

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS – Effective 7/1/2025

For the Traditional Plan

Applies to: Active and Retired Employees

TYPE OF SERVICE	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
Out-of-pocket Maximum	\$500 Individual
Physician (except for routine care and treatment of Mental Illness or Substance Abuse) <ul style="list-style-type: none"> • Inpatient visit • Office visit • Home visit • Specialist consultation <ul style="list-style-type: none"> - Inpatient - Outpatient - Office • Surgery <ul style="list-style-type: none"> - 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
Hospital (also see Mental Illness, Substance Abuse, and Maternity for inpatient benefits) <ul style="list-style-type: none"> • Inpatient - room and board (limit 365 days per occurrence of illness or injury) • Outpatient <ul style="list-style-type: none"> - 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 80% after deductible
Freestanding Surgical Facility	Covered in Full
Urgent Care Facility	\$25.00

(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 <ul style="list-style-type: none"> • Emergency • Transfer 	<p>Covered in Full</p> <p>80% after deductible</p>
Pre-admission Testing	Covered in Full
Convalescent / Skilled Nursing Facility <ul style="list-style-type: none"> • 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)	Covered in Full
Elective Sterilization (no reversal) <ul style="list-style-type: none"> • Inpatient • Outpatient • Office 	<p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p>
Mental Illness Treatment <ul style="list-style-type: none"> • Inpatient - Hospital or Behavioral Health Care Facility • Outpatient - Hospital Clinic, Facility, or Office 	<p>Covered in Full</p> <p>80% after deductible</p>
Substance Abuse Treatment <ul style="list-style-type: none"> • Inpatient - Hospital or Behavioral Health Care Facility • Outpatient - Hospital Clinic, Facility, or Office 	<p>Covered in Full</p> <p>Covered in Full</p>
Maternity Care – Mother <ul style="list-style-type: none"> • Inpatient • Physician (pre-natal care and delivery) Newborn Care (prior to discharge) <ul style="list-style-type: none"> • Inpatient (routine nursery care) • Physician • Circumcision 	<p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p>

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Anesthesia <ul style="list-style-type: none"> • Inpatient • Outpatient • Office 	<p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p>
Allergy Care <ul style="list-style-type: none"> • Treatment, serum, and scratch testing • Testing (laboratory) 	<p>80% after deductible</p> <p>Covered in Full</p>
Chiropractic Care	80% after deductible (medically necessary)
Acupuncture (must be performed by a medical doctor with national certification for acupuncture)	80% after deductible
Podiatrist <ul style="list-style-type: none"> • Visit • Orthotics • Surgery 	<p>80% after deductible</p> <p>Not Covered</p> <p>Covered in Full</p>
Preventive	
<ul style="list-style-type: none"> • GYN routine exam 	Covered in Full
<ul style="list-style-type: none"> • Pap smear (one per calendar year over 18 years of age) 	Covered in Full
<ul style="list-style-type: none"> • Mammogram 	Covered in Full
<ul style="list-style-type: none"> • Well-child care (up to age 19) 	Covered in Full
<ul style="list-style-type: none"> • Routine adult physicals 	Covered in Full (over 19 years of age)
<ul style="list-style-type: none"> • Adult Immunizations 	Covered in Full
<ul style="list-style-type: none"> • PSA Test 	Covered in Full
<ul style="list-style-type: none"> • Colonoscopy (Routine) 	Covered in Full
Pap Smear (medically necessary)	Covered in Full
Mammogram (medically necessary)	Covered in Full
Colonoscopy (medically necessary)	Covered in Full
Diagnostic Office Visit	80% after deductible

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Outpatient Diagnostic Tests <ul style="list-style-type: none"> • Independent Laboratory • Physician's Office • Freestanding Facility • Home 	<p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p>
Outpatient Treatments <ul style="list-style-type: none"> • Chemotherapy • Radiation therapy • Respiratory therapy • Physical therapy • Occupational therapy • Speech therapy 	<p>80% after deductible</p> <p>Covered in Full</p> <p>Not Covered</p> <p>80% after deductible</p> <p>80% after deductible</p> <p>80% after deductible</p>
Durable Medical Equipment, Medical Supplies, and Oxygen	80% after deductible
Prosthetics <ul style="list-style-type: none"> • Internal • External (original device only) 	<p>80% after deductible</p> <p>80% after deductible</p>
Diabetes Treatment <ul style="list-style-type: none"> • Supplies • Counseling/Education • Insulin • Durable Medical Equipment 	<p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p>
Prescription Drugs	80% after deductible ⁽²⁾ (exceptions by school district for Traditional Rx CoPay Plan)

- (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)**.