

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS COMPARISON – Effective 7/1/2025

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 • Office visit • Home visit • Specialist consultation - Inpatient - Outpatient - Office • Surgery - Inpatient - Outpatient - Office - Assistant surgeon ⁽¹⁾ • Second surgical opinion (voluntary)	80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible Covered in Full Covered in Full Covered in Full 20% (deductible does not apply) of allowable expense for primary surgeon Covered in Full	Covered in Full \$20 Copay/Visit \$20 Copay/Visit 80% after deductible \$20 Copay/Visit \$20 Copay/Visit \$55 Copay/Occurrence \$55 Copay/Occurrence \$55 Copay/Occurrence \$30 Copay/Occurrence \$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) • Outpatient - Emergency room (includes physician) - Outpatient surgical center - Clinic - Laboratory - X-rays – diagnostic / therapeutic - Diagnostic tests - Cardiac rehabilitation - Dialysis / Hemodialysis	Covered in Full \$75.00 (waived if admitted) Covered in Full 80% after deductible Covered in Full Covered in Full Covered in Full Covered in Full Covered in Full 80% after deductible	\$255 Copay/Admission \$55 Copay/Visit (waived if admitted) \$55 Copay/Visit \$55 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit 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 - Transfer	Covered in Full 80% after deductible	\$40 Copay/Occurrence 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 - Outpatient - Office	Covered in Full Covered in Full Covered in Full	\$255 Copay/Occurrence \$55 Copay/Occurrence \$55 Copay/Occurrence
Mental Illness Treatment - Inpatient - Hospital or Behavioral Health Care Facility - Outpatient - Hospital Clinic, Facility, or Office	Covered in Full 80% after deductible	\$255 Copay/Admission \$20 Copay/Visit
Substance Abuse Treatment - Inpatient - Hospital or Behavioral Health Care Facility - Outpatient - Hospital Clinic, Facility, or Office	Covered in Full Covered in Full	\$255 Copay/Admission \$20 Copay/Visit
Maternity Care – Mother - Inpatient - Physician (pre-natal care and delivery) Newborn Care (prior to discharge) - Inpatient (routine nursery care) - Physician - Circumcision	Covered in Full Covered in Full Covered in Full Covered in Full Covered in Full	\$255 Copay/Admission \$20 Copay (initial visit only) Covered in Full Covered in Full \$55 Copay/Occurrence

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	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Anesthesia • Inpatient • Outpatient • Office	Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full
Allergy Care • Treatment, serum, and scratch testing • Testing (laboratory)	80% after deductible Covered in Full	\$20 Copay/Visit \$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 • Orthotics • Surgery	80% after deductible Not Covered Covered in Full	80% after deductible 80% after deductible if required by surgery and medically necessary \$55 Copay/Occurrence
Preventive		
• GYN routine exam • Pap smear (one per calendar year over 18 years of age) • Mammogram • Well-child care (up to age 19) • Routine adult physicals • Adult Immunizations • PSA Test • Colonoscopy (Routine)	Covered in Full Covered in Full Covered in Full Covered in Full Covered in Full (over 19 years of age) Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full Covered in Full Covered in Full (over 19 years of age) Covered in Full Covered in Full Covered in Full
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	\$55 Copay/Visit (Surgical Copay)
Diagnostic Office Visit	80% after deductible	\$20 Copay/Visit

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	The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Outpatient Diagnostic Tests • Independent Laboratory • Physician's Office • Freestanding Facility • Home	Covered in Full Covered in Full Covered in Full Covered in Full	\$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit
Outpatient Treatments • Chemotherapy • Radiation therapy • Respiratory therapy • Physical therapy • Occupational therapy • Speech therapy	80% after deductible Covered in Full Not Covered 80% after deductible 80% after deductible 80% after deductible	80% after deductible \$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit \$20 Copay/Visit
Durable Medical Equipment, Medical Supplies, and Oxygen	80% after deductible	80% after deductible
Prosthetics • Internal • External (original device only)	80% after deductible 80% after deductible	80% after deductible 80% after deductible
Diabetes Treatment • Supplies • Counseling/Education • Insulin • Durable Medical Equipment	Covered in Full Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full Covered in Full
Prescription Drugs	80% after deductible ⁽²⁾ (exceptions by school district for Traditional Rx Copay Plan)	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 Rx Discount Plan (100% Prescription Co-Pay Group)**