



Peak Advantage Vista (PPO)

2025 Summary of Benefits

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



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 coverage₁ How long will my plan cover? How much do I pay?	In-Network: <ul style="list-style-type: none"> \$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 coverage₁	In-Network: <ul style="list-style-type: none"> \$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 center₁	In-Network: \$225 copay per visit Out-of-Network: 35% of the total cost
Doctor Visits and Preventive Care	
Doctor visits Primary care	In-Network: \$0 copay for PCP visits Out-of-Network: 35% of the total cost
Specialists ₁	In-Network: \$25 copay for each specialist visit Out-of-Network: 35% of the total cost

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Preventive care	<p>In-Network: You pay \$0</p> <p>Out-of-Network: 35% of the total cost</p>
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/imaging₁	<p>In-Network:</p> <ul style="list-style-type: none"> • \$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) <p>Out-of-Network: 35% of the total cost</p>
Hearing / Dental / Vision	
<p>Hearing services How much do I pay for Hearing Services or Hearing Aids?</p>	<p>In-Network:</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered exams to diagnose and treat hearing and balance issues • \$0 copay for routine hearing services <p>Out-of-Network: 35% of the total cost</p> <p>Hearing aids:</p> <ul style="list-style-type: none"> • \$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 <p>The plan covers 1 hearing aid per ear each year</p>
Dental services	<p>\$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for routine dental services</p> <p>50% of the total cost for comprehensive dental services</p> <p>The plan covers up to \$3,000 in dental services per year</p>

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Vision services	<p>The plan covers up to \$200 for eyeglasses, frames, lenses, or contacts every year in or out of network</p> <p>In-Network:</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered vision services • \$0 copay for one routine eye exams • \$0 copay for: <ul style="list-style-type: none"> ◦ Eyeglasses per year (lenses and frames) ◦ Contact lenses <p>Out-of-Network: 35% of the total cost</p>
Mental Health Services	
Inpatient visits	<p>In-Network:</p> <ul style="list-style-type: none"> • \$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 <p>Out-of-Network: 35% of the total cost</p>
Outpatient visits	<p>In-Network: \$40 copay for Medicare-covered individual or group therapy services</p> <p>Out-of-Network: 35% of the total cost</p>
Skilled Nursing Facility (SNF)	
Skilled Nursing Facility₁ (SNF)	<p>In-Network: We cover up to 100 days in a SNF per benefit period</p> <ul style="list-style-type: none"> • \$0 per day for days 1-20 • \$214 per day for days 21-100 <p>Out-of-Network: 35% of the total cost.</p>
Outpatient Rehabilitation Services	
Physical Therapy₁	<p>In-Network:</p> <ul style="list-style-type: none"> • \$10 copay for cardiac (heart) rehab services • \$30 copay for: <ul style="list-style-type: none"> ◦ Occupational therapy

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	<ul style="list-style-type: none"> Physical therapy Speech and language therapy <p>Out-of-Network: 35% of the total cost</p>
Medical Transportation	
Ambulance₁	<p>In-Network: \$290 copay for each one-way trip by ground or air</p> <p>Out-of-Network: 35% of the total cost</p> <p>Prior authorization required for non-emergency services</p>
Transportation₁	<p>In-Network: \$0 copay for up to 24 one-way trips per year to plan-approved locations</p> <p>Out-of-Network: 35% of the total cost</p>
Medicare Part B Drugs	
Medicare Part B Drugs₁	<p>In-Network:</p> <ul style="list-style-type: none"> Medicare Part B Covered Drugs 20% of the total cost Chemotherapy Drugs 20% of the total cost <p>Out-of-Network:</p> <ul style="list-style-type: none"> 35% of the total cost <p>You will not pay more than \$35 for one-month's supply of insulin</p> <p>Some rebatable Part B drugs may be subject to a lower coinsurance.</p> <p>There may be a cost for the administration of a Part B drug in addition to the cost for the drug itself.</p>

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	

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Additional Benefits	
Acupuncture ₁	<p>In-Network:</p> <ul style="list-style-type: none"> • 20% of the total cost for Medicare-covered services • \$25 copay per visit for up to 20 routine treatments per year <p>Out-of-Network: 35% of the total cost for up to 20 routine treatments per year</p>
Chiropractic Care ₁	<p>In-Network:</p> <ul style="list-style-type: none"> • \$15 copay per Medicare-covered service • \$25 copay for each routine visit <p>Out-of-Network: 35% of the total cost</p>
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	<p>In-Network: \$25 copay</p> <p>Out-of-Network: 35% of the total cost</p>
Worldwide Coverage for Emergency Care	\$95 copay for Emergency care services received outside the U.S.