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

	SUBlue		SUOrange	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 Schedule of Benefits)	30% of Excellus BCBS's Allowable Amount plus difference between Submitted Charges and Allowable Amount (specific exceptions as listed in the Schedule of Benefits)	No coinsurance (specific exceptions as listed in the Schedule of Benefits)	20% of Excellus BCBS's Allowable Amount (specific exceptions as listed in the Schedule of Benefits)	30% of Excellus BCBS's Allowable Amount plus difference between Submitted Charges and Allowable Amount (specific exceptions as listed in the Schedule of Benefits)
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 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.		Eligible International Claims Incurred through the BlueCross BlueShield Global Core Network Only	*Eligible services provided through a participating BlueCross BlueShield 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.*	
Preventive Care	100% covered	Deductible plus some subject to $50 copay 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
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

	SUBlue		SUOrange	SUPro	
	In-Network	**Out-of-Network**	**In-Network Only**	**In-Network**	**Out-of-Network**
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 (For True Medical Emergencies)	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 Generic	20% coinsurance*			15% coinsurance*	
Retail Brand Preferred	25% coinsurance			25% coinsurance	
Retail Brand Non-Preferred	45% coinsurance			40% coinsurance	
Mail Order Generic	$20 copay for up to a 90 day supply*			Lesser of $15 or 15% coinsurance*	
Mail Order Brand Preferred	$50 copay for up to a 90 day supply			Lesser of $45 or 25% coinsurance	
Mail Order Brand Non-Preferred	$90 copay for up to a 90 day supply			Lesser of $90 or 40% coinsurance	
Specialty Mail Order (All)	Same as Mail Order except up to a 30 day supply			Same as Mail Order except up to a 30 day supply	

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

***SUBlue, SUOrange and SUPro Generic Prescription Drugs: $0 Copay** **Certain 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