ASPIRE HEALTH

PRESENTED BY MONTAGE Health Salinas Valley HEALTH

2024 PLAN OPTIONS

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

BENEFIT	Aspire Health Protect (HMO)	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Monthly plan premium	$0	$31	$142	$312
Maximum out-of-pocket	$8,600 in network	$5,500 in network	$3,800 in network	$3,400 in and out of service area combined
Annual Part C deductible (except for prescription drugs)	$0	$0	$0	$0
Out-of-service area cost	N/A	N/A	N/A	30% co-insurance
DOCTOR OFFICE VISITS	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**
Primary care physician (PCP)	$5 co-pay	$5 co-pay	$0	$0 co-pay
Specialty care physician	$45 co-pay	$45 co-pay	$25 co-pay	$20 co-pay
Telehealth visit	$0	$0	$0	$0
INPATIENT CARE				
Inpatient hospital (acute)	Days 1-6: $335 per day	Days 1-6: $335 per day	Days 1-6: $250 per day	Days 1-5: $250 per day
	Days 7-90: $0 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	Days 1-20: $0 per day	Days 1-20: $0 per day	Days 1-20: $0 per day
	Days 21-100: $203 per day	Days 21-100: $184 per day	Days 21-100: $100 per day	Days 21-100: $100 per day

DOCTOR OFFICE VISITS	Aspire Health Protect (HMO) IN NETWORK	Aspire Health Value (HMO) IN NETWORK	Aspire Health Advantage (HMO) IN NETWORK	Aspire Health Plus (HMO-POS) IN NETWORK
OUTPATIENT CARE				N/A
Outpatient hospital surgery/ ambulatory surgical center	20% co-insurance	$300 co-pay	$60-$275 co-pay	$40-$200 co-pay
Home health services	$0	$0	$0	$0
Outpatient mental health, outpatient substance abuse	20% co-insurance	$35 co-pay	$15 co-pay	$0
EMERGENCY SERVICES				
Urgently needed care (waived if admitted within 24 hours)	$25 co-pay	$25 co-pay	$0 co-pay	$0 in and out of service area
Emergency care (waived if admitted within 24 hours)	$100 co-pay	$90 co-pay	$90 co-pay	$90 in and out of service area
Ambulance, ground	$300 co-pay	$300 co-pay	$300 co-pay	$300 in and out of service area
LAB SERVICES AND DIAGNOSTIC TESTS				
Diagnostic tests and procedures	$20 co-pay	$20 co-pay	$10 co-pay	$0
Lab services and X-rays	$20 co-pay	$20 co-pay	$10 co-pay	$0
Diagnostic radiology	20% co-insurance	$90-$250 co-pay	$60-$150 co-pay	$30-$100 co-pay
Therapeutic radiology	20% co-insurance	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	20% co-insurance
Diabetes — monitoring, supplies, and therapeutic shoes	$0	$0	$0	$0
REHABILITATION SERVICES				
Speech, physical, occupational, cardiac	20% co-insurance	$25 co-pay	$15 co-pay	$0
Pulmonary therapy	20% co-insurance	$15 co-pay	$15 co-pay	$0

	Aspire Health Protect (HMO)	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)	
DOCTOR OFFICE VISITS	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**	
PART B DRUGS				N/A	
Chemotherapy	20% co-insurance	20% co-insurance	20% co-insurance	20% co-insurance	
Part B insulin	$35 co-pay	$35 co-pay	$35 co-pay	$35 co-pay	
All other Part B drugs	20% co-insurance	20% co-insurance	20% co-insurance	20% co-insurance	
WELLNESS EXAMS AND SCREENINGS					
Medicare-covered preventive services	$0	$0	$0	$0 in and out of service area	
Influenza vaccine (1 per year)	$0	$0	$0	$0 in and out of service area	
Mammogram (1 per year)	$0	$0	$0	$0 in and out of service area	
VISION					
Diagnostic screenings (Medicare-covered benefits)	$45 co-pay	$45 co-pay	$25 co-pay	$20	
HEARING					
Diagnostic hearing exams (Medicare-covered benefits)	$45 co-pay	$45 co-pay	$25 co-pay	$20	
ADDITIONAL BENEFITS	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**	**OUT OF SERVICE AREA**
CHIROPRACTIC SERVICES					
Medicare-covered benefits	$15 co-pay	$10 co-pay	$10 co-pay	$0	30% co-insurance
Routine care (limited to specific treatment codes)	$20 co-pay	$20 co-pay	$10 co-pay	$0	Not covered
Covered visits per year	4 visits	4 visits	6 visits	12 visits	Not covered

ADDITIONAL BENEFITS	Aspire Health Protect (HMO) IN NETWORK	Aspire Health Value (HMO) IN NETWORK	Aspire Health Advantage (HMO) IN NETWORK	Aspire Health Plus (HMO-POS) IN NETWORK	Aspire Health Plus (HMO-POS) OUT OF SERVICE AREA
ACUPUNCTURE					
Medicare-covered benefits	$0	$0	$0	$0	30% co-insurance
Covered visits per year	12 visits	12 visits	12 visits	12 visits	12 visits
Routine care	$20 co-pay	$20 co-pay	$10 co-pay	$0	Not covered
Covered visits per year	4 visits	4 visits	6 visits	12 visits	Not covered
TRANSPORTATION					
To in-network appointments	$0	$0	$0	$0	Not covered
Covered visits per year (one-way trips)	6	6	12	12	Not covered
ONE PASS™ FITNESS PROGRAM					
Home fitness kits (1 per year)	$0	$0	$0	$0	
Annual gym membership (One Pass™ network)	$0	$0	$0	$0	
Online Brain Training app	$0	$0	$0	$0	
OVER-THE-COUNTER ITEMS					
Allowance (per quarter)	N/A	N/A	$30 per quarter	$30 per quarter	
DENTAL					
Preventive services	N/A	N/A	$0	N/A	

PRESCRIPTION BENEFITS Initial coverage	Aspire Health Protect (HMO)	Aspire Health Value (HMO)	Aspire Health Advantage (HMO)	Aspire Health Plus (HMO-POS)

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 $5,030 in 2024, you will pay the amount(s) listed.

30-day retail co-pays				
Tier 1: Preferred generic	$9 co-pay	$9 co-pay	$4 co-pay	$0
Tier 2: Generic	$18 co-pay	$18 co-pay	$8 co-pay	$10 co-pay
Tier 3: Preferred brand	$47 co-pay	$47 co-pay	$45 co-pay	$42 co-pay
Tier 4: Non-preferred drug	$100 co-pay	$100 co-pay	$95 co-pay	$90 co-pay
Tier 5: Specialty-tier	33% co-insurance	33% co-insurance	33% co-insurance	33% co-insurance
Tier 6: Select insulins	$11 co-pay	$11 co-pay	$11 co-pay	$11 co-pay
GAP coverage	N/A	N/A	Tier 1, 2	Tier 1, 2
100-day co-pays (retail and mail order)				
Tier 1: Preferred generic	$18 co-pay	$18 co-pay	$8 co-pay	$0
Tier 2: Generic	$36 co-pay	$36 co-pay	$16 co-pay	$20 co-pay
Tier 3: Preferred brand	$94 co-pay	$94 co-pay	$90 co-pay	$84 co-pay
Tier 4: Non-preferred drug	$200 co-pay	$200 co-pay	$190 co-pay	$180 co-pay
Tier 5: Specialty-tier	Not available	Not available	Not available	Not available
Tier 6: Select insulins	$22 co-pay	$22 co-pay	$22 co-pay	$22 co-pay
GAP coverage	N/A	N/A	Tier 1, 2	Tier 1, 2

COVERAGE GAP: After your total yearly drug costs reach $5,030, 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 $8,000. 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 $8,000 in 2024, you pay nothing for covered Part D 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 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 PROTECT, VALUE, and PLUS plans

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

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

VISION COVERAGE (VSP™ Vision Care)

Yearly routine eye exam	$10 co-pay
Eyewear	$25 co-pay

ENHANCED BENEFITS — OPTION B

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

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

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

VISION COVERAGE(VSP™ Vision Care)

Yearly routine eye exam	$10 co-pay
Eyewear	$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	$0

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

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(VSP™ Vision Care)

Yearly routine eye exam	$10 co-pay
Eyewear	$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	$0

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

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. H8764_MKT_Annual Benefit Platter_0823_M