

Not just coverage.
Confidence.

Your benefit plan details

Group Name
Onondaga County

Plan Type
OnPoint Pre-65 Retiree

Excellus | Everybody Benefits

Welcome to Excellus BlueCross BlueShield!

Getting the most from your health plan is more important than ever. Excellus BCBS is here to bring together the coverage, programs and resources you need to be on your way to total physical, emotional and financial wellbeing.

You can count on your Excellus BCBS plan for care when and where you need it:



The area's **largest network of doctors and hospitals**, with greater access close to home and in all 50 states



$0 copays for most preventive services such as an annual routine physical exam*, select vaccines, and important health screenings



Free digital support tools for answers anytime, anywhere, such as:

- Online member account
- Mobile app
- Estimate out-of-pocket medical costs
- Find a doctor, specialist or facility that accepts your plan



Find more answers and support at **ExcellusBCBS.com**

In this booklet you will find:

- A chart that summarizes this plan's unique benefits and coverage**
- Helpful information to help you get the most from your plan
- A glossary of terms to help you understand your coverage and options

* Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.
**This benefit summary is not a contract or binding agreement; it is a summary of benefits and services.

Onondaga County

OnPoint Pre-65 Retiree

Plan Features

Student / Dependent Coverage	Covered to age 26
Domestic Partner	Not Covered
Office visit copay (Primary Care Physician)	$17 Copay
Office visit copay (Specialist)	$17 Copay
Coinsurance	20% Out of Network
Deductible	$250 Individual/$750 Family Out of Network

Questions? For assistance call (800) 796-6747,
Call our TTYphone at 1 (800) 421-1220,

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Onondaga County - OnPoint Pre-65 Retiree

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$250	
Deductible - Family	$0	$750	Each individual does not exceed the single deductible.
Deductible Aggregation - Single and Family			Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible. Individual
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	N/A	$1,500	Out-of-pocket maximums accumulate coinsurance and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	N/A	$4,500	Out-of-pocket maximums accumulate coinsurance and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum Aggregation - Single and Family			Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum. Individual

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$17 Copayment	20% Coinsurance Subject to Deductible	$12 Copayment for Pediatric services for members age 0 to19.
Cost Share - Specialist	$17 Copayment	20% Coinsurance Subject to Deductible	$12 Copayment for Pediatric services for members age 0 to19.

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	20% Coinsurance Subject to Deductible	100 Days per year Admission must be 7 days of a prior hospital stay. Limits are combined In and Out of Network.
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined In and Out of Network.
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$17 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	$17 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	$17 Copayment	20% Coinsurance Subject to Deductible	Chemo Injections and Oral Chemo Therapy covered under injectable.
Lung Cancer Screening Outpatient			
Infusion Therapy Outpatient	$17 Copayment	20% Coinsurance Subject to Deductible	
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	$17 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization. In Network Psychological Testing CIF.
Substance Use Care	$17 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to Deductible	40 Visits per year Limits are combined In and Out of Network.
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible	210 Days per lifetime Limits are combined In and Out of Network.

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	Chemo Injections and Oral Chemo Therapy covered under injectable.
Lung Cancer Screening Services			
Infusion Therapy Services	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
Dialysis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	In Network Psychological Testing CIF.
Maternity Care	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	Initial visit $17 copay, then covered in full.
Telehealth	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Covered in Full	Not Covered	Effective 4/1/2020 - Covers online internet consultations between the member and the providers who participate in our Telemedicine Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Digital Physical Therapy	PCP/Specialist - Covered in Full	Not Covered	Covers online internet consultations and services between the member and the providers who participate in our Telemedicine Vori Health Program for Digital Physical Therapy.
Teledermatology	PCP/Specialist - $17 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate with MDLive.
Chiropractic Care	PCP/Specialist - $17 Copayment	50% Coinsurance Subject to Deductible	30 Visits per year Limits are combined In and Out of Network.
Allergy Testing	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests. $12 Copayment for Pediatric services for members age 0 to19.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$17 Copayment	50% Coinsurance Subject to Deductible	
Occupational Rehabilitation	$17 Copayment	20% Coinsurance Subject to Deductible	
Speech Rehabilitation	$17 Copayment	20% Coinsurance Subject to Deductible	

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
Occupational Rehabilitation	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
Speech Rehabilitation	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year Limits are combined In and Out of Network.
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	1 Per year Limits are combined In and Out of Network.
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Per year Age 35 and above. Limits are combined In and Out of Network.
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Age 50 and Over
Bone Density Screening Professional	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	1 Per year Limits are combined In and Out of Network.
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	1 Per year Age 35 and above. Limits are combined In and Out of Network.
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	Age 50 and Over
Bone Density Screening Facility	$17 Copayment	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year Age 50 and Over. Limits are combined In and Out of Network.
Mammography Screening Professional	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $17 Copayment	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	$17 Copayment	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$17 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a DME vendor - covered through Carve-out Rx vendor.
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a DME vendor - covered through Carve-out Rx vendor.
Diabetic Equipment	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	50% Coinsurance Subject to Deductible	Out of Pocket Individual $500/ Family $1,500. Limit applies to medical out of pocket. Oxygen 20% Coinsurance In Network and 20% Coinsurance subject to deductible Out of Network. DME Includes CPAP supplies.
Medical Supplies	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Compression Stockings - 2 pear year. Limits are combined In and Out of Network.
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$35 Copayment	20% Coinsurance Subject to Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. Copay waived if admitted.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$17 Copayment	$17 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$17 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$17 Copayment	20% Coinsurance Subject to Deductible	1 Exam Every 12 months based on Date of Service Limits are combined In and Out of Network.
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$17 Copayment	20% Coinsurance Subject to Deductible	1 Exam Every 12 months based on Date of Service Limits are combined In and Out of Network.
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

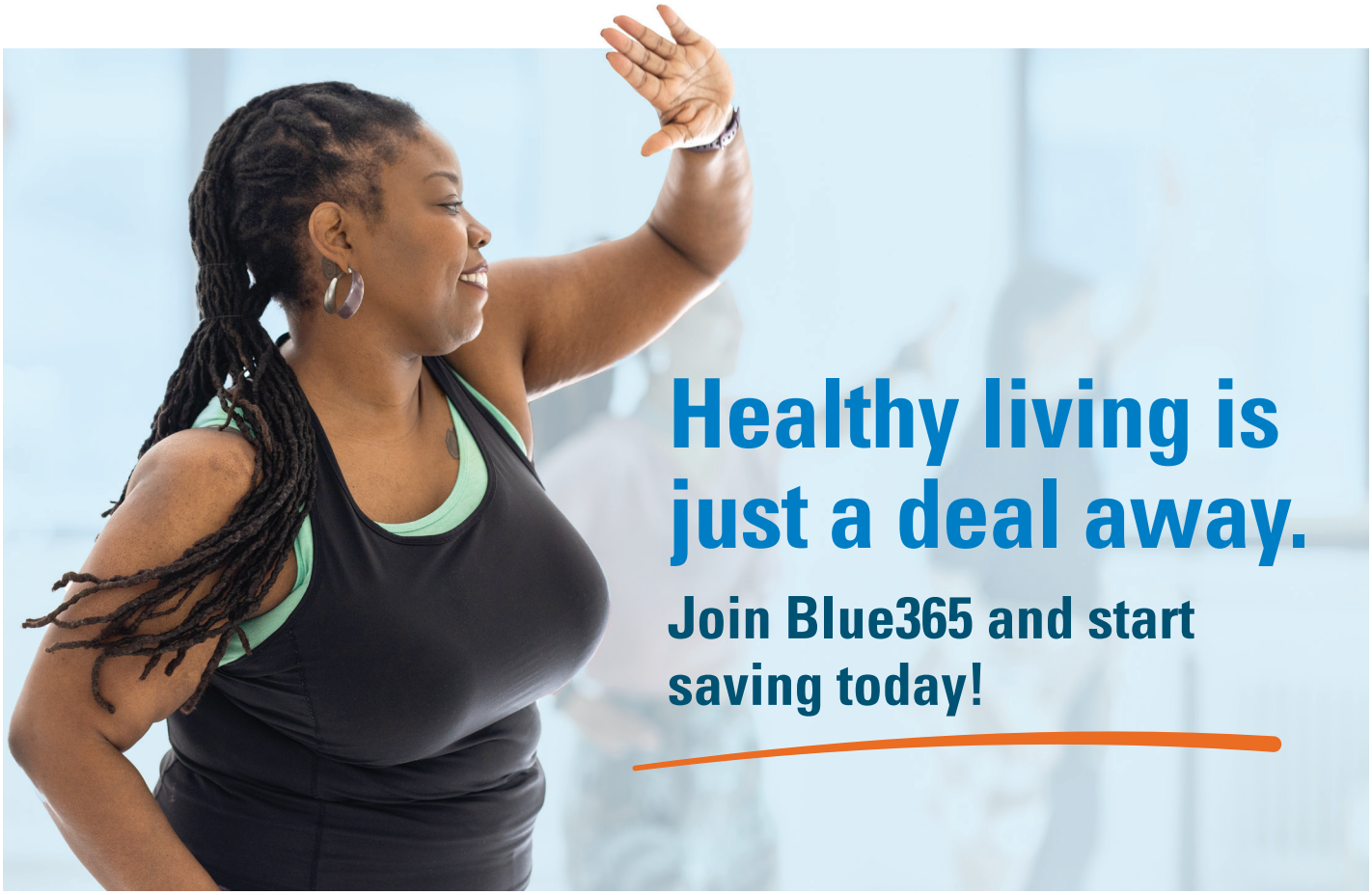
Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			Drug Coverage Excluded

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	N/A		
Days Supply Per Mail Order	N/A		
Copays Per Mail Order Supply	N/A		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.



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How to Register for Blue365

1. Get started with your free registration at **Blue365Deals.com/ExcellusBCBS**
2. Click the **"Join Blue365"** button
3. Enter your BCBS member information
4. Complete your registration

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Know where to get care

You have options when choosing where to go for medical care. Here are some tips to help you make the right choice for where to go the next time you need care.

Where to go	Cost	Choosing the best option
Primary care physician	$	Your doctor should be your **first choice** for routine medical care or minor illnesses or injuries that are not an emergency. You may have an office visit copay depending on your plan. **TIP:** If you can't make it to their office, you might be able to schedule a remote visit with your doctor through phone or video connection, known as telehealth. Check with your primary care physician to see if they offer this option.
Telemedicine	$	If your doctor isn't available for minor medical or behavioral health needs, telemedicine may be an option for you. Telemedicine gives you fast and convenient access to a doctor 24/7/365 wherever you are through your phone, tablet, or computer. Register today at **Member.ExcellusBCBS.com** **Medical telemedicine for:** • Allergies • Asthma • Cold & flu • Constipation • Diarrhea • Fever • Joint aches • Nausea • Pink eye • Rashes • and more **Behavioral health telemedicine for:** • Addictions • Anxiety • Bipolar disorders • Depression • Eating disorders • Grief and loss • LGBTQ support • Panic disorders • Stress • and more **Dermatology telemedicine for:** • Acne • Alopecia (Hair Loss) • Cold Sores • Dermatitis • Eczema • Fungal Skin Infections • Psoriasis • Rosacea • Suspicious Spots & Moles • Warts • and more
Urgent care	$$	If your medical issue is not life threatening and your doctor isn't available, you can visit an urgent care center and get the care you need. • Minor cuts, bruises or burns • Muscle strains or sprains • Cold and flu treatment
Emergency room	$$$	You should only go to the emergency room if you have a serious or potentially life-threatening medical condition. **Call 911** for assistance. Do not try to drive yourself there.

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Excellus Everybody Benefits

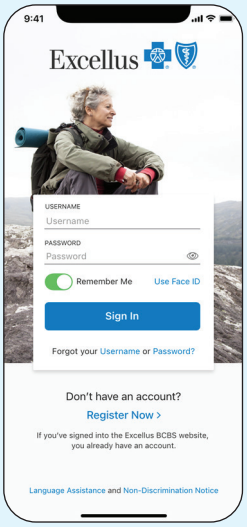
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GET READY FOR A MORE CONVENIENT HEALTH CARE EXPERIENCE

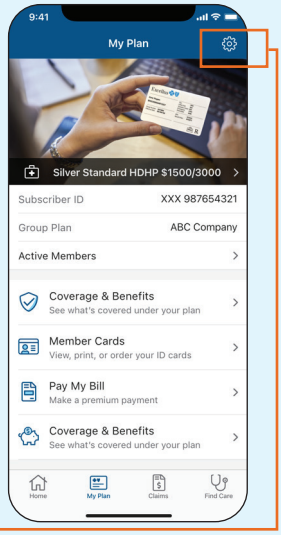
Your Wellframe® quick start guide

Free to all Excellus BlueCross BlueShield members, the Wellframe® App gives you instant access to a dedicated care manager, dietitians, nurses, and other health care professionals to help you meet your health and wellness goals.

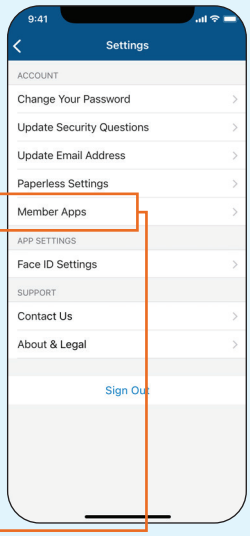
To get started, follow these simple steps:



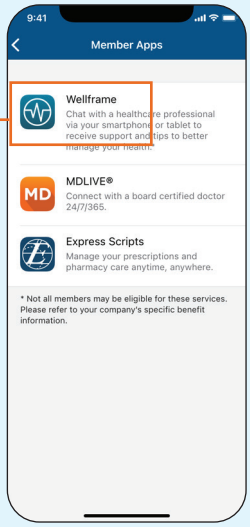
1 Download the Excellus BCBS app and register your online account.



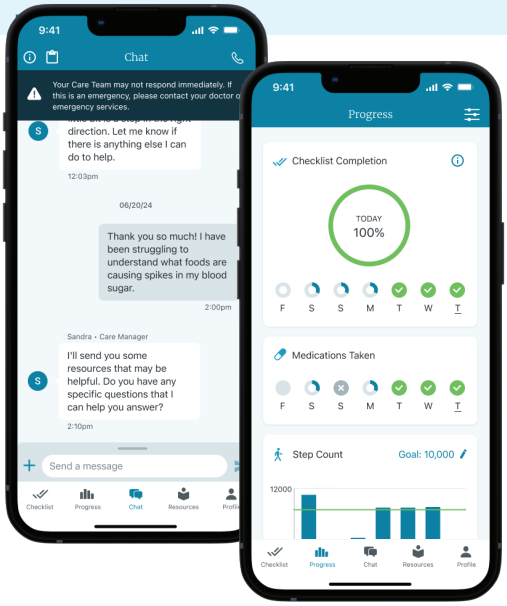
2 Open your Excellus BCBS app and click the settings icon on the top right.



3 Click Member Apps from the dropdown menu.



4 Click Wellframe® and enter code "excelluswelcome" to download.



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Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex. Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros. 注意：如果您说中文，我们可为您提供免费的语言协助。请参见随附的文件以获取我们的联系方式。

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Excellus

Health Plan Terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

Primary Care Physician (PCP)

A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

Referral

Instructions provided by a PCP for specialty care. Most plans do not require referrals.

In-network coverage

The coverage available when you receive services from a provider who participates in your health plan.

Out-of-network coverage

The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

Out-of-area

Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

Copay

A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount

The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance

A cost-sharing method that requires you pay a percentage of the allowed amount for certain medical services.

Deductible

A set dollar amount you pay for services you receive before your insurer will make a payment.

Out-of-pocket maximum

The maximum amount of copays, deductible and coinsurance payments that you will pay for health services each calendar year.

*Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.



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