Astiva Health Savings Plan 001 (HMO) offered by Astiva Health

Annual Notice of Changes for 2026

You're currently enrolled as a member of Astiva Health Premier Plan 010.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Astiva Health Savings Plan 001.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage.*

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-866-688-9021 (TTY users call 711) for more information. 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).

About Astiva Health Savings Plan 001

- Astiva Health is an HMO with a Medicare contract. Enrollment in Astiva Health depends on contract renewal.
- When this material says "we," "us," or "our," it means Astiva Health. When it says "plan" or "our plan," it means Astiva Health Savings Plan 001.
- On January 1, 2026, Astiva Health will be transitioning you from Premier Plan 010 to Savings Plan 001. This material tells you about the differences between your current benefits in Premier Plan 010 and the benefits you'll have on January 1, 2026, as a member of Savings Plan 001.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Astiva Health Savings Plan 001.** Starting January 1, 2026, you'll get your medical and drug coverage through Astiva Health Savings Plan 001. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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OMB Approval 0938-1051 (Expires: August 31, 2026)

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	$0	**$0**
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered services. (Go to Section 1.2 for details.)	$1,500	**$3,045**
Primary care office visits	$0 copay per visit	**$0 copay per visit**
Specialist office visits	$0 copay per visit	**$0 copay per visit**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	You pay $0 copay per day for days 1 – 5. You pay $150 copay per day for days 6 – 15. You $0 copay per day for days 16 – 90.	**You pay $0 copay per day for days 1 – 90+.**
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	**$50 except for covered insulin products and most adult Part D vaccines**

	2025 (this year)	2026 (next year)
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $0 copay 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 can have cost sharing for drugs that are covered under our enhanced benefit.	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1: $0 copay** **Drug Tier 2: $12 copay** **Drug Tier 3: $45 copay** **You pay $35 per month supply of each covered insulin product on this tier.** **Drug Tier 4: $98 copay** **You pay $35 per month supply of each covered insulin product on this tier.** **Drug Tier 5: 29% of the cost** **Drug Tier 6: $0 copay** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.** **You can have cost sharing for drugs that are covered under our enhanced benefit.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	**$0** **No change for the upcoming benefit year.**
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	$0	**$185.00 reduction**

Factors that could change your Part D Premium Amount

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

Section 1.2 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've paid this amount, you generally pay nothing for covered services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) **count** toward your maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$1,500	**$3,045** **Once you've paid $3,045 out of pocket for covered services, you'll pay nothing for your covered services for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.astivahealth.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.astivahealth.com.
- Call Member Services at 1-866-688-9021 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-866-688-9021 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* www.astivahealth.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.astivahealth.com.
- Call Member Services at 1-866-688-9021 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-866-688-9021 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	**2026 (next year)**
Inpatient Hospital (Acute)	You pay $0 copay per day for days 1 – 5. You pay $150 copay per day for days 6 – 15. You pay $0 copay per day for days 16 – 90.	**You pay $0 copay per day for days 1 – 90+.**

	2025 (this year)	2026 (next year)
Inpatient Hospital (Psychiatric)	You pay $0 copay per day for days 1 – 5. You pay $150 copay per day for days 6 – 15. You pay $0 copay per day for days 16 – 90.	**You pay $0 copay per day for days 1 – 90+.**
Skilled Nursing Facility (SNF)	You pay $0 copay per day for days 1 – 20. You pay $214 copay per day for days 21 – 100.	**You pay $0 copay per day for days 1 – 90+.**
Cardiac and Pulmonary Rehabilitation Services	You pay $0 copay.	**You pay $15 copay.**
Emergency Services	You pay $75 copay.	**You pay $125 copay.**
Worldwide Emergency/Urgent Coverage	Up to $50,000 per year	**Up to $100,000 per year**
Occupational Therapy	You pay $15 copay.	**You pay $0 copay.**
Mental Health Services	You pay $0 copay.	**You pay $25 copay.**
Podiatry Services	You pay $0 copay.	**You pay $15 copay.**
Physical Therapy and Speech-Language Pathology Services	You pay $15 copay.	**You pay $0 copay.**

	2025 (this year)	2026 (next year)
Outpatient Diagnostic and Therapeutic Radiological Services	You pay $0 for general diagnostic radiology. You pay a $35 copay per service for complex diagnostic radiology services.	**You pay $50 copayment for PET scan.** **You pay $35 copayment for MRI.** **You pay $0 copayment for all other general diagnostic radiology.**
Outpatient Hospital Services	You pay $50 copay.	**You pay $0 copay.**
Ambulatory Surgical Center (ASC) Services	You pay $0 copay.	**You pay $75 copay.**
Ground Ambulance Services	You pay $50 copay.	**You pay $150 copay.**
Transportation Services	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. Services require prior authorization or a referral.	**Benefit is <u>not</u> covered**

	2025 (this year)	2026 (next year)
Diabetic Supplies	You pay 20% of the total cost for all diabetic supplies.	**You pay $0 copay for diabetic meters and test strips from a preferred vendor.** **You pay 20% of the total cost for diabetic meters and test strips from a non-preferred vendor.** **You pay 20% of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts.** **You pay $0 cost sharing for all other diabetic supplies.**
Acupuncture Treatments	Routine acupuncture is limited to 72 sessions annually, combined with eastern wellness therapy and massage therapy sessions. Routine acupuncture does not require prior authorization or a referral.	**Routine acupuncture is limited to 6 sessions every three months, combined with eastern wellness therapy and massage therapy sessions.** **Unused sessions will rollover per quarter.** **Routine acupuncture does not require prior authorization or a referral.**

	2025 (this year)	2026 (next year)
Health and Wellness	You receive $180 per quarter allowance for fitness, over-the-counter items, and dental services combined. The Fitness Benefit allows 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 Bowling (does not include league fees)	**You receive $99 per month allowance for fitness, over-the-counter items, and dental services combined. The Fitness Benefit allows 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** • **Bowling (does not include league fees)** **Allowance can't be used to pay for personal trainers.** **Membership-based facilities, like golf clubs, country clubs, or massage/spas do not qualify even if they include gym access.** **Private fitness classes or lessons are not allowed.**
Personal Emergency Response System	You pay $0 copay.	**Benefit is not covered**
Kidney Disease Education Services	Services do not require prior authorization or a referral.	**Services require prior authorization or a referral.**

	2025 (this year)	2026 (next year)
Barium Enemas	Services require a referral.	**Services do not require a referral.**
Dental Services	You receive $400 allowance every three months for preventative and comprehensive dental services combined with $0 cost sharing. In addition, you may also apply a $180 combined monthly allowance for fitness, over-the-counter items, and dental services towards dental services. Unlimited diagnostic dental services per year.	**In addition to a $250 allowance per quarter for preventative and comprehensive dental services combined, you may also apply the $99 combined monthly allowance for fitness and over-the-counter items, towards dental services.** **1 diagnostic dental service per year.**
Eyewear	$300 allowance for eyeglasses and contact lenses every two years. Contact lenses are limited to $150 every two years.	**$125 allowance for eyeglasses or contact lenses every two years.**
Hearing Aids	The plan covers two hearing aids per ear per year. The max coverage amount is $500 per year.	**The plan covers one hearing aid per ear per year. The max coverage amount is $500 per year.**

Section 1.6 Changes to Part D 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 calendar 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're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-866-688-9021 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

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 material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get "Extra Help" and didn't get this material with this packet, call Member Services at 1-866-688-9021 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 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 no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  We have no deductible, so this payment stage doesn't apply to you.

- ***Stage 2: Initial Coverage***

In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	**2026 (next year)**
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**$50** **During this stage, you pay $0 cost sharing for drugs on Tier 1 and Tier 6, $12 cost sharing for drugs on Tier 2, and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you've reached the yearly deductible.**

Drug Costs in Stage 2: Initial 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. For more information about the costs of vaccines, or information about the costs for a long-term supply, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1 Preferred Generic:	$0	**$0**
Tier 2 Generic:	$0	**$12** **Your cost for a one-month mail-order prescription is $12.**
Tier 3 Preferred Brand:	$35 You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $35.	**$45** **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:	$95 You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $95.	**$98** **You pay $35 per month supply of each covered insulin product on this tier.**
Tier 5 Specialty Tier:	33% of the cost You pay $35 per month supply of each covered insulin product on this tier.	**29% of the cost**
Tier 6 Select Care Drugs: 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.	$0	**$0**

Changes to the Catastrophic Coverage Stage

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

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

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** **To learn more about this payment option, call us at 1-866-688-9021 (TTY users call 711) or visit www.Medicare.gov.**

SECTION 3 How to Change Plans

To stay in Astiva Health Savings Plan 001, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our **Astiva Health Savings Plan 001**.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from **Astiva Health Savings Plan 001**.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from **Astiva Health Savings Plan 001**.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-866-688-9021 (TTY users call 711) for

more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).

- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Astiva Health offers other Medicare health plans *AND/OR* Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:

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

The Medicare Prescription Payment Plan. The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-866-688-9021 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Astiva Health Savings Plan 001

- **Call Member Services at 1-866-688-9021 (TTY users call 711)**

  We're available for phone calls from 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.

- **Read your 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for *Astiva Health Savings Plan 001*. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.astivahealth.com or call Member Services at 1-866-688-9021 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.astivahealth.com**

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get 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).

Call HICAP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call HICAP at 1-800-434-0222. Learn more about HICAP by visiting *https://www.aging.ca.gov/hicap*

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.