Astiva Health Premier Plan (HMO) offered by Astiva Health

Annual Notice of Changes for 2025

You are currently enrolled as a member of Astiva Health Premier Plan. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.astivahealth.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your

Medicare & You 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in Astiva Health Premier Plan.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Astiva Health Premier Plan.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-866-688-9021 for additional information. (TTY users should call 711.) Hours are 8:00 A.M. to 8:00 P.M., seven days a week, October 1st – March 31st; 8:00 A.M. to 8:00 P.M., Monday – Friday, April 1st – September 30th, except major holidays. This call is free.
- Plan materials are available in alternate formats (e.g. braille, large print, audio).
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Astiva Health Premier Plan

- Astiva Health is an HMO with a Medicare contract. Enrollment in Astiva Health depends on contract renewal.
- When this document says "we," "us," or "our," it means Astiva Health. When it says "plan" or "our plan," it means Astiva Health Premier Plan.

Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Astiva Health Premier Plan in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered services. (See Section 2.2 for details.)	$1,900 for in-network Medicare covered benefits	$1,500 for in-network Medicare covered benefits and in-network non-Medicare covered benefits
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays	$0 for days 1 – 5 $150 per day for days 6 - 10 $0 for additional days	$0 for days 1 – 5 $150 per day for days 6 - 15 $0 for additional days
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $10 copay	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay

Cost	2024 (this year)	2025 (next year)
	You pay $0 per month supply of each covered insulin product on this tier. • Drug Tier 3: $35 copay You pay $0 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% of the cost • Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.	• Drug Tier 2: $0 copay • Drug Tier 3: $35 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% of the cost You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Astiva Health Premier Plan in 2025

If you do nothing by December 7, 2024, we will automatically enroll you in our Astiva Health Premier Plan. This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through Astiva Health Premier Plan. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$1,900 for in-network Medicare covered benefits	$1,500 for in-network Medicare covered benefits and in-network Medicare non-covered benefits Once you have paid $1,500 out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.astivahealth.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* at** www.astivahealth.com **to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* at** www.astivahealth.com **to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Inpatient Hospital (Acute)	You pay $0 for days 1 – 5. You pay a $150 copay per day for days 6 - 10. You pay $0 for unlimited additional days per benefit period. The benefit period begins the day you are admitted into a hospital and ends when you have not received any inpatient hospital care for 60 days in a row.	You pay $0 for days 1 – 5. You pay a $150 copay per day for days 6 – 15. You pay $0 for unlimited additional days per benefit period. The benefit period begins the day you are admitted into a hospital and ends when you are discharged from the hospital.
Inpatient Hospital (Psychiatric)	You pay $0 for days 1 – 5. You pay a $150 copay per day for days 6 – 10. You pay $0 for unlimited additional days per benefit period. The benefit period begins the day you are admitted into a hospital and ends when you have not received any inpatient hospital care for 60 days in a row.	You pay $0 per day for days 1 – 5. You pay a $150 copay per day for days 6 – 15. You pay $0 for days 16 – 90. You pay $0 for up to 60 additional days per benefit period. The benefit period begins the day you are admitted into a hospital and ends when you are discharged from the hospital.

Cost	2024 (this year)	2025 (next year)
Skilled Nursing Facility (SNF)	You pay $0 for days 1 – 20. You pay a $200 copay per day for days 21 - 100. The benefit period begins the day you are admitted into a SNF and ends when you have not received any skilled care in a SNF for 60 days in a row.	You pay $0 for days 1 – 20. You pay a $214 copay per day for days 21 - 100. The benefit period begins the day you are admitted into a SNF and ends when you are discharged from a SNF.
Worldwide Emergency/Urgent Coverage	You pay a $75 copay per visit for worldwide emergency services.	You pay $0 for worldwide emergency services.
Partial Hospitalization	You pay a $100 copay per visit.	You pay an $50 copay per visit.
Occupational Therapy	You pay $0 per visit.	You pay a $15 copay per visit.
Acupuncture	Medicare-covered acupuncture is limited to 20 visits annually. Routine acupuncture is limited to 96 visits annually, combined with massage therapy visits. Routine acupuncture requires prior authorization and a referral.	Medicare-covered acupuncture is limited to 12 visits per 90 days. Routine acupuncture is limited to 72 visits annually, combined with eastern wellness therapies and massage therapy. Routine acupuncture does not require prior authorization or a referral.
Physical Therapy and Speech-Language Pathology Services	You pay $0 per visit.	You pay a $15 copay per visit.

Cost	2024 (this year)	2025 (next year)
Opioid Treatment Program Services	You pay a $10 copay per visit.	You pay a $15 copay per visit.
Outpatient Diagnostic Radiology Services	You pay $0 for general diagnostic radiology. You pay a $15 copay for complex radiology services (physician services). You pay a $30 copay for complex radiology services (facility).	You pay $0 for general diagnostic radiology. You pay a $35 copay for all complex radiology services.
Outpatient Hospital Services	You pay a $100 copay per stay for outpatient hospital services. You pay a $30 copay per stay for outpatient hospital observation services.	You pay a $50 copay per stay for outpatient hospital services. You pay $0 for outpatient hospital observation services.
Ambulatory Surgical Center (ASC) Services	You pay a $30 copay per stay.	You pay $0.
Outpatient Substance Abuse Services	You pay a $10 copay per visit for individual and group sessions.	You pay a $15 copay per visit for individual and group sessions.
Outpatient Blood Services	Services require prior authorization.	Services do not require prior authorization.
Air Ambulance Services	20% coinsurance is waived if you are admitted to the hospital.	20% coinsurance is not waived if you are admitted to the hospital.

Cost	2024 (this year)	2025 (next year)
Ground Ambulance Services	You pay a $100 copay per one-way trip.	You pay a $50 copay per one-way trip.
Transportation Services	You pay $0 for up to 52 one-way trips via a van or medical transport vehicle. The transportation benefit can only be used for medical related purposes.	You pay $0 for up to 48 one-way trips via a van or rideshare service. The transportation benefit can only be used for medical related purposes and within a 30-mile radius from the member's primary residence. If the trip is further than 30 miles, a combined number of trips can be used. The transportation benefit does not provide special accommodations for wheelchairs and gurneys.
Durable Medical Equipment (DME)	Astiva Health has preferred vendors to provide DME.	Astiva Health does not have preferred vendors to provide DME.
Diabetic Supplies	You pay $0 for diabetic supplies from a preferred vendor and 20% of the total cost for diabetic supplies from a non-preferred vendor.	You pay 20% of the total cost for all diabetic supplies.

Cost	2024 (this year)	2025 (next year)
Over-the-Counter (OTC) Items	Qualifying members receive a $25 per month allowance for incontinence products. You receive a $50 per month allowance for over-the-counter items, eastern medicine therapies, and dental services combined. Any unused credits from the monthly allowance do not carry over to the next month.	You receive a $180 per quarter allowance for fitness, over-the-counter items, and dental services combined. Any unused credits from the quarterly allowance do not carry over to the next quarter. You receive a $100 per month allowance for fitness, over-the-counter items, and special supplemental benefits (SSBCI) for the chronically ill combined. Any unused credits from the monthly allowance do not carry over to the next month. SSBCI-eligible members have the choice to forgo using the $100 monthly allowance to pay for over-the-counter and fitness benefits and instead use the allowance to pay for food and produce. SSBCI-eligible members must select the option during enrollment or prior to the effective date. Members can change the selection one time per year.

Cost	2024 (this year)	2025 (next year)
Meal Benefit	Within seven days of being discharged, your doctor can request home-delivered meals for up to 7 consecutive days (2 meals per day) for each hospital admission. The maximum allowance is $15 per meal. The meal benefit covers up to 90 meals per year.	Within seven days of being discharged, your doctor can request home-delivered meals for up to 5 consecutive days (2 meals per day) for each hospital admission. The maximum allowance is $20 per meal. The meal benefit covers up to 30 meals per year.
Eastern Wellness Therapies	You receive a $50 per month allowance for fitness and eastern wellness therapies combined.	You pay $0 for up to 72 eastern wellness therapy visits including cupping, moxa, tuina, gua sha, med-x, and reflexology. An eastern wellness therapy visit equates to a 15-minute session with a maximum of 2 visits (or a 30-minute session) in one day. These 72 visits are combined with routine acupuncture and massage therapy.
Fitness Benefit	Fitness benefits include paying for gym membership and participating in group fitness classes such as instructor-led circuit training, fall prevention, Pilates, Zumba, and strengthening classes. Members have the flexibility to choose various activities based on their preferences and how to spend the allowance.	Fitness benefits allow members to pay fees for activities such as: • Membership fees for gyms or pools • Amenity fees for a volleyball, tennis, and pickle ball • Golf green and golf driving range fees • Tai chi, dance, yoga, or Pilates classes

Cost	2024 (this year)	2025 (next year)
Fitness Benefit, Continued	You receive a $50 per month allowance for fitness and eastern wellness therapies combined.	• Bowling (does not include league fees) You receive a $180 per quarter allowance for fitness, over-the-counter items, and dental services combined. Any unused credits from the quarterly allowance do not carry over to the next quarter. You receive a $100 per month allowance for fitness, over-the-counter items, and special supplemental benefits (SSBCI) for the chronically ill combined. Any unused credits from the monthly allowance do not carry over to the next month. SSBCI-eligible members have the choice to forgo using the $100 monthly allowance to pay for over-the-counter and fitness benefits and instead use the allowance to pay for food and produce. SSBCI-eligible members must select the option during enrollment or prior to the effective date. Members can change the selection one time per year.
Massage Therapy	Massage therapy is limited to 96 visits annually, combined with routine acupuncture.	Massage therapy is limited to 72 visits annually, combined with eastern wellness therapies and routine acupuncture. A massage therapy visit

Cost	2024 (this year)	2025 (next year)
Massage Therapy, Continued		equates to a 15-minute session with a maximum of 2 visits (or a 30-minute session) in one day.
Kidney Disease Education Services	Services require prior authorization and a referral.	Services do not require prior authorization or a referral.
Home Infusion Drugs	You pay 20% of the total cost for all home infusion drugs.	You pay $0 for select home infusion drugs. You pay 20% of the total cost for all other home infusion drugs.
Dental Services	You pay $0 for one dental x-ray per year. You receive an $875 allowance per quarter for preventive and comprehensive dental services combined. You receive a $50 allowance per month for over-the-counter, eastern wellness therapies, and dental services combined.	You pay $0 for up to eight dental x-rays per year. You receive a $400 allowance per quarter for preventive and comprehensive dental services combined. You receive an $180 allowance per quarter for over-the-counter, fitness, and dental services combined.
Fitting/Evaluation for Hearing Aid	You pay $0 for two fittings/evaluations every two years.	You pay $0 for two fittings/evaluations every year.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. The costs in this chart are for a one-month (30-day) supply when you fill your prescription at a	Your cost for a one-month supply is: **Tier 1 Preferred Generic:** You pay $0 per prescription.	Your cost for a one-month supply is: **Tier 1 Preferred Generic:** You pay $0 per prescription.

network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	**Tier 2 Generic:** You pay $10 per prescription. You pay $0 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $10. **Tier 3 Preferred Brand:** You pay $35 per prescription. You pay $0 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $35. **Tier 4 Non-Preferred Drug:** You pay $95 per prescription. Tier 4 drugs are not available through mail-order. **Tier 5 Specialty Tier:** You pay 33% of the total cost. **Tier 6 Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	**Tier 2 Generic:** You pay $0 per prescription. You pay $0 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $0. **Tier 3 Preferred Brand:** You pay $45 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $45. **Tier 4 Non-Preferred Drug:** You pay $95 per prescription. Your cost for a one-month mail-order prescription is $95. **Tier 5 Specialty Tier:** You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 Select Care Drugs:** You pay $0 per prescription. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will

Stage	2024 (this year)	2025 (next year)
		move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-866-688-9021 or visit Medicare.gov.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Astiva Health Premier Plan

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Astiva Health Premier Plan.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

As a reminder, Astiva Health offers other Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Astiva Health Premier Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Astiva Health Premier Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called California Health Insurance Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website https://www.aging.ca.gov/hicap/.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Department of Public Health, Center for Infectious Diseases, Office of AIDS. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call (844) 421-7050. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-866-688-9021 or visit Medicare.gov.

SECTION 8 Questions?

Section 8.1 – Getting Help from Astiva Health Premier Plan

Questions? We're here to help. Please call Member Services at 1-866-688-9021. (TTY only, call 711). We are available for phone calls from 8:00 am to 8:00 pm seven days a week between October 1st – March 31st; 8:00 am to 8:00 pm Monday-Friday between April 1st – September 30th. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for Astiva Health Premier Plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.astivahealth.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.astivahealth.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/Drug List*).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.