CareFirst Medicare Advantage

2027

Summary of Benefits

CareFirst BlueCross BlueShield Advantage Complete (PPO)

H7379-002

January 1, 2027 - December 31, 2027

- 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

2027 Summary of Benefits

CareFirst BlueCross BlueShield Advantage Complete (PPO)

This is a summary of drug and health services covered by CareFirst BlueCross BlueShield Advantage Complete (PPO) plan from January 1, 2027 – December 31, 2027.
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, Baltimore, Baltimore City, Calvert, Caroline, Cecil, Charles, Dorchester, Garrett, Harford, Howard, Montgomery, Prince George's, Somerset, Talbot, Washington, Wicomico.

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.

2027 Summary of Benefits

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	$45	
Deductible	$0	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,300	$10,750 (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]	$300 copay per days 1-5; $0 copay days 6-90	50% coinsurance
Outpatient Hospital Coverage		
Medicare-covered Outpatient Hospital, Including Surgery[1]	$500 copay; $0 colonoscopy	50% coinsurance
Medicare-covered Outpatient Hospital Observation Services[1]	$240 copay	50% coinsurance
Medicare-covered Ambulatory Surgical Center (ASC)[1]	$300 copay	50% coinsurance
Doctor Visits (Primary Care Providers and Specialists)		
Medicare-covered Primary Care Providers (PCP)	$0 copay	50% coinsurance
Medicare-covered Specialist	$25 copay	50% coinsurance

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Premiums and Benefits	In-Network	Out-of-Network
Medicare-covered Preventive Care	$0 copay	50% coinsurance
Medicare-covered Emergency Care	$110 copay	
Medicare-covered Urgently Needed Services	$10 copay	
Diagnostic Services/Labs/Imaging		
Medicare-covered Tests and Procedures[1, 2]	$0 copay	50% coinsurance
Medicare-covered Lab Services[1, 2]	$0 copay	50% coinsurance
Medicare-covered Diagnostic Radiology Services (e.g. CT, MRI)[1]	$250 copay; $0 mammograms	50% coinsurance
Medicare-covered Therapeutic Radiology Services[1]	$80 copay	50% coinsurance
Medicare-covered X-Rays	$20 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	95% coinsurance

Premiums and Benefits	In-Network	Out-of-Network
Hearing Aids	Hearing Aid Levels: Entry: $400 Basic: $575 Prime: $875 Preferred: $1,175 Advanced: $1,475 Premium: $1,875	95% coinsurance per ear per year.
Dental Services		
Medicare-covered Comprehensive Dental	$40 copay	50% coinsurance
Preventive Dental	Routine Dental Coverage: Preventive dental (oral exams, prophylaxis, dental x-rays and fluoride treatment): $0 copay	50% coinsurance
Additional Comprehensive Dental Coverage Clinical review may be required for non-preventive dental services.	$1,700 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

Premiums and Benefits	In-Network	Out-of-Network
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 eyeglass 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. ▪ Single Vision, Bifocal, Trifocal, and Lenticular lenses have a $10 copay for each type of lens 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.	50% coinsurance; $200 maximum for frame, lenses or contact lenses

Premiums and Benefits	In-Network	Out-of-Network
Mental Health Services		
Medicare-covered Individual Office Visits	$5 copay	50% coinsurance
Medicare-covered Group Office Visits	$5 copay	50% coinsurance
Other Benefits and Services		
Medicare-covered Skilled Nursing Facility (SNF)[1]	$0 copay days 1-20 $140 copay days 21-100	50% coinsurance
Medicare-covered Physical Therapy[1]	$5 copay	50% coinsurance
Medicare-covered Ambulance- Ground[3]	$200 copay	50% coinsurance
Medicare-covered Ambulance- Air[3]	$200 copay	50% coinsurance
Routine Transportation	Not Covered	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.*	0% to 20% coinsurance	50% coinsurance

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

Part D

Prescription Drug Benefits	
Annual Prescription Deductible	$400 Tiers 3, 4, 5

Prescription Drug Benefits	
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 $2,400. 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	$3 copay	$3 copay
Tier 3—Preferred Brand	20% coinsurance	20% coinsurance
Tier 4—Non-Preferred Drug	40% coinsurance	40% coinsurance
Tier 5—Specialty Tier	29% coinsurance	29% 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	$6 copay	$3 copay
Tier 3—Preferred Brand	20% coinsurance	20% coinsurance
Tier 4—Non-Preferred Drug	40% coinsurance	40% coinsurance
Tier 5—Specialty Tier	Not covered	Not covered

Prescription Drug Benefits		
Tier	**Standard retail cost sharing** (100-day supply Tiers 1-3) (90-day supply Tier 4)	**Mail-order cost sharing** (100-day supply Tiers 1-3) (90-day supply Tier 4)
Tier 1—Preferred Generic	$0 copay	$0 copay
Tier 2—Generic	$9 copay	$3 copay
Tier 3—Preferred Brand	20% coinsurance	20% coinsurance
Tier 4—Non-Preferred Drug	40% coinsurance	40% coinsurance
Tier 5—Specialty Tier	Not covered	Not covered

Additional Benefits	In-Network	Out-of-Network
Annual Physical	$0 copay	50% coinsurance
Medicare-covered Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	20% coinsurance	50% coinsurance
Medicare-covered Prosthetics (e.g., braces, artificial limbs)[1]	20% coinsurance	50% coinsurance
Fitness (SilverSneakers)	Annual allowance covers this benefit in full through our contracted vendor.	Maximum reimbursement of $5 annually.

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3 Prior authorization may be required for non-emergent services.

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