2021
Summary of Benefits
City of Houston Preferred (HMO)

713-442-2COH (2264)
www.kelseycareadvantage.com/COH

KelseyCare Advantage

2021 SUMMARY OF BENEFITS

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 713-442-2COH (2264) or toll-free at 1-866-535-8405 (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/coh or call 1-866-535-8405 (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, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
	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 Preferred (HMO) plan.

GENERAL PLAN INFORMATION

Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Preferred (HMO) 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 Preferred (HMO) • Monthly Premium and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits
Hours of Operation	• We are available from 8 a.m. to 5 p.m. Monday through Friday. On Saturdays and Sundays, calls are handled by our messaging system.
Phone numbers and Website	• If you are a member of this plan, call 713-442-2COH (2264) or toll-free 1-866-535-8405 (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.www.kelseycareadvantage.com/coh
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:** Harris, Brazoria, Fort Bend, Montgomery, Galveston, Liberty, Chambers, Waller, San Jacinto, Austin, Wharton, Walker, Grimes.
Which doctors and hospitals can I use?	**KelseyCarere Advantage Preferred:** 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.
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/coh). 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. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.kelseycareadvantage.com/coh. Or, call us and we will send you a copy of the formulary.
How will I determine my drug costs?	Our plan groups each medication into one of five "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: Initial Coverage and Catastrophic Coverage.

Summary of Benefits
January 1, 2021 – December 31, 2021

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

	Preferred (HMO)
How much is the monthly premium?	$42.00 per month.
	In addition, you must 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: $3,400 for services you receive from in-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.

	Preferred (HMO)
Inpatient Hospital Coverage [1,2]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There is no limit to the number of benefit periods. There is no limit to the number of covered days. • $300 copay per stay
Outpatient Hospital Coverage [1,2]	• $175 copay
Ambulatory Surgery Center [1,2]	• $150 copay
Doctor Visits (Primary Care Providers and Specialists) [1,2]	Office visit: • Primary care visit: $0 copay • Specialist visit: $25 copay

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

	Preferred (HMO)
Preventive Care[1]	• $0 copay
	Other preventive services including: • 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.
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

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

	Preferred (HMO)
Diagnostic Services, Labs Imaging [1,2]	Diagnostic radiology services (such as MRIs, CT scans): • $0-$150 copay, depending on the service Diagnostic tests and procedures: • $0-$25 copay, depending on the service Lab services: • $0 copay Outpatient x-rays: • $0 copay Therapeutic radiology services (such as radiation treatment for cancer): • $15 copay
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: • $15 copay Routine hearing exam: • $0 copay. You are covered for up to 1 every year.
Dental Services (Medical dental) [1,2]	Medicare covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $0 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)
	• $0 copay Routine eye exam: • $0 copay for 1 routine eye exam every year • $50 allowance every year for contact lenses or eyeglasses. Eyeglasses or contact lenses after cataract surgery: • $0 copay for eyeglasses or contact lenses after cataract surgery

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

	Preferred (HMO)
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. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods. 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. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
	• $300 copay per stay <u>Outpatient individual or group therapy visit</u>: • $20 copay
Skilled Nursing Facility (SNF) [1,2]	Our plan covers up to 100 days in a SNF per benefit period. • $0 copay per day for days 1-20 • $100 copay per day for days 21- 100
Physical Therapy [1,2]	• $15 copay per visit
Ambulance (*Medicare-covered ground and air transportation services)*	• $100 copay for each one-way trip
Transportation	You pay nothing. This plan covers 20 one-way trips for plan-approved locations every year. Transportation is limited to medical appointments and medical facilities within the plan service area. There is no out-of-network coverage for this benefit.
Medicare Part B Drugs [1]	<u>Part B chemotherapy drugs and other Part B drugs:</u> 15% of the cost

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

Prescription Drug Benefits – Part D

Initial Coverage Limit

You pay the following until your yearly out-of-pocket drug costs reach $6,550. 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

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Standard Retail Cost-Sharing

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$15	$30	$45
Tier 2 (Generic)	$20	$40	$60
Tier 3 (Preferred Brand)	$35	$70	$105
Tier 4 (Non-Preferred Drug)	$50	$100	$150
Tier 5 (Specialty Tier)	$80	Not available	Not available

Preferred Retail and Mail Order Cost-Sharing

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$10	$20	$30
Tier 2 (Generic)	$15	$30	$45
Tier 3 (Preferred Brand)	$30	$60	$90
Tier 4 (Non-Preferred Drug)	$45	$90	$135
Tier 5 (Specialty Tier	$75	Not available	Not available

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.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of:

- 5% of the plan’s negotiated price, or
- $3.70 copayment for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs.

Additional Medical Benefits

	Preferred (HMO)
Acupuncture [1,2]	Annually the plan covers up to 12 acupuncture visits within 90 days for chronic low back pain, 8 additional days if improvement.
	• $20 copay per visit
Foot Care (podiatry services) [1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:
	• $15 copay
Medical Equipment/ Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) [1]	• 10% of the cost <u>Therapeutic shoes or inserts, Diabetic Supplies and Prosthetic devices</u>: • 20% of the cost
Wellness Programs (e.g., fitness)	SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes. You pay nothing.

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

	Preferred (HMO)
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 positions): • $15 copay
Diabetes Self-Management Training 1,2	Diabetes self-management training: • $0 copay
Home Health Care 1,2	• $0 copay
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: • $20 copay
Outpatient Surgery[1,2]	Outpatient hospital: • $175 copay
Ambulatory Surgery Center[1,2]	• $150 copay
Over-the-Counter Items (OTC)	Not covered
Renal Dialysis 1,2	• 20% of the cost

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

	Preferred (HMO)
Telemedicine visits	E-Visits and Video Visits are a covered benefit from Kelsey-Seybold primary care and specialty contracted physicians.
	<u>E-Visits / Video Visits / Phone Visits</u> • PCP $0 • Specialist $15
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):
	• $15 copay <u>Occupational therapy visit</u>: • $15 copay

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

KelseyCare Advantage is offered by KS Plan Administrators, LLC, a Medicare Advantage HMO with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information.