

2024 HIGHMARK BLUESHIELD OF NORTHEASTERN NEW YORK - Small Business 2 to 100 RATES SHOWN COVER REGION 1															
METAL TIER	PRODUCT	TIER	MONTHLY RATE	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	COINSURANCE	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	LAB SERVICES	INPATIENT HOSPITAL	OUTPATIENT SURGERY	ER	URGENT CARE	PRESCRIPTION DRUGS
PLATINUM	PLATINUM POS CLASSIC DISCONTINUED 2024 CURRENT SUBSCRIBERS MAP TO PLATINUM RADIUS PLUS	Individual Empl/Spouse Parent/Child(ren) Family													
	PLATINUM RADIUS Plus **	Individual Empl/Spouse Parent/Child(ren) Family	\$1,056.15 \$2,112.31 \$1,795.46 \$3,010.04	N/A	N/A	N/A	\$7,000/\$14,000 Embedded	\$15	\$30	\$30	\$500	\$100	\$150 (CHANGE FOR 2024)	\$75 (CHANGE FOR 2024)	\$10/\$35/\$100
GOLD	GOLD POS CLASSIC DISCONTINUED 2024 CURRENT SUBSCRIBERS MAP TO GOLD BLENDED RADIUS	Individual Empl/Spouse Parent/Child(ren) Family	\$787.64 \$1,575.29 \$1,338.99 \$2,244.78												
	GOLD BLENDED RADIUS	Individual Empl/Spouse Parent/Child(ren) Family	\$897.91 \$1,795.82 \$1,526.45 \$2,559.05	N/A	\$1,250/\$2,500	30% FS	\$9,100/\$18,200 Embedded	\$25 not subject to deductible	\$50 not subject to deductible	\$50 not subject to deductible	30% after deductible	30% after deductible	\$350 not subject to deductible	\$100 not subject to deductible	\$10/\$35/\$100 not subject to deductible
	GOLD EPO HIGH	Individual Empl/Spouse Parent/Child(ren) Family	\$1,118.84 \$2,237.67 \$1,902.02 \$3,188.68	N/A	N/A	N/A	\$9,100/\$18,200 Embedded	\$30	\$50	\$50	\$1000	\$250 (CHANGE FOR 2024)	\$300	\$75	\$10/\$50/\$100 (CHANGE FOR 2024)
	GOLD RADIUS HIGH **	Individual Empl/Spouse Parent/Child(ren) Family	\$978.90 \$1,957.80 \$1,664.13 \$2,789.87	N/A	N/A	N/A	\$9,100/\$18,200 Embedded	\$30	\$50	\$50	\$1,000	\$250 (CHANGE FOR 2024)	\$300	\$75	\$10/\$50/\$100 (CHANGE FOR 2024)
SILVER	SILVER EPO 7000 (HSA QUALIFIED)	Individual Empl/Spouse Parent/Child(ren) Family	\$865.67 \$1,731.33 \$1,471.63 \$2,467.15	True Family *	\$3,500/\$7,000 Aggregate	N/A	\$7,500/\$15,000 Embedded (CHANGE FOR 2024)	\$30 after deductible (CHANGE FOR 2024)	\$50 after deductible (CHANGE FOR 2024)	\$50 after deductible (CHANGE FOR 2024)	\$1,000 after deductible	\$350 after deductible	\$250 after deductible	\$75 After deductible	\$10/\$35/\$100 After deductible

INN In Network OON Out of Network
 ALL RATES COVER BLUE SHIELD REGION 1. ALL RATES ARE DEPENDENT TO AGE 26.
 ALL PLANS INCLUDE ONE \$250 WELLNESS DEBIT CARD PER CONTRACT - RENEWS ANNUALLY

AGGREGATE: For any policy with two or more members, the deductible must be met by any one or any combination of members before the plan makes payments.
 EMBEDDED: Each member must meet their individual deductible before plan pays. Individual deductible also applies to family deductible level. Once family deductible is met, plan begins payment of services for all contract members.
 * TRUE FAMILY DEDUCTIBLE: Unlike embedded deductible plans, there is no limit to the amount one member can pay toward the family deductible. For both types of deductibles, once the deductible is met, you will pay copays or coinsurance when you receive covered services.
 ** THIS PLAN INCLUDES "AWAY FROM HOME CARE@" GUEST MEMBERSHIP. Please contact Highmark Blue Shield to register for away from home care. To ensure coverage by a network provider, confirm on www.bsny.org Find a Doctor link
 PEDIATRIC DENTAL is now embedded in medical plans at no extra charge; Members show their medical card to their dentist for pediatric dental care.

NOTE: In case of a discrepancy in the display of these plan details and rates, The carrier's actual plan details and rates prevail.