

SUPRO: 2020 SCHEDULE OF BENEFITS - EMPLOYEE COST SHARING

| | | | SU Pro (In-Network and Out-of-Network) | |
|--|---|--|--|----------------|
| | | | In Network | Out of Network |
| | | | <ul style="list-style-type: none"> • Excellus BCBS or BlueCard Network • All Eligible International Claims | |
| Cost Sharing Definitions | | | | |
| Annual Deductible¹ | \$200 per individual with a maximum of \$400 for a family | \$300 per individual with a maximum of \$1,000 for a family | | |
| Coinsurance | 5% of allowable amount for inpatient hospitalization - or - 50% of allowable amount for hearing aids - or - 20% of allowable amount for all other services All preventive services covered in full | 5% of allowable amount for inpatient hospitalization - or - 50% of allowable amount for hearing aids - or - 30% of allowable amount for all other services - plus - Difference between submitted charge and allowable amount | | |
| Annual Out-of-Pocket Maximum² | \$1,500 per individual with a maximum of \$3,000 for a family | \$6,000 per individual with a maximum of \$12,000 for a family | | |
| Your Institutional Covered Services | | | | |
| INPATIENT HOSPITAL | | | | |
| Inpatient hospital | Deductible plus coinsurance | Deductible plus coinsurance | | |
| Nursery care | Deductible plus coinsurance | Deductible plus coinsurance | | |
| OUTPATIENT HOSPITAL | | | | |
| Surgery | Deductible plus coinsurance | Deductible plus coinsurance | | |
| Partial Hospitalization | Deductible plus coinsurance | Deductible plus coinsurance | | |
| Routine mammography screenings (one per calendar year for ages 35 and older with exceptions if high risk) | No coinsurance; paid in full | Deductible plus coinsurance | | |
| Routine prostate cancer screenings (one per calendar year for ages 50 and older with exceptions if high risk) | No coinsurance; paid in full | Deductible plus coinsurance | | |
| Routine cervical cancer screenings (one per calendar year for ages 18 and older) | No coinsurance; paid in full | Deductible plus coinsurance | | |
| Colonoscopies | No coinsurance; paid in full | Deductible plus coinsurance | | |

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| Diagnostic machine tests, x-rays, and radiology services (including MRIs, PET and CT scans) | Deductible plus coinsurance | Deductible plus coinsurance |
| Diagnostic laboratory tests | Deductible plus coinsurance | Deductible plus coinsurance |
| Occupational therapy (for situations not covered through a governmental program) | Deductible plus coinsurance | Deductible plus coinsurance |
| Physical therapy | Deductible plus coinsurance | Deductible plus coinsurance |
| Speech therapy (for situations not covered through a governmental program) | Deductible plus coinsurance | Deductible plus coinsurance |
| Respiratory, radiation, cardiac therapies and chemotherapy | Deductible plus coinsurance | Deductible plus coinsurance |
| HOSPITAL EMERGENCY ROOM | | |
| Hospital emergency room | Deductible plus coinsurance | In-network deductible plus in-network coinsurance |
| ADDITIONAL INSTITUTIONAL PROVIDERS | | |
| Ambulatory surgery center | Deductible plus coinsurance | Deductible plus coinsurance |
| Birth center | Deductible plus coinsurance | Deductible plus coinsurance |
| Skilled nursing facility (180 inpatient days) | Deductible plus coinsurance | Deductible plus coinsurance |
| Home health agency | Deductible plus coinsurance | Deductible plus coinsurance |
| Hospice | Deductible plus coinsurance | Deductible plus coinsurance |
| Inpatient mental health disorder care (facility charge) <ul style="list-style-type: none"> • General hospital or psychiatric facility | Deductible plus coinsurance | Deductible plus coinsurance |

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| | In Network <ul style="list-style-type: none"> • Excellus BCBS or BlueCard Network • All Eligible International Claims | Out of Network |
| Inpatient substance use disorder detoxification and rehabilitation <ul style="list-style-type: none"> • General hospital or certified alcohol/substance abuse facility program | Deductible plus coinsurance | Deductible plus coinsurance |
| Outpatient treatment for mental health disorders | Deductible plus coinsurance | Deductible plus coinsurance |
| Outpatient treatment for substance use disorders | Deductible plus coinsurance | Deductible plus coinsurance |
| Your Professional Provider Covered Services | | |
| Surgery and assistance at surgery | Deductible plus coinsurance | Deductible plus coinsurance |
| Second opinion | Deductible plus coinsurance | Deductible plus coinsurance |
| Anesthesia | Deductible plus coinsurance | Deductible plus coinsurance |
| Maternity | No coinsurance; paid in full | Deductible plus coinsurance |
| PROFESSIONAL PROVIDER INPATIENT VISITS | | |
| Inpatient hospital visits by physician or other professional provider | Deductible plus coinsurance | Deductible plus coinsurance |
| Inpatient substance use disorder hospital visits by physician or other professional provider | Deductible plus coinsurance | Deductible plus coinsurance |
| Inpatient skilled nursing facility visits by physician or other professional provider | Deductible plus coinsurance | Deductible plus coinsurance |
| Inpatient mental health disorder care visits by physician or other professional provider | Deductible plus coinsurance | Deductible plus coinsurance |
| PROFESSIONAL PROVIDER VISITS | | |
| Office visits | Deductible plus coinsurance | Deductible plus coinsurance |

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| | In Network <ul style="list-style-type: none"> • Excellus BCBS or BlueCard Network • All Eligible International Claims | Out of Network |
| Well child visits <ul style="list-style-type: none"> • Birth to 2nd birthday - 11 visits • 2nd birthday to 3rd birthday - 2 visits • 3rd birthday to 19th birthday - 1 visit per calendar year | No coinsurance; paid in full | Deductible plus coinsurance |
| Routine physical (one per calendar year) | No coinsurance; paid in full | Deductible plus coinsurance |
| Routine cervical cancer screening (annual routine pap smear; one per calendar year) | No coinsurance; paid in full | Deductible plus coinsurance |
| Allergy testing and treatment | Deductible plus coinsurance | Deductible plus coinsurance |
| Consultation service, office | Deductible plus coinsurance | Deductible plus coinsurance |
| Consultation service, ER | Deductible plus coinsurance | Deductible plus coinsurance |
| Consultation service, hospital | Deductible plus coinsurance | Deductible plus coinsurance |
| Urgent care | Deductible plus coinsurance | Deductible plus coinsurance |
| Kidney dialysis (with ESRD, member must sign up for Medicare upon becoming eligible) | Deductible plus coinsurance | Deductible plus coinsurance |
| Private duty nursing | Deductible plus coinsurance | Deductible plus coinsurance |
| Diabetes education | Deductible plus coinsurance | Deductible plus coinsurance |
| Acupuncture | Deductible plus coinsurance | Deductible plus coinsurance |
| Chiropractic services | Deductible plus coinsurance | Deductible plus coinsurance |
| Routine vision exam (one exam in 24 consecutive months) | Deductible plus coinsurance | Deductible plus coinsurance |
| Routine hearing exam (one exam in 24 consecutive months) | Deductible plus coinsurance | Deductible plus coinsurance |
| THERAPY | | |
| Occupational therapy (for situations not covered through a governmental program) | Deductible plus coinsurance | Deductible plus coinsurance |
| Physical therapy | Deductible plus coinsurance | Deductible plus coinsurance |
| Speech therapy (for situations not covered through a governmental program) | Deductible plus coinsurance | Deductible plus coinsurance |

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| | In Network <ul style="list-style-type: none"> • Excellus BCBS or BlueCard Network • All Eligible International Claims | Out of Network |
| Respiratory, radiation, and cardiac therapies and chemotherapy | Deductible plus coinsurance | Deductible plus coinsurance |
| PREVENTIVE AND DIAGNOSTIC SERVICES | | |
| Diagnostic machine tests, x-rays and radiology services (including MRIs, PET and CT scans) | Deductible plus coinsurance | Deductible plus coinsurance |
| Diagnostic laboratory | Deductible plus coinsurance | Deductible plus coinsurance |
| Routine mammography screenings (one per calendar year for ages 35 and older with exceptions if high risk) | No coinsurance; paid in full | Deductible plus coinsurance |
| Routine prostate cancer screenings (one per calendar year for ages 50 and older with exceptions if high risk) | No coinsurance; paid in full | Deductible plus coinsurance |
| Routine cervical cancer screenings (one per calendar year for ages 18 and older) | No coinsurance; paid in full | Deductible plus coinsurance |
| Colonoscopies | No coinsurance; paid in full | Deductible plus coinsurance |
| Additional Health Services | | |
| Ambulance | Deductible plus coinsurance | In-network deductible plus in-network coinsurance |
| Diabetic equipment and supplies | Deductible plus coinsurance | Deductible plus coinsurance |
| Durable medical equipment | Deductible plus coinsurance | Deductible plus coinsurance |
| Breastfeeding Equipment Rental or Purchase | No coinsurance; paid in full | Rental Coverage Only: Deductible plus coinsurance |
| Hearing Aids Maximum benefit of \$750 for a single hearing aid and \$1,500 for binaural hearing aids; limited to once every three years | <ul style="list-style-type: none"> • Contracted Model: Deductible and 50% of the submitted charge or the allowable amount (whichever is lesser) • Non-Contracted Model: Deductible and 50% of the submitted charge or the allowable amount (whichever is lesser) plus the difference between the submitted charge and the allowable amount. | Deductible and 50% of the submitted charge or the allowable amount (whichever is lesser) plus the difference between the submitted charge and the allowable amount. |
| Medical supplies | Deductible plus coinsurance | Deductible plus coinsurance |
| Prosthetic devices | Deductible plus coinsurance | Deductible plus coinsurance |

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| | In Network <ul style="list-style-type: none"> • Excellus BCBS or BlueCard Network • All Eligible International Claims | Out of Network |
| Biofeedback | Deductible plus coinsurance | Deductible plus coinsurance |
| Infertility coverage | Member cost-sharing follows service; \$20,000 medical plan lifetime limit | Member cost-sharing follows service; \$20,000 medical plan lifetime limit |
| Medical Evacuation | No Coverage | No Coverage |
| Repatriation | No Coverage | No Coverage |
| Prescription Drugs | Claims processed by prescription benefit manager | |

¹ Coverage requires the employee to pay an annual deductible before any other cost sharing is determined. The annual in-network deductible is \$200 per individual with a maximum of \$400 for a family. The annual out-of-network deductible is \$300 per individual with a maximum of \$1,000 for a family. After the annual deductible is satisfied, the employee must pay the coinsurance, if applicable. The coinsurance is then applied to the balance of the allowable amount. For out-of-network services, the employee is also responsible for the difference between the submitted charge and the allowable amount as defined by Excellus BlueCross BlueShield.

² Out-of-pocket maximum refers to the maximum amount of out-of-pocket expenses an employee would pay in a calendar year. The out-of-pocket expenses are defined as the deductibles and coinsurance amounts, exclusive of coinsurance amounts for prescription medicines. The differences between submitted charges and the allowable amounts under the out-of-network level are not subject to the out-of-pocket maximum.

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| Prescription Drugs | |
|----------------------------|---|
| Annual Deductible | No Deductible |
| Out-of-Pocket Maximum | \$2000 single/\$4000 family |
| | |
| Retail: Tier One | 15% coinsurance* |
| Retail: Tier Two | 25% coinsurance |
| Retail: Tier Three | 40% coinsurance |
| | |
| Mail Order: Tier One | Lesser of \$15 or 15% coinsurance* |
| Mail Order: Tier Two | Lesser of \$45 or 25% coinsurance |
| Mail Order: Tier Three | Lesser of \$90 or 40% coinsurance |
| | |
| Specialty Mail Order (All) | Same as mail order except 30 day supply |
| | |
| Infertility Medications | Follows above schedule for retail, mail order and specialty with a \$20,000 lifetime maximum. |

*** Certain Generic Prescription Drugs: \$0 copay - Age, Gender and Other Restrictions Apply
Contact OptumRx at 866.854.2945 (TTY: 711) for Details:**

Aspirin, Breast Cancer Prevention Drugs, Cholesterol Medications, FDA-Approved Tobacco Cessation Drugs and OTC Products, Fluoride, Folic Acid, Iron Supplements, Preparatory Prescriptions for Colonoscopies, Vitamin D Supplements & Women’s Contraceptives.

Prescription drug coverage is not applicable to Medicare-eligible individuals participating in the retiree medical plan.

This is not an exhaustive list of all cost sharing requirements.

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.