CareFirst Medicare Advantage

2026 Summary of Benefits

CareFirst BlueCross BlueShield Group Advantage (PPO)

Frederick County Government

H7379-801

January 1, 2026 - December 31, 2026

- Call 833-939-4103 (TTY:711)
- 8am-6pm EST Monday - Friday

www.carefirst.com/frederickgovt

2026 Summary of Benefits

CareFirst BlueCross BlueShield Group Advantage (PPO)

This is a summary of drug and health services covered by CareFirst BlueCross BlueShield Group Advantage (PPO) plan from January 1, 2026 – December 31, 2026.

CareFirst BlueCross BlueShield Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Medicare Advantage depends upon contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To request a printed copy of your "Evidence of Coverage" document, which is a complete listing of your benefits, please call the phone number in the section below labeled "Want more information?".

This plan has a Provider Directory for all in-network providers that can be accessed through **www.carefirst.com/frederickgovt**.

This document is available in other formats such as Spanish, braille or large print.

Pharmacy

You must generally use network pharmacies to fill your prescriptions for covered Part D or enhanced drugs. You can see our plan's pharmacy directory on our website (**www.carefirst.com/frederickgovt**). Or, call us and we will send you a copy of the pharmacy directory.

Want more information?

For more information, please call us at 833-939-4103 (TTY users should call 711) or visit us at **www.carefirst.com/frederickgovt**.

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Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Monthly Plan Premium	Please refer to your employer's plan materials for your premium amount.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$0
Inpatient Hospital Coverage	
Medicare-covered Inpatient Hospital Coverage[1]	$0 copay
Medicare-covered Inpatient Hospital Psychiatric[1]	$0 copay
Outpatient Hospital Coverage	
Medicare-covered Outpatient Hospital, Including Surgery[1]	$0 copay
Medicare-covered Outpatient Hospital Observation Services[1]	$0 copay
Medicare-covered Ambulatory Surgical Center (ASC)[1]	$0 copay
Doctor Visits (Primary Care Providers and Specialists)	
Medicare-covered Primary Care Providers (PCP)	$0 copay
Medicare-covered Specialist	$0 copay
Medicare-covered Preventive Care	$0 copay
Medicare-covered Emergency Care	$0 copay
Medicare-covered Urgently Needed Services	$0 copay
Diagnostic Services/Labs/Imaging	
Medicare-covered Tests and Procedures[1, 2]	$0 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Medicare-covered Lab Services[1, 2]	$0 copay
Medicare-covered Diagnostic Radiology Services (e.g. CT, MRI)[1]	$0 copay
Medicare-covered Therapeutic Radiology Services[1]	$0 copay
Medicare-covered X-Rays	$0 copay
Hearing Services	
Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues	$0 copay
Routine Hearing Exams	$0 copay
Hearing Aids	$0 per entry level hearing aid $0 per basic level hearing aid $0 per prime level hearing aid $0 per preferred level hearing aid $150 per advanced level hearing aid $950 per premium level hearing aid
Dental Services	
Medicare-covered Comprehensive Dental	$0 copay
Vision Services	
Medicare-covered Exam to Diagnose and Treat Diseases and Conditions of the Eye	$0 copay
Medicare-covered Preventive Glaucoma Screening	$0 copay
Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery	$0 copay
Medicare-covered Diabetic Eye Exam	$0 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Routine Eye Exam	$0 copay for each routine eye exam (includes dilation & refraction) from a Davis Vision provider (one per calendar year). $40 reimbursement out-of-network.
Eyewear Allowance	**Additional Eyewear Coverage**: In-network: Eyewear (Frames and Lenses): • Select Fashion frames purchased from Davis Vision's exclusive collection will be covered in full through our vendor. Designer frames from Davis Vision's exclusive collection are a $0, $15, or $40 copay depending on the type of frames selected. • $200 or $250 at Visionworks plus a 20% discount on any overage for any other frames annually. • Single Vision, Bifocal, Trifocal, and Lenticular clear plastic lenses have a $0 copay for each type of lenses annually. Contacts (Medical and Elective): • If contact lenses are medically necessary they will be covered in full through Davis Vision. • $200 plus 15% off balance for elective contact lenses annually. • 15% discount on Contact lens evaluation, fitting and follow-up care. Out-of-network: Eyewear (Frames and Lenses): • $88 for frames annually. • Single Vision, Bifocal, Trifocal, and Lenticular clear plastic lenses have a $40, $60, $80 or $100 copay depending on the type of lenses annually. Contacts (Medical and Elective): • If contact lenses are medically necessary they will be covered via a $240 reimbursement. • $136 for elective contact lenses annually. Non-Medicare covered / routine services do not count towards your maximum-out-of-pocket (MOOP).
Mental Health Services	
Medicare-covered Individual Office Visits	$0 copay
Medicare-covered Group Office Visits	$0 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Other Benefits and Services	
Medicare-covered Skilled Nursing Facility (SNF)[1]	$0 copay for days 1-100
Medicare-covered Physical Therapy[1]	$0 copay
Medicare-covered Ambulance - Ground[3]	$0 copay
Medicare-covered Ambulance - Air[3]	$0 copay
Routine Transportation	Not Covered
Medicare-covered Part B Prescription Drugs[1] *You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.*	$0 copay

1 Prior authorization may be required and is the responsibility of the provider.
2 Most routine labwork does not require prior authorization.
3 Prior authorization may be required for non-emergent services.

Part D

Prescription Drug Benefits	
Annual Prescription Deductible	This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage Stage.
Initial Coverage Stage	In this stage, the plan pays its share of the cost and you pay your copay or coinsurance. You generally stay in this stage until your year-to-date total drug cost reaches $2,100. Then you move to the Catastrophic Stage.
Catastrophic Coverage	During this payment stage, you pay nothing for your covered Part D or enhanced drugs.
Long Term Care Facility Resident Coverage	If you live in a long-term care facility and get your drugs from their pharmacy, you pay the same copay as a 30-day retail pharmacy prescription.

Prescription Drug Benefits		
Tier	**Standard retail cost sharing** (30-day supply)	**Mail-order cost sharing** (30-day supply)
Tier 1—Generic	$10 copay	$10 copay
Tier 2—Preferred Brand	$30 copay	$30 copay
Tier 3—Non-Preferred Drug	$50 copay	$50 copay
Tier 4—Specialty	$75 copay	$75 copay
Tier	**Standard retail cost sharing** (60-day supply)	**Mail-order cost sharing** (60-day supply)
Tier 1—Generic	$20 copay	$20 copay
Tier 2—Preferred Brand	$60 copay	$60 copay
Tier 3—Non-Preferred Drug	$100 copay	$100 copay
Tier	**Standard retail cost sharing** (100-day supply Tier 1) (90-day supply for Tiers 2-3)	**Mail-order cost sharing** (100-day supply Tier 1) (90-day supply for Tiers 2-3)
Tier 1—Generic	$20 copay	$20 copay
Tier 2—Preferred Brand	$60 copay	$60 copay
Tier 3—Non-Preferred Drug	$100 copay	$100 copay

Additional Benefits	CareFirst BlueCross BlueShield Group Advantage
24-Hour Nurse Advice Hotline	$0 copay
Annual Physical	$0 copay
Fitness (SilverSneakers)	$0 copay
Wigs for Chemotherapy Patients	$350 annual allowance for wigs for chemotherapy patients.

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