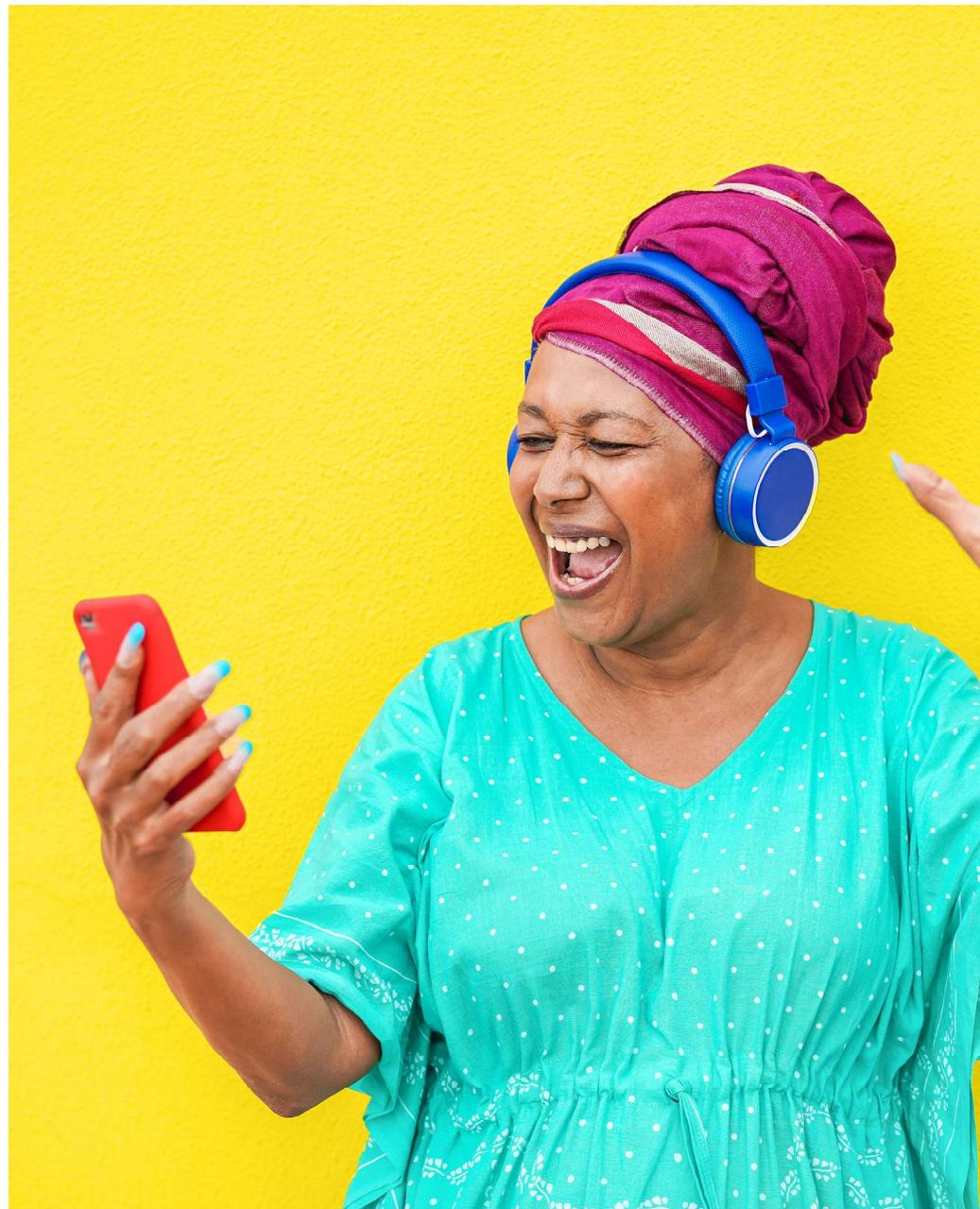
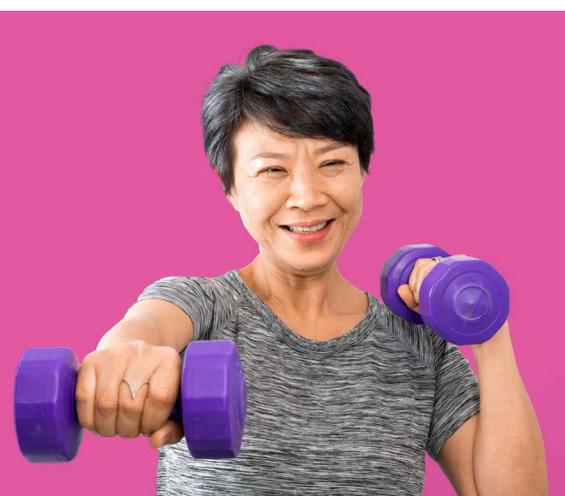


# 2022 SUMMARY OF BENEFITS



## 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 <i>Evidence of Coverage (EOC)</i> , especially for those services that you routinely see a doctor. Visit <a href="http://www.kelseycareadvantage.com">www.kelseycareadvantage.com</a> or call 1-866-535-8343 (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), unless you are enrolled in the KelseyCare Advantage Gold Community plan.
	The KelseyCare Advantage Gold Community 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. 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

<p><b>Tips for comparing your Medicare choices</b></p>	<p>This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Gold Community (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 “<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>
<p><b>Sections in this book</b></p>	<ul style="list-style-type: none"> <li>• Things to know about KelseyCare Advantage Gold Community</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>
<p><b>Hours of Operation</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<p><b>Phone numbers and Website</b></p>	<ul style="list-style-type: none"> <li>• If you are a member of this plan, call toll-free 1-866-535-8343 (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">www.kelseycareadvantage.com</a></li> </ul>
<p><b>Who Can Join?</b></p>	<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> Austin, Chambers, Grimes, Liberty, San Jacinto, Walker, Waller and Wharton.</p>

<p><b>Which doctors and hospitals can I use?</b></p>	<p>KelseyCare Advantage Gold Community has a network of doctors, hospitals, and other providers. <i>For some services you can use providers that are not in our network.</i></p>
<p>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.</p>	
<p><b>Which pharmacies can I use?</b></p>	<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">www.kelseycareadvantage.com</a>). Or, call us at the phone numbers above, and we will send you a copy of the provider and pharmacy directories.</p>
<p><b>What do we cover?</b></p>	<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">www.kelseycareadvantage.com</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>
<p><b>How will I determine my drug costs?</b></p>	<p>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 after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.</p>

# Summary of Benefits

January 1, 2022 – December 31, 2022

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

	KelseyCare Advantage Gold Community (HMO-POS)
<b>How much is the monthly premium?</b>	\$15 per month. In addition, you must continue to keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	\$500 deductible for Point-of-Service covered medical services.
<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>• \$3,450 for services you receive from In-Network providers.</li> <li>• \$10,000 for services you receive from Out-of-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>	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. <u>In-Network:</u> <ul style="list-style-type: none"> <li>• \$375 copay per stay (waived with a COVID-19 diagnosis)</li> <li>• \$0 copay per day for lifetime reserve days (if available)</li> </ul> <u>Out-of-network:</u> <ul style="list-style-type: none"> <li>• 40% coinsurance 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>• \$300 copay</li> </ul> <u>Out-of-Network:</u> <ul style="list-style-type: none"> <li>• 30% coinsurance</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.

<b>KelseyCare Advantage Gold Community (HMO-POS)</b>	
<b>Ambulatory Surgery Center (ASC)<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$225 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance</li> </ul>
<b>Doctor Visits (Primary Care Providers and Specialists)<sup>1,2</sup></b>	<p><u>In-Network office visit:</u></p> <ul style="list-style-type: none"> <li>• Primary care: \$0 copay</li> <li>• Specialist: \$25 copay</li> </ul> <p><u>Out-of-Network office visit:</u></p> <ul style="list-style-type: none"> <li>• Primary care: 50% coinsurance</li> <li>• Specialist: 30% coinsurance</li> </ul>
<b>Preventive Care</b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</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>

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

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

<b>KelseyCare Advantage Gold Community (HMO-POS)</b>	
<b>Urgently Needed Services</b>	\$25 copay
<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> <li>• <u>Out-of-Network:</u> 30% coinsurance</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> <li>• <u>Out-of-Network:</u> 30% coinsurance</li> </ul> <p><u>Lab services:</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$0 copay</li> <li>• <u>Out-of-Network:</u> 30% coinsurance</li> </ul> <p><u>Outpatient X-Rays:</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$0 copay</li> <li>• <u>Out-of-Network:</u> 30% coinsurance</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> \$50 copay</li> <li>• <u>Out-of-Network:</u> 30% coinsurance</li> </ul>
<b>Hearing Services<sup>1,2</sup></b>	<p><u>Exam to diagnose and treat hearing and balance issues:</u></p> <ul style="list-style-type: none"> <li>• <u>In-Network:</u> \$25 copay</li> <li>• <u>Out-of-Network:</u> 30% coinsurance</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 1 routine hearing exam every year.</li> </ul> <p><u>Hearing aid allowance:</u></p> <ul style="list-style-type: none"> <li>• Our plan pays up to \$750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan-allowed amount.</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.

<b>KelseyCare Advantage Gold Community (HMO-POS)</b>	
<b>Medicare-covered Dental Services</b> <sup>1,2</sup> <i>(see the additional benefits section for other dental services available)</i>	<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>• \$25 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</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>\$75 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>• \$25 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>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance for each exam to diagnose and treat diseases of the eye</li> <li>• 50% coinsurance 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> <li>• <u>Out-of-Network:</u> 50% coinsurance up to the Medicare allowed rate</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>• \$375 copay per stay</li> <li>• \$0 copay per day for lifetime reserve days (if available)</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 40% coinsurance per stay</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> <li>• <u>Out-of-Network:</u> 50% coinsurance</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.

<b>KelseyCare Advantage Gold Community (HMO-POS)</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>• \$125 copay per day for days 21-100</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance per stay</li> </ul>
<b>Physical Therapy<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$10 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</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>• \$225 copay for each one-way trip</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for each one-way trip</li> </ul>
<b>Transportation</b>	Not covered
<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>• 20% coinsurance</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance</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.

## Prescription Drug Benefits – Part D

### Initial Coverage Limit

You will pay a yearly deductible of \$100 on Tiers 3, 4, and 5 drugs. You must pay the full cost of your Tiers 3, 4, and 5 drugs until you reach the plan's deductible amount. There is no deductible for Select Insulins. During the Deductible Stage, your out-of-pocket costs for these Select Insulins will be \$30 - \$35 copay for a 30-day supply. After you pay your yearly deductible, you pay the following until your total yearly drug cost reach \$4,430. Total yearly drug costs are the total drug cost paid by both you and our Part D plan.

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)	\$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
(Select Insulins*)	\$35 copay	\$70 copay	\$105 copay
Tier 4 (Non-Preferred Drug)	\$90 copay	\$180 copay	\$270 copay
Tier 5 (Specialty Tier)	31% coinsurance	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

*\*Select Insulins in Tier 3 are covered under the plan's participation in the Part D Senior Savings Model Calendar Year 2022. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services.*

## 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
(Select Insulins*)	\$30 copay	\$60 copay	\$75 copay
Tier 4 (Non-Preferred Drug)	\$80 copay	\$160 copay	\$200 copay
Tier 5 (Specialty Tier)	31% coinsurance	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

*\*Select Insulins in Tier 3 are covered under the plan's participation in the Part D Senior Savings Model Calendar Year 2022. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services.*

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.

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430.

After you enter the coverage gap, you pay 25% of the plan’s negotiated price for covered brand name drugs and 25% of the plan’s negotiated price for covered generic drugs until your out-of-pocket costs total \$7,050, which is the end of the coverage gap. KelseyCare Advantage offers additional gap coverage for Tier 1 and Tier 2 drugs and Select Insulins. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.

### Standard Retail Cost-Sharing (Coverage Gap)

Tier	Drugs Covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	All	\$3 copay	\$6 copay	\$9 copay
Tier 2 (Generic)	All	\$15 copay	\$30 copay	\$45 copay
(Select Insulins)	Varies	\$35 copay	\$70 copay	\$105 copay

### Preferred Retail and Mail Order Cost-Sharing (Coverage Gap)

Tier	Drugs Covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	All	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	All	\$0 copay	\$0 copay	\$0 copay
(Select Insulins)	Varies	\$30 copay	\$60 copay	\$75 copay

### 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 Prescription Drug Benefits

As part of the plan's enhanced drug coverage for Calendar Year 2022, the excluded drug Sildenafil in Tier 2 is covered. Payments you make for excluded drugs are not included in your out-of-pocket costs.

## Additional Medical Benefits

	<b>KelseyCare Advantage Gold Community (HMO-POS)</b>
<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> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance</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>• \$25 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance</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>• 20% coinsurance</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% 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 0% coinsurance for meters and test strips, if you use a preferred brand (Roche and LifeScan).</li> <li>• You pay 0% coinsurance for lancets, lancet devices and control solutions.</li> <li>• Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance (even if preferred brands are used)</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.

	<b>KelseyCare Advantage Gold Community (HMO-POS)</b>
<b>Medical Equipment/Supplies (Continued)</b>	<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> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</li> </ul> <p><u>Continuous Glucose Monitors – Preferred Brands: Dexcom and FreeStyle Libre:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• Continuous blood glucose monitors 15% at retail pharmacy and 20% at DME vendor. All other DME is 20% coinsurance. Preferred continuous blood glucose monitors are Dexcom and FreeStyle Libre, all other CGMs are excluded.</li> <li>• Non-preferred brands not covered</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<b>Wellness Programs (e.g., fitness)</b>	You pay a \$0 copay for SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.
<b>Chiropractic Care<sup>1,2</sup></b>	<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>• \$20 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance</li> </ul>
<b>Diabetes Self-Management Training<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</li> </ul>
<b>Home Health Care<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$10 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</li> </ul>
<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.

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

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

<b>KelseyCare Advantage Gold Community (HMO-POS)</b>	
<b>Outpatient Substance Abuse<sup>1,2</sup></b>	<p><u>Individual or group therapy visit:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$20 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</li> </ul>
<b>Surgery<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$300 copay at outpatient hospital</li> <li>• \$225 copay at ambulatory surgery center</li> </ul> <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> <li>• 30% coinsurance</li> </ul>
<b>Over-the-Counter Items (OTC)</b>	You receive up to \$25 every three months that can be used to purchase eligible items from participating locations or through the plan's catalog for delivery to your home.
<b>Renal Dialysis<sup>1,2</sup></b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• 20% coinsurance</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% 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> <p><u>In-Network:</u></p> <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> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• Not covered</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.

<b>KelseyCare Advantage Gold Community (HMO-POS)</b>	
<b>Outpatient Rehabilitation</b> <sup>1,2</sup>	<p><u>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$25 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</li> </ul> <p><u>Occupational therapy:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$10 copay</li> </ul> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• 50% coinsurance</li> </ul>
<b>Preventive Dental Services</b>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> <li>• \$25 copay per visit</li> </ul> <p><u>Periodic Oral Evaluation:</u> 1 every 6 months  <u>Comprehensive Oral Evaluation:</u> 1 every 36 months  <u>Intraoral–Complete Series of Radiographic Images:</u> 1 every 36 months  <u>Bitewings – two films OR four films:</u> 1 every 12 months  <u>Cleaning:</u> 1 every 6 months</p> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> <li>• <u>Not covered</u></li> </ul>
<b>Optional Dental Services</b> (applicable only if purchased)	<p>You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of \$32.80.</p> <p><u>Coverage Description:</u></p> <p>Annual Maximum – \$3,000  Annual Deductible – \$25  Basic Services (Type II) – You pay 20%  Major Services (Type III) – You pay 50%</p>

Services with a <sup>1</sup> may require prior authorization.  
Services with a <sup>2</sup> may require a referral from your doctor.



This information is not a complete description of benefits. Call 1-866-535-8343 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.