Georgia Municipal Employees Benefit System
Open Access POS 90/70 - $1,000 Deductible Plan
Schedule of Benefits Effective January 1, 2022

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	 $1,000 $3,000	 $2,000 $6,000
Coinsurance	Plan pays 90% after deductible	Plan pays 70% after deductible
Lifetime Maximum	unlimited	unlimited
Out-of-Pocket Calendar Year Maximum* Medical Rx	 $3,000 individual / $6000 family $1,600 individual / $3200 family	 $5,000 individual / $10,000 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 70% after deductible *(deductible waived through age 5)*
• Annual Wellness Examination	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 70% after deductible
• Annual gynecology examination/mammography	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 70% after deductible
• Prostate screening	$0 Physician copayment or $0 Specialist Physician copayment	Plan pays 70% after deductible
Illness or Injury		
• Physician office visit (includes lab, radiology, and office surgery)	$35 copayment	Plan pays 70% after deductible
• LiveHealth Online healthcare provider visit	Plan pays 100%	Plan pays 100%
• Specialty care physician office visit	$45 copayment	Plan pays 70% after deductible
• Second surgical opinion	$45 copayment	Plan pays 70% after deductible
• Allergy care (office visit, testing, serum, and allergy shots)	$35 Physician copayment or $45 Specialist Physician copayment	Plan pays 70% after deductible
• Maternity (prenatal, postnatal)	$0 copayment	Plan pays 70% after deductible
Emergency/Urgent Care Services - Preauthorization is required within 48 hours of ER admission (or ASAP). Failure to preauthorize (out-of-network) 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 90% after deductible	Plan pays 90% 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 90% after deductible	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 90% after deductible	Plan pays 70% after deductible

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services		
• Surgery facility/hospital charges	Plan pays 90% after deductible	Plan pays 70% after deductible
• Diagnostic x-ray and lab services	Plan pays 90% after deductible	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 90% after deductible	Plan pays 70% after deductible
Therapy Services **Day or visit maximums are combined between in-network and out-of-network.**		
• Speech Therapy	Plan pays 90% after deductible	Plan pays 70% after deductible
• Physical, Occupational Therapy	Plan pays 90% after deductible	Plan pays 70% after deductible
▪ Chiropractic – 30-day visit maximum per calendar year combined in and out of network	$45 co-pay office visit Plan pays 90% for all other services after deductible	Plan pays 70% after deductible
• Respiratory Therapy	Plan pays 90% after deductible	Plan pays 70% after deductible
• Radiation Therapy, Chemotherapy	Plan pays 90% after deductible	Plan pays 70% after deductible
Mental Health/Substance Abuse Services **Services may be accessed by calling 1-800-292-2879.**		
• Inpatient (facility and physician fee)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Inpatient Substance Abuse Detoxification (facility and physician fee)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Partial Hospitalization Program (facility and physician fee)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Intensive Outpatient Program (facility and physician fee)	Plan pays 90% after deductible	Plan pays 70% after deductible
• Professional Outpatient Services	$35 copayment	Plan pays 70% 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 90% after deductible	Plan pays 70% after deductible
• Home Health Care – 120-visit calendar year maximum combined in and out of network	Plan pays 90% after deductible	Plan pays 70% 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.