

2024

FREEDOM (HMO-POS)

HONOR (HMO)



SUMMARY OF BENEFITS

1-866-535-8343 (TTY: 711)

[KelseyCareAdvantage.com](https://www.KelseyCareAdvantage.com)

PRE-ENROLLMENT CHECKLIST

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

Understanding the Benefits

	Review the full list of benefits found in the <i>Evidence of Coverage (EOC)</i> , especially for those services that you routinely see a doctor. Visit www.KelseyCareAdvantage.com or call 1-866-535-8343 (TTY users can call 711) to view a copy of the EOC.
	Review the <i>Provider Directory</i> (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
	For KelseyCare Advantage Freedom plan, review the <i>Pharmacy Directory</i> to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

	In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
	Benefits, premiums and/or copayments/coinsurance may change on January 1, 2025.
	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 Freedom plan.
	The KelseyCare Advantage Freedom plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher cost-share for services received by non-contracted providers.

GENERAL PLAN INFORMATION

<p>Tips for comparing your Medicare choices</p>	<p>This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Honor (HMO), and KelseyCare Advantage Freedom (HMO-POS), cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the “<i>Evidence of Coverage</i>.”</p> <p>Tips for comparing your Medicare choices:</p> <ul style="list-style-type: none"> • 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 “<i>Medicare & You</i>” 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.
<p>Sections in this book</p>	<ul style="list-style-type: none"> • Things to know about KelseyCare Advantage Honor, and KelseyCare Advantage Freedom, • Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits (if applicable)
<p>Hours of Operation</p>	<ul style="list-style-type: none"> • Hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 – March 31. From April 1 – September 30, Monday through Friday, hours are 8:00 a.m. to 8:00 p.m. local time. Messaging service used on weekends, after hours, and on federal holidays.
<p>Phone numbers and Website</p>	<ul style="list-style-type: none"> • If you are a member of this plan, call 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: Austin, Brazoria, Chambers, Fort Bend, Grimes, Harris, Liberty, Montgomery, San Jacinto, Walker, Waller, Wharton, and Galveston (excluding the island).</p>

<p>Which doctors and hospitals can I use?</p>	<p>KelseyCare Advantage Honor: 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>KelseyCare Advantage Freedom: Has a network of doctors, hospitals, and other providers. <i>For some services you can use providers that are not in our network.</i></p>
<p>Out-of-Network/non-contracted providers are under no obligation to treat KelseyCare Advantage members, except in emergency situations. Please call our customer service number or see your <i>Evidence of Coverage</i> for more information, including the cost-sharing that applies to Out-of-Network services.</p>		
<p>Which pharmacies can I use?</p>	<p>Part D benefits are not offered with this plan.</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. 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 KelseyCare Advantage Freedom plan. 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. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.</p> <p>Part D prescription drugs are not covered in KelseyCare Advantage Honor</p>	

	KelseyCare Advantage Honor:	KelseyCare Advantage Freedom:
How will I determine my drug costs?	Part D benefits are not offered with this plan.	Our plan groups each medication into one of 6 “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

Summary of Benefits

January 1, 2024 – December 31, 2024

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

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
How much is the monthly premium?	\$0 per month.	\$0 per month.
	In addition, you must continue to keep paying your Medicare Part B premium.	
How much is the deductible?	These plans do not have a medical deductible.	
Is there any limit on how much I will pay for my covered services? (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. 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.	
	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$3,850 for services you receive from In-Network providers. <p>Please note that you will still need to pay your monthly Part B premiums</p>	Your yearly limit(s) in this plan: <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. <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>
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.

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (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> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$295 copay per stay • \$0 copay 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"> • \$325 copay per stay • \$0 copay per day for lifetime reserve days (if available) <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 40% coinsurance per stay
Outpatient Hospital Coverage ^{1,2}	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$200 copay 	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$300 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 20% coinsurance
Ambulatory Surgery Center (ASC) ^{1,2}	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$175 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
Doctor Visits (Primary Care Providers and Specialists) ^{1,2}	<p><u>In-Network office visit:</u></p> <ul style="list-style-type: none"> • Primary care: \$0 copay • Specialist: \$10 copay 	<p><u>In-Network office visit:</u></p> <ul style="list-style-type: none"> • Primary care: \$0 copay • Specialist: \$25 copay <p><u>Out-of-Network office visit:</u></p> <ul style="list-style-type: none"> • Primary care: \$10 copay • Specialist*: \$35 copay <p>*40% coinsurance for each MD Anderson provider visit</p>

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Preventive Care	<u>In-Network:</u> <ul style="list-style-type: none"> • \$0 copay 	<u>In-Network:</u> <ul style="list-style-type: none"> • \$0 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • 50% coinsurance
	Preventive services include: <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.	\$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	\$5 copay	\$25 copay

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (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"> <u>In-Network:</u> \$0 to \$150 copay, depending on the service <p><u>Diagnostic tests and procedures:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 to \$25 copay, depending on the service <p><u>Lab services:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 copay <p><u>Outpatient X-Rays:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 copay <p><u>Therapeutic radiology services (such as radiation treatment for cancer):</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$50 copay 	<p><u>Diagnostic radiology services (such as MRIs, CT scans):</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 to \$150 copay, depending on the service <u>Out-of-Network:</u> 20% coinsurance <p><u>Diagnostic tests and procedures:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 to \$25 copay, depending on the service <u>Out-of-Network:</u> 20% coinsurance <p><u>Lab services:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> 50% coinsurance at any other provider <p><u>Outpatient X-Rays:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 copay <u>Out-of-Network:</u> \$20 copay <p><u>Therapeutic radiology services (such as radiation treatment for cancer):</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$50 copay <u>Out-of-Network:</u> 20% coinsurance

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

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Hearing Services ^{1,2}	<p><u>Exam to diagnose and treat hearing and balance issues:</u></p> <ul style="list-style-type: none"> <u>In-Network:</u> \$0 copay <p><u>Routine hearing exam:</u></p> <p><u>In-Network:</u> \$0 copay. You are covered for up to 1 routine hearing exam every year.</p> <p><u>Hearing aid allowance:</u></p> <p>Our plan pays up to \$750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan allowed amount. 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"> <u>In-Network:</u> \$25 copay <u>Out-of-Network:</u> 20% coinsurance <p><u>Routine hearing exam:</u></p> <p><u>In-Network:</u> \$0 copay. You are covered for up to 1 routine hearing exam every year.</p> <p><u>Hearing aid allowance:</u></p> <p>Our plan pays up to \$750 maximum plan coverage amount per ear for hearing aid benefits every three years. You pay any amount over this plan allowed amount. Replacement batteries are not covered.</p>
Medicare-covered Dental Services ^{1,2} (see the additional benefits section for other dental services available)	<p><u>Medicare-covered Dental Services:</u> (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> \$0 copay 	<p><u>Medicare-covered Dental Services:</u> (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> \$25 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> Not covered
Vision Services	<p><u>Routine eye exam and eyewear:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> \$0 copay for 1 routine vision exam every year <p>\$125 plan coverage limit for eyewear, glasses and/or contact lenses every year unrelated to post-cataract surgery. Allowance can only be used on one date of service.</p>	<p><u>Routine eye exam and eyewear:</u></p> <p><u>In-Network only:</u></p> <ul style="list-style-type: none"> \$0 copay for 1 routine vision exam every year <p>\$125 plan coverage limit for eyewear, glasses and/or contact lenses every year unrelated to post-cataract surgery. Allowance can only be used on one date of service.</p>

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Vision Services (continued)	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay for each exam to diagnose and treat conditions of the eye • \$0 copay for each annual glaucoma screening <p><u>Eyeglasses or contact lenses after cataract surgery:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay 	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 to \$25 copay for each exam to diagnose and treat conditions of the eye • \$0 copay for each annual glaucoma screening <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 20% coinsurance for each exam to diagnose and treat conditions of the eye • 50% coinsurance for each annual glaucoma screening <p><u>Eyeglasses or contact lenses after cataract surgery:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 50% coinsurance up to the Medicare allowed rate.
Mental Health Services (including inpatient)^{1,2}	<p><u>Inpatient visit:</u></p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p>	
	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$295 copay per stay • \$0 copay per day for lifetime reserve days (if available) <p><u>Outpatient individual or group therapy visit:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$20 copay 	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$325 copay per stay • \$0 copay per day for lifetime reserve days (if available) <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 40% coinsurance per stay <p><u>Outpatient individual or group therapy visit:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$20 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • \$35 copay

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

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Skilled Nursing Facility (SNF) ^{1,2}	<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>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% coinsurance per stay
Physical Therapy ^{1,2}	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$10 copay 	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$10 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • \$40 copay
Ambulance (Medicare-covered ground and air transportation services)	<p><u>In-Network:</u></p> <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"> • \$250 copay for each one-way ground ambulance trip • 50% coinsurance for each one-way air ambulance trip.
Transportation	<ul style="list-style-type: none"> • \$0 copay <p>This plan covers up to 20 one-way trips every year to plan-approved locations.</p> <ul style="list-style-type: none"> • Transportation is limited to medical appointments and medical facilities within KelseyCare Advantage plan service area • Wheelchair-accessible vehicles need to be requested at least 24 hours in advance • This benefit does not cover transportation by stretcher or ambulance (ALS or BLS) • A trip is one-way transportation; a round trip is 2 trips 	<ul style="list-style-type: none"> • \$0 copay <p>This plan covers unlimited trips every year to plan-approved locations.</p> <ul style="list-style-type: none"> • Transportation is limited to medical appointments and medical facilities within KelseyCare Advantage plan service area • Wheelchair-accessible vehicles need to be requested at least 24 hours in advance • This benefit does not cover transportation by stretcher or ambulance (ALS or BLS)

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Transportation (continued)	Our SSBCI transportation benefit is available to members with certain chronic health conditions that include ESRD, cancer and severe hematological disorder. These members can receive unlimited non-emergency transportation trips to their medical appointments for dialysis, infusion chemotherapy, radiation therapy and coumadin clinic.	
Medicare Part B Drugs¹	<u>Part B chemotherapy drugs, insulin, and other Part B drugs:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • 0% to 20% coinsurance 	<u>Part B chemotherapy drugs, insulin, and other Part B drugs:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • 0% to 20% coinsurance <u>Out-of-Network:</u> <ul style="list-style-type: none"> • 0% to 20% coinsurance

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

Prescription Drug Benefits – (Medicare Part D Drugs)

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Pharmacy (Part D) Deductible	Part D benefits are not offered with this plan.	\$100 for Tiers 3, 4, and 5 drugs.
Initial Coverage	Part D benefits are not offered with this plan.	You pay the following until your total yearly drug costs reach \$5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage booklet.
<ul style="list-style-type: none"> Standard Retail and Mail Order Cost-Sharing 	Part D benefits are not offered with this plan.	<p>Tier 1 (<i>Preferred Generic</i>) \$3 copay for a one-month supply \$9 copay for a three-month supply</p> <p>Tier 2 (<i>Generic</i>) \$15 copay for a one-month supply \$45 copay for a three-month supply</p> <p>Tier 3 (<i>Preferred Brand</i>) \$45 copay for a one-month supply \$135 copay for a three-month supply</p>

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
<ul style="list-style-type: none"> • Standard Retail and Mail Order Cost-Sharing (continued) 	Part D benefits are not offered with this plan.	<p>Tier 4 (<i>Non-Preferred Drug</i>) \$90 copay for a one-month supply \$270 copay for a three-month supply</p> <p>Tier 5 (<i>Specialty Tier</i>) 31% coinsurance for a one-month supply (long-term supply is not available)</p> <p>Tier 6 (<i>Select Care Drugs</i>) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p>

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
<ul style="list-style-type: none"> Preferred Retail and Mail Order Cost-Sharing (Initial Coverage Limit) 	<p>Part D benefits are not offered with this plan.</p>	<p>Tier 1 (<i>Preferred Generic</i>) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p> <p>Tier 2 (<i>Generic</i>) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p> <p>Tier 3 (<i>Preferred Brand</i>) \$40 copay for a one-month supply. \$100 copay for a three-month supply.</p> <p>Tier 4 (<i>Non-Preferred Drug</i>) \$80 copay for a one-month supply. \$200 copay for a three-month supply.</p> <p>Tier 5 (<i>Specialty Tier</i>) 31% coinsurance for a one-month supply (long-term supply is not available)</p> <p>Tier 6 (<i>Select Care Drugs</i>) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p>

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
<ul style="list-style-type: none"> Standard Retail and Mail Order Cost-Sharing (Coverage Gap) 	<p>Part D benefits are not offered with this plan.</p>	<p><i>Standard Retail and Mail Order Coverage Gap is not covered in Tier 3, Tier 4, and Tier 5</i></p> <p>Tier 1 (Preferred Generic) \$3 copay for a one-month supply. \$9 copay for a three-month supply</p> <p>Tier 2 (Generic) \$15 copay for a one-month supply. \$45 copay for a three-month supply</p> <p>Tier 6 (Select Care Drugs) \$0 copay for a one-month supply. \$0 copay for a three-month supply</p>
<ul style="list-style-type: none"> Preferred Retail and Mail Order Cost-Sharing (Coverage Gap) 	<p>Part D benefits are not offered with this plan.</p>	<p><i>Preferred Retail and Mail Order Coverage Gap is not covered in Tier 3, Tier 4, and Tier 5</i></p> <p>Tier 1 (Preferred Generic) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p> <p>Tier 2 (Generic) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p> <p>Tier 6 (Select Care Drugs) \$0 copay for a one-month supply. \$0 copay for a three-month supply.</p>

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Catastrophic Coverage	Part D benefits are not offered with this plan.	After your yearly out-of-pocket drug costs (<i>including drugs purchased through your retail pharmacy and through mail order</i>) reach \$8,000, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
Additional Prescription Drug Benefits	Part D benefits are not offered with this plan.	As part of the plan's enhanced drug coverage for Calendar Year 2024, the plan covers the following Tier 2 excluded drugs: Sildenafil (generic Viagra), Vitamin D2, Folic Acid, and Vitamin B12. Payments you make for excluded drugs are not included in your out-of-pocket costs.

Additional Medical Benefits

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Acupuncture ^{1,2}	Annually the plan covers up to 12 acupuncture visits within 90 days for chronic low back pain, 8 additional sessions if improvement shown. No more than 20 acupuncture treatments can be given yearly.	
	<u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay 	<u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • \$35 copay
Foot Care (podiatry services) ^{1,2}	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	
	<u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay 	<u>In-Network:</u> <ul style="list-style-type: none"> • \$25 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • \$35 copay
Medical Equipment/Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies) ¹	<u>Durable medical equipment:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • 20% coinsurance 	<u>Durable medical equipment</u> <u>In-Network:</u> <ul style="list-style-type: none"> • 20% coinsurance
	<u>Diabetes monitoring supplies:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • You pay 0% coinsurance for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay 0% coinsurance for lancets, lancet devices and control solutions. <p>Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.</p>	<u>Diabetes monitoring supplies:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • You pay 0% coinsurance for meters and test strips, if you use a preferred brand (Roche and LifeScan). • You pay 0% coinsurance for lancets, lancet devices and control solutions. <p>Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.</p>
		<u>Out-of-Network:</u> <ul style="list-style-type: none"> • 50% coinsurance (even if preferred brands are used)

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

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Medical Equipment/Supplies (continued)	<p><u>Therapeutic shoes or inserts and Prosthetic devices:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 20% coinsurance <p><u>Continuous Glucose Monitors – Preferred Brands: Dexcom G6 and G7:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • Continuous blood glucose monitors (CGM) covered 15% at retail pharmacy and 20% at DME vendor. Preferred CGMs are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy. All other DME is covered at 20%. 	<p><u>Therapeutic shoes or inserts and Prosthetic devices:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 20% coinsurance <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 50% coinsurance <p><u>Continuous Glucose Monitors – Preferred Brands: Dexcom G6 and G7:</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • Continuous blood glucose monitors 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGMs are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy. All other DME is 20% coinsurance. <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 50% coinsurance
Wellness Programs (e.g., fitness)	Not Covered	You pay a \$0 copay for OnePass — Access to a participating gym network, on-demand and livestreaming digital content and a comprehensive cognitive program called BrainHQ.
Chiropractic Care^{1,2}	<p><u>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$20 copay 	<p><u>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</u></p> <p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$20 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • \$35 copay
Diabetes Self-Management Training^{1,2}	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay 	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 50% coinsurance

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

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Home Health Care ^{1,2}	<u>In-Network:</u> <ul style="list-style-type: none"> • \$10 copay 	<u>In-Network:</u> <ul style="list-style-type: none"> • \$10 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • 50% coinsurance
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}	<u>Individual or group therapy visit:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay 	<u>Individual or group therapy visit:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • \$35 copay
Surgery ^{1,2}	<u>In-Network:</u> <ul style="list-style-type: none"> • \$200 copay at outpatient hospital • \$175 copay at ambulatory surgery center 	<u>In-Network:</u> <ul style="list-style-type: none"> • \$300 copay at outpatient hospital • \$225 copay at ambulatory surgery center <u>Out-of-network:</u> <ul style="list-style-type: none"> • 20% coinsurance
Over-the-Counter Items (OTC)	You receive a \$50 allowance every 3 months for OTC items. The remaining amount will not carry over to the next quarter.	You receive a \$95 allowance every 3 months for OTC items. The remaining amount will not carry over to the next quarter.
Renal Dialysis ^{1,2}	<u>In-Network:</u> <ul style="list-style-type: none"> • 20% coinsurance 	<u>In-Network:</u> <ul style="list-style-type: none"> • 20% coinsurance <u>Out-of-Network:</u> <ul style="list-style-type: none"> • 50% coinsurance

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Telemedicine visits	E-Visits and Video Visits are a covered benefit for Kelsey-Seybold primary care and specialty physicians.	
	<u>In-Network:</u> <ul style="list-style-type: none"> • PCP: Phone, E-Visits and Video Visits with a PCP: \$0 copay • Specialist: Specialty, Mental Health and other providers — Phone, E-Visits and Video Visits: \$15 copay 	<u>In-Network:</u> <ul style="list-style-type: none"> • PCP: Phone, E-Visits and Video Visits with a PCP: \$0 copay • Specialist: Specialty, Mental Health and other providers — Phone, E-Visits and Video Visits: \$15 copay <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):	
	<u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay <u>Occupational therapy:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • \$20 copay 	<u>In-Network:</u> <ul style="list-style-type: none"> • \$25 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • 50% coinsurance <u>Occupational therapy:</u> <u>In-Network:</u> <ul style="list-style-type: none"> • \$10 copay <u>Out-of-Network:</u> <ul style="list-style-type: none"> • 50% coinsurance

	KelseyCare Advantage Honor (HMO)	KelseyCare Advantage Freedom (HMO-POS)
Preventive Dental Services	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 0% coinsurance • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehensive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) <p>Services are only covered if provided by an in-network dentist.</p>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 0% coinsurance • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehensive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) <p>Services are only covered if provided by an in-network dentist.</p> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • Not covered
Comprehensive Dental Services	<p><u>In-Network:</u></p> <p>\$2,000 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details.</p> <ul style="list-style-type: none"> • 0% coinsurance for each service. <p><u>Periodontic Services</u> <u>Prosthodontic Services</u> <u>Restorative Services</u> <u>Oral and Maxillofacial Surgery Services</u></p>	<p><u>In-Network:</u></p> <p>\$2,500 annual benefit maximum for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details.</p> <ul style="list-style-type: none"> • 0% coinsurance for each service. <p><u>Periodontic Services</u> <u>Prosthodontic Services</u> <u>Restorative Services</u> <u>Oral and Maxillofacial Surgery Services</u></p> <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • Not covered
Flex Wallet Card	Not available	<p>Your coverage includes a \$750 annual flex wallet card benefit for dental, vision, and hearing services. You can use this allowance to pay for out-of-pocket amounts due to these providers. You will have access to these funds using an issued debit card.</p> <p>Unused allowances do not carry over to the next calendar year.</p>

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

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-535-8343. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

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

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

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-535-8343. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-535-8343. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-535-8343 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-535-8343. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 -866-535-8343번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-535-8343. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-535-8343. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-535-8343 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-535-8343. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-535-8343. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-535-8343. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-535-8343. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますごじます。通訳をご用命になるには、
1-866-535-8343にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。



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

KelseyCare Advantage is offered by KS Plan Administrators, LLC, an HMO with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal. Contact the plan for more information.