



Here is the schedule of benefits for the Accelerate and Access options of the Ascend to Wholeness Healthcare Plan (the Plan). Benefits include medical, dental, vision, prescription, and lifestyle programs. The 2024 Summary Plan Document (SPD) will be available by November 2023 on the Plan Documents page at AscendtoWholeness.org.






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.

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ber Responsibility





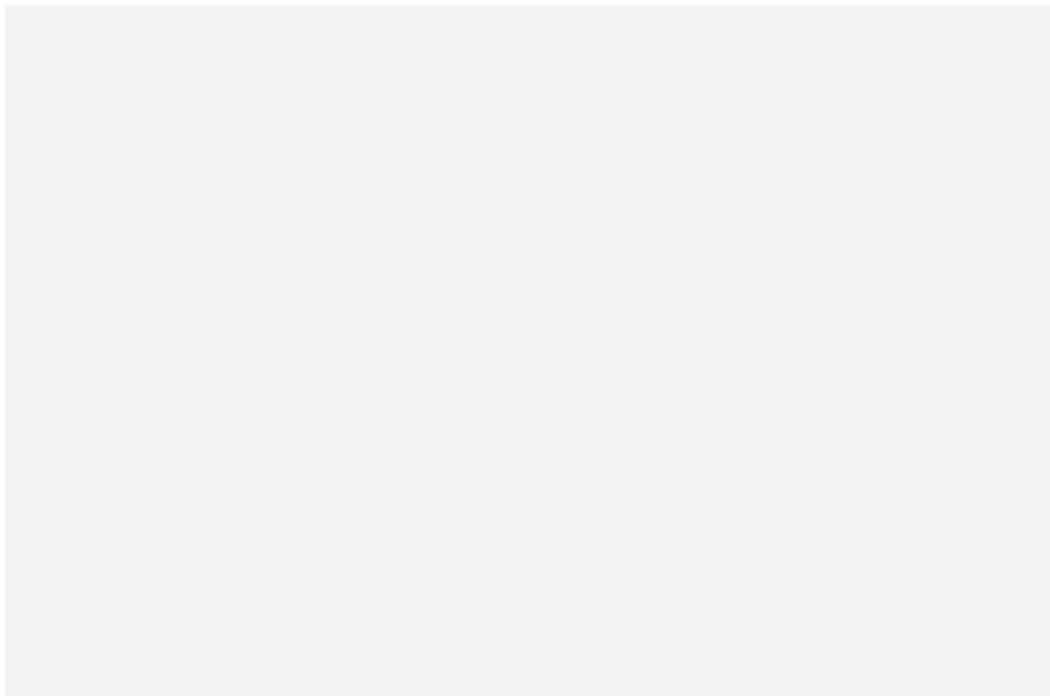
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OTHER SERVICES		
HEARING CARE PROFESSIONAL TESTING/SCREENING	20% (D)	20% (D)
HOME HEALTH CARE		

ALTERNATIVE THERAPIES MASSAGE THERAPY <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Lifetime maximum payable benefit of \$2,400. Does not apply to plan year deductible or out-of-pocket maximum. 	20%	50%
HEARING AIDS <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Lifetime maximum benefit \$16,000. Does not apply to plan year deductible or out-of-pocket maximum. 	20%	50%
LIFESTYLE PROGRAM <ul style="list-style-type: none"> (Previously CHIP) (Weight Watchers) 1 completed session/program per plan year-online or in-person. 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 Pivio is covered (with 0% member cost-sharing with proof)

PRESCRIPTION DRUG Out-of-pocket maximums: Individual/Family	\$1,250/\$2,500	\$1,550/\$3,100
PRESCRIPTION DRUG Chronic Preventive Generic All Other Generic Brand (Preferred) Non-Formulary (Non-Preferred) 30 DA L E AIL	<ul style="list-style-type: none"> • \$2 • \$10 • \$25 • \$45 	<ul style="list-style-type: none"> • \$2 • \$10 • \$55 • \$105
PRESCRIPTION DRUG Chronic Preventive Generic All Other Generic Brand (Preferred) Non-Formulary (Non-Preferred) 90 DA L ALG EE /E I MAIL DE	<ul style="list-style-type: none"> • \$4 • \$20 • \$50 • \$90 	<ul style="list-style-type: none"> • \$4 • \$20 • \$110 • \$210
PRESCRIPTION DRUG <i>SaveOn Specialty Program</i> Filled through Accredo—a specialty drug mail-order pharmacy.		



Dental Benefits

	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 <ul style="list-style-type: none"> • Paid at 100%. • Plan year deductible does not apply. • Applies to plan year maximum payable benefit. 	0%	0%	0%	0%
DENTAL CARE RESTORATIVE CARE <ul style="list-style-type: none"> • Paid at 80% of allowable charges in-network. • Usual and Customary charges apply to out-of-network providers. • Applies to plan year deductible. 	20%	25%	20%	50%
ORTHODONTIC CARE <ul style="list-style-type: none"> • Paid at 50% of allowable charges. • \$2,300 maximum lifetime payable. • Eligible up to age 26 (through age 25). 	50%	50%	50%	50%

VISION CARE <ul style="list-style-type: none"> • 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%	20%