ASPIRE HEALTH PLAN

in collaboration with MONTAGE Health and Salinas Valley Memorial Healthcare System

QUESTIONS? **(866) 798-9356** (TTY 711)

2022 PLAN OPTIONS

BENEFIT	YOU PAY	YOU PAY	YOU PAY
	Aspire Health Value (HMO)	**Aspire Health Advantage (HMO)**	**Aspire Health Plus (HMO-POS)**
Monthly plan premium	$52	$139	$269
Your maximum out-of-pocket (in-network Medicare-covered benefits)	$7,550 in network	$5,000 in network	$3,450 in and out of service area combined
Annual Part C deductible (all services except for prescription drugs)	$0	$0	$0
Out-of-service area cost	N/A	N/A	20% co-insurance
DOCTOR OFFICE VISITS	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**
Primary care physician (PCP)	$15 co-pay	$0	$0 co-pay
Specialty care physician	$45 co-pay	$25 co-pay	$20 co-pay
INPATIENT CARE			
Inpatient hospital (acute)			
	Days 1-6: $335 per day	Days 1-6: $275 per day	Days 1-5: $250 per day
	Days 7-90: $0 per day	Days 7-90: $0 per day	Days 6-90: $0 per day
Skilled Nursing Facility (SNF)			
Days 1-20	$0 per day	$0 per day	$20 per day
Days 21-100	$184 per day	$100 per day	$50 per day

	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)
	IN NETWORK	IN NETWORK	IN NETWORK
OUTPATIENT CARE			
Outpatient hospital surgery/ Ambulatory Surgical Center (ASC) services	$300 co-pay	$60-$275 co-pay	$40-$200 co-pay
Home health services (must meet medical necessity criteria)	$0	$0	$0
Outpatient mental health (individual/group)	$35 co-pay	$15 co-pay	$0
Outpatient substance abuse (individual/group)	$35 co-pay	$15 co-pay	$0
VIRTUAL CARE			
Telehealth visit	$0	$0	$0
EMERGENCY SERVICES			
Urgently needed care (waived if admitted within 24 hours)	$45 co-pay	$25 co-pay	$0 in and out of service area
Emergency care (waived if admitted within 24 hours)	$90 co-pay	$90 co-pay	$90 in and out of service area
Ambulance, ground (when medically necessary, waived if admitted within 24 hours)	$300 co-pay	$250 co-pay	$200 in and out of service area
LAB SERVICES AND DIAGNOSTIC TESTS			
Diagnostic tests and procedures	$20 co-pay	$10 co-pay	$0
Lab services	$20 co-pay	$10 co-pay	$0
X-rays	$20 co-pay	$10 co-pay	$0
Diagnostic radiology	$90-$250 co-pay	$60-$150 co-pay	$30-$100 co-pay
Therapeutic radiology	20% co-insurance	20% co-insurance	20% co-insurance
MEDICAL EQUIPMENT AND SUPPLIES			
Durable Medical Equipment (DME)	20% co-insurance	20% co-insurance	20% co-insurance
Diabetes — monitoring, supplies, and therapeutic shoes	$0	$0	$0

	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)
	IN NETWORK	IN NETWORK	IN NETWORK
REHABILITATION SERVICES			
Speech, physical, occupational, cardiac, pulmonary therapy	$25 co-pay	$15 co-pay	$0
PART B DRUGS			
Chemotherapy	20% co-insurance	20% co-insurance	20% co-insurance
All other Part B drugs	$50 co-pay	$50 co-pay	$50 co-pay
WELLNESS EXAMS AND SCREENINGS			
Medicare covered preventive services	$0	$0	$0 in and out of service area
Influenza vaccine (1 per year)	$0	$0	$0 in and out of service area
Mammogram (1 per year)	$0	$0	$0 in and out of service area
VISION			
Diagnostic screenings (Medicare-covered benefits)	$45 co-pay	$25 co-pay	$0
HEARING			
Diagnostic hearing exams (Medicare-covered benefits)	$45 co-pay	$25 co-pay	$0

ADDITIONAL BENEFITS	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF SERVICE AREA
CHIROPRACTIC SERVICES				
Medicare-covered benefits (manipulation of spine to correct subluxation)	$10 co-pay	$10 co-pay	$0	20% co-insurance
Routine care (limited to specific treatment codes)	$20 co-pay	$10 co-pay	$0	Not covered
Covered visits per year	4 visits	6 visits	12 visits	Not covered
ACUPUNCTURE				
Medicare-covered benefits (for chronic low back pain)	$0	$0	$0	20% co-insurance
Covered visits per year (use within 90 consecutive days)	12 visits	12 visits	12 visits	12 visits
Routine care	$20 co-pay	$10 co-pay	$0	Not covered
Covered visits per year	4 visits	6 visits	12 visits	Not covered
TRANSPORTATION				
To in-network medical appointments	$0	$0	$0	Not covered
Covered visits per year (one-way trips)	6 one-way trips	12 one-way trips	12 one-way trips	Not covered
SILVER&FIT® FITNESS PROGRAM				
Home fitness kits (2 per year)	$10	$10	$10	
Annual gym memberships (must use gyms in the Silver&Fit network)	$50 annual member fee	$25 annual member fee	$0	
OVER-THE-COUNTER ITEMS				
Allowance	N/A	$30 per quarter	$30 per quarter	
DENTAL				
Preventive services	N/A	$0	N/A	

PRESCRIPTION BENEFITS Initial Coverage

Our plan uses a formulary. You can get your prescriptions filled through an in-network retail pharmacy, out-of-network pharmacy, mail order pharmacy or through a long term care pharmacy. Until the total cost of Part D-covered drugs paid by you and us (and any other Part D plan) reaches $4,430 in 2022, you will pay the amount(s) listed.

	Aspire Health Value (HMO) **DEDUCTIBLE: $480** (Tiers 3, 4, 5, 6)	**Aspire Health Advantage (HMO)** **DEDUCTIBLE: $150** brand name and specialty drugs (Tiers 3, 4, 5)	**Aspire Health Plus (HMO-POS)** **NO DEDUCTIBLE**
30-day retail co-pays			
Tier 1: Preferred generic	$9 co-pay	$4 co-pay	$0
Tier 2: Generic	$18 co-pay	$8 co-pay	$10 co-pay
Tier 3: Preferred brand	$47 co-pay	$45 co-pay	$42 co-pay
Tier 4: Non-preferred drug	$100 co-pay	$95 co-pay	$90 co-pay
Tier 5: Specialty-tier	25% co-insurance	30% co-insurance	33% co-insurance
Tier 6: Select insulins	$11 co-pay	$11 co-pay	$11 co-pay
90-day co-pays (mail order)			
Tier 1: Preferred generic	$18 co-pay	$8 co-pay	$0
Tier 2: Generic	$36 co-pay	$16 co-pay	$20 co-pay
Tier 3: Preferred brand	$94 co-pay	$90 co-pay	$84 co-pay
Tier 4: Non-preferred drug	$200 co-pay	$190 co-pay	$180 co-pay
Tier 5: Specialty-tier	Not available	Not available	Not available
Tier 6: Select insulins	$22 co-pay	$22 co-pay	$22 co-pay
GAP Coverage	N/A	Tier 1, 2	Tier 1, 2

COVERAGE GAP: After your total yearly drug costs reach $4,430, 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 25% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $7,050. Some of our plans offer additional coverage in the gap. Please refer to the EOC for more information. Please refer to the EOC for more information.

CATASTROPHIC COVERAGE: After your yearly out-of-pocket drug costs reach $7,050 in 2022, you pay the greater of: 5% co-insurance or $3.95 co-pay for generic (including brand name drugs treated as generic) and an $9.85 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) 31-day transition fills of Part D prescription medications, during the first 90 days of new membership in our plan.

All of our plans allow you to add Enhanced Benefits to your healthcare package.

ENHANCED BENEFITS — OPTION A

$44.90 in additional premium per month (optional) for the VALUE and PLUS plans

DENTAL COVERAGE (Delta Dental™ — $1,000 max/year)

Preventive	$0
Comprehensive	20%–50% co-insurance

VISION COVERAGE (MESVision®)

Yearly routine eye exam	$10 co-pay
Eyewear (coverage limit is $460)	$25 co-pay

ENHANCED BENEFITS — OPTION B

$49.90 in additional premium per month (optional) for the VALUE and PLUS plans

DENTAL COVERAGE (Delta Dental™ — $1,000 max/year)

Preventive	$0
Comprehensive	20%–50% co-insurance

VISION COVERAGE (MESVision®)

Yearly routine eye exam	$10 co-pay
Eyewear (coverage limit is $460)	$25 co-pay

HEARING COVERAGE (TruHearing™)

Yearly routine hearing exam	$20 co-pay
Hearing aids (per hearing aid)	$599 or $899

TRANSPORTATION (to in-network appointments)

Additional 10 one-way rides	$0

HOME-DELIVERED MEALS (Mom's Meals NourishCare®)

- Available after an inpatient hospital or skilled nursing stay, or following surgery
- Available for certain chronic conditions for a temporary period

14 refrigerated meals (2 meals per day for 7 days, customized to the member's preference)	$0

ENHANCED BENEFITS — OPTION C

$43 in additional premium per month (optional) for the ADVANTAGE plan

DENTAL COVERAGE (Delta Dental™ — $1,000 max/year)

Comprehensive	20%–50% co-insurance

VISION COVERAGE (MESVision®)

Yearly routine eye exam	$10 co-pay
Eyewear (coverage limit is $460)	$25 co-pay

HEARING COVERAGE (TruHearing™)

Yearly routine hearing exam	$20 co-pay
Hearing aids (per hearing aid)	$599 or $899

TRANSPORTATION (to in-network appointments)

Additional 10 one-way rides	$0

HOME-DELIVERED MEALS (Mom's Meals NourishCare®)

- Available after an inpatient hospital or skilled nursing stay, or following surgery
- Available for certain chronic conditions for a temporary period

14 refrigerated meals (2 meals per day for 7 days, customized to the member's preference)	$0

Aspire Health Plan is a Medicare Advantage HMO plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal. 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.

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