



2026 Summary of Benefits

KeyCare Advantage Plus (HMO C-SNP)

H6959, Plan 002

This is a summary of drug and health services covered by KeyCare Advantage Plus (HMO C-SNP) from January 1 – December 31, 2026.

KeyCare Advantage Plus (HMO C-SNP) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is not a complete description of benefits. Call 1-844-206-1205, TTY should call 711, for more information.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at [KeyCareAdvantage.com](https://www.KeyCareAdvantage.com), or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-206-1205, TTY/TDD should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

To join KeyCare Advantage Plus (HMO C-SNP), you must:

- Have both Medicare Part A and Medicare Part B,
- -- *and* -- live in our geographic service area,
- -- *and* -- be a United States citizen or be lawfully present in the United States,
- -- *and* -- meet the special eligibility requirements: Our plan is designed to meet the specialized needs of people who have certain medical conditions. To be eligible for our plan, you must have Diabetes Mellitus, Chronic Heart Failure, and Cardiovascular Disorders.

Our service area includes these counties in Maryland: Anne Arundel, Baltimore, Baltimore City, Carroll, Howard, and Prince George's.

KeyCare Advantage Plus (HMO C-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [KeyCareAdvantage.com](https://www.KeyCareAdvantage.com). If you use providers that are not in our network, the plan may not pay for these services.

This document is also available in braille and in large print.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2026* handbook. View it online at www.medicare.gov or ask for 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.

Medical Benefits

Benefit category	Your plan benefits
Monthly plan premium <i>(includes both medical and drug coverage)</i>	\$0 You must continue to pay your Medicare Part B premium.
Deductible	\$0 This plan does not have a medical deductible.
Maximum out-of-pocket amount <i>(does not include Part D prescription drugs)</i>	\$6,900 for in-network services
Inpatient hospital coverage	\$300 copayment per day for days 1-5 \$0 copayment per day for days 6-90 <i>Prior authorization is required.</i>
Outpatient hospital coverage Outpatient hospital services Outpatient hospital observation services	\$0-\$225 copayment; 20% coinsurance \$0 copayment for diagnostic colonoscopy and polyp removal 20% coinsurance for surgery \$225 copayment for all other services <i>Prior authorization is required.</i> 20% coinsurance <i>Prior authorization is required.</i>
Ambulatory Surgical Center (ASC) services	20% coinsurance <i>Prior authorization is required.</i>
Doctor visits Primary care providers Specialists	\$0 copayment \$0-\$20 copayment \$0 copayment for cardiologist, endocrinologist, vascular surgery consultation, or cardiothoracic surgery consultation \$20 copayment for all other services

Benefit category	Your plan benefits										
Preventive care (e.g., flu vaccine, diabetic screenings)	\$0 copayment										
Emergency care	\$95 copayment You do not pay this amount if you are admitted to the hospital within 3 days.										
Urgently needed services	\$40 copayment You do not pay this amount if you are admitted to the hospital within 3 days.										
Diagnostic services/labs/imaging	<table border="0"> <tr> <td data-bbox="250 762 509 835">Diagnostic tests and procedures</td> <td data-bbox="678 762 1333 909"> 20% coinsurance <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i> </td> </tr> <tr> <td data-bbox="250 930 630 1003">Diagnostic radiology services (e.g., MRI, CAT scan)</td> <td data-bbox="678 930 1084 1035"> 20% coinsurance <i>Prior authorization is required.</i> </td> </tr> <tr> <td data-bbox="250 1056 412 1098">Lab services</td> <td data-bbox="678 1056 1385 1161"> \$0 copayment <i>Prior authorization is required only for genetic testing.</i> </td> </tr> <tr> <td data-bbox="250 1182 475 1224">Outpatient x-rays</td> <td data-bbox="678 1182 1333 1329"> \$15 copayment <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i> </td> </tr> <tr> <td data-bbox="250 1350 532 1392">Therapeutic radiology</td> <td data-bbox="678 1350 1084 1455"> 20% coinsurance <i>Prior authorization is required.</i> </td> </tr> </table>	Diagnostic tests and procedures	20% coinsurance <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i>	Diagnostic radiology services (e.g., MRI, CAT scan)	20% coinsurance <i>Prior authorization is required.</i>	Lab services	\$0 copayment <i>Prior authorization is required only for genetic testing.</i>	Outpatient x-rays	\$15 copayment <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i>	Therapeutic radiology	20% coinsurance <i>Prior authorization is required.</i>
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Benefit category	Your plan benefits
<p>Hearing services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Hearing services (Supplemental)</p> <p>Routine hearing exam</p> <p>Fitting/evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>20% coinsurance</p> <p>\$0 copayment Limit 1 visit every 2 years</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$1,150 every year for both ears combined</p> <p>Allowance is shared with vision benefit. See your <i>Evidence of Coverage</i> for more details.</p>
<p>Dental services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Dental services (Supplemental)</p> <p>Preventive and comprehensive services</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$2,000 every year for preventive services and comprehensive services</p> <p>All services must be provided by Liberty Dental. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at libertydentalplan.com/keycareadvantage.</p>

Benefit category	Your plan benefits
<p>Vision services (Medicare-covered)</p> <p>Exam to diagnose and treat diseases and conditions of the eye</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p> <p>Vision services (Supplemental)</p> <p>Routine eye exam</p> <p>Additional routine eyewear</p>	<p>\$0 copayment</p> <p>\$0 copayment</p> <p>20% coinsurance</p> <p>\$0 copayment</p> <p>\$0 copayment Limit 1 visit every 2 years</p> <p>\$1,150 every year for lenses, frames or contacts</p> <p>Allowance is shared with hearing benefit. See your <i>Evidence of Coverage</i> for more details.</p>
<p>Mental health services</p> <p>Inpatient visit</p> <p>Outpatient group therapy visit</p> <p>Outpatient individual therapy visit</p>	<p>\$300 copayment per day for days 1-5 \$0 copayment per day for days 6-90</p> <p><i>Prior authorization is required.</i></p> <p>20% coinsurance</p> <p>20% coinsurance</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20 \$217 copayment per day for days 21-100</p> <p><i>Prior authorization may be required. Please contact the plan for additional details.</i></p>

Benefit category	Your plan benefits
Physical therapy	\$30 copayment <i>Prior authorization may be required. Please contact the plan for additional details.</i>
Ambulance Ground ambulance Air ambulance	\$250 copayment <i>Prior authorization is required for non-emergency Medicare services.</i> 20% coinsurance <i>Prior authorization is required for non-emergency Medicare services.</i>
Transportation <i>(non-emergency)</i>	<u>Not covered</u>
Medicare Part B prescription drugs Chemotherapy/Radiation drugs Other Part B drugs	0%-20% coinsurance Cost-sharing is dependent on the drug administered. <i>Prior authorization is required.</i> 0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum <i>Prior authorization is required.</i>

Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
Prescription drug deductible	\$300 Deductible applies to Tiers 2-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.		
Initial coverage	You stay in the Initial Coverage stage until your total out-of-pocket costs reach \$2,100. You then move on to the Catastrophic Coverage Stage.		
Tier drug coverage	Standard retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 90-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)
Tier 1 (Preferred Generic)	\$0 copayment	\$0 copayment	\$0 copayment
Tier 2 (Generic)	\$15 copayment	\$45 copayment	\$15 copayment
Tier 3 (Preferred Brand)	\$45 copayment	\$135 copayment	\$45 copayment
Tier 4 (Non-Preferred Drug)	\$95 copayment	\$285 copayment	\$95 copayment
Tier 5 (Specialty Tier)	29% coinsurance	Not covered	29% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, you pay nothing for your covered Part D prescription drugs.		

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

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, even if you haven't paid your deductible.

Additional Benefits

Benefit category	Your plan benefits
Diabetic monitoring supplies	\$0 copayment
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance <i>Prior authorization is required.</i>
Healthy Living Flex Card <ul style="list-style-type: none"> • Fitness • General supports for living* • Groceries* • In-home support services • Over-The-Counter (OTC) items 	\$175 every 3 months to spend towards Fitness, In-Home Support Services, and OTC Items. SSBCI members can also spend towards Groceries and Cleaning Services. Benefit is administered by The Helper Bees *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Occupational therapy	\$30 copayment <i>Prior authorization may be required. Please contact the plan for additional details.</i>
Podiatry services (Foot care) Medicare-covered services Routine foot care	\$0 copayment \$0 copayment Limit 4 visits every year
Speech therapy	\$30 copayment <i>Prior authorization may be required. Please contact the plan for additional details.</i>

*Special supplemental benefits for the chronically ill (SSBCI) are only available to members with certain chronic conditions. You may be eligible if you have one of the following conditions:

- Cardiovascular disorders
- Chronic heart failure
- Diabetes mellitus