2026 Summary of Benefits

Peak Advantage Summit (PPO)

Pennsylvania:
Fayette, Greene

H8947.2026.04.0041_C

Premiums and Benefits

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 Summit (PPO) (H8947-002-3)	
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 $20 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?	$5,500 per year for services from in-network providers $8,800 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:** • $325 copay per hospital stay of up to 90 days • $800 copay for 60 Lifetime Reserve days **Out-of-Network:** 35% of the total cost
Outpatient hospital coverage[1]	**In-Network:** • $200 copay per stay for covered hospital services • $200 per stay for covered observation services **Out-of-Network:** 35% of the total cost
Ambulatory surgery center[1]	**In-Network:** $175 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:** $20 copay for each specialist visit **Out-of-Network:** $40 copay

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Preventive care	**In-Network:** You pay $0 **Out-of-Network:** 35% of the total cost
Emergency and Urgent Care	
Emergency care	You pay $100 per visit. Your copay is waived if you are admitted to the hospital within 24 hours
Urgently needed services	You pay $30 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. $15 copay if provided elsewhere • $0 copay for some diagnostic ultrasound, mammography, and diagnostic bone density imaging • $190 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:** • $20 copay for Medicare-covered exams to diagnose and treat hearing and balance issues • $0 copay for routine hearing services **Hearing aids:** • $399 copay for TruHearing Basic models • $599 copay for TruHearing Advanced models • $899 copay for TruHearing Premium models • You pay 35% of the total cost for other hearing aids The plan covers 1 hearing aid per ear each year **Out-of-Network:** 35% of the total cost

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Dental services	$20 copay for Medicare-covered dental benefits $0 copay for routine dental services **In or Out-of-Network:** 50% of the total cost for comprehensive dental services The plan covers up to $5,000 in dental services per year
Vision services	The plan covers up to $350 for eyeglasses, frames, lenses, or contacts every year in or out of network **In-Network:** • $20 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:** • For days 1-3 there will be a $425 copay per day • $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:** $30 copay for Medicare-covered individual or group therapy services **Out-of-Network:** 35% of the total cost
Skilled Nursing Facility (SNF)	
Skilled Nursing Facility$_1$ (SNF)	**In-Network:** We cover up to 100 days in a SNF per benefit period • $0 per day for days 1-20 • $218 per day for days 21-100 **Out-of-Network:** 35% of the total cost.

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Outpatient Rehabilitation Services	

Physical Therapy[1]	**In-Network:**
	• $0 copay for cardiac (heart) rehab services
	• $20 copay for:
	  ◦ Occupational therapy
	  ◦ Physical therapy
	  ◦ Speech and language therapy
	Out-of-Network: 35% of the total cost

Medical Transportation	
Ambulance[1]	**In-Network:** $225 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 36 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 Summit (PPO) (H8947-002-3)		
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 $2,100		
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 drugs	$100	$300
Tier 5: Specialty drugs	33%	Retail supply not available for Tier 5
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 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 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 $2,100, you pay $0	

Additional Benefits

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Additional Benefits	
Acupuncture[1]	**In-Network:** • 20% of the total cost for Medicare-covered services • $20 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 (Spinal Manipulations) • $20 copay for each routine visit **Out-of-Network:** 35% of the total cost
Flexible Spending Debit Card	$440 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	$100 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:** $20 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.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services representative at 1-855-962-7325.

Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit medicare.peakhealth.org or call 1-855-962-7325 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non- contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

Verify Your Eligibility

In order to join Peak Advantage Summit (PPO) you must:

- ☐ Have both Medicare Part A and B
- ☐ Be a U.S. citizen or lawfully present in the country
- ☐ Continue to pay your Medicare Part B premium
- ☐ Live in the Pennsylvania counties of Fayette, Greene.

CONTACT US

We are available for phone calls 10/1 - 3/31: 8 am - 8 pm EST, 7 days a week and 4/1 - 9/30: 8 am - 8 pm EST, Monday - Friday.

You can call us toll-free at **1-855-962-7325**. TTY users should call **711**.

This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. For a full list of covered services, check the Evidence of Coverage (EOC) at medicare.peakhealth.org or call us at the number above.

This document may be available in a non-English language. For additional information call us at the number above.

This document is available in other formats such as braille and large print.

Out-of-network/non-contracted providers are under no obligation to treat Peak Advantage Summit (PPO) plan members, except in emergency situations. Please call Member Services or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

To find out more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at http://www.medicare.gov or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Peak Advantage Summit (PPO) is a PPO with a Medicare contract. Enrollment in Peak Advantage Summit (PPO) depends on contract renewal. Peak Advantage Summit (PPO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.