Excellus

Premium Rate Schedule & Contract Summary

Quote Effective: 01/01/2027 - 12/31/2027

Version Updated: 10/05/2026

Plan ID: 78124NY0890015-00	**Plan Name: Gold Select**	**Enrollment Code: IAY7**
Rating Region: Rochester	**Direct Pay**	

Rate	
Plan Name: Gold Select	
Plan Highlights	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.
Network Structure	This plan provides covered benefits at 100% of hospitals and more than 98% of local doctors in our 31-county network and BlueCard® coverage for nationwide access to participating providers.
Enrollment Code	IAY7
Plan Type	Hybrid
HSA Eligibility	No
Monthly Premium Single $1,569.58 / Subscriber & Spouse $3,139.15 / Subscriber & Children $2,668.28 / Family $4,473.30	
In-Network Benefits	
Deductible	$1,500 Individual / $3,000 Family
Coinsurance	None
Annual Out of Pocket Maximum	$9,500 Individual / $19,000 Family
Primary Care / Specialist Office Visit	$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.
Hospital Benefit	$1,000 copay per admission for unlimited days, subject to the deductible
Emergency Room Care	$500 copay per visit, subject to deductible
Urgent Care	$40 copay per visit, subject to deductible
Prescription Drug	$10/$35/$70

Dependent Coverage To Age **26**, Pediatric Dental Coverage **Included**

A summary of benefits and coverage (SBC) can be found at excellusbcbs.com/sbcfinder, or you can call 1-888-264-7792 to request a copy to be mailed to you. You will need to key in the Plan ID# listed above.

How To enroll:

Complete the enrollment application included and mail to:

Excellus Health Plan, Inc

P.O. Box 21146

Eagan, MN 55121

Questions? Call **1-888-477-5804**

Our dedicated insurance advisors can help complete your enrollment application and answer your questions.

Tips For Enrolling:

- Carefully review the entire enrollment application to make sure it's filled out. An incomplete form will be returned and will delay your enrollment.
- Sign the completed enrollment form.
- Enclose a check or money order for the first month's premium made payable to Excellus Health Plan. The monthly premium amount you owe is shown above.
- **Payment must be received and processed before the plan will become effective.**

Excellus BCBS: Gold Select

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage Period: 01/01/2027 - 12/31/2027

Coverage for: Family | **Plan Type:** EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,500 Individual/$3,000 Family; Out-of-Network: Not Applicable	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive Care and preventive Prescription drugs or to services in Phase 1	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $9,500 Individual/$19,000 Family; Out-of-Network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copayment, after a $25 Copayment not subject to Deductible for the first 3 Primary Care Office Visits	Not Covered	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Specialist visit	$40 Copayment after a $40 Copayment not subject to Deductible for the first 3 visits	Not Covered	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: Not Covered Adult Immunizations: Not Covered Well Child Visit: Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per 1 CalendarYear
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $40 Copay/visit Blood Work: $40 Copay/visit	X-Ray: Not Covered Blood Work: Not Covered	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Imaging (CT/PET scans, MRIs)	$100 Specialist Copay/visit	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	$10/prescription retail, $25/ prescription mail order Deductible does not apply	Not Covered	Most generic drugs are included in Tier 1; however, some generic drugs may also be included in Tier 2 or Tier 3 Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription. Specialty Drugs may be limited to a 30-day supply/prescription. Preauthorization required. If you don't get a
	Tier 2 (Preferred brand drugs)	$35/prescription retail, $87.50/ prescription mail order Deductible does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 3 (Non-preferred brand drugs)	$70/prescription retail, $175/ prescription mail order Deductible does not apply	Not Covered	preauthorization, you must pay the entire cost and submit a claim to us for reimbursement. Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Cost-Sharing for epinephrine devices shall not exceed $100 per Plan Year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 Copay	Not Covered	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	$500 Copay/visit	$500 Copay/visit	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Emergency medical transportation	$500 Copay/visit	$500 Copay/visit	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
	Urgent care	$40 Copay/visit	Not Covered	None Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 Copay	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	Not Covered	Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copayment after a $25 Copayment not subject to Deductible for the first 3 Office Visits	Not Covered	20 visits for family counseling
	Inpatient services	$1,000 Copay	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	$1,000 Copay	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$25 Copay	Not Covered	40 Visits per contract year limit. The visit limit does not apply to Home Health Care for a mental health condition or substance use disorder.
	Rehabilitation services	$25 Copay/visit	Not Covered	60 Visits per 1 CalendarYear limit. The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.
	Habilitation services	$25 Copay/visit	Not Covered	60 Visits per 1 CalendarYear limit. The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.
	Skilled nursing care	$1,000 Copay	Not Covered	200 Days per contract year limit. The visit limit does not apply to Skilled Nursing Care for a mental health condition or substance use disorder.
	Durable medical equipment	50% Coinsurance	Not Covered	None
	Hospice services	$25 Copay	Not Covered	210 Days per contract year limit Family bereavement counseling limited to 5 Visits per contract year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 Copay/visit	Not Covered	1 Exam per contract year
	Children's glasses	50% Coinsurance	Not Covered	1 Purchase per contract year
	Children's dental check-up	20% Coinsurance	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/contactEBSA/consumerassistance.html. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Not Applicable**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist copayment	**$40**
Hospital (facility) copayment	**$1,000**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,690**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,760**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist copayment	**$40**
Hospital (facility) copayment	**$1,000**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$940
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,460**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist copayment	**$40**
Hospital (facility) copayment	**$1,000**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$230
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,850**

The plan would be responsible for the other costs of the EXAMPLE covered services.