ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Single Family	 N/A N/A	 $900 $2,700
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card) Single Family	 $6,350 $12,700	 N/A N/A
MEDICAL BENEFITS		
Allergy Serum & Injections		
Injections (If no office visit charge)	100% after $5 Copay per visit	50% after Deductible
Serum	100% after $40 Copay per visit	50% after Deductible
Ambulance Services		
Ground	100% after $50 Copay per trip	Paid at Participating Provider level of benefits
Air Ambulance	100% after $200 Copay per trip	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	100% after $75 Copay per occurrence	50% after Deductible
Anesthesiologist	100% after $60 Copay per occurrence	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	100% after $50 Copay per pair	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Chemotherapy (Outpatient)	100% after $50 Copay* per visit	50% after Deductible
*Copay applies to all related services and supplies related to a patient receiving chemotherapy even if chemotherapy is not administered at the time the services are rendered.		
Chiropractic Care/Spinal Manipulation	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	20 visits	

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	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Any Single Service Costing Less Than $500	100% after $30 Copay	50% after Deductible
Any Single Service Costing $500 or More	100% after $50 Copay	50% after Deductible
Freestanding Laboratory	100% after $30 Copay	50% after Deductible
Oncotype Diagnostic Testing	100% after $50 Copay	50% after Deductible
Durable Medical Equipment (DME)	100% after $30 Copay (rental); 100% after $200 Copay (purchase)	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	100% after $150 Copay*	Paid at Participating Provider level of benefits
Professional Fees and Ancillary Charges	100% after $40 Copay*	Paid at Participating Provider level of benefits
Non-Emergency Medical Condition		
Facility Charges	100% after $150 Copay*	50% after Deductible
Professional Fees and Ancillary Charges	100% after $40 Copay*	50% after Deductible
*NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the same Hospital utilized for Emergency Services.		
Foot Orthotics	100% after $50 Copay per orthotic	$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)	100% after $50 Copay	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	100% after $50 Copay per occurrence	50% after Deductible
Home Health Care	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	60 visits*	
*Home health aid supplies are not subject to the Calendar Year Maximum.		
Hospice Care		
Inpatient	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Outpatient	100% after $30 Copay per visit	50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	100% after $75 Copay per occurrence	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	100% after $40 Copay per occurrence	50% after Deductible
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%	50% after Deductible
Breast Pumps	100%	100%; Deductible waived
Lactation Consultations	100%	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after $300 Copay per pregnancy	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical Supplies	100% after $30 Copay	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge Professional Fees	100% after $250 Copay per admission 100% after $30 Copay	$300 Copay per admission, then 50% after Deductible 50% after Deductible
Outpatient Facility	100% after $75 Copay per occurrence	50% after Deductible
Office Visits	100% after $30 Copay	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)	100% after $250 Copay	50% after Deductible
Professional Services	100% after $75 Copay	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50%	50% after Deductible
Occupational Therapy (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	60 visits	

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MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physical Therapy (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Physician's Services		
Inpatient/Outpatient Services		
Primary Care Physician	100% after $30 Copay*	50% after Deductible
Specialist	100% after $40 Copay*	50% after Deductible
Office Visits		
Primary Care Physician	100% after $30 Copay*	50% after Deductible
Specialist	100% after $40 Copay*	50% after Deductible
Physician Office Surgery		
Primary Care Physician	Under $1,000 - 100% after $30 Copay*; $1,000 or more - 100% after $50 Copay*	50% after Deductible
Specialist	Under $1,000 - 100% after $40 Copay*; $1,000 or more - 100% after $50 Copay*	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%	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%	Not Covered
Flu Shots/Pneumonia & Shingles Vaccinations	100%	100%; Deductible waived
Routine Hearing Exam	100% after $30 Copay per exam	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)	100% after $200 Copay per item	100% after $200 Copay per item; Deductible waived
Prosthetic Bras	100% after $50 Copay per bra	100% after $50 Copay per bra; Deductible waived
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50%	50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Radiation Therapy (Outpatient)	100% after $50 Copay per visit	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days	
Skilled Nursing Facility	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days	
Speech Therapy (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Surgery (Inpatient)		
Facility	100% after $250 Copay per admission	50% after Deductible
Professional Services	100% after $75 Copay*	50% after Deductible
*Copay applies per surgical session.		
Surgery (Outpatient) (does not include surgery in the Physician's office)		
Facility	100% after $75 Copay*	50% after Deductible
Professional Services	100% after $75 Copay*	50% after Deductible
*Copay applies per surgical session.		
Temporomandibular Joint Dysfunction (TMJ)	100% after $50 Copay per occurrence	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000	
Transplants Facility Services Professional Fees	100% after $250 Copay per admission 100% after $30 Copay (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered Not Covered
* 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	100% after $50 Copay per visit	$50 Copay per visit, then 50% after Deductible

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MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Wig (see Eligible Medical Expenses)	100% after $50 Copay per wig	100% after $50 Copay per wig; Deductible waived
Maximum Benefit per 24 Month Period	1 wig	
All Other Eligible Medical Expenses	100% after $50 Copay*	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.		

ASBA Insurance Trust

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – COPAY GOLD 2018-2019

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	 $6,350 $12,700
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)
Specialty Drug	20% Copay ($100 minimum, $150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic 30 day / 90 day retail Brand Name 30 day / 90 day retail Diabetic Supplies	 $5 Copay / $10 Copay $15 Copay / $30 Copay Same as all other drugs
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 (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.

Mandatory Mail Order Program
This plan will allow maintenance medications to be filled at retail in 30 day quantities only and will be subject to appropriate copay upon each 30 day refill. Member must choose mail order to receive a 90 day quantity on a maintenance drug and benefit from paying only 2 copays for a 3 month (90 day supply).

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.