2027

Summary of Benefits

ASTIVA HEALTH PREMIER PLAN (HMO) 012

SERVICING

SANTA CLARA COUNTY

JANUARY 1, 2027 - DECEMBER 31, 2027

2027

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 SANTA CLARA COUNTY in California.

Except in emergency situations, if you use providers outside of our network, you maybe 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 a 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 diabetes, chronic heart failure, cardiovascular disorders, chronic kidney disease, or chronic lung disease. Having a listed condition does not guarantee benefits. Coverage depends on being a chronically ill enrollee and meeting plan coverage criteria. Current members: 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.

astiva HEALTH

PREMIUMS & BENEFITS	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Maximum Out-of-Pocket (MOOP)	**$2,000** per year	You pay at most $2,000 per year for Medicare-covered services, including copays and coinsurance. Part D cost-sharing does not count towards this amount.
Monthly Plan Premium	**$0**	
Annual Plan Deductible	**$0**	This plan does not have an In-Network deductible.
BENEFIT DETAILS		
Primary Care Physician Office Visit	**$0**	
Specialist Office Visit	**$0**	Prior authorization rules apply.
Urgently Needed Services	**$0**	
Preventive Services	**$0**	There is no coinsurance, copayment or deductible for all Original Medicare preventive services. No authorization required.
Skilled Nursing Facility (SNF)	**$0** Days 1-20 | **$221** Days 21-100	Prior authorization rules apply.
Home Health Services	**$0**	Prior authorization rules apply.
Physical Therapy	**$0**	Prior authorization rules apply.
Podiatry Services	**$0**	Prior authorization rules apply.
Ambulatory Surgery Center (ASC)	**$0**	Prior authorization rules apply.
Outpatient Diagnostic Services • Lab Services • Diagnostic Procedures/Tests • Outpatient X-ray Services • Therapeutic Radiological Services • Diagnostic Radiological Services	 **$0** **$0** **$0** **20%** **$0 - $30**	Prior authorization rules apply. PET scans and MRIs have a copay of up to $30. All other diagnostic radiology services are available at no copay.
Durable Medical Equipment (DME)	**0% - 20%**	Prior authorization rules apply. You pay 0% coinsurance for DME that costs less than or equal to $99 and 20% coinsurance for DME that costs more than $99.

PREMIUMS & BENEFITS	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Mental Health Specialty Services • Individual Sessions • Group Sessions	 **$0** **$0**	Prior authorization rules apply.
Psychiatric Services • Individual Sessions • Group Sessions	 **$25** **$25**	Prior authorization rules apply.
Medicare Part B Drugs	**0% - 20%**	Prior authorization rules apply.
Medicare Part B Insulin Drugs	**0% - 20%**	You pay a maximum of $35 per month.
Medicare Part B Chemotherapy & Radiation Drugs	**0% - 20%**	Prior authorization rules apply.

HOSPITAL & EMERGENCY CARE

Inpatient Hospital – Acute	**$75** Days 1-5 | **$0** Days 6-90	Prior authorization rules apply.
Inpatient Hospital – Psychiatric	**$150** Days 1-5 | **$0** Days 6-90	Prior authorization rules apply.
Outpatient Hospital Services	**$0**	Prior authorization rules apply.
Hospital Observation Services	**$0**	Prior authorization rules apply.
Emergency Room (ER)	**$85**	Copay is waived if you are admitted to the hospital within 48 hours.
Ambulance Services – Ground	**$150**	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	 **$0** | One visit each year **$300** for glasses or **$150** for contact lenses every two years	You must use a provider in the VSP Vision Care network.
Hearing Services • Routine Hearing Exams • Prescription Hearing Aids	 **$0** | One visit each year **$500** per year	 Prior authorization rules apply.
Dental Services	**$3,500** annually | **$1,750** semiannually (Rollover)	Prior authorization rules apply. You must use a provider in the Astiva Health Dental Network.
Worldwide Emergency Coverage	**$50,000** per year	

SUPPLEMENTAL BENEFITS BEYOND ORIGINAL MEDICARE	PREMIER PLAN (HMO) 012	WHAT YOU SHOULD KNOW
Transportation Services (Non-Emergency)	**24 one-way trips** per year	The transportation benefit may be used only for medically related purposes. Trips may be combined.
FLEX Benefit Allowance • Over-the-Counter (OTC) • Fitness • Extra Dental • Eyewear	**$1,224** per year | **$102** per month (Rollover)	This benefit allowance will be loaded into the Astiva Health WEX Card.
Personal Emergency Response System (PERS)	**$0 |** One device per year	Prior authorization rules apply.

PART D PRESCRIPTION DRUG COVERAGE

Part D Deductible	**$0**	
Part D Annual Out-of-Pocket cost threshold	**$2,400**	
Initial Coverage	**Standard Retail** (30-day | 60-day | 90-day supply)	**Standard Mail Order** (30-day | 60-day | 90-day supply)
Tier 1: **Preferred Generic**	**$0 | $0 | $0**	**$0 | $0 | $0**
Tier 2: **Generic**	**$0 | $0 | $0**	**$0 | $0 | $0**
Tier 3: **Preferred Brand Name**	**$35 | $70 | $105**	**$35 | $70 | $70**
Tier 4: **Non-Preferred Brand Name**	**$95** (30-day supply)	Not covered
Tier 5: **Specialty**	**33%** (30-day supply)	Not covered
Tier 6: **Select Care**	**$0 | $0 | $0**	**$0 | $0 | $0**