ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – HDHP $1350 PLAN 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 (combined with Prescription Drug Card Deductible)		
Single	$1,350	$2,500
Family	$2,700*	$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	$6,000	$18,000
Family	$12,000	$28,000
MEDICAL BENEFITS		
Allergy Serum & Injections	80% after Deductible	50% after Deductible
Ambulance Services		
Ground	80% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance	Deductible, then $200 Copay per trip, then 80%	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	80% after Deductible	50% after Deductible
Anesthesiologist	80% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	Deductible, then $50 Copay per pair, then 80%	50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	80% after Deductible	50% after Deductible
Chemotherapy (Outpatient)	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	80% after Deductible	50% after Deductible
Oncotype Diagnostic Testing	80% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	50% after Deductible

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	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Emergency Services		
Emergency Medical Condition		
Facility Charges	80% after Deductible	Paid at Participating Provider level of benefits
Professional Fees and Ancillary Charges	80% after Deductible	Paid at Participating Provider level of benefits
Non-Emergency Medical Condition		
Facility Charges	80% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	80% after Deductible	50% after Deductible
Foot Orthotics	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	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	80% after Deductible	50% after Deductible
Home Health Care	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Hospice Care		
Inpatient	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	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	50% after Deductible
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

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MEDICAL SCHEDULE OF BENEFITS – HDHP $1350 PLAN 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Medical Supplies	80% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Professional Fees	80% after Deductible	50% after Deductible
Outpatient Facility	80% after Deductible	50% after Deductible
Office Visits	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.		
Morbid Obesity (Surgical Treatment Only)		
Facility	Deductible, then $250 Copay, then 80%	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	80% after Deductible	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 visits	
Physical Therapy (Outpatient)	80% after Deductible	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 visits	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits	80% after Deductible	50% after Deductible
Physician Office Surgery	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	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)	Not Covered
Flu Shots/Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	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.		

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MEDICAL SCHEDULE OF BENEFITS – HDHP $1350 PLAN 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Prosthetics (other than bras)	80% after Deductible	50% after Deductible
Prosthetic Bras	80% after Deductible	80% after Deductible
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient)	80% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Calendar Year Maximum Benefit	60 days	
Skilled Nursing Facility	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Maximum Benefit per 12 Month Period	60 days	
Speech Therapy (Outpatient)	80% after Deductible	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 visits	
Surgery (Inpatient)		
Facility	Deductible, then $250 Copay per admission, then 80%	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Surgery (Outpatient)		
Facility	80% after Deductible	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	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	
Transplants Facility Services Professional Fees	 Deductible, then $250 Copay per admission, then 80% 80% after Deductible (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% 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.		

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MEDICAL SCHEDULE OF BENEFITS – HDHP $1350 PLAN 2018-2019

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Urgent Care Facility	Deductible, then $50 Copay per visit, then 80%	50% after Deductible
Wig (see Eligible Medical Expenses)	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 $50 Copay per occurrence, then 80%	50% after Deductible

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PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP $1350 PLAN 2018-2019

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	 $1,350 $2,700*
*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) Single Family	 $6,000 $12,000
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)
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)

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.

Mandatory Mail Order Program
This plan will allow maintenance medications to be filled at retail in 30 day quantities only. For members who would like to purchase a 90 day supply of maintenance medications, the mail order option must be chosen, which could result in additional cost savings.

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.