Georgia Municipal Employees Benefit System
Open Access HMO 80% Plan
Schedule of Benefits — Effective January 1, 2018

All benefits are subject to the calendar year deductible, except those with in-network copayments listed below, 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, if applicable.

Some services may require pre-certification before services are covered by the Plan. Please see the Benefits Booklet under Getting Approval for Benefits for additional information. Primary Care Physician (PCP) selection is encouraged, but not required. No referrals are required.

Deductibles, Coinsurance and Maximums	In-Network Benefit Level No Coverage for Out-of-Network
Calendar Year Deductible* Individual Family	 $150 $450
Coinsurance	Plan pays 80%, Member pays 20% Coinsurance
Lifetime Maximum	Unlimited
Out-of-Pocket Calendar Year Maximums* Medical Rx	 $2,150 individual/$4,300 family $4,450 individual/$8,900 family

**All family members covered under the Plan contribute toward the Family deductible and Family 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 deductibles or the Out-of-Pocket maximums: Premiums, charges by Out-of-Network providers, any amount above the Maximum Allowed Amount (see Benefits Booklet for definition), and charges for health care this Plan doesn't cover.

Covered Services	In-Network Benefit Level (No Coverage Out-of-Network)
Office Visits: Preventive Care	
• Well-child care, immunizations	$0 PCP copayment or $0 Specialist copayment
• Annual Wellness Exam	$0 PCP copayment or $0 Specialist copayment
• Annual gynecology examination/mammography	$0 PCP copayment or $0 Specialist copayment
• Prostate screening	$0 PCP copayment or $0 Specialist copayment
Illness or Injury	
• Primary Care Physician (PCP) office visit (includes lab, radiology and office surgery)	$25 copayment
• Specialist Physician office visit	$35 copayment
• Second surgical opinion (PCP referral required)	$35 copayment
• Maternity (prenatal, postnatal)	$0 copayment
• Allergy care (office visit, testing, serum and allergy shots)	$25 PCP copayment or $35 Specialist copayment
Emergency/Urgent Care Services (See Benefits Booklet for information about coverage of Out-of-Network emergency care)	
• Life-threatening illness, serious accidental injury	$150 copayment *(waived if admitted) (Same for Out-of-Network. See Benefits Booklet for details)*
• Non-emergency use of the emergency room	Not covered
• Urgent Care Center	$60 copayment
• Ambulance (when medically necessary)	Plan pays 80% *(Same for Out-of-Network. See Benefits Booklet for details)*
Inpatient Services	
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Plan pays 80%
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80%

Open Access HMO 80% continued
Effective January 1, 2018

Covered Services	In-Network Benefit Level (No Coverage Out-of-Network)
Outpatient Services	
• Surgery facility/hospital charges	Plan pays 80%
• Diagnostic x-ray and lab services	Plan pays 80%
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80%
Therapy Services	
• Speech Therapy	Plan pays 80%; 20-visit calendar year maximum
• Physical, Occupational Therapy	Plan pays 80%; 20-visit calendar year maximum
• Chiropractic	$35 co-pay office visit; Plan pays 80% for other services after deductible; 30 visit per calendar year maximum.
• Respiratory Therapy	Plan pays 80% 40-visit calendar year maximum
• Radiation Therapy, Chemotherapy	Plan pays 100%
Mental Health/Substance Abuse Services **Services may be accessed by calling 1-800-292-2879.**	
• Inpatient (facility fee) • Inpatient (physician fee)	Plan pays 80% Plan pays 80%
• Inpatient Substance Abuse Detoxification (facility fee) • Inpatient Substance Abuse Detoxification (physician fee)	Plan pays 80% Plan pays 80%
• Partial Hospitalization Program (facility and physician fee)	Plan pays 80%
• Intensive Outpatient Program (facility and physician fee)	Plan pays 80%
• Professional Outpatient Services	$25 copayment
Other Services	
• Skilled Nursing Facility	Plan pays 80%; 90-day calendar year maximum
• Home Health Care	Plan pays 80%; 120-visit calendar year maximum
• Hospice Care	Plan pays 100%; not subject to deductible
Pharmacy Covers up to a 30-day retail supply or up to a 90 day mail order supply; Claim form must be filed for out-of-network; 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	
Generic	$10 copayment
Formulary Brand	$35 copayment
Non-formulary Brand	$60 copayment
Mail order max 90 day supply	
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.