Georgia Municipal Employees Benefit System

Open Access POS 80/60 - $1,500 Deductible Plan

Schedule of Benefits — Effective January 1, 2017

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 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) or the negotiated drug cost 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	$1,500	$3,000
Family	$4,500	$9,000
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible
Lifetime Maximum	unlimited	unlimited
Out-of-Pocket Calendar Year Maximum*		
Medical	$4,500 individual / $9,000 family	$9,000 individual / $18,000 family
Rx	$1,600 individual / $3,200 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)	$40 copayment	Plan pays 60% after deductible
• Specialty care physician office visit	$50 copayment	Plan pays 60% after deductible
• Second surgical opinion	$50 copayment	Plan pays 60% after deductible
• Allergy care (office visit, testing, serum, and allergy shots)	$40 Physician copayment or $50 Specialist Physician copayment	Plan pays 60% after deductible
• Maternity (prenatal, postnatal)	$0 copayment	Plan pays 60% after deductible
Emergency/Urgent Care Services		
• Life-threatening illness or serious accidental injury	$150 copayment *(waived if admitted)*	$150 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% after deductible
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	$50 co-pay office visit Plan pays 80% for all other services after deductible; 30-visit per calendar year limit	Plan pays 60% after deductible; 30-visit calendar year limit
• 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	$40 copayment	Plan pays 60% after deductible
Other Services **Day or visit maximums are combined between in-network and out-of-network.**		
• Skilled Nursing Facility	Plan pays 80% after deductible; 90-day calendar year maximum	Plan pays 60% after deductible; 90-day calendar year maximum
• Home Health Care	Plan pays 80% after deductible; 120-visit calendar year maximum	Plan pays 60% after deductible; 120-visit calendar year maximum
• Hospice Care	Plan pays 100% *(not subject to deductible)*	Plan pays 100% *(not subject to deductible)*
Pharmacy		
Retail max 30 day supply		Claim must be filed for out of network
Generic	$10 copayment	$10 copayment
Formulary Brand	$35 copayment	$35 copayment
Non-formulary Brand	$60 copayment	$60 copayment
Mail order max 90 day supply		Claim must be filed for out of network
Generic	$20 copayment	$20 copayment
Formulary Brand	$70 copayment	$70 copayment
Non-formulary Brand	$120 copayment	$ 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.