ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR DEDUCTIBLE			
Single	$240	$300	$1,200
Family	$720	$900	$3,600
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)			
Single	$3,200	$4,000	N/A
Family	$6,400	$8,000	N/A
MEDICAL BENEFITS			
Allergy Serum & Injections			
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $24 Copay per visit; Deductible waived	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services			
Ground	85% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Air Ambulance	$200 Copay per trip, then 85% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Ambulatory Surgical Center	85% after Deductible	85% after Deductible	50% after Deductible
Anesthesiologist	85% after Deductible	85% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	$40 Copay per pair, then 85%; Deductible waived	$50 Copay per pair, then 85%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs		
Cardiac Rehab (Outpatient)	100% after $20 Copay per visit; Deductible waived	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient)	85% after Deductible	85% after Deductible	50% after Deductible

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	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Chiropractic Care/Spinal Manipulation	100% after $20 Copay per visit; Deductible waived	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 Visits		
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Any Single Service Costing Less Than $500	85% after Deductible	85% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	85% after Deductible	85% after Deductible	50% after Deductible
Freestanding Laboratory	100% after $20 Copay; Deductible waived	100% after $25 Copay; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	85% after Deductible	85% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	85% after Deductible	85% after Deductible	50% after Deductible
Emergency Services			
Emergency Medical Condition			
Facility Charges	85% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Professional Fees and Ancillary Charges	85% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Non-Emergency Medical Condition			
Facility Charges	85% after Deductible	85% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	85% after Deductible	85% after Deductible	50% after Deductible
Foot Orthotics	$40 Copay per orthotic, then 85%; Deductible waived	$50 Copay per orthotic, then 85%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months		
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	85% after Deductible	85% after Deductible	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period		
Hemodialysis (Outpatient)	85% after Deductible	85% after Deductible	50% after Deductible
Home Health Care	85% after Deductible	85% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*		
*Home health care supplies are not subject to the Calendar Year Maximum.			

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MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospice Care			
Inpatient	$200 Copay per admission, then 85%; Deductible waived	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	85% after Deductible	85% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$200 Copay per admission, then 85%; Deductible waived	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	85% after Deductible	85% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.			
Infusion Therapy in Facility or Physician's Office	85% after Deductible	85% after Deductible	50% after Deductible
Maternity (Professional Fees)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	85% after Deductible	85% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical Supplies	85% after Deductible	85% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient			
Facility Charge Professional Fees	$200 Copay per admission, then 85%; Deductible waived 85% after Deductible	$250 Copay per admission, then 85%; Deductible waived 85% after Deductible	$300 Copay per admission, then 50% after Deductible 50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Outpatient Facility	85% after Deductible	85% after Deductible	50% after Deductible
Office Visits	100% after $20 Copay; Deductible waived	100% after $25 Copay; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.			
Morbid Obesity (Surgical Treatment Only)			
Facility (Inpatient and outpatient)	$200 Copay, then 85%; Deductible waived	$250 Copay, then 85%; Deductible waived	50% after Deductible
Professional Services	85% after Deductible	85% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure		
Nutritional Food Supplements	50% after Deductible	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $20 Copay per visit; Deductible waived	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physical Therapy (Outpatient)	100% after $20 Copay per visit; Deductible waived	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physician's Services			
Inpatient/Outpatient Services			
Primary Care Physician Specialist	85% after Deductible 85% after Deductible	85% after Deductible 85% after Deductible	50% after Deductible 50% after Deductible
Office Visits			
Primary Care Physician	100% after $20 Copay*; Deductible waived	100% after $25 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $28 Copay*; Deductible waived	100% after $35 Copay*; Deductible waived	50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician Office Surgery			
Primary Care Physician	Under $1,000 - 100% after $20 Copay*; Deductible waived; $1,000 or more – 85% after Deductible	Under $1,000 - 100% after $25 Copay*; Deductible waived; $1,000 or more – 85% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $28 Copay*; Deductible waived; $1,000 or more – 85% after Deductible	Under $1,000 - 100% after $35 Copay*; Deductible waived; $1,000 or more – 85% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Preventive Services and Routine Care			
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% of the first $300 per Calendar Year, then 10%; Deductible waived	100% of the first $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu Shots/Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $20 Copay per exam; Deductible waived	100% after $25 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam		
NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.			
Prosthetics (other than bras)	85% after Deductible	85% after Deductible	50% after Deductible
Prosthetic Bras	85% after Deductible	85% after Deductible	85% after Deductible
Calendar Year Maximum Benefit	2 bras		
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient)	85% after Deductible	85% after Deductible	50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$200 Copay per admission, then 85%; Deductible waived	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	$200 Copay per admission, then 85%; Deductible waived	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days		
Speech Therapy (Outpatient)	100% after $20 Copay per visit; Deductible waived	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Surgery (Inpatient)			
Facility	$200 Copay per admission, then 85%; Deductible waived	$250 Copay per admission, then 85%; Deductible waived	50% after Deductible
Professional Services	85% after Deductible	85% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include surgery in the Physician's office)			
Facility	85% after Deductible	85% after Deductible	50% after Deductible
Professional Services	85% after Deductible	85% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	$40 Copay per occurrence, then 85%; Deductible waived	$50 Copay per occurrence, then 85%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000		

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MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants			
Facility Charges	$200 Copay per admission, then 85%; Deductible waived	$250 Copay per admission, then 85%; Deductible waived	Not Covered
Professional Fees	85% after Deductible (Aetna IOE Program)*	85% after Deductible (Aetna IOE Program)*	Not Covered
	Not Covered (All Other Network Providers)	Not Covered (All Other Network Providers)	
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.			
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.			
Urgent Care Facility	$40 Copay per visit, then 85%; Deductible waived	$50 Copay per visit, then 85%; Deductible waived	$50 Copay per visit, then 50% after Deductible
Wig (see Eligible Medical Expenses)	$40 Copay per wig, then 85%; Deductible waived	$50 Copay per wig, then 85%; Deductible waived	$50 Copay per wig, then 85%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig		
All Other Eligible Medical Expenses	$40 Copay*, then 85%; Deductible waived	$50 Copay*, then 85%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.			

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PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIC GOLD BANNER 2019-2020

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical) Single Family	 $4,000 $8,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	40% Copay ($40 minimum, $110 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Name Diabetic Supplies	 $5 Copay $15 Copay Same as all other drugs
Specialty Pharmacy Program: 30-day supply	
Specialty Drug	20% Copay ($100 minimum, $150 maximum)
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Walgreens Retail/Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Name Diabetic Supplies Generic Brand Name (non-formulary brand not covered) (Covered Persons must enroll in the Liberty HealthyLiving® program at (877) 852-3512)	 $10 Copay $30 Copay $10 Copay $30 Copay

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

90-Day Supply – Maintenance Medications
This Plan will allow maintenance medications to be filled at Walgreens retail pharmacy and mail order in 90 day quantities, Covered Persons benefit from paying only 2 Copays for a 3 month (90-day) supply. Covered Persons choosing other retail pharmacies for maintenance medications will be limited to a 30 day supply, subject to the applicable Copay.

Specialty Pharmacy Program
Self-administered specialty drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.