astiva HEALTH

2025

Summary of Benefits

ASTIVA HEALTH PREMIER PLAN (HMO) 010

SERVICE AREAS

LOS ANGELES • ORANGE • RIVERSIDE

SAN BERNARDINO • SAN DIEGO

JANUARY 1, 2025 – DECEMBER 31, 2025

2025

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 Bernardino, and San Diego.

Except in emergency situations, if you use 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 at 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). 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.

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PREMIUMS & BENEFITS	ASTIVA HEALTH PREMIER PLAN (HMO) 010	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay $0 per month	You must continue to pay your Medicare Part B premium.
Deductible	You pay $0	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	$1,500 annually	You pay at most $1,500 annually for Medicare-covered services, including copays and coinsurance. Part D cost-sharing does not count towards this amount.
Inpatient Hospital Coverage	You pay $0 for days 1 - 5 You pay $150 for days 6 - 15 You pay $0 for days 16-90	Prior authorization rules apply.
Outpatient Hospital Coverage		
• Hospital Services	You pay $50	Outpatient hospital surgeries have a $50 copay. Prior authorization rules apply.
• Observation Services	You pay $0	Prior authorization rules apply.
Ambulatory Surgical Center	You pay $0	Prior authorization rules apply.
Doctor Visits		
• Primary Care	You pay $0	
• Specialist	You pay $0	Prior authorization rules apply.

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Preventive Care	You pay $0	There is no copay, coinsurance, or deductible for all Original Medicare preventive services. No authorization required.
Emergency Room Coverage	You pay $75	If you are admitted to the hospital within 48 hours, you do not have to pay $75.
Urgently Needed Services	You pay $0	
Outpatient Diagnostic Services		Prior authorization rules apply.
• Lab services	You pay $0	
• Diagnostic tests & procedures	You pay $0	
• Outpatient X-rays	You pay $0	
• Therapeutic Radiology	You pay 20%	
• Diagnostic Radiology	You pay $0 - $35	$0 copay for general diagnostic radiology and $35 copay for complex radiology services.
Durable Medical Equipment (DME)	You pay 0% - 20%	Prior authorization rules apply. You pay 0% coinsurance for items that cost less than or equal to $99 and pay 20% coinsurance for items that cost more than $99.
Hearing Services		Prior authorization rules apply.
• Routine hearing exam	You pay $0	1 visit every year
• Hearing Aids	$1000 allowance per year	Maximum allowance for Prescription Hearing Aids is $1,000 per year with $500 maximum per ear.

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Dental Services	**$400 quarterly $1,600 annually**	Rollover is allowed. Prior authorization rules apply.
Preventive Dental Services		
• Oral Exam	You pay $0	
• X-Rays	You pay $0	
• Diagnostic	You pay $0	
• Prophylaxia	You pay $0	
• Fluoride Treatment	You pay $0	
Comprehensive Dental Services		
• Restorative Services	You pay $0	
• Endodontics	You pay $0	
• Periodontics	You pay $0	
• Prosthodontics, removable	You pay $0	
• Implant Services	You pay $0	
• Prosthodontics, fixed	You pay $0	
• Oral and Maxillofacial Surgery	You pay $0	
• Adjunctive General Services	You pay $0	
Vision Services		You must use a provider in the VSP Vision Care network.
• Routine Eye Exams	1 visit per year. You pay $0	
• Eyewear	$300 allowance for glasses or $150 contact lenses every two years	
Mental Health Services		Prior authorization rules apply.
• Inpatient Psychiatric Coverage	You pay $0 for days 1 - 5 You pay $150 for days 6 - 15 You pay $0 for days 16 - 90	
• Outpatient individual/ group therapy visit		
- Mental Health Specialty Services	You pay $0	
- Psychiatric Services	You pay $25	

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Skilled Nursing Facility	You pay $0 for days 1 - 20 You pay $214 for days 21 - 100	Prior authorization rules apply. No prior hospitalization is required.
Physical Therapy	You pay $15	Prior authorization rules apply.
Ambulance Services (Ground)	You pay $50 one-way trip	A copay is waived if admitted to the hospital.
Routine Transportation	48 one-way trips per year to plan approved locations within a 30 miles radius.	If more than 30 miles, a combined number of trips can be used. This benefit does not provide special accommodations for wheelchairs and gurneys.
Medicare Part B Drugs	You pay 0% - 20%	Prior authorization rules apply.
Medicare Part B Insulin Drugs	You pay $35	You pay no more than $35 for a one-month supply of a Part B insulin.
Medicare Part B Chemotherapy & Radiation Drugs	You pay 0% - 20%	Prior authorization rules apply.

OUTPATIENT PRESCRIPTION DRUGS	ASTIVA HEALTH PREMIER PLAN (HMO) 010	
Part D Deductible	$0	
Part D Annual Out-of-Pocket cost threshold	$2,000	
Initial Coverage	**Standard Retail** (30-day supply)	**Standard Mail-Order**
Tier 1: Preferred Generic	You pay $0	You pay $0 for a 90-day supply
Tier 2: Generic	You pay $0	You pay $0 for a 90-day supply
Tier 3: Preferred Brand	You pay $35	You pay $70 for a 90-day supply
Tier 4: Non-Preferred Brand	You pay $95	You pay $95 for a 30-day supply
Tier 5: Specialty	You pay 33% coinsurance	You pay 33% coinsurance
Tier 6: Select Care Drugs	You pay $0	You pay $0 for a 90-day supply

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FLEX Benefits This benefit will be used for: • Over-the-Counter (OTC) • Fitness & Golf • Eyewear • Dental	**$720 per year** This allowance can be rolled over to next month if unused.	The full amount **$720** is available immediately for member effective between **January 01, 2025 to March 01, 2025.** **$540** will be loaded into Wex card for member effective between **April 01, 2025 to June 01, 2025.** **$360** will be loaded into Wex card for member effective between **July 01, 2025 to September 01, 2025.** **$180** will be loaded into Wex card for member effective between **October 01, 2025 to December 01, 2025.**
EXTRA PLUS Benefits This benefit is in addition to the FLEX benefits. Select ONE of the two options:	**$100 per month** This allowance cannot be rolled over to next month. 1. $100 per month for Grocery (qualified conditions for SSBCI) OR 2. $100 per month for OTC and Fitness	OTC benefits include pain medication, cold & flu medication, first aid supplies. OTC benefits include Herbal Supplemental, • Ginseng • Bird's Nest • Tiger Balm FLEX Benefits and EXTRA PLUS Benefits allowance will be loaded into the Astiva Health WEX Card.
Acupuncture & Massage Therapy & Eastern Wellness Eastern Wellness therapies include: • Cupping and moxa • Tui na and gua sha • Med-x and reflexology	72 sessions	Eastern Wellness therapies are limited to only 24 sessions. Each session is 15 minutes in duration, and two sessions per day are allowed.

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Worldwide Emergency Coverage	$50,000 per year	You pay $0 for copay.
Post Hospital Meal Benefits	$600 per year	Prior authorization rules apply. The meal benefit covers 2 meals per day for 5 consecutive days for each hospital admission. The allowance per meal is $20. This benefit covers up to 30 meals per year.
Personal Emergency Response System (PERS)	You pay $0 for one device per year	Prior authorization rules apply.
Telehealth A telehealth visit can be done online using your computer, tablet, or smartphone.	You pay $0	Teledoc providers can diagnose and treat non-emergent conditions and prescribe medications when necessary.

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