KelseyCare Advantage

2025
SUMMARY OF BENEFITS

Signature (HMO) • Freedom (HMO-POS) • Core (HMO)

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

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 *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.
	For KelseyCare Advantage Freedom (HMO-POS) and Signature (HMO) plans, 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 (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, 2026.
	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 (HMO-POS) 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

Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what KelseyCare Advantage Core (HMO), KelseyCare Advantage Freedom (HMO-POS), and KelseyCare Advantage Signature (HMO) covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "*Evidence of Coverage*." Tips for comparing your Medicare choices: • If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. • If you want to know more about the coverage and costs of Original Medicare, look in your current "*Medicare & You*" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
Sections in this book	• Things to know about KelseyCare Advantage Core (HMO), KelseyCare Advantage Freedom (HMO-POS), and KelseyCare Advantage Signature (HMO) • Monthly Premium, Deductible, Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits (if applicable)
Hours of Operation	• 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.
Phone numbers and Website	• 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
Who Can Join?	To join KelseyCare Advantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area for KelseyCare Advantage Freedom (HMO-POS) and KelseyCare Advantage Core (HMO) 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). **Our service area for KelseyCare Advantage Signature (HMO) includes the following counties in Texas:** Brazoria, Fort Bend, Harris, Montgomery and Galveston (excluding the island).

<table>
<tr><td rowspan="3">Which doctors and hospitals can I use?</td><td>KelseyCare Advantage Core (HMO)</td><td>KelseyCare Advantage Signature (HMO)</td><td>KelseyCare Advantage Freedom (HMO-POS)</td></tr>
<tr><td colspan="2">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.</td><td>Has a network of doctors, hospitals, and other providers. For some services you can use providers that are not in our network. You may pay more when using out-of-network providers.</td></tr>
<tr><td colspan="3">Out-of-Network/non-contracted providers are under no obligation to treat KelseyCare Advantage members, except in emergency situations. Please call Member Services or see your Evidence of Coverage for more information, including the cost-sharing that applies to Out-of-Network services.</td></tr>
<tr><td rowspan="2">Which pharmacies can I use?</td><td>KelseyCare Advantage Core</td><td>KelseyCare Advantage Signature</td><td>KelseyCare Advantage Freedom</td></tr>
<tr><td>Part D benefits are not offered with this plan.</td><td colspan="2">You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
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 on 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.</td></tr>
</table>

<table>
<tr><td>What do we cover?</td><td colspan="3">Our plan members get all the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs in KelseyCare Advantage Freedom and Signature plans.

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.

Part D prescription drugs are not covered in KelseyCare Advantage Core.</td></tr>
<tr><td rowspan="2">How will I determine my drug costs?</td><td>KelseyCare Advantage Core</td><td>KelseyCare Advantage Signature</td><td>KelseyCare Advantage Freedom</td></tr>
<tr><td>Part D benefits are not offered with this plan.</td><td colspan="2">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: Deductible Stage, Initial Coverage Stage, and Catastrophic Coverage Stage</td></tr>
</table>

Summary of Benefits

January 1, 2025 – December 31, 2025

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
How much is the monthly premium?	$0 per month	$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?	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. **Please note that you will still need to pay your monthly Part B premiums and cost-sharing for your Part D prescription drugs.**		
(Maximum out-of-pocket responsibility)	Your yearly limit(s) in this plan: • $4,500 for services you receive from In-Network providers.	Your yearly limit(s) in this plan: • $4,500 for services you receive from In-Network providers.	Your yearly limit(s) in this plan: • $6,500 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 and Out-of-Nework 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 Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Inpatient Hospital Coverage[1]	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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days, per benefit period.		
	<u>In-Network</u> • $325 copay per day for days 1-5 • $0 copay per day for days 6-90 (if available).		<u>In-Network</u> • $375 copay per day for days 1-5 • $0 copay per day for days 6-90 (if available). <u>Out-of-Network</u> • 40% coinsurance per stay
Outpatient Hospital Coverage[1]	<u>In-Network</u> • $300 copay		<u>In-Network</u> • $350 copay <u>Out-of-Network</u> • 40% coinsurance per stay

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Ambulatory Surgery Center (ASC)[1]	In-Network • $300 copay		In-Network • $300 copay Out-of-Network • 40% coinsurance per stay
Doctor Visits (Primary Care Providers and Specialists)[2]	In-Network office visit • Primary care: $0 copay • Specialist: $20 copay		In-Network office visit • Primary care: $0 copay • Specialist: $35 copay Out-of-Network office visit • Primary care: $10 copay • Specialist*: $60 copay **40% coinsurance for each MD Anderson provider visit*

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

<table>
<tr><th></th><th>KelseyCare Advantage Core</th><th>KelseyCare Advantage Signature</th><th>KelseyCare Advantage Freedom</th></tr>
<tr><td rowspan="2">Preventive Care</td><td colspan="2"><u>In-Network</u>
• $0 copay</td><td><u>In-Network</u>
• $0 copay

<u>Out-of-Network</u>
• 40% coinsurance</td></tr>
<tr><td colspan="3">Preventive services include:

• 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, Stool DNA test)
• 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

Any additional preventive services approved by Medicare during the contract year will be covered.</td></tr>
<tr><td>Emergency Care</td><td colspan="3">$125 copay
Copay is waived if you are admitted to the hospital within 3 days for the same condition.

See the “Inpatient Hospital Care” section of this booklet for other costs.</td></tr>
<tr><td>Urgently Needed Services</td><td colspan="2">$25 copay</td><td>$40 copay</td></tr>
</table>

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Diagnostic Services, Labs, Imaging[1]	***Diagnostic radiology services (such as MRIs, CT scans):***		
	In-Network •$25 to $200 copay, depending on the service		In-Network • $25 to $200 copay, depending on the service Out-of-Network • 40% coinsurance
	Diagnostic tests and procedures:		
	In-Network •$0 to $25 copay, depending on the service		In-Network • $0 to $25 copay, depending on the service Out-of-Network • 40% coinsurance
	Lab services:		
	In-Network •$0 copay		In-Network • $0 copay Out-of-Network • 40% coinsurance at any other provider
	Outpatient X-Rays:		
	In-Network • $0 copay		In-Network • $0 copay Out-of-Network • $40% coinsurance
	Therapeutic radiology services (such as radiation treatment for cancer):		
	In-Network • $50 copay		In-Network • $50 copay Out-of-Network • 40% coinsurance

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Hearing Services[1]	***Exam to diagnose and treat hearing and balance issues***		
	In-Network • $0 copay for 1 routine hearing exam per year. • $20 copay for diagnostic hearing exams.		In-Network • $0 copay for 1 routine hearing exam per year. • $35 copay for diagnostic hearing exams. Out-of-Network • 40% coinsurance
	Hearing Aid Allowance		
	Our plan pays up to $750 maximum plan coverage amount per ear for hearing aid(s) every three years. You pay any amount over this plan allowed amount. Replacement batteries are not covered.		
Medicare-covered Dental Services *(see the additional benefits section for other dental services available)*	***This does not include services in connection with care, treatment, filling, removal, or replacement of teeth***		
	In-Network • $0 copay	In-Network • $20 copay	In-Network • $35 copay Out-of-Network • Not covered

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Vision Services	***Routine eye exam and eyewear:*** Members receiving eye exams will have $0 copay for their first visit of the year, regardless of whether the eye exam is for routine or medical services. Members will be charged specialist copay for all subsequent eye exams.		
	In-Network • $0 copay for 1 routine eye exam each year. • $20 for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. • $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. • $0 copay for each annual glaucoma screening		In-Network • $0 copay for 1 routine eye exam each year. • $35 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. • $175 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. • $0 copay for each annual glaucoma screening Out-of-Network • 40% coinsurance for each routine eye exam or Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. • 40% of the total cost for an annual glaucoma screening.

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Vision Services (continued)	***Eyeglasses or contact lenses after cataract surgery:***		
	<u>In-Network</u> • $0 copay for one pair of eyeglasses or contact lenses after cataract surgery.		<u>In-Network</u> • $0 copay for one pair of eyeglasses or contact lenses after cataract surgery. <u>Out-of-Network</u> • 40% of the total cost for one pair of eyeglasses or contact lenses after cataract surgery.

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<table>
<tr><td rowspan="4">Mental Health Services (including inpatient)[1]</td><td colspan="2">Psychiatric Inpatient visit:
You receive up to 190 days of Medicare-covered inpatient psychiatric hospital care in a lifetime. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</td></tr>
<tr><td><u>In-Network</u>
• $325 copay per day for days 1-5
• $0 copay per day for days 6-90 (if available).</td><td><u>In-Network</u>
• $375 copay per day for days 1-5
• $0 copay per day for days 6-90 (if available).

<u>Out-of-Network</u>
• 40% coinsurance per stay</td></tr>
<tr><td colspan="2">Outpatient individual or group therapy visit (no prior authorization needed)</td></tr>
<tr><td><u>In-Network</u>
• $20 copay</td><td><u>In-Network</u>
• $20 copay

<u>Out-of-Network</u>
• 40% coinsurance</td></tr>
</table>

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Skilled Nursing Facility (SNF)[1]	***Our plan covers up to 100 days in a SNF per benefit period.***		
	In-Network • $0 copay per day for days 1-20 • $214 copay per day for days 21-100		In-Network • $0 copay per day for days 1-20 • $214 copay per day for days 21-100 Out-of-Network • 40% coinsurance per stay
Physical Therapy [1]	In-Network • $15 copay		In-Network • $15 copay Out-of-Network • 40% coinsurance
Ambulance (*Medicare-covered ground and air transportation services)*	In-Network • $275 copay for each one-way trip		In-Network • $275 copay for each one-way trip Out-of-Network • $400 copay for each one-way ground or air ambulance trip.

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Transportation (routine)	Not Covered	$0 copay for 10 one-way rides to plan approved locations.	$0 copay for 10 one-way rides to plan approved locations.
Special Supplemental Benefits for the Chronically Ill (transportation services)	In-Network $0 copay for unlimited transportation services to plan-approved locations • The plan will review claims and encounter data to identify if you qualify and send the eligibility to our transportation vendor. • Unlimited one-way trips to plan-approved health-related locations using other covered transportation modes include car, SUV, minivan and wheelchair accessible van. *The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify.*		
	• Our SSBCI transportation benefit is available to members with certain chronic health conditions that include: o ESRD o Cancer o Severe Hematological Disorders • Members can receive unlimited non-emergency transportation trips to their medical appointments for dialysis, infusion chemotherapy, radiation therapy and coumadin clinic. *CHF (congestive heart failure is not a qualifying condition for the Core plan)*.	• Our SSBCI transportation benefit is available to members with certain chronic health conditions that include: o ESRD o Cancer o Congestive Heart Failure (CHF) o Severe Hematological Disorders • Members can receive unlimited non-emergency transportation trips to their medical appointments for dialysis, CHF Clinic, infusion chemotherapy, radiation therapy and coumadin clinic.	• Our SSBCI transportation benefit is available to members with certain chronic health conditions that include**:** o ESRD o Cancer o Congestive Heart Failure (CHF) o Severe Hematological Disorders • Members can receive unlimited non-emergency transportation trips to their medical appointments for dialysis, CHF Clinic, infusion chemotherapy, radiation therapy and coumadin clinic.

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Medicare Part B Drugs[1]	***Part B chemotherapy drugs, Part B insulin, and other Part B drugs:***		
	In-Network • 0% to 20% coinsurance You will not pay more than $35 per month for covered Part B insulin. Service category and plan level deductibles do not apply.		In-Network • 0% to 20% coinsurance Out-of-Network • 0% to 40% coinsurance You will not pay more than $35 per month for covered Part B insulin. Service category and plan level deductibles do not apply.

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Prescription Drug Benefits – (Medicare Part D Drugs)

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Pharmacy (Part D) Deductible	Part D benefits are not offered with this plan.	$100 for Tiers 3, 4, and 5 drugs.	$200 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 $2,000. 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.	
Preferred Retail and Preferred Mail-Order Cost-Sharing (Initial Coverage Limit)	Part D benefits are not offered with this plan.	**Tier 1 (Preferred Generic)** $0 copay for a one-month supply $0 copay for a three-month supply **Tier 2 (Generic)** $5 copay for a one-month supply. $12.50 copay for a three-month supply **Tier 3 (Preferred Brand)** $40 copay for a one-month supply $100 copay for a three-month supply **Tier 4 (Non-Preferred Drug)** 40% coinsurance copay for a one-month supply 40% coinsurance for a three-month supply **Tier 5 (Specialty Tier)** 30% coinsurance for a one- month supply (long-term supply is not available) **Tier 6 (Select Care Drugs)** $0 copay for a one-month supply $0 copay for a 100-day supply	

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.

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Standard Retail and Standard Mail-Order Cost-Sharing	Part D benefits are not with this plan. .	**Tier 1 (Preferred Generic)** $7 copay for a one-month supply $21 copay for a three-month supply **Tier 2 (Generic)** $15 copay for a one-month supply $45 copay for a three-month supply **Tier 3 (Preferred Brand)** $47 copay for a one-month supply $141 copay for a three-month supply **Tier 4 (Non-Preferred Drug)** 40% coinsurance for a one-month supply 40% coinsurance for a three-month supply **Tier 5 (Specialty Tier)** 30% coinsurance for a one-month supply (long-term supply is not available) **Tier 6 (Select Care Drugs)** $0 copay for a one-month supply $0 copay for a 100-day supply	

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Catastrophic Coverage	Part D benefits are not offered with this plan.	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. • During this payment stage, you pay nothing for your covered Part D drugs. For enhanced drugs covered under our enhanced benefit, you continue paying your Initial Coverage Stage cost-share.	
Additional Prescription Drug Benefits	Part D benefits are not offered with this plan.	We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. This includes coverage of the following drugs in the Tier 2 cost-sharing tier: • sildenafil 25 MG – QL 6/30 • sildenafil 50 MG - QL 6/30 • sildenafil 100 MG - QL 6/30 • folic acid 1 MG - QL 30/30 • ergocalciferol 1.25 MG • vitamin B12 1000 MCG/ML The amount you pay for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.	

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Additional Medical Benefits

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Acupuncture[1]	***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.***		
	In-Network • $20 copay		In-Network • $20 copay Out-of-Network • 40% coinsurance
Foot Care (podiatry services)	***Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.***		
	In-Network • $20 copay		In-Network • $35 copay Out-of-Network • 40% coinsurance
Medical Equipment/ Supplies [1]	***Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies)***		
	In-Network • 15%-20% coinsurance		In-Network • 15%-20% coinsurance Out-of-Network • 40% coinsurance

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Medical Equipment/ Supplies (continued)	***Diabetes Monitoring Supplies***		
	In-Network • 0% coinsurance if you use a preferred brand of diabetic testing supplies (includes meters and test strips) • Preferred brands are LifeScan (i.e. OneTouch®) and Roche (i.e. ACCU-CHEK®). • You pay 0% coinsurance for lancets, lancet devices and control solutions. *Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.*		In-Network • 0% coinsurance if you use a preferred brand of diabetic testing supplies (includes meters and test strips) • Preferred brands are LifeScan (i.e. OneTouch®) and Roche (i.e. ACCU-CHEK®). • You pay 0% coinsurance for lancets, lancet devices and control solutions. *Non-preferred brands of diabetic supplies (includes meters and test strips) are not covered.* Out-of-Network • 40% coinsurance (even if preferred brands are used)
	Therapeutic shoes or inserts and Prosthetic devices:		
	In-Network • 20% coinsurance		In-Network • 20% coinsurance Out-of-Network • 40% Coinsurance

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	Continuous Glucose Monitors	
Medical Equipment/ Supplies (continued)	In-Network • Continuous blood glucose monitors (CGM) 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGM's are Dexcom G6/G7 and Freestyle Libre 14/2/3. All other CGM's are not covered.	In-Network • Continuous blood glucose monitors (CGM) 15% coinsurance at retail pharmacy and 20% coinsurance at DME vendor. Preferred CGM's are Dexcom G6/G7 and Freestyle Libre 14/2/3. All other CGM's are not covered. Out-of-Network • 40% coinsurance
Chiropractic Care[1]	***We cover only manual manipulation of the spine to correct subluxation.***	
	In-Network • $20 copay	In-Network • $20 copay Out-of-Network • 40% coinsurance
Diabetes Self-Management Training[1]	In-Network • $0 copay	In-Network • $0 copay Out-of-Network • 40% coinsurance

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	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Home Health Care[1]	In-Network • $0 copay		In-Network • $0 copay Out-of-Network • 40% 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 Disorder Services	***Individual or group therapy visits***		
	In-Network • $20 copay		In-Network • $20 copay Out-of-Network • 40% coinsurance
Surgery[1]	In-Network • $300 copay at outpatient hospital • $300 copay at ambulatory surgery center		In-Network • $350 copay at outpatient hospital • $300 copay at ambulatory surgery center Out-of-Network • 40% coinsurance
Over-the-Counter Items (OTC)	You receive a $25 allowance every 3 months for qualified OTC items.		
Renal Dialysis[1]	In-Network • 20% coinsurance		In-Network • 20% coinsurance Out-of-Network • 40% coinsurance

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Services with a ² may require a referral from your doctor.

	KelseyCare Advantage Core	KelseyCare Advantage Freedom	KelseyCare Advantage Freedom
Telemedicine visits	***Phone, E-Visits, and Video Visits are a covered benefit for Kelsey-Seybold primary care and specialty physicians (In-Network only)***		
	• Primary Care: $0 copay for each Medicare-covered telehealth visit with a primary care provider • Specialty, Mental Health, and Other Providers: $15 copay for each Medicare-covered telehealth visit with a specialist		
Outpatient Rehabilitation[1]	***Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over 36 weeks):***		
	In-Network • $20 copay		In-Network • $35 copay Out-of-Network • 40% coinsurance
	Occupational therapy:		
	In-Network • $20 copay		In-Network • $35 copay Out-of-Network • 40% coinsurance
	Speech and Physical Therapy:		
	In-Network • $15 copay		In-Network • $15 copay Out-of-Network • 40% coinsurance

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Preventive and Comprehensive Dental	$1,500 annual maximum allowable for comprehensive and preventive dental services every year. Coverage begins after the $25 deductible is met. Please see Chapter 4 of the Evidence of Coverage for details and list of covered codes. **Services are only covered if provided by an in-network dentist.**	$2,500 annual maximum allowable for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details and list of covered codes. **Services are only covered if provided by an in-network dentist.**	$2,000 annual maximum allowable for comprehensive and preventive dental services every year. Please see Chapter 4 of the Evidence of Coverage for details and list of covered codes. **Services are only covered if provided by an in-network dentist.**
(Some services may require clinical review)	0% coinsurance for the following preventive services: • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehensive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) 0% coinsurance for the following comprehensive services: • Restorative • Oral and Maxillofacial Surgery • Adjunctive Services	0% coinsurance for the following preventive services: • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehensive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) 0% coinsurance for the following comprehensive services: • Restorative • Endodontics • Periodontic • Prosthodontic • Oral and Maxillofacial Surgery • Adjunctive Services	0% coinsurance for the following preventive services: • Cleanings (Prophylaxis) • Periodic Oral Evaluation • Comprehensive Oral Evaluation • Extensive Oral Evaluation • X-rays (bitewing, intraoral, and panoramic) 0% coinsurance for the following comprehensive services: • Restorative • Endodontics • Periodontic • Prosthodontic • Oral and Maxillofacial Surgery • Adjunctive Services

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

	KelseyCare Advantage Core	KelseyCare Advantage Signature	KelseyCare Advantage Freedom
Optional Dental Services (applicable only if purchased) (Some services may require clinical review)	You have the option to enroll in an optional supplemental Dental benefit for an additional monthly premium of $22.50 per month. Coverage Description: Annual Maximum - $3,000 No Deductible Covered Services – You pay 50%	Optional supplemental dental coverage not available on the Signature plan.	Optional supplemental dental coverage not available on the Freedom plan.

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

Kelsey Care Advantage

Multi-Language Insert

Multi-language Interpreter Services

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 quí vị cần thông dịch viên xin gọi 1-866-535-8343 sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-535-8343번으로 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ざいます。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。

KelseyCare Advantage

Hours of operation:

October 1 to March 31
8:00 a.m. to 8:00 p.m.
7 days a week

April 1 to September 30
8:00 a.m. to 8:00 p.m.
Monday through Friday

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