



INSURANCE PLUS

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President

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2021 HEALTH INSURANCE OPTIONS

2021 NY State Individual Marketplace Plans

Small Group Corporation/LLC Plans

Large Group Association/Union Plans

Dental Plans

****2021 OPEN-ENROLLMENT for the New York State MARKETPLACE:**

*November 1, 2020 - December 15, 2020***

**** This period is for a January 1, 2021 effective date. *Deadlines for the February 1st and March 1st effective dates to be announced. Please note that this open-enrollment period DOES NOT apply to the small and large group programs mentioned in this document.***

See following pages for plans

2021 NY INDIVIDUAL MARKETPLACE PROGRAMS*

*additional marketplace programs available www.nystateofhealth.ny.org

Emblem Health – Select Care and Millennium Networks (www.emblemhealth.com)			
Platinum (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	PCP \$15 / Specialist \$35		
Urgent Care	\$55 copay	Single	\$1,381
Deductible / Coinsurance	N/A – 10% coins. DME & pediatric eyeglasses	Couple	\$2,756
Maximum Out of Pocket	\$2,000 / \$4,000(Family)	Parent/Child	\$2,344
Prescription Plan	\$10 / \$30 / \$60	Family	\$3,926
Gold (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	PCP \$25 after deductible / Specialist \$40 after deductible		
Urgent Care	\$60 after deductible	Single	\$1,141
Deductible / Coinsurance	\$600 / \$1,200 (Family) Deductible	Couple	\$2,278
Maximum Out of Pocket	\$4,000 / \$8,000 (Family)	Parent/Child	\$1,937
Prescription Plan	\$10 / \$35 / \$70	Family	\$3,244
Silver (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	PCP \$30 after deductible / Specialist \$50 after deductible		
Urgent Care	\$70 after deductible	Single	\$ 953
Deductible / Coinsurance	\$1,300 / \$2,600(Family) Deductible	Couple	\$1,900
Maximum Out of Pocket	\$8,500 / \$17,000 (Family)	Parent/Child	\$1,616
Prescription Plan	\$10 / \$35 / \$70	Family	\$2,706
Bronze (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	\$50 after Deductible		
Urgent Care	50% after Deductible	Single	\$ 724
Deductible / Coinsurance	\$4,700 / \$9,400 (Family) Deductible / 50% Coinsurance	Couple	\$1,442
Maximum Out of Pocket	\$8,550 / \$17,100 (Family)	Parent/Child	\$1,227
Prescription Plan	\$10 / \$35 / \$70 after plan deductible	Family	\$2,053
Basic (Catastrophic) (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	PCP - First 3 FREE, then 0% after deduct. / Spec. 0% after ded.		
Urgent Care	0% after Deductible	Single	\$ 455
Deductible / Coinsurance	\$8,150 / \$16,300 (Family)	Couple	\$ 906
Maximum Out of Pocket	\$8,150 / \$16,300 (Family)	Parent/Child	\$ 771
Prescription Plan	0% after plan deductible	Family	\$1,288
Silver Value (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	PCP -First 3 FREE, then \$35 copay / Specialist - \$75 copay		
Urgent Care	\$75 copay	Single	\$ 705
Deductible / Coinsurance	\$6,000 / \$12,000 (Family)	Couple	\$1,404
Maximum Out of Pocket	\$6,000 / \$12,000 (Family)	Parent/Child	\$1,195
Prescription Plan	Generic - \$10 copay / T2&3 - \$0 after deductible	Family	\$1,999
Silver Bold (MILLENNIUM NETWORK) In Network Only, Referrals Required			
Office Copays	PCP – First 3 FREE, then \$50 co-pay / Specialist – \$70 co-pay		
Urgent Care	\$75 copay	Single	\$ 668
Deductible / Coinsurance	\$6,100 / \$12,200 (Family) / 0% Coinsurance	Couple	\$1,332
Maximum Out of Pocket	\$6,100 / \$12,200 (Family)	Parent/Child	\$1,133
Prescription Plan	Generic - \$15 copay / T2&3 - \$0 after deductible	Family	\$1,896
Gold Value (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	PCP – First 3 FREE, then \$45 co-pay / Specialist – \$65 co-pay		
Urgent Care	\$75 copay	Single	\$ 898
Deductible / Coinsurance	\$3,300 / \$6,600 (Family) / 0% Coinsurance	Couple	\$1,791
Maximum Out of Pocket	\$3,300 / \$6,600 (Family)	Parent/Child	\$1,523
Prescription Plan	Generic - \$10 copay / T2&3 - \$0 after deductible	Family	\$2,550

Oscar – Not HSA Compatible (www.hioscar.com)

Platinum Classic (OSCAR NETWORK) In Network Only, No Referrals

Office Copays	\$15 / Specialist \$35	Single	\$1,225
Urgent Care	\$55		
Deductible / Coinsurance	N/A	Couple	\$2,450
Maximum Out of Pocket	\$2,000 / \$4,000(family)	Parent/Child	\$2,083
Prescription Plan	\$10 / \$30 / \$60	Family	\$3,491

Gold Classic (OSCAR NETWORK) In Network Only, No Referrals

Office Copays	\$25 after Deductible / Specialist \$40 after Deductible	Single	\$981
Urgent Care	\$60 after Deductible		
Deductible / Coinsurance	\$600 / \$1,200 (Family) Deductible	Couple	\$1,962
Maximum Out of Pocket	\$4,000 / \$8,000 (Family)	Parent/Child	\$1,667
Prescription Plan	\$10 / \$35 / \$70	Family	\$2,795

Silver Classic (OSCAR NETWORK) In Network Only, No Referrals

Office Copays	\$30 after Deductible / Specialist \$50 after Deductible	Single	\$781
Urgent Care	\$70 after Deductible		
Deductible / Coinsurance	\$1,300 / \$2,600 (Family) Deductible	Couple	\$1,561
Maximum Out of Pocket	\$8,500 / \$17,000 (Family)	Parent/Child	\$1,327
Prescription Plan	\$10 / \$35 / \$70	Family	\$2,225

Bronze Classic (OSCAR NETWORK) In Network Only, No Referrals

Office Copays	3 at \$50; then \$50 after Ded. / Specialist – 3 at \$75, then \$75 after Ded.	Single	\$ 599
Urgent Care	50% after Deductible		
Deductible / Coinsurance	\$4,700 / \$9,400 (Family) Deductible / 50% Coinsurance	Couple	\$1,199
Maximum Out of Pocket	\$8,550 / \$17,100 (family)	Parent/Child	\$ 1,019
Prescription Plan	\$10 / \$35 / \$70 after Plan Deductible	Family	\$1,708

Simple Gold (OSCAR NETWORK) In Network Only, No Referrals

Office Copays	\$15 PCP copay / Specialist \$40 copay	Single	\$912
Urgent Care	\$75 copay		
Deductible / Coinsurance	\$4,000 / \$8,000 Deductible	Couple	\$1,824
Maximum Out of Pocket	\$6,500 / \$13,000	Parent/Child	\$1,551
Prescription Plan	\$10 / \$50 / 30% after deductible	Family	\$2,599

Simple Silver (OSCAR NETWORK) In Network Only, No Referrals

Office Copays	\$25 PCP copay / Specialist \$50 copay	Single	\$ 733
Urgent Care	\$75 copay		
Deductible / Coinsurance	\$6,250 / \$12,500 Deductible	Couple	\$1,465
Maximum Out of Pocket	\$8,550 / \$17,100	Parent/Child	\$1,245
Prescription Plan	\$10 / \$50 / 50% after deductible	Family	\$2,088

Simple Secure (OSCAR NETWORK) In Network Only, No Referrals – Under Age 30 ONLY

Office Copays	PCP - First 3 at \$0 then \$0 after ded. ; Spec. - \$0 after ded.	Single	\$ 185
Urgent Care	\$0 after Deductible		
Deductible / Coinsurance	\$8,550 / \$17,100 Deductible	Couple	\$ 370
Maximum Out of Pocket	\$8,550 / \$17,100	Parent/Child	\$ 315
Prescription Plan	\$0 after Deductible	Family	\$ 528

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Oscar – Not HSA Compatible (www.hioscar.com) - continued

Gold Saver (OSCAR NETWORK) In Network Only, No Referrals			
Office Copays	PCP - \$30 Specialist - 20% after Deductible	Single	\$ 893
Deductible / Coinsurance	\$1,500 / \$3,000 (Family) Deductible	Couple	\$1,786
Maximum Out of Pocket	\$6,000 / \$12,000 (Family)	Parent/Child	\$1,518
Prescription Plan	20% after deductible	Family	\$2,546
Silver Saver (OSCAR NETWORK) In Network Only, No Referrals			
Office Copays	First 2 at \$50. then 30% after Deductible	Single	\$ 694
Deductible / Coinsurance	\$2,500 / \$5,000 (Family) Deductible	Couple	\$1,388
Maximum Out of Pocket	\$7,500 / \$15,000 (Family)	Parent/Child	\$1,180
Prescription Plan	30% after deductible	Family	\$1,978

Additional New York Individual Marketplace Plans available at www.nystateofhealth.ny.org :

Empire Blue Cross HEALTHPLUS
United Healthcare COMPASS
FIDELIS
HealthFirst
MetroPlus

HEALTH INSURANCE OPTIONS

For

CORPORATION / LLC*

***Note that small group programs offered through corporations or LLCs are not subject to the open-enrollment period and can be installed any month of the year.**

OXFORD Platinum FREEDOM PPO: NO REFERRALS REQUIRED

When using FREEDOM providers, you have a:

Office Visit - \$20 Primary Copay / \$40 Specialist Copay
Preventive Care – No Charge
No Plan Deductible
Emergency Room - \$200
Outpatient Facility - \$100 copay
Hospital Admission - \$400 copay

When using YOUR OWN providers, you have a:

Deductible - \$3,000/\$6,000 Individual/Family
Coinsurance - 30%
Emergency Room - \$200
Outpatient Facility – 30% after Deductible
Hospital Admission – 30% after Deductible

Prescription Drug Card - \$5/\$30/\$60 Non-Tier 1 Ded \$50

***MONTHLY RATE: \$1,354 Single/ \$2,708 Couple/ \$2,302 Parent / \$3,859 Family**

**RATES VALID through 12/31/2020*

PHYSICIAN DIRECTORY: www.oxhp.com

OXFORD Platinum FREEDOM EPO: NO REFERRALS REQUIRED

When using FREEDOM providers, you have a:

Office Visit - \$20 Primary Copay / \$40 Specialist Copay
Preventive Care – No Charge
No Plan Deductible
Emergency Room - \$200
Outpatient Facility – Freestanding \$100 / Hosp-based \$300 copay
Hospital Admission - \$500

Prescription Drug Card - \$5/\$30/\$60 Non-Tier 1 Ded \$50

***MONTHLY RATE: \$1,280 Single / \$2,560 Couple / \$2,176 Parent / \$3,648 Family**

**RATES VALID through 12/31/2020*

PHYSICIAN DIRECTORY: www.oxhp.com

OXFORD Gold FREEDOM EPO: NO REFERRALS REQUIRED

When using FREEDOM providers, you have a:

Deductible - \$1,250/\$2,500 Individual/Family

Coinsurance - 20 %

Office Visit - \$25 Primary Copay / \$40 Specialist Copay

Preventive Care – No Charge

Emergency Room - \$400 copay

Outpatient Facility – \$250 after Deductible

Hospital Admission – 20% after Deductible

Prescription Drug Card - Non-Tier 1 \$100 Deduct. then \$15/\$35/\$75

***MONTHLY RATE: \$1,073 Single / \$2,146 Couple / \$1,824 Parent / \$3,057 Family**

*RATES VALID through 12/31/2020

PHYSICIAN DIRECTORY: www.oxhp.com

OXFORD Silver LIBERTY EPO: NO REFERRALS REQUIRED

When using LIBERTY providers, you have a:

Deductible - \$2,500/\$5,000 Individual/Family

Coinsurance - 30 %

Office Visit - \$40 Primary Copay / \$70 Specialist Copay

Preventive Care – No Charge

Emergency Room – 30% coinsurance after Deductible

Outpatient Facility – 30% coinsurance after Deductible

Hospital Admission – 30% coinsurance after Deductible

Prescription Drug Card – Non-Tier 1 \$200 Deduct. then \$15/\$45/\$75

***MONTHLY RATE: \$820 Single / \$1,640 Couple / \$1,394 Parent / \$2,337 Family**

*RATES VALID through 12/31/2020

PHYSICIAN DIRECTORY: www.oxhp.com

AETNA NY GOLD OA EPO: REFERRALS REQUIRED

When using AETNA providers, you have a:

Plan Deductible – \$1,000/\$2,000
Office Visit - \$30 Primary Copay /\$60 Specialist Copay
Preventive Care – No Charge
Emergency Room - \$750 Copay
Outpatient Facility – 10% after deductible
Hospital Admission – 10% after deductible

Prescription Drug Card - \$100 deductible non-T1 - \$15/\$65/50%

***MONTHLY RATE: \$1,103 Single / \$2,206 Couple / \$1,875 Single Parent / \$3,143 Family**

**RATES VALID through 12/31/2020*

PHYSICIAN DIRECTORY: www.aetna.com

EMBLEM PRIME GOLD PREMIER EPO: NO REFERRALS REQUIRED

When using Prime Network providers, you have a:

Annual Deductible - \$350/\$700
Office Visit – 3 Free PCP visits, then \$40 / Specialist - \$60 co-pay
Preventive Care – No Charge
Emergency Room - \$600 co-pay after Deductible
Hospital Admission – 30% coinsurance, after Deductible
Urgent Care - \$75 co-pay

Prescription Drug Card - \$0/\$40/\$80

***MONTHLY RATE: \$904 Single/ \$1,807 Couple/ \$1,536 Parent / \$2,576 Family**

**RATES VALID through 12/31/2020*

PHYSICIAN DIRECTORY: www.emblemhealth.com

LARGE GROUP / PEO PLANS *

**Note that large group programs offered through unions, PEO's and associations are not subject to the open-enrollment period and one can enroll any month throughout the year*

Eligibility Required

CIGNA

BLUE CARD

EMBLEM HIP PRIME

MAGNACARE

DENTAL INSURANCE OPTIONS For CORPORATION/LLC

****OXFORD (OBM) – DENTAL / VISION PLAN:**

ELITE SPECIALTY PLAN OPTION

DENTAL BENEFIT – Can use Oxford provider or provider of choice.

No Waiting Period on Basic and Major Services (optional)
\$50/\$150 Annual Deductible
\$1,000 Annual Maximum (\$1,500 optional)
Discounts include Wellness, Alternative Medicine, and Infertility

When using an Oxford PROVIDER, you have a:

100% Coverage for Preventative
80% Coverage after Deductible for Basic Restorative
50% Coverage after Deductible for Major Care

When using YOUR OWN DOCTOR, you have a:**

100% Coverage for Preventative
80% Coverage after Deductible for Basic Restorative
50% Coverage after Deductible for Major Care

**Out-of-network benefits are paid based on UHC Dental's Maximum Allowable Charge.

VISION BENEFIT – Can use Oxford provider or provider of choice.

Benefits include eye exams, frames, lenses, contact lenses.
Benefits are subject to copays and reimbursement schedule.

***MONTHLY RATES: \$43 Single / \$73 Couple / \$76 Single Parent / \$110 Family**

PROVIDERS DIRECTORY: www.oxhp.com

*Rates are subject to change and to final underwriting.

****ADDITIONAL PROGRAMS ARE AVAILABLE.**

DENTAL INSURANCE OPTIONS For INDEPENDENT CONTRACTORS

GUARDIAN *Managed Choice* DMO – DENTAL PLAN

When using a GUARDIAN Managed DentalGuard Network dentist, you have a:

Deductible - \$0

No Annual Maximum

No Waiting Period

Office Visit - \$5 copay

Preventive – Exam, Cleanings, X-rays – No charge

Fee Schedule applies for:

Diagnostic / Basic Restorative/ Periodontal / Endodontic / Oral Surgery

Prosthetics Repairs / Crown and Bridges / Dentures /Orthodontic

***MONTHLY RATES: \$51 Single / \$78 Emp + 1 / \$105 Family**

PROVIDERS DIRECTORY: WWW.GUARDIANLIFE.COM (MANAGED DENTALGUARD NETWORK)

*RATES VALID through 10/31/2020

UNITED CONCORDIA – DENTAL PLAN:

DENTAL BENEFIT – Can use United Concordia provider or provider of choice.

Deductible - \$50 single/\$150 family

No Waiting Period on Basic and Major Services

No Pre-Existing Condition Limitations

\$1,500 Annual Maximum

When using a UNITED CONCORDIA provider, you have a:

Preventive – Exam, Cleanings, X-rays – No charge (*deductible waived*)

Basic Restorative – 90% after Deductible

Major Care – 60% after Deductible

When using YOUR OWN DOCTOR, you have a:

Preventive – Exam, Cleanings, X-rays – No charge after Deductible

Basic Restorative – 80% after Deductible

Major Care – 50% after Deductible

***MONTHLY RATES: \$61 Single / \$129 Couple / \$122 Single Parent / \$162 Family**

PROVIDERS DIRECTORY: WWW.UNITEDCONCORDIA.COM (ADVANTAGE PLUS NETWORK)

*RATES VALID UNTIL 12/31/2020