ALL RATES UPDATED FOR 2027. ITEMS SHOWN IN RED ARE CHANGE FROM 2026 BENEFITS

2027 HIGHMARK BLUESHIELD OF NORTHEASTERN NEW YORK - Small Business 2 to 100

RATES SHOWN COVER REGION 1-NORTHEASTERN NEW YORK

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 RADIUS POS Plus **	Individual Empl/Spouse Parent/Child(ren) Family	$1,321.01 $2,642.01 $2,245.71 $3,764.87	Embedded	$0/$0	Covered in full	$7,000/$14,000	$10 Copayment	$30 Copayment	$15 Copayment	$500 copayment	$250 Copayment	$250 Copayment (waived if admitted)	$75 Copayment	$10/$40/$125
GOLD	GOLD BLENDED 250D EX POS	Individual Empl/Spouse Parent/Child(ren) Family	$1,059.27 $2,118.54 $1,800.76 $3,018.92	Embedded	$1,500/$3,000	30% after deductible	$12,000/$24,000	$40 Copayment	$60 Copayment	$60 Copayment	30% coins. after deductible	30% coins. after deductible	$550 Copay after ded. (waived if admitted)	$100 not subject to deductible	$10 NoDD/$40 NoDD/$125 Copay
	GOLD EPO HIGH	Individual Empl/Spouse Parent/Child(ren) Family	$1,315.87 $2,631.73 $2,236.97 $3,750.22	Embedded	$0/$0	Covered in Full	$10,000/$20,000	$30 Copayment	$50 Copayment	$50 Copayment	$1,200 Copayment	$250 Copayment	$400 Copayment (waived if admitted)	$75 Copayment	$10 Copay/$55 Copay/$50% Coins.
	GOLD RADIUS HIGH **	Individual Empl/Spouse Parent/Child(ren) Family	$1,182.75 $2,365.51 $2,010.68 $3,370.85	Embedded	$0/$0	Covered in Full	$10,000/$20,000	$30 Copayment	$50 Copayment	$50 Copayment	$1,200 Copayment	$250 Copayment	$400 Copayment (waived if admitted)	$75 Copayment	$10 Copay/$55 Copay/$50% Coins.
SILVER	SILVER EPO 7200 EX POS (HSA QUALIFIED)	Individual Empl/Spouse Parent/Child(ren) Family	$1,045.74 $2,091.49 $1,777.76 $2,980.37	True Family *	$4,000/$8,000	Covered in full after deductible	$8,000/$16,000	$30 after deductible	$50 after deductible	$50 after deductible	$1,000 after deductible	$350 after deductible	$250 after deductible	$75 After deductible	$10/$40/50% 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.bsneny.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.