

2023 BENEFITS AT A GLANCE

Georgia
Dental
Association



MEDICAL

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	\$1,000	\$1,500	\$3,000	\$9,000	\$5,000	\$15,000
• Family	\$3,000	\$4,500	\$9,000	\$27,000	\$10,000	\$30,000
Out of Pocket Maximum (includes deductible)						
• Individual	\$7,900	\$23,700	\$9,100	\$23,700	\$7,500	\$21,150
• Family	\$15,800	\$47,400	\$18,200	\$47,400	\$15,000	\$42,300
Office Visit Copay						
• Primary	\$40 copay	50% after ded	\$40	50% after ded	\$35 after ded	50% after ded
• Specialist	\$60 copay	50% after ded	\$70	50% after ded	\$60 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	\$500 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	\$300 copay per visit + 30% coinsurance	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	\$500 copay + 30% coinsurance	\$500 copay + 30% coinsurance	30% after ded	30% after ded
Urgent Care	\$75 copay	50% after ded	\$75 copay	50% after ded	\$75 copay after ded	50% after ded
Prescription Drug Coverage (30 day supply)			Preferred Network	In/Out-of-Network		
Deductible	Not applicable		\$500 Individual / \$1,000 Family (T2-T4)		Subject to medical ded	
Tier 1	\$25 copay		\$15 copay / \$30 copay	\$25 copay / \$40 copay	\$30 after ded	
Tier 2	\$50 copay		\$55 copay after Rx ded	\$65 copay after Rx ded	\$55 after ded	
Tier 3	\$75 copay		\$100 copay after Rx ded	\$110 copay after Rx ded	\$85 after ded	
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 ded 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	\$1,285.47	\$1,291.47	\$945.21	\$951.21	\$872.26	\$878.26
Employee + Spouse	\$2,939.30	\$2,949.80	\$2,156.67	\$2,167.17	\$1,988.88	\$1,999.37
Employee + Child(ren)	\$2,724.30	\$2,735.71	\$1,999.19	\$2,010.60	\$1,843.73	\$1,855.14
Family	\$4,378.06	\$4,395.47	\$3,210.62	\$3,228.03	\$2,960.29	\$2,977.70



Contact Information

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Medical, Vision, and Basic Life - Anthem Blue Cross Blue Shield

Medical Member Services: 1.855.397.9267

Vision Medical Services: 1.866.723.0515

www.anthem.com

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, policies 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.