

# 2019 PLAN OPTIONS



In collaboration with



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

BENEFIT	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)	
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
<b>Monthly plan premium</b>	\$34.80	\$129	\$249	
<b>Out-of-pocket limit</b> (in-network Medicare-covered benefits)	\$6,700 in-network	\$5,000 in-network	\$0	
<b>Annual Part C deductible</b> (all services except for prescription drugs)	\$0	\$0	\$0	
<b>DOCTOR OFFICE VISITS</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT OF SERVICE AREA</b>
<b>Primary care physician (PCP)</b>	\$12 co-pay	\$6 co-pay	\$0	\$0
<b>Specialty care physician</b>	\$35 co-pay	\$16 co-pay	\$0	\$0
<b>INPATIENT CARE</b>				
<b>Inpatient hospital (acute)</b>				
Days 1-6:	\$300 co-pay per day	\$250 co-pay per day	\$0	\$0
Days 7-90:	\$0 per day	\$0 per day	\$0	\$0
<b>Inpatient mental health care</b>				
Days 1-5:	\$300 co-pay per day	\$250 co-pay per day	\$0	\$0
Days 6-90:	\$0 per day	\$0 per day	\$0	\$0
<b>Skilled Nursing Facility (SNF)</b>				
Days 1-20:	\$0 per day	\$0 per day	\$0	\$0
Days 21-100:	\$165 co-pay per day	\$100 co-pay per day	\$0	\$0
<b>OUTPATIENT CARE</b>				
<b>Outpatient hospital surgery/ Ambulatory Surgical Center (ASC) services</b>	\$300 co-pay	\$275 co-pay	\$0	\$0
<b>Home health services</b> (must meet medical necessity criteria)	\$0	\$0	\$0	\$0
<b>Outpatient mental health (individual/group)</b>	\$35 co-pay	\$16 co-pay	\$0	\$0
<b>Outpatient substance abuse (individual/group)</b>	\$35 co-pay	\$16 co-pay	\$0	\$0
<b>EMERGENCY SERVICES</b>				
<b>Urgently needed care</b> (waived if admitted within 24 hours)	\$45 co-pay	\$40 co-pay	\$0	\$0
<b>Emergency care</b> (waived if admitted within 24 hours)	\$90 co-pay	\$90 co-pay	\$0	\$0
<b>Ambulance services</b> (when medically necessary, waived if admitted within 24 hours)	\$275 co-pay	\$250 co-pay	\$0	\$0
<b>LAB SERVICES AND DIAGNOSTIC TESTS</b>				
<b>Diagnostic tests and procedures</b>	\$20 co-pay	\$10 co-pay	\$0	\$0
<b>Lab services</b>	\$20 co-pay	\$10 co-pay	\$0	\$0
<b>X-rays</b>	\$20 co-pay	\$10 co-pay	\$0	\$0
<b>Diagnostic radiology</b>	\$60-\$190 co-pay	\$30-\$100 co-pay	\$0	\$0
<b>Therapeutic radiology</b>	\$60 co-pay	\$30 co-pay	\$0	\$0
<b>MEDICAL EQUIPMENT &amp; SUPPLIES</b>				
<b>Durable Medical Equipment (DME)</b>	20% co-insurance	20% co-insurance	\$0	\$0
<b>Prosthetic devices</b>	20% co-insurance	20% co-insurance	\$0	\$0
<b>Diabetes — monitoring, supplies and therapeutic shoes</b>	\$0	\$0	\$0	\$0
<b>REHABILITATION SERVICES</b>				
<b>Speech, physical, occupational, cardiac, pulmonary therapy</b>	\$25 co-pay	\$15 co-pay	\$0	\$0
<b>PART B DRUGS</b>				
<b>Chemotherapy</b>	\$75 co-pay	\$65 co-pay	\$0	\$0
<b>All other</b>	20% co-insurance	20% co-insurance	\$0	\$0
<b>WELLNESS EXAMS &amp; SCREENINGS</b>				
<b>Medicare covered preventive services</b>	\$0	\$0	\$0	\$0
<b>Bone mass measurement</b> (1 bone mass measurement every 2 years)	\$0	\$0	\$0	\$0
<b>Influenza vaccine</b> (1 per year)	\$0	\$0	\$0	\$0
<b>Mammogram</b> (1 per year)	\$0	\$0	\$0	\$0
<b>VISION</b>				
<b>Diagnostic Screenings</b> (Medicare-covered benefits)	\$35 co-pay	\$16 co-pay	\$0	\$0

For more information, please call Aspire Health Plan  
Toll Free: **(866) 798-9356**  
TTY users: 711

Open 8 a.m.–8 p.m. PT  
7 days a week | October 1–March 31  
Monday through Friday | April 1–September 30 (except certain holidays)

	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)	
ADDITIONAL BENEFITS	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT OF SERVICE AREA
<b>HEARING</b>				
<b>Diagnostic hearing exams</b> (Medicare-covered benefits)	\$35 co-pay	\$16 co-pay	\$0	\$0
<b>CHIROPRACTIC SERVICES</b>				
<b>Manipulation of spine to correct subluxation</b> (Medicare-covered benefits)	\$10 co-pay	\$10 co-pay	\$0	\$0
<b>Routine care</b> (limited to specific treatment codes)	\$10 co-pay	\$10 co-pay	\$0	Not covered
<b>Covered visits per year</b>	6 visits	6 visits	12 visits	Not covered
<b>ACUPUNCTURE</b>				
<b>Routine care</b>	\$10 co-pay	\$10 co-pay	\$0	Not Covered
<b>Covered visits per year</b>	6 visits	6 visits	12 visits	Not Covered
<b>TRANSPORTATION</b>				
<b>To in-network medical appointments</b>	\$0	\$0	\$0	Not Covered
<b>Covered visits per year</b> (one-way trips)	12 one-way trips	12 one-way trips	12 one-way trips	Not Covered
<b>SILVER&amp;FIT® FITNESS PROGRAM</b>				
<b>Home fitness kits</b> (2 per year)	\$10	\$10	\$10	
<b>Annual gym memberships</b> (must use gyms in the Silver&Fit network)	\$25 annual member fee	\$25 annual member fee	\$25 annual member fee	

Prescription Benefits Initial Coverage	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)
	Deductible: \$380 (Tiers 2, 3, 4 and 5)	Deductible: \$150 brand name & specialty drugs (Tiers 3, 4 and 5)	No deductible
	<b>30-day retail co-pays</b>		
<b>Tier 1: Preferred generic</b>	\$5 co-pay	\$4 co-pay	\$0
<b>Tier 2: Generic</b>	\$11 co-pay	\$8 co-pay	\$10 co-pay
<b>Tier 3: Preferred brand</b>	\$47 co-pay	\$45 co-pay	\$42 co-pay
<b>Tier 4: Non-preferred drug</b>	\$100 co-pay	\$95 co-pay	\$90 co-pay
<b>Tier 5: Specialty-tier</b>	25% co-insurance	30% co-insurance	33% co-insurance
	<b>90-day co-pays (mail order)</b>		
<b>Tier 1: Preferred generic</b>	\$10 co-pay	\$8 co-pay	\$0
<b>Tier 2: Generic</b>	\$22 co-pay	\$16 co-pay	\$20 co-pay
<b>Tier 3: Preferred brand</b>	\$94 co-pay	\$90 co-pay	\$84 co-pay
<b>Tier 4: Non-preferred drug</b>	\$200 co-pay	\$190 co-pay	\$180 co-pay
<b>Tier 5: Specialty-tier</b>	25% co-insurance	30% co-insurance	33% co-insurance
<b>GAP Coverage</b>	N/A	Tier 1, 2	Tier 1, 2

**COVERAGE GAP:** After your total yearly drug costs reach \$3,820, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 25% of the plan's costs for brand drugs and 37% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$5,100. Some of our plans offer additional coverage in the gap. Please refer to the EOC for more information.

**CATASTROPHIC COVERAGE:** After your yearly out-of-pocket drug costs reach \$5,100 in 2019, you pay the greater of: 5% co-insurance or \$3.40 co-pay for generic (including brand name drugs treated as generic) and an \$8.50 co-pay for all other drugs.

**TRANSITION COVERAGE FOR NEW MEMBERS:** For outpatient drugs, up to one (1) 30-day transition fills of Part D prescription medications, during the first 90 days of new membership in our plan. If you are in a Long Term Care Facility you can get up to one (1) 30-day transition fills of Part D prescription medications, during the first 90 days of new membership in our plan.

ENHANCED BENEFITS — OPTION A	
<b>\$44.90 in additional premium per month (optional)</b>	
<b>DENTAL COVERAGE</b> (Delta Dental™ — \$1,000 max/year)	
<b>Preventive</b>	\$0
<b>Comprehensive</b>	20% - 50% co-insurance
<b>VISION COVERAGE</b> (MES Vision®)	
<b>Yearly routine eye exam</b>	\$10 co-pay
<b>Eyewear</b> (coverage limit is \$460)	\$25 co-pay

Aspire Health Plan is a Medicare Advantage HMO plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal. This information is not a complete description of benefits. Call 1-855-570-1600 (TTY: 711) for more information. 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 providers are available in our network. Out-of-network/non-contracted providers are under no obligation to treat Aspire Health Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. We are open 8 a.m.-8 p.m. PT Monday through Friday from April 1 through September 30 (except certain holidays) and 8 a.m.-8 p.m. PT seven days a week from October 1 through March 31.

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ENHANCED BENEFITS — OPTION B	
<b>\$49.90 in additional premium per month (optional)</b>	
<b>DENTAL COVERAGE</b> (Delta Dental™ — \$1,000 max/year)	
<b>Preventive</b>	\$0
<b>Comprehensive</b>	20% - 50% co-insurance
<b>VISION COVERAGE</b> (MES Vision®)	
<b>Yearly routine eye exam</b>	\$10 co-pay
<b>Eyewear</b> (coverage limit is \$460)	\$25 co-pay
<b>HEARING COVERAGE</b> (TruHearing™)	
<b>Yearly routine hearing exam</b>	\$20 co-pay
<b>Hearing aids</b> (per hearing aid)	\$599 or \$899
<b>TRANSPORTATION</b> (to in-network medical appointments)	
<b>Additional 10 one-way rides</b>	\$0
<b>POST DISCHARGE HOME-DELIVERED MEALS</b>	
Offered through Mom's Meals NourishCare®. Meal benefit must be requested within 14 days of an inpatient hospital or skilled nursing facility stay.	
<b>14 refrigerated meals</b>	\$0
(2 meals per day for 7 days, customized to the member's preference)	