Excellus

Version Updated: 09/28/2024

Rating Region: Rochester

Plan ID	Enrollment Code	Plan Name	Plan Highlights	Single	Family	Plan Type	HSA Eligible	Quote Effective	Primary Care Office Visit	Specialist Office Visit	Deductible	Coinsurance	Hospital benefits	Emergency room care	Short-term and maintenance drugs	Out of pocket maximum	Out of network benefits
78124NY0910001-00	IBB9	Base	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	$366.94	$1,045.78	Base	No	01/01/2025 - 12/31/2025	First 3 Primary visits covered at 100%, not subject to the deductible. Fourth and after covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	$9,200 Individual / $18,400 Family	None	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the plan deductible	$9,200 Individual / $18,400 Family	Not Covered
78124NY0900023-00	IBC3	Bronze Secure Plus 3	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	$633.36	$1,805.07	Base	No	01/01/2025 - 12/31/2025	First 3 Primary visits covered at 100%, not subject to the deductible. Fourth and after covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	$9,200 Individual / $18,400 Family	Covered at 100%	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100%, subject to the deductible	Covered at 100%, subject to the plan deductible	$9,200 Individual / $18,400 Family	Not Covered
78124NY0880009-00	IAY3	Platinum Select	Predictable out-of-pocket costs without a deductible, includes ThriveWell.	$1,284.55	$3,660.95	Copay	No	01/01/2025 - 12/31/2025	$15 copay per visit	$25 copay per visit	None	None	$750 copay per admission for unlimited days	$150 copay per visit	$10/$35/$70	$6,350 Individual / $12,700 Family	Not Covered
78124NY0880003-00	IAV9	Platinum Standard	Predictable out-of-pocket costs without a deductible, includes ThriveWell.	$1,296.06	$3,693.78	Copay	No	01/01/2025 - 12/31/2025	$15 copay per visit	$35 copay per visit	None	None	$500 copay per admission for unlimited days	$100 copay per visit	$10/$30/$60	$2,000 Individual / $4,000 Family	Not Covered
78124NY0900017-00	IBB5	Bronze Standard	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in	$662.73	$1,888.79	Deductible	No	01/01/2025 - 12/31/2025	First 3 Primary visits $50 copay, not subject to the deductible. Fourth and after $50 copay, subject to the	First 3 Specialist visits $75 copay, not subject to the deductible. Fourth and after $75 copay, subject to the	$3,800 Individual / $7,600 Family	Covered at 50%	$1,500 copay per admission for unlimited days, subject to the deductible	$500 copay per visit, subject to deductible	$10/$35/$70, subject to the plan deductible	$9,200 Individual / $18,400 Family	Not Covered

			full. Plan includes ThriveWell.					deductible	deductible							
78124NY090 0013-00	IAZ5	Bronze Select	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	$657.21	$1,873.04	Deductible HSA	Yes	01/01/2025 - 12/31/2025	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	$5,500 Individual / $11,000 Family	Covered at 50%	Covered at 50% per admission for unlimited days, subject to the deductible	Covered at 50%, subject to the deductible	$10/40%/50%, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance.	$7,500 Individual / $15,000 Family	Not Covered
78124NY090 0003-00	IAX7	Bronze Standard HSA	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	$662.72	$1,888.76	Deductible HSA	Yes	01/01/2025 - 12/31/2025	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	$5,500 Individual / $11,000 Family	Covered at 50%	Covered at 50% per admission for unlimited days, 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	Not Covered
78124NY090 0009-00	IAZ1	Silver Select	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ThriveWell.	$858.99	$2,448.12	Deductible HSA	Yes	01/01/2025 - 12/31/2025	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	$3,200 Individual / $6,400 Family	Covered at 80%	Covered at 80% per admission for unlimited days, subject to the deductible	Covered at 80%, subject to the deductible	$10/$45/$90, subject to the plan deductible. Preventive drugs are not subject to the deductible; they are subject to the applicable copay or coinsurance.	$7,500 Individual / $15,000 Family	Not Covered
78124NY089 0015-00	IAY7	Gold Select	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ThriveWell.	$1,070.66	$3,051.39	Hybrid	No	01/01/2025 - 12/31/2025	$25 copay per visit, subject to deductible. First 3 visits not subject to the deductible for select services. See benefit summary for details.	$40 copay per visit, subject to deductible. First 3 visits not subject to the deductible for select services. See benefit summary for details.	$1,050 Individual / $2,100 Family	None	$1,000 copay per admission for unlimited days, subject to the deductible	$500 copay per visit, subject to deductible	$10/$35/$70	$8,750 Individual / $17,500 Family	Not Covered
78124NY089 0003-00	IAW5	Gold Standard	A deductible is applied to all covered	$1,114.59	$3,176.57	Hybrid	No	01/01/2025 - 12/31/2025	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	$600 Individual / $1,200	None	$1,000 copay per admission for unlimited	$150 copay per visit, subject to deductible	$10/$35/$70	$7,900 Individual / $15,800 Family	Not Covered

			medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ThriveWell.							Family		days, subject to the deductible				
78124NY0890009-00	IAX1	Silver Standard	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ThriveWell.	$866.20	$2,468.67	Hybrid	No	01/01/2025 - 12/31/2025	First visit $30 copay, not subject to the deductible. Second and after $30 copay, subject to the deductible	First visit $65 Specialist copay, not subject to deductible. Second and after $65 Specialist copay, subject to deductible	$2,100 Individual / $4,200 Family	None	$1,500 copay per admission for unlimited days, subject to the deductible	$500 copay per visit, subject to deductible	$15/$40/$75	$9,200 Individual / $18,400 Family	Not Covered

This is not a contract nor a Summary of Benefits and Coverage (SBC). This benefit summary is intended to highlight the coverage of this program. Benefits are determined by the terms of the Member Certificate. All benefits are subject to medical necessity.
+When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA appropriate cost share for the service will be applied. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

For technical web issues please contact our Web Help Desk at 1-800-278-1247

Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association