

# **2022 Summary of Benefits**

Illinois

**Ascension Complete AMITA Health Reward (HMO)**

H7399 | 001

**Ascension Complete AMITA Health Secure (HMO)**

H7399 | 002

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**We know how important it is to have a health plan you can count on.**

This is a summary of drug and health services covered by Ascension Complete AMITA Health Reward (HMO) and Ascension Complete AMITA Health Secure (HMO) from January 1, 2022 to December 31, 2022.

This booklet will provide you with a summary of what we cover and the cost-sharing responsibilities. It does not list every service, limitation, or exclusion. A complete list of services can be found in the plan's Evidence of Coverage (EOC). You can find the Evidence of Coverage on our website at [ascensioncomplete.com](http://ascensioncomplete.com). Or, you may call us to ask for a copy at the phone number listed on the back cover.

**Who can join?**

To enroll in one of our plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

**Our plans and service areas:**

**H7399001000 Ascension Complete AMITA Health Reward (HMO)** includes these counties in Illinois: Cook, DuPage, Kane, Kankakee, and Will.

**H7399002000 Ascension Complete AMITA Health Secure (HMO)** includes these counties in Illinois: Cook, DuPage, Kane, Kankakee, and Will.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Health Maintenance Organizations (HMOs)** are health care plans offered by an insurance provider with a network of contracted healthcare providers and facilities. HMOs generally require members to select a primary care provider (PCP) to coordinate care and if you need a specialist, the PCP will choose one who is also in our network.

Our plans give you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit [ascensioncomplete.com](http://ascensioncomplete.com). (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor our plan will be responsible for the costs.)

Our plans also include prescription drug coverage and access to our large network of pharmacies. Our plans use a formulary. Our drug plans are designed specifically for Medicare beneficiaries and include a comprehensive selection of affordable generic and brand name drugs.

Which doctors, hospitals and pharmacies can I use? Ascension Complete AMITA Health Reward (HMO)

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and Ascension Complete AMITA Health Secure (HMO) have a network of doctors, hospitals, pharmacies, and other providers. You can save money by using our preferred mail-order pharmacy and by using providers in the plan's network. With some plans if you use providers that are not in our network, your share of the costs for covered services may be higher.

You can see our plan's provider and pharmacy directory and for plans with prescription drug coverage, our complete plan Formulary (list of Part D prescription drugs) on our website at [ascensioncomplete.com](http://ascensioncomplete.com).

For more information, please call us at 1-877-831-9411 (TTY users should call 711). Hours are Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Visit us at [ascensioncomplete.com](http://ascensioncomplete.com).

We must provide information in a way that works for you (in languages other than English, in audio, in braille, in large print, or other alternate formats, etc.). Please call member services if you need plan information in another format.

**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Service Area</b>	<p><b>Our plans and service areas:</b>  <b>H7399001000 Ascension Complete AMITA Health Reward (HMO)</b> includes these counties in Illinois: Cook, DuPage, Kane, Kankakee, and Will.  <b>H7399002000 Ascension Complete AMITA Health Secure (HMO)</b> includes these counties in Illinois: Cook, DuPage, Kane, Kankakee, and Will.</p>	
<b>Monthly plan premium</b> You must continue to pay your Medicare Part B premium.	\$0	\$0
<b>Part B Premium Reduction</b>	This plan offers a \$100 give back every month in your Social Security check.	Not available
<b>Deductible</b>	No deductible	No deductible
<b>Maximum out-of-Pocket Responsibility</b> (does not include prescription drugs)	\$2,900 annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.	\$2,400 annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.
<b>Inpatient Hospital coverage</b>	For each admission, you pay: <ul style="list-style-type: none"> <li>• \$500 copay per day for days 1 through 5</li> <li>• \$0 copay per day for days 6 through 90</li> <li>• \$0 copay per day for days 91 and beyond</li> </ul> *	For each admission, you pay: <ul style="list-style-type: none"> <li>• \$175 copay per day for days 1 through 7</li> <li>• \$0 copay per day for days 8 through 90</li> <li>• \$0 copay per day for days 91 and beyond</li> </ul> *

*Services with an asterisk (\*) may require prior authorization.  
 Services with a square (▪) means a referral may be required.*

**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Outpatient Hospital coverage</b> Outpatient hospital services	\$350 copay for surgical and non-surgical services *	\$175 copay for surgical and non-surgical services *
Outpatient hospital observation services	\$120 copay for outpatient observation services when you enter observation status through an emergency room. \$350 copay for outpatient observation services when you enter observation status through an outpatient facility. *	\$120 copay for outpatient observation services when you enter observation status through an emergency room. \$175 copay for outpatient observation services when you enter observation status through an outpatient facility. *
<b>Ambulatory surgical center (ASC)</b>	\$250 copay *	\$125 copay *
<b>Doctor Visits</b>		
Primary Care Physicians	\$0 copay	\$0 copay
Specialists	\$50 copay	\$20 copay
<b>Preventive Care</b> (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots))	\$0 copay	\$0 copay

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Emergency care</b>	\$120 copay Copay is waived if you are admitted to a hospital within 24 hours.	\$120 copay Copay is waived if you are admitted to a hospital within 24 hours.
Worldwide emergency coverage	\$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.	\$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.
<b>Urgently needed services</b>	\$45 copay Copay is waived if you are admitted to a hospital within 24 hours.	\$20 copay Copay is waived if you are admitted to a hospital within 24 hours.
Worldwide urgent care coverage	\$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.	\$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Diagnostic Services/Labs/Imaging</b>	COVID-19 testing and specified testing-related services at any location are \$0.	COVID-19 testing and specified testing-related services at any location are \$0.
Lab services	\$35 copay *	\$0 copay *
Diagnostic tests and procedures	\$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. \$100 copay for all other Medicare-covered diagnostic procedures and tests. *	\$0 copay *
Outpatient X-rays	\$40 copay *	\$0 copay *
Diagnostic radiology services (e.g. MRI, CAT Scan)	\$0 copay for a DEXA scan. \$0 copay for a diagnostic mammogram. \$350 copay for all other diagnostic radiology services. *	\$0 copay for a DEXA Scan. \$0 copay for a diagnostic mammogram. \$175 copay for all other diagnostic radiology services. *
Therapeutic Radiology	\$60 copay *	\$60 copay *
<b>Hearing services</b>		
Hearing Exam Medicare Covered	\$50 copay *	\$20 copay *

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
Routine hearing exam	<u>Not</u> covered	\$0 copay *  1 exam every year
Hearing Aids  Hearing Aid Fitting/Evaluation(s)	<u>Not</u> covered	\$0 copay *  1 fitting(s) / evaluation(s) every year
Hearing aid allowance  All types	<u>Not</u> covered	Up to a \$1,500 allowance for both ears combined every year for hearing aids.  \$0 copay *  Limited to 2 hearing aid(s) every year
Additional Hearing Information	<b>What you should know</b> Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.	<b>What you should know</b> Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Dental services</b>		
Preventive services	\$0 copay *	\$0 copay *
	Cleanings 2 every year Dental x-rays 1 every 12 to 36 months Oral exams 2 every year	Cleanings 2 every year Dental x-rays 1 every 12 to 36 months Oral exams 2 every year
Fluoride Treatment	\$0 copay *  1 every year	\$0 copay *  1 every year
Comprehensive services Medicare Covered	\$50 copay for each Medicare-covered service. *	\$20 copay for each Medicare-covered service. *
Diagnostic Services	\$0 copay *  1 diagnostic service(s) every year	30% coinsurance *  1 diagnostic service(s) every year
Restorative Services	<u>Not</u> covered	30% coinsurance *  1 restorative service(s) every 12 to 84 months.

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
Endodontics/ Periodontics/ Extractions	<u>Not covered</u>	30% coinsurance *  1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth
Non-routine services	\$0 copay *  1 non-routine service(s) every day to 24 months	30% coinsurance *  1 non-routine service(s) every day to 60 months
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	<u>Not covered</u>	30% coinsurance *  1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime 1 Other service for non-implant codes every 6 to 60 months, implants once per lifetime, implant crowns once every 84 months
Additional Dental Information	<b>What you should know:</b> This plan includes coverage of preventive and comprehensive services up to \$500.	

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Vision Services</b> Eye Exam Medicare Covered	\$0 copay (Medicare-covered diabetic retinopathy screening) \$50 copay (all other Medicare-covered eye exams) *	\$0 copay (Medicare-covered diabetic retinopathy screening) \$20 copay (all other Medicare-covered eye exams) *
Routine eye exam (Refraction)	<u>Not covered</u>	\$0 copay *  1 exam every year
Glaucoma screening	\$0 copay for each Medicare-covered service.	\$0 copay for each Medicare-covered service.
Eyewear Medicare Covered	\$0 copay *	\$0 copay *
Routine eyewear  Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames  Eyewear allowance	<u>Not covered</u>	\$0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year * Up to a \$300 combined allowance every year

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**Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Mental Health Services</b>		
Inpatient visit	For each admission, you pay: <ul style="list-style-type: none"> <li>• \$465 copay per day for days 1 through 5</li> <li>• \$0 copay per day for days 6 through 90</li> </ul> *	For each admission, you pay: <ul style="list-style-type: none"> <li>• \$175 copay per day for days 1 through 7</li> <li>• \$0 copay per day for days 8 through 90</li> </ul> *
Outpatient individual therapy visit	\$40 copay	\$20 copay
Outpatient group therapy visit	\$40 copay	\$20 copay
<b>Skilled nursing facility (SNF)</b>	For each benefit period, you pay: <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$188 copay per day for days 21 through 100</li> </ul> *	For each benefit period, you pay: <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$188 copay per day for days 21 through 100</li> </ul> *
<b>Therapy and Rehabilitation Services</b>		
Physical Therapy	\$40 copay *	\$20 copay *
Outpatient rehabilitation services provided by an occupational therapist	\$40 copay *	\$20 copay *
Pulmonary rehabilitation services	\$10 copay	\$10 copay

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	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Ambulance</b>		
Ground Ambulance	\$350 copay *	\$250 copay *
Air Ambulance	\$350 copay *	\$250 copay *
<b>Transportation Services</b>	<p>Up to 12 one-way trips every year to plan-approved health-related locations. Mileage limits may apply.</p> <p>\$0 copay (per one-way trip) *</p> <p><b>What you should know:</b> The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment. Mileage limitations may apply.</p>	<p>Unlimited routine transportation trips to plan-approved health-related locations.</p> <p>\$0 copay (per one-way trip) *</p> <p><b>What you should know:</b> The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment. Mileage limitations may apply.</p>
<b>Medicare Part B Drugs</b>		
Chemotherapy drugs	20% coinsurance *	20% coinsurance *
Other Part B drugs	20% coinsurance *	20% coinsurance *

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Prescription Drug Coverage	Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001	Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002		
<b>Stage 1: Annual Prescription Deductible</b>				
<b>Deductible</b>	\$480 for Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) Part D prescription drugs. For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately.	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.		
<b>Stage 2: Initial Coverage (after you pay your deductible, if applicable)</b>				
You pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.				
<b>Retail cost-sharing (30-day/90-day supply)</b>				
	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>
<b>Tier 1</b> (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	\$0 / \$0 copay	\$5 / \$15 copay	\$0 / \$0 copay	\$5 / \$15 copay
<b>Tier 2</b> (Generic Drugs - includes generic drugs and may include some brand drugs.)	\$5 / \$15 copay	\$15 / \$45 copay	\$1 / \$3 copay	\$7 / \$21 copay
<b>Tier 3</b> (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	\$37 / \$111 copay	\$47 / \$141 copay	\$37 / \$111 copay	\$47 / \$141 copay

Prescription Drug Coverage	Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001		Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002	
	Preferred	Standard	Preferred	Standard
<b>Tier 4</b> (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	\$90 / \$270 copay	\$100 / \$300 copay	\$90 / \$270 copay	\$100 / \$300 copay
<b>Tier 5</b> (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	25% coinsurance / Not Available	25% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available
<b>Tier 6</b> (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay

Prescription Drug Coverage	Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001		Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002	
<b>Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)</b>				
<b>Mail-order cost-sharing (30-day/90-day supply)</b>				
	Preferred	Standard	Preferred	Standard
<b>Tier 1</b> (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	\$0 / \$0 copay	\$5 / \$15 copay	\$0 / \$0 copay	\$5 / \$15 copay
<b>Tier 2</b> (Generic Drugs - includes generic drugs and may include some brand drugs.)	\$5 / \$0 copay	\$15 / \$45 copay	\$1 / \$0 copay	\$7 / \$21 copay
<b>Tier 3</b> (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	\$37 / \$74 copay	\$47 / \$141 copay	\$37 / \$74 copay	\$47 / \$141 copay
<b>Tier 4</b> (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	\$90 / \$180 copay	\$100 / \$300 copay	\$90 / \$180 copay	\$100 / \$300 copay
<b>Tier 5</b> (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	25% coinsurance / Not Available	25% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available



Prescription Drug Coverage	Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001		Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002	
	Preferred	Standard	Preferred	Standard
<b>Tier 6</b> (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay
<b>Stage 3: Coverage Gap</b>				
	After your total drug costs (including what our plan has paid and what you have paid) reach \$4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.		After your total drug costs (including what our plan has paid and what you have paid) reach \$4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.  During this stage, for Tier 1, Tier 2, and for select drugs on Tier 6, you pay your copayment or coinsurance. Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.	
<b>Stage 4: Catastrophic Coverage</b>				
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of: <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs.</li> </ul>		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of: <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs.</li> </ul>	

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a

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short-term (30-day supply) or long term (90-day supply).

**Excluded Drugs:**

This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of six pills every 30 days.

Because these drugs are excluded from Part D coverage under Medicare, they are not covered by Extra Help. Also, the amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage.

Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.

## Additional Benefits

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Chiropractic Care</b> Medicare-covered	\$20 copay *	\$20 copay *
<b>Acupuncture</b> Medicare-covered	\$0 copay for Medicare-covered Acupuncture received in a PCP office. \$50 copay for Medicare-covered Acupuncture received in a Specialist office. \$20 copay for Medicare-covered Acupuncture received in a Chiropractor office. *	\$0 copay for Medicare-covered Acupuncture received in a PCP office. \$20 copay for Medicare-covered Acupuncture received in a Specialist office. \$20 copay for Medicare-covered Acupuncture received in a Chiropractor office. *
<b>Podiatry Services (Foot Care)</b> Medicare Covered	\$50 copay	\$20 copay
Routine Podiatry Services	\$50 copay  Unlimited visit(s) every year  <b>What you should know:</b> Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.	\$20 copay  Unlimited visit(s) every year  <b>What you should know:</b> Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.

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## Additional Benefits

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Virtual Visits</b>	<p>Our plan offers 24 hours per day, 7 days per week virtual access to board certified clinicians to help address a wide variety of health concerns/questions. A virtual visit is a visit with a clinician via the internet using a smart phone or a computer's web cam. For more information, or to schedule an appointment, visit <a href="http://ascensiononlinecare.org">ascensiononlinecare.org</a> or download the Ascension Online Care app available in the App Store or Google Play store.</p> <p><b>Spiritual Care</b> The health plan offers 24 hours per day, 365 days a year virtual visits and access to professionally trained chaplains through the Ascension On Demand Spiritual Care program. Using the Ascension Online Care platform, members who are experiencing spiritual and emotional concerns can connect to a chaplain to help address their needs and find light in challenging times.</p>	
<b>Home health agency care</b>	\$0 copay *	\$0 copay *
<b>Meals</b>  Post-Acute Meals	<p>\$0 copay for each post-acute meal</p> <ul style="list-style-type: none"> <li>▪ <b>What you should know:</b> You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days.</li> </ul>	<p>\$0 copay for each post-acute meal</p> <ul style="list-style-type: none"> <li>▪ <b>What you should know:</b> You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days.</li> </ul>
<b>Medical Equipment/Supplies</b>  Durable Medical Equipment (DME)	20% coinsurance *	20% coinsurance *

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## Additional Benefits

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
Prosthetics	20% coinsurance *	20% coinsurance *
Diabetic supplies	\$0 copay *	\$0 copay *
Diabetic therapeutic shoes or inserts	20% coinsurance *	20% coinsurance *
<b>Opioid treatment program services</b>	\$50 copay	\$20 copay
<b>Over-the-Counter (OTC) Items</b>	\$0 copay The maximum total benefit is \$35 every three months <b>What you should know:</b> Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.	\$0 copay The maximum total benefit is \$105 every three months <b>What you should know:</b> Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
<b>Wellness Programs</b>	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.
Fitness	\$0 copay Coverage includes: Activity Tracker and Physical Fitness	\$0 copay Coverage includes: Activity Tracker and Physical Fitness

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## Additional Benefits

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
	<p><b>What you should know:</b></p> <p>This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.</p>	<p><b>What you should know:</b></p> <p>This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.</p>
Additional sessions of smoking and tobacco cessation counseling	<p>\$0 copay</p> <p>Limited to 5 visit(s) every year</p>	<p>\$0 copay</p> <p>Limited to 5 visit(s) every year</p>
Additional Routine Annual Physical	<p>\$0 copay</p> <p><b>What you should know:</b> Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.</p>	<p>\$0 copay</p> <p><b>What you should know:</b> Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.</p>
Clinical Care Line	\$0 copay	\$0 copay
Personal emergency medical response device (PERS)	<u>Not</u> covered	\$0 copay
<b>Special Supplemental Benefits for Chronically Ill (SSBCI)</b>	Grocery Delivery: You pay \$0 copay	Grocery Delivery: You pay \$0 copay

*Services with an asterisk (\*) may require prior authorization.*

*Services with a square (■) means a referral may be required.*

## Additional Benefits

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
To qualify for these benefits you must meet specific criteria, including having a qualifying chronic condition and determined to be eligible for high-risk care management. For a complete list of eligibility criteria, please see the Evidence of Coverage.	<p>Plan covers up to \$50 per month to use on plan-approved grocery items. Limitations apply.</p> <p>Spiritual Care: \$0 copay Utility Flex Card: You pay \$0 copay Plan covers up to \$50 per month to help cover the cost of utilities for your home. Limitations apply.</p> <p>Referral may be required *</p>	<p>Plan covers up to \$100 per month to use on plan-approved grocery items. Limitations apply.</p> <p>Spiritual Care: \$0 copay Helper Bees Care Concierge: You pay \$0 copay Provides a monthly allowance of 100 credits for plan-approved services. Limitations apply.</p> <p>Utility Flex Card: You pay \$0 copay Plan covers up to \$125 per month to help cover the cost of utilities for your home. Limitations apply.</p> <p>Referral may be required *</p>
<b>Flex Card</b>	<u>Not covered</u>	<p>\$1,000 yearly benefit</p> <p><b>What you should know:</b></p> <p>The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.</p>

*Services with an asterisk (\*) may require prior authorization.*

*Services with a square (▪) means a referral may be required.*

## Optional Supplemental Benefits

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
<b>Monthly Premium</b>	\$28 premium This additional monthly premium is in addition to the monthly Medicare Part B premium	Not available
<b>Coverage</b>	<p><b>Centene Silver 1500 40%, Vision 200 includes:</b></p> <p><b>Dental services</b> There is a \$1,500 combined benefit maximum for preventive and comprehensive dental services each calendar year.</p> <p>Preventive dental services - Includes 2 exams, 2 cleanings, 1 fluoride treatment and 1 set of dental x-rays. You pay a \$0 copay per visit.</p> <p>Comprehensive dental services include:</p> <ul style="list-style-type: none"> <li>• Non-Routine Services – You pay 40% of the total cost.</li> <li>• Diagnostic services – You pay 40% of the total cost.</li> <li>• Restorative service – You pay 40% of the total cost.</li> <li>• Endodontics – You pay 40% of the total cost.</li> <li>• Periodontics – You pay 40% of the total cost.</li> <li>• Extractions – You pay 40% of the total cost.</li> <li>• Prosthodontics, including</li> </ul>	



**Optional Supplemental Benefits**

	<b>Ascension Complete AMITA Health Reward (HMO) H7399, Plan 001</b>	<b>Ascension Complete AMITA Health Secure (HMO) H7399, Plan 002</b>
	<p>dentures, other oral/maxillofacial surgery, and other services – You pay 40% of the total cost.</p> <p><b>Routine Vision Services</b>                      You pay a \$0 copay for each routine eye exam.                      You pay a \$0 copay for routine vision eyewear.                      There is a plan benefit maximum of \$200 per calendar year.</p>	
<p><i>Prior Authorization may be required</i></p>		

ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. Llame al número de Servicios para Miembros que se indica para su estado en la página siguiente.

注意：如果您說中文，您可以免費獲得語言援助服務。請撥打針對您所在州列示於下一頁的會員服務部電話號碼。

Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí dành cho quý vị. Hãy gọi số điện thoại của bộ phận Dịch Vụ Thành Viên thuộc bang của quý vị ở trang tiếp theo.

주의사항: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다. 다음 페이지에서 가입자의 주에 해당하는 목록 내 가입자 서비스부 번호로 전화해 주십시오.

Atensyon: Kung nagsasalita ka ng Tagalog, may mga available na libreng tulong sa wika para sa iyo. Tumawag sa numero ng Mga Serbisyo para sa Miyembro na nakalista para sa iyong estado sa susunod na page.

Dumngeg: No agsasau ka iti Ilokano, dagiti tulong nga serbisio, a libre, ket available para kaniam. Awagam iti numero dagiti serbisio iti Miembro a nakalista para iti estadom iti sumaruno a panid.

La Silafia: Afai e te tautala i le gagana Samoa, o lo’o avanoa ia te oe ‘au’aunaga fesoasoani i le gagana, e leai se totogi. Vala’au le Member Services numeru lisiina mo lou setete i le isi itulau.

Maliu: Ke wala’au Hawai’i ‘oe, loa’a ke kōkua ma ka unuhi ‘ōlelo me ke kākī ‘ole. E kelepona i ka helu kelepona o ka Māhele Kōkua Hoa i hō’ike ‘ia no kou moku’āina ma kēia ‘ao’ao a’e.

# We're Just a Phone Call Away

## ALABAMA

+ HMO, PPO

 **1-833-623-0771**

+ HMO D-SNP

 **1-833-542-1677**

## FLORIDA

+ HMO, HMO-POS


 **1-833-603-2971**

+ HMO D-SNP

 **1-833-542-1676**


## ILLINOIS

+ HMO

 **1-833-293-5966**

## INDIANA

+ HMO, PPO

 **1-833-525-0824**

+ HMO D-SNP

 **1-833-542-1679**


## KANSAS

+ HMO, PPO

 **1-833-816-6623**

## MICHIGAN

+ HMO, PPO

 **1-833-431-1356**

+ HMO D-SNP

 **1-833-542-1678**

## TENNESSEE

+ HMO, PPO

 **1-833-906-2876**

## TEXAS

+ HMO, PPO

 **1-833-705-1358**

**TTY FOR ALL OF THE ABOVE: 711**

## HOURS OF OPERATION

 **October 1 to March 31:** Monday-Sunday, 8 a.m. to 8 p.m.

 **April 1 to September 30:** Monday-Friday, 8 a.m. to 8 p.m.

 Or visit **[AscensionComplete.com](https://www.ascensioncomplete.com)**

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-831-9411 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

## Understanding the Benefits

- Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit [ascensioncomplete.com](http://ascensioncomplete.com) or call 1-877-831-9411 (TTY: 711) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- For plans with a plan premium (Does not apply to plans with zero plan premium):** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- For HMO plans only:** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- For PPO and PFFS plans only:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- For C-SNP plans only:** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- For D-SNP plans only:** This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

## Contact Us

For more information, please contact us:

### By phone

Toll-free at 1-877-831-9411 (TTY 711). Your call may be answered by a licensed agent.

### Hours of Operation

Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

**Online** [ascensioncomplete.com](https://www.ascensioncomplete.com)

**We're with our members every step of the way.**

Ascension Complete is contracted with Medicare for HMO and PPO plans. Enrollment in Ascension Complete depends on contract renewal.