



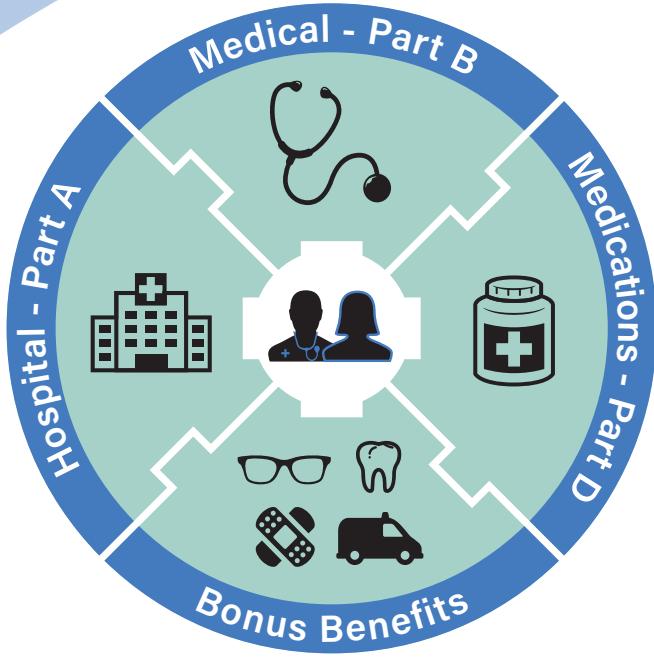
**2021  
SUMMARY  
OF BENEFITS**

**Brandman Health Plan Aspire (HMO C-SNP)**

H7594\_20BHP\_AspireSB2021\_M File & Use 10/06/2020

**CALIFORNIA:  
Los Angeles County**

# All-in-One Health Coverage



## ***The Care You Need. The Value You Expect.***

Complex health conditions like yours can create many challenges. Getting the healthcare you need shouldn't be one of them. That's why Brandman Health Plan (HMO SNP) created a Medicare Advantage plan just for people with dementia. Meet Aspire (HMO C-SNP), the new health plan from Brandman that makes it easier to get the care you need! It's an **ALL-IN-ONE** solution for your healthcare coverage. It combines three types of Medicare coverage into one plan: Part A (hospital), Part B (doctors), and Part D (drugs). Also, it gives you additional benefits that Original Medicare doesn't, such as:

- ✓ \$0 Dentures
- ✓ \$0 Eyewear (up to \$250 value)
- ✓ \$0 Hearing aids (up to \$1000 value)

## ***Save On Insulins With Our Senior Savings Program***

If you have diabetes managed with insulin, check out our Senior Savings Program. It's an easy way to save and have your 90-day prescription delivered to you!

## **Do I Qualify?**

In order to join Brandman Health Plan Aspire (HMO C-SNP) you must:

- Be diagnosed with dementia
- Have both Medicare Part A and B
- Live in Los Angeles County
- Be a U.S. citizen or lawfully present in the country

For questions or to learn more, call Member Services today!



**Brandman  
HEALTH PLAN**

**1-888-697-5662**

Premiums and Benefits	Coverage Details	What you should know
<b>Monthly Plan Premium</b>	This plan does not have a premium.	You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	This plan does not have a deductible for Part C.	Applies to services you get in-network or out-of-network.
<b>Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</b>	The most you will pay each year for Part C services in this plan is \$999.	The most you pay for copays, coinsurance and other costs for medical services for the year.
<b>Inpatient Hospital Coverage</b>	<ul style="list-style-type: none"> <li>▪ You pay \$0 per day for days 1 - 90.</li> <li>▪ Our plan provides a maximum of 60 Lifetime Reserve days. You pay a \$704 copay per day for days 1 – 60. This is the amount for 2020 and may change in 2021. The plan will let you know once Medicare announces this amount for 2021.</li> </ul>	Referral and authorization are required.
<b>Outpatient Hospital Coverage</b>	You pay \$0.	Includes services received in an ambulatory surgical center or outpatient hospital. Referral and prior authorization are required.
<b>Doctor Visits</b>	You pay \$0 for each primary care physician or specialist visit. In-person and telehealth options are available.	Referral and authorization are required for specialist visits.
<b>Preventive Care</b>	You pay \$0.	Prior authorization may be required.
<b>Emergency Care</b>	You pay \$100 per visit.	
<b>Urgently Needed Services</b>	You pay \$0.	
<b>Diagnostic Services/ Labs/Imaging</b> ▪ Diagnostic radiology service (e.g., MRI) ▪ Lab services ▪ Diagnostic tests and procedures ▪ Outpatient x-rays	<ul style="list-style-type: none"> <li>▪ You pay \$0 for:               <ul style="list-style-type: none"> <li>▪ Diagnostic tests and procedures</li> <li>▪ Lab Services</li> <li>▪ Diagnostic radiology services (including X-rays)</li> </ul> </li> <li>▪ You pay 20% of the total cost for therapeutic radiology services.</li> </ul>	Referral and prior authorization are required.
<b>Hearing Exams</b>	<ul style="list-style-type: none"> <li>▪ Routine hearing exam: You pay \$0.</li> <li>▪ Hearing aid allowance: You pay \$0. The plan covers up to \$1,000 per calendar year.</li> </ul>	The plan covers 1 exam per year. Hearing aid allowance is for both ears combined.

Premiums and Benefits	Coverage Details	What you should know
<b>Dental Services</b> <ul style="list-style-type: none"> <li>▪ Exam &amp; Cleaning (every 6 months)</li> <li>▪ Comprehensive Dental (e.g. fillings and dentures)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Medicare-covered Dental services: You pay \$0.</li> <li>▪ Preventive dental services: You pay \$0 for routine office visits. Office visits includes exam, cleaning, fluoride treatment and dental X-ray.</li> <li>▪ You pay \$0 for restorative services; prosthodontics, other oral/ maxillofacial surgery, other services.</li> </ul>	The plan covers up to \$750/year in dental services.
<b>Vision Services</b> <ul style="list-style-type: none"> <li>▪ Exams (1 per year)</li> <li>▪ Glasses or Contacts (1 every two years)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Medicare-covered Vision services: You pay \$0.</li> <li>▪ You pay \$0 for routine eye exams.</li> <li>▪ You pay \$0 for either: <ul style="list-style-type: none"> <li>▪ One pair of eyeglasses (lenses and frames)</li> <li>▪ One pair of contact lenses</li> </ul> </li> </ul>	The plan covers up to \$250 every two years towards lenses and frames or contacts.
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>▪ Inpatient visit</li> <li>▪ Outpatient therapy visit (group or individual)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Inpatient Visit: <ul style="list-style-type: none"> <li>▪ You pay \$0 per day for days 1-60.</li> <li>▪ You pay \$329 per day for days 61 - 90.</li> <li>▪ Our plan provides a maximum of 60 Lifetime Reserve days. You pay a \$704 copay per day for days 1 – 60. This is the amount for 2020 and may change in 2021. The plan will let you know once Medicare announces this amounts for 2021.</li> </ul> </li> <li>▪ Outpatient services: <ul style="list-style-type: none"> <li>▪ You pay \$0 for each Medicare-covered individual or group therapy outpatient mental health visit.</li> </ul> </li> </ul>	Referral and prior authorization may be required. Contact the plan for more information.
<b>Skilled Nursing Facility</b>	We cover up to 100 days in a SNF per benefit period: <ul style="list-style-type: none"> <li>▪ You pay \$0 per day for days 1 – 100.</li> </ul>	Referral and prior authorization are required.
<b>Physical Therapy</b>	You pay \$10 per visit.	Referral and prior authorization are required.
<b>Ambulance</b>	You pay \$125 for each trip by ground or air.	Prior authorization is required for non-emergency trips.
<b>Transportation</b>	<ul style="list-style-type: none"> <li>▪ You pay \$0 for 24 one-way trips by van to covered medical appointments each year.</li> <li>▪ Rides must be scheduled through the plan.</li> </ul>	Referral and prior authorization are required.
<b>Medicare Part B Drugs</b>	<ul style="list-style-type: none"> <li>▪ You pay 20% of the cost.</li> <li>▪ Part B drugs include chemotherapy and home infusion drugs.</li> </ul>	Authorization required.

## Prescription Drugs (Part D)

Part D Deductible: \$0 Your cost sharing is:	Retail or Mail order 30-day supply	Retail 90-day supply	Mail order 90-day supply	Long Term Care 31-day supply
<b>Tier 1: Preferred Generic</b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Tier 2: Generic</b>	You pay \$9	You pay \$27	You pay \$18	You pay \$9
<b>Tier 3: Preferred Brand</b>	You pay \$45	You pay \$135	You pay \$90	You pay \$45
<b>Tier 4: Non-Preferred</b>	You pay \$90	You pay \$270	You pay \$270	You pay \$90
<b>Tier 5: Specialty Tier</b>	You pay 33%	Not available	Not available	You pay 33%
<b>Tier 6: Select Care</b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0

- You pay these amounts until your total yearly drug costs reach \$4,130.
- **Coverage Gap Stage:** Once your total Part D drug costs have reached \$4,130, then you pay 25% of the cost for your drugs and a portion of the dispensing fee
- **Catastrophic Coverage Stage:** Once your yearly out-of-pocket drug costs reach \$6,550, you pay the greater of \$3.70 for generic or a preferred multi-source drug and \$9.20 for all other drugs, or 5%

## Bonus Benefits

Premiums and Benefits	Coverage Details	What you should know
<b>Acupuncture</b>	You pay \$10 per treatment for up to 12 routine treatments per year.	Referral and prior authorization are required.
<b>Health/Wellness</b>	You pay \$0 for fitness center membership at multiple centers.	Home Fitness Kits and Stay Fit Kits also available.
<b>In-home Safety Assessment</b>	You pay \$0 for 1 in-home safety assessment per year.	Referral and prior authorization are required.
<b>Home Meal Delivery</b>	Available for up to: <ul style="list-style-type: none"> <li>▪ 5 days after a hospital stay</li> <li>▪ 14 days for quarantined members</li> </ul>	Up to 3 meals per day provided.
<b>Over-the-Counter Drugs (OTC)</b>	<ul style="list-style-type: none"> <li>▪ \$60 allowance every quarter</li> </ul>	Select a variety of items from our OTC catalog.



### What you should know

Cost-Sharing may change depending on the pharmacy you choose and phase of the Part D benefit. For more information, please call us or access our Evidence of Coverage (EOC) online. Visit [www.brandmanhealthplan.com](http://www.brandmanhealthplan.com) to find:

- The provider & pharmacy directories
- The Formulary (list of covered drugs)
- The EOC - a complete list of benefits



**Member Services:**

1-888-697-5662 / TTY 711

**Hours:**

October 1 – March 31: Seven days a week, from 8:00 a.m. to 8:00 p.m.

April 1 – September 30: Monday through Friday, from 8:00 a.m. to 8:00 p.m.

---

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, or view it online at [www.medicare.gov](http://www.medicare.gov). This information is not a complete description of benefits. Call 1-888-697-5662/TTY 711 for more information. Out-of-network/non-contracted providers are under no obligation to treat Brandman 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.

Brandman Health Plan Aspire is a HMO SNP with a Medicare contract. Enrollment in Brandman Health Plan (HMO SNP) depends on contract renewal. Brandman Health Plan (HMO SNP) 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 1-888-697-5662 (TTY: 711).

