astiva HEALTH

2026

SUMMARY OF BENEFITS

ASTIVA HEALTH PREMIER PLAN (HMO) 015

SERVICING

LOS ANGELES – ORANGE – RIVERSIDE
SAN BERNARDINO – SAN DIEGO

JANUARY 1, 2026 – DECEMBER 31, 2026

astivahealth.com

2026

IMPORTANT PLAN INFORMATION

Astiva Health Premier Plan (HMO) 015 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) 015**, 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.

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. Some benefits mentioned are part of Special Supplemental Benefits for the Chronically Ill (SSBCI). To be eligible, you must have cardiovascular disease, diabetes, or chronic heart failure. Having a listed condition does not guarantee benefits. Coverage depends on being a chronically ill enrollee and meeting plan coverage criteria. 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.

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PREMIUMS & BENEFITS	PREMIER PLAN (HMO) 015	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** per admission	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 **$0 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 **$0 copay** 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.

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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 **$25 copay** You pay **$25 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 Coverage – Acute	You pay **$0 copay** for days 1-5 You pay **$150 copay** for days 6-15 You pay **$0 copay** for days 16-90+	Prior authorization rules apply.
Inpatient Hospital Coverage – Psychiatric	You pay **$0 copay** for days 1-5 You pay **$180 copay** for days 6-15 You pay **$0 copay** for days 16-90+	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 **$75 copay**	Copay is waived if you are admitted to the hospital within 48 hours.
Ambulance Services – Ground	You pay **$50 copay**	Copay is waived if you are admitted to the hospital.

SUPPLEMENTAL BENEFITS BEYOND ORIGINAL MEDICARE	PREMIER PLAN (HMO) 015	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 **$1,000** per year ($500 per ear, per year maximum)	Prior authorization rules apply.
Dental Services	**$350** per quarter (Rollover) Equivalent to **$1,400** per year	Most comprehensive procedures require prior authorization.
Worldwide Emergency Coverage	**$100,000** per year	You pay **$0 copay**

SUPPLEMENTAL BENEFITS BEYOND ORIGINAL MEDICARE	PREMIER PLAN (HMO) 015	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	**$180** per month (Rollover) Equivalent to **$2,160** per year	This benefit allowance will be loaded into the Astiva Health Flex Benefit Card.
Acupuncture, Massage, and Other Eastern Therapies	**64 sessions** per year (16 sessions per quarter) Includes cupping, moxa, tuina, gua sha, med-x, and reflexology	- Unused sessions rollover to the next quarter. - Up to 2 sessions per day. (15 minutes each, maximum 30 minutes per day).
Personal Emergency Response System (PERS)	You pay **$0 copay** One device per year	Prior authorization rules apply.
Post-discharge Meals Benefits	**$600** per year Allowance per meal is $20	- The meal benefit covers 2 meals per day for up to 5 consecutive days for each hospital admission. - Covers up to 30 meals per year.
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	**Standard Retail** (30-day supply)	**Standard Mail Order** (90-day supply)
Tier 1: Preferred Generic	You pay **$0 copay**	You pay **$0 copay**
Tier 2: Generic	You pay **$0 copay**	You pay **$0 copay**
Tier 3: Preferred Brand Name	You pay **$35 copay**	You pay **$70 copay**
Tier 4: Non-Preferred Brand Name	You pay **$95 copay**	N/A
Tier 5: Specialty	You pay **33% coinsurance**	N/A
Tier 6: Select Care	You pay **$0 copay**	You pay **$0 copay**