

2021

Summary of Benefits

Rx (HMO)

Rx+Choice (HMO-POS)



Toll-free 1-866-534-8343, TTY 711



www.kelseycareadvantage.com

KelseyCare Advantage
☆☆☆☆☆

2021 SUMMARY OF BENEFITS

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 713-442-CARE (2273) or toll-free at 1-866-535-8343 (TTY users can call: 711).

Understanding the Benefits

	Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.KelseyCareAdvantage.com or call 1-866-535- 8343 (TTY users can call 711) 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, 2022.
	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 (HMO-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.

GENERAL PLAN INFORMATION

<p>Tips for comparing your Medicare choices</p>	<p>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.”</p> <p>Tips for comparing your Medicare choices</p> <ul style="list-style-type: none"> • 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 can call 1-877-486-2048. 	
<p>Sections in this book</p>	<ul style="list-style-type: none"> • Things to know about KelseyCare Advantage Rx (HMO) and KelseyCare Advantage Rx+Choice (HMO-POS) • Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits 	
<p>Hours of Operation</p>	<ul style="list-style-type: none"> • 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 8:00 a.m. to 8:00 p.m. Central time. 	
<p>Phone numbers and Website</p>	<ul style="list-style-type: none"> • If you are a member of this plan, call 713-442-CARE (2273) or toll-free 1-866-535-8343 (TTY users can call 711). • If you are not a member of this plan, call toll-free 1-800-663-7146 (TTY users can call 711). • Our website: www.kelseycareadvantage.com 	
<p>Who Can Join?</p>	<p>To join KelseyCare Advantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.</p> <p>Our service area includes the following counties in Texas: Harris, Brazoria, Fort Bend, Montgomery and Galveston (excluding the island).</p>	
<p>Which doctors and hospitals can I use?</p>	<p>Rx Plan: 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.</p>	<p>Rx+Choice Plan: Has a network of doctors, hospitals, and other providers. <i>For some services you can use providers that are not in our network.</i></p>
<p>Out-of-network/non-contracted providers are under no obligation to treat KelseyCare Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.</p>		

<p>Which pharmacies can I use?</p>	<p>You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.</p> <p>Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.</p> <p>You can see our plan’s provider directory and pharmacy directory at our website (www.kelseycareadvantage.com). Or, call us at the phone numbers above, and we will send you a copy of the provider and pharmacy directories.</p>
<p>What do we cover?</p>	<p>Like all Medicare health plans, we cover everything that Original Medicare covers – and more.</p> <p>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.</p> <p>Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.</p> <p>We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.</p> <p>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.kelseycareadvantage.com. Or, call us and we will send you a copy of the formulary.</p>
<p>How will I determine my drug costs?</p>	<p>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.</p>

Summary of Benefits

January 1, 2021 – December 31, 2021

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.	\$77 per month.
	In addition, you must keep paying your Medicare Part B premium.	
How much is the deductible?	This plan does not have a medical deductible.	
Is there any limit on how much I will pay for my covered services?	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on the out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly Part B premiums and cost-sharing for your Part D prescription drugs.</p>	
(Maximum Out-of-Pocket Responsibility)	<p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$3,450 for services you receive from in-network providers. 	<p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$3,450 for services you receive from in-network providers. • \$10,000 for services you receive from out-of-network providers.
Is there a limit on how much the plan will pay?	Our plan has a 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}	<p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days, per benefit period.</p> <ul style="list-style-type: none"> • \$150 copay per day for days 1-4 • \$600 maximum • \$0 copay for days 5-90 • \$0 per day for lifetime reserve days (if available) 	<p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days, per benefit period.</p> <p><u>In-network:</u></p> <ul style="list-style-type: none"> • \$150 copay per day for days 1-4 • \$600 maximum • \$0 copay for days 5-90 • \$0 per day for lifetime reserve days (if available) <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • You pay \$1,000 copay per benefit period for days 1-60 • \$250 copay per day for days 61-90 • \$500 copay per day for days 91-150
Outpatient Hospital Coverage ^{1,2}	<ul style="list-style-type: none"> • \$300 copay 	<ul style="list-style-type: none"> • \$300 copay <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • 20% coinsurance for all Medicare-covered outpatient hospital services
Ambulatory Surgery Center ^{1,2}	<ul style="list-style-type: none"> • \$225 copay 	<p><u>In-Network</u></p> <ul style="list-style-type: none"> • \$225 copay <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • 20% coinsurance for all Medicare-covered outpatient hospital services

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	<u>Rx (HMO)</u>	<u>Rx+Choice (HMO-POS)</u>
Doctor Visits (Primary Care Providers and Specialists) ^{1,2}	<u>Office visit:</u> <ul style="list-style-type: none"> • Primary care visit: \$0 copay • Specialist visit: \$25 copay 	<u>In-network office visit</u> <ul style="list-style-type: none"> • Primary care visit: \$0 copay • Specialist visit: \$25 copay <u>Out-of-network office visit:</u> <ul style="list-style-type: none"> • Primary care visit: 50% of the cost • Specialist visit: 20% of the cost
Preventive Care ¹	<ul style="list-style-type: none"> • \$0 copay 	<ul style="list-style-type: none"> • In-network: \$0 copay • Out-of-network: 50% of the cost
	<p>Other preventive services including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screening • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, hepatitis B shots, pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	
Emergency Care	\$120 copay 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	

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	Rx (HMO)	Rx+Choice (HMO-POS)
Diagnostic Services, Labs Imaging ^{1,2}	<p><u>Diagnostic radiology services (such as MRIs, CT scans):</u></p> <ul style="list-style-type: none"> • \$0-\$150 copay, depending on the service <p><u>Diagnostic tests and procedures:</u></p> <ul style="list-style-type: none"> • \$0-\$25 copay, depending on the service <p><u>Lab services:</u></p> <ul style="list-style-type: none"> • \$0 copay <p><u>Outpatient x-rays:</u></p> <ul style="list-style-type: none"> • \$0 copay <p><u>Therapeutic radiology services (such as radiation treatment for cancer):</u></p> <ul style="list-style-type: none"> • \$50 copay 	<p><u>Diagnostic radiology services (such as MRIs, CT scans):</u></p> <ul style="list-style-type: none"> • In-network: \$0-\$150 copay, depending on the service • Out-of-network: 20% of the cost <p><u>Diagnostic tests and procedures:</u></p> <ul style="list-style-type: none"> • In-network: \$0-\$25 copay, depending on the service • Out-of-network: 20% of the cost <p><u>Lab services:</u></p> <ul style="list-style-type: none"> • In-network: \$0 copay • Out-of-network: 20% of the cost <p><u>Outpatient X-Rays:</u></p> <ul style="list-style-type: none"> • In-network: \$0 copay • Out-of-network: 20% of the cost <p><u>Therapeutic radiology services (such as radiation treatment for cancer):</u></p> <ul style="list-style-type: none"> • In-network: \$50 copay • Out-of-network: 20% of the cost
Hearing Services ^{1,2}	<p><u>Exam to diagnose and treat hearing and balance issues:</u></p> <ul style="list-style-type: none"> • \$25 copay <p><u>Routine hearing exam:</u></p> <ul style="list-style-type: none"> • \$0 copay. You are covered for up to 1 every year. <p><u>Hearing aid allowance:</u> Our plan pays up to \$750 per ear every 3 years for hearing aids. You pay any amount over this plan allowed amount. Replacement batteries are not covered.</p>	<p><u>Exam to diagnose and treat hearing and balance issues:</u></p> <ul style="list-style-type: none"> • In-network: \$25 copay • Out-of-network: 20% of the cost <p><u>Routine hearing exam (In-network only):</u></p> <ul style="list-style-type: none"> • In-network: \$0 copay. You are covered for up to 1 every year. <p><u>Hearing aid allowance:</u> Our plan pays up to \$750 per ear every 3 years for hearing aids. You pay any amount over this plan allowed amount. Replacement batteries are not covered.</p>

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	Rx (HMO)	Rx+Choice (HMO-POS)
Dental Services (Medical dental) 1,2	<p>Medicare covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <ul style="list-style-type: none"> • \$25 copay 	<p>Medicare covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$25 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 50% coinsurance for Medicare covered dental services
Preventive Dental Services	<p><u>Preventive dental services:</u></p> <ul style="list-style-type: none"> • \$25 copay per visit <p><u>Cleaning:</u> 1 every six months <u>Dental X-ray(s):</u> 1 per year <u>Oral Exam:</u> 1 every 36 months</p>	<p><u>Preventive dental services:</u></p> <p><u>In-network</u></p> <ul style="list-style-type: none"> • \$25 copay per visit <p><u>Cleaning:</u> 1 every six months <u>Dental X-ray(s):</u> 1 per year <u>Oral Exam:</u> 1 every 36 months</p> <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • Not covered
Optional Dental Services (Comprehensive) (applicable only if purchased)	<p>You have the option to enroll in an optional supplemental dental plan for an additional monthly premium of \$32.80.</p> <p><u>Coverage Description:</u> Annual Maximum - \$3,000 Annual Deductible - \$25 Basic Services (Type II) – You pay 20% Major Services (Type III) – You pay 50% <i>Waiting period – For all Type III services there is a 12-month waiting period.</i></p>	<p>You have the option to enroll in an optional supplemental dental plan for an additional monthly premium of \$32.80.</p>
Vision Services	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</p> <ul style="list-style-type: none"> • \$25 copay <p><u>Routine eye exam:</u></p> <ul style="list-style-type: none"> • \$0 copay for 1 routine eye exam every year • \$75 allowance every year for contact lenses or eyeglasses. <p><u>Eyeglasses or contact lenses after cataract surgery:</u></p> <ul style="list-style-type: none"> • \$0 copay for eyeglasses or contact lenses after cataract surgery 	<ul style="list-style-type: none"> • In-network: \$25 copay • Out-of-network: 20% of the cost <p><u>Routine eye exam (In-network only):</u></p> <ul style="list-style-type: none"> • \$0 copay for 1 routine eye exam every year • \$75 allowance every year for contact lenses or eyeglasses. <p><u>Eyeglasses or contact lenses after cataract surgery:</u></p> <ul style="list-style-type: none"> • <u>In-network:</u> \$0 copay for eyeglasses or contact lenses after cataract surgery

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	Rx (HMO)	Rx+Choice (HMO-POS)
		<ul style="list-style-type: none"> • <u>Out-of-network</u>: 50% of the cost up to the Medicare allowed rate.
Mental Health Services (including inpatient) ^{1,2}	<p>Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>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.</p> <p>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.</p>	
	<ul style="list-style-type: none"> • \$150 copay per day for days 1-4 • \$600 maximum • \$0 copay for days 5-90 • \$0 per day for lifetime reserve days (if available) <p><u>Outpatient individual or group therapy visit:</u></p> <ul style="list-style-type: none"> • \$20 copay 	<p><u>In-network:</u></p> <ul style="list-style-type: none"> • \$150 copay per day for days 1-4 • \$600 maximum • \$0 copay for days 5-90 • \$0 per day for lifetime reserve days (if available) <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • \$1,000 copay per stay per benefit period for days 1-60 • \$250 copay per day for days 61-90 • \$500 copay per day for days 91-150 <p><u>Outpatient individual or group therapy visit:</u></p> <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 50% of the cost

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	Rx (HMO)	Rx+Choice (HMO-POS)
Skilled Nursing Facility (SNF) ^{1,2}	<p>Our plan covers up to 100 days in a SNF per benefit period.</p> <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$125 copay per day for days 21-100 	<p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p><u>In-network:</u></p> <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$125 copay per day for days 21-100 <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • 50% of the cost per stay
Physical Therapy ^{1,2}	<ul style="list-style-type: none"> • \$10 copay per visit 	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$10 copay per visit <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 50% of the cost
Ambulance <i>(Medicare-covered ground and air transportation services)</i>	<ul style="list-style-type: none"> • \$225 copay for each one-way trip 	<p><u>In-network:</u></p> <ul style="list-style-type: none"> • \$225 copay for each one-way trip <p><u>Out-of-network:</u></p> <ul style="list-style-type: none"> • 50% of the cost* <p>*Applies to non-emergency ambulance services</p>
Transportation	<p>You pay nothing.</p> <p>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.</p> <p>There is no out-of-network coverage for this benefit.</p>	
Medicare Part B Drugs ¹	<p><u>Part B chemotherapy drugs and other Part B drugs:</u></p> <ul style="list-style-type: none"> • 20% of the cost 	<p><u>Part B chemotherapy drugs and other Part B drugs:</u></p> <p><u>In-network and out-of-network:</u></p> <ul style="list-style-type: none"> • 20% of the cost

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Prescription Drug Benefits – Part D

Initial Coverage Limit

You will pay a yearly deductible of \$100 on Tiers 3, 4 and 5 drugs. You must pay the full cost of your Tiers 3, 4 and 5 drugs until you reach the plan's deductible amount. There is no deductible for select insulins. During the Deductible Stage, your out-of-pocket costs for these select insulins will be \$30-\$35 for a 30-day supply. After you pay your yearly deductible, you pay the following until your total yearly drug cost reach \$4,130. Total yearly drug costs are the total drug cost paid by both you and our Part D plan.

You may get your drugs at network retail and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	\$3	\$6	\$9
Tier 2 (Generic)	\$10	\$20	\$30
Tier 3 (Preferred Brand)	\$45	\$90	\$135
(Select Insulin*)	\$35	\$70	\$105
Tier 4 (Non-Preferred Drug)	\$90	\$180	\$270
Tier 5 (Specialty Tier)	31%	Not available	Not available

**Select Insulins in Tier 3 are covered under the plan's participation in the Part D Senior Savings Model Calendar Year 2021. To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services.*

Preferred Retail and Mail Order Cost-Sharing

Tier	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	\$0	\$0	\$0
Tier 2 (Generic)	\$5	\$10	\$12.50
Tier 3 (Preferred Brand)	\$40	\$80	\$100
(Select Insulin*)	\$30	\$60	\$75
Tier 4 (Non-Preferred Drug)	\$80	\$160	\$200
Tier 5 (Specialty Tier)	31%	Not available	Not available

**Insulin in Tier 3 are covered under the plan's participation in the Part D Senior Savings Model Calendar Year 2021. To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services.*

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out of network pharmacy but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130.

After you enter the coverage gap, you pay 25% of the plan’s negotiated price for covered brand name drugs and 25% of the plan’s negotiated price for covered generic drugs until your out-of-pocket costs total \$6,550, which is the end of the coverage gap. KelseyCare Advantage offers additional gap coverage for tier 1 drugs, tier 2 drugs and select insulins. Not everyone will enter the coverage gap.

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

Standard Retail Cost-Sharing

Tier	Drugs Covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	All	\$3	\$6	\$9
Tier 2 (Generic)	All	\$10	\$20	\$30
Select Insulin	Varies	\$35	\$70	\$105

Preferred Retail and Mail Order Cost-Sharing

Tier	Drugs Covered	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	All	\$0	\$0	\$0
Tier 2 (Generic)	All	\$5	\$10	\$12.50
Select Insulin	Varies	\$30	\$60	\$75

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550, you pay the greater of:

- 5% of the plan’s negotiated price, or
- \$3.70 copayment for generic (including brand drugs treated as generic) and a \$9.20 copayment for all other drugs.

Additional Medical Benefits

	Rx (HMO)	Rx+Choice (HMO-POS)
Acupuncture ^{1,2}	Annually the plan covers up to 12 acupuncture visits within 90 days for chronic low back pain, 8 additional days if improvement.	
	<ul style="list-style-type: none"> • \$20 copay per visit 	<u>In network:</u> <ul style="list-style-type: none"> • \$20 copay per visit <u>Out-of-network:</u> <ul style="list-style-type: none"> • 20% of the cost
Foot Care (podiatry services) ^{1,2}	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:	
	<ul style="list-style-type: none"> • \$25 copay 	<u>In-network:</u> <ul style="list-style-type: none"> • \$25 copay <u>Out-of-network:</u> <ul style="list-style-type: none"> • 20% of the cost
Medical Equipment/Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) ¹	<ul style="list-style-type: none"> • 20% of the cost <u>Diabetes monitoring supplies:</u> <ul style="list-style-type: none"> • You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay nothing for lancets, lancet devices and control solutions. • Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered. <u>Therapeutic shoes or inserts and Prosthetic devices:</u> <ul style="list-style-type: none"> • 20% of the cost <u>Continuous Glucose Monitors – Preferred Brands: Dexcom and Freestyle Libre</u> <ul style="list-style-type: none"> • 20% of the cost at DME vendor • 15% of the cost at a Pharmacy • Non-preferred brands not covered 	<ul style="list-style-type: none"> • <u>In-network:</u> 20% of the cost • <u>Out-of-network:</u> 50% of the cost <u>Diabetes monitoring supplies:</u> <ul style="list-style-type: none"> • You pay nothing, for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay nothing for lancets, lancet devices and control solutions. • Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered. • <u>Out-of-network:</u> 50% of the cost (even if preferred brands are used) <u>Therapeutic shoes or inserts and Prosthetic devices:</u> <ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 50% of the cost <u>Continuous Glucose Monitors – Preferred Brands: Dexcom and Freestyle Libre</u> <ul style="list-style-type: none"> • 20% of the cost at DME vendor • 15% of the cost at a Pharmacy • Non-preferred brands not covered • <u>Out-of-network:</u> Not covered
	Wellness Programs (e.g., fitness)	SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes. You pay nothing.

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)
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): <ul style="list-style-type: none"> • \$20 copay 	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 20% of the cost
Diabetes Self-Management Training 1,2	Diabetes self-management training: <ul style="list-style-type: none"> • \$0 copay 	Diabetes self-management training: <ul style="list-style-type: none"> • In-network: \$0 copay • Out-of-network: 50% of the cost
Home Health Care 1,2	<ul style="list-style-type: none"> • \$10 copay 	<ul style="list-style-type: none"> • In-network: \$10 copay • 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	Individual or group therapy visit: <ul style="list-style-type: none"> • \$20 copay 	Individual or group therapy visit: <ul style="list-style-type: none"> • In-network: \$20 copay • Out-of-network: 50% of the cost
Outpatient Surgery ^{1,2}	Outpatient hospital: <ul style="list-style-type: none"> • \$300 copay 	Outpatient hospital: <ul style="list-style-type: none"> • In-network: \$300 copay • Out-of-network: 20% of the cost
Ambulatory Surgery Center ^{1,2}	<ul style="list-style-type: none"> • \$225 copay 	<ul style="list-style-type: none"> • In-network: \$225 copay • Out-of-network: 20% of the cost
Over-the-Counter Items (OTC)	Up to \$25 allowance every three months for the purchase of select OTC supplies from Kelsey Pharmacy locations.	
Renal Dialysis 1,2	<ul style="list-style-type: none"> • 20% of the cost 	<ul style="list-style-type: none"> • In-network: 20% of the cost • Out-of-network: 50% of the cost* <p>*Applies to out-of-network renal dialysis in the service area</p>

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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 a covered benefit from Kelsey-Seybold primary care and specialty contracted physicians.	
	<u>E-Visits / Video Visits / Phone Visits</u> <ul style="list-style-type: none"> • PCP \$0 • Specialist \$15 	<u>E-Visits / Video Visits / Phone Visits</u> <ul style="list-style-type: none"> • PCP \$0 • Specialist \$15 <u>Out-of-Network:</u> <ul style="list-style-type: none"> • Not covered
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):	
	<ul style="list-style-type: none"> • \$25 copay <u>Occupational therapy visit:</u> <ul style="list-style-type: none"> • \$10 copay 	<ul style="list-style-type: none"> • In-network: \$25 copay • Out-of-network: 50% of the cost <u>Occupational therapy visit:</u> <ul style="list-style-type: none"> • In-network: \$10 copay • 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.



This information is not a complete description of benefits. Call 1-866-535-8343 for more information. TTY users can call 711.

KelseyCare Advantage is offered by KS Plan Administrators, LLC, 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.