CareFirst Medicare Advantage

# Summary of Benefits

## CareFirst BlueCross BlueShield Group Advantage (PPO)

*District of Columbia Government*

January 1, 2023–December 31, 2023

**CareFirst BlueCross BlueShield Group Advantage (PPO)**
**H7379-801-000**

This document summarizes the benefits of our plans and what you can expect to pay for some benefits. Every plan is required to create a Summary of Benefits document (like the one you're reading now). After you are enrolled in this plan, you will be able to access a complete list of benefits in your Evidence of Coverage by either logging into **carefirst.com/myaccount** or requesting a printed copy by calling Member Services.

### Pharmacy

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory in *My Account* online at **carefirst.com/myaccount**. Or, call us and we will send you a copy of the provider and pharmacy directories.

### Want more information?

Call 833-320-2664 (TTY: 711), Monday through Friday, 8 a.m.–6 p.m. ET.

| Premiums and Benefits | CareFirst BlueCross BlueShield Group Advantage (PPO) |
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| **Information related to monthly premiums, deductibles and limits on how much you pay for services is listed below.**<br><br>**The coverage and cost-sharing listed below applies to both in- and out-of-network.** | |
| **Monthly Plan Premium** | Your employer group calculates your premium.<br><br>You must continue to pay your Part B premium each month. |
| **Deductibles** | No deductible. |
| **Maximum Out-of-Pocket Responsibility**<br><br>**(includes all Medicare-covered benefits, including Part B drugs and supplies and does not include Part D prescription drugs)** | Like all Medicare Advantage health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br><br>Your yearly limit(s) in this plan is $6,000 for services you receive from in-network and out-of-network providers for Medicare-covered services.<br><br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br><br>Please note that you still need to pay your monthly premiums. |
| **Inpatient Hospital coverage**<br><br>Prior authorization may be required for in-network services only. | You pay $50 admission/stay<br><br>Each Medicare-covered inpatient hospital admission/stay benefit period is 90 days. There are no limits to the number of days covered by our plan. |
| **Outpatient Hospital coverage**<br><br>Prior authorization may be required for in-network services only. | |
| **Outpatient hospital services** | You pay a $0 copay for each Medicare-covered outpatient hospital visit. |
| **Ambulatory surgery center** | You pay a $0 copay for each Medicare-covered ambulatory surgical center visit. |
| **Doctor Visits** | |
| **Primary care providers** | You pay a $5 copay per Medicare-covered primary care provider (PCP) visit. |
| **Specialists**<br><br>Prior authorizations may be required for in-network specialist visits. | You pay a $15 copay per Medicare-covered Specialist visit. |

| Premiums and Benefits | CareFirst BlueCross BlueShield Group Advantage (PPO) |
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| **Preventive Care** | Our plan covers Medicare-covered preventive services at no cost.<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | You pay a $50 copay for each Medicare-covered emergency care visit in the United States.<br>Copay waived if admitted to the hospital within 24 hours.<br>Worldwide (outside the U.S.) emergency care also covered. There is a $50,000 combined maximum for Worldwide Emergency/Urgently Needed Services. You pay a $50 copay. |
| **Urgently Needed Services** | You pay a $15 copay for each Medicare-covered urgent care visit.<br>Copay is waived if you are admitted to the hospital within 48 hours.<br>Worldwide (outside the U.S.) urgently needed care coverage also covered. There is a $50,000 combined maximum for Worldwide Emergency/Urgently Needed Services. You pay a $15 copay. |
| **Diagnostic Services/Labs/ Imaging**<br>Prior authorization may be required for in-network services only. | |
| **Diagnostic tests and procedures** | You pay a $0 copay for each Medicare-covered diagnostic test and procedure. |
| **Lab services** | You pay $0 for Medicare-covered lab services. |
| **Diagnostic radiology services (e.g. CT, MRI)** | You pay a $15 copay for Medicare-covered diagnostic radiology.<br>Mammograms are covered with a $0 copay as part of Medicare-covered preventive care. |
| **Therapeutic radiology services** | You pay a $15 copay for Medicare-covered therapeutic radiological services. |
| **Outpatient X-rays** | You pay a $15 copay for Medicare-covered x-rays. |

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| **Hearing Services** | |
| **Evaluations to diagnose medical conditions** | You pay a $15 copay for each Medicare-covered hearing exam. |
| **Routine hearing exams** | You pay a $0 copay for one routine hearing exam annually. You pay $0 copay for one fitting and evaluation for hearing aids annually. These visits are covered through our vendor, NationsHearing. |
| **Hearing aids** | Our plan also covers hearing aids through our vendor, NationsHearing:<br>You pay a $500 to $1,975 copay per hearing aid based on technology level. |
| **Dental Services**<br>Prior authorization may be required for in-network services only. | |
| **Medicare-covered dental services for the reconstruction of the jaw, accidental injury, or extractions in preparation for radiation treatment.** | You pay a $15 copay for each Medicare-covered dental service. |
| **Vision Services** | |
| **Visits to diagnose and treat eye diseases and conditions.** | You pay a $0 copay for Medicare covered eye exam. |
| **Preventive glaucoma screening** | You pay a $0 copay. |
| **Eyeglasses or contact lenses after cataract surgery** | You pay a $0 copay. |
| **Routine diabetic eye exam** | You pay a $0 copay for diabetic eye exams every year through our vendor, Davis Vision. |
| **Routine eye exam** | You pay a $0 copay for a routine eye exam every year (includes dilation and refraction) with in-network providers.<br>You will be reimbursed up to $40 for routine eye exam every year (includes dilation and refraction) with out-of-network providers. |

| Premiums and Benefits | CareFirst BlueCross BlueShield Group Advantage (PPO) |
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| **Vision Services (continued)**<br><br>**Other eyewear allowance** | The frames (retail) or contacts lenses (in lieu of eyeglasses) allowance is $100 annually in-network and $100 allowance annually out-of-network.<br><br>Medically necessary contacts (with prior approval) are covered in-network at no cost and reimbursed up to $285 out-of-network.<br><br>The clear spectacle lenses in any RX (Single Vision/Bifocal/Trifocal/Lenticular) range from $0 copay to $10 copay with in-network providers.<br><br>You will be reimbursed up to $40, $60, or $80 depending on the type of clear spectacle lenses in any RX Single Vision, Bifocal, Trifocal, or Lenticular with out-of-network providers. |
| **Mental Health Services**<br><br>**Outpatient individual therapy per visit**<br><br>**Outpatient group therapy per visit** | You pay a $10 copay for each outpatient individual therapy visit.<br><br>You pay a $5 copay for each outpatient group therapy visit. |
| **Skilled Nursing Facility**<br>Prior authorization may be required for in-network services only. | Our plan covers up to 100 days in a Skilled Nursing Facility.<br>You pay a $0 copay per day for days 1 through 20.<br>You pay a $0 copay per day for days 21 through 100. |
| **Physical Therapy**<br>Prior authorization may be required for in-network services only. | You pay $15 per visit for occupational therapy, physical therapy, or speech-language pathology services. |
| **Ambulance**<br>Authorization may be required for non-emergency Medicare service | You pay a $15 copay for ground services.<br>You pay a $15 copay for air services. |
| **Transportation** | No coverage. |
| **Medicare Part B Drugs**<br>Prior authorization may be required | You pay a $0 copay for Part B chemotherapy or other drugs. |

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| **Acupuncture Services**<br><br>Prior authorization may be required for Medicare-covered in-network services only. | |
| **Medicare-covered Acupuncture services for chronic low back pain** | You pay a $15 copay for acupuncture services at a Specialist office. |
| **Routine Acupuncture services** | You pay a $15 copay for each non-Medicare-covered routine acupuncture visit (up to 20 visits a calendar year). |
| **Chiropractic Services**<br><br>Prior authorization may be required for Medicare-covered in-network services only. | |
| **Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)** | You pay a $15 copay for each Medicare-covered chiropractic visit. |
| **Routine Chiropractic services** | You pay a $15 copay for each non-Medicare covered chiropractic visit (up to 20 visits a calendar year). |
| **Podiatry Services**<br><br>Prior authorization may be required for Medicare-covered in-network services only. | |
| **Medicare-covered Podiatry services for medical and surgical issues** | You pay a $15 copay for each Medicare-covered podiatry visit. |
| **Routine Podiatry services** | You pay a $15 copay for each non-Medicare-covered routine podiatry service (up to 20 visits a calendar year). |
| **Additional Services** | |
| **24-Hour Nurse Advice Line** | You pay a $0 copay for services provided by the 24-Hour Nurse Advice Line. |
| **Video Visit (Telehealth)** | Video Visit through our vendor allows members to securely connect with a provider for urgent care services and behavioral health (therapy and psychiatry).<br><br>You pay a $15 copay for urgent care services and a $10 copay for individual behavioral health (mental health specialty services or psychiatric services). |

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| **In-Home Assessment** | The In-Home Assessment is an annual in-home clinical assessment, similar to a physical. By removing transportation barriers, we've created an easy and effective way for you to gain a more complete picture of your health.<br>You pay a $0 copay. |
| **Onduo** | Members with diabetes who are enrolled in our Onduo care management program will have access to the following no-cost benefits: virtual clinics with primary care providers and specialists, continuous glucose monitors (CGMs) for eligible members, blood pressure cuffs for eligible members, additional diabetic supplies such as test strips and lancets, as well as health and lifestyle coaching, support, and services and access to an app. |
| **Additional Telehealth Services**<br>Prior authorization and referral may be required for Specialist services. | You pay:<br>$5 copay for Primary Care Provider service<br>$15 copay for Specialist service<br>$10 copay for Mental Health Individual session<br>$5 copay for Mental Health Group session<br>$10 copay for Psychiatric Services Individual session<br>$5 copay for Psychiatric Services Group session<br>Additional telehealth is covered through video services with any provider. |
| **SilverSneakers** | You're automatically enrolled in the SilverSneakers® Fitness Program at no additional cost.<br>SilverSneakers can help you live a healthier, more active life through fitness and social connection.<br>Enjoy SilverSneakers On-Demand workout videos from home, SilverSneakers LIVE Classes and Workshops and more through SilverSneakers.com and the SilverSneakers GO app.<br>You can also sign up for a home fitness kit.<br>You'll have access to thousands of gym locations nationwide with use of basic amenities. SilverSneakers offers specially designed, signature exercise classes for all fitness levels plus group exercise classes for all levels at select locations. |

| Medicare Part D Drugs | |
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| **Initial Coverage Stage** | You pay the copays in the tables below until your total yearly drug costs reach $4,660 in 2023. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies, specialty pharmacies and mail order pharmacies. Cost-sharing is based upon the Tier the drug is on and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage booklet.<br><br>Prescription drugs cost-sharing tier descriptions:<br>■ Tier 1—Preferred Generics provide the lowest cost-share<br>■ Tier 2—Generics include a higher cost-share than Tier 1<br>■ Tier 3—Preferred Brands include a mid-level cost-share<br>■ Tier 4—Non-Preferred Drugs include a cost-share higher than Tier 3<br>■ Tier 5—Specialty Tier drugs include the highest cost-share |
| **Coverage Gap** | Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660 in 2023.<br><br>Your employer provides additional coverage during the Coverage Gap stage for covered drugs. During this stage, you continue to pay the same copay for drug as you paid in the Initial Coverage Stage. Once your yearly true out-of-pocket drug costs (including drugs purchased through your retail pharmacy, specialty pharmacies and through mail order) reach $7,400, you move to the Catastrophic Coverage Stage. |
| **Catastrophic Coverage** | Your employer provides additional coverage during the Catastrophic Coverage stage for covered drugs. After your yearly true out-of-pocket drug costs (including drugs purchased through your retail pharmacy, specialty pharmacies and through mail order) reach $7,400 in 2023, you pay the greater of: 5% coinsurance, or $4.15 copay for generic (including brand drugs treated as generic) and an $10.35 copay for all other drugs, with your maximum copay being the copayment you paid during the Initial Coverage Stage. |
| **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. |
| **Vaccines** | **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information. |

| Medicare Part D Drugs | |
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| **Insulin** | **Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. |
| | **CareFirst BlueCross BlueShield Group Advantage (PPO)** |
| **Pharmacy (Part D) Deductible** | There is no pharmacy deductible for this plan. |
| **Retail Pharmacy— 30-day Supply** | Copay for 30-day Supply Retail Pharmacy |
| Tier 1—Preferred Generic | $5 copay |
| Tier 2—Generic | $10 copay |
| Tier 3—Preferred Brand | $20 copay |
| Tier 4—Non-Preferred Drug | $40 copay |
| Tier 5—Specialty Tier | 25% copay |
| **Retail Pharmacy— 60-day Supply** | Copay for 60-day Supply Retail Pharmacy |
| Tier 1—Preferred Generic | $10 copay |
| Tier 2—Generic | $20 copay |
| Tier 3—Preferred Brand | $40 copay |
| Tier 4—Non-Preferred Drug | $80 copay |
| Tier 5—Specialty Tier | A long-term supply is not available for drugs in Tier 5. |
| **Retail Pharmacy— 90-day Supply** | Copay for 90-day Supply Retail Pharmacy |
| Tier 1—Preferred Generic | $10 copay |
| Tier 2—Generic | $20 copay |
| Tier 3—Preferred Brand | $40 copay |
| Tier 4—Non-Preferred Drug | $80 copay |
| Tier 5—Specialty Tier | A long-term supply is not available for drugs in Tier 5. |
| | **CareFirst BlueCross BlueShield Group Advantage (PPO)** |
| **Mail Order— 30-day Supply** | Copay for 30-day Supply Mail Order |
| Tier 1—Preferred Generic | $5 copay |
| Tier 2—Generic | $10 copay |
| Tier 3—Preferred Brand | $20 copay |
| Tier 4—Non-Preferred Drug | $40 copay |
| Tier 5—Specialty Tier | 25% copay |

| Medicare Part D Drugs | |
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| **Mail Order—<br>60-day Supply** | Copay for 60-day Supply Mail Order |
| Tier 1—Preferred Generic | $10 copay |
| Tier 2—Generic | $20 copay |
| Tier 3—Preferred Brand | $40 copay |
| Tier 4—Non-Preferred Drug | $80 copay |
| Tier 5—Specialty Tier | A long-term supply is not available for drugs in Tier 5. |
| **Mail Order—<br>90-day Supply** | Copay for 90-day Supply Mail Order |
| Tier 1—Preferred Generic | $10 copay |
| Tier 2—Generic | $20 copay |
| Tier 3—Preferred Brand | $40 copay |
| Tier 4—Non-Preferred Drug | $80 copay |
| Tier 5—Specialty Tier | A long-term supply is not available for drugs in Tier 5. |