ASBAIT
ARIZONA SCHOOL BOARDS ASSOCIATION INSURANCE TRUST

MEDICAL SCHEDULE OF BENEFITS – CLASSIC GOLD 2024-2025

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$300	$1,200
Family	$900	$3,600
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)		
Single	$4,000	Not Applicable
Family	$8,000	Not Applicable
MEDICAL BENEFITS		
Allergy Serum & Injections		
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services		
Ground Ambulance Services	85% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance Services	$200 Copay per trip, then 85% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	85% after Deductible	50% after Deductible
Anesthesiologist	85% after Deductible	50% after Deductible
Anti-Embolism Garments	$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 $25 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient – includes all related charges)	85% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 Visits	

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diabetic Supplies	100% after $30 Copay per item; Deductible waived	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Any Single Service Costing Less Than $500	85% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	85% after Deductible	50% after Deductible
Freestanding Laboratory	100% after $25 Copay; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	85% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	85% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	85% after Deductible	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	85% after Deductible	Paid at Participating Provider level of benefits
Professional Fees and Ancillary Charges	85% after Deductible	Paid at Participating Provider level of benefits
Non-Emergency Medical Condition		
Facility Charges	85% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	85% after Deductible	50% after Deductible
Empower Health (TIN: 36-4836722)	100%; Deductible waived	Not Applicable
NOTE: Empower Health wellness program is a voluntary wellness program available to the Employee only, Dependent Spouses and Children are not eligible. If you elect to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related choices. You will also be asked to complete a biometric screening, which will include a blood pressure reading and blood test. For more information regarding this program you may call Empower Health at (866) 367-6974.		
Foot Orthotics	$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	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	85% after Deductible	50% after Deductible

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hinge Health Program (TIN 81-1884841)	100%; Deductible waived	Not Applicable
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	85% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*	
*Home health care supplies are not subject to the Calendar Year Maximum.		
Hospice Care		
Inpatient	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	85% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	$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*
Outpatient	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	50% after Deductible
Maternity (non-facility charges)*		
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	85% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical and Surgical Supplies	85% after Deductible	50% after Deductible

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	85% after Deductible	50% after Deductible
Outpatient Facility	85% after Deductible	50% after Deductible
Office Visits	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)	$250 Copay, then 85%; Deductible waived	50% after Deductible
Professional Services	85% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Pain Management	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	Not Applicable	4 visits
Physical Therapy (Outpatient)	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	85% after Deductible	50% after Deductible
Specialist	85% after Deductible	50% after Deductible
Office Visits		
Primary Care Physician	100% after $25 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $35 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery		

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Primary Care Physician	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 $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	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, Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	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	50% after Deductible
Prosthetic Bras	85% after Deductible	85% after Deductible
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient – includes all related charges)	85% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$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	$250 Copay per admission, then 85%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days	
SkinIO Provider (Skin Cancer Screenings)	100%; Deductible waived	Not Applicable
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: 82-2035738		

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Speech Therapy (Outpatient)	100% after $25 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits	
Surgery (Inpatient)		
Facility	$250 Copay per admission, then 85%; Deductible waived	50% after Deductible
Professional Services	85% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include Surgery in the Physician's office)		
Facility	85% after Deductible	50% after Deductible
Professional Services	85% after Deductible	50% after Deductible
Teladoc Network Providers	100%; Deductible waived	Not Applicable
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	$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	
Transplants		
Facility Charges	$250 Copay per admission, then 85%; Deductible waived (Aetna IOE Program)*	Not Covered
Professional Fees	85% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	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.		

CLASSIC GOLD 2024-2025	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Urgent Care Facility	$45 Copay* per visit, then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Virta Health Providers (TIN 36-4841662)	100%; Deductibles and Copays waived	Not Applicable
NOTE: Virta Health is an online specialty medical clinic that reverses Type 2 diabetes safely and sustainably, without the risks, costs, or side effects of medications or Surgery**.** For more information you may complete an application at www.virtahealth.com.		
Wig (see Eligible Medical Expenses)	$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	$50 Copay*, then 85%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.		

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIC GOLD 2024-2025

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	 $5 Copay $15 Copay
Diabetic Supplies Generic Brand	 $5 Copay $15 Copay
Specialty Pharmacy Network: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through PrudentRx Solution	$200 Copay
Enrolled and Available with PrudentRx Solution	$0 Copay
Not Enrolled and Available with PrudentRx Solution	30% Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.	
NOTE: PrudentRx Solution assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a $0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution program.	
CVS Maintenance Choice: Allow Opt-Out: 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	 $10 Copay $30 Copay

BENEFIT DESCRIPTION	BENEFIT
Diabetic Supplies Generic Brand	 $10 Copay $30 Copay
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	 $10 Copay $30 Copay
Diabetic Supplies Generic Brand	 $10 Copay $30 Copay

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 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.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 2 30-day fills of maintenance drugs at any Participating retail pharmacy. After 2 fills, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. 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.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

PrudentRx Copay Program for Specialty Medications
In order to provide a comprehensive and cost-effective Prescription Drug program for you and your family, your Employer has contracted to offer the PrudentRx Solution for certain Specialty Drugs. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% Copay. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their Specialty Drugs, the member will have a $0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing Out-of-Pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more Specialty Drugs included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at (800) 578-4403 to register for any manufacturer copay assistance program available for your Specialty Drug as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call (800) 578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your Plan Deductible or Out-of-Pocket Maximum (if applicable), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your Deductible or Out-of-Pocket Maximum (if any), unless otherwise required by law. A list of Specialty Drugs that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution.

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.