HIGHMARK

Delaware

Complete Blue PPO

Summary of Benefits

January 1, 2026 to December 31, 2026

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

New Castle

This summary of benefits doesn't list every service, limitation, or special circumstance.

Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-844-576-1246** (TTY 711). We're available 7 days a week, 8 a.m. to 8 p.m.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Complete Blue PPO has a network of pharmacies. The out-of-network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

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	Complete Blue PPO Signature (PPO)	Complete Blue PPO Distinct (PPO)
Premium	$0	$105
Part B Premium Reduction	$0	$0
Deductible	$0	$0
Max Out-Of-Pocket	$6,750 IN; $10,000 combined IN and OON	$6,500 IN; $8,950 combined IN and OON
Inpatient Hospital Stay	Days 1 - 7: $375 copay per day per admit & Days 8 - 90: $0 copay per day per admit IN*; Days 1 - 7: $390 copay per day per admit & Days 8 - 90: $0 copay per day per admit OON	Days 1 - 5: $325 copay per day per admit & Days 6 - 90: $0 copay per day per admit IN*; Days 1 - 5: $395 copay per day per admit & Days 6 - 90: $0 copay per day per admit OON
Outpatient Hospital Coverage	ASC[1]: $300 copay IN*; $400 copay OON Facility: $350 copay IN*; $450 copay OON	ASC[1]: $275 copay IN*; $375 copay OON Facility: $325 copay IN*; $425 copay OON
Doctor Office Visit	PCP: $0 copay IN; 40% coinsurance OON Specialist: $50 copay IN; 40% coinsurance OON	PCP: $0 copay IN; 40% coinsurance OON Specialist: $40 copay IN; 40% coinsurance OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN/OON	Covered in Full (Office visit copays may apply) IN/OON
Emergency Room	$130 copay IN/OON	$130 copay IN/OON
Urgently Needed Services	$50 copay IN/OON	$50 copay IN/OON
Lab & Diagnostic Tests	Freestanding Lab: $0 copay IN*; 40% coinsurance OON Office/Outpatient: $10 copay IN*; 40% coinsurance OON	Freestanding Lab: $0 copay IN*; 40% coinsurance OON Office/Outpatient: $10 copay IN*; 40% coinsurance OON
X-Rays/ Advanced Imaging	X-ray: $25 copay IN*; 40% coinsurance OON Advanced Imaging: $350 copay IN*; 40% coinsurance OON	X-ray: $10 copay IN*; 40% coinsurance OON Advanced Imaging: $275 copay IN*; 40% coinsurance OON
Hearing Services	Medicare Covered: $50 copay IN; 40% coinsurance OON. Routine: $30 copay IN; $30 copay OON (1 Per Year). TruHearing Advanced: $699 copay (2 Aids Every Year IN/OON); TruHearing Premium: $999 copay (2 Aids Every Year IN/OON); $500 allowance IN/OON (per year) excludes Advanced/Premium models	Medicare Covered: $40 copay IN; 40% coinsurance OON. Routine: $0 copay IN; $0 copay OON (1 Per Year). TruHearing Advanced: $699 copay (2 Aids Every Year IN/OON); TruHearing Premium: $999 copay (2 Aids Every Year IN/OON); $500 allowance IN/OON (per year) excludes Advanced/Premium models
Dental Services	Medicare Covered: $50 copay IN; 40% coinsurance OON. Routine Office Visit: $0 copay IN; 30% coinsurance OON (2 per year). Routine X-rays: $0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance IN; 50% coinsurance OON; with a maximum $1,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits.	Medicare Covered: $40 copay IN; 40% coinsurance OON. Routine Office Visit: $0 copay IN; 30% coinsurance OON (2 per year). Routine X-rays: $0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance IN; 50% coinsurance OON; with a maximum $1,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits.
Vision Services	Medicare Covered: $50 copay IN; 40% coinsurance OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max applies to specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).	Medicare Covered: $40 copay IN; 40% coinsurance OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max applies to specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay IN*; Days 1 - 3: $500 copay per day per admit & Days 4 - 90: $0 copay OON; Outpatient: $40 copay IN; 40% coinsurance OON	Inpatient: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay IN*; Days 1 - 3: $500 copay per day per admit & Days 4 - 90: $0 copay OON; Outpatient: $30 copay IN; 40% coinsurance OON
Skilled Nursing Facility	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 30% coinsurance OON	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 30% coinsurance OON
Physical Therapy	$40 copay IN*; 40% coinsurance OON	$30 copay IN*; 40% coinsurance OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $505 copay IN**; Non-Emergent: 30% coinsurance OON	Emergent/Non-Emergent: $320 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	Not Covered	Not Covered
Medicare Part B Drugs[†]	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON

	Complete Blue PPO Signature (PPO)	Complete Blue PPO Distinct (PPO)
OTC	$25 allowance once per quarter IN/OON	Not Covered
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN*, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN*, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON
Formulary	Performance	Performance

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips. ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Complete Blue PPO Signature (PPO)

DRUG

After you pay your yearly deductible (excludes insulins), you pay the following until your total yearly drug costs reach $2,100. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	Tier 1-Tier 2: $0, Tier 3-5: $615			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$3 Copay	$9 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	21% of the cost	21% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$15 Copay	$45 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	21% of the cost	21% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$7 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	21% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$21 Copay
		Tier 2 (Generic)	Not Applicable	$45 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	21% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Complete Blue PPO Distinct (PPO)

DRUG

After you pay your yearly deductible (excludes insulins), you pay the following until your total yearly drug costs reach $2,100. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	Tier 1-Tier 2: $0, Tier 3-5: $615			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$3 Copay	$9 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	20% of the cost	20% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$20 Copay	$60 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	20% of the cost	20% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$7 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	20% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$21 Copay
		Tier 2 (Generic)	Not Applicable	$60 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	20% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-866-746-7971 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

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