



## Central Pennsylvania

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### Complete 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:

### Lancaster

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 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 PPO Distinct (PPO)                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Premium                            | \$55                                                                                                                                                                                                                                                                                                                                                                                         |
| 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 <sup>1</sup> : \$225 copay IN*; \$275 copay OON<br>Facility: \$275 copay IN*; \$325 copay OON                                                                                                                                                                                                                                                                                            |
| Doctor Office Visit                | PCP: \$0 copay IN; 40% coinsurance OON<br>Specialist: \$30 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: \$30 copay IN; 40% coinsurance OON.<br>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: \$30 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: 25% coinsurance IN; 50% coinsurance OON;<br>with a maximum \$2,500 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits.   |
| Vision Services                    | Medicare Covered: \$30 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 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: \$305 copay IN**;<br>Non-Emergent: 30% coinsurance OON                                                                                                                                                                                                                                                                                                                |
| Transportation                     | \$0 copay IN*; 30% coinsurance OON                                                                                                                                                                                                                                                                                                                                                           |
| Medicare Part B Drugs <sup>†</sup> | 20% coinsurance IN*; 30% coinsurance OON                                                                                                                                                                                                                                                                                                                                                     |
| OTC                                | \$55 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*,<br>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.

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.

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

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. The Blue Shield® and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

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.