ascend
TO WHOLENESS
HEALTHCARE PLANS

2023
SCHEDULE OF BENEFITS

accelerate access

SCHEDULE OF BENEFITS FOR THE ACCELERATE AND ACCESS OPTIONS

Here is the schedule of benefits for the Accelerate and Access options on the Ascend to Wholeness Healthcare Plan (the Plan). Benefits include medical, dental, vision, prescription, and lifestyle programs. The 2023 Summary Plan Document (SPD) will be available by November on the Plan Documents page at AscendtoWholeness.org.

Medical Benefits

Out-of-network (OON) services are generally not covered. Exceptions include emergencies, behavioral health counselling or approved unavailable services. You may be subject to balance billing. To see your protection and rights from being balance billed, review the **Surprise Medical Bills Notice**. Refer to the SPD for more details.

Benefits	Member Responsibility	
	Accelerate	Access
DEDUCTIBLE • Individual/Family • Services subject to deductible are marked with (D)	**$350/$700**	**$700/$1,400**
COINSURANCE After deductible	**20%**	**20%**
OUT-OF-POCKET MAXIMUMS Individual/Family	**$2,850/$5,700**	**$5,700/$11,400**
PREVENTIVE SERVICES Paid at 100% of allowable charges in-network	**$0**	**$0**
OFFICE VISIT • Copay applies only to office visit charge, based on contracted rate in-network; all other charges are paid at 80% of in-network allowable charge. • Other charges during an office visit apply to plan year deductible and out-of-pocket maximum.	**$25**	**$50**

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Benefits	Member Responsibility	
	Accelerate	Access
Facility/Ambulatory Services		
OUTPATIENT SERVICES • Paid at 80% of allowable charges in-network. • Applies to plan year deductible and out-of-pocket maximum. • Pre-certification required for some outpatient services (see the Services Requiring Pre-Certification section in the SPD).	**20%** **(D)**	**20%** **(D)**
IN-PATIENT/OUTPATIENT HOSPITAL STAYS: Office/Ambulatory Surgical Procedures • Pre-certification required for all inpatient surgeries/stays (except for observation only and normal child delivery in a PPO facility by a PPO provider). • Pre-certification required for some outpatient/ambulatory procedures (see the Services Requiring Pre-Certification section in the SPD). • Applies to plan year deductible and out-of-pocket maximum.	**20%** **(D)**	**20%** **(D)**
ORGAN/TISSUE TRANSPLANTS • Pre-certification required • Applies to plan year deductible and out-of-pocket maximum.	**20%** **(D)**	**20%** **(D)**

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Benefits	Member Responsibility	
	Accelerate	Access
Physician/Provider Services		
THERAPEUTIC SERVICES Physical Therapy Occupational Therapy Speech Therapy • Maximum of 60 visits for any therapeutic category. • Pre-certification required after 12 visits per condition/incident. • Applies to plan year deductible and out-of-pocket maximum. • May require pre-certification. Please refer to SPD for specifics.	**20%** **(D)**	**20%** **(D)**
VISION THERAPY • Maximum of 30 visits per plan year. • Pre-certification required.	**20%** **(D)**	**20%** **(D)**
TELEHEALTH • Telehealth for medical services may be accessed through the Plan's telehealth vendor (Amwell) or from a PPO provider (as long as the PPO provider is appropriately licensed and has the appropriate technology to provide and bill for the covered services). • Telehealth counselling sessions for mental health and substance abuse/chemical depedency may be accessed through the Plan's telehealth vendor (Amwell) or from a PPO provider (as long as the PPO provider is appropriately licensed and has the appro priate technology to provide and bill for the covered services) or from an out-of-network provider. Member may be balanced billed by the out-of-network provider.	**$0 copay**	**$0 copay**

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Benefits	Member Responsibility	
	Accelerate	Access
Physician/Provider Services		
MATERNITY & OBSTETRICS Applies to plan year deductible and out-of-pocket maximum	**20%** **(D)**	**20%** **(D)**
Emergency Care		
EMERGENCY ROOM • Deductible does not apply if not admitted to the hospital.* • If admitted, deductible applies, but copayment is waived. • Emergency room visits are only covered when there is an emergency medical condition.	**20% after $100 copay (D)***	**20% after $100 copay (D)***
EMERGENCY ROOM IN-PATIENT HOSPITAL ADMISSION • Out-of-network services are only covered for emergency services (and post-stabilization services to the extent coverage is requested by the No Surprises Act), after which point out-of-network services will not be covered if the patient refuse transfer to an in-network facility.	**20%** **(D)**	**20%** **(D)**
AMBULANCE SERVICES • Pre-certification required for non-emergency ground transportation and for any air transportation (unless the utilization review manager determines that ground transportation would have endangered the life of the enrollee). • Applies to plan year deductible and out-of-pocket maximum.	**20%** **(D)**	**20%** **(D)**

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Benefits	Member Responsibility	
	Accelerate	Access
Emergency Care		
URGENT CARE CENTERS • May be paid as an office visit or as an emergency room visit according to provider contract. • Deductible does not apply regard less of how billed. • Facility fees for office visits are not paid.	**$25 – when paid as Office Visit or $100 + 20% – when paid as ER visit**	**$50 – when paid as Office Visit or $100 + 20% – when paid as ER visit**
Equipment/Supplies		
DURABLE MEDICAL EQUIPMENT • Pre-certification required for any CPM devices/machines and Dynasplints. • Pre-certification required for other durable medical equipment or repair with billed charges of $2,000 or more. • Pre-certification required for any custom orthotics and for orthotics/prosthetics with billed charges of $2,000 or more. • Pre-certification required for all rentals • Applies to plan year deductible and out-of-pocket maximum.	**20% (D)**	**20% (D)**
BREAST PUMP • Pre-certification required for breast pump expenses of $2,000 or more.	**0%**	**0%**
WIG AS A RESULT OF CHEMO TREATMENT BENEFIT • Plan year maximum benefit $1,000 • Applies to plan year deductible and out-of-pocket maximum.	**20% (D)**	**20% (D)**

Medical Benefits

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Benefits	Member Responsibility	
	Accelerate	Access
Mental Health/Substance Abuse		
MENTAL HEALTH COUNSELING SESSIONS Out-of-network behavioral practitioner care covered at usual and customary rates, member may be balance billed.	**$25**	**$50**
MENTAL HEALTH OUTPATIENT SERVICES/PARTIAL HOSPITALIZATION • Pre-certification required for intensive outpatient programs and some other outpatient services (see the Services Requiring Pre-Certification section in the SPD). • Pre-certification required for partial hospitalization. • Out-of-network behavioral health practitioner care covered at usual and customary rates. • Applies to plan year deductible and out-of-pocket maximum.	**20%** **(D)**	**20%** **(D)**
MENTAL HEALTH IN-PATIENT SERVICES • Paid at 80% of allowable charges in-network • Pre-certification required. • Applies to plan year deductible and out-of-pocket maximum.	**20%** **(D)**	**20%** **(D)**
RESIDENTIAL CARE AND TREATMENT • Pre-certification required. • Applies to plan year deductible and out-of-pocket maximum.	**20%** **(D)**	**20%** **(D)**

Medical Benefits

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Benefits	Member Responsibility	
	Accelerate	Access
Mental Health/Substance Abuse		
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY COUNSELING SESSIONS Out-of-network behavioral health practitioner care covered at usual and customary rates.	**$25**	**$50**
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY Outpatient/Partial Facility Visits • Pre-certification required for inten sive outpatient programs and some other outpatient services (see the Services Requiring Pre-Certification section in the SPD). • Out-of-network behavioral health practitioner care covered at usual and customary rates. • Applies to plan year deductible and out-of-pocket maximum.	**20% (D)**	**20% (D)**
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY In-patient Treatment • Pre-certification required. • Applies to plan year deductible and out-of-pocket maximum.	**20% (D)**	**20% (D)**

Medical Benefits

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Benefits	Member Responsibility	
	Accelerate	Access
Mental Health/Substance Abuse		
TELEHEALTH • Telehealth counseling sessions for mental health and substance abuse/chemical dependency may be accessed through the Plan's telehealth vendor (Amwell) or from a PPO provider or an out-of-network (OON) provider if available. • OON telehealth counseling sessions are covered at usual and customary rates. • Member may be balance billed by OON providers.	**$0 copay**	**$0 copay**
Others Services		
HEARING CARE PROFESSIONAL TESTING/SCREENING	**20% (D)**	**20% (D)**
HOME HEALTH CARE • Maximum of 120 visits per plan year. • Pre-certification required. • Home health care plan submission required. • Applies to plan year deductible and out-of-pocket maximum.	**20% (D)**	**20% (D)**
SKILLED NURSING FACILITY • Pre-certification required. • Applies to plan year deductible and out-of-pocket maximum.	**20% (D)**	**20% (D)**
HOSPICE CARE • Paid at 100% of allowable charges • Pre-certification required.	**$0**	**$0**

Medical Benefits

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Benefits	Member Responsibility	
	Accelerate	Access
Others Services		
OUTPATIENT DIABETES SELF-MANAGEMENT TRAINING (DSMT) • Up to 10 hours (1 hour private and 9 hours group) training from a certified DSMT provider in the first plan year and then up to 2 hours of follow-up training in subsequent plan years.	**0%**	**0%**
NUTRITIONAL COUNSELING • 5 visits per plan year. Additional visits may be authorized by the utilization review manager.	**$0 copay**	**$0 copay**
Unavailable Services		
UNAVAILABLE SERVICES (When in-network medical services are not available) • Only covered with approved Unavailable Service Request Form. • 20%-member responsibility, if approved; otherwise not covered. • Applies to plan year deductible and out-of-pocket maximum.	**N/A**	**N/A**

Medical Benefits - No PPO Network Utilization Required

Benefits	Member Responsibility	
	Accelerate	Access
ALTERNATIVE THERAPIES CHIROPRACTIC SERVICES • Limited to spinal manipulation after annual office visit and X-ray. • Maximum visit limit per plan year = 15. • Must be age 10 or older. • Does not apply to plan year deductible or out-of-pocket maximum.	**20%**	**50%**
ALTERNATIVE THERAPIES ACUPUNCTURE THERAPY • Must be age 18 or older. • Maximum visit limit per plan year = 15. • Does not apply to plan year deductible or out-of-pocket maximum.	**50%**	**Not Covered 100%**
ALTERNATIVE THERAPIES MASSAGE THERAPY • Maximum allowable charge is $90 per visit. • Minimum of a 30-minute visit. • Maximum visit limit per plan year = 15. • Must be age 18 or older. • Does not apply to plan year deductible or out-of-pocket maximum.	**50%**	**Not Covered 100%**
REFRACTIVE EYE SURGERY • Lifetime maximum payable benefit of $2,400. • Does not apply to plan year deductible or out-of-pocket maximum.	**20%**	**50%**

Medical Benefits - No PPO Network Utilization Required

Benefits	Member Responsibility	
	Accelerate	Access
HEARING AIDS • Paid at 80% of allowable charges. • Plan year maximum payable benefit of $3,200. • Does not apply to plan year deductible or out-of-pocket maximum.	**20%**	**20%**
INFERTILITY TREATMENT • Lifetime maximum benefit $16,000. • Does not apply to plan year deductible or out-of-pocket maximum.	**20%**	**50%**
LIFESTYLE PROGRAM CHIP (Complete Health Improvement Program) WW (Weight Watchers) • 1 completed session/program per plan year. • Physician prescription required with claim submission. • Member will be reimbursed upon producing a receipt for covered service. • Does not apply to plan year deductible or out-of-pocket maximum. • Proof of 80% completion required as a condition of coverage.	**0% with proof of 80% completion**	**Only CHIP is covered (with 0% member cost-sharing with proof of 80% completion)** **WW is not covered**

Prescription Benefits

Benefits	Member Responsibility	
	Accelerate	Access
PRESCRIPTION DRUG Out-of-pocket maximums: Individual/Family	**$1,250/$2,500**	**$1,550/$3,100**
PRESCRIPTION DRUG Prescription copayment responsibility 30 DAY SUPPLY – RETAIL		
• Chronic Preventive Generic	• **$2**	• **$2**
• All Other Generic	• **$10**	• **$10**
• Brand (Preferred)	• **$25**	• **$55**
• Non-Formulary (Non-Preferred)	• **$45**	• **$105**
PRESCRIPTION DRUG Prescription copayment responsibility 90 DAY SUPPLY – WALGREENS/ ESI MAIL ORDER		
• Chronic Preventive Generic	• **$4**	• **$4**
• All Other Generic	• **$20**	• **$20**
• Brand (Preferred)	• **$50**	• **$110**
• Non-Formulary (Non-Preferred)	• **$90**	• **$210**
PRESCRIPTION DRUG SaveOn Specialty Program • Filled through Accredo–a specialty drug mail-order pharmacy. • Copayments vary based on specific drug but will be $0 if you sign up for the SaveonSP Program. Any copay will not apply to your out-of-pocket limit. • If you qualify for this program, you will be contacted by Saveon SP, otherwise for more details call SaveonSP at (800) 683-1074.	**$0**	**$0**

- This benefit only covers services/supplies received from Express Scripts (ESI) or from a pharmacy contracted with ESI.
- Copayments apply to the prescription benefit out-of-pocket maximum, except as noted for the SaveOn Specialty Program.
- Penalties for non-compliance do not apply toward plan year out-of-pocket maximum.
- Some chronic preventive generic drugs are also subject to the Affordable Care Act (ACA) and may be covered by the Plan at 100%. Please verify the current covered drugs by calling Express Scripts at (800) 841-5396.
- Out-of-pocket for prescription benefits will be tracked by the Pharmacy Benefit Manager (PBM). Your pharmacy will be notified if you reach the plan year out-of-pocket maximum.
- Any adjudication, pre-certification, Plan provision or requirement of the Plan's designated pre-certification office will take precedence over those documented in the Plan.

Dental Benefits

Benefits	Member Responsibility			
	Accelerate		Access	
	In-Network	Out-of-Network	In-Network	Out-of-Network
PLAN YEAR DEDUCTIBLE Individual/Family	**$100/$300**	**$150/$450**	**$250/$750**	**$500/$1,500**
COINSURANCE After deductible	**20%**	**25%**	**20%**	**50%**
MAXIMUM PAYABLE BENEFIT PER PLAN YEAR Individual/Family	**$2,500/$7,500**	**$2,500/$7,500**	**$2,500/$7,500**	**$2,500/$7,500**
DENTAL CARE | PREVENTIVE CARE • Paid at 100%. • Plan year deductible does not apply. • Applies to plan year maximum payable benefit.	**0%**	**0%**	**0%**	**0%**
DENTAL CARE | RESTORATIVE CARE • Paid at 80% of allowable charges in-network. • Usual & Customary charges apply to out-of-network providers. • Applies to plan year deductible.	**20%**	**25%**	**20%**	**50%**
ORTHODONTIC CARE • Paid at 50% of allowable charges. • $2,300 maximum lifetime payable. • Eligible up to age 26 (through age 25).	**50%**	**50%**	**50%**	**50%**

Vision Benefits

Benefits	Member Responsibility	
	Accelerate	Access
VISION CARE • Paid at 80% of allowable charges. • Plan year maximum payable benefit $450 per member (Accelerate) and $225 per member (Access). • Does not apply to plan year deductible and medical out-of-pocket maximums.	**20%**	**50%**

This Schedule of Benefits is only a summary and briefly describes some benefits of the Ascend to Wholeness Healthcare Plan. Please refer to the Summary Plan document at AscendtoWholeness.org for a complete description of your benefits.

Administered by Adventist Risk Management,® Inc.

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