

2026

# Summary of Benefits

CareFirst BlueCross BlueShield Group Advantage  
(PPO)

Calvert County Public Schools

H7379-801

**January 1, 2026 - December 31, 2026**

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

[www.carefirst.com/learn/groupma](http://www.carefirst.com/learn/groupma)

# 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](http://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](http://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](http://www.carefirst.com/learngroupma).

## 2026 Summary of Benefits

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
<b>Monthly Plan Premium</b>	Please refer to your employer's plan materials for your premium amount.
<b>Deductible</b>	No deductible
<b>Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</b>	\$500
<b>Inpatient Hospital Coverage</b>	
<b>Medicare-covered Inpatient Hospital Coverage<sup>1</sup></b>	\$0 copay
<b>Medicare-covered Inpatient Hospital Psychiatric<sup>1</sup></b>	\$0 copay
<b>Outpatient Hospital Coverage</b>	
<b>Medicare-covered Outpatient Hospital, Including Surgery<sup>1</sup></b>	\$10 copay
<b>Medicare-covered Outpatient Hospital Observation Services<sup>1</sup></b>	\$0 copay
<b>Medicare-covered Ambulatory Surgical Center (ASC)<sup>1</sup></b>	\$0 copay
<b>Doctor Visits (Primary Care Providers and Specialists)</b>	
<b>Medicare-covered Primary Care Providers (PCP)</b>	\$0 copay
<b>Medicare-covered Specialist</b>	\$5 copay
<b>Medicare-covered Preventive Care</b>	\$0 copay
<b>Medicare-covered Emergency Care</b>	\$30 copay
<b>Medicare-covered Urgently Needed Services</b>	\$15 copay
<b>Diagnostic Services/Labs/Imaging</b>	
<b>Medicare-covered Tests and Procedures<sup>1,2</sup></b>	\$5 copay

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Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
<b>Medicare-covered Lab Services<sup>1,2</sup></b>	\$5 copay
<b>Medicare-covered Diagnostic Radiology Services (e.g. CT, MRI)<sup>1</sup></b>	\$20 copay
<b>Medicare-covered Therapeutic Radiology Services<sup>1</sup></b>	\$10 copay
<b>Medicare-covered X-Rays</b>	\$5 copay
<b>Hearing Services</b>	
<b>Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues</b>	\$5 copay
<b>Routine Hearing Exams</b>	\$0 copay
<b>Hearing Aids</b>	\$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
<b>Dental Services</b>	
<b>Medicare-covered Comprehensive Dental</b>	\$0 copay
<b>Vision Services</b>	
<b>Medicare-covered Exam to Diagnose and Treat Diseases and Conditions of the Eye</b>	\$5 copay
<b>Medicare-covered Preventive Glaucoma Screening</b>	\$0 copay
<b>Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery</b>	\$0 copay
<b>Medicare-covered Diabetic Eye Exam</b>	\$0 copay

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Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
<b>Mental Health Services</b>	
<b>Medicare-covered Individual Office Visits</b>	\$5 copay
<b>Medicare-covered Group Office Visits</b>	\$5 copay
<b>Other Benefits and Services</b>	
<b>Medicare-covered Skilled Nursing Facility (SNF)<sup>1</sup></b>	\$0 copay for days 1-100
<b>Medicare-covered Physical Therapy<sup>1</sup></b>	\$5 copay
<b>Medicare-covered Ambulance - Ground<sup>3</sup></b>	\$20 copay
<b>Medicare-covered Ambulance - Air<sup>3</sup></b>	\$50 copay
<b>Routine Transportation</b>	Not Covered
<b>Medicare-covered Part B Prescription Drugs<sup>1</sup></b> <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	
<b>Annual Prescription Deductible</b>	This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage Stage.
<b>Initial Coverage Stage</b>	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.

## 2026 Summary of Benefits

Prescription Drug Benefits	
<b>Catastrophic Coverage</b>	During this payment stage, you pay nothing for your covered Part D or enhanced drugs.
<b>Long Term Care Facility Resident Coverage</b>	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)
<b>Tier 1—Preferred Generic</b>	\$8 copay	\$8 copay
<b>Tier 2—Generic</b>	\$8 copay	\$8 copay
<b>Tier 3—Preferred Brand</b>	\$15 copay	\$15 copay
<b>Tier 4—Non-Preferred Drug</b>	\$30 copay	\$30 copay
<b>Tier 5—Specialty</b>	\$30 copay	\$30 copay
Tier	Standard retail cost sharing (60-day supply)	Mail-order cost sharing (60-day supply)
<b>Tier 1—Preferred Generic</b>	\$16 copay	\$8 copay
<b>Tier 2—Generic</b>	\$16 copay	\$8 copay
<b>Tier 3—Preferred Brand</b>	\$30 copay	\$15 copay
<b>Tier 4—Non-Preferred Drug</b>	\$60 copay	\$30 copay
Tier	Standard retail cost sharing (100-day supply Tier 1) (90-day supply for Tiers 2-4)	Mail-order cost sharing (100-day supply Tier 1) (90-day supply for Tiers 2-4)
<b>Tier 1—Preferred Generic</b>	\$16 copay	\$8 copay
<b>Tier 2—Generic</b>	\$16 copay	\$8 copay
<b>Tier 3—Preferred Brand</b>	\$30 copay	\$15 copay
<b>Tier 4—Non-Preferred Drug</b>	\$60 copay	\$30 copay

## 2026 Summary of Benefits

Additional Benefits	CareFirst BlueCross BlueShield Group Advantage
<b>24-Hour Nurse Advice Hotline</b>	\$0 copay
<b>Routine Acupuncture</b>	\$10 copay for no more than 12 visits
<b>Annual Physical</b>	\$0 copay
<b>Routine Chiropractic Care</b>	\$5 copay for no more than 12 visits
<b>Fitness (SilverSneakers)</b>	\$0 copay
<b>Routine Foot Care</b>	\$5 copay for no more than 12 visits
<b>Wigs for Chemotherapy Patients</b>	\$350 annual allowance for wigs for chemotherapy patients.

- 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.*



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