

# Enhanced Health Benefit



# 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 Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

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.

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

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)。

## Add to your healthcare coverage with an Enhanced Health Benefits package.

Aspire Health Plan provides comprehensive medical and pharmacy benefits, including preventive care and screenings for all our Medicare Advantage plans. But if you're looking for the advantage of enhanced dental, vision, and hearing coverage to add to your Aspire Health Plan, consider our Enhanced Health Benefits package.

Enhanced Health Benefits:		Aspire Health Advantage Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Advantage Plus (HMO-POS)
Additional Monthly Premium		\$33	\$29	\$29
Comprehensive Dental	Deductible	\$0	\$0	\$0
	Coverage	Up to \$1000/yr	Up to \$1000/yr	Up to \$1000/yr
	Crowns	20% coinsurance	20% coinsurance	20% coinsurance
	Maxillofacial, Periodontal	50% coinsurance	50% coinsurance	50% coinsurance
Comprehensive Vision	Deductible	\$0	\$0	\$0
	Coverage	Up to \$460 in eyewear materials every 12 months	An additional \$188 in eyewear materials every 12 months	An additional \$188 in eyewear materials every 12 months
	Routine Eye Exams	\$10 copay	\$10 copay	\$10 copay
	Eyewear Materials (frames, lenses or contacts)	\$25 copay	\$25 copay	\$25 copay
Comprehensive Hearing	Deductible	\$0	\$0	\$0
	Routine Hearing Exam	\$20 copay	\$20 copay	\$20 copay
	Hearing Aid	\$599 or \$899 copay	\$599 or \$899 copay	\$599 or \$899 copay
	Hearing Aid Provider Visits	3 (Enrollment year 1)	3 (Enrollment year 1)	3 (Enrollment year 1)
	Trial Periods	45 days	45 days	45 days
	Batteries	48/hearing aid	48/hearing aid	48/hearing aid
	Extended Warranty	3 years	3 years	3 years

# Enhanced Health Summary of Benefits

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
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	<p>You pay nothing for covered preventive dental services.</p> <p>You pay 20% co-insurance for each dental visit for comprehensive dental services except for oral/maxillofacial surgery.</p> <p>You pay 50% co-insurance for oral/maxillofacial surgery.</p> <p>Our plan pays up to \$1,000 every year.</p> <p>Preventive:</p> <ul style="list-style-type: none"> <li>• Up to 1 oral exam every six months</li> <li>• Up to 1 cleaning every six months</li> <li>• Up to 1 full mouth panoramic series X-ray once every 12 months and up to 1 bite wing series every 12 months</li> </ul> <p>Comprehensive:</p> <ul style="list-style-type: none"> <li>• Restorative services – 1 visit every 36 months</li> <li>• Prosthodontics, other oral/maxillofacial surgery — up to 2 visits every 24 months</li> <li>• Endodontics/periodontics/extractions — 1 visit every 24 months</li> </ul>



<b>ASPIRE HEALTH ADVANTAGE (HMO)</b>	<b>ASPIRE HEALTH ADVANTAGE PLUS (HMO-POS)</b>
<p>Additional \$29.00 per month. You must keep paying your Medicare Part B premium and your \$95.00 monthly plan premium.</p>	<p>Additional \$29.00 per month. You must keep paying your Medicare Part B premium and your \$239.00 monthly plan premium.</p>
<p>You pay 20% co-insurance for each dental visit for comprehensive dental services except for oral/maxillofacial surgery.</p> <p>You pay 50% co-insurance for oral/maxillofacial surgery.</p> <p>Our plan pays up to \$1,000 every year.</p> <ul style="list-style-type: none"><li>• Restorative services – 1 visit every 36 months</li><li>• Prosthodontics, other oral/maxillofacial surgery — up to 2 visits every 24 months</li><li>• Endodontics/periodontics/extractions — 1 visit every 24 months</li></ul>	<p>You pay 20% co-insurance for each dental visit for comprehensive dental services except for oral/maxillofacial surgery.</p> <p>You pay 50% co-insurance for oral/maxillofacial surgery.</p> <p>Our plan pays up to \$1,000 every year.</p> <ul style="list-style-type: none"><li>• Restorative services – 1 visit every 36 months</li><li>• Prosthodontics, other oral/maxillofacial surgery — up to 2 visits every 24 months</li><li>• Endodontics/periodontics/extractions — 1 visit every 24 months</li></ul>

# Enhanced Health Summary of Benefits

BENEFIT	ASPIRE HEALTH ADVANTAGE VALUE (HMO)
Eyewear Benefit	<p>You pay \$10 co-pay for each routine eye exam.</p> <p>You pay one \$25 co-pay for eyewear materials: (frames, lenses, or contacts).</p> <ul style="list-style-type: none"> <li>• One routine eye exam every 12 months from the last date of service. Coverage limit is \$460 in vision benefits every 12 months</li> <li>• One pair of corrective lenses every 12 months</li> <li>• One frame every 12 months up to a retail cost of \$150 total</li> <li>• Contact lens allowance of \$150 total in lieu of frames and lenses</li> <li>• \$120 allowance for progressive lenses</li> <li>• \$85 allowance for polycarbonate lenses</li> <li>• \$70 allowance for photochromic lenses</li> <li>• \$35 allowance for anti-reflective coating</li> <li>• Maximum plan benefit coverage amount is per 12 months from last date of service</li> </ul>
Hearing exam & hearing aid benefit:	<p>You pay \$20 co-pay for exam.</p> <p>You pay \$599 co-pay for each 700 hearing aid.</p> <p>You pay \$899 co-pay for each 900 hearing aid.</p> <ul style="list-style-type: none"> <li>• Routine hearing exam once per year</li> <li>• Up to 2 TruHearing flyte hearing aids per year, one per ear</li> <li>• TruHearing Flyte 700</li> <li>• TruHearing Flyte 900</li> </ul>

## ASPIRE HEALTH ADVANTAGE (HMO)

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

## 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 \$20 co-pay for exam.

You pay \$599 co-pay for each 700 hearing aid.

You pay \$899 co-pay for each 900 hearing aid.

- 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 aid.

- Routine hearing exam once per year
- Up to 2 TruHearing flyte hearing aids per year, one per ear
- TruHearing Flyte 700
- TruHearing Flyte 900

# Dental Benefit Overview

The following is a complete list of dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered. This Plan does not allow alternate benefits. ***If elected, Member is responsible for all non-covered procedures.***

**\$1,000** Calendar Year Maximum

Code	Description	In Network Member Responsibility	Out Network Member Responsibility	Limitations
<b>Diagnostic</b>				
D0120	Periodic oral evaluation	0%	30%	2 exams per calendar year
D0140	Limited oral evaluation	0%	30%	
D0150	Comprehensive oral evaluation	0%	30%	
D0171	Re-evaluation, post operative office visit	0%	30%	
D0180	Comprehensive periodontal evaluation	0%	30%	
D0210	Intraoral, complete series of radiographic images	0%	30%	1 FMX or Panoramic image per calendar year
D0270	Bitewing, single radiographic image	0%	30%	1 series of Bitewing images per calendar year
D0272	Bitewings, two radiographic images	0%	30%	
D0274	Bitewings, four radiographic images	0%	30%	
D0330	Panoramic image	0%	30%	1 FMX or Panoramic image per calendar year
<b>Preventive</b>				
D1110	Prophylaxis, adult	0%	30%	2 Cleanings per calendar year
<b>Restorative</b>				
D2140	Amalgam, 1 surface	20%	60%	Once every 3 calendar years per tooth
D2150	Amalgam, 2 surfaces	20%	60%	
D2160	Amalgam, 3 surfaces	20%	60%	
D2161	Amalgam, 4 or more surfaces	20%	60%	
D2330	Resin-based composite, 1 surface, anterior	20%	60%	
D2331	Resin-based composite, 2 surfaces, anterior	20%	60%	
D2332	Resin-based composite, 3 surfaces, anterior	20%	60%	
D2335	Resin-based composite, 4+ surfaces, anterior	20%	60%	
D2390	Resin-based composite, anterior	20%	60%	
D2391	Resin-based composite, 1 surface, posterior	20%	60%	
D2392	Resin-based composite, 2 surfaces, posterior	20%	60%	
D2393	Resin-based composite, 3 surfaces, posterior	20%	60%	
D2394	Resin-based composite, 4+ surfaces, posterior	20%	60%	

Code	Description	In Network Member Responsibility	Out Network Member Responsibility	Limitations	
<b>Restorative (continued)</b>					
D2740	Crown, porcelain/ceramic substrate	20%	75%		
D2751	Crown, porcelain fused to predominantly base metal	20%	75%		
D2752	Crown, porcelain fused to noble metal	20%	75%		
D2791	Crown, full cast predominantly base metal	20%	75%		
D2792	Crown, full cast noble metal	20%	75%		
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	20%	75%		
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post and core	20%	75%		
D2920	Re-cement or re-bond crown	20%	75%		
D2951	Pin retention, per tooth, in addition to restoration	20%	75%		Once every 5 calendar years per tooth
D2952	Post and core in addition to crown, indirectly fabricated	20%	75%		
D2954	Prefabricated post and core in addition to crown	20%	75%		
<b>Endodontic</b>					
D3110	Pulp cap, direct	20%	75%		
D3120	Pulp cap, indirect	20%	75%		
D3220	Therapeutic pulpotomy	20%	75%		
D3221	Pulpal debridement	20%	75%		
D3310	Root canal, anterior	20%	75%		
D3320	Root canal, bicuspid	20%	75%		
D3330	Root canal, molar	20%	75%		
D3346	Retreatment of previous root canal therapy, anterior	20%	75%		
D3347	Retreatment of previous root canal therapy, bicuspid	20%	75%		
D3348	Retreatment of previous root canal therapy, molar	20%	75%		
D3351	Apexification/recalcification, initial visit	20%	75%		
D3352	Apexification/recalcification, interim	20%	75%		
D3353	Apexification/recalcification, final visit	20%	75%		
D3410	Apicoectomy, anterior	20%	75%		
D3421	Apicoectomy, bicuspid (first root)	20%	75%		



# Dental Benefit Overview

Code	Description	In Network Member Responsibility	Out Network Member Responsibility	Limitations
<b>Endodontic (continued)</b>				
D3425	Apicoectomy, molar (first root)	20%	75%	
D3430	Retrograde filling, per root	20%	75%	
D3450	Root Amputation, per root	20%	75%	
D3920	Hemisection	20%	75%	
<b>Periodontal</b>				
D4210	Gingivectomy/gingivoplasty, 4+ teeth per quad	20%	75%	Once every 2 calendar years per quadrant
D4211	Gingivectomy/gingivoplasty, 1-3 teeth per quad	20%	75%	
D4240	Gingival flap procedure, 4+ teeth per quad	20%	75%	
D4241	Gingival flap procedure, 1-3 teeth per quad	20%	75%	
D4260	Osseous surgery, 4+ teeth per quad	20%	75%	Once every 3 calendar years per quadrant
D4261	Osseous surgery, 1-3 teeth per quad	20%	75%	
D4270	Pedicle soft tissue graft procedure	20%	75%	Once every 2 calendar years per tooth
D4341	Periodontal scaling & root planing, 4+ teeth per quad	20%	75%	Once every 2 calendar years per quadrant
D4342	Periodontal scaling & root planing, 1-3 teeth per quad	20%	75%	
D4355	Full mouth debridement	20%	75%	Once every 3 calendar years
D4910	Periodontal maintenance	20%	75%	2 of (D1110, D4910) per calendar year
<b>Oral and Maxillofacial Services</b>				
D7111	Extraction, coronal remnants, deciduous tooth	50%	75%	
D7140	Extraction, erupted tooth or exposed root	50%	75%	
D7210	Surgical removal of erupted tooth	50%	75%	
D7220	Removal of impacted tooth, soft tissue	50%	75%	
D7230	Removal of impacted tooth, partially bony	50%	75%	
D7240	Removal of impacted tooth, completely bony	50%	75%	
D7241	Removal of impacted tooth, completely bony, complication	50%	75%	
D7250	Surgical removal of residual tooth roots	50%	75%	



# ASPIREHEALTHPLAN

**Your Medicare Advantage.**

One plan, exceptional service, great value.

*This information is not a complete description of benefits. Contact the plan for more information.*

*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 Part B premium.*

*This information is available for free in other languages.*

*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.*