2023 Annual Notice of Change

KelseyCare Advantage Gold Freedom (HMO-POS) offered by KS Plan Administrators, LLC

Annual Notice of Changes for 2023

You are currently enrolled as a member of KelseyCare Advantage Gold Freedom. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.kelseycareadvantage.com. (You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2022, you will stay in KelseyCare Advantage Gold Freedom.
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with KelseyCare Advantage Gold Freedom.
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 713-442-CARE (2273) or toll-free at 1-866-535-8343 for additional information. (TTY users should call 711.) 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.
- This document is also available in braille, large print and other alternate formats. Please call Member Services (phone numbers are in Section 7.1 of this document) 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 Gold Freedom

- 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 document 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 Gold Freedom.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for KelseyCare Advantage Gold Freedom in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* *Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum in-network out-of-pocket amount This is the most you will pay out-of-pocket for your in-network covered Part A and Part B services. (See Section 1.2 for details.)	$3,450	$3,450
Maximum out-of-network Point of Service (POS) out-of-pocket amount This is the most you will pay out-of-pocket for your out-of-network covered Part A and Part B services received through the POS benefit. (See Section 1.2 for details.)	$10,000	$10,000

Cost	2022 (this year)	2023 (next year)
Doctor office visits	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit **Out-of-Network:** Primary care visits: $10 copay per visit Specialist visits*: $35 copay *40% coinsurance for each MD Anderson provider visit	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit **Out-of-Network:** Primary care visits: $10 copay per visit Specialist visits*: $35 copay *40% coinsurance for each MD Anderson provider visit
Inpatient hospital stays	**In-Network:** For Medicare-covered hospital stays: $375 copay per stay 60 lifetime reserve days are covered for $0 copay per day. Acute inpatient hospital stays with a confirmed COVID-19 diagnosis will have the $375 acute inpatient cost-share waived.	**In-Network:** For Medicare-covered hospital stays: $375 copay per stay 60 lifetime reserve days are covered for $0 copay per day. Acute inpatient hospital stays with a confirmed COVID-19 diagnosis will have the $375 acute inpatient cost-share waived.

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays (continued)	**<u>Out-of-Network:</u>** For Medicare-covered hospital stays: 40% coinsurance per stay	**<u>Out-of-Network:</u>** For Medicare-covered hospital stays: 40% coinsurance per stay
Part D prescription drug coverage (See Section 1.5 for details.) (cost for a 30-day supply)	**Deductible:** $100 Deductible only applies to drug Tiers 3, 4, and 5. **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost sharing:* $3 copay *Preferred cost sharing:* $0 copay **Drug Tier 2:** *Standard cost sharing:* $15 copay *Preferred cost sharing:* $0 copay	**Deductible:** $100 Deductible only applies to drug Tiers 3, 4, and 5. **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost sharing:* $3 copay *Preferred cost sharing:* $0 copay **Drug Tier 2:** *Standard cost sharing:* $15 copay *Preferred cost sharing:* $0 copay

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (continued)	**Drug Tier 3:** *Standard cost sharing:* $45 copay *Preferred cost sharing:* $40 copay **Drug Tier 4:** *Standard cost sharing:* $90 copay *Preferred cost sharing:* $80 copay **Drug Tier 5:** *Standard cost sharing:* 31% coinsurance *Preferred cost sharing:* 31% coinsurance **Drug Tier 6:** Not covered	**Drug Tier 3:** *Standard cost sharing:* $45 copay *Preferred cost sharing:* $40 copay **Drug Tier 4:** *Standard cost sharing:* $90 copay *Preferred cost sharing:* $80 copay **Drug Tier 5:** *Standard cost sharing:* 31% coinsurance *Preferred cost sharing:* 31% coinsurance **Drug Tier 6:** *Standard cost sharing:* $0 copay *Preferred cost sharing:* $0 copay

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0 There is no change for the upcoming benefit year.

- 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.

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (next year)
Maximum in-network out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum in-network out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,450	$3,450 Once you have paid $3,450 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. There is no change for the upcoming benefit year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-network Point of Service (POS) out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-network POS out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered out-of-network Part A and Part B services, you will pay nothing for your covered out-of-network Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.kelseycareadvantage.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Dental Services (Non-Medicare-covered Comprehensive)	**In-Network** You pay 50% coinsurance for each non-routine services visit: • Palliative (emergency) Treatment of Dental Pain (D9110): 1 visit per year	**In-Network** You pay 50% coinsurance for each non-routine services visit: • Palliative (emergency) Treatment of Dental Pain (D9110): unlimited visits up to the maximum annual benefit
	Endodontics services visits are not covered.	You pay 50% coinsurance for each endodontics services visit: • End therapy 1 per lifetime • All other endodontics unlimited up to the maximum annual benefit
	You pay 50% coinsurance for each periodontics services visit: • Unlimited number of visits	You pay 50% coinsurance for each periodontics services visit: • Non-Surgical Periodontal Service 1 every 12 months • Periodontal Maintenance 1 every 6 months
	$1,500 annual benefit maximum for comprehensive and preventive dental services every year.	$2,000 annual benefit maximum for comprehensive and preventive dental services every year.

Cost	2022 (this year)	2023 (next year)
Dental Services (Preventive)	**In-Network** You pay a $25 copay for each preventive dental office visit: • Periodic Oral Evaluation (D0120): 1 every 6 months • Limited Oral Evaluation (D0140): 1 every 12 months • Comprehensive Oral Evaluation (D0150): 1 every 12 months • Extensive Oral Evaluation (D0160): Not covered • Intraoral – Complete Series of Radiographic Images (D0210): 1 every 36 months • Radiographs/Diagnostic Imaging (D0272, D0274, D0330): 1 every 12 months • Prophylaxis – Cleaning (D1110): 1 cleaning every 6 months $1,500 annual benefit maximum for comprehensive and preventive dental services every year.	**In-Network** You pay a $0 copay for each preventive dental office visit: • Periodic Oral Evaluation (D0120): 1 every 6 months • Limited Oral Evaluation (D0140): 1 every 12 months • Comprehensive Oral Evaluation (D0150): 1 every 12 months • Extensive Oral Evaluation (D0160): 1 every 12 months • Radiographs/Diagnostic Imaging (D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0277, D0330): 1 every 12 months • Prophylaxis – Cleaning (D1110): 1 cleaning every 6 months $2,000 annual benefit maximum for comprehensive and preventive dental services every year.

Cost	2022 (this year)	2023 (next year)
Flex Wallet Card	Flex Wallet Card is not covered.	Your coverage includes a $500 annual flex wallet card benefit for dental, vision, and hearing allowances. You can use your allowances to pay for out-of-pocket amounts due to these providers. You will have access to these funds using an issued debit card. Unused allowances do not carry over to the next calendar year.
Over-the-Counter (OTC) Items	**In-Network** You pay a $0 copay for OTC items. You receive up to $25 every month. Unused portions do not carry over to the next period.	**In-Network** You pay a $0 copay for OTC items. You receive up to $95 per quarter. Unused portions do not carry over to the next quarter.
Pulmonary Rehabilitation Services (Medicare-covered)	**In-Network** You pay a $25 copay for each Medicare-covered pulmonary rehabilitation services visit.	**In-Network** You pay a $20 copay for each Medicare-covered pulmonary rehabilitation services visit.
Transportation Services	**In-Network** You pay a $0 copay for transportation services (up to 20 one-way trips every year to plan-approved locations).	**In-Network** You pay a $0 copay for transportation services (unlimited trips every year to plan-approved locations).

Section 1.5 – 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

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." The information below shows the changes 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.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

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, even if you haven't paid your deductible.

Getting Help from Medicare – If you chose this plan because you were looking for insulin coverage at $35 or less a month, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Member Services number at 713-442-CARE (2273) or toll-free at 1-866-535-8343 for additional information. (TTY users should call 711.) 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.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tiers 3, 4, and 5 drugs until you have reached the yearly deductible.	The deductible is $100. During this stage, you pay $0 copay Preferred cost sharing and $3 copay Standard cost sharing for a 30-day supply of drugs on Tier 1, and $0 copay Preferred cost sharing and $15 copay Standard cost sharing for a 30-day supply of drugs on Tier 2, and the full cost of drugs on Tiers 3, 4, and 5 until you have reached the yearly deductible.	The deductible is $100. During this stage, you pay $0 copay Preferred cost sharing and $3 copay Standard cost sharing for a 30-day supply of drugs on Tier 1, $0 copay Preferred cost sharing and $15 copay Standard cost sharing for a 30-day supply of drugs on Tier 2, $0 copay Preferred cost sharing and $0 copay Standard cost sharing for a 30-day supply of drugs on Tier 6, and the full cost of drugs on Tiers 3, 4, and 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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 $3 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $45 copay per prescription. *Preferred cost sharing:* You pay $40 copay per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $3 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $45 copay per prescription. *Preferred cost sharing:* You pay $40 copay per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $90 copay per prescription. *Preferred cost sharing:* You pay $80 copay per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 31% coinsurance. *Preferred cost sharing:* You pay 31% coinsurance. **Tier 6:** Not covered. ______________ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $90 copay per prescription. *Preferred cost sharing:* You pay $80 copay per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 31% coinsurance. *Preferred cost sharing:* You pay 31% coinsurance. **Tier 6 (Select Care Drugs):** *Standard cost sharing:* You pay $0 copay. *Preferred cost sharing:* You pay $0 copay. ______________ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Administrative Changes

The information below shows the administrative changes for next year.

Description	2022 (this year)	2023 (next year)
Appeals for Part D Prescription Drugs – Contact Information	KelseyCare Advantage Appeals and Grievances CALL: 1-866-535-8343 TTY: 711 FAX: 713-442-9536 WRITE: KelseyCare Advantage ATTN: Appeals and Grievances P.O. Box 841569 Pearland, TX 77584-9832	CVS Caremark® Prior Authorization Call: 1-888-970-0914 TTY: 711 Fax: 1-855-633-7673 Write: CVS Caremark® P.O. Box 52000, MC109 Phoenix, AZ 85072-2000
Over-the-counter items	Eligible items available from participating CVS locations and by ordering online or over the phone through the plan's catalog for delivery to your home via OTC Health Solutions.	Eligible items available from participating retail locations and by ordering online, over the phone, or by mail through the plan's catalog for delivery to your home via Convey Health Solutions.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in KelseyCare Advantage Gold Freedom

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 by December 7, you will automatically be enrolled in our KelseyCare Advantage Gold Freedom plan.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, KS Plan Administrators, LLC offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from KelseyCare Advantage Gold Freedom.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from KelseyCare Advantage Gold Freedom.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - *– or –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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://hhs.texas.gov/services/health/medicare).

SECTION 6 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. 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; 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.

- **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 7 Questions?

Section 7.1 – Getting Help from KelseyCare Advantage Gold Freedom

Questions? We're here to help. Please call Member Services at 713-442-CARE (2273) or toll-free at 1-866-535-8343. (TTY only, call 711.) We are available for phone calls 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.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for KelseyCare Advantage Gold Freedom. 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. 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. 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 7.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-535-8343. Someone who speaks English/Language can help you. This is a free service.

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. Alguien que hable español puede ayudarte. Este es un servicio gratuito.

您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-535-8343。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-535-8343。我们的中文工作人员很乐意帮助您。 这是一项免费服务

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. 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. 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. 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 an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dies ist ein kostenloser Service.

우리는 당신이 우리의 건강 또는 약물 계획에 대해 가질 수있는 질문에 대답 할 수있는 무료 통역사 서비스를 제공합니다. 통역사를 얻으려면 1-866-535-8343 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. 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:. 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. 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. 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. 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. 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 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。

METHOD	KelseyCare Advantage Member Services - Contact Information
CALL	**1-866-535-8343** 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 P.O. Box 841569 Pearland, TX 77584-9832
WEBSITE	www.kelseycareadvantage.com

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://hhs.texas.gov/services/health/medicare

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