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

Excellus Individual, Family & Sole Proprietors Plans

Premium Period: 2022 (JAN - DEC 2022 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
IAA7	Base (Under 30)	SGL: $225.61 DBL: $451.22 OPF: $ 383.53 FAM: $642.99	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	*$8,700 Individual / $17,400 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	*$8,700 Individual / $17,400 Family *IA*	Not Covered	IAA8	
IAB9	Bronze Secure Plus 3	SGL: $394.86 DBL: $ 789.72 OPF: $671.26 FAM: $1,125.35	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	*$8,700 Individual / $17,400 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	*$8,700 Individual / $17,400 Family *IA*	Not Covered	IAB0	IAB7
IZZI	Bronze Select	SGL: $435.51 DBL: $871.02 OPF: $740.36 FAM: $1,241.20	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	IZZJ	IZZG
IYYQ	Bronze Standard HSA	SGL: $432.61 DBL: $865.23 OPF: $735.44 FAM: $1,232.96	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	IYYR	IYYO
IAA3	Bronze Standard	SGL: $450.32 DBL: $900.64 OPF: $765.55 FAM: $1,283.42	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%	*$4,700 Individual / $9,400 Family *IA*	Subject to $1500 copay per admission*, subject to the deductible	*$500 copay per visit, subject to deductible*	$10/$35/$70, subject to the plan deductible	*$8,700 Individual / $17,400 Family* **IA	Not Covered	IAA4	IAA1
IZZE	Silver Select	SGL: $569.21 DBL: $1,138.42 OPF: $967.67 FAM: $1,622.26	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; preventative drugs not subject to deductible, they are subject to the applicable co	$6,900 Individual / $13,800 Family **FA	Not Covered	IZZF	IZZC
IAC7	Destination 65 Silver	SGL: $ 569.42 DBL: $1,138.84 OPF: $968.01 FAM: $1,622.85	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 $0 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	IAC8	IAC1
IAB5	Silver Standard Plus 3	SGL: $ 559.70 DBL: $1,119.41 OPF: $951.50 FAM: $1,595.16	Hybrid	**3 visits $35 copay not subject to deductible. 4th & after $35 copay subject to deductible.**	$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	IAB6	IAB3

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
IYYK	Silver Standard	SGL: $588.57 DBL: $1,177.14 OPF: $1,000.57 FAM: $1,677.43	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	$300 copay per visit, subject to deductible	$10/$35/$70	$8,500 Individual / $17,000 Family **IA	Not Covered	IYYL	IYYI
IAC3	Destination 65 Gold[2]	SGL: $713.87 DBL: $1,427.74 OPF: $1,213.58 FAM: $2,034.53	Deductible	$15 copay per visit, subject to deductible	$50 copay per visit, subject to deductible	Covered at 80%	$950 Individual / $1,900 Family *	***Subject to $0 copay per day for 5 days, then covered in full, subject to the deductible***	*$90 copay per visit, subject to deductible*	$0/$50/50%, Subject to deductible	$6,700 Individual / $13,400 Family **IA	Not Covered	IAC4	IAC1
IZZA	Gold Select	SGL: $703.14 DBL: $1,406.28 OPF: $1,195.34 FAM: $2,003.96	Hybrid	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	None	$750 Individual / $1,500 Family *IA	*Subject to $1,000 copay per admission*, subject to the deductible*	*$350 copay per visit, subject to deductible*	$10/$35/$70	*$8,000 Individual / $16,000 Family **IA*	Not Covered	IZZB	IYYY
IAB1	Gold Standard Plus 3	SGL: $720.21 DBL:$ 1,440.42 OPF:$1,224.35 FAM: $2,052.59	Hybrid	**3 visits $25 copay not subject to deductible. 4th & after $50 copay 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	IAB2	IAA9
IYYE	Gold Standard	SGL: $ 728.04 DBL: $1,456.08 OPF: $1,237.67 FAM: $2,074.92	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	IYYF	IYYC
IYYW	Platinum Select	SGL: $838.59 DBL: $1,677.18 OPF: $1,425.60 FAM: $2,389.97	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	IYYX	IYYU
IXXY	Platinum Standard	SGL: $853.86 DBL: $1,707.72 OPF: $1,451.57 FAM: $2,433.50	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	IXXZ	IXXW

[1] Per admission for unlimited days

Plans details highlighted in Red Italic indicate a change from 2021 to 2022.

***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 $7050 on an HSA plan or $8700 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.