

2026

Summary of Benefits

CareFirst BlueCross BlueShield Group Advantage
(PPO)

The City of Frederick

H7379-801

January 1, 2026 - December 31, 2026

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

www.carefirst.com/learngrpma

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/learngroupma.

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/learngroupma). 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/learngroupma.

2026 Summary of Benefits

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)	\$6,700
Inpatient Hospital Coverage	
Medicare-covered Inpatient Hospital Coverage¹	\$250 copay
Medicare-covered Inpatient Hospital Psychiatric¹	\$250 copay
Outpatient Hospital Coverage	
Medicare-covered Outpatient Hospital, Including Surgery¹	\$0 copay
Medicare-covered Outpatient Hospital Observation Services¹	\$0 copay
Medicare-covered Ambulatory Surgical Center (ASC)¹	\$0 copay
Doctor Visits (Primary Care Providers and Specialists)	
Medicare-covered Primary Care Providers (PCP)	\$10 copay
Medicare-covered Specialist	\$10 copay
Medicare-covered Preventive Care	\$0 copay
Medicare-covered Emergency Care	\$90 copay
Medicare-covered Urgently Needed Services	\$10 copay
Diagnostic Services/Labs/Imaging	
Medicare-covered Tests and Procedures^{1, 2}	\$0 copay

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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 Services¹	\$0 copay
Medicare-covered X-Rays	\$10 copay
Hearing Services	
Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues	\$10 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 \$275 per preferred level hearing aid \$575 per advanced level hearing aid \$975 per premium level hearing aid
Dental Services	
Medicare-covered Comprehensive Dental	\$10 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

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Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Mental Health Services	
Medicare-covered Individual Office Visits	\$0 copay
Medicare-covered Group Office Visits	\$0 copay
Other Benefits and Services	
Medicare-covered Skilled Nursing Facility (SNF)¹	\$0 copay for days 1-20; \$75 copay for days 21-100
Medicare-covered Physical Therapy¹	\$10 copay
Medicare-covered Ambulance - Ground³	\$10 copay
Medicare-covered Ambulance - Air³	\$10 copay
Routine Transportation	Not Covered
Medicare-covered Part B Prescription Drugs¹ <i>You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.</i>	\$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.

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Prescription Drug Benefits	
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.
\$0 Select Preventive Drugs (Generic only)	Your plan offers select preventive drugs at no cost. Please visit www.carefirst.com/learn/groupma for more information on the coverage.
\$0 Part D Diabetic Supplies	Preferred insulin syringes, insulin pen needles and alcohol pads are covered at \$0 copay. Please visit www.carefirst.com/learn/groupma/prescription-drug-coverage/drug-management-programs.html for more information on the coverage.

Prescription Drug Benefits		
Tier	Standard retail cost sharing (30-day supply)	Mail-order cost sharing (30-day supply)
Tier 1—Generic	\$2 copay	\$2 copay
Tier 2—Preferred Brand	\$25 copay	\$25 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	\$4 copay	\$4 copay
Tier 2—Preferred Brand	\$50 copay	\$50 copay
Tier 3—Non-Preferred Drug	\$100 copay	\$100 copay

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Prescription Drug Benefits		
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	\$4 copay	\$4 copay
Tier 2—Preferred Brand	\$50 copay	\$50 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
Post-Discharge Meals	\$0 copay for home delivered meals. 14 meals (2 meals per day for 7 days) per discharge within 30-days following a qualified hospital or skilled nursing facility stay. Benefit applies up to 3 times per year.
Special Supplemental Benefits for the Chronically Ill	\$0 copay for home delivered meals. Qualifying members with End Stage Renal Disease (ESRD) may receive 56 meals one time per plan year.
Wigs for Chemotherapy Patients	\$350 annual allowance for wigs for chemotherapy patients.

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