2024

astiva HEALTH

SUMMARY OF

BENEFITS

January 1, 2024 – December 31, 2024

ASTIVA HEALTH C-SNP DELUXE PLAN (HMO) 007

SERVICE AREA:

LOS ANGELES ▪ ORANGE ▪ RIVERSIDE
SAN BERNARDINO ▪ SAN DIEGO

2024 IMPORTANT PLAN INFORMATION

Astiva Health C-SNP Deluxe Plan (HMO) 007 is an HMO plan with a Medicare contract. Enrollment in Astiva Health depends on contract renewal. You must continue to pay your Medicare Part B premium.

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" by calling our Member Services Department at the phone number listed in this document or online at www.astivahealth.com.

To join **Astiva Health C-SNP Deluxe Plan (HMO) 007**, 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: Los Angeles, Orange, Riverside, San Bernadino, and San Diego.

Except in emergency situations, if you use the providers outside of our network, you may be responsible for payment in full.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online 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.

The information listed is not a complete description of benefits. Please refer to your Evidence of Coverage for details. Some of the benefits mentioned are part of a special supplemental program for the chronically ill and not all members qualify. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Astiva Health is an HMO with a Medicare Contract. Enrollment in Astiva Health depends on contract renewal. ATTENTION: If you speak Vietnamese/Spanish or other languages, language assistance services, free of charge, are available to you. Documents available in alternative formats such as large print and braille. Call 1-866-688-9021 (TTY:711). The hours of operation are 8:00 am to 8:00 pm seven days a week between October 1 – March 31. 8:00 am to 8:00 pm, Monday – Friday between April 1 –September 30.

SUMMARY OF BENEFITS ASTIVA HEALTH

PREMIUMS AND BENEFITS	ASTIVA HEALTH C-SNP DELUXE PLAN (HMO) 007
Monthly Health Plan Premium	**Part C: $0** **Part D: $0**
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than **$2900** annually includes copays and coinsurance for Medicare-covered services for the year.
Inpatient Hospital Coverage*	**$0 copay** for days 1-10, **$200 copay** for days 11-24, **$0 copay** for days 25-90
Outpatient Hospital Coverage*	
- Hospital Services	**$0 copay**
- Observation Services	**$30 copay**
Ambulatory Surgical Center*	**$30 copay**
Doctor Visits*	
- Primary	**$0 copay**
- Specialist	**$0 copay**
Preventive Care	**$0 copay** Any additional preventive services approved by Medicare during the contract year are covered.

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Emergency Care	**$50 copay** (waived if admitted within 48 hours)
Urgently Needed Services	**$0 copay**
Outpatient Diagnostic Services*	
- Procedures, tests, lab services	**$0 copay**
- X-Ray	**$0 copay**
- Diagnostic (such as MRIs, CT scans)	**$0 copay**
- Therapeutic radiology (such as radiation treatment for cancer)	**20%** coinsurance
Durable Medical Equipment (DME)*	**0%** coinsurance for DME costs less than or equal to $99 **20%** coinsurance for DME that costs more than $99
Hearing Services	
- Routine hearing exam	**$0 copay**
- Hearing aids allowance*	**$1500** maxium per year
Dental Services	**$1500 per year** ($375 per quarter, roll over from quarter to quarter)
Vision Services	
- Routine exam*	**$0 copay**, once per year
- Eyewear coverage limit	**$0 copay** **$300** glasses or **$150** for contact lenses every two years

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Mental Health Services* - Outpatient therapy	**$0 copay** per visit
Skilled Nursing Facility*	**$0 copay** days 1-20, **$200 copay** days 21 - 100
Physical Therapy*	**$0 copay** per visit
Ambulance Services (Ground)	**$100 copay** per one-way trip
Transportation (non-emergency)*	**Unlimited trips** to plan approved locations within 25 miles radius
Medicare Part B Drugs*	**20%** of the cost for Part B drugs (The minimum applies for the mandated IRA fluctuations. The maximum applies for all other chemo/radiation Medicare Part B Drugs.)
Medicare Part B Insulin Drugs*	**$35 copay**
Medicare Part B Chemotherapy/ Radiation Drugs*	**20%** of the cost for Part B drugs (The minimum applies for the mandated IRA fluctuations. The maximum applies for all other chemo/radiation Medicare Part B Drugs.)
Prescription Drug Coverage	
Part D Deductible	**$0**
Part D Initial Coverage Limit	**$5,030**
Part D Out of Pocket Threshold	**$8,000**
Initial Coverage	
Tier 1: Preferred Generic Drugs	**$0 copay** for 30-day supply
Tier 2: Generic Drugs	**$0 copay** for 30-day supply
Tier 3: Preferred Brand Drugs	**$28 copay** for 30-day supply
Tier 4: Non-Preferred Brand Drugs	**$75 copay** for 30-day supply
Tier 5: Specialty Drugs	**33%** coinsurance of the drug cost to the plan
Tier 6: Select Care Drugs	**$0 copay** for 30-day supply

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Gap Coverage Tier 1 & 2	Tier 1: **$0 copay** Tier 2: **$0 copay** for 30 day supply
Gap Coverage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$5030.** You pay the same copays as in the Initial Coverage Stage for Tier 1, Tier 2, and Tier 6 drugs. For drugs in other tiers, you pay **25%** of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and **25%** of the cost for your generic drugs.
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach **$8000**, you pay nothing for covered Part D drugs.

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Value Added Items and Services	
Acupuncture & Therapeutic Massage*	**$0 copay** up to **96** supplemental acupuncture or massage therapy visits, **combined**
Fitness Benefit	**$50** monthly allowance through WEX (Card)
Flexible Spending and Grocery Benefits - OTC/Health & Wellness/Utilities Flexible Spending Allowance - Additional Dental Allowance - SSBCI Healthy Food / Grocery Benefits	**$125 monthly allowance** $25 per month for OTC & Flexible Spending Allowance **or** $75 per quarter for additional dental allowance. (OTC allowance roll over monthly within the quarter) $100 per month
Incontinence Products	**$25** monthly allowance
Post Hospital Meal Benefits*	Up to **$1350 per year** (the meal benefit covers 2 meals per day for 7 consecutive days for each hospital admission. The maximum allowance is **$15** per meal. The meal benefit covers up to 90 meals per year.)
Support for Caregivers*	Up to 52 hours per year
In-home Support Services*	Up to 52 hours per year
PERS (Personal Emergency Response System)*	**$0 copay** for one device per year
Worldwide Emergency Coverage	Up to **$50,000** reimbursement for qualifying expenses (urgently needed or emergency services only)

Services with a * requires prior approval 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