CareFirst
Medicare Advantage

2025 Summary of Benefits

CareFirst BlueCross BlueShield Group Advantage (PPO)

District of Columbia Government

H7379-801

January 1, 2025 - December 31, 2025

- Call 833-320-2664 (TTY:711)
- 8am-6pm EST Monday - Friday

www.carefirst.com/learngroupma

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2025 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, 2025 – December 31, 2025.

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 833-320-2664 (TTY users should call 711) or visit us at **www.carefirst.com/learngroupma**.

2025 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)	$6,000
Inpatient Hospital Coverage	
Medicare-covered Inpatient Hospital Coverage*	$50 copay
Medicare-covered Inpatient Hospital Psychiatric*	$0 copay
Outpatient Hospital Coverage	
Medicare-covered Outpatient Hospital, Including Surgery*	$0 copay
Medicare-covered Outpatient Hospital Observation Services*	$0 copay
Medicare-covered Ambulatory Surgical Center (ASC)*	$0 copay
Doctor Visits (Primary Care Providers and Specialists)	
Medicare-covered Primary Care Providers (PCP)	$5 copay
Medicare-covered Specialist*	$15 copay
Medicare-covered Preventive Care	$0 copay
Medicare-covered Emergency Care	$50 copay
Medicare-covered Urgently Needed Services	$15 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Diagnostic Services/Labs/Imaging	
Medicare-covered Tests and Procedures*	$0 copay
Medicare-covered Lab Services*	$0 copay
Medicare-covered Diagnostic Radiology Services (e.g. CT, MRI)*	$15 copay
Medicare-covered Therapeutic Radiology Services*	$15 copay
Medicare-covered X-Rays*	$15 copay
Hearing Services	
Medicare-covered Exam to Diagnose and Treat Hearing and Balance Issues	$15 copay
Routine Hearing Exams	$0 copay
Hearing Aids	$500 - $1,975 copay
Dental Services	
Medicare-covered Comprehensive Dental*	$15 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

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Routine Eye Exam	$0 copay for each routine eye exam (includes dilation & refraction) from a Davis Vision provider (one per calendar year). Up to $40 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. - $100 for any other frames annually. - Single Vision, Bifocal, Trifocal, and Lenticular lenses have a $10 copay for each type of lenses annually. Contacts (Medical and Elective): - If contact lenses are medically necessary they will be covered in full through Davis Vision. - $100 for elective contact lenses annually. - Contact lens evaluation and fitting is covered in full for standard and specialty contacts. Out-of-network: Eyewear (Frames and Lenses): - Our plan covers up to $100 for any other frames annually. - Single Vision, Bifocal, Trifocal, and Lenticular clear plastic lenses have a $40, $60, or $80 copay depending on the type of lenses annually. Contacts (Medical and Elective): - If contact lenses are medically necessary they will be covered via a $285 reimbursement. - $100 for elective contact lenses annually. - Contact lens evaluation, fitting, and follow-ups are covered up to $60 reimbursement. Non-Medicare covered / routine services do not count towards your maximum-out-of-pocket (MOOP).
Mental Health Services	
Medicare-covered Outpatient*	$5 copay

Premiums and Benefits	CareFirst BlueCross BlueShield Group Advantage
Medicare-covered Individual and Group Office Visits	$10 copay for Individual or $5 copay for Group mental health sessions
Medicare-covered Skilled Nursing Facility (SNF)*	$0 copay
Medicare-covered Physical Therapy*	$15 copay
Medicare-covered Ambulance - Ground*	$15 copay
Medicare-covered Ambulance - Air*	$15 copay
Routine Transportation	Not Covered
Medicare-covered Part B Prescription Drugs* *You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.*	$0 copay

**Prior authorization may be required*

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 $2,000. 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 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	$5 copay	$5 copay
Tier 2—Generic	$10 copay	$10 copay
Tier 3—Preferred Brand	$20 copay	$20 copay
Tier 4—Non-Preferred Drug	$40 copay	$40 copay
Tier 5—Specialty	25% coinsurance	25% coinsurance
Tier	**Standard retail cost sharing** (60-day supply)	**Mail-order cost sharing** (60-day supply)
Tier 1—Preferred Generic	$10 copay	$10 copay
Tier 2—Generic	$20 copay	$20 copay
Tier 3—Preferred Brand	$40 copay	$40 copay
Tier 4—Non-Preferred Drug	$80 copay	$80 copay
Tier	**Standard retail cost sharing** (90-day supply)	**Mail-order cost sharing** (90-day supply)
Tier 1—Preferred Generic	$10 copay	$10 copay
Tier 2—Generic	$20 copay	$20 copay
Tier 3—Preferred Brand	$40 copay	$40 copay
Tier 4—Non-Preferred Drug	$80 copay	$80 copay

Additional Benefits	CareFirst BlueCross BlueShield Group Advantage
24-Hour Nurse Advice Hotline	$0 copay
Routine Acupuncture	$15 copay for no more than 20 visits
Annual Physical	$0 copay
Routine Chiropractic Care	$15 copay for no more than 20 visits
Fitness (SilverSneakers)	$0 copay
Routine Foot Care	$15 copay for no more than 20 visits
Wigs for Chemotherapy Patients	$350 Annual Allowance for Wigs for Chemotherapy Patients.
In Home Assessment	$0 copay
Rewards Program and Value Added Items and Services	
Blue365	If you join the plan, you will get access as a member to Blue365 - discounts and deals locally and nationwide on wellness, fitness, travel, apparel and other items and services.

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