit card. Unused allowances do not carry over to the next calendar year.	Your coverage includes a $1,000 annual flex wallet card benefit for dental, vision, hearing services, and home fitness equipment. You can use this allowance to pay for out-of-pocket amounts due to these providers. You will have access to these funds using an issued debit card. Unused allowances do not carry over to the next calendar year.

KelseyCare Advantage

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-535-8343. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-535-8343. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，**帮**助**您**解答**关**于健康或药物保险的任何疑 问。如果**您**需要此翻译服务，请致电 1-866-535-8343。我们的中文工作人员很乐意**帮**助**您**。 这是一项免费服务。

Chinese Cantonese: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-535-8343。我們講中文的人員將樂意為**您**提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-535-8343. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-535-8343. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-535-8343 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-535-8343. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 -866-535-8343번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-535-8343. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-535-8343 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या द□ा की योजना के बारे में आपके किसी भी प्रश्न के ज□ाब देने के लिए हमारे पास मुफ्त दुभाषिया से□ाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-535-8343 पर फोन करें. कोई व्यक्ति जो हिन्दी बोल□ा ह□आपकी मदद कर सक□ा ह□ यह एक मुफ्त से□ा ह□

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-535-8343. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-535-8343. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-535-8343. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-535-8343. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、
1-866-535-8343にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

This information is not a complete description of benefits. Call 1-866-535-8343 for more information. TTY users can call 711.

KelseyCare Advantage is offered by KS Plan Administrators, LLC, an HMO with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal. Contact the plan for more information.