

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) <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) 	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 	\$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 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.

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Ambulance <ul style="list-style-type: none"> • Emergency • Transfer 	\$35 Copay/Occurrence 80% after deductible
Pre-admission Testing	\$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
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) <ul style="list-style-type: none"> • Inpatient • Outpatient • Office 	\$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) 	\$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) 	\$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 	\$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 	<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>\$15 Copay/Visit</p> <p>\$15 Copay/Visit</p>
Chiropractic Care	<p>\$15 Copay/Visit (limit 15 visits per calendar year; subject to medical necessity)</p>
Acupuncture (must be performed by a medical doctor with national certification for acupuncture)	<p>80% after deductible (limit 15 visits per calendar year)</p>
Podiatrist <ul style="list-style-type: none"> • Visit • Orthotics • Surgery 	<p>80% after deductible</p> <p>80% after deductible if required by surgery and medically necessary</p> <p>\$50 Copay/Occurrence</p>
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 	<p>\$15 Copay/Visit</p> <p>\$15 Copay/Visit</p> <p>\$15 Copay/Visit</p> <p>\$15 Copay/Visit</p> <p>\$15 Copay/Visit (over 19 years of age)</p> <p>\$15 Copay/Visit</p> <p>\$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)</p>
Pap Smear (medically necessary)	<p>\$15 Copay/Visit</p>
Mammogram (medically necessary)	<p>\$15 Copay/Visit</p>
Colonoscopy (medically necessary)	<p>\$50 Copay/Occurrence</p>
Diagnostic Office Visit	<p>\$15 Copay/Visit</p>

(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 	<p style="text-align: center;">\$15 Copay/Visit</p> <p style="text-align: center;">\$15 Copay/Visit</p> <p style="text-align: center;">\$15 Copay/Visit</p> <p style="text-align: center;">\$15 Copay/Visit</p>
Outpatient Treatments <ul style="list-style-type: none"> • Chemotherapy • Radiation therapy • Respiratory therapy • Physical therapy • Occupational therapy • Speech therapy 	<p style="text-align: center;">80% after deductible</p> <p style="text-align: center;">\$15 Copay/Visit ⁽³⁾</p> <p style="text-align: center;">\$15 Copay/Visit ⁽³⁾</p> <p style="text-align: center;">\$15 Copay/Visit ⁽³⁾</p> <p style="text-align: center;">\$15 Copay/Visit ⁽³⁾</p> <p style="text-align: center;">\$15 Copay/Visit</p>
Durable Medical Equipment, Medical Supplies, Diabetic Supplies and Oxygen	80% after deductible
Prosthetics <ul style="list-style-type: none"> • Internal • External (original device only) 	<p style="text-align: center;">80% after deductible</p> <p style="text-align: center;">80% after deductible</p>
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.