Peak Advantage
MEDICARE PLANS

Peak Advantage Vista (PPO)

2025 Summary of Benefits

Ready for better Medicare? Join the **$0 premium plan** that's working harder for West Virginians.

WVU Medicine

Services within this summary of benefits with a [1] may require prior authorization from our plan.
Services with a [2] may require a referral from your doctor.

Peak Advantage Vista (PPO) (H8947-001-001)	
Monthly Premium, Deductible and Limits	
Premiums How much do I need to pay monthly?	Part C Premium: You pay $0 per month Part D Premium: You pay $0 per month You must continue to pay your Medicare Part B premium
Deductible How much do I need to pay before the plan pays?	This plan does not have a Part C deductible.
Maximum Out-of-Pocket costs What's the limit on how much I will pay for in-network or out-of-network services?	$7,250 per year for services from in-network providers $10,750 per year for in and out of network services combined
Hospital	
Inpatient hospital coverage[1] How long will my plan cover? How much do I pay?	**In-Network:** • $0 copay for first 2 days of your hospital stay • $225 copay per day for days 1-3 • $0 copay for days 4-90 • $800 copay for 60 Lifetime Reserve days **Out-of-Network:** 35% of the total cost
Outpatient hospital coverage[1]	**In-Network:** • $275 copay per stay for covered hospital services • $175 per stay for covered observation services **Out-of-Network:** 35% of the total cost
Ambulatory surgery center[1]	**In-Network:** $225 copay per visit **Out-of-Network:** 35% of the total cost
Doctor Visits and Preventive Care	
Doctor visits Primary care Specialists[1]	**In-Network:** $0 copay for PCP visits **Out-of-Network:** 35% of the total cost **In-Network:** $25 copay for each specialist visit **Out-of-Network:** 35% of the total cost

Peak Advantage Vista (PPO) (H8947-001-001)	
Preventive care	**In-Network:** You pay $0 **Out-of-Network:** 35% of the total cost
Emergency and Urgent Care	
Emergency care	You pay $95 per visit. Your copay is waived if you are admitted to the hospital within 24 hours
Urgently needed services	You pay $35 per visit
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs	
Diagnostic services/labs/imaging[1]	**In-Network:** • $0 copay for diagnostic tests and X-rays at your primary care provider's office. $25 copay if provided elsewhere • $0 copay for some diagnostic ultrasound, mammography, and diagnostic bone density imaging • $225 copay for all other Diagnostic Radiological Services (e.g., CT, MRI) **Out-of-Network:** 35% of the total cost
Hearing / Dental / Vision	
Hearing services How much do I pay for Hearing Services or Hearing Aids?	**In-Network:** • $0 copay for Medicare-covered exams to diagnose and treat hearing and balance issues • $0 copay for routine hearing services **Out-of-Network:** 35% of the total cost **Hearing aids:** • $599 copay for TruHearing advanced, 32-channel models • $899 copay for TruHearing premium, 48-channel models • You pay 35% of the total cost for other hearing aids The plan covers 1 hearing aid per ear each year
Dental services	$0 copay for Medicare-covered dental benefits $0 copay for routine dental services 50% of the total cost for comprehensive dental services The plan covers up to $3,000 in dental services per year

Peak Advantage Vista (PPO) (H8947-001-001)	

Vision services	The plan covers up to $200 for eyeglasses, frames, lenses, or contacts every year in or out of network
	In-Network:
	• $0 copay for Medicare-covered vision services
	• $0 copay for one routine eye exams
	• $0 copay for:
	  ◦ Eyeglasses per year (lenses and frames)
	  ◦ Contact lenses
	Out-of-Network: 35% of the total cost

Mental Health Services	
Inpatient visits	**In-Network:** • $0 copay for Medicare covers the first 2 days of your hospital stay • After the Medicare-covered stay, $425 copay per day for days 1-3 • $0 copay per day for days 4-90 • $800 copay for 60 Lifetime Reserve days **Out-of-Network:** 35% of the total cost
Outpatient visits	**In-Network:** $40 copay for Medicare-covered individual or group therapy services **Out-of-Network:** 35% of the total cost
Skilled Nursing Facility (SNF)	
Skilled Nursing Facility$_1$ (SNF)	**In-Network:** We cover up to 100 days in a SNF per benefit period • $0 per day for days 1-20 • $214 per day for days 21-100 **Out-of-Network:** 35% of the total cost.
Outpatient Rehabilitation Services	
Physical Therapy$_1$	**In-Network:** • $10 copay for cardiac (heart) rehab services • $30 copay for: ◦ Occupational therapy

Peak Advantage Vista (PPO) (H8947-001-001)	
	◦ Physical therapy ◦ Speech and language therapy **Out-of-Network:** 35% of the total cost
Medical Transportation	
Ambulance[1]	**In-Network:** $290 copay for each one-way trip by ground or air **Out-of-Network:** 35% of the total cost **Prior authorization required for non-emergency services**
Transportation[1]	**In-Network:** $0 copay for up to 24 one-way trips per year to plan-approved locations **Out-of-Network:** 35% of the total cost
Medicare Part B Drugs	
Medicare Part B Drugs[1]	**In-Network:** • Medicare Part B Covered Drugs 20% of the total cost • Chemotherapy Drugs 20% of the total cost **Out-of-Network:** • 35% of the total cost You will not pay more than $35 for one-month's supply of insulin Some rebatable Part B drugs may be subject to a lower coinsurance. There may be a cost for the administration of a Part B drug in addition to the cost for the drug itself.

Need to Know:

The amount you pay for prescriptions may change depending on the pharmacy you choose and Part D benefit stage. For more information, please call us or visit medicare.peakhealth.org to find:

- The Provider & Pharmacy Directories
- The Formulary (list of covered drugs)
- The EOC - a complete list of benefits

Part D Prescription Drugs

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Peak Advantage Vista (PPO) (001-001)		
Stage 1: Deductible	No deductible (Your coverage begins on the effective date of your enrollment).	
Stage 2: Initial coverage You pay the following costs until your total yearly drug costs reach $2,000		
Standard Retail	**30-day supply**	**90-day supply**
Tier 1: Preferred generic drugs	$15	$45
Tier 2: Generic drugs	$20	$60
Tier 3: Preferred brand drugs	$47	$141
Tier 4: Non-preferred brand drugs	$100	$300
Tier 5: Specialty drugs	33%	Retail supply not available for Tier 5
Standard Mail Order	**30-day supply**	**90-day supply**
Tier 1: Preferred generic drugs	$0	$0
Tier 2: Generic drugs	$4	$12
Tier 3: Preferred brand drugs	$42	$126
Tier 4: Non-preferred brand drugs	$95	$285
Tier 5: Specialty drugs	Mail order supply not available for Tier 5	
Preferred Retail	**30-day supply**	**90-day supply**
Tier 1: Preferred generic drugs	$0	$0
Tier 2: Generic drugs	$4	$12
Tier 3: Preferred brand drugs	$42	$126
Tier 4: Non-preferred brand drugs	$95	$285
Tier 5: Specialty drugs	33%	Preferred Retail supply not available for Tier 5
Catastrophic Coverage Stage	Once your yearly out-of-pocket drug costs reach $2,000, you pay $0	

Services within this summary of benefits with a [1] may require prior authorization from our plan. Services with a [2] may require a referral from your doctor.

Peak Advantage Vista (PPO) (H8947-001-001)	
Additional Benefits	
Acupuncture[1]	**In-Network:** • 20% of the total cost for Medicare-covered services • $25 copay per visit for up to 20 routine treatments per year **Out-of-Network:** 35% of the total cost for up to 20 routine treatments per year
Chiropractic Care[1]	**In-Network:** • $15 copay per Medicare-covered service • $25 copay for each routine visit **Out-of-Network:** 35% of the total cost
Flexible Spending Debit Card	$275 per year to apply towards approved health-related expenses
Wellness Programs	You pay $0 for fitness center memberships and classes at participating gyms
Over-the-Counter (OTC) Health and Wellness products	$75 allowance every quarter for over-the-counter (OTC) health and wellness products, which are available through a mail order catalog service or in a retail setting. Unused allowance may not be carried over from one quarter to the next.
Routine Foot Care[1]	**In-Network:** $25 copay **Out-of-Network:** 35% of the total cost
Worldwide Coverage for Emergency Care	$95 copay for Emergency care services received outside the U.S.