Kelsey Care Advantage

2026
SUMMARY OF BENEFITS

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

1-866-535-8343 (TTY: 711) **KelseyCareAdvantage.com**

About This Document

This Summary of Benefits document provides an outline of health and drug services, it does not list every service that is covered or list every limitation or exclusion. 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 call 711) to view a copy of the EOC.

We're Here to Help!

Our Website – www.kelseycareadvantage.com
Our Phone Numbers –

- If you are not a member, please call **1-800-663-7146** (TTY users call 711)
- If you are a current member, please call **1-866-535-8343** (TTY users call 711)

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.

Who Can Join?

You can enroll in KelseyCare Advantage if:

- You have both Medicare Part A and B (to get and keep Medicare, most people must pay Medicare premiums directly to Medicare)
- You're a citizen or lawfully present in the United States
- You live in the service area for these plans, which include:
  - **Signature plan** - These counties in Texas: Brazoria, Fort Bend, Harris, Montgomery and Galveston (excluding the island)
  - **Freedom and Core plans** - These counties in Texas: Austin, Brazoria, Chambers, Fort Bend, Galveston (excluding the island), Grimes, Harris, Liberty, Montgomery, San Jacinto, Walker, Waller and Wharton

For 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.

Coverage Rules

We cover the services and items listed in this document and the **Evidence of Coverage (EOC)**, if:

- The services or items are medically necessary
- The services and items are considered reasonable and necessary according to Original Medicare's standards
- You get all covered services and items from plan providers listed in our **Provider Directory and Pharmacy Directory**.

Getting Care

KelseyCare Advantage Signature and Core* plans have a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

KelseyCare Advantage Freedom* 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. *For some services you can use providers that are not in our network. You may pay more when using out-of-network providers.*

*Out-of-network/non-contracted providers are under no obligation to treat KelseyCare Advantage members regardless of plan type, except in emergency situations. Please call Member Services or review your EOC for more information, including the cost-sharing that applies to out-of-network services.

Prescription Drug Coverage

You can get prescription medication from any network pharmacy; however, **you may pay less** when you use a Preferred Pharmacy. The Preferred Pharmacies are **Kelsey Pharmacies, H-E-B and CVS Pharmacies.**

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.

PART D PRESCRIPTION DRUGS ARE NOT COVERED IN THE KELSEYCARE ADVANTAGE CORE PLAN.

What's Covered and What You Pay in 2026

Plan Premium, Deductible and Maximum Out-of-Pocket (MOOP)

Out-of-Pocket Costs	Core	Signature	Freedom
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium		
Plan Deductible	These plans do not have a medical deductible		
Maximum Out-of-Pocket (MOOP)	$4,500	$3,900	$6,750 (in-network) $10,000 (out-of-network)
	Once you reach the limit on the out-of-pocket costs we will pay the full cost for the rest of the year.		

Hospital Benefits

Benefit	Core	Signature	Freedom
Inpatient Hospital[1]	$325 per day, days 1-5 $0 per day, days 6-90 (if applicable)	$150 per day, days 1-4 $0 per day, days 5-90 (if applicable)	$375 per day, days 1-5 $0 per day, days 6-90 (if available), (in-network) 40% coinsurance per stay (out-of-network)
Outpatient Hospital[1]	$300 copay	$300 copay	$350 copay (in-network) 40% coinsurance (out-of-network)
Ambulatory Surgical Center (ASC)[1]	$200 copay	$200 copay	$300 copay (in-network) 40% coinsurance (out-of-network)

Doctor Visits

Benefit	Core	Signature	Freedom
Primary Care Provider	$0 copay	$0 copay	$0 copay (in-network) $10 copay (out-of-network)
Specialist[2]	$20 copay	$20 copay	$35 copay (in-network) $60 copay* (out-of-network) **(40% coinsurance for each MD Anderson provider visit)*

Preventive Care, Emergency and Urgent Care

Benefit	Core	Signature	Freedom
Preventive Care	$0 copay	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)
	Please refer to the EOC for a complete list of Preventive Care services.		
Emergency Care (within the U.S.)	$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.		
Urgent Care	$25 copay	$25 copay	$40 copay

Diagnostic services, laboratory and imaging

Benefit	Core	Signature	Freedom
Diagnostic radiology services (MRI, CT scans)[1]	$25 to $200 copay, depending on the service	$25 to $200 copay, depending on the service	$25 to $200 copay, depending on the service (in-network) 40% coinsurance (out-of-network)
Lab services[1]	$0 copay	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)
Diagnostic tests and procedures[1]	$0 to $25 copay, depending on the service	$0 to $25 copay, depending on the service	$0 to $25 copay, depending on the service (in-network) 40% coinsurance (out-of-network)
Outpatient X-rays[1]	$0 copay	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)
Therapeutic radiology services[1]	$50 copay	$50 copay	$50 copay (in-network) 40% coinsurance (out-of-network)

Hearing services

Benefit	Core	Signature	Freedom
Diagnostic hearing exam[1]	$20 copay	$20 copay	$35 copay (in-network) 40% coinsurance (out-of-network)
Routine hearing exam (1 routine hearing exam per year)	$0 copay	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)
Hearing aids	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.		

Dental services (services are only covered if provided by an In-network dentist)

Benefit	Core	Signature	Freedom
Routine Dental **Preventive and comprehensive**[2]	$1,500 annual maximum for covered services $25 deductible 0% coinsurance for covered preventive services like cleanings, fillings and x-rays 0% coinsurance for covered comprehensive services like fillings and extractions*	$2,500 annual maximum for covered services 0% coinsurance for covered preventive services like cleanings, fillings and x-rays 0% coinsurance for covered comprehensive services like fillings, extractions, dentures and crowns*	$2,000 annual maximum for covered services 0% coinsurance for covered preventive services like cleanings, fillings and x-rays 0% coinsurance for covered comprehensive services like fillings extractions, dentures and crowns*
	***See EOC for additional details on limitations and exclusions.**		

Vision services

Benefit	Core	Signature	Freedom
Diagnostic eye exam (including diabetic eye exams)	$20 copay	$20 copay	$35 copay (in-network) 40% coinsurance (out-of-network)
Glaucoma screening	$0 copay	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)

	Core	Signature	Freedom
Routine eye exam (1 routine exam per year)	$0 copay,	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)
Eyeglasses and contacts	$125 annual allowance for prescription eyewear	$125 annual allowance for prescription eyewear	$175 annual allowance for prescription eyewear

Mental health services

Benefit	Core	Signature	Freedom
Inpatient psychiatric stay[1]	$325 per day, days 1-5; $0 per day for days 6-90	$150 per day, days 1-4; $0 per day for days 5-90	$375 per day, days 1-5; $0 per day for days 6-90 (in-network) 40% coinsurance (out-of-network)
Outpatient therapy (individual or group)	$20 copay	$20 copay	$20 copay (in-network) 40% coinsurance (out-of-network)

Rehabilitation therapy

Benefit	Core	Signature	Freedom
Skilled nursing facility (SNF)[1] Our plan covers up to 100 days per benefit period	$0 copay per day, days 1-20; $218 per day, days 21-100	$0 copay per day, days 1-20; $218 per day, days 21-100	$0 copay per day, days 1-20; $218 per day, days 21-100 (in-network) 40% coinsurance (out-of-network)
Physical and speech therapy[1]	$15 copay	$15 copay	$15 copay (in-network) 40% coinsurance (out-of-network)
Occupational therapy[1]	$20 copay	$20 copay	$35 copay (in-network) 40% coinsurance (out-of-network)

Ambulance

Benefit	Core	Signature	Freedom
Ambulance [1] (ground or air, one-way)	$275 copay	$275 copay	$325 copay (in-network) $400 copay (out-of-network)

Transportation

Benefit	Core	Signature	Freedom
Routine transportation (to plan approved locations)	Unlimited	Unlimited	10 one-way rides
Help with Chronic Conditions (transportation services)	Not applicable	Not applicable	$0 copay for unlimited transportation to plan-approved locations The benefits are a part of a special supplemental program for the chronically ill. Not all members qualify. Review the *Evidence of Coverage* for qualifying information.

Medicare Part B drugs (Step Therapy rules may apply)

Benefit	Core	Signature	Freedom
Chemotherapy drugs[1]	0% - 20% coinsurance	0% - 20% coinsurance	0% - 20% coinsurance (in-network) 0% - 40% coinsurance (out-of-network)
Part B Insulin[1]	Up to $35 copay	Up to $35 copay	Up to $35 copay
Other Part B drugs[1]	0% - 20% coinsurance	0% - 20% coinsurance	0% - 20% coinsurance (in-network) 0% - 40% coinsurance (out-of-network)

[1] Services may require prior authorization

[2] Services may require a referral from your doctor

Medicare Part D drugs (Part D benefits are not offered on the Core plan)

Prescription drug payment phases	Signature	Freedom
Deductible phase	There is **no deductible**.	There is **no deductible** for drugs in **Tier 1, 2 and 6**. There is a $200 deductible for drugs in Tier 3, 4 and 5. You pay the full cost (negotiated drug cost) up to the deductible limit.
Initial coverage phase	You pay the following until your total yearly drug costs reach $2,100. 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 review the *Evidence of Coverage*.	

		Signature		Freedom	
Tier	Supply	**Preferred** Retail & Mail Order	Standard Retail, Mail-Order^	**Preferred** Retail & Mail Order	Standard Retail, Mail-Order^
Tier 1 Preferred Generic	30-day^	$0	$7	$0	$7
	90-day	$0	$21	$0	$21
Tier 2 Generict	30-day^	$4	$12	$5	$15
	90-day	$10	$36	$12.50	$45
Tier 3 Preferred Brand*	30-day^	20%	20%	$40	$47
	90-day	20%	20%	$100	$141
Tier 4 Non-Preferred Brand*	30-day^	30%	30%	35%	35%
	90-day	30%	30%	35%	35%
Tier 5 Specialty Tier*	30-day^	30%	30%	30%	30%
	90-day	Not available	Not available	Not available	Not available
Tier 6 Select Care Drugs	30-day^	$0	$0	$0	$0
	100-day	$0	$0	$0	$0

Catastrophic phase	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,100 limit for the calendar year. In this phase, the plan pays the full cost for your covered Part D drugs. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

Additional covered drugs	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.

*** You won't pay more than $35 for a one-month supply of each insulin product, no matter what cost-sharing tier it is on.**

† Tier 2 includes enhanced drug coverage.

^ If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. While you reside in the long-term care facility, you are able to receive up to a 31-day supply.

Additional covered benefits

Acupuncture and Chiropractic care

Benefit	Core	Signature	Freedom
Acupuncture Medicare-covered care limited to services to treat chronic low back pain.	$15 copay	$20 copay	$15 copay (in-network) 40% coinsurance (out-of-network)
Chiropractic services Medicare-covered care limited to manual manipulation of the spine to correct subluxation.	$15 copay	$20 copay	$15 copay (in-network) 40% coinsurance (out-of-network)

Foot care (podiatry services)

Benefit	Core	Signature	Freedom
Foot exams and treatment [1]	$20 copay	$20 copay	$35 copay (in-network) 40% coinsurance (out-of-network)

Diabetic monitoring supplies

Preferred brand includes Roche (i.e. ACCU-CHEK®). *Non-preferred brands of diabetic supplies (including meters and test strips) are not covered.* **Preferred continuous blood glucose monitors (CGM) are Dexcom G6/G7 and Freestyle Libre 14/2/3.** All other CGMs are not covered.

Benefit	Core	Signature	Freedom
Diabetic testing supplies[1]	0% coinsurance	0% coinsurance	0% coinsurance (in-network) 40% coinsurance (out-of-network) (even if preferred brands are used)
Lancets, lancet devices and control solutions[1]	0% coinsurance	0% coinsurance	0% coinsurance (in-network) 40% coinsurance (out-of-network) (even if preferred brands are used)
Therapeutic shoes or inserts[1]	20% coinsurance	20% coinsurance	20% coinsurance (in-network) 40% coinsurance (out-of-network) (even if preferred brands are used)
Continuous blood glucose monitors (CGM) [1]	15% coinsurance at retail pharmacy 20% coinsurance at DME vendor	15% coinsurance at retail pharmacy 20% coinsurance at DME vendor	15% coinsurance at retail pharmacy (in-network) 20% coinsurance at DME vendor (in-network) 40% coinsurance (out-of-network)

Fitness benefit

Benefit	Core	Signature	Freedom
Gym/Fitness	Covered	Covered	Covered

Home care

Benefit	Core	Signature	Freedom
Home health care[1]	$0 copay	$0 copay	$0 copay (in-network) 40% coinsurance (out-of-network)

Medical equipment and supplies

Benefit	Core	Signature	Freedom
Durable medical equipment (DME) [1], such as wheelchairs and oxygen equipment	20% coinsurance	20% coinsurance	20% coinsurance (in-network) 40% coinsurance (out-of-network)

Over-the-counter (OTC) benefit

Benefit	Core	Signature	Freedom
Over-the-counter (OTC) items	You receive a $25 allowance every three months for qualified OTC items. Choose from a variety of approved OTC health and wellness products like first aid, pain relievers, cold medicine and more.		

Substance abuse disorder services

Benefit	Core	Signature	Freedom
Opioid treatment program services[1]	$20 copay	$20 copay	$20 copay (in-network) 40% coinsurance (out-of-network)

Telemedicine (Administered by Kelsey-Seybold primary and specialty care only)

Benefit	Core	Signature	Freedom
E-Visits	$0 copay	$0 copay	$0 copay
Video Visits	$0 copay (PCP) $15 copay (specialty, mental health and other providers)	$0 copay (PCP) $15 copay (specialty, mental health and other providers)	$0 copay (PCP) $15 copay (specialty, mental health and other providers)
eConsults	$0 copay	$0 copay	$0 copay

[1] **Services may require prior authorization**

[2] **Services may require a referral from your doctor**

Quick Reference	
Member Services	713-442-CARE (2273) or 866-535-8343
Kelsey-Seybold Patient Access Center	713-442-0000 (appointment scheduling)
Transportation	713-KCA-RIDE or 855-931-7433
Dental (UHC Dental/Dental Benefit Providers)	844-298-8569
Optum Rx (prescription drugs)	800-707-8194 or www.Optumrx.com
Vision (Spectera/UHC Vision)	877-574-7081 or https://kca.yourvisionplan.com
Over-the-Counter (OTC)	800-688-2719 or www.KCAOTC.com
Fitness	877-504-6830 or www.youronepass.com
24-Hour Nurse Line	713-442-0000
MyKelseyOnline (MKO) **Helpline**	713-442-6565

REQUIRED INFORMATION

KelseyCare Advantage, a product of KS Plan Administrators, LLC, is an HMO and POS Medicare Advantage plan with a Medicare contract. Enrollment in KelseyCare Advantage depends on contract renewal.

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 call 711). 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.

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 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 and Signature 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.
- For KelseyCare Advantage Freedom and Signature plans, review the formulary to make sure your drugs are covered.

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, 2027.
- 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.

Notice of Availability of Language Assistance Services

ATTENTION: If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-866-535-8343. (TTY: 711).

Spanish: ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al 1-866-535-8343. (TTY: 711).

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-866-535-8343 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Chinese: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-866-535-8343（文本电话：711）或咨询您的服务提供商。

Korean: 주의: **[**한국어**]**를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다**.** 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다**.** 1-866-535-8343 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오**.**

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم- أو تحدث إلى مقدم الخدمة

Urdu :دھیان دیں: اگر آپ اردو بولتے ہیں تو مفت زبان میں مدد کی خدمات اور مفت مواصلات

دوسرے فارمیٹس، جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ 1-866-535-8343 پر کال کریں۔

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-866-535-8343 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION: Si vous parlez français, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le 1-866-535-8343. (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-866-535-8343. (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، برای شما در دسترس است. با شماره 1-866-535-8343 (TTY: 711) تماس بگیرید. **Persian**

German: ACHTUNG: Falls Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie 1-866-535-8343. (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો મફત ભાષા સહાય સેવાઓ અને મોટા અક્ષરો જેવા અન્ય ફોર્મેટમાં મફત સંદેશાવ્યવહાર તમારા માટે ઉપલબ્ધ છે. 1-866-535-8343 પર કૉલ કરો. (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-866-535-8343 (TTY: 711) или обратитесь к своему поставщику услуг.

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-866-535-8343（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

Laotian: ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-866-535-8343 (TTY: 711) ຫຼື ຕິດຕໍ່ກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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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