

2024



SUMMARY OF
BENEFITS

January 1, 2024 – December 31, 2024

**ASTIVA HEALTH PREMIER
PLAN (HMO) 010**

SERVICE AREA:

**LOS ANGELES ▪ ORANGE ▪ RIVERSIDE
SAN BERNARDINO ▪ SAN DIEGO**



2024 IMPORTANT PLAN INFORMATION

Astiva Health Premier Plan (HMO) 010 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 Premier Plan (HMO) 010**, 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 PREMIER PLAN (HMO) 010
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 \$1900 annually includes copays and coinsurance for Medicare-covered services for the year.
Inpatient Hospital Coverage*	\$0 copay for days 1-5, \$150 copay for days 6-10, \$0 copay for days 11-90
Outpatient Hospital Coverage* - Hospital Services - Observation Services	\$100 copay \$30 copay
Ambulatory Surgical Center*	\$30 copay
Doctor Visits* - Primary - Specialist	\$0 copay \$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	\$75 copay (waived if admitted within 48 hours)
Urgently Needed Services	\$0 copay
Outpatient Diagnostic Services* <ul style="list-style-type: none"> - Procedures, tests, lab services - X-Ray - Diagnostic (such as MRIs, CT scans) - Therapeutic radiology (such as radiation treatment for cancer) 	\$0 copay \$0 copay \$0 - \$30 copay 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 <ul style="list-style-type: none"> - Routine hearing exam - Hearing aids allowance* 	\$0 copay \$1000 maximum per year
Dental Services	\$3500 per year (\$875 per quarter, roll over from quarter to quarter)
Vision Services <ul style="list-style-type: none"> - Routine exam* - Eyewear coverage limit 	\$0 copay once per year \$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)*	52 one-way 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	\$10 copay for 30-day supply
Tier 3: Preferred Brand Drugs	\$35 copay for 30-day supply
Tier 4: Non-Preferred Brand Drugs	\$95 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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<p>Gap Coverage Tier 1 & 2</p>	<p>Tier 1: \$0 copay Tier 2: \$10 copay for 30 day supply</p>
<p>Gap Coverage</p>	<p>Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$5030.</p> <p>You pay the same copays as in the Initial Coverage Stage for Tier 1, Tier 2, and Tier 6 drugs.</p> <p>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.</p>
<p>Catastrophic Coverage Stage</p>	<p>After your yearly out-of-pocket drug costs reach \$8000, you pay nothing for covered Part D drugs.</p>

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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 <ul style="list-style-type: none"> - OTC/Health & Wellness/Utilities Flexible Spending Allowance - Additional Dental Allowance - SSBCI Healthy Food / Grocery Benefits 	\$50 monthly allowance \$50 per month for OTC & Flexible Spending Allowance or \$150 per quarter for additional dental allowance. (OTC allowance roll over monthly within the quarter) Not covered
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.)
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