

# 2022 SUMMARY OF BENEFITS

## Orange County Astiva Health Advantage (HMO) 001 Astiva Health Value (HMO) 002

**Astiva Health** is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" @ [www.astivahealth.com](http://www.astivahealth.com).

To join **Astiva Health**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in California: Orange and San Diego.

If you use the providers that are not in our network,

we may not pay for these services. For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This document is available in other formats such as Braille or large print.

### Have Questions?

For more information, please call us at 1-866-688-9021 (TTY users should call 711), we are open from 8:00 A.M. - 8:00 P.M., seven days a week between October 1st - March 31st, Monday to Sunday, or visit us at [www.astivahealth.com](http://www.astivahealth.com)

Premiums and Benefits	Astiva Health Advantage (HMO) Orange County 001	Astiva Health Value (HMO) 002 Orange County With Medicare and Full Medi-Cal Eligibility
<b>Monthly Plan Premium</b> • Part C & Part D	\$0 You must continue to pay your Medicare Part B Premium	\$0
<b>Medicare Part B Premium Rebate</b>	\$0	\$0
<b>Deductible</b>	No deductible	No deductible
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	You pay no more than \$845 annually includes copays and other costs for medical services for the year	Limited to \$7,550 per year for medical costs costs
<b>Inpatient Hospital</b>	\$0 copay (unlimited days per admission)	\$0 copay (unlimited days per admission)
<b>Outpatient Hospital</b> • Hospital Service • Observation Services	\$50 copay \$0 copay	\$0 copay \$0 copay
<b>Ambulatory Surgical Center</b>	\$0 copay	\$0 copay
<b>Doctor Visits</b> • Primary • Specialist	\$0 copay \$0 copay (prior authorization is required for specialist visits)	\$0 copay \$0 copay (prior authorization is required for specialist visits)
<b>Preventive Care</b> (e.g., flu vaccine, diabetic screenings)	\$0 copay Other preventive services are available. There are some covered services that have a cost.	\$0 copay Other preventive services are available. There are some covered services that have a cost.
<b>Emergency Care</b>	\$90 copay (waived if admitted within 48 hours)	\$0 copay
<b>Urgently Needed Services</b>	\$0 copay	\$0 copay
<b>Outpatient Diagnostic</b> • Procedures, tests, lab services • X-Ray/Diagnostic	\$0 copay \$0 copay	\$0 copay \$0 copay

• Therapeutic radiology	20% coinsurance	\$0 copay
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid</li> </ul>	\$0 copay for exam/fitting/evaluation (1 per year) \$0 copay for 2 hearing aids (every year) \$1,000 limit (every year) Maximum benefit applies to per aid	\$0 copay for exam/fitting/evaluation (1 per year) \$0 copay for 2 hearing aids (every year) \$1,000 limit (every year) Maximum benefit applies to per aid
<b>Dental Services</b>	Up to \$2000 reimbursement per year for covered services. Cosmetic Dentistry is not covered.	Contact Member Services for Benefits & Providers
<b>Vision Services</b> <ul style="list-style-type: none"> <li>• Routine exam</li> <li>• Eyewear coverage limit</li> </ul>	\$0 copay (1 per year) \$0 copay for glasses/contacts (per year) \$200 plan coverage limit (per year)	\$0 copay (1 per year) \$0 copay for glasses/contacts (per year) \$250 plan coverage limit (per year)
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>• Outpatient group therapy</li> <li>• Individual therapy visits</li> </ul>	\$20 copay \$40 copay	\$0 copay \$0 copay
<b>Skilled Nursing Facility</b>	\$0 copay days 1-20 \$75 copay days 21-100 (no prior hospital stay required)	\$0 per day up to 100 days per benefit period (no prior hospital stay required)
<b>Physical Therapy</b>	\$0 copay	\$0 copay
<b>Ambulance Services</b>	\$99 copay per trip	\$0 copay
<b>Transportation</b>	\$0 copay 48 one-way trips to approved locations within 25 miles	\$0 copay Unlimited to plan – approved locations within 25 miles
<b>Medicare Part B Drugs</b>	20% of the cost for other Part B Drugs	\$0 copay
<b>Part D Deductible</b>	\$0	\$480 deductible (waived for Tiers 1-2) No Deductible if you have Full Extra Help
<b>Initial Coverage Limit</b>	\$ 4,430	\$ 4,430
<b>Part D Out of Pocket Threshold</b>	\$7,050	\$7,050
<b>Initial Coverage</b> <ul style="list-style-type: none"> <li>• Tier 1: Preferred Generic Drugs</li> </ul>	\$0 Copay 30-day supply; \$0 Copay 90-day supply	\$0 Copay 30-day supply; \$0 Copay 90-day supply
<ul style="list-style-type: none"> <li>• Tier 2: Generic Drugs</li> </ul>	\$0 Copay 30-day supply; \$0 Copay 90-day Mail Order	\$0 Copay 30-day supply; \$0 Copay 90-day Mail Order
<ul style="list-style-type: none"> <li>• Tier 3: Preferred Brand Drugs</li> </ul>	\$32 Copay 30-day supply; \$64 Copay 90-day Mail Order	Depending on your level of Extra Help, you pay Generic: \$0, \$1.35, or \$3.95 Brand: \$0, \$4.00, or \$9.85
<ul style="list-style-type: none"> <li>• Tier 4: Non-Preferred Brand Drugs</li> </ul>	\$95 Copay 30-day supply; \$190 Copay 90-day Mail Order	Depending on your level of Extra Help, you pay Generic: \$0, \$1.35, or \$3.95 Brand: \$0, \$4.00, or \$9.85
<ul style="list-style-type: none"> <li>• Tier 5: Specialty Drugs</li> </ul>	33% of the drug cost to the plan Coinsurance	Depending on your level of Extra Help, you pay Generic: \$0, \$1.35, or \$3.95 Brand: \$0, \$4.00, or \$9.85

Gap Coverage Tiers 1 & 2:	\$0 copay	\$0 copay
<b>Gap Coverage</b>	<p>Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430.</p> <p>You pay the same copays as in the Initial Coverage Stage for Tier 1 and Tier 2 drugs. For drugs in other tiers, you pay 25% of the negotiated price (and portion of the dispensing fee) for your brand name drugs and 25% of the cost for your generic drugs.</p>	<p>Depending on your level of Extra Help, you pay</p> <p>Generic: \$0, \$1.35, or \$3.95</p> <p>Brand: 0, \$4.00, or 9.85</p>
<b>Catastrophic Coverage Stage</b>	<p>After your yearly out-of-pocket drug costs reach \$7,050, you pay the greater of:</p> <ul style="list-style-type: none"> <li>– 5% of the cost, or</li> <li>– \$3.95 copay for generic (including drugs that are treated like a generic) and \$9.85 copay for all other drugs.</li> </ul>	<p>Depending on your level of Extra Help, you pay</p> <p>Generic: \$0, \$1.35, or \$3.95</p> <p>Brand: 0, \$4.00, or 9.85</p>
Additional Benefits		
Acupuncture/Chiropractor/Therapeutic Massages	\$0 copay for combined benefits of 48 visits per year	\$0 copay for combined benefits of 48 visits per year
Routine Foot Care	\$0 copay; one visit every three (3) months	\$0 copay; one visit every three (3) months
Over the Counter (OTC) items	\$75 allowance quarterly	\$150 allowance quarterly
Grocery Benefits	\$25 per month for qualifying SSBCI members	\$25 per month for qualifying SSBCI members
Viagra (Sildenafil)	\$0 Co-Payment Tier 2 Generic Viagra (Sildenafil)	\$0 Co-Payment Tier 2 Generic Viagra (Sildenafil)
Gym / Fitness	\$40 reimbursement per month for plan-approved exercise classes/fitness club or Silver & Fit program	\$40 reimbursement per month for plan-approved exercise classes/fitness club or Silver & Fit program
Telehealth	\$0 After-hours doctor advice 9:00 PM - 9:00 AM	\$0 After-hours doctor advice 9:00 PM - 9:00 AM
Worldwide Coverage	Up to \$25,000 reimbursement for qualifying expenses (urgently needed or emergency services only)	Up to \$25,000 reimbursement for qualifying expenses (urgently needed or emergency services only)
<p>Astiva Health is a HMO with a Medicare contract. Enrollment in Astiva Health depends on contract renewal. This information is not a complete description of benefits. Call 1-866-688-9021, our member services hours of operations are from 8:00 A.M. to 8:00 P.M. Monday - Friday except major holidays. Between October 1st - March 31st, Monday to Sunday, 8:00 A.M. - 8:00 P.M.</p>		

## Additional Benefits Beyond Original Medicare

Astiva Health offers you additional benefits beyond what Original Medicare alone provides. We are pleased to be able to provide you value added coverage through these companies we partner with to provide you with exceptional care for your needs.

### Supplemental Benefits and Providers Offered by Astiva Health

#### BENEFITS

**ACUPUNCTURE/CHIROPRACTOR/  
THERAPEUTIC MASSAGE THERAPY**

**DENTAL BENEFITS**

**GYM MEMBERSHIP**

**HEARING AID**

**OVER - THE - COUNTER**

**TRANSPORTATION**

**VISION**

**GROCERY BENEFITS**

**ROUTINE FOOT CARE**

**AFTER HOUR DOCTOR  
ADVICE LINE**

**24/7 NURSE ADVICE LINE**

#### PROVIDERS

American Specialty Health  
1-800-678-9133  
1-866-688-9021  
[www.ashlink.com/ash/astivahealth](http://www.ashlink.com/ash/astivahealth)

Astiva Member Services  
1-866-688-9021

Silver and Fit  
1-877-427-4788  
[www.silverandfit.com](http://www.silverandfit.com)

Astiva Member Services  
1-866-688-9021

Astiva Member Services  
1-866-688-9021

Astiva Member Services  
1-866-688-9021

March Vision  
1-844-336-2724  
[www.marchvisioncare.com](http://www.marchvisioncare.com)

Astiva Member Services  
1-866-688-9021

Podiatry Plan  
1-800-367-7762  
[www.podiatryplan.com](http://www.podiatryplan.com)

Teladoc  
1-800-835-2362  
TTY: 1-855-636-1578  
[www.teladoc.com](http://www.teladoc.com)

1-888-969-3918