Georgia Municipal Employees Benefit System
Open Access POS 80/60 - $750 Deductible Plan
Schedule of Benefits Effective January 1, 2023

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted. In addition to deductibles, members are responsible for copayments and any applicable coinsurance. Members are also responsible for all costs over the plan maximums, where applicable.
Some services may require pre-certification before services are covered by the Plan. Please see the Benefits Booklet under Getting Approval for Medical Benefits for additional information. Primary Care Physician (PCP) selection is encouraged, but not required. No referrals are required.

When using out-of-network providers, members may be responsible for any difference between the Maximum Allowed Amount (see Benefits Booklet for definition) and actual charges, in addition to any copayments, deductibles and/or applicable coinsurance.

Deductibles, Coinsurance and Maximums	In-Network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible* Individual Family	 $750 $2,250	 $1,500 $4,500
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible
Lifetime Maximum	unlimited	unlimited
Out-of-Pocket Calendar Year Maximum* Medical Rx	$3,500 individual / $7,000 family $1,600 individual / $3,200 family	$6,500 individual / $13,000 family $3,200 individual / $6,400 family

**All family members covered under the Plan contribute toward the total Family deductible and Out-of-pocket maximums. The most any one family member contributes is the Individual amount. Once the Family amount is satisfied, there is no further accumulation for any family members for the remainder of the calendar year.*
The following do not apply to the Out-of-Pocket Maximums: Premiums, any amount above the Maximum Allowed Amount (see Benefits Booklet for definition), and charges for health care this Plan doesn't cover. Deductible and Out-of-Pocket amounts are accumulated separately for in-network and out-of-network services.

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Office Visits: Preventive Care		
• Well-child care, immunizations	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 60% after deductible *(deductible waived through age 5)*
• Annual Wellness Examination	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 60% after deductible
• Annual gynecology examination/mammography	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 60% after deductible
• Prostate screening	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 60% after deductible
Illness or Injury		
• Physician office visit (includes lab, radiology, and office surgery)	$30 copayment	Plan pays 60% after deductible
• LiveHealth Online healthcare provider visit	Plan pays 100%	Plan pays 100%
• Specialty care physician office visit	$40 copayment	Plan pays 60% after deductible
• Second surgical opinion	$40 copayment	Plan pays 60% after deductible
• Allergy care (office visit, testing, serum, and allergy shots)	$30 Physician copayment or $40 Specialist Physician copayment	Plan pays 60% after deductible
• Maternity (prenatal, postnatal)	$0 copayment	Plan pays 60% after deductible
Emergency/Urgent Care Services - <u>Preauthorization</u> is required within 48 hours of ER admission (or ASAP). Failure to <u>preauthorize</u> (<u>out-of-network</u>) may result in reduced or no coverage.		
• Emergency room care of life-threatening illness or serious accidental injury	$200 copayment *(waived if admitted)*	$200 copayment *(waived if admitted)*
• Non-emergency use of the emergency room	Not covered	Not covered
• Urgent Care Center	$60 copayment	$60 copayment
• Ambulance (when medically necessary)	Plan pays 80% after deductible	Plan pays 80% of allowed amount after deductible (balance billing may occur)
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services		
• Surgery facility/hospital charges	Plan pays 80% after deductible	Plan pays 60% after deductible
• Diagnostic x-ray and lab services	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible
Therapy Services **Day or visit maximums are combined between in-network and out-of-network.**		
• Speech Therapy	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physical, Occupational Therapy	Plan pays 80% after deductible	Plan pays 60% after deductible
▪ Chiropractic – 30-day visit maximum per calendar year combined in and out of network	$40 co-pay office visit Plan pays 80% for all other services after deductible	Plan pays 60% after deductible
• Respiratory Therapy	Plan pays 80% after deductible	Plan pays 60% after deductible
• Radiation Therapy, Chemotherapy	Plan pays 80% after deductible	Plan pays 60% after deductible
Mental Health/Substance Abuse Services **Services may be accessed by calling 1-800-292-2879.**		
• Inpatient (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Inpatient Substance Abuse Detoxification (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Partial Hospitalization Program (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Intensive Outpatient Program (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Professional Outpatient Services	$30 copayment	Plan pays 60% after deductible
• LiveHealth Online healthcare provider visit	Plan pays 100%	Plan pays 100%
Other Services **Day or visit maximums are combined between in-network and out-of-network.**		
• Skilled Nursing Facility – 90-day calendar year maximum combined in and out of network	Plan pays 80% after deductible	Plan pays 60% after deductible
• Home Health Care – 120-visit calendar year maximum combined in and out of network	Plan pays 80% after deductible	Plan pays 60% after deductible
• Hospice Care	Plan pays 100% *(not subject to deductible)*	Plan pays 100% *(not subject to deductible)*
Pharmacy Covers up to a 30-day supply (retail) or 90 day supply (mail order/CVS retail); Out-of-network –must file claim form for reimbursement, which is limited to Aetna's approved cost minus copay; If a generic is available and the member requests a brand-name drug to be dispensed, the member pays their applicable co-pay plus the difference in cost between the brand and generic drug. Specialty drugs can be filled one time at retail before moving to Aetna Specialty Pharmacy		
Retail max 30 day supply		Must file claim form for reimbursement
Generic	$10 copayment	$10 copayment + cost difference
Formulary Brand	$35 copayment	$35 copayment + cost difference
Non-formulary Brand	$60 copayment	$60 copayment + cost difference
Mail Order/CVS retail pharmacy max 90 day supply		N/A
Generic	$20 copayment	
Formulary Brand	$70 copayment	
Non-formulary Brand	$120 copayment	

The information contained in this summary does not represent a guarantee of the benefits, nor does it change or modify the governing documents underlying the Plan. In the event of a conflict between the information provided and the terms of the governing plan documents, eligibility for benefits and payment of benefits, if any, will be determined in accordance with and subject to applicable governing plan documents.

Georgia Municipal Employees Benefit System: POS 80/60 - $750 Deductible Plan

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for:** Individual/ Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.gacities.com/Ihforms** or call 1-855-397-9267. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 678-651-1039 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$750.00** individual **/$2,250.00** family Out-of-Network: **$1,500.00** individual **/$4,500.00** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The deductible doesn't apply to in-network preventive services, prescription drugs, out-of-network preventive services through age 5, or hospice care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment and a coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network (individual/family): Medical: **$3,500.00/$7,000.00** Rx: **$1,600.00/$3,200.00** Out-of-Network (individual/family): Medical **$6,500.00/$13,000.00** Rx **$3,200.00/$6,400.00**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges by out-of-network providers, and	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.Anthem.com or call 1-855-397-9267 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30.00 copayment /visit; deductible does not apply	40.00% coinsurance after deductible	Co-pay and coinsurance apply to physician charges, x-ray, lab billed through office visit.
	Specialist visit	$40.00 copayment /visit; deductible does not apply	40.00% coinsurance after deductible	Co-pay and coinsurance apply to physician charges, x-ray, lab billed through office visit.
	Other practitioner office visit	Chiropractic $40.00 copayment /visit; deductible does not apply; all other services 20% coinsurance after deductible	Chiropractic 40% coinsurance after deductible	30 visits per calendar year combined in-network and out-of-network.
	Preventive care/screening/ Immunization	No charge	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required for certain outpatient services. Failure to preauthorize (out-of-network or out of state) may result in reduced or no services
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Aetna.com or call 1-800-872-3862	Generic drugs	$10.00 copayment (30 day retail) $20.00 copayment (90 day mail order/CVS retail)	$10.00 copayment 30 day retail + cost difference	Up to 30 day supply at retail, up to 90 day supply for maintenance medications through Aetna mail order or any CVS pharmacy. A reimbursement claim form must be filed for purchases from out-of-network providers, reimbursement will be the Aetna approved cost of the drug minus the copay, subject to additional limits.
	Formulary brand drugs	$35.00 copayment (30 day retail) $70.00 copayment (90 day mail order/CVS retail)	$35.00 copayment 30 day retail + cost difference	Same as above. Additionally, if a generic is available and the member requests a brand-name drug to be dispensed, the member pays their applicable co-pay plus the difference in cost between the brand and generic drug. Preauthorization is required for certain drugs.
	Non-formulary brand drugs	$60.00 copayment (30 day retail) or $120.00 copayment (90 day mail order/CVS retail)	$60.00 copayment 30 day retail + cost difference	
	Specialty drugs	Same as above for generic drugs, formulary brand drugs and non-formulary brand drugs as applicable	Same as above for generic drugs, formulary brand drugs and non-formulary brand drugs as applicable	Up to a 30-day supply (retail permitted for 1 fill, then must use Aetna Specialty Program). A reimbursement claim form must be filed for purchases from out-of-network providers, reimbursement will be the Aetna approved cost of the drug minus the copay, subject to additional limits.
If you have outpatient surgery	Facility fee	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. Failure to preauthorize (out-of-network or out of state) results in reduced or no coverage. 50% co-insurance for non-contracted freestanding ambulatory surgical facility
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$200.00 copayment /visit; deductible does not apply	$200.00 copayment /visit; deductible does not apply	Copayment is waived for Emergency room care if admitted to the hospital. Preauthorization is required within 48 hours of

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	admission (or as soon as possible). Failure to preauthorize (out-of-network) may result in reduced or no coverage. For all out-of-network care, the plan pays based on the allowed amount and you may be balance billed for the difference between the charge and what the plan pays.
	Urgent care	$60.00 copayment /visit; deductible does not apply	$60.00 copayment /visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization before admission is required for all hospital stays except maternity. Failure to preauthorize (out-of-network) results in reduced or no coverage.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Mental/ Behavioral health/ Substance use disorder Outpatient services	$30.00 copayment office based services; deductible does not apply; other services 20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required except for office visits. Failure to preauthorize (out-of-network or out of state) results in reduced or no coverage.
	Mental/ Behavioral Health/ Substance use disorder Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. Failure to preauthorize (out-of-network) results in reduced or no coverage.
If you are pregnant	Office visits – Prenatal and Postnatal care	No charge	40% coinsurance after deductible	None
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required for extended stay or if mother and baby leave separately. Failure to preauthorize (out-of-network) when required may result in reduced or no coverage.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	120-visit calendar year maximum.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	No coverage for physical or occupational therapy due to developmental delay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	No coverage for physical or occupational therapy due to developmental delay.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	90 day calendar year maximum
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required based on clinical policy guidelines. Failure to preauthorize results in reduced or no coverage.
	Hospice services	**$0.00**	**$0.00**	Certification by physician is required. Not subject to deductible.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for Eye exam
	Children's glasses	Not covered	Not covered	No coverage for Glasses
	Children's dental check-up	Not covered	Not covered	No coverage for Dental check-up

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- For available coverage services when traveling outside the U.S., please call 1-855-397-9267
- Free LiveHealth Online medical and mental/behavioral health office visits

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Anthem (medical) 1-855-397-9267 or Aetna (pharmacy) 1-888-792-3862.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-397-9267

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-397-9267

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-397-9267

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-397-9267

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750.00
Specialist copayments	$40.00
Hospital (facility) coinsurance	20%
Other coinsurance	20.00%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700.00**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750.00
Copayments	$10.00
Coinsurance	$1,800.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$2,620.00**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750.00
Specialist copayments	$40.00
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600.00**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750.00
Copayments	$900.00
Coinsurance	$30.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$1,700.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750.00
Specialist copayments	$40.00
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800.00**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750.00
Copayments	$300.00
Coinsurance	$200.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,250.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.