2025 BENEFITS AT A GLANCE

Georgia Dental Association

MEDICAL

Medical - UnitedHealthcare	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	$9,450 $18,900	$23,700 $47,400	$7,500 $15,000	$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	Subject Medical Deductible
Tier 1	$25 copay		$20 copay /$40 copay	$30 copay /$50 copay	$40 after ded	$50 after ded
Tier 2	$50 copay		$75 copay after Rx ded	$85 copay after Rx ded	$75 after ded	$85 after ded
Tier 3	$75 copay		$100 copay after Rx ded	$110 copay after Rx ded	$100 after ded	$110 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	35% after ded up to a $450 max	45% after ded up to a $550 max

MEDICAL MONTHLY RATES

POS 1000

Age Band	EE	ES	EC	EF
< 25	$736.47	$1,448.75	$1,377.52	$2,232.25
25 to 29	$764.46	$1,504.73	$1,430.70	$2,319.03
30 to 34	$861.29	$1,698.38	$1,614.68	$2,619.18
35 to 39	$913.82	$1,803.45	$1,714.49	$2,782.05
40 to 44	$976.29	$1,928.39	$1,833.18	$2,975.70
45 to 49	$1,143.04	$2,261.89	$2,150.00	$3,492.63
50 to 54	$1,449.11	$2,874.04	$2,731.55	$4,441.45
55 to 59	$1,753.91	$3,483.62	$3,310.65	$5,386.30
60 to 64	$2,088.20	$4,152.22	$3,945.82	$6,422.63
65+	$2,166.80	$4,312.00	$4,097.48	$6,671.73

POS 3000

Age Band	EE	ES	EC	EF
< 25	$646.72	$1,269.26	$1,207.00	$1,954.05
25 to 29	$671.19	$1,318.19	$1,253.49	$2,029.89
30 to 34	$755.82	$1,487.44	$1,414.28	$2,292.22
35 to 39	$801.73	$1,579.27	$1,501.52	$2,434.57
40 to 44	$856.33	$1,688.47	$1,605.26	$2,603.82
45 to 49	$1,002.07	$1,979.95	$1,882.16	$3,055.62
50 to 54	$1,269.58	$2,514.97	$2,390.43	$3,884.90
55 to 59	$1,535.97	$3,047.75	$2,896.57	$4,710.70
60 to 64	$1,828.15	$3,632.10	$3,451.71	$5,616.46
65+	$1,896.51	$3,771.43	$3,583.94	$5,833.84

POS HDHP

Age Band	EE	ES	EC	EF
< 25	$502.95	$981.71	$933.83	$1,508.35
25 to 29	$521.77	$1,019.34	$969.58	$1,566.68
30 to 34	$586.85	$1,149.50	$1,093.24	$1,768.42
35 to 39	$622.16	$1,220.13	$1,160.33	$1,877.90
40 to 44	$664.15	$1,304.10	$1,240.11	$2,008.06
45 to 49	$776.23	$1,528.27	$1,453.06	$2,355.51
50 to 54	$981.96	$1,939.72	$1,843.95	$2,993.27
55 to 59	$1,186.82	$2,349.46	$2,233.20	$3,628.35
60 to 64	$1,411.52	$2,798.86	$2,660.13	$4,324.93
65+	$1,463.50	$2,905.41	$2,761.22	$4,491.51

EE = Employee Only

ES = Employee + Spouse

EC = Employee + Child(ren)

EF = Employee + Family

Contact Information

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Medical, Vision, and Basic Life - UnitedHealthcare
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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 - UnitedHealthcare	In-Network	Out-of-Network Reimbursement
Exams	$10 Copay	Up to $40
Eyeglasses		
Single Vision	$20 Copay	Up to $40
Bifocal	$20 Copay	Up to $60
Trifocal	$20 Copay	Up to $80
Frames	$130 Allowance and 30% off remaining balance	Up to $45
Contact Lenses		
Conventional/Disposable	$130 Allowance	Up to $130
Medically Necessary	Covered at 100%	Up to $210
Frequency of Services Exam/Lenses/Contact Lenses/ Frames	12/12/12/12 Months	

Optional Vision Coverage Rates	
Employee	$5.74
Employee + Spouse	$10.05
Employee + Child(ren)	$10.91
Family	$16.66

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

Basic Term Life Insurance - UnitedHealthcare	
Basic Term Life Benefit Up To Age 65	$10,000

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