# 2020
# Summary of Benefits

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

Harris, Brazoria, Fort Bend, Montgomery, Galveston *(partial county)*

H0332: 001,002,003,004

KelseyCare Advantage

## 2020 SUMMARY OF BENEFITS

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# PRE-ENROLLMENT CHECKLIST

KelseyCare Advantage is offered by KS Plan Administrators, LLC, a Medicare Advantage HMO with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information.

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 1-866-535-8343 (TTY: 1-866-302-9336).

**Understanding the Benefits**

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit KelseyCareAdvantage.com or call 1-866-535- 8343 (TTY: 1-866-302-9336) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

**Understanding Important Rules**

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- 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 Rx+Choice (POS) plan.
- The KelseyCare Advantage Rx+Choice plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you and to bill KelseyCare Advantage. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher cost-share for services received by non-contracted providers.

This document is available in other formats such as Braille and large print.

## GENERAL PLAN INFORMATION

### Things to Know About KelseyCare Advantage

### Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00a.m. to 8:00 p.m. Central time.

### KelseyCare Advantage Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-866-535-8343.
- If you are not a member of this plan, call toll-free 1-800-663-7146.
- TTY users should call 1-866-302-9336
- Our website: www.kelseycareadvantage.com

Who Can Join? To join KelseyCare Advantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

| **Our service area includes the following counties in Texas:** | |
|---|---|
| **Harris** | |
| **Brazoria** | **Fort Bend** |
| **Galveston** (excluding the island) | **Montgomery** |

| **Which doctors and hospitals can I use?** | |
|---|---|
| **KelseyCare Advantage (HMO)**<br>**-Rx**<br>**-Essential** | Has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. |
| **KelseyCare Advantage (HMO-POS)**<br>**-Rx+Choice**<br>**-Essential+Choice** | Has a network of doctors, hospitals, and other providers.<br>*For some services you can use providers that are not in our network.* |
| Out-of-network/non-contracted providers are under no obligation to treat KelseyCare Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. | |

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**This section contains benefit information for the Rx and Rx+Choice plans.**

**These plans include drug coverage.**

If you do not need drug coverage, please continue to the section for the Essential and Essential+Choice plan on page 19.

# Summary of Benefits

## January 1, 2020 – December 31, 2020

### KELSEYCARE ADVANTAGE RX (HMO)

### KELSEYCARE ADVANTAGE RX+CHOICE (HMO-POS)

This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Rx (HMO) and KelseyCare Advantage Rx+Choice (HMO-POS) covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

Tips for comparing your Medicare choices

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

| Sections in this booklet | |
|---|---|
| ✓ | Things to know about KelseyCare Advantage Rx (HMO) and KelseyCare Advantage Rx+Choice (HMO-POS) |
| ✓ | Monthly Premium<br>Deductible<br>Limits on How Much You Pay for Covered Services |
| ✓ | Covered Medical and Hospital Benefits |
| ✓ | Prescription Drug Benefits |

## Things to know about KelseyCare Advantage Rx (HMO) and KelseyCare Advantage Rx+Choice (HMO-POS)

| Which pharmacies can I use? |
| --- |
| You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.<br><br>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.<br><br>You can see our plan's provider directory and pharmacy directory at our website (www.kelseycareadvantage.com). Or, call us at the phone numbers above, and we will send you a copy of the provider and pharmacy directories. |

### What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.kelseycareadvantage.com.
- Or, call us and we will send you a copy of the formulary.

### How will I determine my drug costs?

Our plan groups each medication into one of five "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.

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **How much is the monthly premium?** | $0 per month.<br><br>*$38.80 per month with Dental Optional Supplemental Benefit option.* | $77 per month.<br><br>*$115.80 per month with Dental Optional Supplemental Benefit option.* |
| | In addition, you must keep paying your Medicare Part B premium | |
| **How much is the deductible?** | $100 per year for Part D prescription drugs on Tiers 3, 4 and 5. | |
| **Is there any limit on how much I will pay for my covered services?**<br><br>**(Maximum Out-of- Pocket Responsibility)** | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>• $3,400 for covered Part A and Part B services you receive from in-network providers.<br>If you reach the limit on out-of- pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly Part B premiums and cost-sharing for your Part D prescription drugs. | 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.<br>Your yearly limit(s) in this plan:<br>• $3,400 for covered Part A and Part B services you receive from in-network providers.<br>• $10,000 for covered Part A and Part B services you receive from out-of-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| **Is there a limit on how much the plan will pay?** | Our plan has coverage limit every year for certain in-network benefits. Contact us for the services that apply. | |

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Inpatient Hospital Coverage** [1,2] | The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers 90 days for an inpatient hospital stay.<br><br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>• $500 copay per stay | The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers 90 days for an inpatient hospital stay.<br><br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br><br><u>In-network:</u><br>• $500 copay per stay<br><br><u>Out-of-network:</u><br>• You pay $1000 copay per benefit period for days 1 through 60<br>• $250 copay per day for days 61 through 90<br>• $500 copay per day for days 91 through 150 |

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Outpatient Hospital Coverage** [1,2] | $225 copayment for each Medicare- covered ambulatory surgical center visit<br><br>$300 copayment for each Medicare- covered outpatient hospital facility visit<br><br>$300 copayment for other outpatient hospital services, for example: chemotherapy, diagnostic sleep studies or observation stay | $225 copayment for each Medicare-covered ambulatory surgical center visit<br><br>$300 copayment for each Medicare-covered outpatient hospital facility visit<br><br>$300 copayment for other outpatient hospital services, for example: chemotherapy, diagnostic sleep studies or observation stay<br><br>Out-of-network: 20% coinsurance for all Medicare-covered outpatient hospital services |
| **Doctor Visits** (Primary Care Providers and Specialists) 1,2 | Primary care physician visit:<br>$0 copay<br><br>Specialist visit:<br>$35 copay | Primary care physician visit:<br>• In-network: $0 copay<br>• Out-of-network: 50% of the cost<br><br>Specialist visit:<br>• In-network: $35 copay<br>• Out-of-network: 20% of the cost |
| **Preventive Care** (e.g., flu and pneumonia vaccines, diabetic screenings, colorectal cancer screenings) | You pay nothing<br><br>Other preventive services are available.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. | • In-network: You pay nothing<br>• Out-of-network: 50% of the cost<br><br>Other preventive services are available.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | $120 copay<br><br>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs. | |
| **Urgently Needed Services** | $25 copay | |

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Diagnostic Services, Labs Imaging** 1,2 | Diagnostic radiology services (such as MRIs, CT scans):<br>$0-$150 copay, depending on the service<br><br>Diagnostic tests and procedures:<br>$0-$25 copay, depending on the service<br><br>Lab services: You pay nothing.<br><br>Outpatient x-rays: You pay nothing.<br><br>Therapeutic radiology services (such as radiation treatment for cancer):<br>$50 copay | Diagnostic radiology services (such as MRIs, CT scans):<br>• In-network: $0-$150 copay, depending on the service<br>• Out-of-network: 20% of the cost<br><br>Diagnostic tests and procedures:<br>• In-network: $0-$25 copay, depending on the service<br>• Out-of-network: 20% of the cost<br><br>Lab services:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Outpatient X-Rays:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Therapeutic radiology services (such as radiation treatment for cancer):<br>• In-network: $50 copay<br>• Out-of-network: 20% of the cost |
| **Hearing Services**[1,2] | Exam to diagnose and treat hearing and balance issues: $35 copay<br><br>Routine hearing exam (for up to 1 every year): $35 copay<br><br>Hearing aid fitting exam (for up to 1 every year): $35 copay<br><br>Hearing aid allowance: Our plan pays up to $125 every year for hearing aids. You pay any amount over this plan allowed amount. | Exam to diagnose and treat hearing and balance issues:<br>• In-network: $35 copay<br>• Out-of-network: 20% of the cost<br><br>Routine hearing exam:<br>• In-network: $35 copay. You are covered for up to 1 every year.<br><br>Hearing aid fitting exam (for up to 1 every year): $35 copay<br><br>Hearing aid allowance: Our plan pays up to $125 every year for hearing aids. You pay any amount over this plan allowed amount. |

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Dental Services** 1,2 | The limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):<br><br>20% coinsurance for Medicare covered dental services<br><br>***Optional Supplemental Dental Coverage if purchased:***<br>*$38.80 monthly premium* | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):<br><br>In-Network: 20% coinsurance for Medicare covered dental services<br><br>Out-of-Network: 50% coinsurance for Medicare covered dental services<br><br>***Optional Supplemental Dental Coverage if purchased:***<br>*$38.80 monthly premium* |
| **Optional Dental Services** (applicable only if purchased) | You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $38.80. See the Evidence of Coverage (Chapter 4, Section 2.2) for more information. Your coinsurance varies depending on the type dental service. | You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $38.80. See the Evidence of Coverage (Chapter 4, Section 2.2) for more information. Your coinsurance varies depending on the type dental service. |
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):<br>$0 - $35 copay, depending on the service<br>Routine eye exam (for up to 1 every year): You pay nothing<br>Contact lenses or Eyeglasses (for up to 1 every year): Our plan pays up to $75 every year for contact lenses or eyeglasses (frames and lenses).<br><br>You pay any amount over this plan allowed amount.<br><br>Eyeglasses or contact lenses after cataract surgery: You pay nothing. After cataract surgery, eyeglasses or contact lenses are covered up to 100% of Medicare allowable. | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):<br>• In-network: $0 - $35 copay, depending on the service<br>• Out-of-network: 20% of the cost<br><br>Routine eye exam:<br>• In-network: You pay nothing. You are covered for up to 1 every year.<br><br>Contact lenses or Eyeglasses (for up to 1 every year):<br>• In-network: Our plan pays up to $75 every year for contact lenses or eyeglasses (frames and lenses) from an in-network provider. You pay any amount over this plan allowed amount.<br><br>Eyeglasses or contact lenses after cataract surgery:<br>• In-network: You pay nothing up to 100% of the Medicare allowed rate.<br>• Out-of-network: 50% of the cost up to the Medicare allowed rate. |

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

<table>
<tr><th></th><th>Rx (HMO)</th><th>Rx+Choice (HMO-POS)</th></tr>
<tr><td rowspan="2">Mental Health Services (including inpatient) 1,2</td><td colspan="2">Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br><br>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</td></tr>
<tr><td>Inpatient visit: $500 copay per stay<br><br>Outpatient group therapy visit: $20 copay<br><br>Outpatient individual therapy visit: $35 copay</td><td>In-network: $500 copay per stay<br><br>Out-of-network:<br>• $1,000 copay per stay per benefit period for days 1 - 60<br>• $250 copay per day for days 61 - 90<br>• $500 copay per day for days 91 - 150<br><br>Outpatient group therapy visit:<br>In-network: $20 copay<br>Out-of-network: 50% of the cost<br><br>Outpatient individual therapy visit:<br>In-network: $35 copay<br>Out-of-network: 50% of the cost</td></tr>
<tr><td>Skilled Nursing Facility (SNF) 1,2</td><td>Our plan covers up to 100 days in a SNF per benefit period.<br><br>• You pay nothing per day for days 1 through 20<br>• $125 copay per day for days 21 through 100</td><td>Our plan covers up to 100 days in a SNF per benefit period.<br><br>In-network:<br>• You pay nothing per day for days 1 through 20<br>• $125 copay per day for days 21 through 100<br><br>Out-of-network: 50% of the cost per stay</td></tr>
<tr><td>Physical Therapy 1,2</td><td>$10 copay per visit</td><td>In-Network: $10 copay per visit<br><br>Out-of-Network: 50% of the cost</td></tr>
</table>

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Ambulance** | $100 copay for each one-way trip | In-network: $100 copay for each one-way trip<br>Out-of-network: *50% of the cost<br>*Applies to non-emergency ambulance services |
| **Transportation** | You pay nothing.<br>This plan covers 20 one-way trips for plan-approved locations every year. Transportation is limited to medical appointments and medical facilities within the plan service area.<br>Transportation provided by KelseyCare Advantage Transportation via Circulation Health. | |
| **Medicare Part B Drugs** [1] | 20% of the cost for chemotherapy drugs<br>20% of the cost for other Part B drugs | In-network and out-of-network:<br>20% of the cost for chemotherapy drugs<br>20% of the cost for other Part B drugs |
| **Foot Care (podiatry services)** 1,2 | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>$35 copay | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>• In-network: $35 copay<br>• Out-of-network: 20% of the cost |
| **Medical Equipment/ Supplies** (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) 1 | 20% of the cost<br>Diabetes monitoring supplies:<br>• You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan).<br>• You pay nothing for lancets, lancet devices and control solutions.<br>• Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.<br>Therapeutic shoes or inserts: 20% of the cost<br>Prosthetic devices:<br>20% of the cost<br>Related medical supplies: 20% of the cost | • In-network: 20% of the cost<br>• Out-of-network: 50% of the cost<br>Diabetes monitoring supplies:<br>• You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan).<br>• You pay nothing for lancets, lancet devices and control solutions.<br>• Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.<br>• Out-of-network: 50% of the cost (even if preferred brands are used)<br>Therapeutic shoes or inserts:<br>• In-network: 20% of the cost<br>• Out-of-network: 50% of the cost<br>Prosthetic devices:<br>• In-network: 20% of the cost<br>• Out-of-network: 50% of the cost<br>Related medical supplies:<br>• In-network: 20% of the cost<br>• Out-of-network: 50% of the cost |

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Wellness Programs** (e.g., fitness) | SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes. You pay nothing. | |
| **Acupuncture and Other Alternative Therapies** | Not covered | |
| **Chiropractic Care** 1,2 | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of positions):<br>$20 copay | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):<br>• In-network: $20 copay<br>• Out-of-network: 20% of the cost |
| **Diabetes Self-Management Training** 1,2 | Diabetes self-management training:<br>You pay nothing. | Diabetes self-management training:<br>• In-network: You pay nothing<br>• Out-of-network: 50% of the cost |
| **Home Health Care** 1,2 | $10 copay | • In-network: $10 copay<br>• Out-of-network: 50% of the cost |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. | |
| **Outpatient Substance Abuse** 1,2 | Group therapy visit:<br>$20 copay<br>Individual therapy visit:<br>$35 copay | Group therapy visit:<br>• In-network: $20 copay<br>• Out-of-network: 50% of the cost<br>Individual therapy visit:<br>• In-network: $35 copay<br>• Out-of-network: 50% of the cost |
| **Outpatient Surgery**[1,2] | Outpatient hospital:<br>$300 copay | Outpatient hospital:<br>• In-network: $300 copay<br>• Out-of- network: 20% of the cost |
| **Over-the-Counter Items** | Not covered | |
| **Renal Dialysis** 1,2 | $25 copay | • In-network: $25 copay<br>• Out-of-network: *50% of the cost<br>*Applies to out-of-network renal dialysis in the service area |

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

| | Rx (HMO) | Rx+Choice (HMO-POS) |
|---|---|---|
| **Telemedicine visits** | E-Visits and Video Visits are covered benefit for Kelsey-Seybold primary care and specialty physicians.<br><br>E-visits<br>• PCP visit: $0 copay<br>• Specialty visit: $0 copay<br><br>Video visits<br>• PCP visit: $0 copay<br>• Specialty visit: $35 copay | |
| **Outpatient Rehabilitation** 1,2 | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):<br><br>$35 copay<br><br>Occupational therapy visit:<br>$10 copay | Cardiac (heart)rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):<br>• In-network: $35 copay<br>• Out-of-network: 50% of the cost<br><br>Occupational therapy visit:<br>• In-network: $10 copay<br>• Out-of-network: 50% of the cost |
| **Ambulatory Surgery Center** 1,2 | $225 copay | • In-network: $225 copay<br>• Out-of-network: 20% of the cost |

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

## Prescription Drug Benefits – Part D

### Initial Coverage

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. After you pay your yearly deductible, you pay the following until your total yearly drug cost reach $4,020. 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 pharmacies.

### Standard Retail Cost-Sharing

| Tier | One-month supply | Three-month supply |
|---|---|---|
| Tier 1 (Preferred Generic) | $8 copay | $24 copay |
| Tier 2 (Generic) | $10 copay | $30 copay |
| Tier 3 (Preferred Brand) | $45 copay | $135 copay |
| Tier 4 (Non-Preferred Brand) | $70 copay | $210 copay |
| Tier 5 (Specialty Tier) | 31% of the cost | A long-term supply is not available for drugs in Tier 5 Specialty |

**Preferred Retail Cost-Sharing**

| Tier | One-month supply | Three-month supply |
|---|---|---|
| Tier 1 (Preferred Generic) | $3 copay | $7.50 copay |
| Tier 2 (Generic) | $5 copay | $12.50 copay |
| Tier 3 (Preferred Brand) | $40 copay | $100 copay |
| Tier 4 (Non-Preferred Brand) | $60 copay | $150 copay |
| Tier 5 (Specialty Tier | 31% of the cost | A long-term supply is not available for drugs in Tier 5 Specialty. |
| If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br>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 $4,020.

After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. 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**

| Tier | Drugs Covered | One-month supply | Three-month supply |
|---|---|---|---|
| Tier 1 (Preferred Generic) | All | $8 copay | $24 copay |

**Preferred Retail Cost-Sharing**

| Tier | Drugs Covered | One-month supply | Three-month supply |
|---|---|---|---|
| Tier 1 (Preferred Generic) | All | $3 copay | $7.50 copay |

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of:

- 5% of the cost, or
- $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copayment for all other drugs.

**This section contains benefit information for the Essential and Essential+Choice plans.**

**These plans do NOT include drug coverage.**

**If you need drug coverage, please go back to the section for the Rx and Rx+Choice plans on page 6.**

# Summary of Benefits

## January 1, 2020 – December 31, 2020

**KELSEYCARE ADVANTAGE ESSENTIAL (HMO)**

**KELSEYCARE ADVANTAGE ESSENTIAL+CHOICE (HMO-POS)**

This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Essential (HMO) and KelseyCare Advantage Essential+Choice (HMO-POS) covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

**Tips for comparing your Medicare choices**

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

| Sections in this booklet | |
|---|---|
| ✓ | Things to know about KelseyCare Advantage Essential (HMO) and KelseyCare Advantage Essential+Choice (HMO-POS) |
| ✓ | Monthly Premium<br>Limits on How Much You Pay for Covered Services |
| ✓ | Covered Medical and Hospital Benefits |

**What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers – and more.

- **Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare**. For others, you may pay less.
- **Our plan members also get more than what is covered by Original Medicare.**

  Some of the extra benefits are outlined in this booklet.

**KelseyCare Advantage Essential (HMO) and KelseyCare Advantage Essential+Choice (HMO-POS)** cover Part B drugs such as chemotherapy and some drugs administered by your provider.

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **How much is the monthly premium?** | $0 per month. In addition, you must keep paying your Medicare Part B premium.<br><br>*$38.80 per month with Dental Optional Supplemental Benefit option.*<br><br>KelseyCare Advantage will reduce your Medicare Part B premium by up to $10 per month. | $0 per month. In addition, you must keep paying your Medicare Part B premium.<br><br>*$38.80 per month with Dental Optional Supplemental Benefit option.* |
| **How much is the deductible?** | This plan does not have a deductible. | |
| **Is there any limit on how much I will pay for my covered services?**<br><br>**(Maximum Out-of-Pocket Responsibility)** | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br><br>Your yearly limit(s) in this plan:<br><br>• $3,400 for covered Part A and Part B services you receive from in-network providers.<br><br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br><br>Please note that you will still need to pay your monthly Part B premiums. | 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.<br><br>Your yearly limit(s) in this plan:<br><br>• $3,400 for covered Part A and Part B services you receive from in-network providers.<br><br>• $10,000 for covered Part A and Part B services you receive from out-of-network providers.<br><br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br><br>Please note that you will still need to pay your monthly premiums. |
| **Is there a limit on how much the plan will pay?** | Our plan has coverage limit every year for certain in-network benefits. Contact us for the services that apply. | |

## Covered Medical and Hospital Benefits

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **Inpatient Hospital Coverage** [1,2] | The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers 90 days for an inpatient hospital stay.<br><br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>• $500 copay per stay | The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers 90 days for an inpatient hospital stay.<br><br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br><br><u>In-network:</u><br>• $500 copay per stay<br><br><u>Out-of-network:</u><br>• You pay $1000 copay per benefit period for days 1 through 60<br>• $250 copay per day for days 61 through 90<br>• $500 copay per day for days 91 through 150 |

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **Outpatient Hospital Coverage** 1,2 | $225 copayment for each Medicare- covered ambulatory surgical center visit<br>$250 copayment for each Medicare- covered outpatient hospital facility visit<br>$250 copayment for other outpatient hospital services, for example: chemotherapy, diagnostic sleep studies or observation stay | $225 copayment for each Medicare-covered ambulatory surgical center visit<br>$250 copayment for each Medicare-covered outpatient hospital facility visit<br>$250 copayment for other outpatient hospital services, for example: chemotherapy, diagnostic sleep studies or observation stay<br>**Out-of-network:** 20% coinsurance for all Medicare-covered outpatient hospital services |
| **Doctor Visits** (Primary Care Providers and Specialists) 1,2 | Primary care physician visit:<br>$0 copay<br><br>Specialist visit:<br>$20 copay | Primary care physician visit:<br>In-network: $0 copay<br>Out-of-network: 50% of the cost<br><br>Specialist visit:<br>In-network: $20 copay<br>Out-of-network: 20% of the cost |
| **Preventive Care** (e.g., flu and pneumonia vaccines, diabetic screenings, colorectal cancer screenings) | You pay nothing<br>Other preventive services are available.<br>Any additional preventive services approved by Medicare during the contract year will be covered. | • In-Network: You pay nothing<br>• Out-of-network: 50% of the cost<br><br>Other preventive services are available.<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | $120 copay<br>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs. | |
| **Urgently Needed Services** | $25 copay | |

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **Diagnostic Services/ Labs/Imaging** 1,2 | Diagnostic radiology services (such as MRIs, CT scans):<br>$0-$150 copay, depending on the service<br><br>Diagnostic tests and procedures:<br>$0-$25 copay, depending on the service<br><br>Lab services: You pay nothing.<br><br>Outpatient x-rays: You pay nothing.<br><br>Therapeutic radiology services (such as radiation treatment for cancer):<br>$50 copay | Diagnostic radiology services (such as MRIs, CT scans):<br>• In-network: $0-$150 copay, depending on the service<br>• Out-of-network: 20% of the cost<br><br>Diagnostic tests and procedures:<br>• In-network: $0-$25 copay, depending on the service<br>• Out-of-network: 20% of the cost<br><br>Lab services:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br>Outpatient X-Rays:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br>Therapeutic radiology services (such as radiation treatment for cancer):<br>• In-network: $50 copay<br>Out-of-network: 20% of the cost |
| **Hearing Services** 1,2 | Exam to diagnose and treat hearing and balance issues: $20 copay<br><br>Routine hearing exam (for up to 1 every year): $20 copay<br><br>Hearing aid fitting exam (for up to 1 every year): $20 copay<br><br>Hearing aid allowance: Our plan pays up to $500 every year for hearing aids. You pay any amount over this plan allowed amount. | Exam to diagnose and treat hearing and balance issues:<br>In-network: $20 copay<br>Out-of-network: 20% of the cost<br><br>Routine hearing exam:<br>In-network: $20 copay. You are covered for up to 1 every year.<br><br>Hearing aid fitting exam (for up to 1 every year): $20 copay<br><br>Hearing aid allowance: Our plan pays up to $500 every year for hearing aids. You pay any amount over this plan allowed amount. |

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **Dental Services** 1,2 | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): 20% coinsurance for Medicare-covered dental services.<br><br>***Optional Supplemental Dental Coverage if purchased****:*<br>*$38.80 monthly premium* | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):<br>• In-network: 20% coinsurance for Medicare-covered dental services.<br>• Out-of-network: 50% of the cost for Medicare-covered dental services.<br>***Optional Supplemental Dental Coverage if purchased:***<br>*$38.80 monthly premium* |
| **Optional Dental Services** (applicable only if purchased) | You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $38.80. See the Evidence of Coverage (Chapter 4, Section 2.2) for more information. Your coinsurance varies depending on the type dental service. | You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $38.80. See the Evidence of Coverage (Chapter 4, Section 2.2) for more information. Your coinsurance varies depending on the type dental service. |
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $20 copay, depending on the service.<br><br>Routine eye exam (for up to 1 every year): You pay nothing<br><br>Contact lenses or Eyeglasses (for up to 1 every year): Our plan pays up to $75 every year for contact lenses or eyeglasses (frames and lenses). Unrelated to post-cataract surgery.<br><br>You pay any amount over this plan allowed amount.<br><br>Eyeglasses or contact lenses after cataract surgery: You pay nothing. After cataract surgery, eyeglasses or contact lenses are covered up to 100% of Medicare allowable. | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):<br>• In-network: $0 - $20 copay, depending on the service<br>• Out-of-network: 20% of the cost Routine eye exam:<br>• In-network: You pay nothing. You are covered for up to 1 every year.<br><br>Contact lenses or Eyeglasses (for up to 1 every year):<br>• In-network: Our plan pays up to<br><br>$75 every year for contact lenses or eyeglasses (frames and lenses) from an in-network provider. Unrelated to post-cataract surgery. You pay any amount over this plan allowed amount.<br><br>Eyeglasses or contact lenses after cataract surgery:<br>• In-network: You pay nothing up to 100% of the Medicare allowed rate.<br>• Out-of-network: 50% of the cost up to the Medicare allowed rate. |

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

<table>
<tr><th></th><th>Essential (HMO)</th><th>Essential+Choice (HMO-POS)</th></tr>
<tr><td rowspan="2">Mental Health Services (including inpatient) 1,2</td><td colspan="2">Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br><br>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</td></tr>
<tr><td>• $500 copay per stay<br><br>Outpatient group therapy visit:<br>$20 copay<br>Outpatient individual therapy visit:<br>$35 copay</td><td><u>In-network:</u><br>$500 copay per stay<br><br><u>Out-of-network:</u><br>$1,000 copay per stay per benefit period for days 1-60<br><br>$250 copay per day for days 61-90<br><br>$500 copay per day for days 91-150<br><br>Outpatient group therapy visit:<br>In-network: $20 copay<br>Out-of-network: 50% of the cost<br><br>Outpatient individual therapy visit:<br>In-network: $35 copay<br>Out-of-network: 50% of the cost</td></tr>
<tr><td>Skilled Nursing Facility (SNF) 1,2</td><td>Our plan covers up to 100 days in a SNF per benefit period.<br>• You pay nothing per day for days 1 through 20<br>$125 copay per day for days 21 through 100</td><td>Our plan covers up to 100 days in a SNF per benefit period.<br><u>In-network:</u><br>• You pay nothing per day for days 1 through 20<br>• $125 copay per day for days 21 through 100<br><u>Out-of-network:</u><br>50% of the cost per stay</td></tr>
</table>

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **Physical Therapy** | Physical therapy visit:<br>$10 copay | Physical therapy visit:<br>• In-network: $10 copay<br>• Out-of-network: 50% of the cost |
| **Ambulance** 1 | $100 copay for each one-way trip. | • In-network: $100 copay for each one-way trip.<br>• Out-of-network: *50% of the cost<br><br>*Applies to non-emergency ambulance services |
| **Transportation** | You pay nothing.<br>This plan covers 20 one-way trips for plan-approved locations every year. Transportation is limited to medical appointments and medical facilities within the plan service area.<br>Transportation provided by KelseyCare Advantage Transportation via Circulation Health. | |
| **Medicare Part B Drugs** [1] | 20% of the cost for chemotherapy drugs<br>20% of the cost for other Part B drugs | In-network and out-of-network:<br>20% of the cost for chemotherapy drugs<br>20% of the cost for other Part B drugs |
| **Foot Care** *(podiatry services)* 1,2 | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>$20 copay | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>• In-network: $20 copay<br>• Out-of-network: 20% of the cost |
| **Medical Equipment/ Supplies** (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) 1 | 20% of the cost<br><br>Diabetes monitoring supplies:<br>• You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan).<br>• You pay nothing for lancets, lancet devices and control solutions.<br>• Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered. | In-network: 20% of the cost<br>Out-of-network: 50% of the cost<br>Diabetes monitoring supplies:<br>• You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan).<br>• You pay nothing for lancets, lancet devices and control solutions.<br>• Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.<br>• Out-of-network: 50% of the cost (even if preferred brands are used)<br>Therapeutic shoes or inserts:<br>• In-network: 20% of the cost<br>• Out-of-network: 50% of the cost |

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| | Therapeutic shoes or inserts: 20% of the cost<br><br>Prosthetic devices:<br>20% of the cost<br><br>Related medical supplies: 20% of the cost | Prosthetic devices:<br>• In-network: 20% of the cost<br>• Out-of-network: 50% of the cost<br>Related medical supplies:<br>• In-network: 20% of the cost<br>• Out-of-network: 50% of the cost |
| **Wellness Programs** (e.g., fitness) | You pay nothing. SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes. | |
| **Acupuncture and Other Alternative Therapies** | Not covered | |
| **Chiropractic Care** 1,2 | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):<br><br>$20 copay | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):<br>• In-network: $20 copay<br>• Out-of-network: 20% of the cost |
| **Diabetes Self-Management Training** 1,2 | Diabetes self-management training:<br><br>You pay nothing. | Diabetes self-management training:<br>• In-network: You pay nothing<br>• Out-of-network: 50% of the cost |
| **Home Health Care** 1,2 | $10 copay | • In-network: $10 copay<br>• Out-of-network: 50% of the cost |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.<br>Hospice is covered outside of our plan. Please contact us for more details. | |
| **Outpatient Substance Abuse** 1,2 | Group therapy visit:<br>$20 copay<br>Individual therapy visit:<br>$35 copay | Group therapy visit:<br>• In-network: $20 copay<br>• Out-of-network: 50% of the cost<br>Individual therapy visit:<br>• In-network: $35 copay<br>• Out-of-network: 50% of the cost |
| **Outpatient Surgery** 1,2 | Outpatient hospital:<br>$250 copay | Outpatient hospital:<br>• In-network: $250 copay<br>• Out-of-network: 20% of the cost |
| **Over-the-Counter Items** | Not Covered | |

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

| | Essential (HMO) | Essential+Choice (HMO-POS) |
|---|---|---|
| **Renal Dialysis** 1,2 | $25 copay | • In-network: $25 copay<br>• Out-of-network: *50% of the cost<br><br>*Applies to out-of-network renal dialysis in the service area |
| **Telemedicine visits** | E-Visits and Video Visits are covered benefit for Kelsey-Seybold primary care and specialty physicians.<br><br>E-visits<br>PCP visit: $0 copay<br>Specialty visit: $10 copay<br><br>Video visits<br>PCP visit: $0 copay<br>Specialty visit: $20 copay | |
| **Outpatient Rehabilitation** 1,2 | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):<br><br>$20 copay<br><br>Occupational therapy visit:<br>$10 copay | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):<br>• In-network: $20 copay<br>• Out-of-network: 50% of the cost<br><br>Occupational therapy visit:<br>• In-network: $10 copay<br>• Out-of-network: 50% of the cost |
| **Ambulatory Surgery Center** 1,2 | $225 copay | • In-network: $225 copay<br>• Out-of-network: 20% of the cost |

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

**Discrimination is Against the Law**

KelseyCare Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KelseyCare Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

KelseyCare Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact KelseyCare Advantage Member Services. If you believe that KelseyCare Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: KelseyCare Advantage, Attn: Grievance Department, 11511 Shadow Creek Parkway, Pearland, TX 77584, 1-866-535- 8343, TTY 1-866-302-9336, Fax 713-442-9536 You can file a grievance in person, by phone, by mail, or fax. If you need help filing a grievance, KelseyCare Advantage Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Multi-language Interpreter Services Insert**

ATTENTION: If you speak any non-English language, language assistance services, free of charge, are available to you. Call 1-866-535-8343 (TTY: 1-866-302-9936).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-535-8343 (TTY: 1-866-302-9936).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-535-8343 (TTY: 1-866-302-9936).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-535-8343（TTY：1-866-302-9936）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-535-8343 (TTY: 1-866-302-9936)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-535-8343 (رقم هاتف الصم والبكم: 1-866-302-9936).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-535-8343 (TTY: 1-866-302-9936).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-535-8343 (TTY: 1-866-302-9936).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-535-8343 (ATS : 1-866-302-9936).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-535-8343 (TTY: 1-866-302-9936) पर कॉल करें।

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-535-8343 (TTY: 1-866-302-9936) تماس بگیرید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-535-8343 (TTY: 1-866-302-9936).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-535-8343 (TTY: 1-866-302-9936).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-535-8343 (телетайп: 1-866-302-9936).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-535-8343（TTY:1-866-302-9936）まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບ ່ເສັຽຄ່າ, ແມ່ນພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-535-8343 (TTY: 1-866-302-9936).

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**KelseyCare Advantage Member Services**

| Method | Member Services - Contact Information | |
|---|---|---|
| **Call** | **1-866-535-8343**<br><br>Calls to this number are free. Please contact our Member Services number at 713-442-CARE (2273) or toll-free at 1-866-535-8343 for additional information.<br><br>From October 1 through March 31, hours are 8:00 a.m. to 8:00 p.m., seven days a week. During this period on Thanksgiving Day and Christmas Day, calls are handled by our voicemail system. From April 1 through September 30, hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. During this period on Saturdays,<br><br>Sundays, and holidays, calls are handled by our voicemail system. Member Services also has free language interpreter services available for non- English speakers. | |
| **TTY** | **1-866-302-9336** - This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free. From October 1 through March 31, hours are 8:00 a.m. to 8:00 p.m., seven days a week. During this period on Thanksgiving Day and Christmas Day, calls are handled by our voicemail system. From April 1 through September 30, hours are 8:00a.m. to 8:00 p.m., Monday through Friday. During this period on Saturdays, Sundays, and holidays, calls are handled by our voicemail system. Member Services also has free language interpreter services available for non-English speakers. | |
| **Fax** | 713-442-5450 | |
| **Write** | KelseyCare Advantage ATTN: Member Services<br><br>1511 Shadow Creek Parkway<br>Pearland, TX 77584 | - OR –<br><br>P.O. Box 841569 Pearland, TX 77584-9832 |
| **Website** | www.kelseycareadvantage.com | |