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

Excellus Individual, Family & Sole Proprietors Plans

Premium Period: 2020 (JAN - DEC 2020 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
IQQC	Base (Under 30)	SGL: $218.83 DBL: $437.66 OPF: $ 372.01 FAM: $623.67	Deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	None	*$8,150 Individual / $16,300 Family *FA*	Covered at 100% per admission*, subject to the deductible	Covered at 100%, subject to the deductible	Deductible / Coinsurance subject to the plan deductible	*$8,150 Individual / $16,300 Family *FA*	Not Covered	IQQD	
INNE	Bronze Secure Plus 3	SGL: $371.85 DBL: $ 743.71 OPF: $632.16 FAM: $1,059.78	Deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	None	*$8,150 Individual / $16,300 Family *FA*	Covered at 100% per admission*, subject to the deductible	Covered at 100%, subject to the deductible	Deductible / Coinsurance subject to the plan deductible	*$8,150 Individual / $16,300 Family *FA*	Not Covered	INNF	INNC
IPPE	Bronze Select	SGL: $407.31 DBL: $814.62 OPF: $692.43 FAM: $1,160.83	Deductible HSA	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	Covered at 50%	$5,000 Individual / $10,000 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	$6,550 Individual / $13,100 Family **FA	Not Covered	IPPF	IPPC
IOOM	Bronze Standard HSA	SGL: $408.90 DBL: $817.80 OPF: $695.13 FAM: $1,165.38	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 *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	$6,550 Individual / $13,100 Family **IA	Not Covered	IOON	IOOK
IPPY	Bronze Standard	SGL: $416.71 DBL: $833.42 OPF: $708.41 FAM: $1,187.63	Deductible	3 PCP visits covered in full. Next visits 50% subject to deductible	Covered at 50%, subject to the deductible	Covered at 50%	$4,425 Individual / $8,850 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	*$8,150 Individual / $16,300 Family **IA	Not Covered	IPPZ	IPPW
IPPA	Silver Select	SGL: $522.87 DBL: $1,045.73 OPF: $888.87 FAM: $1,490.17	HDHP HSA	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 80%	$2,400 Individual / $4,800 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	$6,900 Individual / $13,800 Family **FA	Not Covered	IPPB	IOOY
INNA	Silver Standard Plus 3	SGL: $ 580.17 DBL: $1,160.34 OPF: $986.29 FAM: $1,653.48	Hybrid	$35 copay per visit, subject to deductible	$55 copay per visit, subject to deductible	None	$1,875 Individual / $3,750 Family *FA	Subject to $1500 copay per admission*, subject to the deductible	$250 copay per visit, subject to deductible	$10/$40/$80	*$8,150 Individual / $16,300 Family *FA*	Not Covered	INNB	IMMY

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
IOOG	Silver Standard	SGL: $607.96 DBL: $1,215.91 OPF: $1,033.53 FAM: $1,732.68	Hybrid	$30 copay per visit, subject to deductible	$50 copay per visit, subject to deductible	None	*$1,300 Individual / $2,600 Family *IA*	Subject to $1500 copay per admission*, subject to the deductible	$250 copay per visit, subject to deductible	$10/$35/$70	*$7,900 Individual / $15,800 Family **IA*	Not Covered	IOOH	IOOE
IOOW	Gold Select	SGL: $667.49 DBL: $1,334.98 OPF: $1,134.73 FAM: $1,902.34	Hybrid	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	None	$750 Individual / $1,500 Family *IA	Subject to $750 copay per admission*, subject to the deductible	$250 copay per visit, subject to deductible	$10/$35/$70	$7,850 Individual / $15,700 Family **IA	Not Covered	IOOX	IOOU
IMMW	Gold Standard Plus 3	SGL: $662.70 DBL:$ 1,325.39 OPF:$1,126.58 FAM: $1,888.69	Hybrid	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	None	$650 Individual / $1,300 Family *IA	Subject to $1000 copay per admission*, subject to the deductible	$150 copay per visit, subject to deductible	$10/$40/$80	$5,000 Individual / $10,000 Family **IA	Not Covered	IMMX	IMMU
IOOA	Gold Standard	SGL: $ 663.91 DBL: $1,327.82 OPF: $1,128.65 FAM: $1,892.15	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	$4,000 Individual / $8,000 Family **IA	Not Covered	IOOB	INNY
IOOS	Plantimun Select	SGL: $787.84 DBL: $1,575.68 OPF: $1,339.33 FAM: $2,245.34	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	IOOT	IOOQ
INNU	Plantinum Standard	SGL: $785.90 DBL: $1,571.80 OPF: $1336.03 FAM: $2,239.80	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	INNV	INNS

* per admission for unlimited days

Plans details highlighted in Red Italic indicate a change from 2018 to 2019.

***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 $6900 on an HSA plan or $8150 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.