CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS – Effective 1/1/2024

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)	
• Inpatient visit	80% after deductible
• Office visit	80% after deductible
• Home visit	80% after deductible
• Specialist consultation	
- Inpatient	80% after deductible
- Outpatient	80% after deductible
- Office	80% after deductible
• Surgery	
- Inpatient	Covered in Full
- Outpatient	Covered in Full
- Office	Covered in Full
- Assistant surgeon (1)	20% (deductible does not apply) of allowable expense for primary surgeon
• Second surgical opinion (voluntary)	Covered in Full
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
• **Outpatient**	
- Emergency room (includes physician)	$75.00 (waived if admitted)
- Outpatient surgical center	Covered in Full
- Clinic	80% after deductible
- Laboratory	Covered in Full
- X-rays – diagnostic / therapeutic	Covered in Full
- Diagnostic tests	Covered in Full
- Cardiac rehabilitation	Covered in Full
- Dialysis / Hemodialysis	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	
• Emergency	Covered in Full
• Transfer	80% after deductible
Pre-admission Testing	Covered in Full
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)	Covered in Full
Elective Sterilization (no reversal)	
• Inpatient	Covered in Full
• Outpatient	Covered in Full
• Office	Covered in Full
Mental Illness Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility	Covered in Full
• Outpatient - Hospital Clinic, Facility, or Office	80% after deductible
Substance Abuse Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility	Covered in Full
• Outpatient - Hospital Clinic, Facility, or Office	Covered in Full
Maternity Care – Mother	
• Inpatient	Covered in Full
• Physician (pre-natal care and delivery)	Covered in Full
Newborn Care (prior to discharge)	
• Inpatient (routine nursery care)	Covered in Full
• Physician	Covered in Full
• Circumcision	Covered in Full

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Anesthesia	
• Inpatient	Covered in Full
• Outpatient	Covered in Full
• Office	Covered in Full
Allergy Care	
• Treatment, serum, and scratch testing	80% after deductible
• Testing (laboratory)	Covered in Full
Chiropractic Care	80% after deductible (medically necessary)
Acupuncture (must be performed by a medical doctor with national certification for acupuncture)	80% after deductible
Podiatrist	
• Visit	80% after deductible
• Orthotics	Not Covered
• Surgery	Covered in Full
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)	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	
• Independent Laboratory	**Covered in Full**
• Physician's Office	**Covered in Full**
• Freestanding Facility	**Covered in Full**
• Home	Covered in Full
Outpatient Treatments	
• Chemotherapy	80% after deductible
• Radiation therapy	Covered in Full
• Respiratory therapy	Not Covered
• Physical therapy	80% after deductible
• Occupational therapy	80% after deductible
• Speech therapy	80% after deductible
Durable Medical Equipment, Medical Supplies, Diabetic Supplies and Oxygen	80% after deductible
Prosthetics	
• Internal	80% after deductible
• External (original device only)	80% after deductible
Diabetic Counseling / Education	**80% after deductible**
Prescription Drugs	80% after deductible (2) (exceptions by school district)

(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**.