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

Excellus Individual, Family & Sole Proprietors Plans

Premium Period: 2026 (JAN - DEC 2025 start dates)
Coverage listed: Dependents to age 26; Yes on Pediatric Dental

Click here to view Plan Benefits and Features

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

Plan Name	Plan	PCP	Specialist	Co-	Plan Year	Hospital	Emergency	Prescription	Out of	Out of	Age 30 Dtl
Name	Premiums	Visit	Visit	Insurance	Deductible	Benefits	Department	Rx Coverage	Pocket Max	Network	Plan Code
Bronze Secure Plus 3 IBC3 HSA	SGL: $768.04 DBL:$1,536.08 OPF:$1,305.66 FAM:$2,188.91	**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	*$10,600 Individual / $21,200 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	*$10,600 Individual / $21,200 Family *IA*	Not Covered	IBC1
Bronze Select IAZ5 HSA	SGL: $833.13 DBL: $1,666.26 OPF:$1,416.33 FAM: $2.374.43	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	IAZ3
Bronze Standard IAX7 HSA	SGL: $851.57 DBL: $1,703.14 OPF:$1,447.68 FAM: $2,426.98	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%	$5,500 Individual / $11,000 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	$8,050 Individual / $16,100 Family **IA	Not Covered	IAX5
Bronze Standard IBB5 HSA	SGL: $851.62 DBL: $1,703.24 OPF:$1,447.75 FAM:$2,427.12	**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%	*$4,125 Individual / $8,250 Family *IA*	$1500 subject to deductible	$500 copay per visit, subject to deductible	$10/$35/$70, subject to the plan deductible	*$10,150 Individual / $20,300 Family **IA*	Not Covered	IBB3
Silver Select 2 IBH0 HSA	SGL: $991.69 DBL: $1,983.38 OPF:$1,685.88 FAM: $2,826.32	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 80%	*$4,500 Individual / $9,000 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	$7,000 Individual / $14,000 Family **IA	Not Covered	IBH9
Silver Select IAZ1 HSA	SGL:$1,081.81 DBL: $2,163.62 OPF:$1,839.09 FAM:$3,083.17	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	*$8,200 Individual / $16,400 Family **FA*	Not Covered	IAY9

Plan Name	Plan	PCP	Specialist	Co-	Plan Year	Hospital	Emergency	Prescription	Out of	Out of	Age 30 Dtl
Name	Premiums	Visit	Visit	Insurance	Deductible	Benefits	Department	Rx Coverage	Pocket Max	Network	Plan Code
Silver Standard IAX1	SGL:$1,105.75 DBL: $2,211.50 OPF:$1,879.77 FAM: $3,151.38	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	*$2,450 Individual / $4,900 Family *IA*	Subject to $1500 copay per admission*, subject to the deductible	$500 copay per visit, subject to deductible	$15/$40/$75	*$10,150 Individual / $20,300 Family **IA*	Not Covered	IAW9
Gold Select IAY7	SGL:$1,350.35 DBL: $2,700.70 OPF:$2,295.60 FAM:$3,848.51	First 3 Primary Visits covered @ 100% not subject to deductible. 4th and after covered @ 100%, subject to deductible	*First 3 visits not subject to deductible, 4th and after $40 copay per visit, subject to deductible*	None	*$1,350 Individual / $2,700 Family *IA*	Subject to $1,000 copay per admission*, subject to the deductible	$500 copay per visit, subject to deductible	$10/$35/$70	*$9,000 Individual / $18,000 Family **IA*	Not Covered	IAY5
Gold Standard IAW5	SGL:$1,409.67 DBL:$2,819.34 OPF:$2,396.43 FAM:$4,017.54	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	None	*$775 Individual / $1,550 Family *IA*	Subject to $1000 copay per admission*, subject to the deductible	$150 copay per visit, subject to deductible	$10/$35/$70	*$10,150 Individual / $20,300 Family **IA*	Not Covered	IAW3
Platinum Select IAY3	SGL: $1,655.30 DBL: $3,310.60 OPF:$2,814.01 FAM:$4,717.60	$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	IAY1
Platinum Standard IAV9	SGL: $1,670.14 DBL: $3,340.28 OPF:$2,839.23 FAM:$4,759.90	$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	IAV7

[1] Per admission for unlimited days

Plans details highlighted in Red Italic indicate a change from 2025 to 2026.

***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 $8,200 on an HSA plan or $10,600 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.