CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS – Effective 7/1/2025

For the Modified Traditional Plan

Applies to: Active and Retired Employees

TYPE OF SERVICE	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 (services with a copay are not subject to the deductible)
Out-of-pocket Maximum	$650 Individual / $1,950 Family
Physician (except for routine care and treatment of Mental Illness or Substance Abuse)	
• Inpatient visit	Covered in Full
• Office visit	$20 Copay/Visit
• Home visit	$20 Copay/Visit
• Specialist consultation	
- Inpatient	80% after deductible
- Outpatient	$20 Copay/Visit
- Office	$20 Copay/Visit
• Surgery	
- Inpatient	$55 Copay/Occurrence
- Outpatient	$55 Copay/Occurrence
- Office	$55 Copay/Occurrence
- Assistant surgeon (1)	$30 Copay/Occurrence
• Second surgical opinion (voluntary)	$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)	$255 Copay/Admission
• **Outpatient**	
- Emergency room (includes physician)	$55 Copay/Visit (waived if admitted)
- Outpatient surgical center	$55 Copay/Visit
- Clinic	$55 Copay/Visit
- Laboratory	$20 Copay/Visit
- X-rays – diagnostic / therapeutic	$20 Copay/Visit
- Diagnostic tests	$20 Copay/Visit
- Cardiac rehabilitation	$20 Copay/Visit
- Dialysis / Hemodialysis	80% after deductible
Freestanding Surgical Facility	$55 Copay/Visit
Urgent Care Facility	$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	$40 Copay/Occurrence
• Transfer	80% after deductible
Pre-admission Testing	$20 Copay/Admission
Convalescent / Skilled Nursing Facility	
• Inpatient (limit 100 days per occurrence of illness or injury)	Covered in Full
Home Health Care (limit 40 visits per calendar year)	Covered in Full
Private Duty Nursing – in-home care (medically necessary)	80% after deductible
Transplants (limit 365 days per occurrence of illness)	$255 Copay/Occurrence
Elective Sterilization (no reversal)	
• Inpatient	$255 Copay/Occurrence
• Outpatient	$55 Copay/Occurrence
• Office	$55 Copay/Occurrence
Mental Illness Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility	$255 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office	$20 Copay/Visit
Substance Abuse Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility	$255 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office	$20 Copay/Visit
Maternity Care – Mother	
• Inpatient	$255 Copay/Admission
• Physician (pre-natal care and delivery)	$20 Copay (initial visit only)
Newborn Care (prior to discharge)	
• Inpatient (routine nursery care)	Covered in Full
• Physician	Covered in Full
• Circumcision	$55 Copay/Occurrence

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Anesthesia	
• Inpatient	Covered in Full
• Outpatient	Covered in Full
• Office	Covered in Full
Allergy Care	
• Treatment, serum, and scratch testing	$20 Copay/Visit
• Testing (laboratory)	$20 Copay/Visit
Chiropractic Care	$20 Copay/Visit (medically necessary)
Acupuncture (must be performed by a medical doctor with national certification for acupuncture)	80% after deductible (limit 15 visits per calendar year)
Podiatrist	
• Visit	80% after deductible
• Orthotics	80% after deductible if required by surgery and medically necessary
• Surgery	$55 Copay/Occurrence
Preventive	
• GYN routine exam	Covered in Full
• Pap smear (one per calendar year over 18 years of age)	Covered in Full
• Mammogram	Covered in Full
• Well-child care (up to age 19)	Covered in Full
• Routine adult physicals	Covered in Full (over 19 years of age)
• Adult Immunizations	Covered in Full
• PSA Test	Covered in Full
• Colonoscopy (Routine)	Covered in Full
Pap Smear (medically necessary)	$20 Copay/Visit
Mammogram (medically necessary)	$20 Copay/Visit
Colonoscopy (medically necessary)	$55 Copay/Visit (Surgical Copay)
Diagnostic Office Visit	$20 Copay/Visit

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Outpatient Diagnostic Tests	
• Independent Laboratory	$20 Copay/Visit
• Physician's Office	$20 Copay/Visit
• Freestanding Facility	$20 Copay/Visit
• Home	$20 Copay/Visit
Outpatient Treatments	
• Chemotherapy	80% after deductible
• Radiation therapy	$20 Copay/Visit
• Respiratory therapy	$20 Copay/Visit
• Physical therapy	$20 Copay/Visit
• Occupational therapy	$20 Copay/Visit
• Speech therapy	$20 Copay/Visit
Durable Medical Equipment, Medical Supplies, and Oxygen	80% after deductible
Prosthetics	
• Internal	80% after deductible
• External (original device only)	80% after deductible
Diabetes Treatment	
• Supplies	Covered in Full
• Counseling/Education	Covered in Full
• Insulin	Covered in Full
• Durable Medical Equipment	Covered in Full
Prescription Drugs	Generic: 20% Copay Preferred Brand: 25% Copay Non-preferred Brand: 30% Copay