CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS
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	$100 Individual / $300 Family
Out-of-pocket Maximum	$400 Individual
Lifetime Maximum	$1,000,000
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)	Covered in Full
- 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	Covered in Full

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

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS
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.
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 (limit 30 days per calendar year)	Covered in Full
• Outpatient - Hospital Clinic, Facility, or Office (limit 30 visits per calendar year)	80% after deductible
Substance Abuse Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility (limit 4 weeks for one period of confinement and 6 weeks per calendar year)	Covered in Full
• Outpatient - Hospital Clinic, Facility, or Office (limit 60 visits per calendar year; 20 of such visits may be utilized by family members of covered individual)	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

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS
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.
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 (2)	Covered in Full
• Well-child care (up to age 19)	Covered in Full
• Routine adult physicals	Up to maximum of $500 per calendar year for covered employees over 50 years of age
• PSA Test	One per calendar year over 50 years of age
• Colonoscopy	One every five calendar years if family history of colorectal cancer
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

(2) Mammography is limited to the following scheduled frequency of services: ages 35 to 39 – one baseline mammogram; ages 40 and older – one mammogram annually; and for women at any age who have a first degree relative with a prior history of breast cancer upon the recommendation of her physician.

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS
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.
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 (exceptions by school district)

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS

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
Lifetime Maximum	$1,000,000
Physician (except for routine care and treatment of Mental Illness or Substance Abuse)	
• Inpatient visit	Covered in Full
• Office visit	$15 Copay/Visit
• Home visit	$15 Copay/Visit
• Specialist consultation	
- Inpatient	80% after deductible
- Outpatient	$15 Copay/Visit
- Office	$15 Copay/Visit
• Surgery	
- Inpatient	$50 Copay/Occurrence
- Outpatient	$50 Copay/Occurrence
- Office	$50 Copay/Occurrence
- Assistant surgeon (1)	$25 Copay/Occurrence
• Second surgical opinion (voluntary)	$15 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)	$250 Copay/Admission
• **Outpatient**	
- Emergency room (includes physician)	$35 Copay/Visit (waived if admitted)
- Outpatient surgical center	$50 Copay/Visit
- Clinic	$50 Copay/Visit
- Laboratory	$15 Copay/Visit
- X-rays – diagnostic / therapeutic	$15 Copay/Visit
- Diagnostic tests	$15 Copay/Visit
- Cardiac rehabilitation	$15 Copay/Visit
- Dialysis / Hemodialysis	80% after deductible
Freestanding Surgical Facility	$50 Copay/Visit
Urgent Care Facility	$35 Copay/Visit

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

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS

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.
Ambulance	
• Emergency	$35 Copay/Occurrence
• Transfer	80% after deductible
Pre-admission Testing	$15 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)	$250 Copay/Occurrence
Elective Sterilization (no reversal)	
• Inpatient	$250 Copay/Occurrence
• Outpatient	$50 Copay/Occurrence
• Office	$50 Copay/Occurrence
Mental Illness Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility (limit 30 days per calendar year)	$250 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office (limit 30 visits per calendar year)	$15 Copay/Visit
Substance Abuse Treatment	
• Inpatient - Hospital or Behavioral Health Care Facility (limit 4 weeks for one period of confinement and 6 weeks per calendar year)	$250 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office (limit 60 visits per calendar year; 20 of such visits may be utilized by family members of covered individual)	$15 Copay/Visit
Maternity Care – Mother	
• Inpatient	$250 Copay/Admission
• Physician (pre-natal care and delivery)	$15 Copay (initial visit only)
Newborn Care (prior to discharge)	
• Inpatient (routine nursery care)	Covered in Full
• Physician	Covered in Full
• Circumcision	$50 Copay/Occurrence

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS

For the Modified Traditional Plan

Applies to: Active and Retired Employees

TYPE OF SERVICE	MODIFIED TRADITIONAL PLAN
Anesthesia	
• Inpatient	Covered in Full
• Outpatient	Covered in Full
• Office	Covered in Full
Allergy Care	
• Treatment, serum, and scratch testing	$15 Copay/Visit
• Testing (laboratory)	$15 Copay/Visit
Chiropractic Care	$15 Copay/Visit (limit 15 visits per calendar year; subject to medical necessity)
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	$50 Copay/Occurrence
Preventive	
• GYN routine exam	$15 Copay/Visit
• Pap smear (one per calendar year over 18 years of age)	$15 Copay/Visit
• Mammogram [(2)]	$15 Copay/Visit
• Well-child care (up to age 19)	$15 Copay/Visit
• Routine adult physicals	$15 Copay/Visit (over 19 years of age)
• PSA Test	$15 Copay/Visit
• Colonoscopy	$50 Copay/Occurrence (one every 24 months for members considered high risk; if not high risk, then once every 10 years for members over 50 years of age)
Pap Smear (medically necessary)	$15 Copay/Visit
Mammogram (medically necessary)	$15 Copay/Visit
Colonoscopy (medically necessary)	$50 Copay/Occurrence
Diagnostic Office Visit	$15 Copay/Visit

(2) Mammography is limited to the following scheduled frequency of services: ages 35 to 39 – one baseline mammogram; ages 40 and older – one mammogram annually; and for women at any age who have a first degree relative with a prior history of breast cancer upon the recommendation of her physician.

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS

For the Modified Traditional Plan

Applies to: Active and Retired Employees

TYPE OF SERVICE	MODIFIED TRADITIONAL PLAN
Outpatient Diagnostic Tests	
• Independent Laboratory	$15 Copay/Visit
• Physician's Office	$15 Copay/Visit
• Freestanding Facility	$15 Copay/Visit
• Home	$15 Copay/Visit
Outpatient Treatments	
• Chemotherapy	80% after deductible
• Radiation therapy	$15 Copay/Visit
• Respiratory therapy	$15 Copay/Visit (3)
• Physical therapy	$15 Copay/Visit (3)
• Occupational therapy	$15 Copay/Visit (3)
• Speech therapy	$15 Copay/Visit
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	Covered in Full
Prescription Drugs	Generic: 20% Copay Preferred Brand: 25% Copay Non-preferred Brand: 30% Copay

(3) 30 visits per calendar year combined.

The Modified Traditional Plan may also include a confidential *preventive care wellness outreach program* designed to assist participants with illness education, prevent the deterioration of chronic conditions, provide preventive care measures and promote healthy lifestyles.

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS COMPARISON

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	$100 Individual / $300 Family	$200 Individual / $600 Family (services with a copay are not subject to the deductible)
Out-of-pocket Maximum	$400 Individual	$650 Individual / $1,950 Family
Lifetime Maximum	$1,000,000	$1,000,000
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	$15 Copay/Visit
• Home visit	80% after deductible	$15 Copay/Visit
• Specialist consultation		
- Inpatient	80% after deductible	80% after deductible
- Outpatient	80% after deductible	$15 Copay/Visit
- Office	80% after deductible	$15 Copay/Visit
• Surgery		
- Inpatient	Covered in Full	$50 Copay/Occurrence
- Outpatient	Covered in Full	$50 Copay/Occurrence
- Office	Covered in Full	$50 Copay/Occurrence
- Assistant surgeon [1]	20% (deductible does not apply) of allowable expense for primary surgeon	$25 Copay/Occurrence
• Second surgical opinion (voluntary)	Covered in Full	$15 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	$250 Copay/Admission
• **Outpatient**		
- Emergency room (includes physician)	Covered in Full	$35 Copay/Visit (waived if admitted)
- Outpatient surgical center	Covered in Full	$50 Copay/Visit
- Clinic	80% after deductible	$50 Copay/Visit
- Laboratory	Covered in Full	$15 Copay/Visit
- X-rays – diagnostic / therapeutic	Covered in Full	$15 Copay/Visit
- Diagnostic tests	Covered in Full	$15 Copay/Visit
- Cardiac rehabilitation	Covered in Full	$15 Copay/Visit
- Dialysis / Hemodialysis	80% after deductible	80% after deductible
Freestanding Surgical Facility	Covered in Full	$50 Copay/Visit
Urgent Care Facility	Covered in Full	$35 Copay/Visit

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

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS COMPARISON

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.	
Ambulance		
• Emergency	Covered in Full	$35 Copay/Occurrence
• Transfer	80% after deductible	80% after deductible
Pre-admission Testing	Covered in Full	$15 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	$250 Copay/Occurrence
Elective Sterilization (no reversal)		
• Inpatient	Covered in Full	$250 Copay/Occurrence
• Outpatient	Covered in Full	$50 Copay/Occurrence
• Office	Covered in Full	$50 Copay/Occurrence
Mental Illness Treatment		
• Inpatient - Hospital or Behavioral Health Care Facility (limit 30 days per calendar year)	Covered in Full	$250 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office (limit 30 visits per calendar year)	80% after deductible	$15 Copay/Visit
Substance Abuse Treatment		
• Inpatient - Hospital or Behavioral Health Care Facility (limit 4 weeks for one period of confinement and 6 weeks per calendar year)	Covered in Full	$250 Copay/Admission
• Outpatient - Hospital Clinic, Facility, or Office (limit 60 visits per calendar year; 20 of such visits may be utilized by family members of covered individual)	Covered in Full	$15 Copay/Visit
Maternity Care – Mother		
• Inpatient	Covered in Full	$250 Copay/Admission
• Physician (pre-natal care and delivery)	Covered in Full	$15 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	$50 Copay/Occurrence

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS COMPARISON

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.	
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	$15 Copay/Visit
• Testing (laboratory)	Covered in Full	$15 Copay/Visit
Chiropractic Care	80% after deductible (medically necessary)	$15 Copay/Visit (limit 15 visits per calendar year; subject to medical necessity)
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	$50 Copay/Occurrence
Preventive		
• GYN routine exam	Covered in Full	$15 Copay/Visit
• Pap smear (one per calendar year over 18 years of age)	Covered in Full	$15 Copay/Visit
• Mammogram (2)	Covered in Full	$15 Copay/Visit
• Well-child care (up to age 19)	Covered in Full	$15 Copay/Visit
• Routine adult physicals	Up to maximum of $500 per calendar year for covered employees over 50 years of age	$15 Copay/Visit (over 19 years of age)
• PSA Test	One per calendar year over 50 years of age	$15 Copay/Visit
• Colonoscopy	One every five calendar years if family history of colorectal cancer	$50 Copay/Occurrence (one every 24 months for members considered high risk; if not high risk, then once every 10 years for members over 50 years of age)
Pap Smear (medically necessary)	Covered in Full	$15 Copay/Visit
Mammogram (medically necessary)	Covered in Full	$15 Copay/Visit
Colonoscopy (medically necessary)	Covered in Full	$50 Copay/Occurrence
Diagnostic Office Visit	80% after deductible	$15 Copay/Visit

(2) Mammography is limited to the following scheduled frequency of services: ages 35 to 39 – one baseline mammogram; ages 40 and older – one mammogram annually; and for women at any age who have a first degree relative with a prior history of breast cancer upon the recommendation of her physician.

CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' HEALTHCARE PLAN

SCHEDULE OF BENEFITS COMPARISON

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.	
Outpatient Diagnostic Tests		
• Independent Laboratory	Covered in Full	$15 Copay/Visit
• Physician's Office	Covered in Full	$15 Copay/Visit
• Freestanding Facility	Covered in Full	$15 Copay/Visit
• Home	Covered in Full	$15 Copay/Visit
Outpatient Treatments		
• Chemotherapy	80% after deductible	80% after deductible
• Radiation therapy	Covered in Full	$15 Copay/Visit
• Respiratory therapy	Not Covered	$15 Copay/Visit (3)
• Physical therapy	80% after deductible	$15 Copay/Visit (3)
• Occupational therapy	80% after deductible	$15 Copay/Visit (3)
• Speech therapy	80% after deductible	$15 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 (exceptions by school district)	Generic: 20% Copay Preferred Brand: 25% Copay Non-preferred Brand: 30% Copay

(3) 30 visits per calendar year combined for **The Modified Traditional Plan** only.

The **Modified Traditional Plan** may also include a confidential *preventive care wellness outreach program* designed to assist participants with illness education, prevent the deterioration of chronic conditions, provide preventive care measures and promote healthy lifestyles.