2021
Summary of Benefits

Essential (HMO)
Essential+Choice (HMO-POS)


Toll-free 1-866-534-8343, TTY 711


www.kelseycareadvantage.com

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-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.

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 Essential+Choice (HMO-POS) plan.
	The KelseyCare Advantage Essential+Choice 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 and to bill KelseyCare Advantage. 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

<table>
<tr><td>Tips for comparing your Medicare choices</td><td colspan="2">This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Essential (HMO) and KelseyCare Advantage Essential+Choice (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/TDD users should call 1-877-486-2048.</td></tr>
<tr><td>Sections in this book</td><td colspan="2">• Things to know about KelseyCare Advantage Essential (HMO) and KelseyCare Advantage Essential+Choice (HMO-POS)
• Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services
• Covered Medical and Hospital Benefits</td></tr>
<tr><td>Hours of Operation</td><td colspan="2">• From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
• From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.</td></tr>
<tr><td>Phone numbers and Website</td><td colspan="2">• If you are a member of this plan, call 713-442-CARE (2273) or toll-free at 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</td></tr>
<tr><td>Who Can Join?</td><td colspan="2">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 and Galveston (excluding the island).</td></tr>
<tr><td>Which doctors and hospitals can I use?</td><td>Essential Plan:
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.</td><td>Essential+Choice Plan:
Has a network of doctors, hospitals, and other providers. For some services you can use providers that are not in our network.</td></tr>
<tr><td colspan="3">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.</td></tr>
</table>

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 B drugs such as chemotherapy and some drugs administered by your provider. These plans do not cover Part D prescription drugs.

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

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

<table>
<tr><th></th><th>Essential (HMO)</th><th>Essential+Choice (HMO-POS)</th></tr>
<tr><td rowspan="2">How much is the monthly premium?</td><td>$0 per month.
KelseyCare Advantage will reduce your Medicare Part B premium by up to $10 per month.</td><td>$0 per month.</td></tr>
<tr><td colspan="2">In addition, you must keep paying your Medicare Part B premium.</td></tr>
<tr><td>How much is the deductible?</td><td colspan="2">This plan does not have a medical deductible.</td></tr>
<tr><td rowspan="2">Is there any limit on how much I will pay for my covered services?

(Maximum Out-of-Pocket Responsibility)</td><td colspan="2">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.</td></tr>
<tr><td>Your yearly limit(s) in this plan:
$3,450 for services you receive from in-network providers.</td><td>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.</td></tr>
<tr><td>Is there a limit on how much the plan will pay?</td><td colspan="2">Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</td></tr>
</table>

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

	Essential (HMO)	Essential+Choice (HMO-POS)
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. • $150 copay per day for days 1-4 • $600 maximum • $0 copay for days 5-90 • $0 per day for lifetime reserve days (if available)	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. In-network: • $150 copay per day for days 1-4 • $600 maximum • $0 copay for days 5-90 • $0 per day for lifetime reserve days (if available) Out-of-network: • You pay $1,000 copay per benefit period for days 1-60 • $250 copay per day for days 61-90 • $500 copay per day for days 91-150
Outpatient Hospital Coverage [1,2]	• $250 copay	• $250 copay Out-of-network: • 20% coinsurance for all Medicare-covered outpatient hospital services
Ambulatory Surgery Center (ASC) [1,2]	• $225 copay	• $225 copay Out-of-Network • 20% coinsurance for all Medicare-covered ASC services

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<table>
<tr><th></th><th>Essential (HMO)</th><th>Essential+Choice (HMO-POS)</th></tr>
<tr><td>Doctor Visits
(Primary Care Providers and Specialists) [1,2]</td><td><u>Office visit:</u>
• Primary care visit: $0 copay
• Specialist visit: $20 copay</td><td><u>In-network office visit</u>
• Primary care visit: $0 copay
• Specialist visit: $20 copay

<u>Out-of-network office visit</u>:
• Primary care visit: 50% of the cost
• Specialist visit: 20% of the cost</td></tr>
<tr><td rowspan="2">Preventive Care[1]</td><td>• $0 copay</td><td>• In-network: $0 copay
• Out-of-network: 50% of the cost</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Emergency Care</td><td colspan="2">$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.</td></tr>
<tr><td>Urgently Needed Services</td><td colspan="2">$25 copay</td></tr>
</table>

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

	Essential (HMO)	Essential+Choice (HMO-POS)
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): • $50 copay	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $0-$150 copay, depending on the service • Out-of-network: 20% of the cost Diagnostic tests and procedures: • In-network: $0-$25 copay, depending on the service • Out-of-network: 20% of the cost Lab services: • In-network: $0 copay • Out-of-network: 20% of the cost Outpatient X-Rays: • In-network: $0 copay • Out-of-network: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $50 copay • Out-of-network: 20% of the cost
Hearing Services [1,2]	Exam to diagnose and treat hearing and balance issues: • $20 copay Routine hearing exam: • $0 copay. You are covered for up to 1 every year. Hearing aid allowance: Our plan pays up to $750 per ear every 3 years for hearing aids. You pay any amount over this plan allowed amount. Replacement batteries are not covered.	Exam to diagnose and treat hearing and balance issues: • In-network: $20 copay • Out-of-network: 20% of the cost Routine hearing exam (In-network only): • In-network: $0 copay. You are covered for up to 1 every year. Hearing aid allowance: Our plan pays up to $750 per ear every 3 years for hearing aids. You pay any amount over this plan allowed amount. Replacement batteries are not covered.

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	Essential (HMO)	Essential+Choice (HMO-POS)
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): • $20 copay	Medicare covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-Network: • $20 copay Out-of-Network: • 50% coinsurance for Medicare covered dental services
Preventive Dental Services	Preventive dental services: • $25 copay per visit Cleaning: 1 every six months Dental X-ray(s): 1 per year Oral Exam: 1 every six months	Preventive dental services: In-network • $25 copay per visit Cleaning: 1 every six months Dental X-ray(s): 1 per year Oral Exam: 1 every six months Out-of-network: • Not covered
Optional Dental Services (Comprehensive) (applicable only if purchased)	You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $32.80.	You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $32.80.
	Coverage Description: Annual Maximum - $3,000 Annual Deductible - $25 Basic Services (Type II) – You pay 20% Major Services (Type III) – You pay 50% *Waiting period – For all Type III services there is a 12-month waiting period.*	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	
	• $20 copay Routine eye exam: • $0 copay for 1 routine eye exam every year • $75 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	• In-network: $20 copay • Out-of-network: 20% of the cost Routine eye exam (In-network only): • $0 copay for 1 routine eye exam every year • $75 allowance every year for contact lenses or eyeglasses. Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay for eyeglasses or contact lenses after cataract surgery

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<table>
<tr><th></th><th>Essential (HMO)</th><th>Essential+Choice (HMO-POS)</th></tr>
<tr><td></td><td></td><td>• Out-of-network: 50% of the cost up to the Medicare allowed rate.</td></tr>
<tr><td rowspan="3">Mental Health Services (including inpatient) [1,2]</td><td colspan="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.</td></tr>
<tr><td>• $150 copay per day for days 1-4
• $600 maximum
• $0 copay for days 5-90
• $0 per day for lifetime reserve days (if available)

Outpatient individual or group therapy visit:
• $20 copay</td><td>In-network:
• $150 copay per day for days 1-4
• $600 maximum
• $0 copay for days 5-90
• $0 per day for lifetime reserve days (if available)

Out-of-network:
• $1,000 copay per stay per benefit period for days 1-60
• $250 copay per day for days 61-90
• $500 copay per day for days 91-150

Outpatient or individual group therapy visit:
• In-network: $20 copay
• Out-of-network: 50% of the cost</td></tr>
</table>

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	Essential (HMO)	Essential+Choice (HMO-POS)
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 • $125 copay per day for days 21-100	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% of the cost per stay
Physical Therapy [1,2]	• $10 copay per visit	In-Network: • $10 copay per visit Out-of-Network: • 50% of the cost
Ambulance (*Medicare-covered ground and air transportation services)*	• $200 copay for each one-way trip	In-network: $200 copay for each one-way trip Out-of-network: *50% of the cost *Applies to non-emergency ambulance services
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.	
Medicare Part B Drugs [1]	Part B chemotherapy drugs and other Part B drugs: • 20% of the cost	Part B chemotherapy drugs and other Part B drugs: In-network and out-of-network: • 20% of the cost

Services with a [1] may require prior authorization.
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Additional Medical Benefits

	Essential (HMO)	Essential+Choice (HMO-POS)
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	In network: • $20 copay per visit Out-of-network: • 20% of the cost
Foot Care (podiatry services) [1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:	
	• $20 copay	In-network: • $20 copay Out-of-network: • 20% of the cost
Medical Equipment/ Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) [1]	• 20% of the cost Diabetes monitoring supplies: • You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay nothing for lancets, lancet devices and control solutions. • Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered. Therapeutic shoes or inserts and Prosthetic devices: • 20% of the cost Continuous Glucose Monitors – Preferred Brands: Dexcom and Freestyle Libre • 20% of the cost at DME vendor • 15% of the cost at a Pharmacy • Non-preferred brands not covered	• In-network: 20% of the cost • Out-of-network: 50% of the cost Diabetes monitoring supplies: • You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay nothing 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% of the cost (even if preferred brands are used) Therapeutic shoes or inserts and Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 50% of the cost Continuous Glucose Monitors – Preferred Brands: Dexcom and Freestyle Libre • 20% of the cost at DME vendor • 15% of the cost at a Pharmacy • Non-preferred brands not covered • Out-of-network: Not covered

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

	Essential (HMO)	Essential+Choice (HMO-POS)
Wellness Programs (e.g., fitness)	SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes. You pay nothing.	
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): • $20 copay	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: 20% of the cost
Diabetes Self-Management Training 1,2	Diabetes self-management training: $0 copay	Diabetes self-management training: • In-network: $0 copay • Out-of-network: 50% of the cost
Home Health Care 1,2	• $10 copay	• In-network: $10 copay • Out-of-network: 50% of the cost
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	Individual or group therapy visit: • In-network: $20 copay • Out-of-network: 50% of the cost
Outpatient Surgery[1,2]	Outpatient hospital: • $250 copay	Outpatient hospital: • In-network: $250 copay • Out-of- network: 20% of the cost
Ambulatory Surgery Center[1,2]	• $225 copay	• In-network: $225 copay • Out-of-network: 20% of the cost
Over-the-Counter Items (OTC)	Up to $25 allowance every three months for the purchase of select OTC supplies from select pharmacy locations.	

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	Essential (HMO)	Essential+Choice (HMO-POS)
Renal Dialysis 1,2	• 20% of the cost	• In-network: 20% of the cost • Out-of-network: *50% of the cost *Applies to out-of-network renal dialysis in the service area
Telemedicine visits	E-Visits and Video Visits are covered benefit for Kelsey-Seybold primary care and specialty physicians.	
	E-Visits / Video Visits / Phone Visits • PCP $0 • Specialist $15	E-Visits / Video Visits / Phone Visits • PCP $0 • Specialist $15 Out-of-Network: • Not covered
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):	
	• $20 copay Occupational therapy visit: • $10 copay	• In-network: $20 copay • Out-of-network: 50% of the cost Occupational therapy visit: • In-network: $10 copay • Out-of-network: 50% of the cost

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KelseyCare Advantage

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.