

# KelseyCare Advantage

## Plan Selection Form

Date:

Member Name:

Member Number:

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check the appropriate box below:

\_\_\_\_\_ KelseyCare Advantage RX HMO  
Plan Premium: \$0.  
Medicare Part D Prescription Coverage, \$10 Copay for Primary Care office visits, \$35 Copay for Specialist visits, \$60 Copay for Worldwide Emergency Coverage, \$500 copayment per acute hospital admission for days 1-90 plus a \$100 copay per day for days 91-150, and a \$3,400 out of pocket maximum for Medicare covered services.

\_\_\_\_\_ KelseyCare Advantage RX + Choice HMO/POS  
Plan Premium: \$57.00 per month.  
Medicare Part D Prescription Coverage, \$10 Copay for Primary Care office visits, \$35 Copay Specialist visits, \$60 Copay for Worldwide Emergency Coverage, \$500 copayment per acute hospital admission for days 1-90 plus a \$100 copay per day for days 91-150, and a \$3,400 in-network out of pocket maximum for Medicare covered services.

Includes Point-of-Service (POS) Benefits: POS or out of network benefits cover certain medically necessary services from non plan providers. When using the POS benefit you are responsible for more of the cost share. The POS benefit has a \$6,700 out-of-network out of pocket limit every year for Medicare covered services.

\_\_\_\_\_ KelseyCare Advantage Essential HMO  
Plan Premium: \$0.  
This plan does not include Medicare Part D prescription coverage. \$10 Copay for Primary Care office visits, \$20 Copay for Specialist visits, \$60 Copay for Worldwide Emergency Coverage, \$500 copayment per acute hospital admission for days 1-90 plus a \$100 copay per day for days 91-150, \$75 allowance for eyewear every year, \$500 allowance for hearing aids every year, \$30.00 monthly Social Security Part B premium buy down, \$3,400 out of pocket maximum for Medicare covered services. This plan does not include Medicare Part D coverage.

\_\_\_\_\_ KelseyCare Advantage Essential + Choice HMO/POS  
Plan Premium: \$0.

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This plan does not include Medicare Part D prescription coverage. \$10 Copay for Primary Care office visits, \$20 Copay for Specialist visits, \$60 Copay for Worldwide Emergency Coverage, \$500 copayment per acute hospital admission for days 1-90 plus a \$100 copay per day for days 91-150, \$75 allowance for eyewear every year, \$500 allowance for hearing aids every year, \$3,400 in-network out of pocket maximum for Medicare covered services.

Includes Point-of-Service (POS) Benefits: POS or out of network benefits cover certain medically necessary services from non plan providers. When using the POS benefit you are responsible for more of the cost share. The POS benefit has a \$6,700 out-of-network out of pocket limit every year for Medicare covered services.

## YOUR PLAN PREMIUM

### **KelseyCare Advantage RX**

**If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail each month or quarterly. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

### **KelseyCare Advantage Rx+Choice**

**You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.]**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for extra help with your Medicare prescription coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

### **Please select a premium payment option:**

Receive a bill

Electronic Fund Transfer (EFT)

Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

# KelseyCare Advantage

**Account holder name:** \_\_\_\_\_

**Bank routing number:** \_\_\_\_\_ **Bank account number:** \_\_\_\_\_

Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums)

**Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:**

\_\_\_\_\_ Spanish

Please contact KelseyCare Advantage at 713-442-CARE (2273) or 1-866-535-8343 if you need information in another format or language than what is listed above. TTY users should call 1-866-302-9336. Our office hours are Monday through Sunday 8:00 a.m. to 8:00 p.m.

**Signature:**

**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Relationship to Enrollee:** \_\_\_\_\_

Please mail this form to:

KelseyCare Advantage  
PO Box 61609  
Houston, Texas 77208-9905