At a Glance: A Comparison of Syracuse University's Health Care Plans

	SUBlue	SUBlue	SUOrange	SUPro	SUPro
	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network
Annual Deductible (single/family)	$100 / $250	$300 / $1,000	$100 / $250	$200 / $400	$300 / $1,000
Coinsurance	No coinsurance (specific exceptions as listed in the medical benefits booklet)	30% of Excellus BCBS's allowable amount plus difference between submitted charges and allowable amount (specific exceptions as listed in the medical benefits booklet)	No coinsurance (specific exceptions as listed in the medical benefits booklet)	20% of Excellus BCBS's allowable amount (specific exceptions as listed in the medical benefits booklet)	30% of Excellus BCBS's allowable amount plus difference between submitted charges and allowable amount (specific exceptions as listed in the medical benefits booklet)
Annual Out-of-Pocket Maximum (Single/Family)	$2,000 / $4,000	$6,000 / $12,000	$2,000 / $4,000	$1,500 / $3,000	$6,000 / $12,000
Referral Required	No	No	No	No	No
International Claims	***Eligible services provided through a participating BlueCross BlueShield (BCBS) Global Core Network provider:*** Member pays in-network deductible, copay and/or coinsurance at time of service. ***Eligible services provided through a non-participating provider:*** Member pays total due at time of service, and then is reimbursed through Excellus BCBS once paperwork is submitted. Eligible services are based on submitted amount, and the responsibility of the member is the in-network deductible, copay and/or coinsurance.	Same as In-Network	Eligible international claims incurred through the BCBS Global core network only	***Eligible services provided through a participating BlueCross BlueShield (BCBS) Global Core Network provider:*** Member pays in-network deductible and coinsurance at time of service. ***Eligible services provided through a non-participating provider:*** Member pays total due at time of service, and then is reimbursed through Excellus BCBS once paperwork is submitted. Eligible services are based on submitted amount, and the responsibility of the member is the in-network deductible and coinsurance.	Same as In-Network
Preventive Care	100% covered	Deductible plus coinsurance	100% covered	100% covered	Deductible plus coinsurance
Primary Care Physician	Deductible plus $35 copay	Deductible plus $35 copay plus coinsurance	Deductible plus $35 copay	Deductible plus coinsurance	Deductible plus coinsurance
Specialist	Deductible plus $50 copay	Deductible plus $50 copay plus coinsurance	Deductible plus $50 copay	Deductible plus coinsurance	Deductible plus coinsurance
Inpatient Hospitalization	Deductible plus $350 copay	Deductible plus $350 copay plus coinsurance	Deductible plus $350 copay	Deductible plus 5% coinsurance	Deductible plus 5% coinsurance

	SUBlue	SUBlue	SUOrange	SUPro	SUPro
	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network
Outpatient Surgery	Deductible plus $200 copay	Deductible plus $200 copay plus coinsurance	Deductible plus $200 copay	Deductible plus coinsurance	Deductible plus coinsurance
Ambulatory Surgery	Deductible plus $150 copay	Deductible plus $150 copay plus coinsurance	Deductible plus $150 copay	Deductible plus coinsurance	Deductible plus coinsurance
Physical Therapy	Deductible plus $35 copay	Deductible plus $35 copay plus coinsurance	Deductible plus $35 copay	Deductible plus coinsurance	Deductible plus coinsurance
Diagnostic Machines Tests, X-Rays, and Radiology (Including MRIs, PET and CT Scans)	Deductible plus $50 copay	Deductible plus $50 copay plus coinsurance	Deductible plus $50 copay	Deductible plus coinsurance	Deductible plus coinsurance
Urgent Care	Deductible plus $50 copay	Deductible plus $50 copay plus coinsurance	Deductible plus $50 copay	Deductible plus coinsurance	Deductible plus coinsurance
Emergency Room	Deductible and $150 copay	In-network deductible and $150 copay	Deductible and $150 copay (includes out-of-network coverage but in-network deductible applies)	Deductible plus coinsurance	In-network deductible plus in-network coinsurance
PRESCRIPTION DRUGS	**SUBlue & SUOrange**			**SUPro**	
Annual Deductible	No deductible			No deductible	
Out-of-Pocket Maximum	$2,000 single / $4,000 family			$2,000 single / $4,000 family	
Retail, Tier One	20% coinsurance*			15% coinsurance*	
Retail, Tier Two	25% coinsurance			25% coinsurance	
Retail, Tier Three	45% coinsurance			40% coinsurance	
Mail Order, Tier One	$20 copay for up to a 90 day supply*			Lesser of $15 or 15% coinsurance*	
Mail Order, Tier Two	$50 copay for up to a 90 day supply			Lesser of $45 or 25% coinsurance	
Mail Order, Tier Three	$90 copay for up to a 90 day supply			Lesser of $90 or 40% coinsurance	
Specialty Mail Order	Same as Mail Order except up to a 30 day supply			Same as Mail Order except up to a 30 day supply	
Infertility Medications	Follows above schedule for retail, mail order and specialty with a $20,000 lifetime maximum			Follows above schedule for retail, mail order and specialty with a $20,000 lifetime maximum	

Prescription drug coverage is not applicable to Medicare-eligible individuals participating in the Retiree Medical Plan.

***SUBlue, SUOrange and SUPro Certain Generic Prescription Drugs: $0 Copay** **Age, Gender and Other Restrictions Apply. Contact OptumRx at 866.854.2945 for more details (TTY: 711)**
Aspirin
Breast Cancer Prevention Drugs
Cholesterol Medications
FDA-Approved Tobacco Cessation Drugs and OTC Products
Fluoride
Folic Acid
Iron Supplements
Preparatory Prescriptions associated with Colonoscopies
Vitamin D Supplements
Women's Contraceptives

Every effort has been made to ensure that the information contained within this document is accurate. However, benefits are governed by legal documents (which, in certain circumstances, may include insurance contracts). If there is any difference between the information in this document and the official documents, the official documents will control. As is the case with all of Syracuse University's benefit plans, the University reserves the right to modify or terminate these benefits at any time.