KelseyCare Advantage

2022 Annual Notice of Changes

713-442-2COH (2264) (TTY: 711) www.KelseyCareAdvantage.com

KelseyCare Advantage Preferred (HMO) offered by KS Plan Administrators, LLC

Annual Notice of Changes for 2022

You are currently enrolled as a member of KelseyCare Advantage Preferred. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051
(Expires: February 29, 2024)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 713-442-2COH (2264) or toll-free at 1-866-535-8405 for additional information. (TTY users should call 711.) 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.
- This booklet is also available in braille, large print and other alternate formats. Please call Member Services (phone numbers are in Section 6.1 of this booklet) for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About KelseyCare Advantage Preferred

- KelseyCare Advantage is offered by KS Plan Administrators, LLC, an HMO with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means KS Plan Administrators, LLC (dba KelseyCare Advantage). When it says "plan" or "our plan," it means KelseyCare Advantage Preferred.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for KelseyCare Advantage Preferred in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.kelseycareadvantage.com/COH. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$42	$42
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,400	$3,400
Doctor office visits	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-Network:** For Medicare-covered hospital stays: $300 copay per stay	**In-Network:** For Medicare-covered hospital stays: $300 copay per stay There is no limit to the number of days covered. Inpatient hospital stays with a confirmed COVID-19 diagnosis will have the $300 cost-share waived.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.) (cost for a 30-day supply) If you have questions about the Drug List, you can call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).	**Deductible:** $0 **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost-sharing:* $15 copay *Preferred cost-sharing:* $10 copay **Drug Tier 2:** *Standard cost-sharing:* $20 copay *Preferred cost-sharing:* $15 copay **Drug Tier 3:** *Standard cost-sharing:* $35 copay *Preferred cost-sharing:* $30 copay **Drug Tier 4:** *Standard cost-sharing:* $50 copay *Preferred cost-sharing:* $45 copay **Drug Tier 5:** *Standard cost-sharing:* $80 copay *Preferred cost-sharing:* $75 copay	**Deductible:** $0 **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost-sharing:* $15 copay *Preferred cost-sharing:* $10 copay **Drug Tier 2:** *Standard cost-sharing:* $20 copay *Preferred cost-sharing:* $15 copay **Drug Tier 3:** *Standard cost-sharing:* $35 copay *Preferred cost-sharing:* $30 copay **Drug Tier 4:** *Standard cost-sharing:* $50 copay *Preferred cost-sharing:* $45 copay **Drug Tier 5:** *Standard cost-sharing:* $80 copay *Preferred cost-sharing:* $75 copay

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$42	$42

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.kelseycareadvantage.com/COH. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.kelseycareadvantage.com/COH. You may also call Member Services for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Inpatient Hospital Care	**In-Network:** For Medicare-covered hospital stays: You pay a $300 copay per stay	**In-Network:** For Medicare-covered hospital stays: You pay a $300 copay per stay. There is no limit to the number of days covered. Inpatient hospital stays with a confirmed COVID-19 diagnosis will have the $300 cost-share waived.
Meal Benefit	**In-Network:** Not Covered	**In-Network:** 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. Prior authorization is required.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are granted a formulary exception, you will receive an approval letter telling you the date when the exception will expire. You do not need to make a new request until that date has passed.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.kelseycareadvantage.com/COH. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $10 copay per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $20 copay per prescription. *Preferred cost sharing:* You pay $15 copay per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $35 copay per prescription. *Preferred cost sharing:* You pay $30 copay per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $10 copay per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $20 copay per prescription. *Preferred cost sharing:* You pay $15 copay per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $35 copay per prescription. *Preferred cost sharing:* You pay $30 copay per prescription.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (Continued)	**Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $50 copay per prescription. *Preferred cost sharing:* You pay $45 copay per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay $80 copay. *Preferred cost sharing:* You pay $75 copay. Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	**Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $50 copay per prescription. *Preferred cost sharing:* You pay $45 copay per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay $80 copay. *Preferred cost sharing:* You pay $75 copay. Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage does not apply to you. The other drug coverage stage – the Catastrophic Coverage Stage – is for people with high drug costs. **Most members do not reach the Catastrophic Coverage Stage**. For information about your costs in this stage, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in KelseyCare Advantage Preferred

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically be enrolled in our KelseyCare Advantage Preferred plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year; if you want to change for 2022 please contact the City of Houston Benefits Department.

SECTION 3 Deadline for Changing Plans

If you want to change plans, please contact the City of Houston Benefits Department during open enrollment period. You may also change plans monthly throughout the year.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Texas, the SHIP is called Health Information Counseling and Advocacy Program (HICAP).

Health Information Counseling and Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Information Counseling and Advocacy Program (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Health Information Counseling and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about Health Information Counseling and Advocacy Program (HICAP) by visiting their website (https://www.tdi.texas.gov/consumer/hicap).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas Kidney Health Care Program (KHC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090.

SECTION 6 Questions?

Section 6.1 – Getting Help from KelseyCare Advantage Preferred

Questions? We're here to help. Please call Member Services at 713-442-2COH (2264) or toll-free at 1-866-535-8405. (TTY only, call 711.) We are available for phone calls 8:00 a.m. to 8:00 p.m. Monday through Friday, local time. Messaging service used weekends, after hours, and on federal holidays.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for KelseyCare Advantage Preferred. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.kelseycareadvantage.com/COH. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.kelseycareadvantage.com/COH. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Method	KelseyCare Advantage Member Services - Contact Information	
Call	**713-442-2COH (2264)** Calls to this number are free. 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. Member Services also has free language interpreter services available for non-English speakers.	
TTY	**711** Calls to this number are free. 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.	
Fax	713-442-5450	
Write	KelseyCare Advantage ATTN: Member Services 11511 Shadow Creek Parkway Pearland, TX 77584	- OR – KelseyCare Advantage ATTN: Member Services P.O. Box 841569 Pearland, TX 77584-9832
Website	www.kelseycareadvantage.com/COH	

Health Information Counseling and Advocacy Program (HICAP)

Health Information Counseling and Advocacy Program (HICAP) is a state program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare.

METHOD	Health Information Counseling and Advocacy Program (HICAP) (Texas' SHIP) - Contact Information
CALL	1-800-252-9240
TTY	1-800-735-2989 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	701 West 51st Street MC: W352 Austin, TX 78751
Website	https://www.tdi.texas.gov/consumer/hicap

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