Ascension **Complete**

2023
Summary of Benefits

Indiana

Ascension Complete St. Vincent Access (PPO)

H1774 | 002

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 St. Vincent Access (PPO) from January 1, 2023 to December 31, 2023.

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. To request a copy, please call 1-866-281-2878 (TTY 711): Hours are Monday - Sunday, 8 am - 8 pm (all time zones).

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. To be eligible, the beneficiary must also be a United States citizen or are lawfully present in the United States.

Our service area includes these counties in Indiana: Boone, Cass, Clinton, Gibson, Hamilton, Hancock, Hendricks, Henry, Howard, Madison, Miami, Montgomery, Posey, Putnam, Randolph, Shelby, Tipton, Vanderburgh, and Warrick.

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 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.

Preferred Provider Organizations (PPOs) You'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use contracted providers in our network. Out-of-network providers may choose not to bill our plan and may ask you to pay for services up front. If this happens, you can fill out a claim form and submit it to us with a copy of the bill and any documentation you have about payments you have made.
Out-of-network/non-contracted providers are under no obligation to treat Ascension Complete St. Vincent Access (PPO) plan members, except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Our plans also include prescription drug coverage and access to our large network of pharmacies. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these 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 St. Vincent Access (PPO) has 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.

For more information, please call us at 1-866-281-2878 (TTY users should call 711). Hours are Monday - Sunday, 8 am - 8 pm (all time zones). Visit us at 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

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Service Area	Our service area includes these counties in Indiana: Boone, Cass, Clinton, Gibson, Hamilton, Hancock, Hendricks, Henry, Howard, Madison, Miami, Montgomery, Posey, Putnam, Randolph, Shelby, Tipton, Vanderburgh, and Warrick.
PPO plans do not require a prior authorization or referral for out-of-network services.	
Monthly plan premium (includes both medical and drugs)	$0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$2,900 in-network annually $5,450 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.
Inpatient Hospital coverage	**In-Network** For each admission, you pay: • $440 copay per day for days 1 through 4 • $0 copay per day for days 5 through 90 • $0 copay per day for days 91 and beyond * **Out-of-Network** For each admission, you pay: • $440 copay per day for days 1 through 4 • $0 copay per day for days 5 and beyond

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

Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Outpatient Hospital coverage Outpatient hospital services	**In-Network** 20% coinsurance for surgical and non-surgical services * **Out-of-Network** 20% coinsurance for surgical and non-surgical services
Outpatient hospital observation services	**In-Network** $125 copay for outpatient observation services when you enter observation status through an emergency room. 20% coinsurance for outpatient observation services when you enter observation status through an outpatient facility. * **Out-of-Network** $125 copay for outpatient observation services when you enter observation status through an emergency room. 20% coinsurance for outpatient observation services when you enter observation status through an outpatient facility.
Ambulatory surgical center (ASC) services	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Doctor Visits Primary Care Physicians	**In-Network** $0 copay **Out-of-Network** $25 copay

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Specialists	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Preventive Care (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))	**In-Network** $0 copay **Out-of-Network** $0 copay
Emergency care	$125 copay Copay is waived if you are admitted to a hospital within 24 hours.
Worldwide emergency coverage	$125 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.
Urgently needed services	$40 copay Copay is waived if you are admitted to a hospital within 24 hours.
Worldwide urgent care coverage	$125 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

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Diagnostic Services/Labs/Imaging	COVID-19 testing and specified testing-related services at any location are $0.
Lab services	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Diagnostic tests and procedures	**In-Network** $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. 20% coinsurance for all other Medicare-covered diagnostic procedures and tests. * **Out-of-Network** $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. 20% coinsurance for all other Medicare-covered diagnostic procedures and tests.
Outpatient X-rays	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $0 copay for a Diagnostic Mammogram. 20% coinsurance for all other diagnostic radiology services. * **Out-of-Network** $0 copay for a Diagnostic Mammogram. 20% coinsurance for all other diagnostic radiology services.
Therapeutic Radiology	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Hearing services Hearing Exam Medicare Covered	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Routine hearing exam	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance 1 exam every year

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

Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Hearing Aids	
Hearing Aid Fitting/Evaluation(s)	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance 1 fitting(s) / evaluation(s) every year
Hearing aid allowance	Up to a $350 allowance per ear every year for hearing aids.
All types	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance Limited to 2 hearing aid(s) every year
Additional Hearing Information	**What you should know** 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

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Dental services	
Preventive services	**In-Network** $0 copay * **Out-of-Network** 70% coinsurance Cleanings 2 every year Dental x-rays 1 every 12 to 36 months depending on type of service Oral exams 2 every year
Fluoride Treatment	**In-Network** $0 copay * **Out-of-Network** 70% coinsurance 1 every year
Comprehensive services Medicare-covered	**In-Network** 20% coinsurance for each Medicare-covered service. * **Out-of-Network** 20% coinsurance for each Medicare-covered service.

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Diagnostic Services	**In-Network** 40% coinsurance * **Out-of-Network** 70% coinsurance 1 diagnostic service(s) every year
Restorative Services	**In-Network** 40% coinsurance * **Out-of-Network** 70% coinsurance 1 restorative service(s) every 12 to 84 months depending on type of service
Endodontics/ Periodontics/ Extractions	**In-Network** 40% coinsurance * **Out-of-Network** 70% coinsurance 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months depending on type of service 1 extraction(s) per tooth
Non-routine services	**In-Network** 40% coinsurance * **Out-of-Network** 70% coinsurance 1 non-routine service(s) every date of service to 60 months depending on type of service

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	**In-Network** 40% coinsurance * **Out-of-Network** 70% coinsurance Prosthodontics - every 12 to 84 months depending on type of service. Oral/maxillofacial surgery - every 12 to 60 months or per lifetime depending on type of service. Other services - every 6 to 60 months depending on type of service.
Additional Dental Information	**What you should know:** This plan includes coverage of comprehensive services up to $5,000 per plan year.
Vision Services Eye Exam Medicare Covered	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) 20% coinsurance (all other Medicare-covered eye exams) * **Out-of-Network** $0 copay (Medicare-covered diabetic retinopathy screening) 20% coinsurance (all other Medicare-covered eye exams)
Routine eye exam (Refraction)	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance 1 exam every year

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

Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Glaucoma screening	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** $0 copay for each Medicare-covered service.
Eyewear Medicare Covered	**In-Network** $0 copay * **Out-of-Network** $0 copay
Routine eyewear	
Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance
Eyewear allowance	Up to a $200 combined allowance towards contacts and glasses (lenses and/or frames) every year.
Mental Health Services	
Inpatient visit	**In-Network** For each admission, you pay: • $575 copay per day for days 1 through 4 • $0 copay per day for days 5 through 90 * **Out-of-Network** For each admission, you pay: • $575 copay per day for days 1 through 4 • $0 copay per day for days 5 through 90

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Outpatient individual therapy visit	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Outpatient group therapy visit	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Skilled nursing facility (SNF)	**In-Network** For each admission, you pay: • $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 40 • $0 copay per day for days 41 through 100 * **Out-of-Network** For each admission, you pay: • $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 100
Therapy and Rehabilitation Services Physical Therapy	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Outpatient rehabilitation services provided by an occupational therapist	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Pulmonary rehabilitation services	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance
Ambulance Ground Ambulance	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Air Ambulance	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Transportation Services	**In-Network** Not covered **Out-of-Network** Not covered

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Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Medicare Part B Drugs Chemotherapy drugs	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Other Part B drugs	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance

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

Prescription Drug Coverage	**Ascension Complete St. Vincent Access (PPO) H1774, Plan 002**	
Stage 1: Annual Prescription Deductible		
Deductible	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.	
Stage 2: Initial Coverage (after you pay your deductible, if applicable)		
You pay the following until your total yearly drug costs reach $4,660. 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.		
Important Message About What You Pay for Vaccines and Insulin: Our plan covers most Part D vaccines at no cost to you, even if you have not paid your deductible (if your plan has a deductible). You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it is on, even if you have not paid your deductible (if your plan has a deductible).		
Retail cost-sharing (30-day/90-day supply)		
	Preferred	**Standard**
Tier 1 Preferred Generic Drugs	$0 / $0 copay	$5 / $15 copay
Tier 2 Generic Drugs	$5 / $15 copay	$10 / $30 copay
Tier 3 Preferred Brand Drugs	$37 / $111 copay	$47 / $141 copay
Tier 4 Non-Preferred Drugs	$90 / $270 copay	$100 / $300 copay
Tier 5 Specialty Tier	33% coinsurance / Not Available	33% coinsurance / Not Available
Tier 6 Select Care Drugs	$0 / $0 copay	$0 / $0 copay

Prescription Drug Coverage	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002	
Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)		
Mail-order cost-sharing (30-day/90-day supply)		
	Preferred	**Standard**
Tier 1 Preferred Generic Drugs	$0 / $0 copay	$5 / $15 copay
Tier 2 Generic Drugs	$5 / $0 copay	$10 / $30 copay
Tier 3 Preferred Brand Drugs	$37 / $74 copay	$47 / $141 copay
Tier 4 Non-Preferred Drugs	$90 / $180 copay	$100 / $300 copay
Tier 5 Specialty Tier	33% coinsurance / Not Available	33% coinsurance / Not Available
Tier 6 Select Care Drugs	$0 / $0 copay	$0 / $0 copay
Stage 3: Coverage Gap		
	After your total drug costs (including what our plan has paid and what you have paid) reach $4,660, 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.	
Stage 4: Catastrophic Coverage		
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: • 5% coinsurance, or • $4.15 copay for generic (including brand drugs treated as generic) and $10.35 copay for all other drugs.	

Generic drugs may be covered on tiers other than Tier 1 and Tier 2. Please check this plan's Formulary to validate the specific tier on which your drugs are covered.

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

Excluded Drugs:

Ascension Complete St. Vincent Access (PPO) include(s) 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

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Chiropractic Care Medicare-covered	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Acupuncture Medicare-covered	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. 20% coinsurance for Medicare-covered Acupuncture received in a Specialist office. 20% coinsurance for Medicare-covered Acupuncture received in a Chiropractor office. * **Out-of-Network** $25 copay for Medicare-covered Acupuncture received in a PCP office. 20% coinsurance for Medicare-covered Acupuncture received in a Specialist office. 20% coinsurance for Medicare-covered Acupuncture received in a Chiropractor office.
Podiatry Services (Foot Care) Medicare Covered	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance

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

Additional Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Routine Podiatry Services	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance Unlimited visit(s) every year
Virtual Visits	Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device. For more information, or to schedule an appointment, call Teladoc at 1-800-835-2362 (TTY:711) 24 hours a day, 7 days a week.
Home health agency care	**In-Network** $0 copay * **Out-of-Network** $0 copay
Meals Post-Acute Meals	 $0 copay **What you should know:** You pay nothing for meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days with a maximum of 42 meals per occurrence for an unlimited number of occurrences per year.

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

Additional Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Medical Equipment/Supplies Durable Medical Equipment (DME)	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Prosthetics	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Diabetic supplies	**In-Network** $0 copay * **Out-of-Network** $0 copay Limitations may apply
Diabetic therapeutic shoes or inserts	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance
Opioid treatment program services	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance

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

Additional Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Over-the-Counter (OTC) Items	$0 copay Maximum benefit is $80 every three months to spend on plan-approved OTC items. Limitations may apply. At the end of each benefit period, any unused benefit dollars will expire. **What you should know:** You can purchase eligible OTC items from participating CVS retail locations with your plan's Member ID Card or from the catalog by phone or online for home delivery. - To place an order over the phone call: 1-866-528-4679, (TTY 711) - Order via the catalog online at www.cvs.com/otchs/ascensioncomplete
Wellness Programs Fitness	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay Coverage includes: Activity Tracker and Physical Fitness **What you should know:** 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 fitness tracker may be selected as part of a home fitness kit.
Additional sessions of smoking and tobacco cessation counseling	**In-Network** $0 copay **Out-of-Network** $0 copay Limited to 5 visit(s) every year

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

Additional Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Additional Routine Annual Physical	**In-Network** $0 copay **Out-of-Network** $0 copay **What you should know:** The exam includes a detailed medical/family history, performance of a detailed head-to-toe assessment with a hands-on examination of all the body systems, recommendations for preventive screenings/care, and counseling about healthy behaviors, and is beyond the Annual Wellness Visit services.
24-Hour Nurse Advice Line	$0 copay
Spiritual Care	$0 copay 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. Chaplains are experienced in such things as spiritual assessments, care for grief and loss and stress management. Using the Ascension Online Care platform or through Ascension's care management team, members who are experiencing spiritual and emotional concerns can connect to a chaplain to help address their needs and find light in challenging times.
Counseling services	$0 copay In addition to the Medicare-covered outpatient mental health benefits, we cover counseling for general topics such as marriage, family and grief. You may see a Medicare-qualified mental health professional, or access these services over the phone and online using our plan's virtual visit provider. Virtual visits are accessible 24 hours a day, 7 days a week.

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

Additional Benefits

	Ascension Complete St. Vincent Access (PPO) H1774, Plan 002
Flex Card	$1,000 yearly benefit **What you should know:** The flex card benefit is a debit card that may be used to cover out of pocket dental, vision or hearing costs. The flex card has a limit of $250 for vision services. The remaining balance may be spent between dental and hearing services as you see fit.

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

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para obtener un intérprete, simplemente llámenos a los números del plan que figuran en las siguientes páginas. Alguien que hable español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们有免费的口译服务来回答您就我们的健康或药物计划提出的任何问题。如需口译员，只需拨打以下页面上的计划号码致电联系我们。会说中文普通话的人员可以协助您。此为免费服务。

Chinese Cantonese: 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打以下頁面上的計劃號碼致電聯絡我們。會說粵語的人員可以協助您。此為免費服務。

Tagalog: Meron kaming libreng serbisyo ng interpreter para sagutin anumang tanong na meron ka tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan lang kami sa mga numero ng plano na nasa sumusunod na mga pahina. Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser au sujet de notre régime de soins médicaux ou de notre régime d'assurance-médicaments. Pour bénéficier des services d'un interprète, il suffit de nous appeler aux numéros de régime indiqués dans les pages suivantes. Quelqu'un qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi cung cấp dịch vụ phiên dịch viên miễn phí để trả lời bất kỳ câu hỏi nào quý vị có về chương trình y tế hoặc thuốc của chúng tôi. Để nhận được dịch vụ phiên dịch, chỉ cần gọi cho chúng tôi theo số điện thoại của chương trình trong các trang sau. Người nào đó nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetscherdienst, um alle Ihre Fragen zu unserem Gesundheits- oder Medikamentenplan zu beantworten. Um einen Dolmetscher zu finden, rufen Sie uns einfach unter den auf den folgenden Seiten angegebenen Plan-Nummern an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist für Sie kostenlos.

Korean: 저희의 건강 또는 약품 플랜에 대한 질문에 답해 드릴 수 있는 무료 통역 서비스를 제공합니다. 통역사에게 연결하려면 다음 페이지에 있는 플랜 번호로 전화하시기 바랍니다. 한국어를 하는 분이 도와드릴 수 있습니다. 이 통화는 무료 서비스입니다.

Russian: Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы, которые могут возникнуть у вас о нашем плане медицинского страхования или страхового покрытия лекарственных препаратов. Чтобы получить устного переводчика, просто позвоните нам по номерам планов, указанным на следующих страницах. Вам поможет тот, кто говорит по-русски. Эта услуга предоставляется бесплатно.

Arabic: نوفر خدمات مترجم فوري للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. للاستعانة بمترجم، ما عليك سوى الاتصال بنا على أرقام الخطة في الصفحات التالية. شخص يتحدث العربية بمكنه مساعدتك. هذه الخدمة تقدم مجانًا.

Hindi: हमारे स्वास्थ्य या दवा योजना के बारे में आपके होने वाले किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। दुभाषिया प्राप्त करने के लिए, हमें निम्नलिखित पृष्ठों पर दिए गए प्लान नंबरों पर कॉल करें। कोई हिंदी भाषी व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Disponiamo di servizi di interpretariato gratuiti per rispondere ad eventuali domande in merito al nostro piano sanitario o farmaceutico. Per ottenere un interprete, chiami i recapiti del piano disponibili nelle pagine successive. Qualcuno che parla italiano Le sarà d'aiuto. Si tratta di un servizio gratuito.

Portugués: Temos serviços de intérprete gratuitos para responder quaisquer perguntas que você possa ter sobre nossos planos de saúde ou de medicamentos. Para solicitar um intérprete, ligue para nós através dos números do plano nas páginas a seguir. Um funcionário que fala português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan nimewo plan yo ki sou paj annapre yo. Yon moun ki pale Kreyòl Franse kapab ede ou. Se yon sèvis gratis li ye.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe w przypadku pytań dotyczących naszego planu zdrowotnego i lekowego. Aby skorzystać z tłumacza, prosimy zadzwonić do nas pod numery podane na kolejnych stronach. Pomocą posłużą osoby mówiące po polsku. Usługa jest bezpłatna.

Japanese: 当社の医療プランまたは処方薬プランについての質問にお答えする無料の通訳サービスをご利用いただけます。通訳サービスをご利用になるには、以降のページにおけるプランの番号までお電話ください。日本語を話すスタッフが対応いたします。これは無料のサービスです。

Hawaiian: Aia iā mākou he mau lawelawe māhele ʻōlelo manuahi e pane i nā ʻano nīnau āu no ka mākou papahana mālama olakino a hoʻolako lāʻau. No ka ʻimi i mea māhele ʻōlelo, e kelepona wale mai iā mākou ma nā helu kelepona e waiho nei ma kēia mau ʻaoʻao e koe nei. Na kekahi māhele ʻōlelo Hawaiʻi e kōkua iā ʻoe. He lawelawe manuahi kēia.

Ilocano: Addaankami kadagiti libre a serbisio ti panagipatarus tapno masungbatan dagiti aniaman a saludsodmo maipapan iti salun-at wenno plano iti agas. Tapno makaala iti tagaipatarus, tawagannakami laeng kadagiti numero ti plano kadagiti sumaganad a panid. Matulongannaka ti maysa a tao nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Samoan: E iai a matou auaunaga faʼaliliu upu fua e tali ai soʻo se fesili e te ono iai e uiga i la matou fuafuaga faʼalesoifua maloloina poʻo vailaʼau. Mo le mauaina o se faʼaliliu upu, naʻo le valaʼau mai i numera o fuafuaga o loʻo i itulau nei. E mafai e se tasi e tautala i le gagana Samoa ona fesoasoani ia te oe. Ose auaunaga e leai se totogi.

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**

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 Member Services representative at 1-866-281-2878 (TTY: 711). Hours are Monday - Sunday, 8 am - 8 pm (all time zones).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit ascensioncomplete.com or call 1-866-281-2878 (TTY: 711) to view a copy of the EOC. Hours are Monday - Sunday, 8 am - 8 pm (all time zones).
- ☐ 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ 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, 2024.
- ☐ **For PPO, PFFS and POS plans:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, 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.

Contact Us

For more information, please contact us:

By phone

Toll-free at 1-866-281-2878 (TTY 711). Your call may be answered by a licensed agent.

Hours of Operation

Monday - Sunday, 8 am - 8 pm (all time zones)

Online 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.

Out-of-network/non-contracted providers are under no obligation to treat 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.