CareFirst Medicare Advantage

2027

Summary of Benefits

CareFirst BlueCross BlueShield Group Advantage (PPO)

Transit Employees' Health & Welfare Plan

H7379-801

January 1, 2027 - December 31, 2027

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

www.carefirst.com/learngroupma

2027 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, 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 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.

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)	$1,000
Inpatient Hospital Coverage	
Medicare-covered Inpatient Hospital Coverage[1]	$0 copay
Medicare-covered Inpatient Hospital Psychiatric[1]	$0 copay
Outpatient Hospital Coverage	
Medicare-covered Outpatient Hospital, Including Surgery[1]	$0 copay
Medicare-covered Outpatient Hospital Observation Services[1]	$0 copay
Medicare-covered Ambulatory Surgical Center (ASC)[1]	$0 copay
Doctor Visits (Primary Care Providers and Specialists)	
Medicare-covered Primary Care Providers (PCP)	$15 copay
Medicare-covered Specialist	$15 copay
Medicare-covered Preventive Care	$0 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Medicare-covered Emergency Care	$50 copay
Medicare-covered Urgently Needed Services	$15 copay
Diagnostic Services/Labs/Imaging	
Medicare-covered Tests and Procedures[1,2]	$0 copay
Medicare-covered Lab Services[1,2]	$0 copay
Medicare-covered Diagnostic Radiology Services (e.g. CT, MRI)[1]	$0 copay
Medicare-covered Therapeutic Radiology Services[1]	$0 copay
Medicare-covered X-Rays	$0 copay
Hearing Services	
Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues	$0 copay
Routine Hearing Exams	$0 copay in-network 95% coinsurance out-of-network
Hearing Aids	In-Network: $0 per entry level hearing aid $0 per basic level hearing aid $0 per prime level hearing aid $0 per preferred level hearing aid $0 per advanced level hearing aid $0 per premium level hearing aid

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
	Out-of-Network: 95% coinsurance per hearing aid per ear
Dental Services	
Medicare-covered Comprehensive Dental	$0 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
Routine Eye Exam	$0 copay for each routine eye exam (includes dilation & refraction) from a Davis Vision provider (one per calendar year). $35 reimbursement out-of-network.
Eyewear Allowance	**Additional Eyewear Coverage:** In-Network: Eyewear (Frames and Lenses): • Select frames purchased from Davis Vision's exclusive collection will be covered in full through our vendor. • $200 or $250 at Visionworks plus a 20% discount on any overage for any other frames annually. • Single Vision, Bifocal, Trifocal, and Lenticular lenses have a $0 copay for each type of lenses annually.

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
	Contacts (Medical and Elective): • If contact lenses are medically necessary they will be covered in full through Davis Vision. • $200 plus 15% off balance for elective contact lenses annually. • Contact lens evaluation and fitting is covered in full for standard contacts. $300 plus 15% off balance for evaluation and fitting for specialty contacts. Out-of-Network: Eyewear (Frames and Lenses): • $45 for frames annually. • Single Vision, Bifocal, Trifocal, and Lenticular clear plastic lenses have a $25, $45, or $75 copay depending on the type of lenses annually. Contacts (Medical and Elective): • If contact lenses are medically necessary they will be covered via a $200 reimbursement. • $113 for elective contact lenses annually. Contact lens evaluation, fitting, and follow-ups are covered at a $50 reimbursement for standard or specialty lenses. Non-Medicare covered / routine services do not count towards your maximum-out-of-pocket (MOOP).
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 1-100
Medicare-covered Physical Therapy[1]	$15 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Medicare-covered Ambulance – Ground[3]	$0 copay
Medicare-covered Ambulance – Air[3]	$0 copay
Routine Transportation	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 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 $2,400. Then you move to the Catastrophic Stage.
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.

Prescription Drug Benefits		
Tier	**Standard retail cost sharing** (30-day supply)	**Mail-order cost sharing** (30-day supply)
Tier 1—Preferred Generic	$10 copay	$10 copay
Tier 2—Generic	$10 copay	$10 copay
Tier 3—Preferred Brand	$25 copay	$25 copay
Tier 4—Non-Preferred Drug	$40 copay	$40 copay
Tier 5—Specialty Tier	$40 copay	$40 copay
Tier	**Standard retail cost sharing** (60-day supply)	**Mail-order cost sharing** (60-day supply)
Tier 1—Preferred Generic	$20 copay	$20 copay
Tier 2—Generic	$20 copay	$20 copay
Tier 3—Preferred Brand	$50 copay	$50 copay
Tier 4—Non-Preferred Drug	$80 copay	$80 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)
Tier 1—Preferred Generic	$20 copay	$20 copay
Tier 2—Generic	$20 copay	$20 copay
Tier 3—Preferred Brand	$50 copay	$50 copay
Tier 4—Non-Preferred Drug	$80 copay	$80 copay

Additional Benefits	CareFirst BlueCross BlueShield Group Advantage
24-Hour Nurse Advice Hotline	$0 copay

Additional Benefits	CareFirst BlueCross BlueShield Group Advantage
Routine Acupuncture	$15 copay for no more than 12 visits
Annual Physical	$0 copay
Routine Chiropractic Care	$15 copay for no more than 12 visits
Fitness (SilverSneakers)	Annual allowance covers this benefit in full through our contracted vendor $5 annual reimbursement out-of-network
Wigs for Chemotherapy Patients	$350 annual allowance

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.*

CareFirst Medicare Advantage

CONNECT WITH US:

Davis Vision is an independent company that provides administrative services for vision care to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members and offers an extensive national network of optometrists, ophthalmologists and opticians. Davis Vision is solely responsible for the services it provides.

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CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.