ascend
TO WHOLENESS
HEALTHCARE PLANS

# 2021 Plan Comparison
SUMMARY

## Your Healthcare Plans: Accelerate and Access Side by Side

**The Ascend to Wholeness Healthcare Plans (the Plan) are designed to empower you to achieve your goals of complete whole-person health through the mind, body, and spirit. This is accomplished through robust benefits provided by the plans, geared to assist and educate you on your current health as well as provide a strong foundation for life-long changes to achieve a "wholistic" approach to a healthy lifestyle.**

**Effective January 1, 2021**, you have two health plan choices, Accelerate and Access, depending on your 2020 engagement level. These plans include Medical, Dental, Vision, and Prescription benefits that are highly competitive in the market, and Affordable Care Act (ACA) compliant. Both plans also give you full access to whole-person health and wellness programs to help you avoid preventable illnesses and manage pre-existing medical conditions.

**Learn more in the 2021 Plan Guide and on www.AscendToWholeness.org.**

The Plan Comparison Summary was created with the intent to help you compare both plans and see which one best fits your lifestyle, health concerns, and out-of-pocket expenses. For a copy of the full plan document please see the 2021 Summary Plan Document (SPD) at www.AscendtoWholeness.org. This document will be posted by November.

**Please note these important items are remaining the same:**

- Medical benefit services are only covered through the In-Network Preferred Provider Organization (PPO) Aetna Signature Administrators network. Out-of-network care will require prior authorization by the Plan. Certain treatment does not require in-network providers, including emergency care, urgent behavioral care, health practitioner care, alternative therapies (massage, acupuncture, chiropractic), refractive eye surgery, hearing aids and infertility treatments (please verify your Plan includes these benefits before making an appointment). If specialized care is unavailable at an in-network facility, please contact member services at (888) 276-4732 for additional assistance. It is your responsibility to verify that your chosen medical provider is in the Aetna Signature Administrators PPO.
- Verify your provider's medical and dental network status by clicking on the links or visit www.AscendtoWholeness.org. While the Plans do not require dental care to be provided by an in-network provider it is often less expensive to use a dental provider who is.
- Your Medical and Prescription benefits Out-of-Pocket (OOP) maximum accruals include coinsurance, deductibles, and co-payments. Once you reach this maximum the Plan pays 100%.
- Your Medical and Prescription benefits Out-of-Pocket maximum responsibilities are noted below. No combination of your medical and prescription benefits OOP will exceed the max allowable by the ACA.
- The Accelerate Plan will reimburse members for participation in CHIP and Weight Watchers. See details below in the Schedule of Benefits section and in the SPD.

## Out-of-Pocket Maximums

| | Individual | | | Family | | |
|---|---|---|---|---|---|---|
| *Plan* | *Medical* | *Pharmacy* | TOTAL | *Medical* | *Pharmacy* | TOTAL |
| accelerate | $2,750 | $1,250 | **$4,000** | $5,500 | $2,500 | **$8,000** |
| access | $5,600 | $1,550 | **$7,150** | $11,200 | $3,100 | **$14,300** |

# Schedule of Benefits

**The Schedule of Benefits is only a summary.** You should also read the full Plan document, the Summary Plan Document (SPD), for additional information about your benefits. The 2021 SPD will be available by November at **www.AscendToWholeness.org** on the Plan Documents page.

## Medical Benefits

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **DEDUCTIBLE**<br>Individual / Family | $300/$600 | $600/$1,200 |
| **CO-INSURANCE**<br>(after deductible) | 20% | 20% |
| **OUT-OF-POCKET MAXIMUMS**<br>Individual / Family | $2,750/$5,500 | $5,600/$11,200 |
| **PREVENTIVE SERVICES**<br>Paid at 100% of allowable charges in-network | $0 | $0 |
| **OFFICE VISIT**<br>• 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<br>• Other charges during an office visit apply to plan year deductible and out-of-pocket maximum | $25 | $50 |
| **FACILITY / AMBULATORY SERVICES** | | |
| **OUTPATIENT SERVICES**<br>• Paid at 80% of allowable charges in-network<br>• Applies to Plan Year deductible and out-of-pocket maximum<br>• Pre-certification required for some outpatient services (see the "Services Requiring Pre-Certification" section in the SPD) | 20% | 20% |
| **INPATIENT/OUTPATIENT HOSPITAL STAYS:**<br>*Office/Ambulatory Surgical Procedures*<br>• Pre-certification required for all inpatient surgeries/stays (except for observation only and normal child delivery in a PPO facility by a PPO provider)<br>• Pre-certification required for some outpatient/ambulatory procedures (see the "Services Requiring Pre-Certification" section in the SPD)<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **ORGAN/TISSUE TRANSPLANTS**<br>• Pre-certification required to receive full Plan benefits<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |

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Medical Benefits *continued from page 2...*

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **PHYSICIAN/PROVIDER SERVICES** | | |
| **THERAPEUTIC SERVICES**<br>Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br><br>• Maximum of 60 visits for any therapeutic category<br>• Maximum of 90 visits collectively for all therapeutic categories<br>• Pre-certification required after 12 visits per condition/incident<br>• Applies to plan year deductible and out-of-pocket maximum<br><br>May require pre-certification. Please refer to SPD for specifics. | 20% | 20% |
| **VISION THERAPY**<br>• Maximum of 30 visits per Plan Year<br>• Pre-certification required | 20% | 20% |
| **TELEHEALTH**<br><br>Including, but not limited to:<br><br>• General medical care<br>• General pediatric care<br>• Behavioral health therapy (for ages 10 and older)<br>• Psychiatry (for ages 18 and older)<br>• Lactation consultations<br><br>Telehealth 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 service). | $0 | $0 |
| **MATERNITY & OBSTETRICS**<br>• Applies to Plan Year deductible and out-of-pocket maximum | 20% | 20% |
| **EMERGENCY CARE** | | |
| **EMERGENCY ROOM (Copays and Co-Insurance)**<br>• Paid at 80% of allowable charges after copay per occurrence<br>• Copay waived if admitted<br>• Paid at Usual and Customary for out-of-network | $100 + 20% | $100 + 20% |
| **EMERGENT IN-PATIENT HOSPITAL ADMISSION**<br>• Out-of-network services are only covered until the patient's medical condition is stable, at which point the patient must consent to a transfer to an in-network facility | 20% | 20% |
| **AMBULANCE SERVICES**<br>• 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)<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **URGENT CARE CENTERS**<br>• May be paid as an office visit or as an emergency room visit according to provider contract<br>• Deductible does not apply regardless of how billed<br>• Facility fees for office visits are not paid | $25 – Office Visit/UC POS<br><br>$100 + 20% - ER | $50 – Office Visit/UC POS<br><br>$100 + 20% - ER |

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Medical Benefits *continued from page 3...*

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **EQUIPMENT / SUPPLIES** | | |
| **DURABLE MEDICAL EQUIPMENT**<br>• Pre-certification required for any CPM devices/machines and Dynasplints<br>• Pre-certification required for other durable medical equipment or repair with billed charges of $2,000 or more<br>• Pre-certification required for any custom orthotics and for orthotics/prosthetics with billed charges of $2,000 or more<br>• Pre-certification required for all rentals<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **BREAST PUMP**<br>• Pre-certification required for breast pump expenses of $2,000 or more | 0% | 0% |
| **WIG AS A RESULT OF CHEMO TREATMENT BENEFIT**<br>• Plan year maximum benefit $1,000<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **MENTAL HEALTH / SUBSTANCE ABUSE** | | |
| **MENTAL HEALTH COUNSELING SESSIONS**<br>• Out-of-network behavioral practitioner office visit covered at usual and customary rates, member may be balance billed | $25 | $50 |
| **MENTAL HEALTH OUTPATIENT SERVICES/PARTIAL HOSPITALIZATION**<br>• Pre-certification required for intensive outpatient programs and some other outpatient services (see the "Services Requiring Pre-Certification" section in the SPD)<br>• Pre-certification required for partial hospitalization<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **MENTAL HEALTH INPATIENT SERVICES**<br>• Paid at 80% of allowable charges in-network<br>• Pre-certification required to receive full plan benefits<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **RESIDENTIAL CARE AND TREATMENT**<br>• Pre-certification required<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **SUBSTANCE ABUSE/CHEMICAL DEPENDENCY COUNSELING SESSIONS**<br>• Out-of-network behavioral health practitioner office visit covered at usual and customary rates | $25 | $50 |
| **SUBSTANCE ABUSE/CHEMICAL DEPENDENCY:**<br><br>*Outpatient/Partial Facility Visits*<br><br>• Pre-certification required for intensive outpatient programs and some other outpatient services (see the "Services Requiring Pre-Certification" section in the SPD)<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |

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Medical Benefits *continued from page 4...*

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **SUBSTANCE ABUSE/CHEMICAL DEPENDENCY**<br>*Inpatient Treatment*<br>• Pre-certification required<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **OTHER SERVICES** | | |
| **HEARING CARE**<br>*Professional Testing/Screening*<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **HOME HEALTH CARE**<br>• Maximum of 120 visits per Plan Year<br>• Pre-certification required to receive full Plan benefits<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **SKILLED NURSING FACILITY**<br>• Pre-certification required<br>• Applies to plan year deductible and out-of-pocket maximum | 20% | 20% |
| **HOSPICE CARE**<br>• Paid at 100% of allowable charges<br>• Pre-certification required to receive full plan benefits | $0 | $0 |
| **OUTPATIENT DIABETES SELF-MANAGEMENT TRAINING (DSMT)**<br>• 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**<br>• 5 visits per plan year<br>• Additional visits may be authorized through Care Management<br>• Paid at 100% less member copay | $0 | $10 |
| **UNAVAILABLE SERVICES** | | |
| **UNAVAILABLE SERVICES**<br>*(when in-network medical services are not available)*<br>• Only covered with approved Unavailable Service Request Form 20% Member responsibility if approved; otherwise not covered | N/A | N/A |

## Medical Benefits—No PPO Network Utilization Required

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **ALTERNATIVE THERAPIES**<br>• Have a collective limit of 45 alternative therapy visits per plan year; no single therapy category to exceed 30 visits per plan year<br>• Does not apply to plan year deductible or out-of-pocket maximum | | |
| **ALTERNATIVE THERAPIES I CHIROPRACTIC SERVICES**<br>• Limited to spinal manipulation after annual office visit and X-ray<br>• Must be age 10 or older | 20% | 50% |
| **ALTERNATIVE THERAPIES I ACUPUNCTURE THERAPY**<br>• Must be age 18 or older | 50% | 100%<br>Not Covered |
| **ALTERNATIVE THERAPIES I MASSAGE THERAPY**<br>• Maximum allowable charge is $90 per visit<br>• Minimum of a 30-minute visit<br>• Must be age 18 or older | 50% | 100%<br>Not Covered |
| **REFRACTIVE EYE SURGERY**<br>• Lifetime maximum payable benefit of $2,400<br>• Does not apply to Plan Year deductible or out-of-pocket maximum | 20% | 50% |
| **HEARING AIDS**<br>• Paid at 80% of allowable charges<br>• Plan Year maximum payable benefit of $3,200<br>• Does not apply to Plan year deductible or out-of-pocket maximum | 20% | 20% |
| **INFERTILITY TREATMENT**<br>• Lifetime maximum benefit $16,000<br>• Does not apply to Plan Year deductible or out-of-pocket maximum | 20% | 50% |
| **LIFESTYLE PROGRAM I WEIGHT WATCHERS**<br>• 1 program per plan year<br>• Physician's referral is required with the submission of the first month's claim | 0% with proof of<br>80% completion | 100%<br>Not Covered |
| **LIFESTYLE PROGRAM I CHIP**<br>• 1 program per plan year<br>• Physician's referral is required with the submission of the first month's claim | 0% with proof of<br>80% completion | Only CHIP is covered<br>(with 0% member cost-sharing<br>with proof of<br>80% completion)<br>No other lifestyle<br>programs are covered |

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## Prescription Benefits

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **PRESCRIPTION DRUG**<br>Out-of-Pocket Maximums: Individual/Family | $1,250/$2,500 | $1,550/$3,100 |
| **PRESCRIPTION DRUG**<br>Prescription co-payment responsibility<br>RETAIL—30-DAY SUPPLY<br>• Generic<br>• Brand<br>• Non-Formulary | <br><br><br>$10<br>$20<br>$40 | <br><br><br>$10<br>$50<br>$100 |
| **PRESCRIPTION DRUG**<br>Prescription co-payment responsibility<br>MAIL ORDER—90-DAY SUPPLY/Walgreen's Smart 90 Retail<br>• Generic<br>• Brand<br>• Non-Formulary | <br><br><br>$20<br>$40<br>$80 | <br><br><br>$20<br>$100<br>$200 |
| **PRESCRIPTION DRUG**<br>SaveOn Specialty Program<br>• Filled through Accredo - specialty drug mail-order pharmacy.<br>• Copayments vary based on the specific drug, but will be $0 if you sign up for the SaveonSP Program. Any copayment will not apply to your out-of-pocket limit (but copayment will be $0 if you use the SaveonSP program)<br>• If you qualify for this program, you will be contacted by SaveonSP, otherwise for further details please call SaveonSP at 1-800-683-1074 | $0 | $0 |

**NOTES:**

- ***This benefit only covers services/supplies received from Express Scripts (ESI) or from a pharmacy contracted with ESI.***
- *Co-payments 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.*
- *The Plan pays 100% (and Members pay $0) for preventive prescription drugs. Please verify the current covered prescriptions by calling Express Scripts at 1-800-841-5396.*
- *Out-of-pocket for prescription benefits will be tracked by the Prescription Benefit Manager. 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.*

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## Dental Benefits

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

## Vision Benefits

| Benefits | Accelerate | Access |
|---|---|---|
| | MEMBER RESPONSIBILITY | |
| **VISION CARE**<br>• Paid at 80% of allowable charges<br>• Plan Year maximum payable benefit $450 per member (Accelerate Plan) and $225 per member (Access Plan)<br>• Plan year deductible does not apply<br>• Does not apply to plan year medical out-of-pocket maximums | 20% | 20% |

This Plan Comparison is a summary and briefly describes some of the benefits and member responsibilities of the Access and Accelerate Plans. This summary does not provide coverage of any kind, nor does it modify the terms of the Plans. Please refer to the Summary Plan document at **www.AscendToWholeness.org** on the Plan Documents page for a complete description of your benefits.

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