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ARIZONA SCHOOL BOARDS ASSOCIATION INSURANCE TRUST

MEDICAL SCHEDULE OF BENEFITS – HDHP A BANNER 2025-2026

HDHP A BANNER 2025-2026	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	$2,600	$3,150	$3,500
Family	$5,200*	$6,300*	$7,000*
***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	$6,500	$7,500	Not Applicable
Family	$13,000	$15,000	Not Applicable
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 $230 Copay per trip, then 80%	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
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	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		

HDHP A BANNER 2025-2026	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diabetic Supplies	80% after Deductible	80% after Deductible	50% after Deductible
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, Nuclear Medicine)	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
Empower Health (TIN: 36-4836722)	Not Applicable	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	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)	Not Applicable	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.			

HDHP A BANNER 2025-2026	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Home Health Care	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Hospice Care			
Inpatient	Deductible, then $230 Copay per admission, then 80%	Deductible, then $280 Copay per admission, then 80%	50% after Deductible
Outpatient	80% after Deductible	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	Deductible, then $230 Copay per admission, then 80%	Deductible, then $280 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 $230 Copay per admission, then 80%	Deductible, then $280 Copay per admission, then 80%	50% after Deductible
Professional Fees	80% after Deductible	80% after Deductible	50% after Deductible

HDHP A BANNER 2025-2026	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Outpatient Facility	80% after Deductible	80% after Deductible	50% after Deductible
Office Visits	Deductible, then $20 Copay, then 100%	Deductible, then $25 Copay, then 100%	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 $230 Copay, then 80%	Deductible, then $280 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		
Pain Management	Paid based on place of service	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	Not Applicable	Not Applicable	4 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	50% after Deductible
Office Visits:			
Primary Care Physician	Deductible, then $20 Copay*, then 100%	Deductible, then $25 Copay*, then 100%	50% after Deductible
Specialist	Deductible, then $60 Copay*, then 100%	Deductible, then $65 Copay*, then 100%	50% after Deductible
Physician Office Surgery	80% after Deductible	80% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Preventive Care for Certain Chronic Conditions (see Eligible Medical Expenses)	100%; Deductible waived	100%; Deductible waived	Not Covered
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

HDHP A BANNER 2025-2026	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
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
Teladoc Primary360	Not Applicable	100%; Deductible waived	Not Applicable
Flu, 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		
Psychological and Neuropsychological Testing	80% after Deductible	80% 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 $230 Copay per admission, then 80%	Deductible, then $280 Copay per admission, then 80%	50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	Deductible, then $230 Copay per admission, then 80%	Deductible, then $280 Copay per admission, then 80%	50% after Deductible
Maximum Benefit per 12 Month Period	60 days		
SkinIO Provider (Skin Cancer Screenings)	Not Applicable	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			
Speech Therapy (Outpatient)	80% after Deductible	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits		

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HDHP A BANNER 2025-2026	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Surgery (Inpatient)			
Facility	Deductible, then $230 Copay per admission, then 80%	Deductible, then $280 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
Teladoc Network Providers			
General Medical Consultations	Not Applicable	100% after Deductible ($56 consult fee applies toward the Deductible)	Not Applicable
Primary 360 – Initial Visit	Not Applicable	100% after Deductible ($165 consult fee applies toward the Deductible)	Not Applicable
Primary 360 – Established Visit	Not Applicable	100% after Deductible ($99 consult fee applies toward the Deductible)	Not Applicable
Behavioral Health Consultations	Not Applicable	100% after Deductible	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	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)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

HDHP A BANNER 2025-2026	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Temporomandibular Joint Dysfunction (TMJ)	Deductible, then $70 Copay per occurrence, then 80%	Deductible, then $80 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	Deductible, then $230 Copay per admission, then 80% (Aetna IOE Program)*	Deductible, then $280 Copay per admission, then 80% (Aetna IOE Program)*	Not Covered
Professional Fees	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	80% 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% 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	Deductible, then $70 Copay*, then 100%	Deductible, then $75 Copay*, then 100%	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Virta Health Providers (TIN 36-4841662)	100%; Deductibles and Copays waived	Paid at Tier 1 level of benefits	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)	Deductible, then $70 Copay per wig, then 80%	Deductible, then $80 Copay per wig, then 80%	Deductible, then $80 Copay per wig, then 80%
Maximum Benefit	1 every 24 months		
All Other Eligible Medical Expenses	Deductible, then $70 Copay per occurrence, then 80%	Deductible, then $80 Copay per occurrence, then 80%	50% after Deductible

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PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP A BANNER 2025-2026

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	$2,600
Family	$5,200*
***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	$6,500
Family	$13,000
Retail Pharmacy: 30-day supply	
Generic Drug	Deductible, then $15 Copay
Preferred Drug	Deductible, then 20% Copay, minimum $55, maximum $100
Non-Preferred Drug	Deductible, then 40% Copay, minimum $70, maximum $140
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
Preventive Maintenance Drug	100% (Deductible waived)
Specialty Pharmacy Network: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through PrudentRx Solution	Deductible, then $230 Copay
Enrolled and Available with PrudentRx Solution	Deductible, then $0 Copay
Not Enrolled and Available with PrudentRx Solution	Deductible, then 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.	
Maintenance Choice Network– Allow Opt-Out: 90-day supply	
Generic Drug	Deductible, then $30 Copay
Preferred Drug	Deductible, then 20% Copay, minimum $80, maximum $205
Non-Preferred Drug	Deductible, then 40% Copay, minimum $110, maximum $255
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
Preventive Maintenance Drug	100% (Deductible waived)

BENEFIT DESCRIPTION	BENEFIT
Mail Order: 90-day supply	
Generic Drug	Deductible, then $30 Copay
Preferred Drug	Deductible, then 20% Copay, minimum $80, maximum $205
Non-Preferred Drug	Deductible, then 40% Copay, minimum $110, maximum $255
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
Preventive Maintenance Drug	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 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 considered a penalty and is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum. This provision does not apply to contraceptives classified as a Preventive Drug by HHS.

Maintenance Choice Network
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 Maintenance Choice Network 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 Solution for Specialty Drugs

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, after satisfaction of any applicable Deductible. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their Specialty Drugs, your Out of Pocket responsibility is reduced. For drugs listed on the Plan's Preventive Drug List, the member will have a $0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution; and (b) for all other drugs, the member will have a $0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution after the member's Deductible has been satisfied.

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 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.