Kelsey Care Advantage

GOLD freedom (HMO-POS)

2023 SUMMARY OF BENEFITS

1-866-535-8343 (TTY: 711) | www.KelseyCareAdvantage.com

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, 2024.
	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 Gold Freedom plan.
	The KelseyCare Advantage Gold Freedom 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 Gold Freedom (HMO-POS) covers 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 can call 1-877-486-2048.
Sections in this book	• Things to know about KelseyCare Advantage Gold Freedom • 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 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).

Which doctors and hospitals can I use?	KelseyCare Advantage Gold Freedom 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, 2023 – December 31, 2023

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

	KelseyCare Advantage Gold Freedom (HMO-POS)
How much is the monthly premium?	$0 per month. In addition, you must continue to keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a medical deductible.
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: • $3,450 for services you receive from In-Network providers. • $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. <u>In-Network:</u> • $375 copay per stay (waived with a COVID-19 diagnosis) • $0 copay per day for lifetime reserve days (if available) <u>Out-of-network:</u> • 40% coinsurance per stay (waived with a COVID-19 diagnosis)
Outpatient Hospital Coverage[1,2]	<u>In-Network:</u> • $300 copay <u>Out-of-Network:</u> • 20% coinsurance

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

	KelseyCare Advantage Gold Freedom (HMO-POS)
Ambulatory Surgery Center (ASC)[1,2]	In-Network: • $225 copay Out-of-Network: • 20% coinsurance
Doctor Visits (Primary Care Providers and Specialists)[1,2]	In-Network office visit: • Primary care: $0 copay • Specialist: $25 copay Out-of-Network office visit: • Primary care: $10 copay • Specialist*: $35 copay *40% coinsurance for each MD Anderson provider visit
Preventive Care	In-Network: • $0 copay Out-of-Network: • 50% coinsurance
	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.

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	KelseyCare Advantage Gold Freedom (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.
Urgently Needed Services	$25 copay
Diagnostic Services, Labs, Imaging[1,2]	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 Lab services: • In-Network: $0 copay • Out-of-Network: $0 copay at LabCorp or 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
Hearing Services[1,2]	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.

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	KelseyCare Advantage Gold Freedom (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: • $25 copay Out-of-Network: • $35 copay
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. In-Network: • $25 copay for each exam to diagnose and treat diseases of the eye • $0 copay for each annual glaucoma screening Out-of-Network: • 20% coinsurance for each exam to diagnose and treat diseases 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
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: • $375 copay per stay • $0 copay per day for lifetime reserve days (if available) Out-of-Network: • 40% coinsurance per stay Outpatient individual or group therapy visit: • In-network: $20 copay • Out-of-Network: $35 copay

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	KelseyCare Advantage Gold Freedom (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 Out-of-Network: • 50% coinsurance per stay
Physical Therapy[1,2]	In-Network: • $10 copay Out-of-Network: • $40 copay
Ambulance (*Medicare-covered ground and air transportation services)*	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
Transportation	• $0 copay This plan covers unlimited trips every year to plan-approved locations. Transportation is limited to medical appointments and medical facilities within the plan service area.
Medicare Part B Drugs[1]	Part B chemotherapy drugs and other Part B drugs: In-Network: • 20% coinsurance Out-of-Network: • 20% coinsurance

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Prescription Drug Benefits – Part D

Initial Coverage Limit

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 Select Insulins. During the Deductible Stage, your out-of-pocket costs for these Select Insulins will be $30 - $35 copay for a 30-day supply. After you pay your yearly deductible, you pay the following until your total yearly drug cost reach $4,660. Total yearly drug costs are the total drug cost paid by both you and our Part D plan.

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

Standard Retail Cost-Sharing (Initial Coverage Limit)

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$3 copay	$6 copay	$9 copay
Tier 2 (Generic)	$15 copay	$30 copay	$45 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay
(Select Insulins*)	$35 copay	$70 copay	$105 copay
Tier 4 (Non-Preferred Drug)	$90 copay	$180 copay	$270 copay
Tier 5 (Specialty Tier)	31% coinsurance	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay

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, even if you haven't paid your deductible.

**Select Insulins in Tier 3 are covered under the plan's participation in the Part D Senior Savings Model Calendar Year 2023. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services.*

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

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$0 copay	$0 copay	$0 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$100 copay
(Select Insulins*)	$30 copay	$60 copay	$75 copay
Tier 4 (Non-Preferred Drug)	$80 copay	$160 copay	$200 copay
Tier 5 (Specialty Tier)	31% coinsurance	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay

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, even if you haven't paid your deductible.

**Select Insulins in Tier 3 are covered under the plan's participation in the Part D Senior Savings Model Calendar Year 2023. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services.*

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 $4,660.

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 $7,400, which is the end of the coverage gap. KelseyCare Advantage offers additional gap coverage for Tier 1, Tier 2, and Tier 6 drugs and Select Insulins. 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 Cost-Sharing (Coverage Gap)

Tier	Drugs Covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	All	$3 copay	$6 copay	$9 copay
Tier 2 (Generic)	All	$15 copay	$30 copay	$45 copay
Tier 6 (Select Care Drugs)	All	$0 copay	$0 copay	$0 copay
(Select Insulins)	Varies	$35 copay	$70 copay	$105 copay

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

Tier	Drugs Covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	All	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	All	$0 copay	$0 copay	$0 copay
Tier 6 (Select Care Drugs)	All	$0 copay	$0 copay	$0 copay
(Select Insulins)	Varies	$30 copay	$60 copay	$75 copay

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, even if you haven't paid your deductible.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of:

- 5% of the plan's negotiated price, or
- $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs.

Additional Prescription Drug Benefits

As part of the plan's enhanced drug coverage for Calendar Year 2023, 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 Gold Freedom (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 Out-of-Network: • $35 copay
Foot Care (podiatry services)[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-Network: • $25 copay Out-of-Network: • $35 copay
Meals[1]	You pay a $0 copay for up to 2 meals per day for 7 days after discharge from an inpatient stay with a COVID-19 diagnosis.
Medical Equipment/ Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies)[1]	Durable medical equipment: In-Network: • 20% coinsurance Out-of-Network: • 50% coinsurance 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)

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	KelseyCare Advantage Gold Freedom (HMO-POS)
Medical Equipment/ Supplies (continued)	Therapeutic shoes or inserts and Prosthetic devices: In-Network: • 20% coinsurance Out-of-Network: • 50% coinsurance Continuous Glucose Monitors – Preferred Brands: Dexcom and FreeStyle Libre: In-Network: • Continuous blood glucose monitors 15% at retail pharmacy and 20% at DME vendor. All other DME is 20% coinsurance. Preferred continuous blood glucose monitors are Dexcom and FreeStyle Libre, all other CGMs are excluded. • Non-preferred brands not covered Out-of-Network: • 50% coinsurance
Wellness Programs (e.g., fitness)	You pay a $0 copay for SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.
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 Out-of-Network: • $35 copay
Diabetes Self-Management Training[1,2]	In-Network: • $0 copay Out-of-Network: • 50% coinsurance
Home Health Care[1,2]	In-Network: • $10 copay Out-of-Network: • 50% coinsurance

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	KelseyCare Advantage Gold Freedom (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 Out-of-Network: • $35 copay
Surgery[1,2]	In-Network: • $300 copay at outpatient hospital • $225 copay at ambulatory surgery center Out-of-network: • 20% coinsurance
Over-the-Counter Items (OTC)	You receive up to $95 per quarter.
Renal Dialysis[1,2]	In-Network: • 20% coinsurance Out-of-Network: • 50% coinsurance
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 and Mental Health Phone, E-Visits and Video Visits: $15 copay Out-of-Network: • Not covered

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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: • $25 copay Out-of-Network: • 50% coinsurance Occupational therapy: In-Network: • $10 copay Out-of-Network: • 50% coinsurance
Preventive Dental Services	In-Network: • $0 copay • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehensive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) FCL Dental is the dental provider network. Services are only covered if provided by a dentist contracted with FCL Dental. Out-of-Network: • Not covered

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	KelseyCare Advantage Gold Freedom (HMO-POS)
Comprehensive Dental Services	In-Network: $2,000 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details. • 50% coinsurance for each service. Endodontic Services Periodontic Services Prosthodontic Services Restorative Services Oral and Maxillofacial Surgery Services Out-of-Network: Not covered
Flex Wallet Card	Your coverage includes a $500 annual flex wallet card benefit for dental, vision, and hearing allowances. You can use your allowances 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.

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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.

Tenemos servicios de intérprete gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para obtener un intérprete, simplemente llámenos al 1-866-535-8343. Alguien que hable español puede ayudarte. Este es un servicio gratuito.

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。

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

Mayroon kaming libreng interpreter serbisyo upang sagutin ang anumang mga katanungan na maaaring mayroon ka tungkol sa aming kalusugan o drug plan. Para makakuha ng interpreter, tawagan lang tayo sa 1-866-535-8343. Makakatulong sa iyo ang isang taong nagsasalita ng Tagalog. Ito ay isang libreng serbisyo.

Nous avons des services d'interprète gratuits pour répondre à toutes vos questions sur notre régime de soins de santé ou d'assurance-médicaments. Pour obtenir un interprète, appelez-nous au 1-866-535-8343. Quelqu'un qui parle Français peut vous aider. Il s'agit d'un service gratuit.

Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào quý vị có thể có về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có được một thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-866-535-8343. Một người nói tiếng Việt có thể giúp bạn. Đây là một dịch vụ miễn phí.

Wir haben kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie zu unserem Gesundheits- oder Drogenplan haben könnten. Um einen Dolmetscher zu bekommen, rufen Sie uns einfach unter 1-866-535-8343 an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dies ist ein kostenloser Service.

우리는 당신이 우리의 건강 또는 약물 계획에 대해 가질 수있는 질문에 대답 할 수있는 무료 통역사 서비스를 제공합니다. 통역사를 얻으려면 1-866-535-8343 으로 전화하십시오. 한국어를 구사하는 사람이 당신을 도울 수 있습니다. 이것은 무료 서비스입니다.

У нас есть бесплатные услуги переводчика, чтобы ответить на любые ваши вопросы о нашем плане здоровья или лекарств. Чтобы получить переводчика, просто позвоните нам по телефону 1-866-535-8343. Тот, кто говорит по-русски, может вам помочь. Это бесплатная услуга.

لدينا خدمات الترجمة الفورية المجانية للإجابة على أي أسئلة قد تكون لديكم حول خطتنا الصحية أو الدوائية .للحصول على مترجم فوري ، ما عليك سوى الاتصال بنا على 1-866-535-8343)الهاتف النصي:. يمكن لشخص يتحدث العربية مساعدتك .هذه خدمة مجانية.

Abbiamo servizi di interpretariato gratuiti per rispondere a qualsiasi domanda tu possa avere sul nostro piano sanitario o farmacologico. Per ottenere un interprete, basta chiamarci al numero 1-866-535-8343. Qualcuno che parla italiano può aiutarti. Questo è un servizio gratuito.

Temos serviços gratuitos de intérprete para responder a quaisquer perguntas que você possa ter sobre nosso plano de saúde ou drogas. Para conseguir um intérprete, basta nos ligar para 1-866-535-8343. Alguém que fale português pode ajudá-lo. Este é um serviço gratuito.

Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou sante nou oswa plan dwòg nou. Pou jwenn yon entèprèt, jis rele nou nan 1-866-535-8343. Yon moun ki pale kreyòl ayisyen kapab ede w. Sa a se yon sèvis gratis.

Mamy bezpłatne usługi tłumacza, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu zdrowotnego lub narkotykowego. Aby uzyskać tłumacza, wystarczy zadzwonić do nas pod numer 1-866-535-8343. Ktoś, kto mówi po polsku, może ci pomóc. Jest to bezpłatna usługa.

हमारे पास हमारे स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ्त दुभाषिया सेवाएं हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-535-8343 पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निशुल्क सेवा है।

無料の通訳サービスがあり、健康や薬物計画に関するご質問にお答えします。 通訳を依頼するには、1-866-535-8343までお電話ください。日本語を話す人が助けてくれます。 これは無料のサービスです。

KelseyCare Advantage

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.