



2026

SUMMARY OF BENEFITS

**ASTIVA HEALTH
PREMIER PLAN (HMO) 012**

SERVICING

SANTA CLARA COUNTY

JANUARY 1, 2026 – DECEMBER 31, 2026

astivahealth.com

2026

IMPORTANT PLAN INFORMATION

Astiva Health PREMIER PLAN (HMO) 012 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) 012**, 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 county in California: Santa Clara.

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.

The information listed is not a complete description of benefits. Please refer to the Evidence of Coverage for details. Astiva Health is an HMO with Medicare contract. Enrollment in Astiva Health depends on contract renewal. Out-of-Network/Non-Contracted Providers are under no obligation to treat plan members, except in emergency situations. Attention: If you speak Vietnamese/Spanish/Korean or other languages, language assistance services, free of charge, are available to you. Documents are available in alternative formats such as large prints and Braille. Call 1-866-688-9021 (TTY: 711) to speak to our Member Services. The hours of operation are 8:00AM to 8:00PM, Monday to Sunday, between October 1 to March 31, and 8:00AM to 8:00PM, Monday to Friday, between April 1 to September 30.




PREMIUMS & BENEFITS	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Maximum Out-of-Pocket (MOOP)	\$1,500 per year	You pay at most \$1,500 per year for Medicare-covered services, including copays and coinsurance. Part D cost-sharing does not count towards this amount.
Monthly Plan Premium	You pay \$0 per month	You must continue to pay your Medicare Part B premium.
Annual Plan Deductible	You pay \$0	This plan does not have an In-Network deductible.
♥ BENEFITS DETAILS		
Primary Care Physician Office Visit	You pay \$0 copay	
Specialist Office Visit	You pay \$0 copay	Prior authorization rules apply.
Urgently Needed Services	You pay \$0 copay	
Preventive Services	You pay \$0 copay	There is no coinsurance, copayment or deductible for all Original Medicare preventive services. No authorization required.
Skilled Nursing Facility (SNF)	You pay \$0 copay for days 1-20 You pay \$0 copay for days 21-100	Prior authorization rules apply.
Home Health Services	You pay \$0 copay	Prior authorization rules apply.
Physical Therapy	You pay \$0 copay	Prior authorization rules apply.
Podiatry Services	You pay \$0 copay	Prior authorization rules apply.
Ambulatory Surgery Center (ASC)	You pay \$75 copay	Prior authorization rules apply.
Outpatient Diagnostic Services - Lab services - Diagnostic tests & procedures - Outpatient X-rays - Therapeutic Radiology - Diagnostic Radiology	You pay \$0 copay You pay \$0 copay You pay \$0 copay You pay 20% coinsurance You pay \$0 - \$30 copay	Prior authorization rules apply. PET Scan \$30, MRI \$20, All others \$0
Durable Medical Equipment (DME)	You pay 0% - 20% coinsurance	Prior authorization rules apply. You pay 0% coinsurance for items that cost less than or equal to \$99 and 20% coinsurance for items that costs more than \$99.

PREMIUMS & BENEFITS	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Mental Health Specialty Services - Individual Sessions - Group Sessions	You pay \$0 copay You pay \$0 copay	Prior authorization rules apply.
Psychiatric Services - Individual Sessions - Group Sessions	You pay \$40 copay You pay \$40 copay	Prior authorization rules apply.
Medicare Part B Drugs	You pay 0% - 20% coinsurance	Prior authorization rules apply.
Medicare Part B Insulin Drugs	You pay 0% - 20% coinsurance	You pay a maximum of \$35 per month.
Medicare Part B Chemotherapy & Radiation Drugs	You pay 0% - 20% coinsurance	Prior authorization rules apply.
🏥 HOSPITAL & EMERGENCY CARE		
Inpatient Hospital – Acute	You pay \$0 copay per admission	Prior authorization rules apply.
Inpatient Hospital – Psychiatric	You pay \$0 copay per admission	Prior authorization rules apply.
Outpatient Hospital Services	You pay \$0 copay	Prior authorization rules apply.
Hospital Observation Services	You pay \$0 copay	Prior authorization rules apply.
Emergency Room (ER)	You pay \$85 copay	Copay is waived if you are admitted to the hospital within 48 hours.
Ambulance Services – Ground	You pay \$150 copay	Copay is waived if you are admitted to the hospital.

SUPPLEMENTAL BENEFITS BEYOND ORIGINAL MEDICARE	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Vision Services - Routine Eye Exams - Eyewear	You pay \$0 copay . One visit each year \$300 for glasses or \$150 contact lenses every two years	You must use a provider in the VSP Vision Care network.
Hearing Services - Routine Hearing Exams - Hearing Aids	You pay \$0 copay . One visit each year \$500 per year	
Dental Services	\$875 per quarter (Rollover) Equivalent to \$3,500 per year	Most comprehensive procedures require prior authorization.
Worldwide Emergency Coverage	\$50,000 per year	You pay \$0 copay

SUPPLEMENTAL BENEFITS BEYOND ORIGINAL MEDICARE	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Transportation Services (Non-Emergency)	24 one-way trips per year for medical purposes	Transportation distance must be within a 30-mile radius from member's primary residence. If it exceeds 30-miles, a combined number of trips can be used.
FLEX Benefit Allowance This benefit can be used for: - Over-the-Counter (OTC) - Fitness - Dental - Eyewear	\$105 per month (Rollover) Equivalent to \$1,260 per year	This benefit allowance will be loaded into the Astiva Health Flex Benefit Card.
Personal Emergency Response System (PERS)	You pay \$0 copay One device per year	Prior authorization rules apply.
Telehealth	You pay \$0 copay	

PART D PRESCRIPTION DRUG COVERAGE			
Part D Deductible	\$0		
Part D Annual Out-of-Pocket cost threshold	\$2,100		
Initial Coverage Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Name Tier 4: Non-Preferred Brand Name Tier 5: Specialty Tier 6: Select Care	Standard Retail (30-day supply) You pay \$0 copay You pay \$0 copay You pay \$35 copay You pay \$95 copay You pay 33% coinsurance You pay \$0 copay	Standard Mail Order (90-day supply) You pay \$0 copay You pay \$5 copay You pay \$70 copay N/A N/A You pay \$0 copay	