Health Insurance Options

GIG Workers Universe - Anthem plans

PLAN OPTION	#1	#2	#4	#7
PLAN NAME	Base Plan	Bronze 4000 Plan	Silver 2500 Plan	Liberty Plan
CONTRACTED FEE SCHEDULE	National PPO Network	National PPO Network	National PPO Network	National PPO Network
IN - NETWORK BENEFITS	IN - NETWORK	IN - NETWORK	IN - NETWORK	IN - NETWORK
Deductible (Individual/Family)	$3,000 / $6,000	$4,000 / $10,000	$2,500 / $7,500	None
Coinsurance (Plan Pays/Member Pays)	50% / 50%	80% / 20%	80% / 20%	Plan pays 100% after copays
Max out of Pocket (Individual/Family)	$5,350 / $10,700	$9,100 / $18,200	$9,100 / $18,200	$5,350 / $10,700
Physician/Specialist Copay	Ded then 50% coinsurance	$45 PCP / $45 Specialist copay	$30 PcP / $30 Specialist copay	$30 PCP / $50 Specialist copay
Preventative Care & Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Hospital Services	Ded then 50% coinsurance	Ded then 20% coinsurance	Ded then 20% coinsurance	$500/day - Max $1,000 copay then 100%
Outpatient Hospital Services	Ded then 50% coinsurance	Ded then 20% coinsurance	Ded then 20% coinsurance	$150 copay then 100%
Outpatient Mental Health Services	Not Covered	$45 copay	$30 copay	$50 copay
Diagnostic Laboratory (Office)	Ded then 50% coinsurance	$30 copay	$30 copay	$20 copay
Diagnostic X-ray/Imaging (Office)	Ded then 50% coinsurance	Ded then 20% coinsurance	Ded then 20% coinsurance	$75 copay
Emergency Room (Accident & Illness)	Ded then 50% coinsurance	$350 copay	$200 copay	$150 copay then 100%
Urgent Care	Ded then 50% coinsurance	$80 copay	Ded then 20% coinsurance	$30 copay then 100%
OUT - OF - NETWORK BENEFITS	OUT - OF - NETWORK	OUT - OF - NETWORK	OUT - OF - NETWORK	OUT - OF - NETWORK
Deductible (Individual/Family)	Not Covered	$5,000 / $15,000	$5,000 / $15,000	Not Covered
Coinsurance (Plan Pays/Member Pays)	Not Covered	50% / 50%	50% / 50%	Not Covered
Max Out of Pocket (Individual/Family)	Not Covered	$13,500 / $36,000	$13,500 / $36,000	Not Covered
PRESCRIPTION BENEFITS	PRESCRIPTION BENEFITS	PRESCRIPTION BENEFITS	PRESCRIPTION BENEFITS	PRESCRIPTION BENEFITS
Deductible (individual/Family)	None	None	None	$100 / $300
Retail	$10/$35/$70 (Max 30 days)	$10/$50/$75 (Max 30 days)	$10/$50/$100 (Max 30 days)	$15/$35/$75 (Max 30 days)
Mail Order	$25/$87.50/$175 (Max 60 days)	$25/$87.50/$175 (31 to 90 days)	$20/$100/$200 (31 to 90 days)	$30/$70/$150 (Max 60 days)
Specialty Medications	Not Covered	Not Covered	Not Covered	Not Covered
Max Out of Pocket (Individual/Family)	$1,000 / $2,000	None	None	$1,000 / $2,000
MEDICAL & RX MONTHLY RATES	CURRENT RATE	CURRENT RATE	CURRENT RATE	CURRENT RATE
Employee Rate	$ 998.00	$ 1,130.00	$ 1,254.00	$ 1,396.00
Employee & (1) Child Rate	$ 1,577.00	$ 1,678.00	$ 1,755.00	$ 2,298.00
Employee & Spouse Rate	$ 1,863.00	$ 2,223.00	$ 2,260.00	$ 2,751.00
Employee & Family Rate	$ 2,316.00	$ 2,572.00	$ 2,736.00	$ 3,289.00

*The rates are illustrative and still require the standard underwriting process to determine final eligibility.