



## **Orange Ulster School Districts' Health Plan Effective 1/1/23**

**The following information applies to Active Employees and Pre-65 Retirees**

**CLAIMS PROCESSOR:** Trustmark Health Benefits 1-888-604-9397

**myTrustmarkBenefits ONLINE PORTAL:**

Our secure online portal lets you access your benefits and claims, view your EOBs, and more. Visit [www.mytrustmarkbenefits.com](http://www.mytrustmarkbenefits.com) to register and log in.

**myTrustmarkBenefits MOBILE APP:**

You still need to connect with your health benefits while you're on the go. You can find a doctor, connect with Trustmark Health Benefits customer service, access your ID card, and much more using our mobile app. Download for free today from Apple's App Store or Google Play.

**PLAN ADMINISTRATOR:** Matt Bourgeois • Executive Director • (845) 781-4890

**NETWORK:** Blue Cross/Blue Shield Association's Blue Card Program

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### **PRECERTIFICATION REQUIREMENTS:**

**HealthCare Strategies** – Call (800) 582-1535 to precertify the following services:

Inpatient Admissions • Air Ambulance • Durable Medical Equipment (over \$1,500 exclusive of Insulin Pumps) • Gender Dysphoria/Sex Reassignment Surgeries • Gene Therapy/CAR-T Therapy • Genetic Testing • Home Health Care • Infertility Treatment/Assisted Reproduction Procedures • Outpatient Surgery limited to Nasal Surgeries, Breast Surgeries, Bariatric Surgery, Abdominoplasty, Lipectomy & Panniculectomy • Transplants • ABA Therapy • Private Duty Nursing

**Quantum Health Solutions** – Call (888) 214-4001 to precertify the following Mental Health and Substance Use Disorder services:

Outpatient Counseling • Medication Management • Partial Hospitalization • Intensive Outpatient Treatment • Inpatient Admissions



**MEDICAL SCHEDULE OF BENEFITS**  
**Blue Cross/Blue Shield Association's Blue Card Program**

	IN-NETWORK	OUT-OF-NETWORK
<p>Payment for In-Network services is based on provider's negotiated rate. Provider cannot balance bill charges in excess of negotiated rate.            Payment for Out-of-Network services is based on Usual, Customary and Reasonable (UCR).            Provider can balance bill charges in excess of UCR.</p>		
<b>Deductible (Per Calendar Year)</b>	Individual      \$0 Family            \$0	Individual      \$1,000 Family            \$3,000  No member will have more than a \$500 calendar year deductible for treatment from an out of network Mental Health/Substance Use Disorder provider.
	<p>In-Network and Out-of-Network Deductibles are combined and cross apply Family Accumulation – The Individual Deductible for all family members will accumulate to the family Deductible. One family member cannot satisfy the entire family Deductible.            Copays do not accumulate toward the Deductible.</p>	
<b>Coinsurance</b>	Plan Pays        100% Member Pays    0% Unless otherwise indicated	Plan Pays        80% Member Pays    20% Unless otherwise indicated
<b>Medical Out-of-Pocket Maximum</b> Includes Medical Deductible, Copays and Coinsurance	Individual        \$4,650 Family            \$9,300	Individual        \$4,650 Family            \$9,300
<b>Pharmacy Out-of-Pocket Maximum</b> Includes Prescription Deductible and Copays	Individual        \$2,500 Family            \$5,000	Individual        \$2,500 Family            \$5,000
<b>Combined Out-of-Pocket Maximum</b> Includes Deductible, Copays and Coinsurance (Medical and Pharmacy)	Individual        \$7,150 Family            \$14,300	Individual        \$7,150 Family            \$14,300
	<p>In-Network and Out-of-Network OOPM are combined and cross apply. Once you have reached your OOPM, the Plan will pay 100% of eligible expenses for services for the remainder of the calendar year.            Family Accumulation – The Individual OOPM for all family members will accumulate to the family OOPM. One family member cannot satisfy the entire family OOPM.            Prior authorization penalties and ineligible expenses do not accumulate to the OOPM.</p>	
<b>Lifetime Maximum</b>	Unlimited	



COVERED SERVICES	IN-NETWORK Plan Pays	OUT-OF-NETWORK Plan Pays
<b>Acupuncture</b> 50 visits per calendar year	100% after \$25 Copay per visit	80% of U&C after Deductible and \$25 copay
<b>Allergy Services</b> Office Visit & Testing  Injection & Serum	100% after \$25 Copay per visit  100%	80% of U&C after Deductible and \$25 copay  80% of U&C after Deductible and \$25 copay
<b>Ambulance Services</b> Air & Ground Services	100% after \$70 copay	100% of U&C after \$70 copay
<b>Ambulatory Surgical Facility</b>	100% after \$50 copay	80% of U&C after Deductible and \$85 copay
<b>Anesthesia</b>	100% after \$25 Copay per visit	80% of U&C after Deductible and \$25 copay
<b>Autism Spectrum Disorders</b> Applied Behavioral Analysis (ABA)	100% after \$25 Copay per visit	80% of U&C after Deductible and \$25 copay per service
<b>Breast Pumps</b> Covered up to \$300 for electric and manual pumps and \$100 for initial pump accessories	100% of Plan Allowance	
<b>Cardiac Rehabilitation (Outpatient)</b> Physician  Outpatient Facility	100% after \$25 Copay per visit  100% after \$50 Copay per visit	80% of U&C after Deductible and \$25 copay  80% of U&C after Deductible and \$85 copay
<b>Chemotherapy</b>	100%	80% of U&C after Deductible and \$85 copay
<b>Chiropractic</b>	100% after \$25 Copay per visit	80% of U&C after Deductible and \$25 copay



COVERED SERVICES	IN-NETWORK Plan Pays	OUT-OF-NETWORK Plan Pays
<b>Diagnostic, X-ray and Lab (Outpatient)</b> Outpatient Hospital  Inpatient Hospital  Independent Lab/Imaging Center/Office  Quest Diagnostics	100% after \$50 Copay per visit  100%  100% after \$25 Copay per visit  100% after \$5 Copay per visit	80% of U&C after Deductible and \$85 copay  80% of U&C after Deductible  80% of U&C after Deductible and \$25 copay  N/A
<b>Durable Medical Equipment</b> (includes orthotics)	100% after \$25 Copay per piece of equipment	100% of U&C after Deductible and \$25 copay per piece of equipment
<b>Emergency Room</b> Emergency Care  Non-Emergency Care	100% after \$100 copay per visit  100% after \$100 copay per visit	In-Network benefit applies  80% of U&C after Deductible and \$85 copay
<b>Hearing Aid and Exam</b> Hardware limited to one device up to \$1,500 per ear every 3 calendar years	100% of Plan Allowance	
<b>Home Health Care</b> 180 visits per calendar year	100%	80% of U&C after Deductible
<b>Home Infusion Services</b>	100%	80% of U&C after Deductible
<b>Hospice Care</b>	100%	100% (deductible waived)
<b>Hospital</b> Inpatient  Outpatient Surgical	100% after \$100 copay per admission  100% after \$50 copay	80% of U&C after Deductible and \$500 copay per admission  80% of U&C after Deductible and \$85 copay
<b>Infertility Treatment/ Assisted Reproduction</b> Treatment includes office visits, testing, IVF, GIFT, ZIFT, AID AND IUI.  Maximum Lifetime Benefit: 3 IVF cycles  Infertility Specialty Medication	100% after \$25 copay per service  Plan pays 100% for covered Infertility Treatment at Diamond Institute (Center of Excellence) Diamond Institute 973-761-5600  Plan pays 100% for covered Infertility Specialty Medications when obtained from Schrafts II Pharmacy. Schrafts II Pharmacy 855-724-7238	80% of U&C after Deductible and \$25 copay per service



COVERED SERVICES	IN-NETWORK Plan Pays	OUT-OF-NETWORK Plan Pays
<b>Maternity</b> Prenatal/Postnatal Initial Office Visit Delivery Inpatient Facility	100% \$25 Copay \$25 Copay 100% after \$100 copay per admission	80% of U&C after Deductible and \$25 copay 80% of U&C after Deductible and \$25 copay 80% of U&C after Deductible 80% of U&C after Deductible and \$500 copay per admission
<b>Mental Health*</b> Office Visit Virtual Visit Inpatient Treatment Residential Treatment Partial Day Program/Intensive Outpatient Treatment	\$25 Copay per visit 100% 100% after \$100 copay per admission 100% after \$100 copay per admission 100% after \$100 copay per course of treatment	80% of U&C after \$500 Deductible and \$25 copay 80% of U&C after \$500 Deductible and \$25 copay 80% of U&C after \$500 Deductible and \$500 copay per admission 80% of U&C after \$500 Deductible and \$500 copay per admission 80% of U&C after \$500 Deductible and \$500 copay per course of treatment
<b>Contact Quantum Health at (888)214-4001 for mental health, behavioral health and substance use disorder services. Preauthorization is required.*</b>		
<b>Morbid Obesity – Bariatric Surgery</b> Inpatient Outpatient	100% after \$100 copay per admission 100% after \$50 copay	80% of U&C after Deductible and \$500 copay per admission 80% of U&C after Deductible and \$85 copay
<b>Occupational Therapy (Outpatient)</b> Facility Office	100% after \$50 copay \$25 Copay per visit	80% of U&C after Deductible and \$85 copay 80% of U&C after Deductible and \$25 copay



COVERED SERVICES	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
<b>Physical Therapy (Outpatient)</b> Facility  Office	100% after \$50 copay  \$25 Copay per visit	80% of U&C after Deductible and \$85 copay  80% of U&C after Deductible and \$25 copay
<b>Physician Office Visits (Non-Routine)</b>	\$25 Copay per visit	80% of U&C after Deductible and \$25 copay
<b>Physician Visits (Inpatient)</b>	100%	80% of U&C after Deductible
<b>Radiation Therapy</b> Outpatient Facility  Office	100% after \$50 copay  100%	80% of U&C after Deductible and \$85 copay  80% of U&C after Deductible and \$25 copay
<b>Routine Health Maintenance</b>	100%	80% of U&C after Deductible and \$25 copay
<b>Skilled Nursing Facility</b> 100 days per calendar year	100% after \$100 copay per admission	80% of U&C after Deductible and \$500 copay per admission
<b>Speech Therapy (Outpatient)</b> Facility  Office	100% after \$50 copay  100% after \$25 copay	80% of U&C after Deductible and \$85 copay  80% of U&C after Deductible and \$25 copay
<b>Substance Use Disorder*</b> Office Visit  Inpatient Treatment  Residential Treatment  Partial Day Program/Intensive Outpatient Treatment	\$25 Copay per visit  100% after \$100 copay per admission  100% after \$100 copay per admission  100% after \$100 copay per course of treatment	80% of U&C after \$500 Deductible and \$25 copay  80% of U&C after \$500 Deductible and \$500 copay per admission  80% of U&C after \$500 Deductible and \$500 copay per admission  80% of U&C after \$500 Deductible and \$500 copay per course of treatment
<b>*Contact Quantum Health at (888)214-4001 for mental health, behavioral health and substance use disorder services. Preauthorization is required.*</b>		
<b>Surgery – Physician</b>	100% after \$25 copay	80% of U&C after Deductible and \$25 copay



COVERED SERVICES	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
<b>Telehealth</b> Virtual Visit with your PCP or Specialist in lieu of an in person office visit.	100%	80% of U&C after Deductible and \$25 copay
<b>Telemedicine</b> Virtual service provided by Empire Live Health Online (Telemedicine 24/7 by computer, tablet or smart phone )	100%	N/A
<b>Transplant</b>  Outpatient Physician  Inpatient Facility  Inpatient Physician	100% after \$25 copay  100% after \$100 copay per admission  100%	80% of U&C after Deductible and \$25 copay  40% after Deductible  80% of U&C after Deductible
	Centers of Excellence ONLY include \$10,000 Limit per Transplant for Transportation/Lodging/Meals	No Coverage for Transportation/Lodging/Meals
<b>Urgent Care</b>	100% after \$35 copay	80% of U&C after Deductible and \$45 copay
<b>Wigs</b> Covered for hair loss due to chemotherapy, radiation, scalp burns. or alopecia. Limited to 1 wig per lifetime up to \$800.	100% after \$25 copay	80% of U&C after Deductible and \$25 copay



**PRESCRIPTION  
SCHEDULE OF BENEFITS**

**EmpiRx**  
**Customer Service 877-241-7123**  
[www.empirxhealth.com](http://www.empirxhealth.com)

	GENERIC	PREFERRED BRAND	NON-PREFERRED BRAND
<b>Retail Pharmacy</b>			
30-Day Supply	\$5 Copay	\$35 Copay	\$60 Copay
90-Day Supply	\$10 Copay	\$70 Copay	\$120 Copay
<b>Mail Order Pharmacy</b>			
90-Day Supply	\$10 Copay	\$70 Copay	\$120 Copay
<b>Specialty Medication</b>			
30-Day Supply	N/A	\$35 Copay	\$60 Copay

Note: If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copay PLUS the difference in cost between the brand-name drug and the generic drug.