2024 ANNUAL NOTICE OF CHANGE (ANOC)

ASTIVA HEALTH

OMB Approval 0938-1051 (Expires: February 29, 2024)

Astiva Health Premier Plan (HMO) offered by Astiva Health

Annual Notice of Changes for 2024

You are currently enrolled as a member of *Astiva Health Classic Plan (HMO)*. 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 *https://astivahealth.com/en-us/plan-benefits* .

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 authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

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

☐ 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 www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ 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, 2023, you will stay in *Astiva Health Premier Plan (HMO)*.
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with *Astiva Health Premier Plan (HMO)*.
   - If you recently moved into, currently live in, or just moved out of 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.

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 and alternate formats (e.g. braille, large print, audio).

Member Services also has free language interpreter services available for non-English speakers.

- **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 (HMO)*

- *Astiva Health is a 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 (Plan/Part D Sponsor)*. When it says "plan" or "our plan," it means *Astiva Health Premier Plan (HMO)*.

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Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for *Astiva Health Premier Plan (HMO)* in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (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 Part A and Part B services. (See Section 2.2 for details.)	*$3000*	*$2500*
Doctor office visits	Primary care visits: $0 for PCPs; *$10* per visit. Specialist visits $0 per visit	Primary care visits: $0 for PCPs *$0* per visit. Specialist visits $0 per visit
Inpatient hospital stays	*$0 days 1-90*	$0 copay for days 1-5, $150 copay for days 6-10, $0 copay for days 11-90
Part D prescription drug coverage (See Section 2.5 for details.)	• Deductible: $0 **During the Initial Coverage Stage:** • Drug Tier 1: $0 copay for 30-day supply • Drug Tier 2: $4 copay for 30-day supply	• Deductible: $0 **During the Initial Coverage Stage:** • Drug Tier 1: $0 copay for 30-day supply • Drug Tier 2: $10 copay for 30-day supply

Cost	2023 (this year)	2024 (next year)
	• Drug Tier 3: $28 copay for 30-day supply • Drug Tier 4: $75 copay for 30-day supply • Drug Tier 5: 33% coinsurance of the drug cost to the plan • Drug Tier 6: $0 copay for 30-day supply • You pay no more than $35 for Insulin on Tier 1, Tier 2, Tier 3, or Tier 4 **Catastrophic Coverage:** • During this payment stage, depending on your level of copayment; You pay the greater of $4.15 for generic or a preferred multi-source drug and $10.35 for all other drugs, or 5%.	• Drug Tier 3: $35 copay for 30-day supply • Drug Tier 4: $95 copay for 30-day supply • Drug Tier 5: 33% coinsurance of the drug cost to the plan • Drug Tier 6: $0 copay for 30-day supply • You pay no more than $35 for Insulin on Tier 1, Tier 2, Tier 3, or Tier 4 **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.

SECTION 1 We Are Changing the Plan's Name

On January 1, 2024, our plan name will change from *Astiva Health Classic (HMO)* to *Astiva Health Premier Plan (HMO).*

Members will receive new ID cards prior to December 31, 2023. The name change to Astiva Health Premier Plan (HMO) will not impact member communications or your ability to obtain medical service or prescription drugs.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *Astiva Health Premier Plan (HMO)* in 2024

On January 1, 2024, *Astiva Health Plan* will be transitioning you from *Astiva Health Classic Plan (HMO)* to Astiva Health Premier Plan (HMO). The information in this document tells you about the differences between your current benefits in *Astiva Health Classic Plan (HMO)* and the benefits you will have on January 1, 2024, as a member of *Astiva Health Premier Plan (HMO)].*

If you do nothing by December 7, 2023, we will automatically enroll you in our *Astiva Health Premier Plan (HMO)* This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through *Astiva Health Premier Plan (HMO)*. 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	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	*$0 premium*	*$0 premium.*

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

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*:* Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays)) count toward your maximum out-of-pocket amount.	*$1500 in Classic Plan (HMO)*	*$1900 in Premier Plan (HMO)* Once you have paid *$1900* out-of-pocket for covered*:* Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

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 no changes to our network of providers for next year.

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are no changes to our network of pharmacies for next year.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* 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	2023 (this year)	2024 (next year)
Inpatient Hospital-Psychiatric	You pay a $150 days 1-7; $0 days 8-90	You pay a $0 days 1-5; $150 days 6-10; $0 days11-90
Skilled Nursing Facility (SNF)	*You Pay $0 copay days 1-20; $75 days 21-65; $0 days 66-100.*	*You pay $0 copay days 1-20; $200 days 21-100*
Emergency Services	*You pay $50 per visit.*	*You pay $75 per visit.*
Podiatry	*You pay* $0 copay per visit for routine foot care (1 visit every 3 months).	*Not a covered benefit.*
Acupuncture	*You pay $10 unlimited visits*	*You pay $0 copay up to 96 supplemental acupuncture or massage therapy visits, combined.*
Outpatient Hospital Services/ Observation services / Ambulatory Surgery Center (ASC)	*You pay $50 copay per stay*	*You pay $100 copay for outpatient hospital services per stay, $30 copay for observation and ambulatory surgical center services per stay*
Transportation	*You pay $0 copay for 40 one-way trips*	*You pay $0 for 52 one-way trips within 25 miles*

Cost	2023 (this year)	2024 (next year)
Fitness	*You pay $0.* There is no coinsurance, copayment, or deductible for the Silver & Fit Healthy Aging and Exercise Program as a mandatory supplemental benefit.	*You have $50 per month. Fitness benefit is offered as a combined flex card benefit.*
Medicare Part B Rx Drugs and Home Infusion Drugs	*You pay 20% coinsurance*	*You pay 0-20% coinsurance* There are some Part B to Part B medications that are subject to step therapy rules.
Dental Services (Preventative & Comprehensive)	*You pay $0 monthly premium for Dental by DeltaCare and $2500 copay direct reimbursement with receipts per year.*	*You have $875 dental allowance every 3 months.*
Vision	*You have $300 allowance per year through EyeMed vendor*	*You have $300 for glasses or $150 for contact lenses every two years through VSP vendor*
Hearing Aids	*You have $1000 per year allowance.*	*You have $1000 per year allowance.*
Post Hospital Meal Benefit	*You have $0 copay for 90 post hospital meals per year.*	*You pay $0 copay for up to $1350 per year allowance; or $15 a meal for up to 90 meals per year.*
Incontinence Products	*Not a covered benefit*	*You have a $25 monthly allowance.*
Worldwide Emergency/Urgent Coverage	*You pay $50 copay per admission.*	*You pay $75 copay per admission. Copay waived if admitted within 48 hours.*

Partial Hospitalization	*You pay $10 copay per day.*	*You pay $100 copay per day.*

Cost	2023 (this year)	2024 (next year)
Psychiatric Services	*You pay $20 copay per individual or group session.*	*You pay $25 copay per individual or group session.*
Outpatient Diagnostic and Therapeutic Radiological Services	*You pay $0 copay per diagnostic procedure and 20% coinsurance per therapeutic radiology service.*	*You pay $30 copay per diagnostic procedures and 20% coinsurance per therapeutic radiology service; and $15 copay per complex radiology physician services.*
Ambulance Services	*You pay $50 copay per one-way trip.*	*You pay $100 copay per one-way trip.*
OTC/Health & Wellness/Utilities Flexible Spending Allowance	*You have $400 per year allowance for OTC items.*	*You have $50 per month allowance. This OTC benefit allowance is offered via a combined flex spending card*

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. **You can get the *complete* "Drug List"** by calling Member Services (see the back cover) or visiting our website (*www.AstivaHealth.com*).

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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

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.

Starting in 2024, we may immediately remove a brand name drug on our "Drug List" if, at the same time, we replace it with a new generic version on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may 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.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.]

Changes to Prescription Drug 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 does not apply to you.** We have included 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.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (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	2023 (this year)	2024 (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.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Tier 1 Preferred Generic Drugs*:** You pay $0 copay for 30-day supply. ***Tier 2 Generic Drugs*:** You pay $4 copay for 30-day supply. ***Tier 3 Preferred Brand Drugs*:** You pay $28 copay for 30-day supply. ***Tier 4 Non-Preferred Drugs*:** You pay $75 copay for 30-day supply. ***Tier 5 Specialty Tier Drugs*:** You pay 33% coinsurance of the drug cost to the plan for 30-day supply. ***Tier 6 Select Care Drugs*:** You pay $0 copay for 30-day supply.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Tier 1 Preferred Generic Drugs*:** You pay $0 copay for 30-day supply. ***Tier 2 Generic Drugs*:** You pay $10 copay for 30-day supply. ***Tier 3 Preferred Brand Drugs*:** You pay $35 copay for 30-day supply. ***Tier 4 Non-Preferred Drugs*:** You pay $95 copay for 30-day supply. This tier is limited to a 30-day supply. ***Tier 5 Specialty Tier Drugs*:** You pay 33% coinsurance of the drug cost to the plan for 30-day supply. This tier is limited to a 30-day supply. ***Tier 6 Select Care Drugs*:** You pay $0 copay for 30-day supply.

Stage	2023 (this year)	2024 (next year)
	• You pay no more than $35 for Insulin on Tier 1, Tier 2, Tier 3, or Tier 4	• You pay no more than $35 for Insulin on Tier 1, Tier 2, Tier 3, or Tier 4
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month 30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply; for mail-order prescriptions, 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."**	Once your total drug costs have reached $4660, you will move to the next stage (the Coverage Gap Stage). Your Costs for Drugs in Tiers 1, Tier 2, and Tier 6 Remain the Same in the Coverage Gap Stage.	Once your total drug costs have reached $5030, you will move to the next stage (the Coverage Gap Stage). Your Costs for Drugs in Tiers 1, Tier 2, and Tier 6 Remain the Same in the Coverage Gap Stage.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2023 (this year)	2024 (next year)
Astiva Health Plan is changing its Vision vendor from EyeMed to Vision Service Provider VSP	*Astiva Health vendor for 2023 for vision benefit is EyeMed*	*Astiva Health vendor for 2024 will be Vision Service Provider (VSP)*

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in *Astiva Health Premier Plan (HMO)*

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 (HMO).*

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 2024 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2). As a reminder, *Astiva Health Plan* 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 (HMO)*.
- 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 (HMO)*

- 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, 2024.

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, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of 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.

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. ***California Health Insurance*** Counseling and Advocacy ***Program*** (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 ***California Health Insurance*** Counseling and Advocacy ***Program*** (HICAP). at 1-800-434-0222. You can learn more about ***California Health Insurance*** Counseling and Advocacy ***Program*** (HICAP) by visiting their website (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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or 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 (applications).
- **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. 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 AIDS Drug Assistance Program (ADAP) For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-*844-421-7050 or visit website at www.cdph.ca.gov* .

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. 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 *AIDS Drug Assistance Program (ADAP).* For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-*844-421-7050 or www.cdph.ca.gov*

- SECTION 8 Questions?

Section 8.1 – Getting Help from *Astiva Health Premier Plan (HMO)*

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 *we are open 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 or visit at www.astivahealth.com* Calls to these numbers are free.

Read your *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for *Astiva Health Premier Plan (HMO).* 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 2024*

Read the *Medicare & You 2024* 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.