KelseyCare Advantage

2024

GOLD COMMUNITY (HMO-POS)

ANNUAL NOTICE OF CHANGE

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

KelseyCareAdvantage.com

H0332_008ANOC24_M

KelseyCare Advantage Freedom (HMO-POS) offered by KS Plan Administrators, LLC

Annual Notice of Changes for 2024

You are currently enrolled as a member of KelseyCare Advantage Gold Community. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.KelseyCareAdvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

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

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

- If you don't join another plan by December 7, 2023, you will stay in KelseyCare Advantage Gold Community.
- By providing my telephone number and/or email address to KelseyCare Advantage, I agree to receive automated calls, prerecorded messages, e-mails, and/or voice/text messages related to my application or account from KelseyCare Advantage and its affiliates. I understand that message and data rates may apply, terms and privacy information are available at www.KelseyCareAdvantage.com. If you would like to opt-out, contact Member Services at 713-442-CARE (2273) or toll-free at 1-866-535-8343 and ask to be added to our do not call list. TTY users can call 711.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with KelseyCare Advantage Gold Community.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 713-442-CARE (2273) or toll-free at 1-866-535-8343 for additional information. (TTY users should call 711.) Hours are 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. This call is free.
- This document is also available in braille, large print and other alternate formats. Please call Member Services (phone numbers are in Section 8.1 of this document) for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About KelseyCare Advantage Freedom

- 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.
- When this document says "we," "us," or "our", it means KS Plan Administrators, LLC (dba KelseyCare Advantage). When it says "plan" or "our plan," it means KelseyCare Advantage Freedom.

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Summary of Important Costs for 2024

The table below compares the 2023 costs for KelseyCare Advantage Gold Community and 2024 costs for KelseyCare Advantage Freedom in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* *Your premium may be higher than this amount. See Section 2.1 for details.	$15	$0
Deductible	**In-Network:** $0 **Out-of-Network:** $500	**In-Network:** $0 **Out-of-Network:** $0
Maximum in-network out-of-pocket amount This is the most you will pay out-of-pocket for your in-network covered Part A and Part B services. (See Section 2.2 for details.)	$3,450	$3,450
Maximum out-of-network Point of Service (POS) out-of-pocket amount This is the most you will pay out-of-pocket for your out-of-network covered Part A and Part B services received through the POS benefit. (See Section 2.2 for details.)	$10,000	$10,000

Cost	2023 (this year)	2024 (next year)
Doctor office visits	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit **Out-of-Network:** Primary care visits: 50% coinsurance Specialist visits: 30% coinsurance	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit **Out-of-Network:** Primary care visits: $10 copay Specialist visits: $35 copay for each Medicare-covered specialist visit. *40% coinsurance for each MD Anderson provider visit
Inpatient hospital stays	**In-Network:** For Medicare-covered hospital stays: $375 copay per stay 60 lifetime reserve days are covered for $0 copay per day. Acute inpatient hospital stays with a confirmed COVID-19 diagnosis will have the $375 acute inpatient cost-share waived.	**In-Network:** For Medicare-covered hospital stays: $325 copay per stay 60 lifetime reserve days are covered for $0 copay per day.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (continued)	**Out-of-Network:** For Medicare-covered hospital stays: 40% coinsurance per stay	**Out-of-Network:** For Medicare-covered hospital stays: 40% coinsurance per stay
Part D prescription drug coverage (See Section 2.5 for details.)	**Deductible:** $100 except for covered insulin products and most adult Part D vaccines. Deductible only applies to drug Tiers 3, 4, and 5. **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost sharing:* $3 copay *Preferred cost sharing:* $0 copay **Drug Tier 2:** *Standard cost sharing:* $15 copay *Preferred cost sharing:* $0 copay	**Deductible:** $100 except for covered insulin products and most adult Part D vaccines. Deductible only applies to drug Tiers 3, 4, and 5. **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost sharing:* $3 copay *Preferred cost sharing:* $0 copay **Drug Tier 2:** *Standard cost sharing:* $15 copay *Preferred cost sharing:* $0 copay

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	**Drug Tier 3:** *Standard cost sharing:* $45 copay Insulin Standard Cost Sharing You pay $35 per month supply of each select insulin product on this tier. *Preferred cost sharing:* $40 copay Insulin Preferred Cost Sharing You pay $30 per month supply of each select insulin product on this tier.	**Drug Tier 3:** *Standard cost sharing:* $45 copay Insulin Standard Cost Sharing You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* $40 copay Insulin Preferred Cost Sharing You pay $35per month supply of each select insulin product on this tier.
	Drug Tier 4: *Standard cost sharing:* $90 copay Insulin Standard Cost Sharing You pay $35 per month supply of each select insulin product on this tier. *Preferred cost sharing:* $80 copay Insulin Preferred Cost Sharing You pay $35 per month supply of each select insulin product on this tier.	**Drug Tier 4:** *Standard cost sharing:* $90 copay Insulin Standard Cost Sharing You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* $80 copay Insulin Preferred Cost Sharing You pay $35 per month supply of each covered insulin product on this tier.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	**Drug Tier 5:** *Standard cost sharing:* 31% coinsurance Insulin Standard Cost Sharing You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 31% coinsurance Insulin Preferred Cost Sharing You pay $35 per month supply of each covered insulin product on this tier. **Drug Tier 6:** *Standard cost sharing:* $0 copay *Preferred cost sharing:* $0 copay Catastrophic Coverage: • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.).	**Drug Tier 5:** *Standard cost sharing:* 31% coinsurance Insulin Standard Cost Sharing You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* 31% coinsurance Insulin Preferred Cost Sharing You pay $35 per month supply of each covered insulin product on this tier. **Drug Tier 6:** *Standard cost sharing:* $0 copay *Preferred cost sharing:* $0 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in KelseyCare Advantage Freedom in 2024

On January 1, 2024, KS Plan Administrators, LLC will be combining KelseyCare Advantage Gold Community with one of our plans, KelseyCare Advantage Freedom. The information in this document tells you about the differences between your current benefits in KelseyCare Advantage Gold Community and the benefits you will have on January 1, 2024 as a member of KelseyCare Advantage Freedom.

If you do nothing by December 7, 2023, we will automatically enroll you in our KelseyCare Advantage Freedom. This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through KelseyCare Advantage Freedom. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$15	$0
Monthly Premium for Dental Optional Supplemental Benefits This plan premium applies to you only if you are enrolled in Dental optional supplemental benefits. (You must also continue to pay your Medicare Part B Premium.)	$32.80	Not available

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

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2023 (this year)	2024 (next year)
Maximum in-network out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum in-network out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,450	$3,450 Once you have paid $3,450 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.
Maximum out-of-network Point of Service (POS) out-of-pocket amount Your costs for covered medical services (such as copays **and deductibles**) count toward your maximum out-of-network POS out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered out-of-network Part A and Part B services, you will pay nothing for your covered out-of-network Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.KelseyCareAdvantage.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Acupuncture for chronic low back pain (Medicare-covered)	**Out-of-Network** You pay 30% coinsurance for each Medicare-covered visit.	**Out-of-Network** You pay $35 copay for each Medicare-covered visit.
Ambulance services	**Out-of-Network** You pay 50% coinsurance for each one-way Medicare-covered ground transportation service.	**Out-of-Network** You pay $250 copay for each one-way Medicare-covered ground transportation service.
Ambulatory surgical center services	**Out-of-Network** You pay 30% coinsurance for Medicare-covered surgery services at an ambulatory surgical center.	**Out-of-Network** You pay 20% coinsurance for Medicare-covered surgery services at an ambulatory surgical center.
Chiropractic services (Medicare-covered)	**Out-of-Network** You pay 30% coinsurance for each Medicare-covered chiropractic visit.	**Out-of-Network** You pay $35 copay for each Medicare-covered chiropractic visit.
Dental services (Medicare-covered)	**Out-of-Network** You pay 50% coinsurance for each Medicare-covered dental services visit.	**Out-of-Network** Not covered

Cost	2023 (this year)	2024 (next year)
Dental services (Non-Medicare-covered Comprehensive)	Not covered	$2,500 annual benefit maximum for comprehensive and preventive dental services every year. **In-Network** You pay 0% coinsurance for each non-routine services visit (Unlimited up to the maximum annual benefit). You pay 0% coinsurance for each restorative services visit (unlimited number of visits). You pay 0% coinsurance for each extraction services visit (unlimited number of visits). You pay 0% coinsurance for each endodontics services visit (Endodontic therapy 1 per lifetime All other endodontics unlimited up to the maximum annual benefit). You pay 0% coinsurance for each periodontics services visit (Non-Surgical Periodontal Service 1 every 12 months Periodontal Maintenance 1 every 60 months). You pay 0% coinsurance for each prosthodontics and other oral/maxillofacial surgery services visit (unlimited number of visits). **Out-of-Network** Not covered.

Cost	2023 (this year)	2024 (next year)
Dental services (optional supplemental)	Optional supplemental dental benefits are covered for an extra premium. You pay 20% for basic services and 50% for major services. $25 deductible and $2,000 annual benefit maximum for Non-Medicare covered comprehensive dental services each year.	Comprehensive dental services are not covered as an optional supplemental benefit. Comprehensive Non-Medicare covered services are offered with no extra premium. See Dental services (non-Medicare comprehensive).
Dental services (preventive)	No plan coverage limit.	$2,500 annual benefit maximum for comprehensive and preventive dental services every year.
Durable Medical Equipment (DME) and related supplies	Continuous blood glucose monitors 15% at retail pharmacy and 20% at DME vendor. All other DME is 20% coinsurance. Preferred continuous blood glucose monitors (CGM) are Dexcom and FreeStyle Libre, all other CGMs are excluded.	Continuous blood glucose monitors 15% at retail pharmacy and 20% at DME vendor. All other DME is 20% coinsurance. The preferred continuous blood glucose (CGM) monitors are Dexcom G6 and Dexcom G7, all other CGMs are subject to step therapy.
Flex wallet card	Not covered	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. Unused allowances do not carry over to the next calendar year.

Cost	2023 (this year)	2024 (next year)
Health and wellness education programs	You pay $0 copay for physical fitness services. The plan provides a fitness program to all members. The fitness program provides members with a national network of gym and fitness centers to help prevent disease and injury through increased physical activity. The program includes an initial intake and outreach, ongoing education materials on staying healthy and the ability to self-track their activity progress.	You pay $0 copay for memory fitness and physical fitness services. Our fitness program supports our members to stay active physically, mentally, and socially. The program includes access to a participating gym network, on-demand and livestreaming digital content, a comprehensive cognitive program called BrainHQ, home kits, and classes for balance and fall prevention, strength and endurance training and other exercise classes.
Hearing services (Medicare-covered)	**Out-of-Network** You pay 30% coinsurance for each Medicare-covered hearing exam. No prior authorization required.	**Out-of-Network** You pay 20% coinsurance for each Medicare-covered hearing exam. No prior authorization required for Medicare-covered hearing exams.
Meal benefit	You pay $0 copay. With authorization, post Acute Inpatient discharge with a COVID-19 diagnosis - member is eligible for 2 meals per day for 7 days.	Meal benefit is not covered.
Occupational therapy services	Prior authorization required. Referral is required.	No prior authorization or referral required within Kelsey-Seybold Medical Group.

Cost	2023 (this year)	2024 (next year)
Opioid treatment program services	**In-Network** You pay PCP- $0 copay Specialists - $25 copay Mental Health Individual Sessions - $20 copay Mental Health Group Sessions - $20 copay Drugs that are part of Opioid Treatment Services- 20% coinsurance Specialists and mental health services require authorization and a referral for each Medicare-covered opioid treatment program services visit.	**In-Network** You pay PCP - $0 copay Specialists - $20 copay Mental health individual/group sessions - $20 copay Drugs that are part of Opioid Treatment Services- 20% coinsurance for each Medicare-covered opioid treatment program services visit.
Outpatient diagnostic lab services	**Out-of-Network** You pay 30% coinsurance for Medicare-covered outpatient lab services.	**Out-of-Network** You pay 50% coinsurance for Medicare-covered outpatient lab services.
Outpatient diagnostic procedures and tests	**Out-of-Network** You pay 30% coinsurance for Medicare-covered diagnostic procedures and tests.	**Out-of-Network** You pay 20% coinsurance for Medicare-covered diagnostic procedures and tests.
Outpatient diagnostic and therapeutic radiology services	**Out-of-Network** You pay 30% coinsurance for Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans). You pay 30% coinsurance for Medicare-covered outpatient X-rays. You pay 30% coinsurance for Medicare-covered outpatient therapeutic radiology services (such as radiation treatment for cancer).	**Out-of-Network** You pay 20% coinsurance for Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans). You pay $20 copay for Medicare-covered outpatient X-rays. You pay 20% coinsurance for Medicare-covered outpatient therapeutic radiology services (such as radiation treatment for cancer).

Cost	2023 (this year)	2024 (next year)
Outpatient mental health specialty services	**Out-of-Network** You pay 50% coinsurance for each Medicare-covered individual therapy visit. You pay 50% coinsurance for each Medicare-covered group therapy visit.	**Out-of-Network** You pay $35 copay for each Medicare-covered individual therapy visit. You pay $35 copay for each Medicare-covered group therapy visit.
Outpatient psychiatrist services	**Out-of-Network** You pay 50% coinsurance for each Medicare-covered individual therapy visit with a psychiatrist. You pay 50% coinsurance for each Medicare-covered group therapy visit with a psychiatrist.	**Out-of-Network** You pay $35 copay for each Medicare-covered individual therapy visit with a psychiatrist. You pay $35 copay for each Medicare-covered group therapy visit with a psychiatrist.
Outpatient substance abuse services	**Out-of-Network** You pay 50% coinsurance for each Medicare-covered individual therapy visit. You pay 50% coinsurance for each Medicare-covered group therapy visit.	**Out-of-Network** You pay $35 copay for each Medicare-covered individual therapy visit. You pay $35 copay for each Medicare-covered group therapy visit.
Over-the-counter items	You receive up to $40 per quarter that can be used to purchase plan-approved OTC items.	You receive up to $95 per quarter that can be used to purchase plan-approved OTC items.
Podiatry services (Medicare-covered)	**Out-of-Network** You pay 30% coinsurance for each Medicare-covered podiatry visit.	**Out-of-Network** You pay $35 copay for each Medicare-covered podiatry visit.

Cost	2023 (this year)	2024 (next year)
Services to treat kidney dialysis	Prior authorization required. Referral is required.	No prior authorization required for kidney dialysis services. No referral required for kidney dialysis services.
Specialist visits	**Out-of-Network** You pay 30% coinsurance for each Medicare-covered specialist visit.	**Out-of-Network** You pay $35 copay for each Medicare-covered specialist visit. *40% coinsurance for each MD Anderson provider visit
Transportation services	Transportation services are not covered.	You pay $0 copay for transportation services. Unlimited trips. • 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)
Vision care (Medicare-covered eye exams)	**In-Network** You pay $25 copay for each Medicare-covered eye exam.	**In-Network** You pay $0 to $25 copay for each Medicare-covered eye exam. At Kelsey-Seybold Clinics, first eye exam visit $0 copay, $25 copay for all subsequent eye exams.

Cost	2023 (this year)	2024 (next year)
Vision care (Medicare-covered eye exams) (continued)	**Out-of-Network** You pay 30% coinsurance for each Medicare-covered eye exam.	**Out-of-Network** You pay 20% coinsurance for each Medicare-covered eye exam.
Worldwide emergency/urgent services	You pay $120 copay for each emergency care visit worldwide. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. You pay $200 copay for each emergency/urgent transportation service worldwide. The plan does not pay for transportation back to the United States and its territories after out-of-the-country emergency care. The plan will pay up to 100% of what Medicare would allow for the services if they had been obtained in the United States and its territories, less any copayments and coinsurance. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. Worldwide transportation cost sharing is not waived if you are admitted to the hospital within 24 hours for the same condition. No maximum plan benefit coverage amount.	You pay 20% coinsurance for each emergency care visit worldwide. Worldwide ER services cost sharing is not waived if you are admitted to the hospital for the same condition. You pay 20% coinsurance for each emergency/urgent transportation service worldwide. The plan does not pay for transportation back to the United States and its territories after out-of-the-country emergency care. The plan will pay 80% of what Medicare would allow for the services if they had been obtained in the United States and its territories. There is no worldwide coverage for care outside of the emergency room, emergency transportation or emergency hospital admission. $20,000 maximum plan coverage limit per lifetime.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

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

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tiers 3, 4, and 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $100. During this stage, you pay $0 copay Preferred cost sharing and $3 copay Standard cost sharing for a 30-day supply of drugs on Tier 1, and $0 copay Preferred cost sharing and $15 copay Standard cost sharing for a 30-day supply of drugs on Tier 2, $0 copay Preferred cost sharing and $0 copay Standard cost sharing for a 30-day supply of drugs on Tier 6, and the full cost of drugs on Tiers 3, 4, and 5 until you have reached the yearly deductible.	The deductible is $100. During this stage, you pay $0 copay Preferred cost sharing and $3 copay Standard cost sharing for a 30-day supply of drugs on Tier 1, $0 copay Preferred cost sharing and $15 copay Standard cost sharing for a 30-day supply of drugs on Tier 2, $0 copay Preferred cost sharing and $0 copay Standard cost sharing for a 30-day supply of drugs on Tier 6, and the full cost of drugs on Tiers 3, 4, and 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List."	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $3 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $45 copay per prescription. You pay $35 per month supply of each select insulin product on this tier. *Preferred cost sharing:* You pay $40 copay per prescription. You pay $30 per month supply of each select insulin product on this tier.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $3 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $45 copay per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay $40 copay per prescription. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $90 copay per prescription. You pay $35 per month supply of each select insulin product on this tier. *Preferred cost sharing:* You pay $80 copay per prescription. You pay $35 per month supply of each select insulin product on this tier. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 31% coinsurance. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 31% coinsurance. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6:** **Select Care Drugs):** *Standard cost sharing:* You pay $0 copay. *Preferred cost sharing:* You pay $0 copay.	**Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $90 copay per prescription. You pay $35 per month supply of each select insulin product on this tier. *Preferred cost sharing:* You pay $80 copay per prescription. You pay $35 per month supply of each select insulin product on this tier. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 31% coinsurance. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 31% coinsurance. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 (Select Care Drugs):** *Standard cost sharing:* You pay $0 copay. *Preferred cost sharing:* You pay $0 copay.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	_____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

The information below shows the administrative changes for next year. For more information, please refer to your 2024 Evidence of Coverage or 2024 Summary of Benefits.

Description	2023 (this year)	2024 (next year)
Fitness benefit administration	Fitness benefit administration performed by Tivity Health using the registered trademark, SilverSneakers®.	Fitness benefit administration performed by Optum Healthcare Solutions using the trademark, Optum OnePass™ with access to a broader network of fitness facilities.

Description	2023 (this year)	2024 (next year)
Service area	In order to be eligible for this plan you must live in one of the following Texas counties: Texas: Austin, Chambers, Grimes, Liberty, San Jacinto, Walker, Waller, and Wharton.	In order to be eligible for this plan you must live in one of the following Texas counties: Texas: Austin, Brazoria, Chambers, Fort Bend, Grimes, Harris, Liberty, Montgomery, San Jacinto, Walker, Waller, and Wharton. Our service area includes these parts of counties in Texas: Galveston, the following zip codes only: 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, and 77592.
Vision benefit administration	Vision benefit administration and claim processing performed by Vision Service Plan Insurance (VSP).	Vision benefit administration and claim processing performed by UnitedHealthcare Vision with access to a broader vision network of providers.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in KelseyCare Advantage Freedom

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our KelseyCare Advantage Freedom plan.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

As a reminder, KS Plan Administrators, LLC offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from KelseyCare Advantage Freedom.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from KelseyCare Advantage Freedom.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Texas, the SHIP is called Health Information Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Information Counseling and Advocacy Program (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Health Information Counseling and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about Health Information Counseling and Advocacy Program (HICAP) by visiting their website (https://hhs.texas.gov/services/health/medicare).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas Kidney Health Care Program (KHC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090.

SECTION 8 Questions?

Section 8.1 – Getting Help from KelseyCare Advantage Freedom

Questions? We're here to help. Please call Member Services at 713-442-CARE (2273) or toll-free at 1-866-535-8343. (TTY only, call 711.) We are available for phone calls 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.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for KelseyCare Advantage Freedom. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.KelseyCareAdvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.KelseyCareAdvantage.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/"Drug List").*

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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 -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 द□ा की योजना के बारे में आपके किसी भी प्रश्न के ज□ाब देने के लिए हमारे पास मुफ्त दुभाषिया से□ाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-535-8343 पर फोन करें. कोई व्यक्ति जो हिन्दी बोल□ा ह□आपकी मदद कर सक□ा ह□ यह एक मुफ्त से□ा ह□

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。