



## Delaware

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### Freedom Blue PPO

# Summary of Benefits

January 1, 2026 to December 31, 2026

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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:

### Kent, New Castle, Sussex

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**

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.

Freedom 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."

|                                    | Freedom Blue PPO Valor (PPO)                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Premium                            | \$0                                                                                                                                                                                                                                                                                                                                                                                                |
| Part B Premium Reduction           | \$70                                                                                                                                                                                                                                                                                                                                                                                               |
| Deductible                         | \$0                                                                                                                                                                                                                                                                                                                                                                                                |
| Max Out-Of-Pocket                  | \$6,000 IN; \$8,950 combined IN and OON                                                                                                                                                                                                                                                                                                                                                            |
| Inpatient Hospital Stay            | \$275 copay per admit IN*; \$395 copay per admit OON                                                                                                                                                                                                                                                                                                                                               |
| Outpatient Hospital Coverage       | ASC <sup>1</sup> : \$195 copay IN*; \$350 copay OON<br>Facility: \$245 copay IN*; \$375 copay OON                                                                                                                                                                                                                                                                                                  |
| Doctor Office Visit                | PCP: \$0 copay IN; 40% coinsurance OON<br>Specialist: \$10 copay IN; 40% coinsurance OON                                                                                                                                                                                                                                                                                                           |
| Preventive/Screening               | Covered in Full (Office visit copays may apply) IN/OON                                                                                                                                                                                                                                                                                                                                             |
| Emergency Room                     | \$130 copay IN/OON                                                                                                                                                                                                                                                                                                                                                                                 |
| Urgently Needed Services           | \$40 copay IN/OON                                                                                                                                                                                                                                                                                                                                                                                  |
| Lab & Diagnostic Tests             | Freestanding Lab: \$0 copay IN*; 40% coinsurance OON<br>Office/Outpatient: \$10 copay IN*; 40% coinsurance OON                                                                                                                                                                                                                                                                                     |
| X-Rays/ Advanced Imaging           | X-ray: \$20 copay IN*; 40% coinsurance OON<br>Advanced Imaging: \$225 copay IN*; 40% coinsurance OON                                                                                                                                                                                                                                                                                               |
| Hearing Services                   | Medicare Covered: \$10 copay IN; 40% coinsurance OON.<br>Routine: \$0 copay IN; \$0 copay OON (1 Per Year). TruHearing Advanced: \$699 copay (2 Aids Every Year IN/OON);<br>TruHearing Premium: \$999 copay (2 Aids Every Year IN/OON); \$500 allowance IN/OON (per year) excludes Advanced/<br>Premium models                                                                                     |
| Dental Services                    | Medicare Covered: \$10 copay IN; 40% coinsurance OON.<br>Routine Office Visit: \$0 copay IN; 30% coinsurance OON (2 per year).<br>Routine X-rays: \$0 copay IN; 30% coinsurance OON (1 per year).<br>Comprehensive: 40% coinsurance IN; 40% coinsurance OON;<br>with a maximum \$3,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full<br>benefits.      |
| Vision Services                    | Medicare Covered: \$10 copay IN; 40% coinsurance OON.<br>Routine: \$0 copay IN; \$50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered<br>in full. IN/OON: A \$200 benefit max applies to non-standard frames or a \$200 benefit max applies to specialty contact<br>lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye). |
| Mental Health Services             | Inpatient: Days 1 - 3: \$325 copay per day per admit & Days 4 - 90: \$0 copay per day per admit IN*; Days 1 - 3: \$475<br>copay per day per admit & Days 4 - 90: \$0 copay per day per admit OON<br>Outpatient: \$5 copay IN; 40% coinsurance OON                                                                                                                                                  |
| Skilled Nursing Facility           | \$0 copay/day (days 1 - 20), \$218 copay/day (days 21 - 100) IN*; 30% coinsurance OON                                                                                                                                                                                                                                                                                                              |
| Physical Therapy                   | \$15 copay IN*; 40% coinsurance OON                                                                                                                                                                                                                                                                                                                                                                |
| Ambulance (per one-way trip)       | Emergent/Non-Emergent: \$425 copay IN**;<br>Non-Emergent: 30% coinsurance OON                                                                                                                                                                                                                                                                                                                      |
| Transportation                     | Not Covered                                                                                                                                                                                                                                                                                                                                                                                        |
| Medicare Part B Drugs <sup>†</sup> | 20% coinsurance IN*; 30% coinsurance OON                                                                                                                                                                                                                                                                                                                                                           |
| OTC                                | \$100 allowance once per quarter IN/OON                                                                                                                                                                                                                                                                                                                                                            |
| Durable Medical Equipment          | 0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories,<br>20% Coinsurance for all other covered items IN*,<br>50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other<br>covered items OON                                                                              |
| Formulary                          | Not Covered                                                                                                                                                                                                                                                                                                                                                                                        |

\*Indicates a service that requires prior authorization.

\*\*Indicates a service that requires prior authorization for non-emergent trips.

ASC<sup>1</sup>=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.



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.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.