



INSURANCE PLUS AGENCY

15 West Main Street
Oyster Bay, NY 11771
516-922-1200 / 212-268-4473
516-922-2829 fax

rose@insuranceplusagency.com
www.insuranceplusagency.com

Rose Gagliardi
President

January 01, 2022

2022 HEALTH INSURANCE OPTIONS

2022 NY State Individual Marketplace Plans

Small Group Corporation/LLC Plans

Large Group Association/Union Plans

Dental Plans

****2022 OPEN-ENROLLMENT for the New York State MARKETPLACE:**

Extended to February 15th for a March 1st effective date

See following pages for plans

2022 NY INDIVIDUAL MARKETPLACE PROGRAMS*

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

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	\$1,383
Deductible / Coinsurance	N/A – 10% coins. DME & pediatric eyeglasses	Couple	\$2,766
Maximum Out of Pocket	\$2,000 / \$4,000(Family)	Parent/Child	\$2,351
Prescription Plan	\$10 / \$30 / \$60	Family	\$3,941
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	\$1,143
Deductible / Coinsurance	\$600 / \$1,200 (Family) Deductible	Couple	\$2,285
Maximum Out of Pocket	\$4,000 / \$8,000 (Family)	Parent/Child	\$1,942
Prescription Plan	\$10 / \$35 / \$70	Family	\$3,256
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	\$ 951
Deductible / Coinsurance	\$1,300 / \$2,600(Family) Deductible	Couple	\$1,902
Maximum Out of Pocket	\$8,500 / \$17,000 (Family)	Parent/Child	\$1,617
Prescription Plan	\$10 / \$35 / \$70	Family	\$2,710
Bronze (SELECT CARE NETWORK) In Network Only, Referrals Required			
Office Copays	\$50 after Deductible		
Urgent Care	50% after Deductible	Single	\$ 723
Deductible / Coinsurance	\$4,700 / \$9,400 (Family) Deductible / 50% Coinsurance	Couple	\$1,447
Maximum Out of Pocket	\$8,700 / \$17,400 (Family)	Parent/Child	\$1,230
Prescription Plan	\$10 / \$35 / \$70 after plan deductible	Family	\$2,062
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	\$ 452
Deductible / Coinsurance	\$8,700 / \$17,400 (Family)	Couple	\$ 905
Maximum Out of Pocket	\$8,700 / \$17,400 (Family)	Parent/Child	\$ 769
Prescription Plan	0% after plan deductible	Family	\$1,289
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	\$ 694
Deductible / Coinsurance	\$6,300 / \$12,600 (Family)	Couple	\$1,388
Maximum Out of Pocket	\$6,300 / \$12,600 (Family)	Parent/Child	\$1,180
Prescription Plan	Generic - \$10 copay / T2&3 - \$0 after deductible	Family	\$1,977
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	\$ 659
Deductible / Coinsurance	\$6,500 / \$13,000 (Family) / 0% Coinsurance	Couple	\$1,318
Maximum Out of Pocket	\$6,500 / \$13,000 (Family)	Parent/Child	\$1,120
Prescription Plan	Generic - \$15 copay / T2&3 - \$0 after deductible	Family	\$1,878
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	\$ 887
Deductible / Coinsurance	\$4,000/ \$8,000 (Family) / 0% Coinsurance	Couple	\$1,774
Maximum Out of Pocket	\$4,000 / \$8,000 (Family)	Parent/Child	\$1,508
Prescription Plan	Generic - \$10 copay / T2&3 - \$0 after deductible	Family	\$2,528

2022 NY INDIVIDUAL MARKETPLACE PROGRAMS*

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

Emblem Health – Select Care and Millennium Networks continued

Gold Premier (SELECT CARE NETWORK) In Network Only, Referrals NOT Required

Office Copays	PCP First 3 FREE, then \$25 co-pay / Specialist – \$45 co-pay		
Urgent Care	\$75 co-pay	Single	\$ 905
Deductible / Coinsurance	\$800 / \$1,600 (Family)	Couple	\$1,810
Maximum Out of Pocket	\$6,200 / \$12,400 (Family)	Parent/Child	\$1,539
Prescription Plan	\$0 co-pay generic / T2&3 - \$60/80 after plan deductible	Family	\$2,579

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

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

Office Copays	\$15 / Specialist \$35		
Urgent Care	\$55	Single	\$1,318
Deductible / Coinsurance	N/A	Couple	\$2,636
Maximum Out of Pocket	\$2,000 / \$4,000 (family)	Parent/Child	\$2,241
Prescription Plan	\$10 / \$30 / \$60	Family	\$3,756

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

Office Copays	\$25 after Deductible / Specialist \$40 after Deductible		
Urgent Care	\$60 after Deductible	Single	\$1,062
Deductible / Coinsurance	\$600 / \$1,200 (Family) Deductible	Couple	\$2,125
Maximum Out of Pocket	\$4,000 / \$8,000 (Family)	Parent/Child	\$1,806
Prescription Plan	\$10 / \$35 / \$70	Family	\$3,028

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

Office Copays	\$30 after Deductible / Specialist \$50 after Deductible		
Urgent Care	\$70 after Deductible	Single	\$859
Deductible / Coinsurance	\$1,300 / \$2,600 (Family) Deductible	Couple	\$1,719
Maximum Out of Pocket	\$8,500 / \$17,000 (Family)	Parent/Child	\$1,461
Prescription Plan	\$10 / \$35 / \$70	Family	\$2,449

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

Office Copays	\$50 after Ded. / Specialist – \$75 after Ded.		
Urgent Care	\$75 after Deductible	Single	\$657
Deductible / Coinsurance	\$4,700 / \$9,400 (Family) Deductible	Couple	\$1,315
Maximum Out of Pocket	\$8,700 / \$17,400 (family)	Parent/Child	\$1,118
Prescription Plan	\$10 / \$35 / \$70 after Plan Deductible	Family	\$1,874

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

Office Copays	\$30 PCP copay / Specialist 20% after Ded		
Urgent Care	20% after Deductible	Single	\$966
Deductible / Coinsurance	\$1,500 / \$3,000 Deductible; Coinsurance - 20%	Couple	\$1,932
Maximum Out of Pocket	\$6,300 / \$12,600	Parent/Child	\$1,642
Prescription Plan	20% after deductible	Family	\$2,753

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

Office Copays	\$50 PCP copay / Specialist 30% after Ded		
Urgent Care	\$75 copay	Single	\$764
Deductible / Coinsurance	\$2,500 / \$5,000 Deductible; Coinsurance 30%	Couple	\$1,528
Maximum Out of Pocket	\$7,900 / \$15,800	Parent/Child	\$1,298
Prescription Plan	30% after deductible	Family	\$2,177

Simple Secure (OSCAR NETWORK) In Network Only, No Referrals – Under Age 30 ONLY			
Office Copays	\$0 after ded; Spec - \$0 after ded		
Urgent Care	\$0 after Deductible	Single	\$187
Deductible / Coinsurance	\$8,700 / \$17,400 - Deductible	Couple	\$374
Maximum Out of Pocket	\$8,700 / \$17,400	Parent/Child	\$318
Prescription Plan	\$0 after Deductible	Family	\$533
Gold Simple PCP Saver (OSCAR NETWORK) In Network Only, No Referrals			
Office Copays	PCP - \$15 Specialist - \$40		
Urgent Care	\$75	Single	\$987
Deductible / Coinsurance	\$4,000 / \$8,000 (Family) Deductible	Couple	\$1,975
Maximum Out of Pocket	\$6,800 / \$13,600 (Family)	Parent/Child	\$1,678
Prescription Plan	\$10/\$50 T3 - 30% after deductible	Family	\$2,814
Silver Simple PCP Saver (OSCAR NETWORK) In Network Only, No Referrals			
Office Copays	PCP - \$25 Specialist - \$50		
Urgent Care	\$75	Single	\$808
Deductible / Coinsurance	\$6,750 / \$13,500 (Family) Deductible	Couple	\$1,617
Maximum Out of Pocket	\$8,700 / \$17,400 (Family)	Parent/Child	\$1,374
Prescription Plan	\$10/\$50 T3 - 50% after deductible	Family	\$2,304

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

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 - \$250
Outpatient Facility - Freestanding \$100 / Hosp-based \$300 copay
Hospital Admission - \$400 copay

When using YOUR OWN providers, you have a:

Deductible - \$3,000/\$6,000 Individual/Family
Coinsurance - 30%
Emergency Room - \$250
Outpatient Facility – 30% after Deductible
Hospital Admission – 30% after Deductible

Prescription Drug Card - \$5/\$35/\$70 Non-Tier 1 Rx Deductible \$100/person

***MONTHLY RATE: \$1,368 Single/ \$2,737 Couple/ \$2,326 Parent / \$3,900 Family**

**RATES VALID through 03/31/2022*

PHYSICIAN DIRECTORY: www.uhceservices.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 - \$250
Outpatient Facility – Freestanding \$100 / Hosp-based \$300 copay
Hospital Admission - \$400

Prescription Drug Card - \$5/\$35/\$70 Non-Tier 1 Rx Deductible \$100/person

***MONTHLY RATE: \$1,316 Single / \$2,633 Couple / \$2,238 Parent / \$3,752 Family**

**RATES VALID through 03/31/2022*

PHYSICIAN DIRECTORY: www.uhceservices.com

OXFORD Gold FREEDOM EPO: NO REFERRALS REQUIRED

When using FREEDOM providers, you have a:

Deductible - \$1,750/\$3,500 Individual/Family

Coinsurance - 20 %

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

Preventive Care – No Charge

Emergency Room - \$500 copay

Outpatient Facility – Freestanding - \$150 / Hospital - \$250

Hospital Admission – 20% Coinsurance after Deductible

Prescription Drug Card - Non-Tier 1 \$150 Rx Deductible then \$10/\$40/\$80

***MONTHLY RATE: \$1,106 Single / \$2,212 Couple / \$1,880 Parent / \$3,152 Family**

*RATES VALID through 03/31/2022

PHYSICIAN DIRECTORY: www.uhceservices.com

OXFORD Silver LIBERTY EPO: NO REFERRALS REQUIRED

When using LIBERTY providers, you have a:

Deductible - \$3,000/\$6,000 Individual/Family

Coinsurance - 35%

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

Preventive Care – No Charge

Emergency Room – 50% coinsurance after Deductible

Outpatient Facility – 35% coinsurance after Deductible

Hospital Admission – 35% coinsurance after Deductible

Prescription Drug Card – \$200 Rx Deductible then \$10/\$50/\$90

***MONTHLY RATE: \$881 Single / \$1,763 Couple / \$1,499 Parent / \$2,512 Family**

*RATES VALID through 03/31/2022

PHYSICIAN DIRECTORY: www.uhceservices.com

AETNA NY GOLD OA EPO: REFERRALS REQUIRED

When using AETNA providers, you have a:

Plan Deductible – \$1,400/\$2,800
Office Visit - \$30 Primary Copay /\$75 Specialist Copay
Preventive Care – No Charge
Emergency Room - \$750 Copay
Outpatient Facility – 20% after deductible
Hospital Admission – 20% after deductible

Prescription Drug Card - \$15/\$65/50% Non-T1 Rx Deductible \$100 indiv/\$200 family

***MONTHLY RATE: \$1,002 Single / \$2,004 Couple / \$1,703 Single Parent / \$2,855 Family**

**RATES VALID through 03/31/2022*

PHYSICIAN DIRECTORY: www.aetna.com

EMBLEM PRIME GOLD PREMIER EPO: NO REFERRALS REQUIRED

When using Prime Network providers, you have a:

Annual Deductible - \$450/\$900
Office Visit – 3 Free PCP visits, then \$25 / Specialist - \$40 co-pay
Preventive Care – No Charge
Emergency Room - \$800 co-pay after Deductible
Hospital Admission – 30% coinsurance, after Deductible
Urgent Care - \$75 co-pay

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

***MONTHLY RATE: \$1,054 Single/ \$2,108 Couple/ \$1,791 Parent / \$3,003 Family**

**RATES VALID through 03/31/2022*

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 PPO

BLUE CARD/BCBS PPO

EMBLEM PRIME/GHI

MAGNACARE

DENTAL INSURANCE OPTIONS For CORPORATION/LLC

****ADDITIONAL OPTIONS AVAILABLE**

****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.uhc.com

***Rates are subject to change based on final underwriting.**

DENTAL INSURANCE OPTIONS

For

INDEPENDENT CONTRACTORS

****ADDITIONAL OPTIONS AVAILABLE**

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 10/31/2022

UNITED CONCORDIA – DENTAL PLAN:

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: \$60 Single / \$132 Couple / \$123 Single Parent / \$193 Family**

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

*RATES VALID UNTIL 12/31/2022