2024

astiva HEALTH

SUMMARY OF

# BENEFITS

**January 1, 2024 – December 31, 2024**

## ASTIVA HEALTH SAVINGS PLAN (HMO) 001

SERVICE AREA:

**LOS ANGELES ▪ ORANGE ▪ RIVERSIDE**
**SAN BERNARDINO ▪ SAN DIEGO**

# 2024 IMPORTANT PLAN INFORMATION

**Astiva Health Savings Plan (HMO) 001** 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 Savings Plan (HMO) 001**, 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 Bernadino, and San Diego.

Except in emergency situations, if you use the 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 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). The 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.

# SUMMARY OF BENEFITS ASTIVA HEALTH

| PREMIUMS AND BENEFITS | ASTIVA HEALTH SAVINGS PLAN (HMO) 001 |
|---|---|
| **Monthly Health Plan Premium** | **Part C: $0**<br>**Part D: $0** |
| **Medicare Part B Premium Rebate** | **$1978.80 per year**<br>($164.90 per month) |
| **Deductible** | No deductible |
| **Maximum Out-of-Pocket Responsibility**<br>(does not include prescription drugs) | You pay no more than **$2500** annually includes copays and coinsurance for Medicare-covered services for the year. |
| **Inpatient Hospital Coverage*** | **$0 copay** for days 1-10,<br>**$200 copay** for days 11-22,<br>**$0 copay** for days 23-90 |
| **Outpatient Hospital Coverage*** | |
| - Hospital Services | **$200 copay** |
| - Observation Services | **$75 copay** |
| **Ambulatory Surgical Center*** | **$75 copay** |
| **Doctor Visits*** | |
| - Primary | **$0 copay** |
| - Specialist | **$0 copay** |
| **Preventive Care** | **$0 copay**<br>Any additional preventive services approved by Medicare during the contract year are covered. |

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| **Emergency Care** | **$125 copay**<br>(waived if admitted within 48 hours) |
| **Urgently Needed Services** | **$0 copay** |
| **Outpatient Diagnostic Services*** | |
| - Procedures, tests, lab services | **$0 copay** |
| - X-Ray | **$0 copay** |
| - Diagnostic (such as MRIs, CT scans) | **$0 - $75 copay** |
| - Therapeutic radiology (such as radiation treatment for cancer) | **20%** coinsurance |
| **Durable Medical Equipment (DME)*** | **0%** coinsurance for DME costs less than or equal to $99<br>**20%** coinsurance for DME that costs more than $99 |
| **Hearing Services** | |
| - Routine hearing exam | **$10 copay** |
| - Hearing aids allowance* | Not covered |
| **Dental Services** | **$1000 per year**<br>($250 per quarter, roll over from quarter to quarter) |
| **Vision Services** | |
| - Routine exam* | **$0 copay** once per year |
| - Eyewear coverage limit | **$0 copay**<br>**$125** glasses or contact lenses every two years |

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| **Mental Health Services*** - Outpatient therapy | **$25 copay** per visit |
| **Skilled Nursing Facility*** | **$0 copay** days 1 -20, **$200 copay** days 21 - 100 |
| **Physical Therapy*** | **$10 copay** per visit |
| **Ambulance Services (Ground)** | **$150 copay** per one-way trip |
| **Transportation (non-emergency)*** | **52 one-way** trips to plan approved locations within 25 miles radius |
| **Medicare Part B Drugs*** | **20%** of the cost for Part B drugs (The minimum applies for the mandated IRA fluctuations. The maximum applies for all other chemo/radiation Medicare Part B Drugs.) |
| **Medicare Part B Insulin Drugs*** | **$35 copay** |
| **Medicare Part B Chemotherapy/ Radiation Drugs*** | **20%** of the cost for Part B drugs (The minimum applies for the mandated IRA fluctuations. The maximum applies for all other chemo/radiation Medicare Part B Drugs.) |
| | |
| **Prescription Drug Coverage** | |
| Part D Deductible | **$0** |
| Part D Initial Coverage Limit | **$5,030** |
| Part D Out of Pocket Threshold | **$8,000** |
| **Initial Coverage** | |
| **Tier 1:** Preferred Generic Drugs | **$0 copay** for 30-day supply |
| **Tier 2:** Generic Drugs | **$15 copay** for 30-day supply |
| **Tier 3:** Preferred Brand Drugs | **$45 copay** for 30-day supply |
| **Tier 4:** Non-Preferred Brand Drugs | **$98 copay** for 30-day supply |
| **Tier 5:** Specialty Drugs | **33%** coinsurance of the drug cost to the plan |
| **Tier 6:** Select Care Drugs | **$0 copay** for 30-day supply |

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| **Gap Coverage Tier 1 & 2** | Tier 1: **$0 copay**<br>Tier 2: **$15 copay**<br>for 30 day supply |
| **Gap Coverage** | Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$5030.**<br><br>You pay the same copays as in the Initial Coverage Stage for Tier 1, Tier 2, and Tier 6 drugs.<br><br>For drugs in other tiers, you pay **25%** of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and **25%** of the cost for your generic drugs. |
| **Catastrophic Coverage Stage** | After your yearly out-of-pocket drug costs reach **$8000**, you pay nothing for covered Part D drugs. |

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| **Value Added Items and Services** | |
| **Acupuncture & Therapeutic Massage*** | **$0 copay** up to **96** supplemental acupuncture or massage therapy visits, **combined** |
| **Fitness Benefit** | **$50** monthly allowance through WEX (Card) |
| **Incontinence Products** | **$25** monthly allowance |
| **Post Hospital Meal Benefits*** | Up to **$1350 per year** (the meal benefit covers 2 meals per day for 7 consecutive days for each hospital admission. The maximum allowance is **$15** per meal. The meal benefit covers up to 90 meals per year.) |
| **Worldwide Emergency Coverage** | Up to **$50,000** reimbursement for qualifying expenses (urgently needed or emergency services only) |

**Services with a * requires prior approval or a referral from your doctor.**

For more information on the pharmacy-specific copays, please call Member Services at the phone number in this document or access your Evidence of Coverage at www.astivahealth.com