ASPIRE HEALTH

PRESENTED BY MONTAGE Health Salinas Valley HEALTH

2025 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	$27	$146	$336
Maximum out-of-pocket	$7,000 in network	$6,000 in network	$4,300 in network	$3,900 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: $385 per day	Days 1-6: $375 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 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: $214 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				
Outpatient hospital surgery/ ambulatory surgical center	$300 co-pay	$300 co-pay	$60-$275 co-pay	$40-$200 co-pay
Home health services	$0	$0	$0	$0
Outpatient mental health, outpatient substance abuse	10% 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)	$110 co-pay	$110 co-pay	$110 co-pay	$110 in and out of service area
Ambulance, ground	$325 co-pay	$325 co-pay	$325 co-pay	$325 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	10% 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	10% co-insurance	$25 co-pay	$15 co-pay	$0
Pulmonary therapy	10% 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					
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 reaches $2,000 in 2025, you will pay the amount(s) listed.

Annual Deductible	$200 Tiers 1-6	$0	$0	$0
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	30% 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
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

CATASTROPHIC COVERAGE: After your yearly out-of-pocket drug costs reach $2,000 in 2025, 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

$42.00 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

$46.00 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

$40.00 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 is a Medicare Advantage HMO plan sponsor with a Medicare contract. Enrollment in Aspire Health 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 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_0824_M