1110 Crosspointe Lane Webster NY 14580
Phone: 585-265-3960

Excellus Individual, Family & Sole Proprietors Plans

Premium Period: 2024 (JAN - DEC 2024 start dates)
Coverage listed: Dependents to age 26; Yes on Pediatric Dental

Click on Plan Code link to open detailed Plan Summary information sheets

These plans are available to any individual, family or sole proprietor.

Plan Code	Plan Name	Plan Premiums	Plan Type	PCP Visit	Specialist Visit	Co-Insurance	Plan Year Deductible	Hospital Benefits	Emergency Department	Prescription Rx Coverage	Out of Pocket Max	Out of Network	No Ped Dtl Plan Code	Age 30 Dtl Plan Code
IAP9	Base (Under 30)	SGL: $301.78 DBL: $603.57 OPF: $ 513.04 FAM: $860.08	Base	**First 3 Primary Visits covered @ 100% not subject to deductible. 4th and after covered @ 100%, subject to deductible**	Covered at 100%, subject to the deductible	None	*$9,450 Individual / $18,900 Family *IA*	Covered at 100% per admission*, subject to the deductible	Covered at 100%, subject to the deductible	Deductible / Coinsurance subject to the plan deductible	*$9,450 Individual / $18,900 Family *IA*	Not Covered	IAP0	
IAQ3	Bronze Secure Plus 3	SGL: $516.57 DBL: $1,033.15 OPF: $878.17 FAM: $1,472.24	Base	**First 3 Primary Visits covered @ 100% not subject to deductible. 4th and after covered @ 100%, subject to deductible**	Covered at 100%, subject to the deductible	None	*$9,450 Individual / $18,900 Family *IA*	Covered at 100% per admission*, subject to the deductible	Covered at 100%, subject to the deductible	Deductible / Coinsurance subject to the plan deductible	*$9,450 Individual / $18,900 Family *IA*	Not Covered	IAQ4	IAQ1
IAN5	Bronze Select	SGL: $544.84 DBL: $1,089.69 OPF: $926.23 FAM: $1,552.81	Deductible HSA	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%	$5,500 Individual / $11,000 Family *FA	Covered at 50% per admission*, subject to the deductible	Covered at 50%, subject to the deductible	$10/40%/50% , subject to the plan deductible	*$7,500 Individual / $15,000 Family **FA*	Not Covered	IAN6	IAN3
IAL7	Bronze Standard HSA	SGL: $548.77 DBL: $1,097.54 OPF: $932.91 FAM: $1,563.99	Deductible HSA	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%	$6,100 Individual / $12,200 Family *IA	Covered at 50% per admission*, subject to the deductible	Covered at 50%, subject to the deductible	$10/$35/$70, subject to the plan deductible	*$7,150 Individual / $14,300 Family **IA*	Not Covered	IAL8	IAL5
IAP5	Bronze Standard	SGL: $548.77 DBL: $1,097.54 OPF: $932.91 FAM: $1,563.99	Deductible	**3 visits $50 copay not subject to deductible. 4th & after $50 copay subject to deductible.**	**3 visits $75 copay not subject to deductible. 4th & after $75 copay subject to deductible.**	Covered at 50%	*$4,600 Individual / $9,200 Family *IA*	Subject to $150 copay per admission*, subject to the deductible	$500 copay per visit, subject to deductible	$10/$35/$70, subject to the plan deductible	*$9,450 Individual / $18,900 Family **IA*	Not Covered	IAP6	IAP3
IAN1	Silver Select	SGL: $712.13 DBL: $1,424.25 OPF:$1,210.61 FAM:$2,029.56	HDHP HSA	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 80%	*$3,200 Individual / $6,400 Family *FA*	Covered at 80% per admission*, subject to the deductible	Covered at 80%, subject to the deductible	$10/$45/$90, subject to the plan deductible; preventative drugs not subject to deductible, they are subject to the applicable copay	$7,500 Individual / $15,000 Family **FA	Not Covered	IAN2	IAM9

Plan Code	Plan Name	Plan Premiums	Plan Type	PCP Visit	Specialist Visit	Co-Insurance	Plan Year Deductible	Hospital Benefits	Emergency Department	Prescription Rx Coverage	Out of Pocket Max	Out of Network	No Ped Dtl Plan Code	Age 30 Dtl Plan Code
IAL1	Silver Standard	SGL: $717.25 DBL: $1,434.50 OPF:$1,219.32 FAM: $2,044.17	Hybrid	First visit$30 copay not subject to deductible, 2nd and after $30 copay, subject to deductible	First visit $65 copay not subject to deductible, 2nd and after $65 copay, subject to deductible	None	*$2,100 Individual / $4,200 Family *IA*	Subject to $1500 copay per admission*, subject to the deductible	$500 copay per visit, subject to deductible	$15/$40/$75	*$9,450 Individual / $18,900 Family **IA*	Not Covered	IAL2	IAK9
IAM7	Gold Select	SGL: $891.09 DBL: $1,782.19 OPF: $1,514.86 FAM:$2,539.62	Hybrid	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	None	*$1,000 Individual / $2,000 Family *IA*	Subject to $1,000 copay per admission*, subject to the deductible	$500 copay per visit, subject to deductible	$10/$35/$70	$8,000 Individual / $16,000 Family **IA	Not Covered	IAM8	IAM5
IAK5	Gold Standard	SGL: $ 922.93 DBL: $1,845.86 OPF:$1,568.98 FAM:$2,630.35	Hybrid	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	None	$600 Individual / $1,200 Family *IA	Subject to $1000 copay per admission*, subject to the deductible	$150 copay per visit, subject to deductible	$10/$35/$70	*$5,900 Individual / $11,800 Family **IA*	Not Covered	IAK6	IAK3
IAM3	Platinum Select	SGL: $1,064.74 DBL: $2,129.48 OPF: $1,810.06 FAM:$3,034.51	Copay	$15 copay per visit	$25 copay per visit	None	None	Subject to $750 copay per admission*	$150 copay per visit	$10/$35/$70	$6,350 Individual / $12,700 Family **IA	Not Covered	IAM4	IAM1
IAJ9	Platinum Standard	SGL: $1,075.05 DBL: $2,150.10 OPF:$1,827.59 FAM:$3,063.89	Copay	$15 copay per visit	$35 copay per visit	None	None	Subject to $500 copay per admission*	$100 copay per visit	$10/$30/$60	$2,000 Individual / $4,000 Family **IA	Not Covered	IAJ0	IAJ7

[1.] Per admission for unlimited days

Plans details highlighted in Red Italic indicate a change from 2023 to 2024.

***FA:** Deductible – Family Aggregation: For plans that cover 2 or more members, the entire family's deductible must be met by one or any contribution of covered members before copays or coinsurance is applied for any family member.

***IA:** Deductible – Individual Aggregation: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before copays or coinsurance is applied for that family member.

***FA:** Out-of-Pocket Max (OOPMax) – For plans that cover 2 or more members, the entire family's OOPMax must be met by one or any contribution of covered members, **except** that no one individual's OOPMax can be greater than $7500 on an HSA plan or $9100 on a non-HSA plan . Once a family's OOPMax is reached, plan services are covered in full for all the covered members of the family.

****IA:** Out-of-Pocket Max (OOPMax) – Individual Aggregation: Each covered family member only needs to satisfy his or her individual OOPMax, not the entire family OOPMax. Once an individual's OOPMax is reached, plan services are covered in full for that individual.