



Excellus Individual, Family & Sole Proprietors Plans

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

1110 Crosspointe Lane Webster NY 14580

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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
IBB9	Base (Under 30)	SGL: \$366.94 DBL: \$733.88 OPF: \$ 623.80 FAM: \$1,045.78	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	\$9,200 Individual / \$18,400 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	\$9,200 Individual / \$18,400 Family *IA	Not Covered	IBB0	
IBC3	Bronze Secure Plus 3	SGL: \$633.36 DBL: \$1,266.71 OPF: \$1,076.70 FAM: \$1,805.07	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	\$9,200 Individual / \$18,400 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	\$9,200 Individual / \$18,400 Family *IA	Not Covered	IBC4	IBC2
IAZ5	Bronze Select	SGL: \$657.21 DBL: \$1,314.42 OPF: \$1,117.26 FAM: \$1,873.04	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	IAZ6	IAZ4
IAX7	Bronze Standard HSA	SGL: \$662.72 DBL: \$1,325.45 OPF: \$1,126.63 FAM: \$1,888.76	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	\$8,050 Individual / \$16,100 Family **IA	Not Covered	IAX7	IAX6
IBB5	Bronze Standard	SGL: \$662.73 DBL: \$1,325.47 OPF: \$1,126.64 FAM: \$2,468.67	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%	\$3,800 Individual / \$7,600 Family *IA	\$1500 subject to deductible	\$500 copay per visit, subject to deductible	\$10/\$35/\$70, subject to the plan deductible	\$9,200 Individual / \$18,400 Family **IA	Not Covered	IBB6	IBB4
IAZ1	Silver Select	SGL: \$858.99 DBL: \$1,717.98 OPF: \$1,460.29 FAM: \$2,448.12	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	IAZ2	IAZ0

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
IAX1	Silver Standard	SGL: \$866.20 DBL: \$1,732.40 OPF: \$1,472.54 FAM: \$2,468.67	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	<i>\$9,200 Individual / \$18,400 Family **IA</i>	Not Covered	IAX2	IAW0
IAY7	Gold Select	SGL: \$1,070.66 DBL: \$2,141.33 OPF: \$1,820.13 FAM: \$3,051.39	Hybrid	<i>First 3 Primary Visits covered @ 100% not subject to deductible. 4th and after covered @ 100%, subject to deductible</i>	\$40 copay per visit, subject to deductible	None	<i>\$1,050 Individual / \$2,200 Family *IA</i>	Subject to \$1,000 copay per admission*, subject to the deductible	\$500 copay per visit, subject to deductible	\$10/\$35/\$70	<i>\$8,750 Individual / \$17,500 Family **IA</i>	Not Covered	IAY8	IAY6
IAW5	Gold Standard	SGL: \$1,114.59 DBL: \$2,229.17 OPF: \$1,894.79 FAM: \$3,176.57	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	<i>\$7,900 Individual / \$15,800 Family **IA</i>	Not Covered	IAW6	IAW4
IAY3	Platinum Select	SGL: \$1,284.55 DBL: \$2,569.09 OPF: \$2,183.72 FAM: \$3,660.95	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	IAY4	IAY2
IAV9	Platinum Standard	SGL: \$1,296.06 DBL: \$2,592.12 OPF: \$2,203.30 FAM: \$3,693.78	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	IAV0	IAV8

¹ Per admission for unlimited days

Plans details highlighted in Red Italic indicate a change from 2024 to 2025.

***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 \$9200 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.