



Southeastern Pennsylvania

Complete Blue PPO

Summary of Benefits

January 1, 2025 to December 31, 2025

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:

Bucks, Chester, Philadelphia, Montgomery

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 8 a.m. to 8 p.m., 7 days a week.

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.

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.

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 Choice Deluxe | Complete Blue PPO Premier |
|------------------------------------|--|---|
| Premium | \$9.00 | \$38.00 |
| Part B Premium Reduction | \$0.00 | \$0.00 |
| Deductible | \$0 | \$0 |
| Max Out-Of-Pocket | \$6,750 IN; \$9,550 combined IN and OON | \$6,100 IN; \$8,950 combined IN and OON |
| Inpatient Hospital Stay | \$425 copay per admit IN*; \$425 copay per admit OON | \$425 copay per admit IN*; \$425 copay per admit OON |
| Outpatient Hospital Coverage | ASC ¹ : \$200 copay IN*; \$200 copay OON Facility: \$300 copay IN*; \$300 copay OON | ASC ¹ : \$150 copay IN*; \$150 copay OON Facility: \$250 copay IN*; \$250 copay OON |
| Doctor Office Visit | PCP: \$0 copay IN; \$0 copay OON Specialist: \$25 copay IN; \$25 copay OON | PCP: \$0 copay IN; \$0 copay OON Specialist: \$20 copay IN; \$20 copay 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 | \$125 copay IN/OON | \$125 copay IN/OON |
| Urgently Needed Services | \$50 copay IN/OON | \$15 copay IN/OON |
| Lab & Diagnostic Tests | Office /Lab: \$0 copay IN*; \$0 copay OON; Outpatient: \$0 copay IN*; \$0 copay OON | Office /Lab: \$0 copay IN*; \$0 copay OON; Outpatient: \$0 copay IN*; \$0 copay OON |
| X-Rays/ Advanced Imaging | X-ray: \$30 copay IN*; \$30 copay OON Advanced Imaging: \$300 copay IN*; \$300 copay OON | X-ray: \$15 copay IN*; \$15 copay OON Advanced Imaging: \$225 copay IN*; \$225 copay OON |
| Hearing Services | Medicare Covered: \$25 copay IN; \$25 copay OON. Routine: \$15 copay IN; \$15 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year); \$500 allowance IN/OON (per year) | Medicare Covered: \$20 copay IN; \$20 copay OON. Routine: \$0 copay IN; \$0 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year); \$500 allowance IN/OON (per year) |
| Dental Services | Medicare Covered: \$25 copay IN; \$25 copay OON. Routine Office Visit: \$0 copay IN; 30% coinsurance OON (1 per six months). Routine X-rays: \$0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance IN; 50% coinsurance OON; with a maximum \$4,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits. | Medicare Covered: \$20 copay IN; \$20 copay OON. Routine Office Visit: \$0 copay IN; 30% coinsurance OON (1 per six months). Routine X-rays: \$0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 0% coinsurance IN; 50% coinsurance OON; with a maximum \$3,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits. |
| Vision Services | Medicare Covered: \$25 copay IN; \$25 copay 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 for specialty contact lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye). | Medicare Covered: \$20 copay IN; \$20 copay 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 for 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 per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per day per admit OON; Outpatient: \$40 copay IN; \$40 copay OON | Inpatient: \$300 copay per admit IN*; \$300 copay per day per admit OON; Outpatient: \$30 copay IN; \$30 copay OON |
| Skilled Nursing Facility | \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) IN*; 30% coinsurance OON | \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) IN*; 30% coinsurance OON |
| Physical Therapy | \$25 copay IN*; \$25 copay OON | \$0 copay IN*; \$0 copay OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: \$290 copay IN**; Non-Emergent: 30% coinsurance OON | Emergent/Non-Emergent: \$250 copay IN**; Non-Emergent: 30% coinsurance OON |
| Transportation | \$0 copay IN*; 30% coinsurance OON | \$0 copay IN*; 30% coinsurance OON |
| Medicare Part B Drugs ¹ | 20% coinsurance IN*; 30% coinsurance OON | 20% coinsurance IN*; 30% coinsurance OON |
| OTC | Not Covered | \$75 allowance once per quarter IN/OON |

| | Complete Blue PPO Choice Deluxe | Complete Blue PPO Premier |
|---------------------------|---|--|
| Flex Card | \$485 allowance/year for dental, vision, hearing and OTC. \$200 allowance/year for Part B with a \$50 limit per transaction. | Not Covered |
| Durable Medical Equipment | 20% coinsurance IN*; 30% coinsurance OON | 20% coinsurance IN*; 30% coinsurance OON |
| Formulary | Performance | 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 PPO Choice Deluxe

You pay the following until your total yearly drug costs reach \$2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| | | | | | |
|------------------------------|---|--------------------------------------|-----------------------------|----------------------|-------------------------------------|
| Deductible | \$0 | | | | |
| DRUG | 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) | \$5 Copay | \$15 Copay |
| | | | Tier 3 (Preferred Insulin) | \$35 Copay | \$105 Copay |
| | | | Tier 3 (Preferred Brand) | 25% of the cost | 25% of the cost |
| | | | Tier 4 (Insulin) | \$35 Copay | \$105 Copay |
| | | | Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost |
| | | | Tier 5 (Specialty Tier) | 33% 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) | 25% of the cost | 25% of the cost |
| | | | Tier 4 (Insulin) | \$35 Copay | \$105 Copay |
| | | | Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost |
| | | | Tier 5 (Specialty Tier) | 33% 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 | \$0 Copay |
| | | | Tier 3 (Preferred Insulin) | Not Applicable | \$105 Copay |
| | | | Tier 3 (Preferred Brand) | Not Applicable | 25% of the cost |
| | | | Tier 4 (Insulin) | Not Applicable | \$105 Copay |
| | | | Tier 4 (Non-Preferred Drug) | Not Applicable | 50% of the cost |
| | | | Tier 5 (Specialty Tier) | 33% 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 | | 25% of the cost | | |
| Tier 4 (Insulin) | Not Applicable | | \$105 Copay | | |
| Tier 4 (Non-Preferred Drug) | Not Applicable | | 50% of the cost | | |
| Tier 5 (Specialty Tier) | 33% 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 \$2,000, 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 Premier

You pay the following until your total yearly drug costs reach \$2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| | | | | | |
|------------------------------|---|--------------------------------------|-----------------------------|----------------------|-------------------------------------|
| Deductible | \$0 | | | | |
| DRUG | 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) | \$5 Copay | \$15 Copay |
| | | | Tier 3 (Preferred Insulin) | \$35 Copay | \$105 Copay |
| | | | Tier 3 (Preferred Brand) | 25% of the cost | 25% of the cost |
| | | | Tier 4 (Insulin) | \$35 Copay | \$105 Copay |
| | | | Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost |
| | | | Tier 5 (Specialty Tier) | 33% 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) | 25% of the cost | 25% of the cost |
| | | | Tier 4 (Insulin) | \$35 Copay | \$105 Copay |
| | | | Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost |
| | | | Tier 5 (Specialty Tier) | 33% 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 | \$0 Copay |
| | | | Tier 3 (Preferred Insulin) | Not Applicable | \$105 Copay |
| | | | Tier 3 (Preferred Brand) | Not Applicable | 25% of the cost |
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| Tier 3 (Preferred Brand) | Not Applicable | | 25% of the cost | | |
| Tier 4 (Insulin) | Not Applicable | | \$105 Copay | | |
| Tier 4 (Non-Preferred Drug) | Not Applicable | | 50% of the cost | | |
| Tier 5 (Specialty Tier) | 33% 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 \$2,000, 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.



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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 Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company, which are independent licensees of the Blue Cross Blue Shield Association. 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 Complete Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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 1-866-682-7972 (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.