SUBLUE AND SUORANGE: 2019 SCHEDULE OF BENEFITS -EMPLOYEE COST SHARING

	SUBlue		SUOrange
	In-Network • Excellus BCBS or BlueCard Network • No Referral Required • Includes All Eligible International Claims	**Out-of-Network**	**In-Network Only** • Excellus BCBS or BlueCard Network • No Referral Required • Includes Eligible International Claims Incurred through the BlueCross BlueShield Global Core Network Only
Cost Sharing Definitions			
Annual Deductible[1] (amounts are <u>not</u> cumulative across levels)	$100 per individual with a maximum of $250 for a family	$300 per individual with a maximum of $1,000 for a family	$100 per individual with a maximum of $250 for a family
Coinsurance	No coinsurance (with exceptions listed below)	30% allowable amount plus the difference between submitted charge and the allowable amount *(exceptions noted below)*	No coinsurance (with exceptions listed below)
Annual Out-of-Pocket Maximum[2] (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			
Inpatient hospital	Deductible and $350 copay per admission	Deductible, $350 copay per admission, and coinsurance	Deductible and $350 copay per admission
Nursery care	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
OUTPATIENT HOSPITAL			
Surgery	Deductible and $200 copay	Deductible, $200 copay, and coinsurance	Deductible and $200 copay
Pre-surgical testing	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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

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HOSPITAL EMERGENCY ROOM			
Hospital 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)
ADDITIONAL INSTITUTIONAL PROVIDERS			
Ambulatory surgery center	Deductible and $150 copay	Deductible, $150 copay, and coinsurance	Deductible and $150 copay
Birth center	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Skilled nursing facility (180 inpatient days)	Deductible and $350 copay per admission	Deductible, $350 copay per admission, and coinsurance	Deductible and $350 copay per admission
Home health agency	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Hospice	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Inpatient mental health disorder care *(facility charge)* • **General hospital or psychiatric facility**	Deductible and $350 copay per admission	Deductible, $350 copay per admission, and coinsurance	Deductible and $350 copay per admission
Inpatient substance use disorder detoxification and rehabilitation • **General hospital or certified alcohol/ substance abuse facility program**	Deductible and $350 copay per admission	Deductible, $350 copay per admission, and coinsurance	Deductible and $350 copay per admission

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Outpatient treatment for mental health disorders • **Includes Partial Hospitalization**	Deductible and $35 copay	Deductible, $35 copay, and coinsurance	Deductible and $35 copay
Outpatient treatment for substance use disorders • **Includes Partial Hospitalization**	Deductible and $35 copay	Deductible, $35 copay, and coinsurance	Deductible and $35 copay
Your Professional Provider Covered Services			
Surgery and assistance at surgery	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Breast reconstruction surgery	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Second opinion	No deductible or copay; paid in full	Deductible *plus the difference between submitted charge and allowable amount*	No deductible or copay; paid in full
Anesthesia	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Maternity	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
PROFESSIONAL PROVIDER INPATIENT VISITS			
Inpatient hospital visits by physician or other professional provider	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Inpatient substance use disorder hospital visits by physician or other professional provider	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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Inpatient skilled nursing facility visits by physician or other professional provider	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Inpatient mental health disorder care visits by physician or other professional provider	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
PROFESSIONAL PROVIDER VISITS			
Office visits	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)	Deductible, $35 copay (PCP) or $50 copay (Specialist), and coinsurance	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)
Well child visits • Birth to 2nd birthday: 9 visits • 2nd birthday to 7th birthday: 5 visits • 7th birthday to 19th birthday: 1 visit per calendar year (immunizations are covered according to recommendations by the Advisory Committee on Immunization Practices)	No deductible or copay; paid in full	Deductible *plus the difference between submitted charge and allowable amount*	No deductible or copay; paid in full
Routine physical (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	Deductible *plus the difference between submitted charge and allowable amount*	No deductible or copay; paid in full
Routine cervical cancer screening (annual routine pap smear)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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Allergy testing and treatment	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)	Deductible, $50 copay, and coinsurance	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)
Consultation service (clinic, ER, office, outpatient)	Deductible and $50 copay (Specialist)	Deductible, $50 copay, and coinsurance	Deductible and $50 copay (Specialist)
Consultation service, hospital	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Urgent care	Deductible and $50 copay	Deductible, $50 copay, and coinsurance	Deductible and $50 copay
Kidney dialysis (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
Outpatient treatment for mental health disorders (1 therapy visit per day)	Deductible and $35 copay	Deductible, $35 copay, and coinsurance	Deductible and $35 copay
Private duty nursing	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Diabetes education	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)	Deductible, $50 copay, and coinsurance	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)
Acupuncture	Deductible and $50 copay	Deductible, $50 copay, and coinsurance	Deductible and $50 copay
Chiropractic services	Deductible and $50 copay	No Coverage	Deductible and $50 copay

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Routine vision exam (one exam in 24 consecutive months)	Deductible and $50 copay (Specialist)	No Coverage	Deductible and $50 copay (Specialist)
Routine hearing exam (one exam in 24 consecutive months)	Deductible and $50 copay (Specialist)	No Coverage	Deductible and $50 copay (Specialist)
THERAPY			
Occupational therapy (for situations not covered through a governmental program)	Deductible and $35 copay	Deductible, $35 copay, and coinsurance	Deductible and $35 copay
Physical therapy	Deductible and $35 copay	Deductible, $35 copay, and coinsurance	Deductible and $35 copay
Speech therapy (for situations not covered through a governmental program)	Deductible and $35 copay	Deductible, $35 copay, and coinsurance	Deductible and $35 copay
Respiratory, radiation, and cardiac therapies and chemotherapy	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
PREVENTIVE OR DIAGNOSTIC SERVICES			
Diagnostic machine tests, x-rays and radiology services (including MRIs, PET and CT scans, certain mammography screenings)	Deductible and $50 copay	Deductible, $50 copay, and coinsurance	Deductible and $50 copay
Diagnostic laboratory	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full

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Routine mammography screenings (one per calendar year for ages 35 and older with exceptions if high risk)	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Routine prostate cancer screenings (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
Routine cervical cancer screenings (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
Colonoscopies	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Additional Health Services			
Ambulance	Deductible and $100 copay	In-network Deductible and $100 copay	Deductible and $100 copay (includes out-of-network coverage but in-network deductible applies)
Diabetic equipment and supplies	Deductible and $30 copay	Deductible, $30 copay, and coinsurance	Deductible and $30 copay
Durable medical equipment	Deductible and 10% allowable amount	Deductible and 40% allowable amount *plus the difference between submitted charge and allowable amount*	Deductible and 10% allowable amount
Breastfeeding equipment, rental or purchase	No deductible or copay; paid in full	Rental Coverage Only: Deductible and 40% of allowable amount *plus the difference between the actual charge and the Allowed Charge.*	No deductible or copay; paid in full

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Hearing aids 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	• **Contracted Model:** Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) • **Non-Contracted Model**: Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount.*	Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount.*	• **Contracted Model:** Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) • **Non-Contracted Model**: Deductible and 50% of the billed charge or the allowable amount (whichever is lesser) *plus the difference between the actual charge and the allowable amount.*
Medical supplies	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Prosthetic devices	No deductible or copay; paid in full	Deductible and coinsurance	No deductible or copay; paid in full
Biofeedback	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)	Deductible, $35 copay (PCP) or $50 copay (Specialist), and coinsurance	Deductible and $35 copay (PCP) or Deductible and $50 copay (Specialist)
Medical evacuation	No Coverage	No Coverage	No Coverage
Repatriation	No Coverage	No Coverage	No Coverage
Prescription drugs	Claims processed by prescription benefit manager (with the exception of certain vaccines)		

[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 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.

[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, 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.

Each medical program is governed by the plan document. If there is any difference between the information on these summary sheets and the plan document, the plan document will rule.

Prescription Drug Coverage	
Annual Deductible	No Deductible
Out-of-Pocket Maximum (Separate from Medical)	$2,000 per individual with a maximum of $4,000 for a family
Retail: Generic	20% coinsurance*
Retail: Brand Formulary	25% coinsurance
Retail: Brand Non-Formulary	45% coinsurance
Mail Order: Generic	$20*
Mail Order: Brand Formulary	$50
Mail Order: Brand Non-Formulary	$90
Specialty Mail Order (All)	Same as Mail Order except 30 day supply
Contraceptives	Follows above schedule for retail and mail order

***Generic Prescription Drugs: $0 copay - Certain Age, Gender and Other Restrictions Apply; Contact OptumRx for more details at 866-854-2945 (TTY: 711):** 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.