Georgia Municipal Employees Benefit System: Open Access HMO 90% Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual / Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.gmanet.com/lhforms or by calling 678-651-1039.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Shown below for (individual/family): Medical **$1,000/$2,000** Rx **$4,450/$8,900**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, charges by out-of-network providers, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.BCBSGA.com or call 1-855-397-9267 for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes. This plan does not cover services determined not to be medically necessary.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	Not covered	Co-pay applies to physician charges, x-ray, lab billed through office visit.
	Specialist visit	$30 co-pay/visit	Not covered	Co-pay applies to physician charges, x-ray, lab billed through office visit.
	Other practitioner office visit	Chiropractic $30 co-pay/visit; 10% coinsurance for all other services	Not covered	30 visits per calendar year in-network
	Preventive care/screening/immunization	No charge	Not covered	Must be properly coded as preventive care
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay per prescription retail $20 co-pay per prescription mail order	Not covered	Covers up to a 30-day retail supply; Covers up to 90-day mail order supply; Claim form must be filed for out-of-network

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition (continued) More information about **prescription drug coverage** is available at www.Aetna.com or call 1-888-792-3862	Formulary brand drugs	$35 co-pay per 30-day prescription retail or $70 co-pay per prescription mail order	Not covered	Covers up to a 30-day retail supply; Covers up to 90-day mail order supply; Claim form must be filed for out-of-network
	Non-formulary brand drugs	$60 co-pay per 30-day prescription retail or $120 co-pay per prescription mail order	Not covered	Covers up to a 30-day retail supply; Covers up to 90-day mail order supply; Claim form must be filed for out-of-network
	Specialty drugs	Same as above for generic drugs, formulary brand drugs and non-formulary brand drugs as applicable	Not covered	Covers up to a 30-day Aetna Specialty Pharmacy mail-order; Claim form must be filed for out-of-network
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Pre-Authorization may be required for certain outpatient procedures.
	Physician/surgeon fees	10% coinsurance	Not covered	Pre-Authorization may be required for certain outpatient procedures.
If you need immediate medical attention	Emergency room services	$150 co-pay/visit	Covered as in-network	Co-pay is waived if admitted
	Emergency medical transportation	10% coinsurance	Covered as in-network	None
	Urgent care	$60 co-pay/visit	Covered as in-network	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Pre-Admission Certification required for all inpatient admissions except maternity.
	Physician/surgeon fee	10% coinsurance	Not covered	Pre-Admission Certification required for all inpatient admissions except maternity.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay office based services; other services 10% coinsurance after deductible	Not covered	Educational services are not covered, see Exclusions in Plan documents.
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	Pre-Admission Certification required for all inpatient
	Substance use disorder outpatient services	$20 co-pay office based services; other services 10% coinsurance after deductible	Not covered	None
	Substance use disorder inpatient services	10% coinsurance	Not covered	Pre-Admission Certification required for all inpatient
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	10% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	120-day visit limit calendar year maximum

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Rehabilitation services	10% coinsurance	Not covered	No coverage for therapy due to developmental delay. 20 visit c/y max for speech, physical, occupational. 40 visit c/y max for respiratory.
	Habilitation services	10% coinsurance	Not covered	Same as above.
	Skilled nursing care	10% coinsurance	Not covered	90-day calendar year maximum.
	Durable medical equipment	10% coinsurance	Not covered	Pre-certification may be required as noted on clinical policy guidelines.
	Hospice service	No charge	Not covered	Certification by physician is required. Not subject to deductible.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for Eye exam
	Glasses	Not covered	Not covered	No coverage for Glasses
	Dental check-up	Not covered	Not covered	No coverage for Dental check-up

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**
• Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, see the plan documents at www.gmanet.com/lhforms or contact the plan at 678-651-1039.

For more information on your rights to continue coverage, contact the plan at 678-651-1039. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-397-9267 (medical) or 1-888-792-3862 (pharmacy)

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-397-9267 (medical) or 1-888-792-3862 (pharmacy)

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health plan does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,730
- **Patient pays:** $ 810

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$640
Limits or exclusions	$150
Total	**$810**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,300
- **Patient pays:** $1,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,010
Coinsurance	$10
Limits or exclusions	$80
Total	**$1,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.