2018
Enhanced Health Benefit

Aspire Health Value (HMO) | Aspire Health Advantage (HMO) | Aspire Health Plus (HMO-POS)

ASPIRE HEALTH PLAN

Your Medicare Advantage.
All-in-one plans. Exceptional service. Great value.

In collaboration with

Community Hospital of the Monterey Peninsula
Montage Health

Salinas Valley Memorial Healthcare System

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 Value (HMO)**	**Aspire Health Advantage (HMO)**	**Aspire Health Plus (HMO-POS)**
Additional Monthly Premium		$35	$31	$31
Comprehensive Dental	Deductible	$0	$0	$0
	Coverage	Up to $1000/yr	Up to $1000/yr	Up to $1000/yr
	Crowns	20% co-insurance	20% co-insurance	20% co-insurance
	Maxillofacial, Periodontal	50% co-insurance	50% co-insurance	50% co-insurance
Comprehensive Vision	Deductible	$0	$0	$0
	Coverage	Up to $460 in eyewear materials every 12 months	An additional $188 (up to $460 total) in eyewear materials every 12 months	An additional $188 (up to $460 total) in eyewear materials every 12 months
	Routine Eye Exams	$10 copay	$10 copay	$0
	Eyewear Materials (frames, lenses or contacts)	$25 copay	$25 copay	$0
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 VALUE (HMO)
How much is the monthly premium?	Additional $35.00 per month. You must keep paying your Medicare Part B premium and your $35.50 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 PLUS (HMO-POS)
Additional $31.00 per month. You must keep paying your Medicare Part B premium and your $129.00 monthly plan premium.	Additional $31.00 per month. You must keep paying your Medicare Part B premium and your $247.00 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

Enhanced Health Summary of Benefits

BENEFIT	ASPIRE HEALTH 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 TruHearing Advanced hearing aid. You pay $899 co-pay for each TruHearing Premium hearing aid. • Routine hearing exam once per year • Up to 2 TruHearing flyte hearing aids per year, one per ear You must see a TruHearing provider to use this benefit. Call (844) 208-2631 to schedule an appointment.

ASPIRE HEALTH ADVANTAGE (HMO)	ASPIRE HEALTH PLUS (HMO-POS)
You pay one $25 co-pay for eyewear materials: (frames, lenses, or contacts). • Additional $188 in vision benefits every 12 months (for up to $460 total). • 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 nothing for eyewear materials: (frames, lenses, or contacts). • Additional $188 in vision benefits every 12 months (for up to $460 total). • 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 TruHearing Advanced hearing aid. You pay $899 co-pay for each TruHearing Premium hearing aid. • Routine hearing exam once per year • Up to 2 TruHearing flyte hearing aids per year, one per ear You must see a TruHearing provider to use this benefit. Call (844) 208-2631 to schedule an appointment.	You pay $20 co-pay for exam. You pay $599 co-pay for each TruHearing Advanced hearing aid. You pay $899 co-pay for each TruHearing Premium hearing aid. • Routine hearing exam once per year • Up to 2 TruHearing flyte hearing aids per year, one per ear You must see a TruHearing provider to use this benefit. Call (844) 208-2631 to schedule an appointment.

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.

Code	Description	In Network Member Responsibility	Out of Network Member Responsibility	Limitations
Diagnostic				
D0120	Periodic oral evaluation, established patient	0%	30%	2 exams per calendar year
D0140	Limited oral evaluation, problem focused	0%	30%	
D0150	Comprehensive oral evaluation, new or established patient	0%	30%	
D0160	Oral evaluation, problem focused	0%	30%	
D0170	Re-evaluation, limited, problem focused	0%	30%	
D0171	Re-evaluation, post operative office visit	0%	30%	
D0180	Comprehensive periodontal evaluation, new or established	0%	30%	
D0210	Full mouth radiographic image	0%	30%	1 FMX or Panoramic image per calendar year
D0220	Periapical, first radiographic image	0%	30%	
D0230	Periapical, each additional radiographic image	0%	30%	
D0270	Bitewing, single radiographic image	0%	30%	1 series of Bitewing images per calendar year
D0272	Bitewings, two radiographic images	0%	30%	
D0273	Bitewings, three radiographic images	0%	30%	
D0274	Bitewings, four radiographic images	0%	30%	
D0330	Panoramic image	0%	30%	1 FMX or Panoramic image per calendar year
Preventive				
D1110	Prophylaxis, adult	0%	30%	2 Cleanings per calendar year
D1208	Topical applicaiton of fluoride	0%	30%	1 per calendar year
Restorative				
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%	

Code	Description	In Network Member Responsibility	Out of Network Member Responsibility	Limitations
Restorative (continued)				
D2332	Resin-based composite, 3 surfaces, anterior	20%	60%	Once every 3 calendar years per tooth
D2335	Resin-based composite, 4+ surfaces, anterior	20%	60%	
D2390	Comp Resin Crown, 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%	
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%	
Endodontic				
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%	

Dental Benefit Overview

Code	Description	In Network Member Responsibility	Out of Network Member Responsibility	Limitations
Endodontic (continued)				
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%	
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%	
Periodontal				
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 per calendar year (replaces D1110)

Code	Description	In Network Member Responsibility	Out of Network Member Responsibility	Limitations
Oral and Maxillofacial Services				
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%	

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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 is a summary of drug and health services covered by Aspire Health Plan (HMO) January 1, 2018 — December 31, 2018. Aspire Health Plan is Medicare Advantage HMO plan sponsor 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) Other Physicians are available in our network.

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Member Services (855) 570-1600 (TTY:711)
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