Summary of Benefits

JANUARY 1 – DECEMBER 31

2017

ASPIREHEALTHPLAN

Your Medicare Advantage.
One plan, exceptional service, great value.

This is a summary of drug and health services covered by Aspire Health Plan (HMO) January 1, 2017 — December 31, 2017. Aspire Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

H8764_MKT_SB_0816_CMS Accepted 09/26/2016

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$36.00 monthly plan premium in addition to your monthly Part B premium.
Medical Services Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$5,000 annually. The most you pay for co-pays, co-insurance and other costs for medical services for the year for services you receive from in-network providers. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.
Inpatient Hospital Coverage[1]	Our plan covers 90 days for an inpatient hospital stay. You pay $300 co-pay per day for days 1 through 6. You pay nothing per day for days 7 through 90. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Note:
Services with a [1] may require prior authorization.
Services with a [2] may require a referral from your doctor.

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ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
$95.00 monthly plan premium in addition to your monthly Part B premium.	$239.00 monthly plan premium in addition to your monthly Part B premium.
This plan does not have a deductible.	This plan does not have a deductible.
$4,500 annually. The most you pay for co-pays, co-insurance and other costs for medical services for the year for services you receive from in-network providers. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.	$50 annually. The most you pay for co-pays, co-insurance and other costs for medical services for the year for services you receive from in-network providers. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.
Our plan covers 90 days for an inpatient hospital stay. You pay $275 co-pay per day for days 1 through 6. You pay nothing per day for days 7 through 90. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: You pay nothing for days 1-90. Out-of-network*: You pay nothing for days 1-90. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Doctor Visits » Primary Care » Specialists	Primary care visit: You pay $10 co-pay per visit. Specialist visit: You pay $35 co-pay per visit.
Preventive Care	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease reduction visit • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screening • HIV screening • Obesity screening • Screening for sexually transmitted disease • Smoking and tobacco use counseling

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
Primary care visit: You pay $10 co-pay per visit. Specialist visit: You pay $30 co-pay per visit.	In-network: Primary care visit: You pay nothing per visit. Specialist visit: You pay nothing per visit. Out-of-network*: Primary care visit: You pay nothing per visit. Specialist visit: You pay nothing per visit. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease reduction visit • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screening • HIV screening • Obesity screening • Screening for sexually transmitted disease • Smoking and tobacco use counseling	In-network: You pay nothing. Out-of-network*: You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease reduction visit • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screening • HIV screening • Obesity screening • Screening for sexually transmitted disease • Smoking and tobacco use counseling *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Emergency Care	You pay $75 co-pay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Urgently Needed Services	You pay $45 co-pay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Diagnostic Services/Labs/Imaging[1]	
» Diagnostic radiology service (e.g. MRI)	Diagnostic radiology services (such as MRIs, CT scans): You pay $60 co-pay per service.
» Lab services	Lab services: You pay $20 co-pay per service.
» Diagnostic tests and procedures	Diagnostic tests and procedures: You pay $20 co-pay per service.
» Outpatient x-rays	Outpatient X-rays: You pay $20 co-pay per X-ray. Therapeutic radiology services (such as radiation treatment for cancer): You pay $60 co-pay per service.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay $75 co-pay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	In-network: You pay nothing per visit. Out-of-network: You pay nothing per visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
You pay $40 co-pay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	In-network: You pay nothing per visit. Out-of-network*: You pay nothing per visit. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Diagnostic radiology services (such as MRIs, CT scans): You pay $40 co-pay per service. Lab services: You pay $15 co-pay per service. Diagnostic tests and procedures: You pay $15 co-pay per service. Outpatient X-rays: You pay $15 co-pay per X-ray. Therapeutic radiology services (such as radiation treatment for cancer): You pay $40 co-pay per service.	In-network: You pay nothing for each service. Out-of-network*: You pay nothing for each service. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Hearing Services » Hearing exam	You pay $35 co-pay for each Medicare-covered diagnostic hearing exam. Additional hearing services are available in the Enhanced Health Benefit option for an additional premium of $33.00 per month. Please refer to the Optional Benefit section for more details.
Dental Services	Dental coverage is limited to services covered by Medicare under Medicare Part A hospital and Medicare Part B medical benefits. Additional dental services are available in the Enhanced Health Benefit option for an additional premium of $33.00 per month. Please refer to the Optional Benefit section for more details.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay $30 co-pay for each Medicare-covered diagnostic hearing exam. Additional hearing services are available in the Enhanced Health Benefit option for an additional premium of $29.00 per month. Please refer to the Optional Benefit section for more details.	In-network: You pay nothing. Out-of-network*: You pay nothing. Additional hearing services are available in the Enhanced Health Benefit option for an additional premium of $29.00 per month. Please refer to the Optional Benefit section for more details. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Preventive dental services: Oral exam (up to 1 every six months): You pay nothing. Cleaning (up to 1 every six months): You pay nothing. Dental x-ray(s): (up to 1 full mouth/panoramic series every 12 months): You pay nothing. (up to 1 bite wing series every 12 months): You pay nothing. No prior authorization required for covered services accessed in-network. Additional dental services are available in the Enhanced Health Benefit option for an additional premium of $29.00 per month. Please refer to the Optional Benefit section for more details.	Preventive dental services: Oral exam (up to 1 every six months): You pay nothing. Cleaning (up to 1 every six months): You pay nothing. Dental x-ray(s): (up to 1 full mouth/panoramic series every 12 months): You pay nothing. (up to 1 bite wing series every 12 months): You pay nothing. Prior authorization by Liberty Dental is required for covered benefits out-of-network. No prior authorization is required for covered benefits accessed in-network. Additional dental services are available in the Enhanced Health Benefit option for an additional premium of $29.00 per month. Please refer to the Optional Benefit section for more details.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Vision Services[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay $35 co-pay. Eyeglasses or contact lenses after cataract surgery: You pay nothing, prior authorization required. Additional vision services are available in the Enhanced Health Benefit option for an additional premium of $33.00 per month. Please refer to the Optional Benefit section for more details.

ASPIRE HEALTH ADVANTAGE (HMO)

Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay $30 co-pay.

Routine eye exam (for up to 1):
You pay $10 co-pay.

Contact lenses (for up to 1): You pay $25 co-pay.

Eyeglasses (frames and lenses) (for up to 1 every 12 months): You pay $25 co-pay.

Eyeglasses frames (for up to 1 every 12 months): You pay $25 co-pay.

Eyeglasses lenses (for up to 1 every 12 months): You pay $25 co-pay.

Eyeglasses or contact lenses after cataract surgery: You pay nothing.

Our plan pays up to $100 every 12 months for eyewear.

Additional vision services are available in the Enhanced Health Benefit option for an additional premium of $29.00 per month. Please refer to the Optional Benefit section for more details

ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)

In-network:
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing.

Out-of-network*:
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing.

You pay nothing for medically necessary eyeglasses or contact lenses after cataract surgery, prior authorization required. In and out of network.

Additional Vision Services:
In-network:
Routine eye exam (for up to 1): You pay $10 co-pay.

Contact lenses (for up to 1): You pay $25 co-pay.

Eyeglasses (frames and lenses) (for up to 1 every 12 months): You pay $25 co-pay.

Eyeglasses frames (for up to 1 every 12 months): You pay $25 co-pay.

Eyeglasses lenses (for up to 1 every 12 months): You pay $25 co-pay.

Our plan pays up to $100 every 12 months for eyewear.

Additional vision services are available in the Enhanced Health Benefit option for an additional premium of $29.00 per month. Please refer to the Optional Benefit section for more details.

Additional services and benefits (not covered by Medicare) are not covered out-of-network.

*Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Mental Health Services[1] » Inpatient	Inpatient visit: You pay $300 co-pay per day for days 1 through 5. You pay nothing per day for days 6 through 90. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
» Outpatient group therapy visit	Outpatient group therapy visit: You pay $35 co-pay.
» Outpatient individual therapy visit	Outpatient individual therapy visit: You pay $35 co-pay.

ASPIRE HEALTH ADVANTAGE (HMO)

Inpatient visit:

You pay $275 co-pay per day for days 1 through 5.

You pay nothing per day for days 6 through 90.

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

Outpatient group therapy visit: You pay $30 co-pay.

Outpatient individual therapy visit: You pay $30 co-pay.

ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

In-network:

Inpatient visit: You pay nothing per day for days 1 through 90.

Outpatient group therapy visit: You pay nothing.

Outpatient individual therapy visit: You pay nothing.

Out-of-network*:

Inpatient visit: You pay nothing per day for days 1 through 90.

Outpatient group therapy visit: You pay nothing.
Outpatient individual therapy visit: You pay nothing.

*Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Skilled Nursing Facility[1]	You pay nothing per day for days 1 through 20. $150 co-pay per day for days 21 through 100. Our plan covers up to 100 days in a SNF.
Rehabilitation Services[1] » Cardiac (heart) rehab visit » Occupational therapy visit » Physical therapy and speech therapy and language therapy visit	Cardiac (heart) rehab services: You pay $35 co-pay for each visit. Occupational therapy visit: You pay $35 co-pay for each visit. Physical therapy and speech and language therapy visit: You pay $35 co-pay for each visit.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay nothing per day for days 1 through 20. $100 co-pay per day for days 21 through 100. Our plan covers up to 100 days in a SNF.	Our plan covers up to 100 days in a SNF. In-network: You pay nothing per day for days 1 through 100. Out-of-network*: You pay nothing per day for days 1 through 100. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Cardiac (heart) rehab visit: You pay $30 co-pay for each visit. Occupational therapy visit: You pay $30 co-pay for each visit. Physical therapy and speech and language therapy visit: You pay $30 co-pay for each visit.	In-network: Cardiac (heart) rehab visit: You pay nothing. Occupational therapy visit: You pay nothing. Physical therapy and speech and language therapy visit: You pay nothing. Out-of-network*: Cardiac (heart) rehab visit: You pay nothing. Occupational therapy visit: You pay nothing. Physical therapy and speech and language therapy visit: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Ambulance[1]	You pay $250 co-pay. If you are admitted to the hospital, you do not have to pay for the ambulance services. You must receive Authorization from plan prior to utilization of non-emergency ambulance services.
Transportation[1]	You pay nothing. 12 one-way trips each year to plan approved locations. To arrange transportation, please contact the plan 3 business days in advance to allow for proper scheduling.
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay $35 co-pay.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay $250 co-pay. If you are admitted to the hospital, you do not have to pay for the ambulance services. You must receive Authorization from plan prior to utilization of non-emergency ambulance services.	In-network: You pay nothing. Out-of-network*: You pay nothing. If you are admitted to the hospital, you do not have to pay for the ambulance services. You must receive Authorization from plan prior to utilization of non-emergency ambulance services. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
You pay nothing. 12 one-way trips each year to plan approved locations. To arrange transportation, please contact the plan 3 business days in advance to allow for proper scheduling.	In-network: You pay nothing. 12 one-way trips each year to plan approved locations. To arrange transportation, please contact the plan 3 business days in advance to allow for proper scheduling. Out-of-network: Routine transportation is not covered out-of-network
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay $30 co-pay.	In-network: You pay nothing. Out-of-network*: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Medical Equipment/Supplies[1]	You pay 20% of the cost for each durable medical equipment or supply.
Wellness Programs[1, 2]	**Enhanced Disease Management** You pay nothing for enhanced disease management. Members participating in these programs are assigned to a qualified clinician with specialized knowledge of their disease(s) who routinely monitor the members' health status and program participation. Covered services include: • Diabetes Prevention Program- Evidence-based and adapted from the Centers for Disease Control, this program has shown success in helping people avoid or delay type 2 diabetes. Group sessions are held for 16 weeks, followed by 8 monthly meetings. Lifestyle coaching for healthy eating, exercise, and weight loss is included and goals are pursued safely and gradually. • Life Connections- For people who have been diagnosed with hypertension, hypercholesterolemia, diabetes, and/or coronary artery disease. This program includes specific classes focused on improving the person's condition, one-on-one health coaching with a registered dietician or nurse and regular reports to doctors to ensure proper care is provided.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay 15% of the cost for each durable medical equipment or supply.	In-network: You pay nothing. Out-of-network*: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Enhanced Disease Management You pay nothing for enhanced disease management. Members participating in these programs are assigned to a qualified clinician with specialized knowledge of their disease(s) who routinely monitor the members' health status and program participation. Covered services include: • Diabetes Prevention Program- Evidence-based and adapted from the Centers for Disease Control, this program has shown success in helping people avoid or delay type 2 diabetes. Group sessions are held for 16 weeks, followed by 8 monthly meetings. Lifestyle coaching for healthy eating, exercise, and weight loss is included and goals are pursued safely and gradually. • Life Connections- For people who have been diagnosed with hypertension, hypercholesterolemia, diabetes, and/or coronary artery disease. This program includes specific classes focused on improving the person's condition, one-on-one health coaching with a registered dietician or nurse and regular reports to doctors to ensure proper care is provided.	**Enhanced Disease Management** In-network: You pay nothing for enhanced disease management. Members participating in these programs are assigned to a qualified clinician with specialized knowledge of their disease(s) who routinely monitor the members' health status and program participation. Covered services include: • Diabetes Prevention Program- Evidence-based and adapted from the Centers for Disease Control, this program has shown success in helping people avoid or delay type 2 diabetes. Group sessions are held for 16 weeks, followed by 8 monthly meetings. Lifestyle coaching for healthy eating, exercise, and weight loss is included and goals are pursued safely and gradually. • Life Connections- For people who have been diagnosed with hypertension, hypercholesterolemia, diabetes, and/or coronary artery disease. This program includes specific classes focused on improving the person's condition, one-on-one health coaching with a registered dietician or nurse and regular reports to doctors to ensure proper care is provided. Out-of-network: Enhanced disease management program benefits are not covered out-of-network.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Medicare Part B Drugs[1]	You pay 20% of the cost for Medicare-covered Part B prescription drugs. You pay $45 co-pay for each Medicare-covered outpatient chemotherapy treatment, per day.
OUTPATIENT PRESCRIPTION DRUGS	
Prescription Drug Benefits[1]	**Initial Coverage** You pay the full cost of drugs on tiers 2, 3, 4, and 5 until the yearly deductible of $360 is met. Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

STANDARD RETAIL COST-SHARING

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$4 co-pay	$8 co-pay
Tier 2 (Generic)	$15 co-pay	$30 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$94 co-pay
Tier 4 (Non-Preferred Brand)	$100 co-pay	$200 co-pay
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay 20% of the cost for Medicare-covered Part B prescription drugs. You pay $45 co-pay for each Medicare-covered outpatient chemotherapy treatment, per day.	In-network: You pay nothing. Out-of-network*: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

Initial Coverage You pay the full cost of drugs on tiers 3, 4, and 5 until the yearly deductible of $150 is met. Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.	**Initial Coverage** This plan does not have a yearly deductible. Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

STANDARD RETAIL COST-SHARING

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 co-pay	$4 co-pay
Tier 2 (Generic)	$8 co-pay	$16 co-pay
Tier 3 (Preferred Brand)	$45 co-pay	$90 co-pay
Tier 4 (Non-Preferred Brand)	$100 co-pay	$200 co-pay
Tier 5 (Specialty Tier)	30% of the cost	30% of the cost

STANDARD RETAIL COST-SHARING

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 co-pay	$4 co-pay
Tier 2 (Generic)	$8 co-pay	$16 co-pay
Tier 3 (Preferred Brand)	$45 co-pay	$90 co-pay
Tier 4 (Non-Preferred Brand)	$100 co-pay	$200 co-pay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
OUTPATIENT PRESCRIPTION DRUGS (continued)	
Prescription Drug Benefits[1] (continued)	STANDARD MAIL ORDER COST-SHARING **Tier** / **Three-month supply** Tier 1 (Preferred Generic) — $8 co-pay Tier 2 (Generic) — $30 co-pay Tier 3 (Preferred Brand) — $94 co-pay Tier 4 (Non-Preferred Brand) — $200 co-pay Tier 5 (Specialty Tier) — 25% of the cost
ADDITIONAL MEDICAL BENEFITS	
Acupuncture and Other Alternative Therapies	Not covered.
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay $10 co-pay. Routine chiropractic care: Not covered.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
STANDARD MAIL ORDER COST-SHARING	STANDARD MAIL ORDER COST-SHARING
Tier / **Three-month supply**	**Tier** / **Three-month supply**
Tier 1 (Preferred Generic) $4 co-pay	Tier 1 (Preferred Generic) $4 co-pay
Tier 2 (Generic) $16 co-pay	Tier 2 (Generic) $16 co-pay
Tier 3 (Preferred Brand) $90 co-pay	Tier 3 (Preferred Brand) $90 co-pay
Tier 4 (Non-Preferred Brand) $200 co-pay	Tier 4 (Non-Preferred Brand) $200 co-pay
Tier 5 (Specialty Tier) 30% of the cost	Tier 5 (Specialty Tier) 33% of the cost
You pay $10 per visit (for up to 6 visits every year).	In-network: You pay nothing per visit (for up to 6 visits every year. Out-of-network*: Not covered
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay $10 co-pay. Routine chiropractic visit (for up to 6 visits every year): You pay $10 co-pay.	In-network: Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing. Routine chiropractic visit (for up to 12 visits every year): You pay nothing. Out-of-network*: Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California. Routine chiropractic care is not covered out of network.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Diabetes Supplies and Services	Diabetes monitoring supplies: You pay nothing. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: You pay nothing.
Home Health Care[1]	You pay nothing. Our plan covers the costs of Medicare-covered home health services.
Outpatient Substance Abuse[1]	Group therapy visit: You pay $35 co-pay. Individual therapy visit: You pay $35 co-pay.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
Diabetes monitoring supplies: You pay nothing. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: You pay nothing.	In-network: You pay nothing for diabetes monitoring supplies, diabetes self-management training, therapeutic shoes and inserts. Out-of-network*: You pay nothing for diabetes monitoring supplies, diabetes self-management training, therapeutic shoes and inserts. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
You pay nothing. Our plan covers the costs of Medicare-covered home health services.	In-network: You pay nothing. Out-of-network: You pay nothing. Our plan covers the costs of Medicare-covered home health services. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Group therapy visit: You pay $30 co-pay. Individual therapy visit: You pay $30 co-pay.	In-network: Group therapy visit: You pay nothing. Individual therapy visit: You pay nothing. Out-of-network*: Group therapy visit: You pay nothing. Individual therapy visit: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Outpatient Surgery[1]	Ambulatory surgical center: You pay $300 co-pay. Outpatient hospital: You pay $0-300 co-pay or 0-20% of the cost, depending on the service. Outpatient Hospital Services including Outpatient Surgery: You pay $300. Chemotherapy infusion visit: You pay $45 co-pay per treatment, per day. Outpatient IV Therapy and transfusion services: 20% co-insurance. Diagnostic colonoscopy and endoscopy surgical procedures: You pay $35 co-pay per procedure. Other Outpatient Hospital Services: 20% co-insurance. Part B drug co-insurance will apply for medications administered.
Prosthetic Devices (braces, artificial limbs, etc.)[1]	Prosthetic devices: You pay 20% of the cost. Related medical supplies: You pay 20% of the cost.
Renal Dialysis[1]	You pay nothing.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
Ambulatory surgical center: You pay $275 co-pay. Outpatient hospital: You pay $0-275 co-pay or 0-20% of the cost, depending on the service. Outpatient Hospital Services including Outpatient Surgery: You pay $275. Chemotherapy infusion visit: You pay $45 co-pay per treatment, per day. Outpatient IV Therapy and transfusion services: 20% co-insurance. Diagnostic colonoscopy and endoscopy surgical procedures: You pay $30 co-pay per procedure. Other Outpatient Hospital Services: 20% co-insurance. Part B drug co-insurance will apply for medications administered.	In-network: You pay nothing for ambulatory surgical center services, outpatient hospital services including outpatient surgery, outpatient IV therapy, chemotherapy infusion and transfusion services. Out-of-network*: You pay nothing for ambulatory surgical center services, outpatient hospital services including outpatient surgery, outpatient IV therapy, chemotherapy infusion and transfusion services. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
Prosthetic devices: You pay 20% of the cost. Related medical supplies: You pay 15% of the cost.	In-network: You pay nothing. Out-of-network: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.
You pay nothing.	In-network: You pay nothing. Out-of-network*: You pay nothing. *Out-of-network coverage is restricted to Medicare-participating practitioners and Medicare-covered services accessed outside of the plan's service area of Monterey County, California.

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
OPTIONAL ENHANCED HEALTH BENEFITS (you must pay an extra premium each month for these benefits)	
How much is the monthly premium?	Additional $33.00 per month. You must keep paying your Medicare Part B premium and your $36.00 monthly plan premium.
Dental Benefits	You pay nothing for covered preventive dental services. You pay 20% co-insurance for each dental visit for comprehensive dental services except for oral/maxillofacial surgery. You pay 50% co-insurance for oral/maxillofacial surgery. Our plan pays up to $1,000 every year. Preventive: • Up to 1 oral exam every six months • Up to 1 cleaning every six months • Up to 1 full mouth panoramic series X-ray once every 12 months and up to 1 bite wing series every 12 months Comprehensive: • Restorative services – 1 visit every 36 months • Prosthodontics, other oral/maxillofacial surgery – up to 2 visits every 24 months • Endodontics/periodontics/extractions – 1 visit every 24 months

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Additional $29.00 per month. You must keep paying your Medicare Part B premium and your $95.00 monthly plan premium.	Additional $29.00 per month. You must keep paying your Medicare Part B premium and your $239.00 monthly plan premium.
You pay 20% co-insurance for each dental visit for comprehensive dental services except for oral/maxillofacial surgery. You pay 50% co-insurance for oral/maxillofacial surgery. Our plan pays up to $1,000 every year. • Restorative services – 1 visit every 36 months • Prosthodontics, other oral/maxillofacial surgery up to 2 visits every 24 months • Endodontics/periodontics/extractions – 1 visit every 24 months	You pay 20% co-insurance for each dental visit for comprehensive dental services except for oral/maxillofacial surgery. You pay 50% co-insurance for oral/maxillofacial surgery. Our plan pays up to $1,000 every year. • Restorative services – 1 visit every 36 months • Prosthodontics, other oral/maxillofacial surgery – up to 2 visits every 24 months • Endodontics/periodontics/extractions – 1 visit every 24 months

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Eyewear Benefit	You pay $10 co-pay for each routine eye exam. You pay one $25 co-pay for eyewear materials: (frames, lenses, or contacts). • One routine eye exam every 12 months from the last date of service. Coverage limit is $460 in vision benefits every 12 months • One pair of corrective lenses every 12 months • One frame every 12 months up to a retail cost of $150 total • Contact lens allowance of $150 total in lieu of frames and lenses • $120 allowance for progressive lenses • $85 allowance for polycarbonate lenses • $70 allowance for photochromic lenses • $35 allowance for anti-reflective coating • Maximum plan benefit coverage amount is per 12 months from last date of service
Hearing exam & hearing aid benefit:	You pay $20 co-pay for exam. You pay $599 co-pay for each 700 hearing aid. You pay $899 co-pay for each 900 hearing. • Routine hearing exam once per year • Up to 2 TruHearing flyte hearing aids per year, one per ear • TruHearing Flyte 700 • TruHearing Flyte 900

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)
You pay one $25 co-pay for eyewear materials: (frames, lenses, or contacts). • Additional $188 in vision benefits every 12 months. • Additional $50 allowance toward frames • Additional $33 allowance toward progressive lens coverage • $70 allowance for photochromic lenses • $35 allowance for anti-reflective coating • Maximum plan benefit coverage amount is per 12 months from last date of service	You pay one $25 co-pay for eyewear materials: (frames, lenses, or contacts). • Additional $188 in vision benefits every 12 months. • Additional $50 allowance toward frames • Additional $33 allowance toward progressive lens coverage • $70 allowance for photochromic lenses • $35 allowance for anti-reflective coating • Maximum plan benefit coverage amount is per 12 months from last date of service
You pay $20 co-pay for exam. You pay $599 co-pay for each 700 hearing aid. You pay $899 co-pay for each 900 hearing. • Routine hearing exam once per year • Up to 2 TruHearing flyte hearing aids per year, one per ear • TruHearing Flyte 700 • TruHearing Flyte 900	You pay $20 co-pay for exam. You pay $599 co-pay for each 700 hearing aid. You pay $899 co-pay for each 900 hearing. • Routine hearing exam once per year • Up to 2 TruHearing flyte hearing aids per year, one per ear • TruHearing Flyte 700 • TruHearing Flyte 900

The benefit information provided is a summary of what we cover and what you pay. It 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." You can see the Evidence of Coverage at our website at ***www.aspirehealthplan.org***

To join Aspire Health Plan (HMO), 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: Monterey.

Aspire Health Plan (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

Limitations, co-payments and restrictions may apply. Benefits, premium deductibles and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium.

This information is available for free in other language. Please call our customer service number toll free at (855) 570-1600 (TTY users call 711). We are open 8 a.m.—8 p.m. PST Monday through Friday (except certain holidays) from February 15 through September 30 and 8 a.m.—8 p.m. PST seven days a week from October 1 through February 14.

Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de atención al cliente en (855) 570-1600 or Usuarios de TTY deben llamar al 711. Estamos abiertas de 8 a.m.—8 p.m. PST de lunes a viernes (excepto ciertos días festivos) del 15 de febrero al 30 de septiembre y las 8 a.m.—8 p.m. PST siete días a la semana para el período del 1 de octubre al 14 de febrero.

ASPIREHEALTHPLAN

Your Medicare Advantage.
One plan, exceptional service, great value.

For more information, please call us at the phone number below or visit us at ***www.aspirehealthplan.org****.*

Toll-free: 855-570-1600, TTY users should call 711.

From October 1 to February 14, you can call us 7 days a week from 8 a.m.—8 p.m. PST.

From February 15 to September 30, you can call us Monday through Friday from 8 a.m.—8 p.m. PST.

You can see our plan's Provider & Pharmacy Directory at our website at ***www.aspirehealthplan.org****.*

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at ***www.aspirehealthplan.org****.*

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at ***http://www.medicare.gov*** *or get a copy 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.*

This document is available in other formats such as large print.

10 Ragsdale Drive, Suite 101 | Monterey, CA 93940

Aspire Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aspire Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aspire Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:

    ○ Qualified sign language interpreters
    ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:

    ○ Qualified interpreters
    ○ Information written in other languages

If you need these services, contact Aspire Health Plan Grievance Coordinator.

If you believe that Aspire Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance Coordinator, Aspire Health Plan, 10 Ragsdale Dr. Suite 101, Monterey, CA 93940, phone: (855) 570-1600, TTY: 711, fax: (831) 657-0703, email: compliance@aspirehealthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Aspire Health Plan Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ASPIREHEALTHPLAN

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. **Call 1-855-570-1600 (TTY: 711).**

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-570-1600 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-570-1600 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-570-1600 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-570-1600 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-570-1600 (TTY: 711) 번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-570-1600 (TTY (հեռատիպ)՝ 711):

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما رایگان برای 1-855-570-1600 (TTY: 711) تماس بگیرید.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-570-1600 (телетайп: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-855-570-1600（TTY:711）まで、お電話にてご連絡ください。

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 558 075 0061.

(رقم هاتف الصم والبكم : (TTY:117).

Panjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-570-1600 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khner, Cambodia

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-570-1600 (TTY: 711)។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-570-1600 (TTY: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-570-1600 (TTY: 711) पर कॉल करें।

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-570-1600 (TTY: 711).