



Excelsus Individual, Family & Sole Proprietors Plans

Premium Period: 2021 (JAN - DEC 2021 start dates)
 Coverage listed: Dependents to age 26; Yes on Pediatric Dental

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

[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	Age 30 Dtl
IUUK	Base (Under 30)	SGL: \$216.55 DBL: \$433.11 OPF: \$ 368.15 FAM: \$617.18	Deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	None	\$8,550 Individual / \$17,100 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	\$8,550 Individual / \$17,100 Family *IA	Not Covered	IUUL	
IUUW	Bronze Secure Plus 3	SGL: \$385.66 DBL: \$ 771.32 OPF: \$655.62 FAM: \$1,099.13	Deductible	<i>First 3 Primary Visits covered @ 100% not subject to deductible. 4th and after covered @ 100%, subject to deductible</i>	Covered at 100%, subject to the deductible	None	\$8,550 Individual / \$17,100 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	\$8,550 Individual / \$17,100 Family *IA	Not Covered	IUUT	IUUU
ITTM	Bronze Select	SGL: \$410.81 DBL: \$821.61 OPF: \$698.37 FAM: \$1,170.80	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	\$7,000 Individual / \$14,000 Family **FA	Not Covered	ITTN	ITTK
ISSU	Bronze Standard HSA	SGL: \$413.00 DBL: \$826.00 OPF: \$702.10 FAM: \$1,177.04	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	\$6,900 Individual / \$13,800 Family **IA	Not Covered	ISSV	ISSS
IUUG	Bronze Standard	SGL: \$426.32 DBL: \$852.65 OPF: \$724.75 FAM: \$1,215.02	Deductible	<i>3 visits \$50 copay not subject to deductible. 4th & after \$50 copay subject to deductible.</i>	<i>3 visits \$75 copay not subject to deductible. 4th & after \$75 copay subject to deductible.</i>	Covered at 50%	\$4,700 Individual / \$9,400 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	\$8,550 Individual / \$17,100 Family **IA	Not Covered	IUUH	IUUE
ITTI	Silver Select	SGL: \$534.11 DBL: \$1,068.23 OPF: \$907.99 FAM: \$1,522.22	HDHP HSA	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	Covered at 80%	\$2,550 Individual / \$5,100 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	ITTI	ITTG
IVVE	Destination 65 Silver	SGL: \$ 534.31 DBL: \$1,068.62 OPF: \$908.33 FAM: \$1,522.79	HDHP HSA	\$15 copay per visit, subject to deductible	\$50 copay per visit, subject to deductible	Covered at 80%	\$3,000 Individual / \$6,000 Family *FA	Subject to \$380 per day for 5 days, then covered in full, subject to the deductible	\$90 copay per visit, subject to deductible	\$0/\$50/50%	\$7,000 Individual / \$14,000 Family *FA	Not Covered	IVVE	IVVC
IUUS	Silver Standard Plus 3	SGL: \$ 576.53 DBL: \$1,153.06 OPF: \$980.10 FAM: \$1,643.10	Hybrid	<i>3 visits \$35 copay not subject to deductible. 4th & after \$35 copay subject to deductible.</i>	\$55 copay per visit, subject to deductible	None	\$1,875 Individual / \$3,750 Family *IA	Subject to \$1500 copay per admission*, subject to the deductible	\$300 copay per visit, subject to deductible	\$10/\$40/\$80	\$8,500 Individual / \$17,000 Family *IA	Not Covered	IUUT	IUUQ

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
ISSO	Silver Standard	SGL: \$606.31 DBL: \$1,212.61 OPF: \$1,030.72 FAM: \$1,727.97	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	<i>\$300 copay per visit, subject to deductible</i>	\$10/\$35/\$70	<i>\$8,500 Individual / \$17,000 Family **IA</i>	Not Covered	ISSP	ISSM
IVVA	Destination 65 Gold ²	SGL: \$644.72 DBL: \$1,289.43 OPF: \$1,096.02 FAM: \$1,837.44	HDHP HSA	<i>\$15 copay per visit, subject to deductible</i>	<i>\$50 copay per visit, subject to deductible</i>	None	\$1,400 Individual / \$2,300 Family *	<i>Subject to \$380 copay per day for 5 days, then covered in full, subject to the deductible</i>	<i>\$90 copay per visit, subject to deductible</i>	\$0/\$50/50%, Subject to deductible	<i>\$6,700 Individual / \$13,400 Family **IA</i>	Not Covered	IVVB	IUUY
ITTE	Gold Select	SGL: \$671.33 DBL: \$1,342.66 OPF: \$1,141.26 FAM: \$1,913.28	Hybrid	\$25 copay per visit, subject to deductible	\$40 copay per visit, subject to deductible	None	\$750 Individual / \$1,500 Family *IA	<i>Subject to \$1,000 copay per admission*, subject to the deductible</i>	<i>\$350 copay per visit, subject to deductible</i>	\$10/\$35/\$70	<i>\$8,000 Individual / \$16,000 Family **IA</i>	Not Covered	ITTF	ITTC
IUUO	Gold Standard Plus 3	SGL: \$684.41 DBL: \$1,368.81 OPF: \$1,163.49 FAM: \$1,950.56	Hybrid	<i>3 visits \$25 copay not subject to deductible. 4th & after \$50 copay subject to deductible.</i>	\$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	IUUP	IUUM
ISSI	Gold Standard	SGL: \$687.28 DBL: \$1,374.56 OPF: \$1,168.38 FAM: \$1,958.75	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	ISSJ	ISSG
ITTA	Platinum Select	SGL: \$800.66 DBL: \$1,601.33 OPF: \$1,361.13 FAM: \$2,281.89	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	ITTB	ISSY
ISSC	Platinum Standard	SGL: \$793.60 DBL: \$1,587.21 OPF: \$1,349.13 FAM: \$2,261.77	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	ISSD	ISSA

¹ Per admission for unlimited days

Plans details highlighted in Red Italic indicate a change from 2020 to 2021.

***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 \$7000 on an HSA plan or \$8550 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.

² These plans are designed similarly to Medicare Advantage Plans and might be best suited for people that will be moving into an MA plan soon.