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Rose Gagliardi
President

June 10, 2022

2022 HEALTH INSURANCE OPTIONS

2022 NY State Individual Marketplace Plans

Small Group Corporation/LLC Plans

Large Group Association/Union Plans

Dental 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 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*: $1,437 Single/ $2,873 Couple/ $2,442 Parent / $4,095 Family**

RATES VALID through 09/30/2022

PHYSICIAN DIRECTORY: **Error! Hyperlink reference not valid.**

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*: $1,382 Single / $2,764 Couple / $2,350 Parent / $3,939 Family**

RATES VALID through 09/30/2022

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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*: $1,161 Single / $2,322 Couple / $1,974 Parent / $3,309 Family**

RATES VALID through 09/30/2022

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*: $978 Single / $1,956 Couple / $1,662 Parent / $2,787 Family**

RATES VALID through 09/30/2022

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:* $1,053 Single / $2,106 Couple / $1,790 Single Parent / $3,001 Family**

RATES VALID through 09/30/2022

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*: $1,101 Single/ $2,201 Couple/ $1,871 Parent / $3,137 Family**

RATES VALID through 09/30/2022

PHYSICIAN DIRECTORY: **Error! Hyperlink reference not valid.**

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**