

Comparison of SU Health Care Plans

	SUBBlue (Levels One, Two, and Three)			SUOrange	SUPro (In-Network and Out-of-Network)	
	Level 1 POMCO/PHCS/Multiplan With Referral	Level2 POMCO/PHCS/Multiplan Without Referral	Level3 Out-of-Network	Level 1 POMCO/PHCS/Multiplan With Referral	In-Network POMCO/PHCS/Multiplan	Out-of-Network
MEDICAL						
Annual Deductible (single/family)	No deductible	No deductible	\$300/\$1,000	No deductible	\$200/\$400	\$300/\$1,000
Coinsurance	No coinsurance	10% of Allowable Amount	30% of Allowable Amount plus difference between Submitted Charges and Allowable Amount	No coinsurance	20% of Allowable Amount	30% of Allowable Amount plus difference between Submitted Charges and Allowable Amount
Annual Out-of-Pocket Maximum (single/family)	\$2,000/\$4,000	\$4,000/\$8,000	\$6,000/\$12,000	\$2,000/\$4,000	\$1,500/\$3,000	\$6,000/\$12,000
Preventive Care	100% covered (some subject to \$20 copay)	Coinsurance plus some subject to \$25 copay	Deductible plus some subject to \$25 copay plus coinsurance	100% covered (some subject to \$20 copay)	100% covered (no copay or deductible)	Deductible plus coinsurance
Primary Care Physician	\$20 copay	\$25 copay plus coinsurance	\$25 copay plus deductible plus coinsurance	\$20 copay	Deductible plus coinsurance	Deductible plus coinsurance
Specialist	\$25 copay	\$25 copay plus coinsurance	\$25 copay plus deductible plus coinsurance	\$25 copay	Deductible plus coinsurance	Deductible plus coinsurance
Inpatient Hospitalization	\$250 copay	\$250 copay plus coinsurance	\$250 copay plus deductible plus coinsurance	\$250 copay	Deductible plus 5% coinsurance	Deductible plus 5% coinsurance
Outpatient Surgery	\$100 copay	\$100 copay plus coinsurance	\$100 copay plus deductible plus coinsurance	\$100 copay	Deductible plus coinsurance	Deductible plus coinsurance
Physical Therapy	\$20 copay	\$20 copay plus coinsurance	\$20 copay plus deductible plus coinsurance	\$20 copay	Deductible plus coinsurance	Deductible plus coinsurance
Diagnostic x-ray, radiology	\$20 copay	\$20 copay plus coinsurance	\$20 copay plus deductible plus coinsurance	\$20 copay	Deductible plus coinsurance	Deductible plus coinsurance
Diagnostic machine tests	\$25 copay	\$25 copay plus coinsurance	\$25 copay plus deductible plus coinsurance	\$25 copay	Deductible plus coinsurance	Deductible plus coinsurance
Emergency Room (for true medical emergencies)	\$50 copay	\$50 copay	\$50 copay plus deductible	\$50 copay	Deductible plus coinsurance	Deductible plus coinsurance

PRESCRIPTION DRUGS	SUBBlue & 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 Formulary	20% coinsurance	25% coinsurance
Retail Brand Non-Formulary	40% coinsurance	40% coinsurance
Mail Order Generic	\$20 copay for 90 day supply	Lesser of \$15 or 15% coinsurance
Mail Order Brand Formulary	\$40 copay for 90 day supply	Lesser of \$45 or 25% coinsurance
Mail Order Brand Non Formulary	\$80 copay for 90 day supply	Lesser of \$90 or 40% coinsurance
Specialty Mail Order (All)	Same as Mail Order except 30 day supply	Same as Mail Order except 30 day supply
Contraceptives	50% coinsurance for generic or formulary	Same as Other Rx for all tiers