CareFirst Medicare Advantage

2026 Summary of Benefits

CareFirst BlueCross BlueShield Advantage Essential (PPO)

H7379-001

January 1, 2026 - December 31, 2026

- Call 833-536-2001 (TTY:711)
- 8am-8pm EST 7 days a week October 1 - March 31 and Monday - Friday, April 1 - September 30

www.carefirst.com/medicareadvantage

2026 Summary of Benefits

CareFirst BlueCross BlueShield Advantage Essential (PPO)

This is a summary of drug and health services covered by CareFirst BlueCross BlueShield Advantage Essential (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 get a complete list of services we cover, please refer to the "Evidence of Coverage" document or find a copy online at **www.carefirst.com/medicareadvantage**.

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

Who is eligible for our plans?

Anyone qualified for Medicare Part A, enrolled in Medicare Part B and living in our service area. The CareFirst BlueCross BlueShield Medicare Advantage service area includes the following counties in Maryland: Allegany, Anne Arundel, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester.

Understanding your options

Medicare benefit options are available through Original Medicare, which is run by the Federal government. Another option is to enroll in Medicare benefits through a Medicare Advantage health plan like CareFirst BlueCross BlueShield Medicare Advantage. A Medicare Plan Finder tool is available at **medicare.gov**. Additionally, you can view the free "Medicare & You" handbook at that same website. Printed handbooks are available by request—for your copy, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 711.

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 drugs. You can see our plan's pharmacy directory on our website **www.carefirst.com/medicareadvantage**. Or, call us and we will send you a copy of the pharmacy directory.

Want more information?

For more information, please call us at 833-536-2001 (TTY users should call 711) or visit us at **www.carefirst.com/medicareadvantage**.

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Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	$0	
Deductible	$0	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$8,300	$13,300 (combined with in-network)
Inpatient Hospital Coverage		
Medicare-covered Inpatient Hospital Coverage[1]	$385 copay per days 1-5; $0 copay days 6-90 Our plan covers 90 days for each Medicare-covered inpatient hospital stay. Lifetime reserve applies.	50% coinsurance
Medicare-covered Inpatient Hospital Psychiatric[1]	$250 copay per days 1-5; $0 copay days 6-90	50% coinsurance
Outpatient Hospital Coverage		
Medicare-covered Outpatient Hospital, Including Surgery[1]	$350 copay	50% coinsurance
Medicare-covered Outpatient Hospital Observation Services[1]	$295 copay	50% coinsurance
Medicare-covered Ambulatory Surgical Center (ASC)[1]	$200 copay	50% coinsurance
Doctor Visits (Primary Care Providers and Specialists)		
Medicare-covered Primary Care Providers (PCP)	$0 copay	50% coinsurance
Medicare-covered Specialist	$45 copay	50% coinsurance
Medicare-covered Preventive Care	$0 copay	50% coinsurance
Medicare-covered Emergency Care	$115 copay	$115 copay
Medicare-covered Urgently Needed Services	$0 copay for virtual visit; $25 copay for in-office visit	

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Premiums and Benefits	In-Network	Out-of-Network
Diagnostic Services/Labs/Imaging		
Medicare-covered Tests and Procedures[1, 2]	$15 copay	50% coinsurance
Medicare-covered Lab Services[1, 2]	$0 copay	50% coinsurance
Medicare-covered Diagnostic Radiology Services (e.g. CT, MRI)[1]	$200 copay	50% coinsurance
Medicare-covered Therapeutic Radiology Services[1]	$80 copay	50% coinsurance
Medicare-covered X-Rays	$25 copay	50% coinsurance
Hearing Services		
Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues	$20 copay	50% coinsurance
Routine Hearing Exams	$0 once a year	50% coinsurance
Hearing Aids	Entry Level: $475 Basic: $650 Prime: $950 Preferred: $1,250 Advanced: $1,550 Premium: $1,950	
Dental Services		
Medicare-covered Comprehensive Dental	$40 copay	50% coinsurance

Premiums and Benefits	In-Network	Out-of-Network
Preventive Dental	Routine Dental Coverage: Preventive dental (oral exams, prophylaxis, dental x-rays and fluroide treatment): $0 copay	50% coinsurance
Additional Comprehensive Dental Coverage Clinical review may be required for non-preventive dental services.	$1,000 annual allowance for comprehensive dental services	50% coinsurance
Vision Services		
Medicare-covered Exam to Diagnose and Treat Diseases and Conditions of the Eye	$20 copay	50% coinsurance
Medicare-covered Preventive Glaucoma Screening	$0 copay	50% coinsurance
Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery	$0 copay	50% coinsurance
Medicare-covered Diabetic Eye Exam	$0 copay	50% coinsurance
Routine Eye Exam	$0 copay once a year	50% coinsurance
Eyewear Allowance	**Additional Eyewear Coverage**: Eyewear (Frames and Lenses): $10 Copay for lenses ■ Select frames purchased from Davis Vision's exclusive collection will be covered in full through our vendor. ■ $200 allowance for any other frames annually.	50% coinsurance; $200 maximum

Premiums and Benefits	In-Network	Out-of-Network
	▪ Single Vision, Bifocal, Trifocal, and Lenticular lenses have a $10 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. ▪ $250 allowance for elective contact lenses annually. ▪ Contact lens evaluation and fitting is a maximum copay of $60 and corneal contact lens fitting is a $0 copay. Non-Medicare covered / routine services do not count toward your maximum-out-of-pocket (MOOP).	
Mental Health Services		
Medicare-covered Individual Office Visits	$10 copay	50% coinsurance
Medicare-covered Group Office Visits	$10 copay	50% coinsurance
Other Benefits and Services		
Medicare-covered Skilled Nursing Facility (SNF)[1]	$0 days 1-20, $200 days 21-100	50% coinsurance
Medicare-covered Physical Therapy[1]	$15 copay	50% coinsurance
Medicare-covered Ambulance - Ground[3]	$300 copay	50% coinsurance

Premiums and Benefits	In-Network	Out-of-Network
Medicare-covered Ambulance - Air[3]	$300 copay	50% Coinsurance
Routine Transportation	$0 copay for 32 one-way rides with plan approved vendor	
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 to 20% coinsurance	50% coinsurance

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 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 copays as a 30-day retail pharmacy prescriptions.

Prescription Drug Benefits		
Tier	**Standard retail cost sharing** (30-day supply)	**Mail-order cost sharing** (30-day supply)
Tier 1—Preferred Generic	$0 copay	$0 copay
Tier 2—Generic	$5 copay	$5 copay
Tier 3—Preferred Brand	20% coinsurance	20% coinsurance
Tier 4—Non-Preferred Drug	40% coinsurance	40% coinsurance
Tier 5—Specialty	33% coinsurance	33% coinsurance
Tier	**Standard retail cost sharing** (60-day supply)	**Mail-order cost sharing** (60-day supply)
Tier 1—Preferred Generic	$0 copay	$0 copay
Tier 2—Generic	$10 copay	$5 copay
Tier 3—Preferred Brand	20% coinsurance	20% coinsurance
Tier 4—Non-Preferred Drug	40% coinsurance	40% coinsurance
Tier	(100-day supply Tiers 1-3) (90-day supply Tier 4)	(100-day supply Tiers 1-3) (90-day supply Tier 4)
Tier 1—Preferred Generic	$0 copay	$0 copay
Tier 2—Generic	$15 copay	$5 copay
Tier 3—Preferred Brand	20% coinsurance	20% coinsurance
Tier 4—Non-Preferred Drug	40% coinsurance	40% coinsurance

Additional Benefits	In-Network	Out-of-Network
Routine Acupuncture	$20 copay ; 12 visits per year	50% coinsurance
Annual Physical	$0 copay	50% coinsurance
Routine Chiropractic Care	$15 copay; 12 visits per year	50% coinsurance
Medicare-covered Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	20% coinsurance	50% coinsurance

Additional Benefits	In-Network	Out-of-Network
Medicare-covered Prosthetics (e.g., braces, artificial limbs)[1]	20% coinsurance	50% coinsurance
Fitness (SilverSneakers)	$0 copay	
Over the Counter (OTC) items	$50 per quarter	
Routine Foot Care	$10 copay, 12 visits per year	50% coinsurance

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