

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) <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) 	<ul style="list-style-type: none"> 80% after deductible 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 	<ul style="list-style-type: none"> Covered in Full \$15 Copay/Visit \$15 Copay/Visit 80% after deductible \$15 Copay/Visit \$15 Copay/Visit \$50 Copay/Occurrence \$50 Copay/Occurrence \$50 Copay/Occurrence \$25 Copay/Occurrence \$15 Copay/Occurrence
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 	<ul style="list-style-type: none"> Covered in Full Covered in Full Covered in Full 80% after deductible Covered in Full Covered in Full Covered in Full Covered in Full Covered in Full 80% after deductible 	<ul style="list-style-type: none"> \$250 Copay/Admission \$35 Copay/Visit (waived if admitted) \$50 Copay/Visit \$50 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit 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.

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Ambulance <ul style="list-style-type: none"> • Emergency • Transfer 	Covered in Full 80% after deductible	\$35 Copay/Occurrence 80% after deductible
Pre-admission Testing	Covered in Full	\$15 Copay/Admission
Convalescent / Skilled Nursing Facility <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • Inpatient • Outpatient • Office 	Covered in Full Covered in Full Covered in Full	\$250 Copay/Occurrence \$50 Copay/Occurrence \$50 Copay/Occurrence
Mental Illness Treatment <ul style="list-style-type: none"> • Inpatient - Hospital or Behavioral Health Care Facility (limit 30 days per calendar year) • Outpatient - Hospital Clinic, Facility, or Office (limit 30 visits per calendar year) 	Covered in Full 80% after deductible	\$250 Copay/Admission \$15 Copay/Visit
Substance Abuse Treatment <ul style="list-style-type: none"> • Inpatient - Hospital or Behavioral Health Care Facility (limit 4 weeks for one period of confinement and 6 weeks per calendar year) • 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 Covered in Full	\$250 Copay/Admission \$15 Copay/Visit
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 	Covered in Full Covered in Full Covered in Full Covered in Full Covered in Full	\$250 Copay/Admission \$15 Copay (initial visit only) Covered in Full Covered in Full \$50 Copay/Occurrence

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Anesthesia <ul style="list-style-type: none"> • Inpatient • Outpatient • Office 	Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full
Allergy Care <ul style="list-style-type: none"> • Treatment, serum, and scratch testing • Testing (laboratory) 	80% after deductible Covered in Full	\$15 Copay/Visit \$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 <ul style="list-style-type: none"> • Visit • Orthotics • Surgery 	80% after deductible Not Covered Covered in Full	80% after deductible 80% after deductible if required by surgery and medically necessary \$50 Copay/Occurrence
Preventive <ul style="list-style-type: none"> • GYN routine exam • Pap smear (one per calendar year over 18 years of age) • Mammogram ⁽²⁾ • Well-child care (up to age 19) • Routine adult physicals • PSA Test • Colonoscopy 	Covered in Full Covered in Full Covered in Full Covered in Full Up to maximum of \$500 per calendar year for covered employees over 50 years of age One per calendar year over 50 years of age One every five calendar years if family history of colorectal cancer	\$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit (over 19 years of age) \$15 Copay/Visit \$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.

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Outpatient Diagnostic Tests <ul style="list-style-type: none"> • Independent Laboratory • Physician's Office • Freestanding Facility • Home 	Covered in Full Covered in Full Covered in Full Covered in Full	\$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit \$15 Copay/Visit
Outpatient Treatments <ul style="list-style-type: none"> • 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 \$15 Copay/Visit \$15 Copay/Visit ⁽³⁾ \$15 Copay/Visit ⁽³⁾ \$15 Copay/Visit ⁽³⁾ \$15 Copay/Visit
Durable Medical Equipment, Medical Supplies, Diabetic Supplies and Oxygen	80% after deductible	80% after deductible
Prosthetics <ul style="list-style-type: none"> • Internal • External (original device only) 	80% after deductible 80% after deductible	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.