CareFirst Medicare Advantage

Summary of Benefits

CareFirst BlueCross BlueShield Medicare Advantage

January 1, 2022 – December 31, 2022

CareFirst BlueCross BlueShield Advantage Core (HMO)
H6067-001-001, H6067-001-002

CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
H6067-002-001, H6067-002-002

Summary of Benefits 2022
CareFirst BlueCross BlueShield Medicare Advantage

This document summarizes the benefits of our plans and what you can expect to pay when you seek care. Every plan is required to create a Summary of Benefits document (like the one you're reading now). For additional information, including a complete list of benefits, call us and request an "Evidence of Coverage" document or find a copy online at **carefirst.com/medicare**.

Who is eligible for our plans?

Anyone qualified for Medicare Part A, enrolled in Medicare Part B and living in our service area. The CareFirst BlueCross BlueShield Medicare Advantage service area includes the following counties in Maryland: Anne Arundel, Baltimore, Baltimore City, Carroll, Frederick, Harford, Howard, Montgomery and Prince George's.

Understanding your options

Medicare benefits are available through Original Medicare, which is run by the Federal government. Another option is to enroll in Medicare benefits through a Medicare Advantage health plan with CareFirst BlueCross BlueShield Medicare Advantage.

A Medicare Plan Finder tool is available at medicare.gov. Additionally, you can view the free "Medicare & You" handbook at that same website. Printed handbooks are available by request—for your copy, call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

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 on our website (**carefirst.com/medicareadvantage**). Or, call us and we will send you a copy of the provider and pharmacy directories.

Provider Networks

CareFirst BlueCross BlueShield Medicare Advantage members are generally not covered for out-of-network services except for emergent or urgent situations, dialysis, and other special circumstances approved in advance by the plan. Please call our member services number or see your Evidence of Coverage for more information.

Referrals may be required for specialty care only.

Want more information?

Call 855-290-5744 (TTY:711) 8:00 a.m.-8:00 p.m. ET, 7 days a week from October 1 through March 31. From April 1 through September 30, our hours are 8:00 a.m.–8:00 p.m. ET, Monday through Friday.

Website: **carefirst.com/medicareadvantage**

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Information related to monthly premiums, deductibles and limits on how much you pay for services is listed below. **If you use providers that are not in our network, the plan may not pay for these services. Referrals may be required for specialty care.**		
Monthly Plan Premium	$35.00 You must continue to pay your Part B premium each month.	$95.00 You must continue to pay your Part B premium each month.
Deductibles	No deductible.	No deductible.
Maximum Out-of-Pocket Responsibility **(does not include 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. Your yearly limit(s) in this plan is $7,550.00 for services you receive from in-network providers for Medicare-covered services. 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. Please note that you still need to pay your monthly premiums.	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. Your yearly limit(s) in this plan is $6,550.00 for services you receive from in-network providers for Medicare-covered services. 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. Please note that you still need to pay your monthly premiums.
Inpatient Hospital coverage Prior authorization may be required.	Our plan covers 90 days for each Medicare-covered inpatient hospital stay. You pay a $350.00 copay per day for days 1 through 5. You pay a $0.00 copay per day for days 6 through 90. Our plan also covers 60 lifetime reserve days. These are extra days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per contract year.	Our plan covers 90 days for each Medicare-covered inpatient hospital stay. You pay a $275.00 copay per day for days 1 through 5. You pay a $0.00 copay per day for days 6 through 90. Our plan also covers 60 lifetime reserve days. These are extra days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per contract year.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Outpatient Hospital coverage Prior authorization may be required.		
Outpatient hospital services	You pay a $250.00 copay for each Medicare-covered outpatient hospital visit.	You pay a $150.00 copay for each Medicare-covered outpatient hospital visit.
Ambulatory surgery center	You pay a $200.00 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $100.00 copay for each Medicare-covered ambulatory surgical center visit.
Doctor Visits		
Primary care providers	You pay a $5.00 copay per Medicare-covered primary care provider (PCP) visit.	You pay a $0.00 copay per Medicare-covered primary care provider (PCP) visit.
Specialists Prior authorization and referrals may be required for specialist visits.	You pay a $50.00 copay per Medicare-covered Specialist visit.	You pay a $30.00 copay per Medicare-covered Specialist visit.
Preventive Care	Our plan covers many preventive services at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.	Our plan covers many preventive services at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay a $90.00 copay for each Medicare-covered emergency care visit. Copay waived if admitted to the hospital within 24 hours. Worldwide (outside the U.S.) emergency coverage also covered. There is a $25,000 combined maximum for Worldwide Emergency/Urgently Needed Services. You pay a $90.00 copay. Copay is not waived if admitted to the hospital.	You pay a $90.00 copay for each Medicare-covered emergency care visit. Copay waived if admitted to the hospital within 24 hours. Worldwide (outside the U.S.) emergency coverage also covered. There is a $50,000 combined maximum for Worldwide Emergency/Urgently Needed Services. You pay a $0.00 copay.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Urgently Needed Services	You pay a $30.00 copay for each Medicare-covered urgent care visit. Copay is waived if you are admitted to the hospital within 48 hours. Worldwide (outside the U.S.) urgently needed care coverage also covered. There is a $25,000 combined maximum for Worldwide Emergency/ Urgently Needed Services. You pay a $30.00 copay. Copay is not waived if admitted to the hospital.	You pay a $20.00 copay for each Medicare-covered urgent care visit. Copay is waived if you are admitted to the hospital within 48 hours. 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 $0.00 copay.
Diagnostic Services/Labs/ Imaging Prior authorization may be required.		
Diagnostic tests and procedures	You pay a $50.00 copay for each Medicare-covered diagnostic test and procedure.	You pay a $40.00 copay for each Medicare-covered diagnostic test and procedure.
Lab services	You pay $0.00 for Medicare-covered lab services.	You pay $0.00 for Medicare-covered lab services.
Diagnostic radiology services (e.g. CT, MRI)	You pay a $200.00 copay for Medicare-covered diagnostic radiology. Mammograms are covered with a $0.00 copay as part of Medicare-covered preventive care.	You pay a $150.00 copay for Medicare-covered diagnostic radiology. Mammograms are covered with a $0.00 copay as part of Medicare-covered preventive care.
Therapeutic radiology services	You pay 20% coinsurance for Medicare-covered therapeutic radiological services.	You pay 20% coinsurance for Medicare-covered therapeutic radiological services.
Outpatient X-rays	You pay a $20.00 copay for Medicare-covered x-rays.	You pay a $10.00 copay Medicare-covered x-rays.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Hearing Services		
Evaluations to diagnose medical conditions	You pay a $40.00 copay for each Medicare-covered hearing exam.	You pay a $20.00 copay for each Medicare-covered hearing exam.
Routine hearing exams	You pay a $0.00 copay for one routine hearing exam annually. You pay $0.00 copay for one fitting and evaluation for hearing aids annually. These visits are covered through our vendor, NationsHearing.	You pay a $0.00 copay for one routine hearing exam annually. You pay $0.00 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: You pay a $475.00 to $1,950.00 copay per hearing aid based on technology level. You pay a $975.00 to $3,925.00 copay for two hearing aids based on technology level.	Our plan also covers hearing aids through our vendor, NationsHearing: You pay a $400.00 to $1,875.00 copay per hearing aid based on technology level. You pay a $900.00 to $3,850.00 copay for two hearing aids based on technology level.
Dental Services		
Medicare-covered dental services for the reconstruction of the jaw, accidental injury, or extractions in preparation for radiation treatment.	You pay a $40.00 copay for each Medicare-covered dental service.	You pay a $20.00 copay for each Medicare-covered dental service.
Preventive Services Frequencies vary based on service.	Our plan also covers preventive dental services: You pay a $30.00 copay for oral exams. You pay a $30.00 copay for prophylaxis (cleaning). You pay a $25.00 copay for fluoride treatment. You pay a $30.00 copay for dental x-rays.	Our plan also covers preventive dental services: You pay a $20.00 copay for oral exams. You pay a $20.00 copay for prophylaxis (cleaning). You pay a $20.00 copay for fluoride treatment. You pay a $20.00 copay for dental x-rays.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Dental Services (continued)		
Additional comprehensive dental Prior authorization may be required. Frequencies vary based on service.	There are no additional comprehensive dental services covered in this plan.	Our plan also covers additional comprehensive dental services: You pay a $15.00 to $30.00 copay for non-routine services, including caries-arresting medicament (treatment to help stop active decay) and emergency dental pain treatment. You pay a $30.00 to $60.00 copay for basic restorative services, including amalgam and composite fillings. You pay a $50.00 to $60.00 copay for non-surgical periodontics. You pay a $40.00 to $50.00 copay for non-surgical extractions.
Vision Services		
Visits to diagnose and treat eye diseases and conditions.	You pay a $40.00 copay for Medicare covered eye exam.	You pay a $20.00 copay for Medicare covered eye exam.
Preventive glaucoma screening	You pay a $0.00 copay.	You pay a $0.00 copay.
Eyeglasses or contact lenses after cataract surgery	You pay a $0.00 copay.	You pay a $0.00 copay.
Routine eye exam	You pay a $20.00 copay for a routine eye exam every year (includes dilation and refraction) through our vendor, Davis Vision.	You pay a $10.00 copay for a routine eye exam every year (includes dilation and refraction) through our vendor, Davis Vision.
Routine diabetic eye exam	You pay a $0.00 copay for diabetic eye exams every year through our vendor, Davis Vision.	You pay a $0.00 copay for diabetic eye exams every year through our vendor, Davis Vision.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Vision Services (continued)		
Other eyewear allowance	Our plan also covers additional eye wear through our vendor, Davis Vision: Select frames purchased from our vendor's exclusive collection will be covered in full through our vision services partner. Any frames outside the collection will have a $75.00 allowance annually. You pay a $20.00 copay for eyeglass lenses. If contact lenses are medically necessary they will be covered in full through our vendor, Davis Vision. The elective contact lenses allowance is $100.00 each year. Contact lens evaluation and fitting is not covered.	Our plan also covers additional eye wear through our vendor, Davis Vision: Select frames purchased from our vendor's exclusive collection will be covered in full through our vision services partner. Any frames outside the collection will have a $100.00 allowance annually. You pay a $10.00 copay for eyeglass lenses. If contact lenses are medically necessary they will be covered in full through our vendor, Davis Vision. The elective contact lenses allowance is $125.00 each year. Contact lens evaluation and fitting is not covered.
Mental Health Services		
Outpatient individual therapy per visit	You pay a $40.00 copay for each outpatient individual therapy visit.	You pay a $20.00 copay for each outpatient individual therapy visit.
Outpatient group therapy per visit	You pay a $20.00 copay for each outpatient group therapy visit.	You pay a $10.00 copay for each outpatient group therapy visit.
Skilled Nursing Facility Prior authorization may be required.	Our plan covers up to 100 days in a Skilled Nursing Facility. You pay a $0.00 copay per day for days 1 through 20. You pay a $180.00 copay per day for days 21 through 100.	Our plan covers up to 100 days in a Skilled Nursing Facility. You pay a $0.00 copay per day for days 1 through 20. You pay a $160.00 copay per day for days 21 through 100.
Physical Therapy Prior authorization may be required.	You pay $35.00 per visit for occupational therapy, physical therapy, or speech-language pathology services.	You pay $25.00 per visit for occupational therapy, physical therapy, or speech-language pathology services.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Ambulance Authorization may be required for non-emergency Medicare service	You pay a $240.00 copay for ground services. You pay 20% coinsurance for air services.	You pay a $200.00 copay for ground services. You pay 20% coinsurance for air services.
Transportation	No coverage.	No coverage.
Medicare Part B Drugs Prior authorization may be required	You pay 20% coinsurance for Part B chemotherapy or other drugs.	You pay 20% coinsurance for Part B chemotherapy or other drugs.
Other Services		
24-Hour Nurse Advice Line	You pay a $0.00 copay for services provided by the 24-Hour Nurse Advice Line.	You pay a $0.00 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). You pay a $30.00 copay for urgent care services and a $40.00 copay for individual behavioral health (mental health specialty services or psychiatric services).	Video Visit through our vendor allows members to securely connect with a provider for urgent care services and behavioral health (therapy and psychiatry). You pay a $20.00 copay for urgent care services and a $20.00 copay for individual behavioral health (mental health specialist services and psychiatric services).
Acupuncture Services **Acupuncture for chronic low back pain** **Routine acupuncture services**	 You pay a $50.00 copay for acupuncture services at a Specialist office. Routine acupuncture visits are not covered in this plan.	 You pay a $30.00 copay for acupuncture services at a Specialist office. You pay a $20.00 copay for each non-Medicare-covered routine acupuncture visit (up to 12 visits a calendar year).
Chiropractic Services Prior authorization may be required.	You pay a $20.00 copay for each Medicare-covered chiropractic visit. Routine chiropractic care is not covered in this plan.	You pay a $10.00 copay for each Medicare-covered chiropractic visit. You pay a $10.00 copay for each non-Medicare-covered routine chiropractic service (up to 12 visits a calendar year).

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Podiatry Services Prior authorization may be required.	You pay a $40.00 copay for each Medicare-covered podiatry visit. Routine podiatry care is not covered in this plan.	You pay a $30.00 copay for each Medicare-covered podiatry visit. You pay a $10.00 copay for each non-Medicare-covered routine podiatry service (up to 12 visits a calendar year).
Psychiatric Services	You pay a $40.00 copay for each individual session. You pay a $20.00 copay for each group session.	You pay a $20.00 copay for each individual session. You pay a $10.00 copay for each group session.
Additional Telehealth Services Prior authorization and referral may be required for Specialist services.	You pay: $5.00 copay for Primary Care Provider service $50.00 copay for Specialist service $40.00 copay for Mental Health Individual session $20.00 copay for Mental Health Group session $40.00 copay for Psychiatric Services Individual session $20.00 copay for Psychiatric Services Group session Additional telehealth is covered through video services with in-network providers only.	You pay: $0.00 copay for Primary Care Provider service $30.00 copay for Specialist service $20.00 for Mental Health Individual session $10.00 for Mental Health Group session $20.00 for Psychiatric Services Individual session $10.00 for Psychiatric Services Group session Additional telehealth is covered through video services with in-network providers only.
SilverSneakers	You're automatically enrolled in the SilverSneakers® Fitness Program at no additional cost. SilverSneakers can help you live a healthier, more active life through fitness and social connection. Enjoy SilverSneakers On-Demand workout videos from home, LIVE Classes and Workshops and more through SilverSneakers.com and the SilverSneakers GO app. You can also sign up for a home fitness kit. 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.	

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
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.	

Dental and Vision Add-On

Available to enrollees in CareFirst BlueCross BlueShield Advantage Enhanced (HMO) plan only. Dental and vision benefits are not available for enrollment separately.

Benefit	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Monthly Premium	Not Applicable	$17.00 per month in addition to your monthly plan premium for the Enhanced plan.
Dental benefits	Dental and Vision Add-On not available with this plan.	The plan has a maximum coverage amount of $1,000 per year for comprehensive dental services. Additional services included in the upgrade package: **Non-Routine Services** You pay a $15.00 copay for application of desensitizing medicament. **Major Restorative Services** Major restorative services copays vary depending on services that include surgical placement, abutment, implants, debridement, radiographic/ surgical implant, onlays, crowns, re-cement, re-bond, core buildup, and more. The services are mainly once every 5 years, however some services are once every 12 months and some are as needed. You pay a $15.00 to $500.00 copay. **Endodontics** Endodontics copays vary depending on services that include endodontic therapy, retreatment, apicoectomy, retrograde filing, root amputation, and more. The services are mainly once per tooth per lifetime, however some are as needed. You pay a $100.00 to $200.00 copay.

Dental and Vision Add-On

Available to enrollees in CareFirst BlueCross BlueShield Advantage Enhanced (HMO) plan only. Dental and vision benefits are not available for enrollment separately.

Benefit	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Dental benefits (continued)	Dental and Vision Add-On not available with this plan.	**Surgical Periodontics** Surgical Periodontics copays vary depending on services that include gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, bone replacement, and more. The services are all once every 5 years. You pay a $100.00 to $300.00 copay. **Surgical Extractions** You pay a $100.00 copay for surgical extractions for an erupted tooth, impacted tooth, or removal of residual tooth roots, and more. **Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services** Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services copay vary depending on services that include pontic-cast/titanium/porcelain/resin, retainer crown, complete denture, immediate denture, maxillary partial denture, mandibular, adjust complete/ partial denture, repairs and replacements, rebase, reline, tissue conditioning, overdenture, and more. The services range from once every 12 months, 36 months, and 5 years for Prosthodontics. The services range from once per tooth per lifetime or as needed for Other Oral/Maxillofacial. You pay a $40.00 to $700.00 copay.

Dental and Vision Add-On

Available to enrollees in CareFirst BlueCross BlueShield Advantage Enhanced (HMO) plan only. Dental and vision benefits are not available for enrollment separately.

Benefit	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Vision benefits	Dental and Vision Add-On not available with this plan.	Additional allowances included with the upgrade: ■ Additional $100.00 for the frame allowance is added for a total frame allowance of $200.00 ■ Additional $100.00 for the contact lens allowance is added for a total contact allowance of $225.00 ■ Upgrade of contact lens evaluation and fitting is covered up to $60.00

Medicare Part D Drugs	
Initial Coverage Stage	You pay the copays in the tables below until your total yearly drug costs reach $4,430 in 2022. 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. Prescription drugs cost-sharing tier descriptions: ■ Tier 1—Preferred Generics provide the lowest cost-share ■ Tier 2—Generics include a higher cost-share than Tier 1 ■ Tier 3—Preferred Brands include a mid-level cost-share ■ Tier 4—Non-Preferred Drugs include a cost-share higher than Tier 3 ■ Tier 5—Specialty drugs include the highest cost-share
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430 in 2022. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050 which is the end of the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy, specialty pharmacies and through mail order) reach $7,050.00 in 2022 you pay the greater of: 5% coinsurance, or $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other 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 as copays as a 30-day retail pharmacy prescriptions for both Core and Enhanced plans.

Medicare Part D Drugs

	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Pharmacy (Part D) Deductible	There is no pharmacy deductible for this plan.	There is no pharmacy deductible for this plan.
Retail Pharmacy—30-day Supply	Copay for 30-day Supply Retail Pharmacy	Copay for 30-day Supply Retail Pharmacy
Tier 1—Preferred Generic	$7.00 per prescription	$5.00 per prescription
Tier 2—Generic	$20.00 per prescription	$15.00 per prescription
Tier 3—Preferred Brand	$47.00 per prescription	$47.00 per prescription
Tier 4—Non-Preferred Drug	$100.00 per prescription	$100.00 per prescription
Tier 5—Specialty	33% of the total cost per prescription	33% of the total cost per prescription
Retail Pharmacy—60-day Supply	Copay for 60-day Supply Retail Pharmacy	Copay for 60-day Supply Retail Pharmacy
Tier 1—Preferred Generic	$14.00 per prescription	$10.00 per prescription
Tier 2—Generic	$40.00 per prescription	$30.00 per prescription
Tier 3—Preferred Brand	$94.00 per prescription	$94.00 per prescription
Tier 4—Non-Preferred Drug	$200.00 per prescription	$200.00 per prescription
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Retail Pharmacy—90-day Supply	Copay for 90-day Supply Retail Pharmacy	Copay for 90-day Supply Retail Pharmacy
Tier 1—Preferred Generic	$21.00 per prescription	$15.00 per prescription
Tier 2—Generic	$60.00 per prescription	$45.00 per prescription
Tier 3—Preferred Brand	$141.00 per prescription	$141.00 per prescription
Tier 4—Non-Preferred Drug	$300.00 per prescription	$300.00 per prescription
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Medicare Part D Drugs

	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Mail Order—30-day Supply	Copay for 30-day Supply Mail Order	Copay for 30-day Supply Mail Order
Tier 1—Preferred Generic	$7.00 per prescription	$5.00 per prescription
Tier 2—Generic	$20.00 per prescription	$15.00 per prescription
Tier 3—Preferred Brand	$47.00 per prescription	$47.00 per prescription
Tier 4—Non-Preferred Drug	$100.00 per prescription	$100.00 per prescription
Tier 5—Specialty	33% of the total cost per prescription	33% of the total cost per prescription
Mail Order—60-day Supply	Copay for 60-day Supply Mail Order	Copay for 60-day Supply Mail Order
Tier 1—Preferred Generic	$14.00 per prescription	$10.00 per prescription
Tier 2—Generic	$40.00 per prescription	$30.00 per prescription
Tier 3—Preferred Brand	$94.00 per prescription	$94.00 per prescription
Tier 4—Non-Preferred Drug	$200.00 per prescription	$200.00 per prescription
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Mail Order—90-day Supply	Copay for 90-day Supply Mail Order	Copay for 90-day Supply Mail Order
Tier 1—Preferred Generic	$14.00 per prescription	$10.00 per prescription
Tier 2—Generic	$40.00 per prescription	$30.00 per prescription
Tier 3—Preferred Brand	$94.00 per prescription	$94.00 per prescription
Tier 4—Non-Preferred Drug	$200.00 per prescription	$200.00 per prescription
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Medicare Part D Drug Gap Coverage

	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Enhanced Gap Coverage	Gap coverage is not available for this plan.	Enhanced plan members entering the coverage gap stage (donut hole) will pay the copay listed below for Tier 1—Preferred Generic drugs, or 25% of the plan's cost of the drug whichever is the lowest while in the coverage gap stage. 30-day Retail Supply: $5.00 60-day Retail Supply: $10.00 90-day Retail Supply: $15.00 30-day Mail Order: $5.00 60-day Mail Order: $10.00 90-day Mail Order: $10.00 $5.00 30-day for OON (Out-of-network) and 31-day for LTC (Long-Term Care drugs)