



2027 Summary of Benefits

Peak Advantage Vista (PPO)

West Virginia:

Barbour, Boone, Braxton, Brooke, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hancock, Harrison, Jackson, Kanawha, Lewis, Logan, Marion, Marshall, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Webster, Wetzel, Wirt, Wood, Wyoming

H8947.2027.04.0123_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 Vista (PPO) (H8947-001-001)	
Monthly Premium, Deductible and Limits	
Premiums How much do I need to pay monthly?	Monthly plan premium: \$0 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?	\$7,500 per year for services from in-network providers \$10,900 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: \$750 copay per hospital stay of up to 90 days \$800 copay for 60 Lifetime Reserve days \$0 copay for 2 additional hospital days if you run out of Lifetime Reserve days Out-of-Network: 35% of the total cost
Outpatient hospital coverage₁ Outpatient surgery Observation services	In-Network: \$275 copay per stay for covered hospital services \$250 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 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 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 \$115 per visit. Your copay is waived if you are admitted to the hospital within 24 hours
Urgently needed services	You pay \$40 per visit
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs	
Diagnostic services/labs/imaging, Diagnostic radiology services (e.g. MRI, CT, PET) Lab services Diagnostic tests and procedures Outpatient X-rays Therapeutic radiology	In-Network: \$25 copay for the following services when performed or processed at any location other than the PCP's office (if sample is collected at PCP's office, and then sent to an offsite lab, a copay will apply): • Diagnostic tests and procedures, • Lab Services In-Network: \$25 copay for the following services when performed at any location other than the PCP's office: • X-rays • Diagnostic ultrasound • Mammograms • Bone density imaging In-Network: \$0 copay for the following services when performed and processed in a PCP's office (examples of lab and diagnostic tests performed and commonly billed from the PCP office are urine tests, rapid strep, finger stick test for hemoglobin (Iron), etc.): • Diagnostic tests and procedures • Lab Services In-Network: \$0 copay for the following services when performed in a PCP's office: • X-rays • Diagnostic ultrasound

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

- Mammograms
- Bone density imaging

In-Network:

\$225 copay for other diagnostic radiological service (ex. CT or MRI)

\$60 copay for Medicare-covered therapeutic radiological services.

\$0 copay for blood.

Out-of-Network:

35% of the total cost.

Prior authorization may be required.

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

Dental services

In-Network

\$20 copay for Medicare-covered dental benefits

Out-of-Network:

35% of the total cost for Medicare-covered dental benefits.

In or Out-of-Network:

\$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

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Vision services Diagnostic exam Eyewear after cataract surgery Routine eye exam Routine eyewear	The plan covers up to \$200 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: \$40 copay for Medicare-covered individual or group therapy services Out-of-Network: 35% of the total cost

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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.
Outpatient Rehabilitation Services	
Physical Therapy ₁ Speech and Language Therapy Occupational Therapy	In-Network: \$0 copay for cardiac (heart) rehab services \$20 copay for physical therapy, speech and language therapy \$30 copay for occupational therapy Out-of-Network: 35% of the total cost
Medical Transportation	
Ambulance ₁	In-Network: \$280 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 Chemotherapy drugs Other Part B drugs Insulin	In-Network: 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) (H8947-001-001)		
Stage 1: Deductible	No deductible	
Stage 2: Initial coverage You pay the following costs until your total yearly drug costs reach \$2,400		
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	25%	25%
Tier 4: Non-preferred drugs	25%	25%
Tier 5: Specialty drugs	33%	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	25%	25%
Tier 4: Non-preferred drugs	25%	25%
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	25%	25%
Tier 4: Non-preferred drugs	25%	25%
Tier 5: Specialty drugs	33%	Not available for Tier 5
Catastrophic Coverage Stage	Once your yearly out-of-pocket drug costs reach \$2,400, you pay \$0	

Additional 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.

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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 (Spinal Manipulations) • \$25 copay for each routine visit (10 visits per year) Out-of-Network: 35% of the total cost
Flexible Spending Debit Card	\$375 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	\$55 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 (10 visits per year) Out-of-Network: 35% of the total cost
Worldwide Coverage for Emergency Care	\$115 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, 2028.
- ☐ 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 Vista (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 West Virginia counties of Barbour, Boone, Braxton, Brooke, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hancock, Harrison, Jackson, Kanawha, Lewis, Logan, Marion, Marshall, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Webster, Wetzel, Wirt, Wood, Wyoming.

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 Vista (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 Vista (PPO) is a Medicare Advantage PPO plan with a Medicare contract and is offered by Peak Health Insurance Corporation. Enrollment in Peak Advantage Vista (PPO) depends on contract renewal. Peak Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Peak Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Peak Health provides free aids and services to people with disabilities to communicate effectively with us and free language services to people whose primary language is not English. If you need these services, contact Peak Advantage Vista (PPO) at 1-855-962-7325.