ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – HDHP A BANNER PLAN 2021-2022

	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 (combined with Prescription Drug Card Deductible)			
Single	$1,500	$2,000	$2,500
Family	$3,000*	$4,000*	$5,000*
*Note: If you have Family coverage, the Family Deductible must be satisfied before the Plan will pay any benefits.			
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)			
Single	$4,500	$5,500	$18,000
Family	$9,000	$11,000	$28,000
MEDICAL BENEFITS			
Allergy Serum & Injections	80% after Deductible	80% after Deductible	50% after Deductible
Ambulance Services			
Ground Ambulance Services	80% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Air Ambulance Services	Deductible, then $200 Copay per trip, then 80%	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits Up to 300% of Medicare Allowable Rate
Ambulatory Surgical Center	80% after Deductible	80% after Deductible	50% after Deductible
Anesthesiologist	80% after Deductible	80% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	Deductible, then $40 Copay per pair, then 80%	Deductible, then $50 Copay per pair, then 80%	50% after Deductible
Calendar Year Maximum Benefit	3 pairs		
Cardiac Rehab (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Chemotherapy (Outpatient – includes all related charges)	80% after Deductible	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	20 visits		
Diabetic Supplies	80% after Deductible	80% 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)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Oncotype Diagnostic Testing	80% after Deductible	80% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	80% after Deductible	80% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	80% after Deductible	50% after Deductible
Emergency Services			
Emergency Medical Condition			
Facility Charges	80% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Professional Fees and Ancillary Charges	80% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Non-Emergency Medical Condition			
Facility Charges	80% after Deductible	80% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	80% after Deductible	80% after Deductible	50% after Deductible
Foot Orthotics	80% after Deductible	80% after Deductible	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)	80% after Deductible	80% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period		
Hemodialysis (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Hinge Health Program (TIN 81-1884841)	N/A	100%; Deductible waived	N/A
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.			
Home Health Care	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Hospice Care			
Inpatient	Deductible, then $200 Copay per admission, then 80%	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Outpatient	80% after Deductible	80% after Deductible	50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – HDHP A BANNER PLAN 2021-2022

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	Deductible, then $200 Copay per admission, then 80%	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	80% after Deductible	80% 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	80% after Deductible	80% after Deductible	50% after Deductible
Maternity (non-facility charges)*			
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	80% after Deductible	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	80% after Deductible	80% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient			
Facility Charge	Deductible, then $200 Copay per admission, then 80%	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Professional Fees	80% after Deductible	80% after Deductible	50% after Deductible
Outpatient Facility	80% after Deductible	80% after Deductible	50% after Deductible
Office Visits/Telemedicine	80% after Deductible	80% after Deductible	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.			

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MEDICAL SCHEDULE OF BENEFITS – HDHP A BANNER PLAN 2021-2022

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Morbid Obesity (Surgical Treatment Only)			
Facility	Deductible, then $200 Copay, then 80%	Deductible, then $250 Copay, then 80%	50% after Deductible
Professional Services	80% after Deductible	80% 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)	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physical Therapy (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physician's Services			
Inpatient/Outpatient Services	80% after Deductible	80% after Deductible	80% after Deductible
Office Visits	80% after Deductible	80% after Deductible	50% after Deductible
Physician Office Surgery	80% after Deductible	80% after Deductible	50% after Deductible
Telemedicine	80% after Deductible	80% after Deductible	50% after Deductible
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	80% after Deductible	80% after Deductible	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)	80% after Deductible	80% after Deductible	50% after Deductible
Prosthetic Bras	80% after Deductible	80% after Deductible	80% after Deductible
Calendar Year Maximum Benefit	2 bras		

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MEDICAL SCHEDULE OF BENEFITS – HDHP A BANNER PLAN 2021-2022

	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient – includes all related charges)	80% after Deductible	80% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	Deductible, then $200 Copay per admission, then 80%	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	Deductible, then $200 Copay per admission, then 80%	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Maximum Benefit per 12 Month Period	60 days		
SkinIO Provider (Skin Cancer Screenings)	N/A	100%; Deductible waived	N/A
NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 85-3057521			
Speech Therapy (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Surgery (Inpatient)			
Facility	Deductible, then $200 Copay per admission, then 80%	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Professional Services	80% after Deductible	80% after Deductible	50% after Deductible
Surgery (Outpatient)			
Facility	80% after Deductible	80% after Deductible	50% after Deductible
Professional Services	80% after Deductible	80% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	Deductible, then $40 Copay per occurrence, then 80%	Deductible, then $50 Copay per occurrence, then 80%	50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000		

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	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants			
Facility Services	Deductible, then $200 Copay per admission, then 80% (Aetna IOE Program)*	Deductible, then $250 Copay per admission, then 80% (Aetna IOE Program)*	Not Covered
Professional Fees	80% after Deductible (Aetna IOE Program)*	80% 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% after 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	80% after Deductible	80% after Deductible	50% after Deductible
Wig (see Eligible Medical Expenses)	Deductible, then $40 Copay per wig, then 80%	Deductible, then $50 Copay per wig, then 80%	Deductible, then $50 Copay per wig, then 80%
Maximum Benefit	1 every 24 months		
All Other Eligible Medical Expenses	Deductible, then $40 Copay per occurrence, then 80%	Deductible, then $50 Copay per occurrence, then 80%	50% after Deductible

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PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP A BANNER PLAN 2021-2022

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible) Single Family	 $2,000 $4,000*
*Note: If you have Family coverage, the Family Deductible must be satisfied before the Plan will pay any benefits.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance – combined with major medical Out-of-Pocket) Single Family	 $5,500 $11,000
Retail Pharmacy: 30-day supply	
Generic Drug	80% after Deductible
Preferred Drug	80% after Deductible
Non-Preferred Drug	80% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	80% after Deductible
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.	
Retail/Mail Order: 90-day supply	
Generic Drug	80% after Deductible
Preferred Drug	80% after Deductible
Non-Preferred Drug	80% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

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, 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 any retail pharmacy and through mail order in 90 day quantities.

Mandatory 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 list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.