

**Orange Ulster School Districts’ Health Plan**

**Effective 1/1/25**

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

**CLAIMS PROCESSOR:** Luminare Health Benefits - 855-656-3261

**ONLINE PORTAL**:

Our secure online portal lets you access your benefits and claims, view your EOBs,

and more. Visit [www.myLuminareHealth.com](http://www.myLuminareHealth.com) to register and log in.

**MOBILE APP**:

Need information about your health benefits while you’re on the go? You can find

a doctor, connect with Luminare Health 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:** Anthem (Formerly Blue Cross/Blue Shield)

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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 Hearing Aids, CPAP machines & Insulin Pumps) • Gender Dysphoria/Sex Reassignment Surgeries • Gene Therapy/CAR-T Therapy • Genetic Testing • Home Health Care • Private Duty Nursing • Transplants Infertility Treatment/Assisted Reproduction Procedures • Any Surgeries Considered Cosmetic

Outpatient Surgery requiring precertification: Abdominoplasty, Bariatric Surgeries, Breast Surgeries, Lipectomy, Nasal Surgeries & Panniculectomy

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

Partial Hospitalization • Intensive Outpatient Treatment • Inpatient Admissions • ABA Therapy

Quantum Health Solutions is able to assist with access to providers and treatment for Mental Health and Substance Use Disorder treatment. Please contact Quantum Health (888) 214-4001

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| **MEDICAL SCHEDULE OF BENEFITS**  **Anthem (formerly Blue Cross Blue Shield)** | | |
|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| * 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. | | |
| **Deductible (Per Calendar Year)** | 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. |
| * 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. | |
| **Coinsurance** | Plan Pays 100%  Member Pays 0%  Unless otherwise indicated | Plan Pays 75%  Member Pays 25%  Unless otherwise indicated |
| **Medical - Out-of-Pocket Maximum (OOPM)**  Includes Medical Deductible, Copays and Coinsurance | Individual $4,650  Family $9,300 | Individual $6,200  Family $12,400 |
| **Pharmacy (Rx) - Out-of-Pocket Maximum (OOPM)**  Includes Prescription Deductible and Copays | Individual $2,500  Family $5,000 | Individual $3,000  Family $6,000 |
| **Combined (Medical+Rx) Out-of-Pocket Maximum (OOPM)**  Includes Deductible, Copays and Coinsurance (Medical and Pharmacy) | Individual $7,150  Family $14,300 | Individual $9,200  Family $18,400 |
| * 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. | |
| **Lifetime Maximum** | Unlimited | |

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| **COVERED SERVICES** | | | **IN-NETWORK**  **Plan Pays** | **OUT-OF-NETWORK**  **Plan Pays** | | |
| **Acupuncture**  50 visits per calendar year | | | 100% after $25 Copay per visit | 75% of U&C after Deductible and $25 copay | | |
| **Allergy Services**   * Office Visit & Testing * Injection & Serum | | | 100% after $25 Copay per visit  100% | 75% of U&C after Deductible and $25 copay  75% of U&C after Deductible and $25 copay | | |
| **Ambulance Services**  Air & Ground Services | 100% after $70 copay | | | | 100% of U&C after $70 copay | |
| **Ambulatory Surgical Facility** | | 100% after $50 copay | | | | 75% of U&C after Deductible and $85 copay |
| **Anesthesia** | | 100% after $25 Copay per visit | | | | 75% of U&C after Deductible and $25 copay |
| **Autism Spectrum Disorders**  Applied Behavioral Analysis (ABA) | | 100% after $25 Copay per visit | | | | 75% of U&C after Deductible and $25 copay per service |
| **Bariatric Surgery**   * Inpatient   Outpatient | | 100% after $100 copay per admission  100% after $50 copay | | | | 75% of U&C after Deductible and $500 copay per admission  75% of U&C after Deductible and $85 copay |
| **Breast Pumps**  Covered up to $300 for electric and manual pumps and $100 for initial pump supplies | | 100% of Plan Allowance  (Purchase on your own from anywhere and complete a claim form and attach receipt for reimbursement to Luminare after the baby is born) | | | | |
| **Cardiac Rehabilitation (Outpatient)**   * Physician * Outpatient Facility | | 100% after $25 Copay per visit  100% after $50 Copay per visit | | | | 75% of U&C after Deductible and $25 copay  75% of U&C after Deductible and $85 copay |
| **Cardiac Scoring**  (Calcium testing) | | Not covered | | | | Not covered |
| **Chemotherapy** | | 100% | | | | 75% of U&C after Deductible and $85 copay |
| **Chiropractic** | | 100% after $25 Copay per visit | | | | 75% of U&C after Deductible and $25 copay |

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| **COVERED SERVICES** | **IN-NETWORK**  **Plan Pays** | | | | **OUT-OF-NETWORK**  **Plan Pays** |
| **Diagnostic, X-ray and Lab (Outpatient)**  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 | | 75% of U&C after Deductible and $85 copay  75% of U&C after Deductible  75% of U&C after Deductible and $25 copay  N/A | |
| **Durable Medical Equipment**  **Supplies**  (includes orthotics) | | 100% after $25 Copay per order | | 75% of U&C after Deductible and $25 copay per order | |
| **Emergency Room**  Emergency Care  Non-Emergency Care | 100% after $100 copay per visit  100% after $100 copay per visit | | | | In-Network benefit applies  75% of U&C after Deductible and $125 copay |
| **Hearing Aid and Exam**  Hardware limited to one device up to $1,500 per ear every 3 calendar years | 100% of Plan Allowance  (Can be purchased from an Anthem provider and submitted to insurance or member can purchase from any other provider such as Costco, Amazon etc., complete a claim form and attach receipt for reimbursement from Luminare.) | | | | |
| **Home Health Care**  180 visits per calendar year | 100% | | | | 75% of U&C after Deductible |
| **Home Infusion Services** | 100% | | | | 75% of U&C after Deductible |
| **Hospice Care** | 100% | | | | 100% (deductible waived) |
| **Hospital**   * Inpatient * Outpatient Surgical | 100% after $100 copay per admission  100% after $50 copay | | | | 75% of U&C after Deductible and $500 copay per admission  75% of U&C after Deductible and $85 copay |
| **Infertility Treatment/ Assisted Reproduction**  Treatment includes office visits, testing, IVF, GIFT, ZIFT, AID AND IUI.  Maximum Lifetime Benefit: 3 IVF cycles  Infertility Specialty meds | | 100% after $25 copay per service | 75% of U&C after Deductible and $25 copay per service | | |
| Plan pays 100% for covered Infertility Specialty Medications when obtained from Schrafts II Pharmacy.    Schrafts II Pharmacy 855-724-7238 | | | |

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| **COVERED SERVICES** | **IN-NETWORK**  **Plan Pays** | **OUT-OF-NETWORK**  **Plan Pays** |
| **Maternity**   * Prenatal/Postnatal * Initial Office Visit * Delivery * Inpatient Facility | 100%  100% after $25 Copay  100% after $25 Copay  100% after $100 copay per admission | 75% of U&C after Deductible and $25 copay  75% of U&C after Deductible and $25 copay  75% of U&C after Deductible  75% of U&C after Deductible and $500 copay per admission |
| **Mental Health**   * Office Visit   Virtual Visit  ABA Therapy\*   * Inpatient Treatment\* * Residential Treatment\* * Partial Day Program\* with Intensive Outpatient Treatment | 100% after $25 Copay per visit  100%  100% after $25 Copay per visit  100% after $100 copay per admission  100% after $100 copay per admission  100% after $100 copay per course of treatment | 75% of U&C after $500 Deductible and $25 copay  75% of U&C after $500 Deductible and $25 copay  75% of U&C after $500 Deductible and $500 copay per admission  75% of U&C after $500 Deductible and $500 copay per admission  75% of U&C after $500 Deductible and $500 copay per admission  75% of U&C after $500 Deductible and $500 copay per course of treatment |
| **\*Preauthorization is required.**  **Contact Quantum Health at (888) 214-4001 for mental health, ABA Therapy (behavioral health) and substance use disorder services.** | |
| **Nutritionist/ Nutritional Counseling**  (up to 4 visits yr) | 100% after $25 copay | 75% of U&C after Deductible and $25 copay |
| **Occupational Therapy (Outpatient)**  Facility  Office | 100% after $50 copay  $10 Copay per visit | 75% of U&C after Deductible and $85 copay  75% of U&C after Deductible and $25 copay |

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| **COVERED SERVICES** | **IN-NETWORK**  **Plan Pays** | **OUT-OF-NETWORK**  **Plan Pays** |
| **Physical Therapy (Outpatient)**  Facility  Office | 100% after $50 copay  $10 Copay per visit | 75% of U&C after Deductible and $85 copay  75% of U&C after Deductible and $25 copay |
| **Physician Office Visits (Non-Routine)** | $25 Copay per visit | 75% of U&C after Deductible and $25 copay |
| **Physician Visits (Inpatient)** | 100% | 75% of U&C after Deductible |
| **Radiation Therapy**  Outpatient Facility  Office | 100%  100% | 75% of U&C after Deductible and $85 copay  75% of U&C after Deductible and $25 copay |
| **Routine Health Maintenance:**  Ob/Gyn (2x/yr)  Routine Physical  Mammogram  Pap Smear  Bone Density  Colonoscopy(1x every 5yrs)  Prostate Screening | 100% | 75% of U&C after Deductible and $25 copay |
| **Skilled Nursing Facility**  180 days per calendar year | 100% after $100 copay per admission | 75% of U&C after Deductible and $500 copay per admission |
| **Speech Therapy (Outpatient)**  Facility  Office | 100% after $50 copay  100% after $25 copay | 75% of U&C after Deductible and $85 copay  75% of U&C after Deductible and $25 copay |
| **Substance Use Disorder**   * Office Visit * Inpatient Treatment\* * Residential Treatment\* * Partial Day Program\* with 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 | 75% of U&C after $500 Deductible and $25 copay  75% of U&C after $500 Deductible and $500 copay per admission  75% of U&C after $500 Deductible and $500 copay per admission  75% of U&C after $500 Deductible and $500 copay per course of treatment |
| **\*Preauthorization is required. Contact Quantum Health at (888) 214-4001 for mental health, behavioral health and substance use disorder services.** | |

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| **COVERED SERVICES** | **IN-NETWORK**  **Plan Pays** | **OUT-OF-NETWORK**  **Plan Pays** |
| **Surgery** - Physician | 100% after $25 copay | 75% of U&C after Deductible and $25 copay |
| **Telehealth**   |  | | --- | | Virtual Visit with your PCP or Specialist in lieu of an in person office visit. | | 100% | 75% of U&C after Deductible and $25 copay |
| **Telemedicine**   |  | | --- | | Virtual service provided by Anthem’s Live Health Online (Telemedicine 24/7 by computer, tablet or smart phone ) | | 100% | N/A |
| **Transplant**   * Outpatient Physician * Inpatient Facility * Inpatient Physician | 100% after $25 copay  100% after $100 copay per admission  100% | 75% of U&C after Deductible and $25 copay  75% of U&C after Deductible and $100 copay per admission  75% 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 |
| **Travel-International:**  **(For Emergency Care ONLY)** | N/A | 100% after Deductible and applicable OON Co-Pays |
| **Urgent Care** | 100% after $35 copay | 75% of U&C after Deductible and $45 copay |
| **Weight Watchers-WW**  (6-month membership)  Contact OUH plan office to obtain access code. | 100% after $25 copay to OUH  (Member can attend in-person or virtual meetings; or use the WW app to participate on their own) | N/A |
| **Wigs**  Up to $800, once every 3 years, covered for hair loss due to chemotherapy, radiation, scalp burns. or alopecia. | 100% after $25 copay per wig | 75% of U&C after Deductible and $25 copay per wig |

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| **PRESCRIPTION**  **SCHEDULE OF BENEFITS** | | | | |
| **Navitus Rx**  Navitus Customer Service - 855-673-6504  Mail Order – Costco – 800-607-6861  Specialty – Lumicera – 855-847-3553  www.navitus.com | | | | |
|  | **GENERIC** | **PREFERRED BRAND** | **NON-PREFERRED**  **BRAND** |
| **Retail Pharmacy** |  | | |
| 30-Day Supply | $5 Copay | $35 Copay | $60 Copay |
| 90-Day Supply | $10 Copay | $70 Copay | $120 Copay |
| **Mail Order Pharmacy** |  | | |
| 90-Day Supply | $10 Copay | $70 Copay | $120 Copay |
| **Specialty Medication** | | | |
| 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.

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