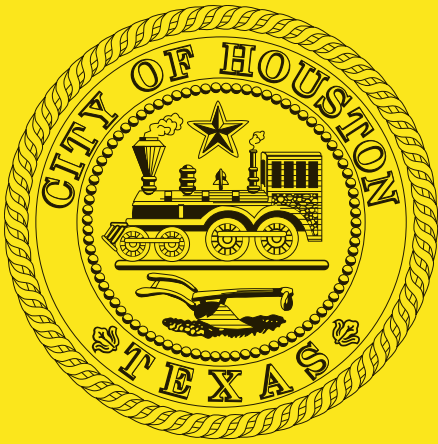


# KelseyCare Advantage

## 2022 SUMMARY OF BENEFITS



H0332\_COHSB22

## 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 <i>Evidence of Coverage (EOC)</i> , especially for those services that you routinely see a doctor. Visit <a href="http://www.kelseycareadvantage.com/COH">www.kelseycareadvantage.com/COH</a> or call 1-866-535-8405 (TTY users can call 711) to view a copy of the EOC.
	Review the <i>Provider Directory</i> (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 <i>Pharmacy Directory</i> 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, 2023.
	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).

## GENERAL PLAN INFORMATION

<b>Tips for comparing your Medicare choices</b>	<p>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 “<i>Evidence of Coverage</i>.”</p> <p>Tips for comparing your Medicare choices:</p> <ul style="list-style-type: none"> <li>• 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 <a href="http://www.medicare.gov">http://www.medicare.gov</a>.</li> <li>• If you want to know more about the coverage and costs of Original Medicare, look in your current “<i>Medicare &amp; You</i>” handbook. View it online at <a href="http://www.medicare.gov">http://www.medicare.gov</a> 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.</li> </ul>
<b>Sections in this book</b>	<ul style="list-style-type: none"> <li>• Things to know about KelseyCare Advantage Preferred</li> <li>• Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services</li> <li>• Covered Medical and Hospital Benefits</li> <li>• Prescription Drug Benefits</li> </ul>
<b>Hours of Operation</b>	<ul style="list-style-type: none"> <li>• Hours are 8:00 a.m. to 8:00 p.m. Monday through Friday, local time. Messaging service used weekends, after hours, and on federal holidays.</li> </ul>
<b>Phone numbers and Website</b>	<ul style="list-style-type: none"> <li>• If you are a member of this plan, call toll-free 1-866-535-8405 (TTY users can call 711).</li> <li>• If you are not a member of this plan, call toll-free 1-800-663-7146 (TTY users can call 711). Our website: <a href="http://www.kelseycareadvantage.com/COH">www.kelseycareadvantage.com/COH</a></li> </ul>
<b>Who Can Join?</b>	<p>To join KelseyCare Advantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.</p> <p><b>Our service area includes the following counties in Texas:</b> Harris, Fort Bend, Montgomery, Galveston, Brazoria, Chambers, Liberty, Austin, San Jacinto, Waller, Walker, Wharton.</p>

<b>Which doctors and hospitals can I use?</b>	KelseyCare 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 <i>Evidence of Coverage</i> for more information, including the cost sharing that applies to Out-of-Network services.	
<b>Which pharmacies can I use?</b>	<p>You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.</p> <p>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.</p> <p>You can see our plan's provider directory and pharmacy directory at our website (<a href="http://www.kelseycareadvantage.com/COH">www.kelseycareadvantage.com/COH</a>). Or, call us at the phone numbers above, and we will send you a copy of the provider and pharmacy directories.</p>
<b>What do we cover?</b>	<p>Like all Medicare health plans, we cover everything that Original Medicare covers – and more.</p> <p><b>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.</b> For others, you may pay less.</p> <p>Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.</p> <p>We cover Part D drugs. We cover Part B drugs such as chemotherapy and some drugs administered by your provider.</p> <p>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (<a href="http://www.kelseycareadvantage.com/COH">www.kelseycareadvantage.com/COH</a>). 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.</p>
<b>How will I determine my drug costs?</b>	Our plan groups each medication into one of 5 “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, 2022 – December 31, 2022

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

	KelseyCare Advantage Preferred (HMO)
<b>How much is the monthly premium?</b>	\$42 per month. In addition, you must continue to keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	This plan does not have a medical deductible.
<b>Is there any limit on how much I will pay for my covered services?</b>	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. <b>Please note that you will still need to pay your monthly Part B premiums and cost sharing for your Part D prescription drugs.</b>
(Maximum Out-of-Pocket Responsibility)	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>\$3,400 for services you receive from In-Network providers.</li> </ul>
<b>Is there a limit on how much the plan will pay?</b>	Our plan has a coverage limit every year for certain In-Network benefits. Contact us for the services that apply.
<b>Inpatient Hospital Coverage<sup>1,2</sup></b>	<u>In-Network:</u> <ul style="list-style-type: none"> <li>\$300 copay per stay (waived with a COVID-19 diagnosis)</li> </ul>
<b>Outpatient Hospital Coverage<sup>1,2</sup></b>	<u>In-Network:</u> <ul style="list-style-type: none"> <li>\$175 copay</li> </ul>
<b>Ambulatory Surgery Center (ASC)<sup>1,2</sup></b>	<u>In-Network:</u> <ul style="list-style-type: none"> <li>\$150 copay</li> </ul>
<b>Doctor Visits</b> (Primary Care Providers and Specialists) <sup>1,2</sup>	<u>In-Network office visit:</u> <ul style="list-style-type: none"> <li>Primary care: \$0 copay</li> <li>Specialist: \$25 copay</li> </ul>

Services with a <sup>1</sup> may require prior authorization.

Services with a <sup>2</sup> may require a referral from your doctor.



	KelseyCare Advantage Preferred (HMO)
<b>Preventive Care</b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul> <p>Preventive services include:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screening</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including Flu shots, hepatitis B shots, pneumococcal shots</li> <li>• “Welcome to Medicare” preventive visit (one-time)</li> <li>• Yearly “Wellness” visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Emergency Care</b>	<p>\$120 copay</p> <p>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.</p>
<b>Urgently Needed Services</b>	<p>\$25 copay</p>
<b>Diagnostic Services, Labs, Imaging<sup>1,2</sup></b>	<p><u>Diagnostic radiology services (such as MRIs, CT scans):</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$0 to \$150 copay, depending on the service</li> </ul> <p><u>Diagnostic tests and procedures:</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$0 to \$25 copay, depending on the service</li> </ul> <p><u>Lab services:</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$0 copay</li> </ul> <p><u>Outpatient X-Rays:</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$0 copay</li> </ul> <p><u>Therapeutic radiology services (such as radiation treatment for cancer):</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$15 copay</li> </ul>

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	<b>KelseyCare Advantage Preferred (HMO)</b>
<b>Hearing Services</b> <sup>1,2</sup>	<p><u>Exam to diagnose and treat hearing and balance issues:</u></p> <ul style="list-style-type: none"> <li><u>In-Network:</u> \$15 copay</li> </ul> <p><u>Routine hearing exam:</u></p> <ul style="list-style-type: none"> <li><u>In-Network:</u> \$0 copay. You are covered for up to one (1) routine hearing exam each year.</li> </ul>
<b>Medicare-covered Dental Services</b> <sup>1,2</sup> (see the additional benefits section for other dental services available)	<p><u>Medicare covered dental services:</u> (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>\$0 copay</li> </ul>
<b>Vision Services</b>	<p><u>Routine eye exam and eyewear:</u></p> <p><u>In-Network only:</u></p> <ul style="list-style-type: none"> <li>\$0 copay for 1 routine vision exam every year</li> </ul> <p>\$50 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.</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>\$0 copay for each exam to diagnose and treat diseases of the eye</li> <li>\$0 copay for each annual glaucoma screening</li> </ul> <p><u>Eyeglasses or contact lenses after cataract surgery:</u></p> <ul style="list-style-type: none"> <li><u>In-Network:</u> \$0 copay</li> </ul>
<b>Mental Health Services</b> (including inpatient) <sup>1,2</sup>	<p><u>Inpatient visit:</u></p> <p>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.</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>\$300 copay per stay</li> <li>\$0 copay for lifetime reserve days (if available)</li> </ul> <p><u>Outpatient individual or group therapy visit:</u></p> <ul style="list-style-type: none"> <li><u>In-network:</u> \$20 copay</li> </ul>

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	<b>KelseyCare Advantage Preferred (HMO)</b>
<b>Skilled Nursing Facility (SNF)<sup>1,2</sup></b>	<p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1-20</li> <li>• \$100 copay per day for days 21-100</li> </ul>
<b>Physical Therapy<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$15 copay</li> </ul>
<b>Ambulance</b> <i>(Medicare-covered ground and air transportation services)</i>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$100 copay for each one-way trip</li> </ul>
<b>Transportation</b>	<ul style="list-style-type: none"> <li>• \$0 copay</li> </ul> <p>This plan covers up to 20 one-way trips to plan approved locations every year. Transportation is limited to medical appointments and medical facilities within the plan service area.</p>
<b>Medicare Part B Drugs<sup>1</sup></b>	<p><u>Part B chemotherapy drugs and other Part B drugs:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• 15% coinsurance</li> </ul>

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## Prescription Drug Benefits – Part D

### Initial Coverage Limit

You pay the following until your yearly out-of-pocket drug costs reach \$7,050. 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 Cost-Sharing

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	\$15 copay	\$30 copay	\$45 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$35 copay	\$70 copay	\$105 copay
Tier 4 (Non-Preferred Drug)	\$50 copay	\$100 copay	\$150 copay
Tier 5 (Specialty Tier)	\$80 copay	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

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

<b>Tier</b>	<b>30-day supply</b>	<b>60-day supply</b>	<b>90-day supply</b>
Tier 1 (Preferred Generic)	\$10 copay	\$20 copay	\$30 copay
Tier 2 (Generic)	\$15 copay	\$30 copay	\$45 copay
Tier 3 (Preferred Brand)	\$30 copay	\$60 copay	\$90 copay
Tier 4 (Non-Preferred Drug)	\$45 copay	\$90 copay	\$135 copay
Tier 5 (Specialty Tier)	\$75 copay	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

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 \$7,050, you pay the greater of:

- 5% of the plan's negotiated price, or
- \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs.

## Additional Medical Benefits

	KelseyCare Advantage Preferred (HMO)
<b>Acupuncture</b> <sup>1,2</sup>	<p>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.</p> <p><u>In network:</u></p> <ul style="list-style-type: none"> <li>• \$20 copay</li> </ul>
<b>Foot Care (podiatry services)</b> <sup>1,2</sup>	<p><u>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$15 copay</li> </ul>
<b>Meals</b> <sup>1</sup>	<p>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.</p>
<b>Medical Equipment/Supplies</b> (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) <sup>1</sup>	<p><u>Durable medical equipment:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• 10% coinsurance</li> </ul> <p><u>Diabetes monitoring supplies:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• You pay 20% coinsurance for lancets, lancet devices and control solutions.</li> </ul> <p><u>Therapeutic shoes or inserts and Prosthetic devices:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• 20% coinsurance</li> </ul>
<b>Wellness Programs</b> (e.g., fitness)	<p>You pay a \$0 copay for SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.</p>
<b>Chiropractic Care</b> <sup>1,2</sup>	<p><u>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$15 copay</li> </ul>
<b>Diabetes Self-Management Training</b> <sup>1,2</sup>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul>
<b>Home Health Care</b> <sup>1,2</sup>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul>

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	<b>KelseyCare Advantage Preferred (HMO)</b>
<b>Hospice</b>	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.
<b>Outpatient Substance Abuse<sup>1,2</sup></b>	<u>Individual or group therapy visit:</u> <u>In-Network:</u> <ul style="list-style-type: none"> <li>• \$20 copay</li> </ul>
<b>Surgery<sup>1,2</sup></b>	<u>In-Network:</u> <ul style="list-style-type: none"> <li>• \$175 copay at outpatient hospital</li> <li>• \$150 copay at ambulatory surgery center</li> </ul>
<b>Over-the-Counter Items (OTC)</b>	Not covered
<b>Renal Dialysis<sup>1,2</sup></b>	<u>In-Network:</u> <ul style="list-style-type: none"> <li>• 20% coinsurance</li> </ul>
<b>Telemedicine visits</b>	<p>E-Visits and Video Visits are a covered benefit for Kelsey-Seybold primary care and specialty physicians.</p> <u>In-Network:</u> <ul style="list-style-type: none"> <li>• PCP: Phone, E-Visits and Video Visits with a PCP: \$0 copay</li> <li>• Specialist: Specialty and Mental Health Phone, E-Visits and Video Visits: \$15 copay</li> </ul>
<b>Outpatient Rehabilitation<sup>1,2</sup></b>	<u>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):</u> <u>In-Network:</u> <ul style="list-style-type: none"> <li>• \$15 copay</li> </ul> <u>Occupational therapy:</u> <u>In-Network:</u> <ul style="list-style-type: none"> <li>• \$15 copay</li> </ul>

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This information is not a complete description of benefits. Call 1-866-535-8405 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.