CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS COMPARISON – 1/1/2024 PLAN CHANGES

For the Traditional Plan and Modified Traditional Plan

Applies to: Active and Retired Employees

TYPE OF SERVICE	TRADITIONAL PLAN	MODIFIED TRADITIONAL PLAN
	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Calendar Year Deductible	$200 Individual / $600 Family	$200 Individual / $600 Family (services with a copay are not subject to the deductible)
Out-of-pocket Maximum	$500 Individual	$650 Individual / $1,950 Family
Physician (except for routine care and treatment of Mental Illness or Substance Abuse)		
• Inpatient visit	80% after deductible	Covered in Full
• Office visit	80% after deductible	$20 Copay/Visit
• Home visit	80% after deductible	$20 Copay/Visit
• Specialist consultation		
- Inpatient	80% after deductible	80% after deductible
- Outpatient	80% after deductible	$20 Copay/Visit
- Office	80% after deductible	$20 Copay/Visit
• Surgery		
- Inpatient	Covered in Full	$55 Copay/Occurrence
- Outpatient	Covered in Full	$55 Copay/Occurrence
- Office	Covered in Full	$55 Copay/Occurrence
- Assistant surgeon (1)	20% (deductible does not apply) of allowable expense for primary surgeon	$30 Copay/Occurrence
• Second surgical opinion (voluntary)	Covered in Full	$20 Copay/Occurrence
Hospital (also see Mental Illness, Substance Abuse, and Maternity for inpatient benefits)		
• **Inpatient** - room and board (limit 365 days per occurrence of illness or injury)	Covered in Full	$255 Copay/Admission
• **Outpatient**		
- Emergency room (includes physician)	$75.00 (waived if admitted)	$55 Copay/Visit (waived if admitted)
- Outpatient surgical center	Covered in Full	$55 Copay/Visit
- Clinic	80% after deductible	$55 Copay/Visit
- Laboratory	Covered in Full	$20 Copay/Visit
- X-rays – diagnostic / therapeutic	Covered in Full	$20 Copay/Visit
- Diagnostic tests	Covered in Full	$20 Copay/Visit
- Cardiac rehabilitation	Covered in Full	$20 Copay/Visit
- Dialysis / Hemodialysis	80% after deductible	80% after deductible
Freestanding Surgical Facility	Covered in Full	$55 Copay/Visit
Urgent Care Facility	$25.00	$40 Copay/Visit

(1) If the allowable expense for the primary surgeon is $200 or less, services for an assistant surgeon will not be covered.

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Ambulance		
• Emergency	Covered in Full	$40 Copay/Occurrence
• Transfer	80% after deductible	80% after deductible
Pre-admission Testing	Covered in Full	$20 Copay/Admission
Convalescent / Skilled Nursing Facility		
• Inpatient (limit 100 days per occurrence of illness or injury)	Covered in Full	Covered in Full
Home Health Care (limit 40 visits per calendar year)	Covered in Full	Covered in Full
Private Duty Nursing – in-home care (medically necessary)	80% after deductible	80% after deductible
Transplants (limit 365 days per occurrence of illness)	Covered in Full	$255 Copay/Occurrence
Elective Sterilization (no reversal)		
• Inpatient	Covered in Full	$255 Copay/Occurrence
• Outpatient	Covered in Full	$55 Copay/Occurrence
• Office	Covered in Full	$55 Copay/Occurrence
Mental Illness Treatment		
• Inpatient - Hospital or Behavioral Health Care Facility	Covered in Full	$255 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office	80% after deductible	$20 Copay/Visit
Substance Abuse Treatment		
• Inpatient - Hospital or Behavioral Health Care Facility	Covered in Full	$255 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office	Covered in Full	$20 Copay/Visit
Maternity Care – Mother		
• Inpatient	Covered in Full	$255 Copay/Admission
• Physician (pre-natal care and delivery)	Covered in Full	$20 Copay (initial visit only)
Newborn Care (prior to discharge)		
• Inpatient (routine nursery care)	Covered in Full	Covered in Full
• Physician	Covered in Full	Covered in Full
• Circumcision	Covered in Full	$55 Copay/Occurrence

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Anesthesia		
• Inpatient	Covered in Full	Covered in Full
• Outpatient	Covered in Full	Covered in Full
• Office	Covered in Full	Covered in Full
Allergy Care		
• Treatment, serum, and scratch testing	80% after deductible	$20 Copay/Visit
• Testing (laboratory)	Covered in Full	$20 Copay/Visit
Chiropractic Care	80% after deductible (medically necessary)	$20 Copay/Visit (medically necessary)
Acupuncture (must be performed by a medical doctor with national certification for acupuncture)	80% after deductible	80% after deductible (limit 15 visits per calendar year)
Podiatrist		
• Visit	80% after deductible	80% after deductible
• Orthotics	Not Covered	80% after deductible if required by surgery and medically necessary
• Surgery	Covered in Full	$55 Copay/Occurrence
Preventive		
• GYN routine exam	Covered in Full	Covered in Full
• Pap smear (one per calendar year over 18 years of age)	Covered in Full	Covered in Full
• Mammogram	Covered in Full	Covered in Full
• Well-child care (up to age 19)	Covered in Full	Covered in Full
• Routine adult physicals	Covered in Full (over 19 years of age)	Covered in Full (over 19 years of age)
• Adult Immunizations	Covered in Full	Covered in Full
• PSA Test	One per calendar year over 50 years of age	Covered in Full
• Colonoscopy	Covered in Full (one every 24 months for members considered high risk, if not high risk, then once every 10 years)	Covered in Full (one every 24 months for members considered high risk; if not high risk, then once every 10 years)
Pap Smear (medically necessary)	Covered in Full	$20 Copay/Visit
Mammogram (medically necessary)	Covered in Full	$20 Copay/Visit
Colonoscopy (medically necessary)	Covered in Full	$20 Copay/Visit
Diagnostic Office Visit	80% after deductible	$20 Copay/Visit

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Outpatient Diagnostic Tests		
• Independent Laboratory	Covered in Full	$20 Copay/Visit
• Physician's Office	Covered in Full	$20 Copay/Visit
• Freestanding Facility	Covered in Full	$20 Copay/Visit
• Home	Covered in Full	$20 Copay/Visit
Outpatient Treatments		
• Chemotherapy	80% after deductible	80% after deductible
• Radiation therapy	Covered in Full	$20 Copay/Visit
• Respiratory therapy	Not Covered	$20 Copay/Visit
• Physical therapy	80% after deductible	$20 Copay/Visit
• Occupational therapy	80% after deductible	$20 Copay/Visit
• Speech therapy	80% after deductible	$20 Copay/Visit
Durable Medical Equipment, Medical Supplies, Diabetic Supplies and Oxygen	80% after deductible	80% after deductible
Prosthetics		
• Internal	80% after deductible	80% after deductible
• External (original device only)	80% after deductible	80% after deductible
Diabetic Counseling / Education	80% after deductible	Covered in Full
Prescription Drugs	80% after deductible [2] (exceptions by school district)	Generic: 20% Copay Preferred Brand: 25% Copay Non-preferred Brand: 30% Copay

(2) Prescription costs must be paid up front at the pharmacy. Submit to Excellus BCBS for reimbursement for the **Traditional Plan 100% Prescription Co-Pay Group**.