CareFirst Medicare Advantage

2027 Summary of Benefits

CareFirst BlueCross BlueShield Advantage Salute (PPO)

H7379-003

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 Salute (PPO)

This is a summary of drug and health services covered by CareFirst BlueCross BlueShield Advantage Salute (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, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester, and District of Columbia.

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.

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	
Part B Premium Buydown	$100	
Deductible	$0	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$5,900	$8,950 (combined with in-network)
Inpatient Hospital Coverage		
Medicare-covered Inpatient Hospital Coverage[1]	$335 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]	$245 copay per days 1-5; $0 copay days 6-90	50% coinsurance
Outpatient Hospital Coverage		
Medicare-covered Outpatient Hospital, Including Surgery[1]	$250 copay; $0 colonoscopy	50% coinsurance
Medicare-covered Outpatient Hospital Observation Services[1]	$250 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

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Premiums and Benefits	In-Network	Out-of-Network
Medicare-covered Specialist	$30 copay	50% coinsurance
Medicare-covered Preventive Care	$0 copay	50% coinsurance
Medicare-covered Emergency Care	$110 copay	
Medicare-covered Urgently Needed Services	$25 copay	
Diagnostic Services/Labs/Imaging		
Medicare-covered Tests and Procedures[1,2]	$50 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; $0 mammograms	50% coinsurance
Medicare-covered Therapeutic Radiology Services[1]	20% coinsurance	50% coinsurance
Medicare-covered X-Rays	$20 copay	50% coinsurance
Hearing Services		
Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues	$30 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: $0 Basic: $175 Prime: $475 Preferred: $775 Advanced: $1,075 Premium: $1,475	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 Routine services do not count towards your maximum-out-of-pocket (MOOP).	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	$25 copay	50% coinsurance
Medicare-covered Preventive Glaucoma Screening	$0 copay	50% coinsurance

Premiums and Benefits	In-Network	Out-of-Network
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. ▪ 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	50% coinsurance; $200 maximum for frame, lenses or contact lenses

Premiums and Benefits	In-Network	Out-of-Network
	copay of $60 and corneal contact lens fitting is a $0 copay.	
Mental Health Services		
Medicare-covered Individual Office Visits	$0 virtual mental health visits; $10 copay for Individual or Group mental health sessions	50% coinsurance
Medicare-covered Group Office Visits	$0 virtual mental health visits; $10 copay for Individual or Group mental health sessions	50% coinsurance
Other Benefits and Services		
Medicare-covered Skilled Nursing Facility (SNF)[1]	$0 copay days 1-20 $200 copay days 21-100	50% coinsurance
Medicare-covered Physical Therapy[1]	$35 copay	50% coinsurance
Medicare-covered Ambulance- Ground[3]	$240 copay	50% coinsurance
Medicare-covered Ambulance- Air[3]	20% coinsurance	50% coinsurance
Routine Transportation	Annual allowance covers this benefit in full through our contracted vendor; 24 one-way rides with plan approved vendor	Benefit coverage is the same in and out of network. Maximum reimbursement for out-of-network is $10 annually.

Premiums and Benefits	In-Network	Out-of-Network
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.

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	$10 copay; 12 visits per year	50% coinsurance
Medicare-covered Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	15% coinsurance	50% coinsurance
Medicare-covered Prosthetics (e.g., braces, artificial limbs)[1]	15% coinsurance	50% coinsurance
Fitness (SilverSneakers)	Annual allowance covers this benefit in full through our contracted vendor.	Maximum reimbursement of $5 annually.
Over the Counter (OTC) items	$40 per quarter	Benefit coverage is the same in and out of network. Maximum is combined in and out-of-network.
Routine Foot Care	$10 copay, 12 visits per year	50% coinsurance

Additional Benefits	In-Network	Out-of-Network
Healthcare Prepaid Card	$75 monthly allowance. Members with the below qualifying conditions can use their healthcare prepaid card for groceries, rent and/or utilities. No monthly or annual rollover: ▪ Chronic alcohol use disorder and other substance use disorders (SUDs) ▪ Autoimmune disorders ▪ Cancer ▪ Cardiovascular disorders ▪ Chronic heart failure ▪ Dementia ▪ Diabetes mellitus ▪ Overweight, obesity, and metabolic syndrome ▪ Chronic gastrointestinal disease ▪ Chronic kidney disease (CKD) ▪ Severe hematologic disorders ▪ HIV/AIDS ▪ Chronic lung disorders ▪ Chronic and disabling mental health conditions ▪ Neurologic disorders ▪ Stroke ▪ Post-organ transplantation ▪ Immunodeficiency and Immunosuppressive disorders ▪ Conditions associated with cognitive impairment	Benefit coverage is the same in and out of network. Maximum is combined in and out-of-network.

Additional Benefits	In-Network	Out-of-Network
	▪ Conditions with functional challenges ▪ Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell ▪ Conditions that require continued therapy services in order for individuals to maintain or retain functioning ▪ Chronically underweight	

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2 *Most routine lab work does not require prior authorization.*
3 *Prior authorization may be required for non-emergent services.*

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