HIGHMARK

Delaware

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:

Kent, 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**
- **Formulary** *(full Part D prescription drug list)*

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.

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."

H8166_25_2300_M

	Complete Blue PPO Distinct (PPO)
Premium	$134
Part B Premium Reduction	$16
Deductible	$0
Max Out-Of-Pocket	$6,500 IN; $8,950 combined IN and OON
Inpatient Hospital Stay	Days 1 - 5: $355 copay per day per admit & Days 6 - 90: $0 copay per day per admit IN*; Days 1 - 5: $425 copay per day per admit & Days 6 - 90: $0 copay per day per admit OON
Outpatient Hospital Coverage	ASC[1]: $300 copay IN*; $375 copay OON Facility: $350 copay IN*; $425 copay OON
Doctor Office Visit	PCP: $0 copay IN; 40% coinsurance OON Specialist: $55 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: $10 copay IN*; 40% coinsurance OON Office/Outpatient: $20 copay IN*; 40% coinsurance OON
X-Rays/ Advanced Imaging	X-ray: $10 copay IN*; 40% coinsurance OON Advanced Imaging: $300 copay IN*; 40% coinsurance OON
Hearing Services	Medicare Covered: $55 copay IN; 40% coinsurance OON
Dental Services	Medicare Covered: $55 copay IN; 40% coinsurance OON.
Vision Services	Medicare Covered: $55 copay IN; 40% coinsurance OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). IN/OON:$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: $500 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	$35 copay IN*; 40% coinsurance OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $320 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	Not Covered
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.

ASC[1]=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)

DRUG

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	Tiers 1-5: $615			
Initial Coverage	**Standard Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	25% of the cost	25% of the cost
		Tier 2 (Generic)	25% of the cost	25% of the cost
		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)	25% of the cost	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	25% of the cost
		Tier 2 (Generic)	Not Applicable	25% of the cost
		Tier 3 (Preferred Select 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	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.

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.