



Southeastern Pennsylvania

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:

Bucks, Chester, Montgomery, Philadelphia

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	\$109
Part B Premium Reduction	\$0
Deductible	\$0
Max Out-Of-Pocket	\$6,750 IN; \$9,550 combined IN and OON
Inpatient Hospital Stay	Days 1 - 7: \$275 copay per day per admit & Days 8 - 90: \$0 copay per admit IN*; Days 1 - 7: \$390 copay per day per admit & Days 8 - 90: \$0 copay per admit OON
Outpatient Hospital Coverage	ASC ¹ : \$300 copay IN*; \$350 copay OON Facility: \$350 copay IN*; \$400 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	\$50 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: \$30 copay IN*; 40% coinsurance OON Advanced Imaging: \$300 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: 50% coinsurance IN; 50% coinsurance OON; with a maximum \$1,500 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: \$475 copay per day per admit & Days 4 - 90: \$0 copay OON; Outpatient: \$40 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	\$35 copay IN*; 40% coinsurance OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: \$375 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	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
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 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			
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)	\$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.