2021

Annual Notice of Change

Rx+Choice (HMO-POS)

Toll-free **1-866-535-8343**, **TTY 711**

www.kelseycareadvantage.com

KelseyCare Advantage

H0332_004ANOC21_M File & Use 09/14/2020

KelseyCare Advantage Rx+Choice (HMO-POS) offered by KS Plan Administrators, LLC

Annual Notice of Changes for 2021

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

- **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.

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

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information.

OMB Approval 0938-1051
(Expires: December 31, 2021)

Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

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

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

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

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in KelseyCare Advantage Rx+Choice.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in KelseyCare Advantage Rx+Choice.
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible de forma gratuita en español.

- 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 October 1 – March 31, 8:00 a.m. to 8:00 p.m. local time, seven days a week. From April 1 – September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. local time. Messaging service used weekend, after hours and on federal holidays.

- This booklet is also available in braille, large print and other alternate formats. Please call Member Services (phone numbers are in Section 7.1 of this booklet) for more information.

- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About KelseyCare Advantage Rx+Choice

- 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.
- When this booklet says "we," "us," or "our," it means KS Plan Administrators, LLC. When it says "plan" or "our plan," it means KelseyCare Advantage Rx+Choice.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for KelseyCare Advantage Rx+Choice in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.kelseycareadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$77	$77
Maximum 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.)	$3,400	$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
Doctor office visits	**In-Network:** Primary care visits: $0 per visit. Specialist visits: $35 per visit.	**In-Network:** Primary care visits: $0 per visit. Specialist visits: $25 per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are	**In-Network:** For Medicare-covered hospital stays: $500 copayment per each acute hospital admission	**In-Network:** For Medicare-covered hospital stays: $150 copayment per each acute hospital admission

Cost	2020 (this year)	2021 (next year)
Inpatient hospital stays (continued) formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	for days 1 - 90. 90 covered days per benefit period and 60 lifetime reserve days, available to use during your lifetime. $0 copayment per day for lifetime reserve days 1 - 60.	per day for days 1 - 4. Maximum of $600 per stay. $0 copayment per day for days 5 - 90. 90 covered days per benefit period, with no limit to the number of benefit periods. Members have a total of 60 reserve days available to use during their lifetime. $0 copayment per day for lifetime reserve days 1 - 60.
Part D prescription drug coverage (cost for a 30-day supply) (See Section 1.6 for details.) To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).	**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:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription.	**Deductible:** $100 Deductible only applies to drug tiers 3, 4 and 5. There is no deductible for select insulins. You pay $30 - $35 for a 30-day supply for select insulins. **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost-sharing:* You pay $3 per prescription. *Preferred cost-sharing:* You pay $0 per prescription.

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (continued)	**Drug Tier 2:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription.	**Drug Tier 2:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription.
	Drug Tier 3: *Standard cost-sharing:* You pay $45 per prescription. *Preferred cost-sharing:* You pay $40 per prescription.	**Drug Tier 3:** *Standard cost-sharing:* You pay $45 per prescription. You pay $35 for select insulins per prescription. *Preferred cost-sharing:* You pay $40 per prescription. You pay $30 for select insulins per prescription.
	Drug Tier 4: *Standard cost-sharing:* You pay $70 per prescription. *Preferred cost-sharing:* You pay $60 per prescription.	**Drug Tier 4:** *Standard cost-sharing:* You pay $90 per prescription. *Preferred cost-sharing:* You pay $80 per prescription.
	Drug Tier 5: *Standard cost-sharing and Preferred cost-sharing:* You pay 31% of the total cost per prescription.	**Drug Tier 5:** *Standard cost-sharing and Preferred cost-sharing:* You pay 31% of the total cost per prescription.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$77	$77
Monthly Premium with Dental Optional Supplemental Benefits This plan premium applies to you only if you are enrolled in Dental optional supplemental benefits. (You must also continue to pay your Medicare Part B Premium.)	$115.80	$109.80

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

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

Cost	2020 (this year)	2021 (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 plan	$3,400	$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

Cost	2020 (this year)	2021 (next year)
Maximum in-network out-of-pocket amount (continued) premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Part A and Part B services for the rest of the calendar 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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-network POS out-of-pocket amount. There is no change for the upcoming benefit year.	$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 Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.kelseycareadvantage.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2021 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year.An updated *Pharmacy Directory* is located on our website at www.kelseycareadvantage.com. You may also call Member Services for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2021 *Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Acupuncture	**In-Network:** Acupuncture is not a covered benefit from January 1 - 20, 2020. On or after January 21, 2020, your copay is $20 for each Medicare-covered visit.	**In-Network:** Your copay is $20 for each Medicare-covered visit.

Cost	2020 (this year)	2021 (next year)
Ambulance services	**In-Network:** You pay a $100 copayment for each one-way Medicare-covered ambulance trip.	**In-Network:** You pay a $225 copayment for each one-way Medicare-covered ambulance trip.
Cardiac rehabilitation	**In-Network:** You pay a $35 copayment for each cardiac rehabilitation visit.	**In-Network:** You pay a $25 copayment for each cardiac rehabilitation visit.
Convenient care	**In-Network:** Convenient care is not covered.	**In-Network:** Plan covers convenient care at Minute Clinic by CVS only. You pay a $25 copayment per visit.
Dental Services	**In-Network:** You pay a 20% coinsurance for Medicare-covered dental services.	**In-Network:** You pay a $25 copay for Medicare-covered dental services and the following preventative dental services: Cleaning: 1 every 6 months Dental X-ray(s): 1 per year Oral Exam: 1 every 36 months
	Out-of-Network: You pay a 50% coinsurance for Medicare-covered dental services. Routine dental care is not covered unless you have	**Out-of-Network:** You pay a 50% coinsurance for Medicare-covered dental services. Preventative dental services are not covered out-of-network.

Cost	2020 (this year)	2021 (next year)
Dental Services (continued)	enrolled in our optional supplemental dental benefit plan.	
Dialysis Treatment - Renal	**In-Network:** You pay a $25 copayment for each renal dialysis treatment.	**In-Network:** You pay a 20% coinsurance for each renal dialysis treatment.
Doctor office visits	**In-Network:** You pay a $35 copayment for each specialist visit.	**In-Network:** You pay a $25 copayment for each specialist visit.
Hearing services	**In-Network:** You pay a $35 copayment for Medicare-covered diagnostic hearing exams. You pay a $35 copayment for one (1) hearing aid fitting exam every year. You pay a $35 copayment for one (1) routine hearing exam each year. You have a $125 plan allowance for hearing aids every year.	**In-Network:** You pay a $25 copayment for Medicare-covered diagnostic hearing exams. You pay a $25 copayment for one (1) hearing aid fitting exam every year. You pay a $0 copayment for one (1) routine hearing exam each year. You have a maximum allowance of $750 per ear towards the cost of non-implantable hearing aid(s) every three years.
Inpatient hospital care	**In-Network:** For Medicare-covered hospital stays: You pay a $500 copayment per each hospital admission for days 5 - 90.	**In-Network:** For Medicare-covered hospital stays: You pay a $150 copayment per day for days 1 - 4. Maximum of $600 per stay. You pay a $0 copayment per day for days 5 - 90. 90 covered days per benefit period, with no

Cost	2020 (this year)	2021 (next year)
Inpatient hospital care (continued)	90 covered days per benefit period and 60 lifetime reserve days, available to use during your lifetime. You pay a $0 copayment per day for lifetime reserve days 1 - 60.	limit to the number of benefit periods. Members have a total of 60 reserve days available to use during their lifetime. $0 copayment per day for lifetime reserve days 1 - 60.
Inpatient mental health care services	**In-Network:** You pay a $500 copayment per each acute inpatient mental health admission.	**In-Network:** You pay a $150 copayment per day up to day 4 per admission. Maximum of $600 per stay. 90 covered days per benefit period, there is no limit to the number of benefit periods. 60 Lifetime Reserve Days - $0 copayment per day. 40 additional psychiatric inpatient hospital days per lifetime - $0 copayment per day. Lifetime Reserve Days are additional days that the plan will pay for when members are in a hospital for more than the number of days covered by the plan. Members have a total of 60 reserve days that can be used during their lifetime. The plan covers up to 40 additional days in a Psychiatric hospital. The 40 additional Psychiatric days are offered once during the beneficiary

Cost	2020 (this year)	2021 (next year)
Inpatient mental health care services (continued)		lifetime. Medicare hospital benefit periods do apply. For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hospital) is considered a new admission.
Lymphedema/Wound Care	**In-Network:** You pay a $35 copayment for each visit.	**In-Network:** You pay a $25 copayment for each visit.
Outpatient mental health care services	**In-Network:** You pay a $35 copayment for each Medicare-covered individual therapy visit.	**In-Network:** You pay a $20 copayment for each Medicare-covered individual therapy visit.
Outpatient substance abuse services	**In-Network:** You pay a $35 copayment for each Medicare-covered individual therapy visit.	**In-Network:** You pay a $20 copayment for each Medicare-covered individual therapy visit.
Over-the-Counter items (OTC)	Over-the-Counter items (OTC) are not covered.	You receive $25 every quarter for approved over-the-counter items through select pharmacy locations. Unused amounts do not carry over to the next quarter or the next calendar year.

Cost	2020 (this year)	2021 (next year)
Part B drugs	**In-Network:** Part B drugs are not subject to Step Therapy requirements.	**In-Network:** Part B drugs may be subject to Step Therapy requirements.
Partial hospitalization services	**In-Network:** You pay a $35 copayment for each day.	**In-Network:** You pay a $25 copayment for each day.
Podiatry services	**In-Network:** You pay a $35 copayment for each podiatry visit.	**In-Network:** You pay a $25 copayment for each podiatry visit.
Pulmonary rehabilitation services	**In-Network:** You pay a $30 copayment for each pulmonary rehabilitation visit.	**In-Network:** You pay a $25 copayment for each pulmonary rehabilitation visit.
Telehealth	**In-Network:** You pay a $0 copayment for each PCP e-visit. You pay a $0 copayment for each Specialist e-visit. You pay a $0 copayment for each PCP video visit. You pay a $35 copayment for each Specialist video visit.	**In-Network:** You pay a $0 copayment for each PCP e-visit, video visit or phone visit. You pay a $15 copayment for each Specialist e-visit, video visit or phone visit.
Vision care	**In-Network:** You pay a $35 copayment for each diagnosis/ treatment.	**In-Network:** You pay a $25 copayment for each diagnosis/ treatment.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (www.kelseycareadvantage.com).

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

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

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

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

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

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

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

Changes to Prescription Drug Costs

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

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

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

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $100. During this stage, you pay $3 Preferred cost-sharing and $8 Standard cost-sharing for a 30-day supply of drugs on Tier 1, and $5 Preferred cost-sharing and $10 Standard cost-sharing for a 30-day supply of drugs on Tier 2, and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.	The deductible is $100. During this stage, you pay $0 Preferred cost-sharing and $3 Standard cost-sharing for a 30-day supply of drugs on Tier 1, and $5 Preferred cost-sharing and $10 Standard cost-sharing for a 30-day supply of drugs on Tier 2, and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. There is no deductible for KelseyCare Advantage Rx+Choice for select

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage (continued)		insulins. You pay $30 - $35 for a 30-day supply for select insulins.

Changes to Your Cost Sharing in the Initial Coverage Stage

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

Stage	2020 (this year)	2021 (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 $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. **Tier 2 (Generic):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost-sharing:* You pay $3 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 (Generic):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $45 per prescription. *Preferred cost-sharing:* You pay $40 per prescription. **Tier 4 (Non-Preferred Brand):** *Standard cost-sharing:* You pay $70 per prescription. *Preferred cost-sharing:* You pay $60 per prescription. **Tier 5 (Specialty):** *Standard* and *Preferred cost-sharing:* You pay 31% of the total cost per prescription. _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	**Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $45 per prescription. You pay $35 for select insulins per prescription. *Preferred cost-sharing:* You pay $40 per prescription. You pay $30 for select insulins per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost-sharing:* You pay $90 per prescription. *Preferred cost-sharing:* You pay $80 per prescription. **Tier 5 (Specialty Tier):** *Standard* and *Preferred cost-sharing:* You pay 31% of the total cost per prescription. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. KelseyCare Advantage Rx+Choice offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $30-$35. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

The information below shows the administrative changes for next year which includes important contact information.

Description	2020 (this year)	2021 (next year)
Prescription Benefit Manager	**OptumRx** Customer Service 1-866-589-5222	**CVS Caremark®** Customer Care 1-888-970-0914
Coverage Decisions for Part D Prescription Drugs – contact information	**KelseyCare Advantage Pharmacy Services** Call: 713-442-4810 or 1-844-541-8507 TTY: 1-855-815-2061 Fax: 713-442-4848 or 1-844-541-8508 Write: KelseyCare Advantage Attn: Pharmacy Services 11511 Shadow Creek Parkway Pearland, TX 77584-9832 –OR– P.O. Box 841569 Pearland, TX 77584	**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
Mail Order Pharmacy Contact Information	Mail Order Pharmacy is not covered	**CVS Caremark® Mail Service Pharmacy** Call: 210-706-2200 Fax: 210-706-2201 TTY: 711

Description	2020 (this year)	2021 (next year)
		7034 Alamo Downs Parkway San Antonio, TX 78238-4509

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in KelseyCare Advantage Rx+Choice

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 Rx+Choice 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 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *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, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

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 Rx+Choice.

- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from KelseyCare Advantage Rx+Choice.
- 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 this (phone numbers are in Section 7.1 of this booklet).
  - – *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, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2021, 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, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

Health Information Counseling and Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare.

Health Information Counseling and Advocacy Program (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Health Information Counseling and Advocacy Program (HICAP) in partnership with the Texas Department of Health and Human

Services at 1-800-252-9240. You can learn more about Health Information Counseling and Advocacy Program (HICAP) by visiting their website (hhs.texas.gov).

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. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas Kidney Healthcare Program (KHC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Texas HIV Medication Program. 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 Rx+Choice

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 from October 1 - March 31, 8:00 a.m. to 8:00 p.m. local time, seven days a week. From April 1 - September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. local time. Messaging service used weekends, after hours and on federal holidays.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for KelseyCare Advantage Rx+Choice. 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

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

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Method	KelseyCare Advantage Member Services - Contact Information	
Call	**1-866-535-8343** Calls to this number are free. Hours are October –March 31, 8:00 a.m. to 8:00 p.m. local time, seven days a week. From April 1 – September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. local time. Messagingservice used weekend, 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 October –March 31, 8:00 a.m. to 8:00 p.m. local time, seven days a week. From April 1 – September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. local time. Messagingservice used weekend, after hours and on federal holidays.	
Fax	713-442-5450	
Write	KelseyCare Advantage ATTN: Member Services 11511 Shadow Creek Parkway Pearland, TX 77584	- OR – 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	The Texas Department of Health and Human Services - Contact Information
CALL	1-800-252-9240 or 512-424-6500 – Monday through Friday 8:00 a.m. – 5:00 p.m.
TTY	Texas Relay 1-800-735-2989 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	The Texas Department of Health and Human Services P.O. Box 13247 Austin, TX 78711-3247
Website	hhs.texas.gov

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