SUMMARY OF

BENEFITS

January 1, 2023 – December 31, 2023

ASTIVA HEALTH C-SNP SAVINGS (HMO) 007
ASTIVA HEALTH C-SNP PREMIUM (HMO) 008

SERVICE AREA:

ORANGE COUNTY
SAN DIEGO COUNTY

astiva HEALTH

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SUMMARY OF BENEFITS ASTIVA HEALTH		
PREMIUMS AND BENEFITS	**ASTIVA HEALTH C-SNP SAVINGS (HMO) 007**	**ASTIVA HEALTH C-SNP PREMIUM (HMO) 008**
Monthly Health Plan Premium	**Part C: $0** **Part D: $0**	**Part C: $0** **Part D: $38.90** Your premium may be paid by Extra Help
Medicare Part B Premium Rebate	**$8 per month**	Not covered
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than **$1500** annually includes copays and coinsurance for Medicare-covered services for the year.	You pay no more than **$8000** annually includes copays and coinsurance for Medicare-covered services for the year.
Inpatient Hospital Coverage*	**$0 copay**	**$250** per day for days 1-7, **$75** per day for days 8 - 30
Outpatient Hospital Coverage*		
- Hospital Services	**$0 copay**	**20%**
- Observation Services	**$0 copay**	**20%**
Ambulatory Surgical Center*	**$0 copay**	**20%**
Doctor Visits*		
- Primary	**$0 copay**	**$0 copay**
- Specialist	**$0 copay**	**$0 copay**
Preventive Care*		
(e.g., flu vaccine, diabetic screenings)	**$0 copay** other preventive servcies are available. There are some covered services that have a cost.	**$0 copay** other preventive servcies are available. There are some covered services that have a cost.

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Emergency Care	**$50 copay** (waived if admitted within 24 hours)	**$95 copay** (waived if admitted within 24 hours)
Urgently Needed Services	**$0 copay**	**$0 copay**
Outpatient Diagnostic Services*		
- Procedures, tests, lab services	**$0 copay**	**$0 copay**
- X-Ray/Diagnostic	**$0 copay**	**$0 copay**
- Therapeutic radiology	**20%**	**20%**
Durable Medical Equipment (DME)*	**$0** copay for items $99 or less, **20%** coinsurance of the Medicare-allowed amount for items over $99.	**$0** copay for items $99 or less, **20%** coinsurance of the Medicare-allowed amount for items over $99.
Hearing Services*		
- Routine hearing exam	**$0 copay**	**$0 copay**
- Hearing aids allowance	**$2000** maximum per year, direct member reimbursement for qualifying expenses.	**$2000** maximum per year, direct member reimbursement for qualifying expenses.
Dental Services*	Comprehensive dental coverage including dentures and implants, (plus $0 copay for oral exams, cleanings, and X-rays) through DeltaCare® USA.	Comprehensive dental coverage including dentures and implants, (plus $0 copay for oral exams, cleanings, and X-rays) through DeltaCare® USA.
Vision Services*		
- Routine exam	**$0 copay**, once per year	**$0 copay**, once per year
- Eyewear coverage limit	$0 copay for glasses/ contacts per year, **$300** plan coverage limit annually through **EyeMed Vision Care®**.	$0 copay for glasses/ contacts per year, **$300** plan coverage limit annually through **EyeMed Vision Care®**.

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Mental Health Services*		
Outpatient therapy	**$0 copay** per visit	**$0 copay** per visit
Skilled Nursing Facility*	**$0 copay** days 1 -20 **$75 copay** per day, days 21 - 65, **$0 copay** days 66 -100	**$0 copay** days 1 -20 **$185 copay** per day, days 21 - 100
Physical Therapy*	**$0 copay** per visit	**$0 copay** per visit
Ambulance Services	**$50 copay** per trip	**$50 copay** per trip
Transportation (non-emergency)*	**$0 copay** **90 one-way trips** to plan approved locations within 25 miles radius	**$0 copay** **90 one-way trips** to plan approved locations within 25 miles radius
Medicare Part B Drugs	**20%** of the cost for Part B drugs	**20%** of the cost for Part B drugs
Part D Deductible	**$0**	**$505**
Part D Initial Coverage Limit	**$4,660**	**$4,660**
Part D Out of Pocket Threshold	**$7,400**	**$7,400**
Initial Coverage		
Tier 1: Preferred Generic Drugs	**$0 copay** for 30-day supply	**$0 copay** for 30-day supply
Tier 2: Generic Drugs	**$4 copay** for 30-day supply	**$4 copay** or Depending on your level you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35
Tier 3: Preferred Brand Drugs	**$28 copay** for 30-day supply	**$28 copay** or Depending on your level you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35
Tier 4: Non-Preferred Brand Drugs	**$75 copay** for 30-day supply	**$75 copay** or Depending on your level you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35
Tier 5: Specialty Drugs	**33%** coinsurance of the drug cost to the plan	**25%** coinsurance or Depending on your level you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35
Tier 6: Select Care Drugs	**$0 copay** for 30-day supply	**$0 copay** for 30-day supply

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Gap Coverage Tier 1 & 2	**$0 - $4 copay** for 30 days supply	**$0 - $4 copay** for 30 days supply. Depending on your level of Extra Help, you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35
Gap Coverage	Begins after the total yearly drug cost (including what our plan has paid and what you've paid) reaches $4660. 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 drug and 25% of the cost for your generic drugs.	Depending on your level of Extra Help, you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: 5% of the cost , or $4.15 copay for generic (including drugs that are treated like a generic) and $10.35 copay for all other drugs.	Depending on your level of Extra Help, you pay Generic: $0 or $1.45 or $4.15; Brand: $0, $4.30, or $10.35

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Value Added Items and Services		
Acupuncture Services* (Medicare - covered acupuncture)	**$0 copay unlimited**	**$0 copay unlimited**
Routine Foot Care*	**$0 copay**; one visit every three (3) months	**$0 copay**; one visit every three (3) months
Gym Membership	**$0 copay** gym membership provided by **Silver & Fit Program®**	**$0 copay** gym membership provided by **Silver & Fit Program®**
Flexible Spending and Grocery Benefits - Health & Wellness Flexible Spending Allowance* - SSBCI Healthy Food/ Grocery Benefits	**$1,320 annually** **$600 per year** (**$150** quarterly including OTC, health & wellness treatments or gym membership upgrade and dental copay) **$720 per year** (**$60** monthly for qualifying SSBCI members.)	**$1,440 annually** **$600 per year** (**$150** quarterly including OTC, health & wellness treatments or gym membership upgrade and dental copay) **$840 per year** (**$70** monthly for qualifying SSBCI members.)
Post Hospital Meal Benefits*	$0 copay for home meal delivery maximum **90 meals** per year.	$0 copay for home meal delivery maximum **90 meals** per year.
Support for Caregivers*	**up to 52 hours per year**	**up to 52 hours per year**
In-home Support Services*	**up to 52 hours per year**	**up to 52 hours per year**
Telehealth	**$0 copay** This service is covered when offered through your physician's office.	**$0 copay** This service is covered when offered through your physician's office.
Worldwide Coverage	Up to **$50,000** reimbursement for qualifying expenses (emergency services only)	Up to **$50,000** reimbursement for qualifying expenses (emergency services only)

Services with a * may require prior authorization or a referral from your doctor.
For more information on the pharmacy-specific copays, please call Member Services at the phone number in this document or access your Evidence of Coverage at www.astivahealth.com