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Medical Benefits at-A-Glance - 2022

Anthem

Medical - Anthem BCBS	POS 1000		POS 3000		POS HDHP (HSA Compatible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance (Plan pays)	80%	50%	70%	50%	70%	50%
Calendar Year Deductible • Individual • Family	$1,000 $3,000	$1,500 $4,500	$3,000 $9,000	$9,000 $27,000	$5,000 $10,000	$15,000 $30,000
Out of Pocket Maximum (includes deductible) • Individual • Family	$7,900 $15,800	$23,700 $47,400	$7,900 $15,800	$23,700 $47,400	$7,050 $14,100	$21,150 $42,300
Office Visit Copay • Primary • Specialist	$30 copay $50 copay	50% after deductible 50% after deductible	$35 $60	50% after deductible 50% after deductible	$35 after deductible $60 after deductible	50% after deductible 50% after deductible
Preventive Care	100% covered	50% after deductible	100% covered	50% after deductible	100% covered	50% after deductible
Hospital Services						
Inpatient Hospital - Facility	$500 copay per admission + 30% after deductible	50% after deductible	$300 copay per admission + 30% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient Hospital - Physician	20% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient Services - Free Standing Surgical Center	$150 copay + 20% coinsurance	50% after deductible	$200 copay + 30% coinsurance	50% after deductible	30% after deductible	50% after deductible
Emergency Room Services (Copay waived if admitted)	$375 copay + 20% coinsurance	$375 copay + 20% coinsurance	$375 copay + 30% coinsurance	$375 copay + 30% coinsurance	30% after deductible	30% after deductible
Urgent Care	$75 copay	50% after deductible	$75 copay	50% after deductible	$75 copay after deductible	50% after deductible
Prescription Drug Coverage (30 day supply)			**Preferred Network**	**In/Out-of-Network**		
Deductible	Not applicable		$350 Individual / $700 Family (T2-T4)		Subject to medical deductible	
Tier 1	$15 copay		$5 copay/$20 copay	$15 copay/$30 copay	$20 after deductible	
Tier 2	$40 copay		$45 copay after Rx deductible	$55 copay after Rx deductible	$45 after deductible	
Tier 3	$65 copay		$90 copay after Rx deductible	$100 copay after Rx deductible	$85 after deductible	
Tier 4	25% coinsurance up to $350 max		25% after Rx ded up to a $450 max	35% after Rx ded up to a $550 max	25% after deductible up to a $350 max	

Monthly Medical Rates	POS 1000		POS 3000		POS HDHP (HSA Compatible)	
	Medical w/o Vision	Medical w/ Vision	Medical w/o Vision	Medical w/ Vision	Medical w/o Vision	Medical w/ Vision
Employee	$1,120.99	$1,126.99	$824.72	$830.72	$761.20	$767.19
Employee + Spouse	$2,560.97	$2,571.47	$1,879.54	$1,890.04	$1,733.44	$1,743.94
Employee + Child(ren)	$2,373.77	$2,385.18	$1,742.43	$1,753.83	$1,607.06	$1,618.47
Family	$3,813.71	$3,831.12	$2,797.22	$2,814.62	$2,579.26	$2,596.66

GDA PLUS+ insurance
GDAplus.com

GDIS
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Contact Information

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Medical Member Services: 1.855.397.9267
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This document is intended as a convenient summary of the major points of benefit plans. This booklet does not cover all provisions, limitations and exclusions. The official plan documents, polices and certificates of insurance govern in all cases and are available for your inspection at any time.

Vision - Anthem BCBS	In-Network	Out-of-Network Reimbursement
Exams	$10 Copay	Up to $48
Eyeglasses		
Single Vision	$20 Copay	Up to $36
Bifocal	$20 Copay	Up to $54
Trifocal	$20 Copay	Up to $69
Progressive (Standard)	$65 Copay	N/A
Frames	$130 Allowance and 20% off remaining balance	Up to $64
Contact Lenses		
Conventional/Disposable	$130 Allowance and 15% off remaining balance	Up to $105
Medically Necessary	Covered at 100%	Up to $210
Frequency of Services		
Exam/Lenses/Contact Lenses/Frames	12/12/12/12 Months	

Basic Life Insurance - Greater Georgia Life	
Basic Life Benefit	$10,000

Your family or beneficiary will get the benefit amount if your pass away.