



Northeastern Pennsylvania

Complete Blue Plus 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:

Lycoming, Sullivan

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

Visit us at [medicare.highmark.com](https://www.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 **1-833-227-9375** (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](https://www.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 Plus 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."

Complete Blue Plus PPO Distinct (PPO)

Premium	\$72
Part B Premium Reduction	\$0
Deductible	\$0
Max Out-Of-Pocket	\$6,750 IN; \$8,950 combined IN and OON
Inpatient Hospital Stay	Days 1 - 5: \$175 copay per day per admit & Days 6 - 90: \$0 copay per admit IN*; Days 1 - 5: \$250 copay per day per admit & Days 6 - 90: \$0 copay per admit OON
Outpatient Hospital Coverage	ASC ¹ : \$250 copay IN*; \$300 copay OON Facility: \$300 copay IN*; \$350 copay OON
Doctor Office Visit	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
Emergency Room	\$130 copay IN/OON
Urgently Needed Services	\$40 copay IN/OON
Lab & Diagnostic Tests	Freestanding Lab: \$0 copay IN*; 40% coinsurance OON Office/Outpatient: \$10 copay IN*; 40% coinsurance OON
X-Rays/ Advanced Imaging	X-ray: \$20 copay IN*; 40% coinsurance OON Advanced Imaging: \$195 copay IN*; 40% coinsurance OON
Hearing Services	Medicare Covered: \$40 copay IN; 40% coinsurance OON. Routine: \$15 copay IN; \$15 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: \$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: 25% coinsurance IN; 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits.
Vision Services	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 \$200 benefit max applies to non-standard frames or a \$200 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: \$425 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
Physical Therapy	\$30 copay IN*; 40% coinsurance OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: \$370 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	\$0 copay IN*; 30% coinsurance OON
Medicare Part B Drugs [†]	20% coinsurance IN*; 30% coinsurance OON
OTC	\$50 allowance once per quarter IN/OON
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
Formulary	Performance

*Indicates a service that requires prior authorization.

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

ASC¹=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 Plus PPO Distinct (PPO)

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)	23% of the cost	23% 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)	23% of the cost	23% 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	23% 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	23% 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.

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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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