2027 BENEFITS AT A GLANCE

Georgia Dental Association



MEDICAL PLANS

Anthem

Medical - Anthem	POS 1500		POS 3500		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	$1,500 $4,500	$1,500 $4,500	$3,500 $10,500	$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	$9,450 $18,900	$23,700 $47,400	$8,700 $17,400	$21,150 $42,300
Office Visit Copay • Primary • Specialist	$40 copay $60 copay	50% after ded 50% after ded	$50 copay $80 copay	50% after ded 50% after ded	$50 after ded $80 after ded	50% after ded 50% after ded
Preventive Care	100% covered	50% after ded	100% covered	50% after ded	100% covered	50% after ded
Hospital Services						
Inpatient Hospital - Facility	$500 copay per admission + 20% after ded	50% after ded	$1,000 copay per admission + 30% after ded	50% after ded	30% after ded	50% after ded
Inpatient Hospital - Physician	20% after ded	50% after ded	30% after ded	50% after ded	30% after ded	50% after ded
Outpatient Surgery	$350 copay per visit + 20% after ded	50% after ded	$500 copay per visit + 30% after ded	50% after ded	30% after ded	50% after ded
Outpatient Services - Free Standing Surgical Center	$150 copay per visit + 20% coinsurance	50% after ded	$200 copay per visit + 30% coinsurance	50% after ded	30% after ded	50% after ded
Emergency Room Services (Copay waived if admitted)	$500 copay + 20% coinsurance	$500 copay + 20% coinsurance	$750 copay + 30% coinsurance	$750 copay + 30% coinsurance	30% after ded	30% after ded
Urgent Care	$75 copay	50% after ded	$100 copay	50% after ded	$100 copay after ded	50% after ded
Prescription Drug Coverage (30 day supply)			Preferred Network	In/Out-of-Network	Preferred Network	In/Out-of-Network
Deductible	Not applicable		$600 Individual / $1,200 Family (T2-T4)		Subject Medical Deductible	
Tier 1	$15 copay		$20 copay /$40 copay	$30 copay /$50 copay	$40 copay after ded	$50 copay after ded
Tier 2	$50 copay		$75 copay after Rx ded	$85 copay after Rx ded	$75 copay after ded	$85 copay after ded
Tier 3	$75 copay		$100 copay after Rx ded	$110 copay after Rx ded	$100 copay after ded	$110 copay after ded
Tier 4	25% coinsurance up to $350 max		25% after Rx ded up to a $450 max	35% coinsurance after Rx ded up to a $550 max	35% after ded up to $450 Max	45% after ded up to $550 Max

GDIS Georgia Dental Insurance Services

MEDICAL PLANS

Anthem - High Performance Network

The Blue High Performance Network (BlueHPN) is a network of top doctors, hospitals, and specialists carefully curated in each local market. In-network coverage is only available in certain areas nationwide. You will be responsible for the full cost of an out-of-network doctor visit. Out-of-network coverage is not available with this plan. Only urgent care and emergency care will be covered. Visit **blueHPNquiz.anthem.com** to find out if the HPN plans are right for you.

Medical - Anthem	HPN 3500	HPN HDHP (HSA Compatible)
	In-network	In-network
Coinsurance (Plan pays)	70%	70%
Calendar Year Deductible • Individual • Family	$3,500 $10,500	$5,000 $10,000
Out of Pocket Maximum (includes deductible) • Individual • Family	$9,450 $18,900	$8,700 $17,400
Office Visit Copay • Primary • Specialist	$50 copay $80 copay	$50 after ded $80 after ded
Preventive Care	100% covered	100% covered
Hospital Services		
Inpatient Hospital - Facility	$1,000 copay per admission + 30% after ded	30% after ded
Inpatient Hospital - Physician	30% after ded	30% after ded
Outpatient Surgery	$500 copay per visit + 30% after ded	30% after ded
Outpatient Services - Free Standing Surgical Center	$200 copay + 30% after deductible	30% after ded
Emergency Room Services (Copay waived if admitted)	$750 copay + 30% coinsurance	30% after ded
Urgent Care	$100 copay	$100 copay after ded

Prescription Drug Coverage (30 day supply)	Preferred Network	In-network	Preferred Network	In-network
Deductible	$600 Individual / $1,200 Family (T2-T4)		Subject Medical Deductible	
Tier 1	$20 copay / $40 copay	$30 copay / $50 copay	$40 copay after ded	$50 copay after ded
Tier 2	$75 copay after Rx ded	$85 copay after Rx ded	$75 copay after ded	$85 copay after ded
Tier 3	$100 copay after Rx ded	$110 copay after Rx ded	$100 copay after ded	$110 copay after ded
Tier 4	25% coinsurance after Rx ded up to a $450 Max	35% coinsurance after Rx ded up to a $550 Max	35% after ded up to $450 Max	45% after ded up to a $550 Max

MEDICAL MONTHLY RATES

POS 1500

Age Band	EE	ES	EC	EF
< 25	$924.73	$1,892.98	$1,782.32	$2,884.28
25 to 29	$964.86	$1,975.24	$1,859.77	$3,009.68
30 to 34	$1,095.92	$2,243.92	$2,112.72	$3,419.24
35 to 39	$1,168.48	$2,392.64	$2,252.74	$3,645.97
40 to 44	$1,260.44	$2,581.16	$2,430.22	$3,933.34
45 to 49	$1,487.02	$3,045.66	$2,867.53	$4,641.42
50 to 54	$1,895.16	$3,882.33	$3,655.24	$5,916.84
55 to 59	$2,301.61	$4,715.53	$4,439.66	$7,186.96
60 to 64	$2,747.03	$5,628.65	$5,299.33	$8,578.91
65+	$2,859.25	$5,861.43	$5,518.32	$8,935.11

POS 3500

Age Band	EE	ES	EC	EF
< 25	$806.47	$1,650.55	$1,554.07	$2,514.71
25 to 29	$841.45	$1,722.25	$1,621.58	$2,624.02
30 to 34	$955.70	$1,956.47	$1,842.09	$2,981.06
35 to 39	$1,018.95	$2,086.12	$1,964.16	$3,178.71
40 to 44	$1,099.12	$2,250.47	$2,118.88	$3,429.23
45 to 49	$1,296.64	$2,655.40	$2,500.10	$4,046.50
50 to 54	$1,652.44	$3,384.77	$3,186.79	$5,158.35
55 to 59	$2,006.75	$4,111.13	$3,870.61	$6,265.58
60 to 64	$2,395.04	$4,907.13	$4,620.03	$7,479.01
65+	$2,492.53	$5,109.72	$4,810.60	$7,789.21

POS HDHP

Age Band	EE	ES	EC	EF
< 25	$617.01	$1,262.12	$1,188.39	$1,922.61
25 to 29	$643.74	$1,316.94	$1,240.00	$2,006.16
30 to 34	$731.07	$1,495.95	$1,408.53	$2,279.04
35 to 39	$779.41	$1,595.04	$1,501.83	$2,430.11
40 to 44	$840.68	$1,720.65	$1,620.08	$2,621.58
45 to 49	$991.65	$2,030.14	$1,911.45	$3,093.36
50 to 54	$1,263.59	$2,587.60	$2,436.29	$3,943.16
55 to 59	$1,534.39	$3,142.75	$2,958.93	$4,789.41
60 to 64	$1,831.16	$3,751.14	$3,531.72	$5,716.84
65+	$1,905.07	$3,905.36	$3,676.76	$5,953.31

GDIS
Georgia Dental Insurance Services

MEDICAL MONTHLY RATES

High Performance Network

HPN 3500

Age Band	EE	ES	EC	EF
< 25	$758.24	$1,551.66	$1,460.99	$2,363.97
25 to 29	$791.12	$1,619.07	$1,524.45	$2,466.73
30 to 34	$898.52	$1,839.24	$1,731.73	$2,802.35
35 to 39	$957.98	$1,961.11	$1,846.47	$2,988.14
40 to 44	$1,033.33	$2,115.59	$1,991.91	$3,223.62
45 to 49	$1,219.00	$2,496.22	$2,350.26	$3,803.86
50 to 54	$1,553.44	$3,181.83	$2,995.74	$4,848.99
55 to 59	$1,886.50	$3,864.59	$3,638.54	$5,889.78
60 to 64	$2,251.50	$4,612.85	$4,342.99	$7,030.41
65+	$2,342.99	$4,803.13	$4,521.97	$7,321.83

HPN HDHP

Age Band	EE	ES	EC	EF
< 25	$564.79	$1,155.08	$1,087.61	$1,759.43
25 to 29	$589.25	$1,205.23	$1,134.83	$1,835.87
30 to 34	$669.15	$1,369.02	$1,289.05	$2,085.56
35 to 39	$713.39	$1,459.70	$1,374.41	$2,223.79
40 to 44	$769.45	$1,574.63	$1,482.61	$2,398.99
45 to 49	$907.59	$1,857.81	$1,749.22	$2,830.67
50 to 54	$1,156.41	$2,367.89	$2,229.44	$3,608.24
55 to 59	$1,404.21	$2,875.86	$2,707.67	$4,382.57
60 to 64	$1,675.76	$3,432.54	$3,231.77	$5,231.17
65+	$1,743.16	$3,573.44	$3,364.27	$5,447.32

EE = Employee Only

ES = Employee + Spouse

EC = Employee + Child(ren)

EF = Employee + Family

BASIC LIFE INSURANCE

UnitedHealthcare

Your family or beneficiary will receive the benefit amount if you pass away. This is automatically included with Medical coverage on the primary insured.

Insurance Coverage	Benefit
Basic Term Life Up to Age 65	$10,000

VISION

Anthem

	In-Network	Out-of-Network Reimbursement
Exams	$10 Copay	Up to $48 reimbursement
Eyeglasses		
Single Vision	$20 Copay	Up to $36 reimbursement
Bifocal	$20 Copay	Up to $54 reimbursement
Trifocal	$20 Copay	Up to $69 reimbursement
Frames	$130 allowance, then 20% off remaining balance	Up to $64 reimbursement
Contact Lenses		
Conventional/Disposable	$130 allowance	Up to $105 reimbursement
Medically Necessary	Covered in full	Up to $210 reimbursement
Frequency of Services Exam/Lenses/Contact Lenses/Frames	12/12/12/12 Months	

Optional Vision Coverage Rates	
Employee	$5.80
Employee + Spouse	$10.15
Employee + Child(ren)	$11.02
Family	$16.82

Note: Must enroll in medical coverage to enroll in vision coverage.

ACCIDENT INSURANCE

Anthem

Benefit Schedule	
Emergency Services Benefits	$100-$500
Accident Follow Up Care Benefits	$25-$200
Specified Injury & Services Benefits	$50-$750
Dislocations Schedule	$160-$1,900
Fractures Schedule	$200-$2,000
Catastrophic Injury Benefits	Up to $5,000
Hospital Confinement Benefits	Admission: $500; Daily: $100
ICU Confinement Benefits	Admission: $1,000; Daily: $200
AD&D Benefits	Up to $50,000; $150,000 Common Carrier
Organized Sports Injury Benefit - for covered injuries while participating in organized sports	10%; up to $10,000

Accident Insurance - Monthly Rates	
Employee	$5.43
Employee + Spouse	$8.49
Employee + Child(ren)	$8.87
Family	$14.00

HOSPITAL INDEMNITY INSURANCE

Anthem

Benefit Schedule	
Hospital Confinement - First Day Benefit	$500
First Day Hospital Confinement - Annual Max	1 day
Hospital Confinement - Daily Benefit	$100
Daily Hospital Confinement - Annual Max	31 days
Intensive Care Unit Confinement - Daily Benefit	$200
Daily Intensive Care Unit Confinement - Annual Max	31 days

Hospital Indemnity Insurance - Monthly Rates	
Employee	$10.31
Employee + Spouse	$21.38
Employee + Child(ren)	$15.61
Family	$27.35

CRITICAL ILLNESS INSURANCE

Anthem

Coverage Amount	
Employee	$10,000
Spouse	$5,000
Child(ren)	$5,000

Benefit Schedule	
Cancer Benefits	
Invasive Cancer	100% of Coverage Amount
Treatment Free Period	12 months
Non-Invasive Cancer	25% of Coverage Amount
Benign Brain Tumor	100% of Coverage Amount
Vascular Benefits	
Heart Failure	100% of Coverage Amount
Heart Attack (Myocardial Infarction)	100% of Coverage Amount
Stroke	100% of Coverage Amount
Coronary Artery Disease	25% of Coverage Amount
Other Specified Illness Benefits	
Coma	100% of Coverage Amount
Paralysis	100% of Coverage Amount
Major Organ Failure	100% of Coverage Amount
End Stage Renal Disease	100% of Coverage Amount
Loss of Hearing	100% of Coverage Amount
Loss of Speech	100% of Coverage Amount
Loss of Vision	100% of Coverage Amount
Infectious Disease (5 Days)	10% of Coverage Amount

Monthly Rates				
Age Band	EE	ES	EC	EF
18-24	$3.64	$5.93	$5.44	$8.01
25-29	$4.44	$7.12	$6.23	$9.21
30-34	$4.89	$7.83	$6.69	$9.92
35-39	$6.13	$9.68	$7.93	$11.76
40-44	$8.46	$13.30	$10.25	$15.39
45-49	$13.06	$20.52	$14.85	$22.60
50-54	$17.86	$28.10	$19.66	$30.18
55-59	$24.04	$37.91	$25.83	$40.00
60-64	$33.72	$53.17	$35.51	$55.26
65-69	$47.29	$74.09	$49.08	$76.18
70-74	$63.56	$99.29	$65.36	$101.38
75-79	$83.74	$130.38	$85.54	$132.47
80-84	$98.00	$152.21	$99.79	$154.30

Contact Information

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Basic Life - United Healthcare
Member Services:
800.873.9573
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Voluntary Benefits - Anthem
Member Services:
1.800.331.1476
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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.



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