# 2023 SUMMARY OF BENEFITS

KelseyCare Advantage

## Greater Houston Plan (Shell)

Dimensions
Your future. Your choice.

1-866-534-0556 (TTY: 711) | www.KelseyCareAdvantage.com/shell

# 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 713-442-7555 or toll-free at 1-866-534-0556 (TTY users can call 711).

## Understanding the Benefits

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| | 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/shell or call 1-866-534-0556 (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

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| | 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). |

## GENERAL PLAN INFORMATION

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| **Tips for comparing your Medicare choices** | This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Greater Houston Plan (Shell) (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*."<br><br>Tips for comparing your Medicare choices:<br><br>• 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.<br>• 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 Greater Houston Plan (Shell)<br>• Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services<br>• Covered Medical and Hospital Benefits<br>• Prescription Drug Benefits |
| **Hours of Operation** | • 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. |
| **Phone numbers and Website** | • If you are a member of this plan, call toll-free 1-866-534-0556 (TTY users can call 711).<br>• 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/shell |
| **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.<br><br>**Our service area includes the following counties in Texas:** Harris, Fort Bend, Montgomery, Galveston, Brazoria, Chambers, Liberty, Waller. |

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| **Which doctors and hospitals can I use?** | KelseyCare Advantage Greater Houston Plan (Shell) 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.<br>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.<br>You can see our plan's provider directory and pharmacy directory at our website (www.kelseycareadvantage.com/shell). 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.<br>**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.<br>Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.<br>We cover Part D drugs. We cover Part B drugs such as chemotherapy and some drugs administered by your provider.<br>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.kelseycareadvantage.com/shell). 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: Initial Coverage 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 Greater Houston Plan (Shell) (HMO) |
|---|---|
| **How much is the monthly premium?** | Please contact Shell Benefits Center for premium information.<br>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?**<br><br>(Maximum Out-of-Pocket Responsibility) | 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.<br>**Please note that you will still need to pay your monthly Part B premiums and cost sharing for your Part D prescription drugs.**<br><br>Your yearly limit(s) in this plan:<br>• $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. |
| **Inpatient Hospital Coverage**[1,2] | In-Network:<br>• $250 copay per stay |
| **Outpatient Hospital Coverage**[1,2] | In-Network:<br>• $250 copay |
| **Ambulatory Surgery Center (ASC)**[1,2] | In-Network:<br>• $225 copay |
| **Doctor Visits** (Primary Care Providers and Specialists)[1,2] | In-Network office visit:<br>• Primary care: $0 copay<br>• Specialist: $20 copay |

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

| | KelseyCare Advantage Greater Houston Plan (Shell) (HMO) |
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| **Preventive Care** | In-Network:<br>• $0 copay |
| | Preventive services include:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screening<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, hepatitis B shots, pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | $75 copay<br>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** | $35 copay |
| **Diagnostic Services, Labs, Imaging**[1,2] | Diagnostic radiology services (such as MRIs, CT scans):<br>• In-Network: $0 to $150 copay, depending on the service<br>Diagnostic tests and procedures:<br>• In-Network: $0 to $25 copay, depending on the service<br>Lab services:<br>• In-Network: $0 copay<br>Outpatient X-Rays:<br>• In-Network: $0 copay<br>Therapeutic radiology services (such as radiation treatment for cancer):<br>• In-Network: $50 copay |

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| | KelseyCare Advantage Greater Houston Plan (Shell) (HMO) |
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| **Hearing Services**[1,2] | Exam to diagnose and treat hearing and balance issues:<br>• In-Network: $20 copay<br>Routine hearing exam:<br>• In-Network: $20 copay. You are covered for up to one (1) routine hearing exam each year.<br>Hearing aid allowance:<br>• Our plan pays up to $500 allowance for non-implantable hearing aid(s) every year. You pay any amount over this plan-allowed amount. |
| **Medicare-covered Dental Services** [1,2] *(see the additional benefits section for other dental services available)* | Medicare covered dental services:<br>(this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):<br>In-Network:<br>• $20 copay |
| **Vision Services** | Routine eye exam<br>In-Network only:<br>• $0 copay for 1 routine vision exam every year<br>In-Network:<br>• $20 copay for each exam to diagnose and treat diseases of the eye<br>• $0 copay for each annual glaucoma screening<br>Eyeglasses or contact lenses after cataract surgery:<br>• In-Network: $0 copay |
| **Mental Health Services** (including inpatient)[1,2] | Inpatient visit:<br>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.<br>In-Network:<br>• $250 copay per stay<br>• $0 copay for lifetime reserve days (if available)<br>Outpatient individual or group therapy visit:<br>• In-network: $0 copay |

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| | KelseyCare Advantage Greater Houston Plan (Shell) (HMO) |
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| **Skilled Nursing Facility (SNF)**[1,2] | Our plan covers up to 100 days in a SNF per benefit period.<br>In-Network:<br>• $0 copay per day for days 1-20<br>$125 copay per day for days 21-100 |
| **Physical Therapy**[1,2] | In-Network:<br>• $20 copay |
| **Ambulance** (*Medicare-covered ground and air transportation services)* | In-Network:<br>• $100 copay for each one-way trip |
| **Transportation** | • $0 copay<br>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. |
| **Medicare Part B Drugs**[1] | Part B chemotherapy drugs and other Part B drugs:<br>In-Network:<br>• 20% coinsurance |

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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 $7,400. 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 (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 |
| Tier 4 (Non-Preferred Drug) | $90 copay | $180 copay | $270 copay |
| Tier 5 (Specialty Tier) | 31% coinsurance | 31% coinsurance | 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.

**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 |
| Tier 4 (Non-Preferred Drug) | $80 copay | $160 copay | $200 copay |
| Tier 5 (Specialty Tier) | 31% coinsurance | 31% coinsurance | 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.

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 $7,400, 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 Greater Houston Plan (Shell) (HMO) |
|---|---|
| **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.<br>In network:<br>• $20 copay |
| **Foot Care (podiatry services)**[1,2] | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>In-Network:<br>• $20 copay |
| **Medical Equipment/ Supplies** (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies)[1] | Durable medical equipment:<br>In-Network:<br>• 20% coinsurance<br>Diabetes monitoring supplies:<br>In-Network:<br>• You pay 0% coinsurance for lancets, lancet devices and control solutions.<br>Therapeutic shoes or inserts and Prosthetic devices:<br>In-Network:<br>• 20% 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):<br>In-Network:<br>• $20 copay |
| **Diabetes Self-Management Training**[1,2] | In-Network:<br>• $0 copay |
| **Home Health Care**[1,2] | In-Network:<br>• $10 copay |

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| | KelseyCare Advantage Greater Houston Plan (Shell) (HMO) |
|---|---|
| **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:<br>In-Network:<br>• $0 copay |
| **Surgery**[1,2] | In-Network:<br>• $250 copay at outpatient hospital<br>• $225 copay at ambulatory surgery center |
| **Over-the-Counter Items (OTC)** | Not covered |
| **Renal Dialysis**[1,2] | In-Network:<br>• $25 copay |
| **Telemedicine visits** | E-Visits and Video Visits are a covered benefit for Kelsey-Seybold primary care and specialty physicians.<br>In-Network:<br>• PCP: Phone, E-Visits and Video Visits with a PCP: $0 copay<br>• Specialist: Specialty and Mental Health Phone, E-Visits and Video Visits: $15 copay |
| **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):<br>In-Network:<br>• $20 copay<br>Occupational therapy:<br>In-Network:<br>• $20 copay |
| **Private Duty Nursing** | • $0 copay<br>There is a $5,000 limit per plan year for private duty nursing services. Once the plan has paid $5,000 in a plan year, you are responsible to pay all charges for the remainder of the plan year. |

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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 (TTY: 711). Alguien que hable español puede ayudarte. Este es un servicio gratuito.

我們提供免費的口譯服務，以回答您對我們的健康或藥物計劃的任何問題。 要獲得口譯員，請致電1-866-535-8343（TTY：711）與我們聯繫。會說中文的人可以說明你。 這是一項免費服務。

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 (TTY: 711). 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 (TTY : 711). 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 (TTY: 711). 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 (TTY: 711) an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dies ist ein kostenloser Service.

우리는 당신이 우리의 건강 또는 약물 계획에 대해 가질 수 있는 질문에 대답 할 수있는 무료 통역사 서비스를 제공합니다. 통역사를 얻으려면 1-866-535-8343 (TTY : 711)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 (TTY: 711). 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: 711). 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 (TTY: 711). 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 (TTY: 711). 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 (TTY: 711). Yon moun ki pale kreyòl ayisyen kapab ede w. Sa a se yon sèvis gratis.

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 (TTY: 711). 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 (TTY: 711). 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 (TTY: 711) 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(TTY:711)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 1-866-534-0556 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.