

SUPRO: 2026 SCHEDULE OF BENEFITS - EMPLOYEE COST SHARING

SU Pro (In-Network and Out-of-Network)		
	In-Network • Excellus BCBS or BlueCard Network • All Eligible International Claims	Out-of-Network
Cost Sharing Definitions		
Annual Deductible¹	\$250 per individual with a maximum of \$500 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 or Partial Hospitalization	Deductible plus coinsurance	Deductible plus coinsurance
Mammography and breast cancer screenings	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) • General hospital or psychiatric facility	Deductible plus coinsurance	Deductible plus coinsurance

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Inpatient substance use disorder detoxification and rehabilitation 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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Well child visits • 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 and telemedicine	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
Telemedicine and Telehealth through MDLIVE	Deductible plus coinsurance	Deductible plus coinsurance
THERAPY (Includes Telemedicine)		
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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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
Mammography and breast cancer screenings	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
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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	• 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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Biofeedback	Deductible plus coinsurance	Deductible plus coinsurance
Infertility coverage (eligible treatment limited to \$20,000 per Lifetime; prescription drugs are subject to a separate \$20,000 per Lifetime limit)	Cost-sharing follows type of service, exclusions apply	Cost-sharing follows type of service, exclusions apply
Medical Evacuation	No Coverage	No Coverage
Repatriation	No Coverage	No Coverage
Prescription Drugs	Most claims processed by prescription benefit manager	

¹ 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 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 (Separate from Medical)	No Deductible
Annual Out-of-Pocket Maximum (Separate from Medical)	\$2,000 per individual with a maximum of \$4,000 for a family
Lifetime Maximum Benefit for Certain Infertility Treatment (Separate from Medical)	\$20,000
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

*Certain Generic 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.