



Premium Rate Schedule & Contract Summary

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

Version Updated: 10/05/2026

Plan ID: 78124NY0900013-00	Plan Name: Bronze Select	Enrollment Code: IAZ5
Rating Region: Rochester	Direct Pay	
Rate		
Plan Name: Bronze Select		
Plan Highlights	A deductible is applied to all covered medical and prescription drug benefits. 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	IAZ5	
Plan Type	Deductible HSA	
HSA Eligibility	Yes	
Monthly Premium Single \$962.16 / Subscriber & Spouse \$1,924.32 / Subscriber & Children \$1,635.67 / Family \$2,742.15		
In-Network Benefits		
Deductible	\$6,500 Individual / \$13,000 Family	
Coinsurance	Covered at 50%	
Annual Out of Pocket Maximum	\$8,500 Individual / \$17,000 Family	
Primary Care / Specialist Office Visit	Covered at 50%, subject to the deductible / Covered at 50%, subject to the deductible	
Hospital Benefit	Covered at 50% per admission for unlimited days, subject to the deductible	
Emergency Room Care	Covered at 50%, subject to the deductible	
Urgent Care	Covered at 50%, subject to the deductible	
Prescription Drug	\$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.	
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:		
<ul style="list-style-type: none">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.		

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Excellus BCBS: Bronze 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.excellusbcb.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: \$6,500 Individual/\$13,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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: \$8,500 Individual/\$17,000 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 , the overall family out-of-pocket limit must be 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.excellusbcb.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	50% Coinsurance	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	50% Coinsurance	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: 50% Coinsurance Blood Work: 50% Coinsurance	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)	50% Coinsurance	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	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 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.
	Tier 2 (Preferred brand drugs)	40% Coinsurance	Not Covered	
	Tier 3 (Non-preferred brand drugs)	50% Coinsurance	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	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	50% Coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% Coinsurance	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	50% Coinsurance	50% Coinsurance	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	50% Coinsurance	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)	50% Coinsurance	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	50% Coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% Coinsurance	Not Covered	20 visits for family counseling
	Inpatient services	50% Coinsurance	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)	
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	50% Coinsurance	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	50% Coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	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	50% Coinsurance	Not Covered	60 Visits per contract year limit. The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.
	Habilitation services	50% Coinsurance	Not Covered	60 Visits per contract year limit. The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder.
	Skilled nursing care	50% Coinsurance	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	50% Coinsurance	Not Covered	210 Days per contract year limit Family bereavement counseling limited to 5 Visits per contract year
If your child needs dental or eye care	Children's eye exam	50% Coinsurance	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.*-----

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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](#) \$6,500
- [Coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,500
Copayments	\$0
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$8,520

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,500
- [Coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,420
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,440

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,500
- [Coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- 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
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In this example, Mia would pay (This condition is not covered, so patient pays 100%):

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of the EXAMPLE covered services.