Excellus BlueCross BlueShield
LIVE FEARLESS

Version Updated: 09/13/2019
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
78124NY0880009-00	IOOS	Platinum Select	Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.	$787.84	$2,245.34	Copay	No	01/01/2020 - 12/31/2020	$15 copay per visit	$25 copay per visit	None	None	Subject to $750 copay per admission for unlimited days	$150 copay per visit	$10/$35/$70	$6,350 Individual / $12,700 Family	Not Covered
78124NY0880003-00	INNU	Platinum Standard	Predictable out-of-pocket costs without a deductible, includes ExerciseRewards.	$785.90	$2,239.80	Copay	No	01/01/2020 - 12/31/2020	$15 copay per visit	$35 copay per visit	None	None	Subject to $500 copay per admission for unlimited days	$100 copay per visit	$10/$30/$60	$2,000 Individual / $4,000 Family	Not Covered
78124NY0910001-00	IQQC	Base	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	$218.83	$623.67	Deductible	No	01/01/2020 - 12/31/2020	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	$8,150 Individual / $16,300 Family	None	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100%, subject to the deductible	$0, subject to the plan deductible	$8,150 Individual / $16,300 Family	Not Covered
78124NY0900023-00	INNE	Bronze Secure Plus 3	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	$371.85	$1,059.78	Deductible	No	01/01/2020 - 12/31/2020	Covered at 100%, subject to the deductible	Covered at 100%, subject to the deductible	$8,150 Individual / $16,300 Family	Covered at 100%	Covered at 100% per admission for unlimited days, subject to the deductible	Covered at 100%, subject to the deductible	$0, subject to the plan deductible	$8,150 Individual / $16,300 Family	Not Covered
78124NY0900017-00	IPPY	Bronze Standard	A deductible is applied to	$416.71	$1,187.63	Deductible	No	01/01/2020 - 12/31/2020	3 Primary Care visits covered	Covered at 50%, subject to	$4,425 Individual /	Covered at 50%	Covered at 50% per	Covered at 50%, subject to	$10/$35/$70, subject to the	$8,150 Individual / $16,300 Family	Not Covered

			all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.					in full. Next visits covered at 50%, subject to the deductible	the deductible	$8,850 Family		admission for unlimited days, subject to the deductible	the deductible	plan deductible		
78124NY0900013-00	IPPE	Bronze Select	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	$407.31	$1,160.83	Deductible HSA	Yes	01/01/2020 - 12/31/2020	Covered at 50%, subject to the deductible	Covered at 50%, subject to the deductible	$5,000 Individual / $10,000 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	$6,550 Individual / $13,100 Family	Not Covered
78124NY0900003-00	IOOM	Bronze Standard HSA	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	$408.90	$1,165.38	Deductible HSA	Yes	01/01/2020 - 12/31/2020	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	$6,550 Individual / $13,100 Family	Not Covered
78124NY0900009-00	IPPA	Silver Select	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	$522.87	$1,490.17	Deductible HSA	Yes	01/01/2020 - 12/31/2020	Covered at 80%, subject to the deductible	Covered at 80%, subject to the deductible	$2,400 Individual / $4,800 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	$6,900 Individual / $13,800 Family	Not Covered
78124NY0890015-00	IOOW	Gold Select	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible.	$667.49	$1,902.34	Hybrid	No	01/01/2020 - 12/31/2020	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	$750 Individual / $1,500 Family	None	Subject to $750 copay per admission for unlimited days, subject to the deductible	$250 copay per visit, subject to deductible	$10/$35/$70	$7,850 Individual / $15,700 Family	Not Covered

			Preventive services are covered in full. Plan includes ExerciseRewards.													
78124NY0890003-00	IOOA	Gold 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 ExerciseRewards.	$663.91	$1,892.15	Hybrid	No	01/01/2020 - 12/31/2020	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	$600 Individual / $1,200 Family	None	Subject to $1000 copay per admission for unlimited days, subject to the deductible	$150 copay per visit, subject to deductible	$10/$35/$70	$4,000 Individual / $8,000 Family	Not Covered
78124NY0890019-00	IMMW	Gold Standard Plus 3	A deductible is applied to all covered medical and prescription drug benefits. Preventive services are covered in full. Plan includes ExerciseRewards.	$662.70	$1,888.69	Hybrid	No	01/01/2020 - 12/31/2020	$25 copay per visit, subject to deductible	$40 copay per visit, subject to deductible	$650 Individual / $1,300 Family	None	Subject to $1000 copay per admission for unlimited days, subject to the deductible	$150 copay per visit, subject to deductible	$10/$40/$80	$5,000 Individual / $10,000 Family	Not Covered
78124NY0890009-00	IOOG	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 ExerciseRewards.	$607.96	$1,732.68	Hybrid	No	01/01/2020 - 12/31/2020	$30 copay per visit, subject to deductible	$50 copay per visit, subject to deductible	$1,300 Individual / $2,600 Family	None	Subject to $1500 copay per admission for unlimited days, subject to the deductible	$250 copay per visit, subject to deductible	$10/$35/$70	$7,900 Individual / $15,800 Family	Not Covered
78124NY0890025-00	INNA	Silver Standard Plus 3	A deductible is applied to all covered medical and prescription drug benefits. Preventive	$580.17	$1,653.48	Hybrid	No	01/01/2020 - 12/31/2020	$35 copay per visit, subject to deductible	$55 copay per visit, subject to deductible	$1,875 Individual / $3,750 Family	None	Subject to $1500 copay per admission for unlimited days, subject to the deductible	$250 copay per visit, subject to deductible	$10/$40/$80	$8,150 Individual / $16,300 Family	Not Covered

			services are covered in full. Plan includes ExerciseRewards.														

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.

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