

## SUBBlue and SUOrange: 2024 Schedule of Benefits – Employee Cost Sharing

SUBBlue		SUOrange
<p style="text-align: center; margin: 0;"><b>In-Network</b></p> <ul style="list-style-type: none"> <li>Excellus BCBS or BlueCard Network</li> <li>No Referral Required</li> <li>Includes All Eligible International Claims</li> </ul>	<p style="text-align: center; margin: 0;"><b>Out-of-Network</b></p>	<p style="text-align: center; margin: 0;"><b>In-Network Only</b></p> <ul style="list-style-type: none"> <li>Excellus BCBS or BlueCard Network</li> <li>No Referral Required</li> <li>Includes Eligible International Claims Incurred through the BlueCross BlueShield Global Core Network Only</li> </ul>

### Cost Sharing Definitions

<b>Annual Deductible<sup>1</sup></b> (amounts are <u>not</u> cumulative across levels)	\$150 per individual with a maximum of \$300 for a family	\$300 per individual with a maximum of \$1,000 for a family	\$150 per individual with a maximum of \$300 for a family
<b>Coinsurance</b>	No coinsurance (with exceptions listed below)	30% allowable amount plus the difference between submitted charge and the allowable amount ( <i>exceptions noted below</i> )	No coinsurance (with exceptions listed below)
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b> (amounts <u>are</u> cumulative across levels)	\$2,000 per individual with a maximum of \$4,000 for a family	\$6,000 per individual with a maximum of \$12,000 for a family	\$2,000 per individual with a maximum of \$4,000 for a family

### Your Institutional Covered Services

#### INPATIENT HOSPITAL

<b>Inpatient hospital</b>	Deductible and \$350 copay per admission	Deductible, \$350 copay per admission, and coinsurance	Deductible and \$350 copay per admission
<b>Nursery care</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

#### OUTPATIENT HOSPITAL

<b>Surgery or Partial Hospitalization</b>	Deductible and \$200 copay	Deductible, \$200 copay, and coinsurance	Deductible and \$200 copay
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<b>Mammography and breast cancer screenings</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Routine prostate cancer screenings</b> (one per calendar year for ages 50 and older with exceptions if high risk)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Routine cervical cancer screenings</b> (one per calendar year for ages 18 and older)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Colonoscopies</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Diagnostic machine tests, x-rays, and radiology services</b> (including MRIs, PET and CT scans)	Deductible and \$50 copay	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay
<b>Diagnostic laboratory tests</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Occupational therapy</b> (for situations not covered through a governmental program)	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Physical therapy</b>	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Speech therapy</b> (for situations not covered through a governmental program)	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Respiratory, radiation, cardiac therapies and chemotherapy</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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<b>HOSPITAL EMERGENCY ROOM</b>			
<b>Hospital emergency room</b>	Deductible and \$150 copay	In-network Deductible and \$150 copay	Deductible and \$150 copay (includes out-of-network coverage but in-network deductible applies)
<b>ADDITIONAL INSTITUTIONAL PROVIDERS</b>			
<b>Ambulatory surgery center</b>	Deductible and \$150 copay	Deductible, \$150 copay, and coinsurance	Deductible and \$150 copay
<b>Birth center</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Skilled nursing facility</b> (180 inpatient days)	Deductible and \$350 copay per admission	Deductible, \$350 copay per admission, and coinsurance	Deductible and \$350 copay per admission
<b>Home health agency</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Hospice</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Inpatient mental health disorder care (facility charge)</b> <ul style="list-style-type: none"> <li>General hospital or psychiatric facility</li> </ul>	Deductible and \$350 copay per admission	Deductible, \$350 copay per admission, and coinsurance	Deductible and \$350 copay per admission
<b>Inpatient substance use disorder detoxification and rehabilitation</b> <ul style="list-style-type: none"> <li>General hospital or certified alcohol/substance abuse facility program</li> </ul>	Deductible and \$350 copay per admission	Deductible, \$350 copay per admission, and coinsurance	Deductible and \$350 copay per admission

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Your Professional Provider Covered Services			
<b>Surgery and assistance at surgery</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Second opinion</b>	No deductible or copay; paid in full	Deductible <b>plus the difference between submitted charge and allowable amount</b>	No deductible or copay; paid in full
<b>Anesthesia</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Maternity</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
PROFESSIONAL PROVIDER INPATIENT VISITS			
<b>Inpatient hospital visits by physician or other professional provider</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Inpatient substance use disorder hospital visits by physician or other professional provider</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Inpatient skilled nursing facility visits by physician or other professional provider</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Inpatient mental health disorder care visits by physician or other professional provider</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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PROFESSIONAL PROVIDER VISITS			
<b>Office visits</b>	Deductible and \$35 copay (PCP) or Deductible and \$50 copay (Specialist)	Deductible and \$35 copay (PCP) and coinsurance or  Deductible and \$50 copay (Specialist) and coinsurance	Deductible and \$35 copay (PCP) or Deductible and \$50 copay (Specialist)
<b>Well child visits</b> <ul style="list-style-type: none"> <li>Birth to 2nd birthday: 11 visits</li> <li>2nd birthday to 3rd birthday: 2 visits</li> <li>3rd birthday to 19th birthday: 1 visit per calendar year</li> </ul> (immunizations are covered according to recommendations by the Advisory Committee on Immunization Practices)	No deductible or copay; paid in full	<b>Deductible plus the difference between submitted charge and allowable amount</b>	No deductible or copay; paid in full
<b>Routine physical</b> (one physical per calendar year; immunizations are covered according to recommendations by the Advisory Committee on Immunization Practices)	No deductible or copay; paid in full	<b>Deductible plus the difference between submitted charge and allowable amount</b>	No deductible or copay; paid in full
<b>Routine cervical cancer screening</b> (annual routine pap smear)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Allergy testing and treatment</b>	Deductible and \$35 copay (PCP) or  Deductible and \$50 copay (Specialist)	Deductible and \$35 copay (PCP) and coinsurance or  Deductible and \$50 copay (Specialist) and coinsurance	Deductible and \$35 copay (PCP) or  Deductible and \$50 copay (Specialist)

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<b>Consultation service (clinic, ER, office, outpatient, telemedicine)</b>	Deductible and \$50 copay (Specialist)	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay (Specialist)
<b>Consultation service, hospital</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Urgent care</b>	Deductible and \$50 copay	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay
<b>Kidney dialysis</b> (with ESRD, member must sign up for Medicare upon becoming eligible)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Outpatient treatment for mental health disorders</b>	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Private duty nursing</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Diabetes education</b>	Deductible and \$35 copay (PCP) or Deductible and \$50 copay (Specialist)	Deductible and \$35 copay (PCP) and coinsurance or  Deductible and \$50 copay (Specialist) and coinsurance	Deductible and \$35 copay (PCP) or Deductible and \$50 copay (Specialist)
<b>Acupuncture</b>	Deductible and \$50 copay	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay
<b>Chiropractic services</b>	Deductible and \$50 copay	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay

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<b>Routine vision exam</b> (one exam in 24 consecutive months)	Deductible and \$50 copay (Specialist)	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay (Specialist)
<b>Routine hearing exam</b> (one exam in 24 consecutive months)	Deductible and \$50 copay (Specialist)	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay (Specialist)
<b>Telemedicine and Telehealth through MDLIVE</b>	Deductible and copay associated with in-person visit	Deductible, copay associated with in-person visit, and coinsurance	Deductible and copay associated with in-person visit
<b>THERAPY (Includes Telemedicine)</b>			
<b>Occupational therapy</b> (for situations not covered through a governmental program)	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Physical therapy</b>	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Speech therapy</b> (for situations not covered through a governmental program)	Deductible and \$35 copay	Deductible, \$35 copay, and coinsurance	Deductible and \$35 copay
<b>Respiratory, radiation, and cardiac therapies and chemotherapy</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>PREVENTIVE OR DIAGNOSTIC SERVICES</b>			
<b>Diagnostic machine tests, x-rays and radiology services</b> (including MRIs, PET and CT scans)	Deductible and \$50 copay	Deductible, \$50 copay, and coinsurance	Deductible and \$50 copay
<b>Diagnostic laboratory</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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<b>Mammography and breast cancer screenings</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Routine prostate cancer screenings</b> (one per calendar year for ages 50 and older with exceptions if high risk)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Routine cervical cancer screenings</b> (one per calendar year for ages 18 and older)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Colonoscopies</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Additional Health Services</b>			
<b>Ambulance</b>	Deductible and \$100 copay	In-network Deductible and \$100 copay	Deductible and \$100 copay (includes out-of-network coverage but in-network deductible applies)
<b>Diabetic equipment and supplies</b>	Deductible and \$30 copay	Deductible, \$30 copay, and coinsurance	Deductible and \$30 copay
<b>Durable medical equipment</b>	Deductible and 10% allowable amount	Deductible and 40% allowable amount <b>plus the difference between submitted charge and allowable amount</b>	Deductible and 10% allowable amount
<b>Breastfeeding equipment, rental or purchase</b>	No deductible or copay; paid in full	Rental Coverage Only: Deductible and 40% of allowable amount <b>plus the difference between the actual charge and the Allowed Charge.</b>	No deductible or copay; paid in full



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<b>Hearing aids</b>  For both in-network and out-of-network: 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"> <li><b>Contracted Model:</b> Deductible and 50% of the billed charge or the allowable amount (whichever is lesser)</li> <li><b>Non-Contracted Model:</b> Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) <b>plus the difference between the actual charge and the allowable amount.</b></li> </ul>	Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) <b>plus the difference between the actual charge and the allowable amount.</b>	<ul style="list-style-type: none"> <li><b>Contracted Model:</b> Deductible and 50% of the billed charge or the allowable amount (whichever is lesser)</li> <li><b>Non-Contracted Model:</b> Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) <b>plus the difference between the actual charge and the allowable amount.</b></li> </ul>
<b>Medical supplies</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Prosthetic devices</b>	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
<b>Biofeedback</b>	Deductible and \$35 copay (PCP) or Deductible and \$50 copay (Specialist)	Deductible and \$35 copay (PCP) and coinsurance or Deductible and \$50 copay (Specialist) and coinsurance	Deductible and \$35 copay (PCP) or Deductible and \$50 copay (Specialist)
<b>Infertility Coverage</b> (\$20,000 medical plan lifetime limit)	Cost-sharing follows type of service, exclusions apply	Cost-sharing follows type of service, excl. apply	Cost-sharing follows type of service, excl. apply
<b>Repatriation or Medical evacuation</b>	No Coverage	No Coverage	No Coverage
<b>Prescription drugs</b>	Claims processed by prescription benefit manager (with the exception of certain vaccines)		

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<sup>1</sup> Coverage requires the employee to pay an annual deductible before any other cost sharing is determined. After the annual deductible is satisfied, the employee must pay the copay, if applicable. The coinsurance is then applied to the balance of the allowable amount. The employee is also responsible for the difference between the submitted charge and the allowable amount as defined by Excellus BCBS.

<sup>2</sup> 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, coinsurance and copayment amounts, exclusive of costs for prescription medicines. The differences between submitted charges and the allowable amounts are not subject to the out-of-pocket maximum.

<b>Prescription Drug Coverage</b>	
<b>Annual Deductible</b>	No deductible
<b>Out-of-Pocket Maximum (Separate from Medical)</b>	\$2,000 per individual with a maximum of \$4,000 for a family
<b>Retail: Tier One</b>	20% coinsurance*
<b>Retail: Tier Two</b>	25% coinsurance
<b>Retail: Tier Three</b>	45% coinsurance
<b>Mail Order: Tier One</b>	\$20*
<b>Mail Order: Tier Two</b>	\$50
<b>Mail Order: Tier Three</b>	\$90
<b>Specialty Mail Order (All)</b>	Same as mail order except 30 day supply

**\*Certain Preventive Care Prescription Drugs: \$0 copay - Age, Gender and Other Restrictions Apply. Contact Optum Rx for more details at 866.854.2945 (TTY: 711).**

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.