Georgia Municipal Employees Benefit System: POS 90/70 - $1,000 Deductible Plan

Coverage Period: 01/01/2025 – 12/31/2025

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: **$1,000.00** individual **/$3,000.00** family Out-of-Network: **$2,000.00** individual **/$6,000.00** 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: **$3,000.00/$6,000.00** Rx:**$1,600.00/$3,200.00** Out-of-Network (individual/family): Medical **$5,500.00/$11,000.00** 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	$35.00 copayment /visit; deductible does not apply	30.00% coinsurance after deductible	Co-pay and coinsurance apply to physician charges, x-ray, lab billed through office visit.
	Specialist visit	$45.00 copayment /visit; deductible does not apply	30.00% coinsurance after deductible	Co-pay and coinsurance apply to physician charges, x-ray, lab billed through office visit.
	Other practitioner office visit	Chiropractic $45.00 copayment /visit; deductible does not apply; all other services 10% coinsurance after deductible	Chiropractic 30% coinsurance after deductible	30 visits per calendar year combined in-network and out-of-network.
	Preventive care/screening/ Immunization	No charge	30% 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)	10% coinsurance after deductible	30% 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)	10% coinsurance after deductible	30% 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	10% coinsurance after deductible	30% 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	10% coinsurance after deductible	30% 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)	
If you need immediate medical attention (continued)	Emergency medical transportation	10% coinsurance after deductible	10% 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)	10% coinsurance after deductible	30% 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	10% coinsurance after deductible	30% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Mental/ Behavioral health/ Substance use disorder Outpatient services	$35.00 copayment office based services; deductible does not apply; other services 10% coinsurance after deductible	30% 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	10% coinsurance after deductible	30% 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	30% coinsurance after deductible	None
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	None
	Childbirth/delivery facility services	10% coinsurance after deductible	30% 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	10% coinsurance after deductible	30% coinsurance after deductible	120-visit calendar year maximum.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	No coverage for physical or occupational therapy due to developmental delay.
	Habilitation services	10% coinsurance after deductible	30% 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)	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	90 day calendar year maximum
	Durable medical equipment	10% coinsurance after deductible	30% 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	$1,000.00
Specialist copayments	$45.00
Hospital (facility) coinsurance	10%
Other coinsurance	10.00%

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	$1,000.00
Copayments	$10.00
Coinsurance	$900.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$1,970.00**

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

The plan's overall deductible	$1,000.00
Specialist copayments	$45.00
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$900.00
Copayments	$1,000.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$1,920.00**

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

The plan's overall deductible	$1,000.00
Specialist copayments	$45.00
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,000.00
Copayments	$300.00
Coinsurance	$70.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,370.00**

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