CITY OF CLARKSTON
where possibilities grow

3921 CHURCH STREET ♦ CLARKSTON, GEORGIA 30021
(404) 296-6489 ♦WWW.CLARKSTONGA.GOV

Mayor Beverly H. Burks
Councilmembers:
Jamie Carroll *Laura Hopkins*
Awet Eyasu *Ytterenickia Bell*
Debra Johnson *Susan Hood*

Tammi Saddler Jones, Interim City Manager

SPECIAL CALLED CITY COUNCIL MEETING AGENDA

Thursday, September 14, 2023 - 7:00PM IN-PERSON & VIRTUAL

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **NEW BUSINESS**
   A. To consider and adopt a resolution changing the Georgia Municipal Employees Benefits Services (GMEBS) Health Insurance Plan for the City of Clarkston 2024 Benefits.

4. **ADJOURNMENT**

PUBLIC PARTICIPATION BY VIDEO CONFERENCE

The City of Clarkston, Georgia will conduct the Special City Council Meeting at 7:00 p.m. on Thursday, September 14, 2023. The public may participate in the meeting by using the following information below:

https://us02web.zoom.us/j/83480600886?pwd=K25aUUFPL1pybFVkQW9STlVDVStDUT09

Dial by your location
+1 301 715 8592 US (Washington DC)
+1 312 626 6799 US (Chicago)
+1 646 558 8656 US (New York)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 9128 US (San Jose)
Meeting ID: 834 8060 0886
Find your local number: https://us02web.zoom.us/u/kBEtJ3TsL

CITY OF CLARKSTON

CLARKSTON CITY COUNCIL WORK SESSION

BUSINESS AGENDA / MINUTES

MEETING DATE: SEPTEMBER 14, 2023

ITEM NO: 3A

HEARING TYPE:
Special Called Meeting

ACTION TYPE:
Vote

SUBJECT: To consider and adopt Resolution to Change GMEBS Health Insurance Plan for City of Clarkston 2024 Benefits

DEPARTMENT: Administration

PUBLIC HEARING: ☐YES ☒ NO

ATTACHMENT: ☒ YES ☐ NO
Pages:

INFORMATION CONTACT:
Tammi Saddler Jones, Interim City Manager

PHONE NUMBER: 404-296-6489

PURPOSE: To consider and adopt changing Health Benefit plans available for City of Clarkston employees through GMEBS (Georgia Municipal Employees Benefits Services) for the plan year 2024.

NEED/ IMPACT: The City of Clarkston has not previously made changes to our Health Benefits plan option for several years now. Health Insurance benefits costs have continued to escalate over the past several years. Our percentage increase for 2024 is 3%. In comparison to previous years, in 2021 rates increased by 13%, 2022 rates increased by 5%, and 2023 rates increased by 20%.

Currently the city offers three plan options:

HMO 90
Current Premium Rates
Employee $ 848.00
Employee & Family $ 1,999.00

***NEW* 2024 Premium Rates**
Employee $ 873.00
Employee & Family $ 2,059.00

New Rates increase by 3%

PPO 90/70 500
Current Premium Rates
Employee $ 840.00
Employee & Family $ 1,975.00

NEW 2024 Premium Rates
Employee $ 865.00
Employee & Family $ 2,034.00

New Rates increase by 3%

PPO 80/60 500
Current Premium Rates
Employee $ 799.00
Employee & Family $ 1,877.00

NEW 2024 Premium Rates
Employee $ 823.00
Employee & Family $ 1,933.00

New Rates increase by 3%

Proposed HMO 80%
2024 Premium Rates
Employee $806.00
Employee & Family $1901.00

The City of Clarkston currently pays 100% of the health insurance premium for employees only and 50% the cost family coverage amount above the employee only rate.

The City of Clarkston currently offers employees a substandard dental program that is basically a discount on services provided and the city does not offer any type of Vision plan. We would like to consider changing our HMO 90% Open Access Plan to the HMO 80% Open Access Plan to reduce our overall premiums and add the GMEBS PPO Delta Dental Plan and the Anthem Blue View Vision Plan for 2024. We propose that the City of Clarkston continue to pay 100% for employee coverage and 50% of the cost of family coverage.

Keeping Current HMO 90% Plan – No Other Changes
Our cost analysis between the two plans shows that we keep the HMO 90% Plan for 2024, the overall cost increase for health insurance premiums will be $14,034.

Keeping Current HMO 90% Plan and Adding Delta Dental and Vision Plan
Our cost analysis between the two plans shows that we keep the HMO 90% Plan for 2024, the overall cost increase for health insurance premiums will be $14,034. The cost increase of adding the Delta Dental Plan would be $13,500 and the cost increase of adding the Anthem Blue View Vision Plan would be $4,379.40. The total benefits cost increase would be $31,913.40.

Change to HMO 80% Plan and Adding Delta Dental and Vision Plan
Our cost analysis between the two plans shows that we change to the HMO 80% Plan for 2024, the overall savings for health insurance premiums will be $22,230. The cost increase of adding the Delta Dental Plan would be $13,500 and the cost increase of adding the Anthem Blue View Vision Plan would be $4,379.40. We can implement the new dental and vision plans and still have an approximate savings of $4,350.

The change from the HMO 90% Plan to the HMO 80% Plan difference to our employees will be as follows:

The individual annual deductible for employees will increase from $250 to $500.
The family annual deductible for employees will increase from $750 to $1,500.
The copay for office visits for primary care and Specialist office visits will increase by $5 per visit.

RECOMMENDATIONS:
Staff recommendation is to change from the HMO 90% Plan to HMO 80% Plan and adding Delta Dental and Vision plans. The staff also recommends continuing to offer the PPO 90/70 500 Plan and the PPO 80/60 500 Plan for 2024 since a few employees are enrolled in those plans.

RESOLUTION NO. _____

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF CLARKSTON, GEORGIA ADOPTING CHANGES TO THE GEORGIA MUNICIPAL EMPLOYEES BENEFITS SERVICES HEALTH INSURANCE PLAN FOR THE CITY OF CLARKSTON 2024 BENEFITS PLAN YEAR.

* * * * *

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF CLARKSTON, GEORGIA:

Section 1. That the City Council hereby adopts changes to the Georgia Municipal Employees Benefits Services (GMEBS) Health Insurance Plan for 2024 Benefits Plan Year. A copy of said Declaration Page is attached to this resolution as "Exhibit A" and is incorporated herein for all purposes.

PASSED, APPROVED and RESOLVED this _____ day of _____ 2023.

_____
Beverly H. Burks, Mayor

ATTEST:

_____
Tomika R. Mitchell, City Clerk

EXHIBIT A

City of Clarkston
GMA-GMEBS Life & Health Insurance Fund
Health Insurance Rate Information Project for FY2024

Keeping Current HMO 90% and Making No Other Changes

2023 Current Rates
2023 Health Insurance Rates - City Pays 100% Employee, plus 50% per month for family

	EE Only Monthly	City Pays Monthly	Employee Portion Monthly	Employee Bi-Weekly Deduction 26 pp	Annual Premium Cost To Employee for Family Coverage
HMO (90%)-Open Access	848.00	848.00	-	-	-
PPO 90/70 500	840.00	840.00	-	-	$ -
PPO (80/60)- 500	799.00	799.00	-	-	$ -
	EE & Family				
HMO (90%)-Open Access	1,999.00	1,423.50	575.50	265.62	$ 6,906.00
PPO 90/70 500	1,975.00	1,407.50	567.50	261.92	$ 6,810.00
PPO (80/60)- 500	1,877.00	1,338.00	539.00	248.77	$ 6,468.00

Estimated Assuming Full Employment All Year for 45 TOTAL Positions
Cost Allocation Between City of Clarkston and Employee Portion

Employee Count	**Total Monthly Cost**	**Total Annual Cost**	**Annual City Paid Portion**	**Annual Employee Paid Portion**	**Average Annual Cost to City Per Employee for this Option**
38.00	32,224.00	386,688.00	386,688.00	-	10,176.00
2.00	1,680.00	20,160.00	20,160.00	-	10,080.00
1.00	799.00	9,588.00	9,588.00		9,588.00
3.00	5,997.00	71,964.00	51,246.00	20,718.00	17,082.00
1.00	1,975.00	23,700.00	16,890.00	6,810.00	16,890.00
-	-	-	-	-	-
45.00	42,675.00	512,100.00	484,572.00	27,528.00	

proof 512,100.00

2024 Rates Increased by 3%
2024 Health Insurance Rates - City Pays 100% Employee, plus 50% per month for family coverage

	EE Only Monthly	City Pays Monthly	Employee Portion Monthly	Employee Bi-Weekly Deduction 24 pp	Annual Premium Cost To Employee for Family Coverage
HMO (80%) Open Access	873.00	873.00	-		
PPO 90/70 500	865.00	865.00	-	-	
PPO (80/60)- 500	799.00	799.00	-	-	
				-	
	EE & Family				
HMO (80%)-Open Access	2,059.00	1,466.00	593.00	296.50	$ 7,116.00
PPO 90/70 500	2,034.00	1,449.50	584.50	292.25	$ 7,014.00
PPO (80/60)- 500	1,933.00	1,366.00	567.00	283.50	$ 6,804.00

Cost Allocation Between City of Clarkston and Employee Portion for Budget

Employee Count	**Total Monthly Cost**	**Total Annual Cost**	**Annual City Paid Portion**	**Annual Employee Paid Portion**	**Average Annual Cost to City Per Employee for this Option**
38.00	33,174.00	398,088.00	398,088.00	-	10,476.00
2.00	1,730.00	20,760.00	20,760.00	-	10,380.00
1.00	799.00	9,588.00	9,588.00		9,588.00
3.00	6,177.00	74,124.00	52,776.00	21,348.00	17,592.00
1.00	2,034.00	24,408.00	17,394.00	7,014.00	17,394.00
-	-	-	-	-	-
45.00	43,914.00	526,968.00	498,606.00	28,362.00	
			proof	526,968.00	
Net Decrease from 2023 Rates		14,868.00	14,034.00	834.00	
		2.90%	2.90%	3.03%	

The City plans to coordinate with GMEBS to consider upgrading Employee Life Insurance coverage limits for Implementation in JULY 2024

City of Clarkston
GMA-GMEBS Life & Health Insurance Fund
Health Insurance Rate Information Project for FY2024

Keeping Current HMO 90% and Adding Dental and Vision

2023 Current Rates
2023 Health Insurance Rates - City Pays 100% Employee, plus 50% per month for family

	EE Only Monthly	City Pays Monthly	Employee Portion Monthly	Employee Bi-Weekly Deduction 26 pp	Annual Premium Cost To Employee for Family Coverage
HMO (90%)-Open Access	848.00	848.00	-	-	-
PPO 90/70 500	840.00	840.00	-	-	$ -
PPO (80/60)- 500	799.00	799.00	-	-	$ -
	EE & Family				
HMO (90%)-Open Access	1,999.00	1,423.50	575.50	265.62	$ 6,906.00
PPO 90/70 500	1,975.00	1,407.50	567.50	261.92	$ 6,810.00
PPO (80/60)- 500	1,877.00	1,338.00	539.00	248.77	$ 6,468.00

Estimated Assuming Full Employment All Year for 45 TOTAL Positions
Cost Allocation Between City of Clarkston and Employee Portion

	Employee Count	**Total Monthly Cost**	**Total Annual Cost**	**Annual City Paid Portion**	**Annual Employee Paid Portion**	**Average Annual Cost to City Per Employee for this Option**
HMO (90%)-Open Access	38.00	32,224.00	386,688.00	386,688.00	-	10,176.00
PPO 90/70 500	2.00	1,680.00	20,160.00	20,160.00	-	10,080.00
PPO (80/60)- 500	1.00	799.00	9,588.00	9,588.00		9,588.00
HMO (90%)-Open Access	3.00	5,997.00	71,964.00	51,246.00	20,718.00	17,082.00
PPO 90/70 500	1.00	1,975.00	23,700.00	16,890.00	6,810.00	16,890.00
	-	-	-	-	-	-
	45.00	42,675.00	512,100.00	484,572.00	27,528.00	
				proof	512,100.00	

2024 Rates Increased by 3%
2024 Health Insurance Rates - City Pays 100% Employee, plus 50% per month for family coverage

	EE Only Monthly	City Pays Monthly	Employee Portion Monthly	Employee Bi-Weekly Deduction 24 pp	Annual Premium Cost To Employee for Family Coverage
HMO (80%) Open Access	873.00	873.00	-		
PPO 90/70 500	865.00	865.00	-	-	
PPO (80/60)- 500	799.00	799.00	-	-	
				-	
	EE & Family				
HMO (80%)-Open Access	2,059.00	1,466.00	593.00	296.50	$ 7,116.00
PPO 90/70 500	2,034.00	1,449.50	584.50	292.25	$ 7,014.00
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Cost Allocation Between City of Clarkston and Employee Portion for Budget

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HMO (80%) Open Access	38.00	33,174.00	398,088.00	398,088.00	-	10,476.00
PPO 90/70 500	2.00	1,730.00	20,760.00	20,760.00	-	10,380.00
PPO (80/60)- 500	1.00	799.00	9,588.00	9,588.00		9,588.00
HMO (80%)-Open Access	3.00	6,177.00	74,124.00	52,776.00	21,348.00	17,592.00
PPO 90/70 500	1.00	2,034.00	24,408.00	17,394.00	7,014.00	17,394.00
	-	-	-	-	-	-
	45.00	43,914.00	526,968.00	498,606.00	28,362.00	
				proof	526,968.00	
Net Decrease from 2023 Rates			14,868.00	14,034.00	834.00	
			2.90%	2.90%	3.03%	

Additional Benefit Improvments for 2024

Add PPO Delta Dental Plan	$25	Compared to $13 in 2023 for a poor plan	45	$1,125	13,500.00	13,500.00
Add Anthem Blue View Vision Plan	8.11	No Vision Plan offered in 2023	45	$365	4,379.40	4,379.40
			Net Decrease from 2023 with new plans			31,913.40

The City plans to coordinate with GMEBS to consider upgrading Employee Life Insurance coverage limits for Implementation in JULY 2024

City of Clarkston
GMA-GMEBS Life & Health Insurance Fund
Health Insurance Rate Information Project for FY2024

Change to HMO 80% and Add Dental and Vision

2023 Current Rates
2023 Health Insurance Rates - City Pays 100% Employee, plus 50% per month for family

	EE Only Monthly	City Pays Monthly	Employee Portion Monthly	Employee Bi-Weekly Deduction 26 pp	Annual Premium Cost To Employee for Family Coverage
HMO (90%)-Open Access	848.00	848.00	-	-	-
PPO 90/70 500	840.00	840.00	-	-	$ -
PPO (80/60)- 500	799.00	799.00	-	-	$ -
	EE & Family				
HMO (90%)-Open Access	1,999.00	1,423.50	575.50	265.62	$ 6,906.00
PPO 90/70 500	1,975.00	1,407.50	567.50	261.92	$ 6,810.00
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HMO (90%)-Open Access	38.00	32,224.00	386,688.00	386,688.00	-	10,176.00
PPO 90/70 500	2.00	1,680.00	20,160.00	20,160.00	-	10,080.00
PPO (80/60)- 500	1.00	799.00	9,588.00	9,588.00		9,588.00
HMO (90%)-Open Access	3.00	5,997.00	71,964.00	51,246.00	20,718.00	17,082.00
PPO 90/70 500	1.00	1,975.00	23,700.00	16,890.00	6,810.00	16,890.00
	-	-	-	-	-	-
	45.00	42,675.00	512,100.00	484,572.00	27,528.00	
				proof	512,100.00	

2024 Rates Increased by 3%
2024 Health Insurance Rates - City Pays 100% Employee, plus 50% per month for family coverage

	EE Only Monthly	City Pays Monthly	Employee Portion Monthly	Employee Bi-Weekly Deduction 24 pp	Annual Premium Cost To Employee for Family Coverage
HMO (80%) Open Access	806.00	806.00	-		
PPO 90/70 500	829.00	829.00	-	-	
PPO (80/60)- 500	790.00	790.00	-	-	
				-	
	EE & Family				
HMO (80%)-Open Access	1,901.00	1,353.50	547.50	273.75	$ 6,570.00
PPO 90/70 500	1,955.00	1,392.00	563.00	281.50	$ 6,756.00
PPO (80/60)- 500	1,863.00	1,326.50	536.50	268.25	$ 6,438.00

Cost Allocation Between City of Clarkston and Employee Portion for Budget

	Employee Count	**Total Monthly Cost**	**Total Annual Cost**	**Annual City Paid Portion**	**Annual Employee Paid Portion**	**Average Annual Cost to City Per Employee for this Option**
HMO (80%) Open Access	38.00	30,628.00	367,536.00	367,536.00	-	9,672.00
PPO 90/70 500	2.00	1,658.00	19,896.00	19,896.00	-	9,948.00
PPO (80/60)- 500	1.00	790.00	9,480.00	9,480.00		9,480.00
HMO (80%)-Open Access	3.00	5,703.00	68,436.00	48,726.00	19,710.00	16,242.00
PPO 90/70 500	1.00	1,955.00	23,460.00	16,704.00	6,756.00	16,704.00
	-	-	-	-	-	-
	45.00	40,734.00	488,808.00	462,342.00	26,466.00	
				proof	488,808.00	
Net Decrease from 2023 Rates			(23,292.00)	(22,230.00)	(1,062.00)	
			-4.55%	-4.59%	-3.86%	

Additional Benefit Improvments for 2024

Add PPO Delta Dental Plan	$25	Compared to $13 in 2023 for a poor plan	45	$1,125	13,500.00	13,500.00
Add Anthem Blue View Vision Plan	8.11	No Vision Plan offered in 2023	45	$365	4,379.40	4,379.40
Net Decrease from 2023 with new plans						(4,350.60)

The City plans to coordinate with GMEBS to consider upgrading Employee Life Insurance coverage limits for Implementation in JULY 2024

FOR GMEBS USE ONLY

DECLARATION EFFECTIVE DATE

01/01/2024

GMEBS LIFE & HEALTH PROGRAM
EMPLOYER DECLARATION & APPLICATION
EMPLOYEE HEALTH, DENTAL & VISION BENEFITS
CLARKSTON

NOTE TO EMPLOYER: THIS FORM DESIGNATES GMEBS HEALTH AND DENTAL BENEFITS THAT YOU REQUEST BE MADE AVAILABLE, THE POSITIONS THAT ARE ELIGIBLE FOR SUCH BENEFITS, AND THE EXTENT THE BENEFITS ARE AVAILABLE TO DEPENDENTS. TO BECOME EFFECTIVE, THIS DECLARATION MUST BE APPROVED BY YOUR GOVERNING AUTHORITY, AND BY THE GMEBS LIFE & HEALTH PROGRAM ADMINISTRATOR. UPON SUCH APPROVAL, THIS DECLARATION WILL REPLACE AND SUPERSEDE ANY PRIOR EMPLOYER DECLARATION ON FILE WITH THE GMEBS LIFE & HEALTH PROGRAM ADMINISTRATOR. IF YOU WISH TO OFFER HEALTH / DENTAL COVERAGE FOR RETIREES, YOU MUST APPROVE A SEPARATE RETIREE DECLARATION.

ELECTIONS MADE IN THIS DOCUMENT MAY OR MAY NOT RESULT IN PENALTIES IF YOU ARE AN APPLICABLE LARGE EMPLOYER ("ALE ") UNDER THE AFFORDABLE CARE ACT ("ACA"). IT IS YOUR RESPONSIBILITY TO CONSULT WITH YOUR ATTORNEY ABOUT WHETHER YOU ARE AN APPLICABLE LARGE EMPLOYER AND THE CONSEQUENCES OF YOUR ELECTIONS. REGARDLESS OF YOUR SIZE, BY EXECUTING THIS DECLARATION, YOU CERTIFY THAT YOU WILL NOT IMPOSE ELIGIBILITY CONDITIONS THAT ARE NOT SET FORTH IN THIS DOCUMENT, OR IMPOSE A LONGER WAITING PERIOD THAN IS SET FORTH IN THIS DOCUMENT. EFFECTIVE JANUARY 1, 2015, IF YOU ARE AN APPLICABLE LARGE EMPLOYER, YOU MAY INCUR ACA PENALTIES IF: 1) YOU DO NOT IDENTIFY ALL "FULL TIME EMPLOYEES" AS DEFINED BY THE ACA AND OFFER THEM HEALTH COVERAGE; 2) YOU DO NOT OFFER HEALTH COVERAGE TO DEPENDENT CHILDREN; OR 3) YOU DO NOT SUBSIDIZE HEALTH COVERAGE ENOUGH TO MAKE THE COST OF EMPLOYEE-ONLY HEALTH COVERAGE AFFORDABLE (AS DEFINED BY THE ACA).

SECTION 1. ELIGIBLE POSITIONS; TYPE OF BENEFITS REQUESTED

1A. Regular Employees– The Employer requests the following benefits for all Regular Employees (as defined below).

Regular Employees: A Regular Employee who resides in the United States, and is employed in a salaried or hourly rated position that requires 30 Hours of Service per week or more and is expected to last at least 48 weeks. An Hour of Service is an hour for which an employee is paid, or is entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

☒ Health ☒ Dental ☒ Vision

1B. Elected or Appointed Members of the Governing Authority – The Employer requests the following benefits for all active elected or appointed members of the Employer's Governing Authority. This would include the Chief Legal Officer, Associate Legal Officer and Municipal Judges unless identified as being excluded by Employer below.

☒ Health ☒ Dental ☒ Vision

Exclude from Benefits: (EMPLOYER FILL IN BOX WITH "X")

☐ Chief Legal Officer ☐ Associate Legal Officer ☐ Municipal Judges

1C. [**For ALE's only** - Participating Employers that are ALE's may determine that certain workers who do not meet the definition of a Regular Employee above are "ACA Full-Time Employees." For example, an Employer might determine that a newly hired employee in a nine-month position that requires 30 Hours of Service per week is an ACA Full-Time Employee. For coverage in calendar years 2015 and later, Participating Employers that are ALE's may offer the coverage elected in 1A to anyone it determines to be an ACA Full-Time Employee.]

SECTION 2. EMPLOYEE ELIGIBILITY WAITING PERIOD

Individuals who are hired or take office into an Eligible position after the Employer's effective date of group health/dental coverage are eligible to enroll for such coverage on the first day of the calendar month following or coinciding with the date that they complete the following number of days of continuous, active service in an Eligible position.

☐ 0 ☒ 30 ☐ 45 ☐ 60

Those rehired into an Eligible position are not subject to a waiting period unless rehired after 13 consecutive weeks without an Hour of Service.

[**For ALE's only** - The waiting period elected above applies for any newly hired workers the Employer identifies as being "ACA Full-Time Employees" pursuant to Section 1.C. If the Employer determines a worker to be an ACA Full-Time Employee based on Hours of Service during an initial measurement period, the waiting period: 1) starts at the end of the initial measurement period, and 2) must be shortened as needed for coverage to be effective no later than 13 months from the date of hire (or the first day of the following month if the worker did not start on the first day of the month.)]

Note: The Employer's waiting period must be the same for all GMEBS Life & Health Program coverages offered by the Employer (i.e., health, dental, life, short term disability, etc.) There will be no exceptions to waiting period unless Employer submits documentation waiving the stated waiting period.

SECTION 3. EMPLOYER HEALTH PLAN ELECTION

If the "Health" box for any Employee position in Section 1A or 1B above is checked, the boxes checked below indicate the Health Plan option(s) and deductibles requested and coverage for dependents:

	Plan Name/Deductible	Employee	Employee + Spouse	Employee + Child	Family
x	HMO (80%)-Open Acc	x			x
x	PPO 90/70 500	x			x
x	PPO(80/60) - 500	x			x

SECTION 4. EMPLOYER DENTAL PLAN ELECTION If the "Dental" box for any Employee position in Section 1A or 1B above is checked, the box checked below indicates whether coverage is requested for eligible dependents.

☐ Employee Only ☒ Employee + Dependents (spouse and children)

SECTION 5. EMPLOYER VISION PLAN ELECTION

If the "Vision" box for any Employee position in Section 1A or 1B above is checked, the boxes checked below indicates whether coverage is requested for eligible dependents:

	Employee	Employee + Spouse	Employee + Child	Family
x	x	x	x	x

SECTION 6. EMPLOYER REPRESENTATIVE – Please list by title or position the person designated by the Employer to represent the Employer in all communications with GMEBS and the Program Administrator concerning the GMEBS Life & Health Program: Tomika Mitchell

The Employer may identify in writing to the Program Administrator an additional agent or authorized representative (such as an insurance broker) as being authorized to receive communications, including enrollment information for billing purposes.

SECTION 7. EMPLOYER ADOPTION - The Employer acknowledges that this Employer Declaration and Application will not become effective unless and until it is approved by the GMEBS Life & Health Program Administrator, and that upon such approval this Employer Declaration and Application will replace and supersede any prior Employer Declaration and Application concerning health and dental coverage for employees that is on file with the GMEBS Life & Health Program Administrator. The Employer further acknowledges that GMEBS' approval of this Employer Declaration and Application is contingent upon the Employer having adopted the GMEBS Life and Health Program Participation Agreement, as amended. If the Employer has elected Vision Coverage, the Employer also agrees to the following Vision Participation Agreement required by Anthem, the insurer of the Vision Coverage:

- By electing Vision Coverage, Employer is electing to participate in the Master Policy for Anthem Vision Coverage held by GMEBS (the Policyholder.)
- The eligibility and waiting period provisions elected above are incorporated by reference in this Vision Participation Agreement.
- Employer shall fulfill the obligations of the “group” or the “employer” set forth in the Vision Coverage Certificate.
- The Employer affirms that it will not offer any other vision coverage while offering Vision Coverage through GMEBS.
- If the Employer engages in fraudulent conduct or misrepresentations when requesting or offering Vision Coverage, Anthem has the right to rescind, cancel or terminate the Employer’s participation in the Anthem Vision Coverage effective on the date of the fraudulent conduct or misrepresentation, regardless of the date of Anthem’s discovery of such conduct. The Employer shall be liable to Anthem for any and all payments made or losses or damages sustained by Anthem arising as a result of such conduct.
- In the event the Employer has failed to provide to Anthem’s satisfaction, any information requested by Anthem, Anthem may terminate the Employer’s participation in Vision Coverage upon thirty (30) days written notice.
- If the Employer fails to timely notify the Life & Health Program Administrator of an employee or dependent’s loss of eligibility, and Anthem is unable to recover claim amounts paid to an ineligible individual, the Employer shall be liable to reimburse Anthem for all unrecovered claim amounts paid.
- Employer agrees not to impede any individual enrolled in Employer’s Vision Coverage from performing his or her obligations under the Certificate of Coverage, and agrees to assist such individuals in performing their obligations.

Approved by the Mayor and Council/Commission of the City of **CLARKSTON** , Georgia this _____ day of _____, 20_____.

Attest: CITY OF _____,GEORGIA

_____ _____
Signature of City Clerk Signature of Mayor

_____ _____
Print Name of City Clerk Print Name of Mayor
(SEAL)

Please do not write below this line (for GMEBS USE ONLY)

The terms of the foregoing Employer Declaration and Application are approved by the GMEBS Life & Health Program Administrator this ____ day of _____, 20_____.
Subject to the applicable terms of the GMEBS Life and Health Program Participation Agreement and the Plan(s), the effective date of the coverages (or any change in coverage) as reflected in this Employer Declaration and Application will be the date shown under “Declaration Effective Date” on the first page of this form.

GMEBS LIFE & HEALTH PROGRAM ADMINISTRATOR
By:_____

GEORGIA MUNICIPAL ASSOCIATION

RISK MANAGEMENT AND EMPLOYEE BENEFIT SERVICES BOARD OF TRUSTEES

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Mayor, Union City

EXECUTIVE STAFF

Randy Logan
Deputy Executive Director

August 2, 2023

Tomika Mitchell
City of Clarkston
1055 Rowland Street
Clarkston, GA 30021-1711

Dear Tomika:

Each year, an actuary reviews the premium levels and plan designs offered by the Georgia Municipal Employees Benefit System (GMEBS) Life and Health Insurance Fund to determine if rates are sufficient to support claims and medical cost trends for the next plan year. This important renewal notice is being provided as well to the management and/or an elected official due renewal, open enrollment and new plan year deadlines described in this letter. Renewal Survey Link

2024 Premium Renewal Summary (January 1, 2024)

HMO 90

Current Premium Rates

Employee	$ 848.00
Employee & Spouse	$ 0.00
Employee & Child(ren)	$ 0.00
Employee & Family	$ 1,999.00

***NEW* 2024 Premium Rates**

Employee	$ 873.00
Employee & Spouse	$ 0.00
Employee & Child(ren)	$ 0.00
Employee & Family	$ 2,059.00

PPO 90/70 500

Current Premium Rates

Employee	$ 840.00
Employee & Spouse	$ 0.00
Employee & Child(ren)	$ 0.00
Employee & Family	$ 1,975.00

New 2024 Premium Rates

Employee	$ 865.00
Employee & Spouse	$ 0.00
Employee & Child(ren)	$ 0.00
Employee & Family	$ 2,034.00

PPO 80/60 500

Current Premium Rates

Employee	$ 799.00
Employee & Spouse	$ 0.00
Employee & Child(ren)	$ 0.00
Employee & Family	$ 1,877.00

New 2024 Premium Rates

Employee	$ 823.00
Employee & Spouse	$ 0.00
Employee & Child(ren)	$ 0.00
Employee & Family	$ 1,933.00

Key Renewal Dates for Plan Year 2024

Aug 1 – Aug 4
Delivery of Renewal Email to Employer Contacts

Aug 10
Renewal Survey Due (see Link)

Aug 1 – Sep 12
Renewal reviews, meetings or requests with Life & Health to assist in plan option changes for 2024.

Please complete Renewal Survey to schedule and to meet with the Life & Health team.

Sept 15 (Friday)
Submission of 2024 Selections Due if making Medical Plan Option changes and/or Dental or Vision plan updates.

October 1 (Sunday)
Open Enrollment begins

Each year the GMESB Board of Trustees reviews and approves any suggested plan option updates as well as the annual premium renewal for the Life & Health Trust which is presented by the actuarial team. Thank you for your continued participation in the GMA Life & Health program. We are here to serve you and your employees.

Within the Life & Health program, complete benefit options and services are available for your consideration during this renewal period.

The renewal covers the following (pharmacy & on demand health care provided as part of options in blue):

- **Medical** - the choice between multiple medical plan designs and Anthem network options
- Pharmacy - comprehensive pharmacy formulary coverage and deep network access provided by Aetna.
- On Demand Health Care –
  - Virtual primary care through Anthem,
  - Telehealth services for both medical and mental or behavioral health services by Live Health Online at no cost for either service accessed.
  - Delta Dental's ToothPic virtual access to dental care
- **Dental** – PPO in-network or out of network coverage with Delta Dental
- **Vision** – Full vision care coverage under the Anthem Blue View Vision plan and network

Additional information for the Life & Health renewal:

- The Renewal period is from August 1, 2023, through September 15, 2023, to serve you and your employees best during Open Enrollment.
- For the 2024 plan year, there will be no changes in the plan designs for Medical, Dental or Vision.
- The premiums billed for the Dental plan and Vision plan will remain the same (see below).
- Please note that Dental and Vision plans must be opted in by the Employer and is not provided as part of the Medical plan option.

Premiums per Month	Dental	Vision
Employee	$25.00	$8.11
Employee & Spouse	n/a	$16.22
Employee & Child(ren)	n/a	$16.62
Employee & Dependent(s)	$76.00	$24.72

To serve your needs best and timely, please complete the survey in this link as soon as possible (Renewal Survey Link). The Life & Health team is looking forward to assisting you with questions or with any possible plan changes or additions your benefit plan options. Please see handout for information for details on Open Enrollment.

Thank you again for your participation in the Life & Health program. Please let us know how we can be of assistance during this year's Renewal period.

Sincerely,

Denise Joyce
Sr. Director of Operations, RMEBS

Cc: Beverly Burks, Mayor
Shawanna Qawiy, City Manager

Georgia Municipal Employees Benefit System
Open Access HMO 90% Plan
Schedule of Benefits — Effective January 1, 2023

In addition to copayments, members are responsible for 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.

Deductibles, Coinsurance and Maximums	**In-Network Benefit Level No Coverage for Out-of-Network**
Calendar Year Deductible* Individual Family	 $250 $750
Coinsurance	Plan pays 90%, Member pays 10% Coinsurance
Lifetime Maximum	Unlimited
Out-of-Pocket Calendar Year Maximums* Medical Rx	 $1,500 individual/$3,000 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)	$20 copayment
• LiveHealth Online healthcare provider visit	No charge
• Specialist Physician office visit	$30 copayment
• Second surgical opinion (PCP referral required)	$30 copayment
• Maternity (prenatal, postnatal)	$0 copayment
• Allergy care (office visit, testing, serum and allergy shots)	$20 PCP copayment or $30 Specialist copayment
• Medical Chats/Virtual Visits from LiveHealth Online or K Health, through their affiliated Provider groups.	No charge
• Virtual Health Support- Healthy Back & Joints (LiveHealth Online); Healthy Blood Pressure (Live Health Online); Diabetes Support (Lark App)	No charge
Emergency/Urgent Care Services (See Benefits Booklet for information about coverage of Out-of-Network emergency/urgent care)	
• Life-threatening illness, serious accidental injury	$200 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 90% *(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 90%
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 90%

Open Access HMO 90% continued
Effective January 1, 2023

Covered Services	In-Network Benefit Level (No Coverage Out-of-Network)
Outpatient Services	
• Surgery facility/hospital charges	Plan pays 90%
• Diagnostic x-ray and lab services	Plan pays 90%
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 90%
Therapy Services	
• Speech Therapy	Plan pays 90%; 20-visit calendar year maximum
• Physical, Occupational Therapy	Plan pays 90%; 20-visit calendar year maximum
• Chiropractic	$30 co-pay office visit; Plan pays 90% for other services after deductible; 30 visit per calendar year maximum.
• Respiratory Therapy	Plan pays 90% 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 90% Plan pays 90%
• Inpatient Substance Abuse Detoxification (facility fee) • Inpatient Substance Abuse Detoxification (physician fee)	Plan pays 90% Plan pays 90%
• Partial Hospitalization Program (facility and physician fee)	Plan pays 90%
• Intensive Outpatient Program (facility and physician fee)	Plan pays 90%
• Professional Outpatient Services	$20 copayment
• LiveHealth Online healthcare provider visit	No charge
• Medical Chats/Virtual Visits from LiveHealth Online or K Health, through their affiliated Provider groups.	No charge
• Virtual Health Support- Healthy Back & Joints (LiveHealth Online); Healthy Blood Pressure (Live Health Online); Diabetes Support (Lark App)	No charge
Other Services	
• Skilled Nursing Facility	Plan pays 90%; 90-day calendar year maximum
• Home Health Care	Plan pays 90%; 120-visit calendar year maximum
• Hospice Care	Plan pays 100%
Pharmacy Covers up to a 30-day supply (retail) or 90 day supply (mail order/CVS retail); If generic is available and member requests brand-name drug, member pays the 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/CVS retail pharmacy 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.

Georgia Municipal Employees Benefit System:
HMO 90 Open Access

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for:** Individual/ Family | **Plan Type:** HMO

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/lhforms** or call 678-651-1039. 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 (individual/family): **$250** individual/**$750** 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 preventive care or prescription drugs.	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 **$1,500/$3,000** Rx **$4,450/$8,900**	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 health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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.	Except for emergency and urgent care, this plan only pays benefits for care provided by a provider in the plan's network. If you use an out-of-network provider you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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	$20 copayment /visit	Not Covered	Copayment applies to physician charges, x-ray, lab billed through office visit.
	Specialist visit	$30 copayment /visit	Not Covered	Copayment applies to physician charges, x-ray, lab billed through office visit.
	Other practitioner office visit	Chiropractic $35 copayment /visit; all other services 10% coinsurance	Not Covered	30 visits per calendar year. .
	Preventive care/screening/ Immunization	No charge	Not Covered	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)	20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	None
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 copayment (30-day retail) $20 copayment (90 day mail order/CVS retail)	Not Covered	Up to 30 day supply at retail, up to 90 day supply for maintenance medications through Aetna mail order or any CVS pharmacy.
	Preferred brand drugs	$35 copayment (30-day retail) $70 copayment (90 day mail order/CVS retail)	Not Covered	Same as above. Additionally, if generic is available and member requests brand-name drug, member pays applicable co-pay plus cost difference between brand-name and generic. Preauthorization is required for certain drugs.
	Non-preferred brand drugs	$60 copayment (30-day retail) $120 copayment (90-day mail order/CVS)	Not Covered	
	Specialty drugs	Same as above for each category (generic, etc.)	Not Covered	Up to a 30-day supply (retail permitted for 1 fill, then must use Aetna Specialty Program).

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 have outpatient surgery	Facility fee	10% coinsurance	Not Covered	Preauthorization may be required for certain outpatient procedures.
	Physician/surgeon fees	10% coinsurance	Not Covered	Preauthorization may be required for certain outpatient procedures.
If you need immediate medical attention	Emergency room care	$200 copayment /visit	$200 copayment /visit	Copayment is waived for Emergency room care if admitted to the hospital. Preauthorization is required within 48 hours of 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.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	$60 copayment /visit	$60 copayment /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not Covered	Preauthorization before admission is required for all hospital stays except maternity.
	Physician/surgeon fees	10% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Mental/ Behavioral health/ Substance use disorder Outpatient services	$20 copayment office based services; other services 10% coinsurance	Not Covered	Preauthorization is required except for office visits.
	Mental/ Behavioral health/ Substance use disorder Inpatient services	10% coinsurance	Not Covered	Preauthorization is required.
If you are pregnant	Office visits – Prenatal and Postnatal care	No charge	Not Covered	None
	Childbirth/delivery professional services	10% coinsurance	Not Covered	None
	Childbirth/delivery facility services	10% coinsurance	Not Covered	Preauthorization is required for extended stay or if mother and baby leave separately.
If you need help	Home health care	10% coinsurance	Not Covered	120-visit calendar year maximum

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)	
recovering or have other special health needs	Rehabilitation services	10% coinsurance	Not Covered	No coverage for physical or occupational therapy due to developmental delay. 20-visit calendar year maximum
	Habilitation services	10% coinsurance	Not Covered	No coverage for physical or occupational therapy due to developmental delay. 20-visit calendar year maximum
	Skilled nursing care	10% coinsurance	Not Covered	90 day calendar year maximum
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization may be required based on clinical policy guidelines.
	Hospice services	$0	Not Covered	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
- Non-emergency care when traveling outside the service area
- 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
- 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: 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.

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	$250
Specialist copayments	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,320**

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

The plan's overall deductible	$250
Specialist copayments	$30
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$800
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,140**

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

The plan's overall deductible	$250
Specialist copayments	$30
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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

Georgia Municipal Employees Benefit System
Open Access HMO 80% Plan
Schedule of Benefits — Effective January 1, 2023

In addition to copayments, members are responsible for 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.

Deductibles, Coinsurance and Maximums	**In-Network Benefit Level No Coverage for Out-of-Network**
Calendar Year Deductible* Individual Family	 $500 $1,500
Coinsurance	Plan pays 80%, Member pays 10% Coinsurance
Lifetime Maximum	Unlimited
Out-of-Pocket Calendar Year Maximums* Medical Rx	 $2,650 individual/$5,300 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)	$20 copayment
• LiveHealth Online healthcare provider visit	No charge
• Specialist Physician office visit	$30 copayment
• Second surgical opinion (PCP referral required)	$30 copayment
• Maternity (prenatal, postnatal)	$0 copayment
• Allergy care (office visit, testing, serum and allergy shots)	$20 PCP copayment or $30 Specialist copayment
• Medical Chats/Virtual Visits from LiveHealth Online or K Health, through their affiliated Provider groups, or through Sydney App.	No charge
• Virtual Health Support- Healthy Back & Joints (LiveHealth Online); Healthy Blood Pressure (Live Health Online); Diabetes Support (Lark App)	No charge
Emergency/Urgent Care Services (See Benefits Booklet for information about coverage of Out-of-Network emergency/urgent care)	
• Life-threatening illness, serious accidental injury	$200 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 90% *(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, 2023

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	$30 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	$20 copayment
• LiveHealth Online healthcare provider visit	No charge
• Medical Chats/Virtual Visits from LiveHealth Online or K Health, through their affiliated Provider groups.	No charge
• Virtual Health Support- Healthy Back & Joints (LiveHealth Online); Healthy Blood Pressure (Live Health Online); Diabetes Support (Lark App)	No charge
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%
Pharmacy Covers up to a 30-day supply (retail) or 90 day supply (mail order/CVS retail); If generic is available and member requests brand-name drug, member pays the 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/CVS retail pharmacy 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.

Georgia Municipal Employees Benefit System:
HMO 80 Open Access

Coverage Period: 01/01/2023 – 12/31/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for:** Individual/ Family | **Plan Type:** HMO

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/lhforms** or call 678-651-1039. 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: **$500** individual /**$1500** 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 preventive care or prescription drugs.	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 **$2,650/$5,300** Rx **$4,450/$8,900**	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 health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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.	Except for emergency and urgent care, this plan only pays benefits for care provided by a provider in the plan's network. If you use an out-of-network provider you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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	$25 copayment /visit; deductible does not apply	Not Covered	Copayment applies to physician charges, x-ray, lab billed through office visit.
	Specialist visit	$35 copayment /visit; deductible does not apply	Not Covered	Copayment applies to physician charges, x-ray, lab billed through office visit.
	Other practitioner office visit	Chiropractic $35 copayment /visit; deductible does not apply; all other services 20% coinsurance. after deductible	Not Covered	30 visits per calendar year.
	Preventive care/screening/ Immunization	No charge	Not Covered	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)	20% coinsurance after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	None
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 copayment (30-day retail) $20 copayment (90 day mail order/CVS retail)	Not Covered	Up to 30 day supply at retail, up to 90 day supply for maintenance medications through Aetna mail order or any CVS pharmacy.
	Preferred brand drugs	$35 copayment (30-day retail) $70 copayment (90 day mail order/CVS retail)	Not Covered	Same as above. Additionally, if generic is available and member requests brand-name, member pays the applicable co-pay plus the cost difference between brand and generic. Preauthorization is required for certain drugs.
	Non-preferred brand drugs	$60 copayment (30-day retail) $120 copayment (90 day mail order/CVS	Not Covered	

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 (continued)		retail)		
	Specialty drugs	Same as above for each category of drug (generic, etc.)	Not Covered	Up to a 30-day supply (retail permitted for 1 fill, then must use Aetna Specialty Program).
If you have outpatient surgery	Facility fee	20% coinsurance after deductible	Not Covered	Preauthorization may be required for certain outpatient procedures.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Preauthorization may be required for certain outpatient procedures.
If you need immediate medical attention	Emergency room care	$200 copayment /visit; deductible does not apply	$200 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 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.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	$60 copayment /visit; deductible does not apply	$60 copayment /visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Preauthorization before admission is required for all hospital stays except maternity.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	

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 mental health, behavioral health, or substance abuse services	Mental/ Behavioral health/ Substance use disorder Outpatient services	$25 copayment office based services; deductible does not apply; other services 20% coinsurance after deductible	Not Covered	Preauthorization is required except for office visits.
	Mental/ Behavioral Health/ Substance use disorder Inpatient services	20% coinsurance after deductible	Not Covered	Preauthorization is required.
If you are pregnant	Office visits – Prenatal and Postnatal care	No charge	Not Covered	None
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	Preauthorization is required for extended stay or if mother and baby leave separately.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	120-visit calendar year maximum
	Rehabilitation services	20% coinsurance after deductible	Not Covered	No coverage for physical or occupational therapy due to developmental delay. 20-visit calendar year maximum
	Habilitation services	20% coinsurance after deductible	Not Covered	No coverage for physical or occupational therapy due to developmental delay. 20-visit calendar year maximum
	Skilled nursing care	20% coinsurance after deductible	Not Covered	90 day calendar year maximum
	Durable medical equipment	20% coinsurance after deductible	Not Covered	Preauthorization may be required based on clinical policy guidelines.
	Hospice services	$0	Not Covered	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
- Non-emergency care when traveling outside the service area
- 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
- 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: 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.

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	$500
Specialist copayments	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,470**

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

The plan's overall deductible	$500
Specialist copayments	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	$500
Specialist copayments	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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

GEORGIA MUNICIPAL ASSOCIATION

Plan Designs

Disclaimer

This presentation is a high-level summary comparison of different available plan designs. It is designed for use by employers deciding which plan designs to offer. It is NOT appropriate for use by potential or current enrollees who are choosing among plan designs offered by the employer. This presentation does not include the terms and conditions of the plans and does not create any

contract. The terms and conditions of the plans are set forth in the applicable Benefits Booklet (PPO, POS, HMO, or HSA-eligible High Deductible) and the Schedule of Benefits for the selected plan design. Potential or current enrollees should always review the applicable Summaries of Benefits and Coverage (SBCs) when comparing available plan options. The SBCs define important terms and note important limitations and exclusions. SBCs are posted on the GMA website.

This presentation and its contents should not be shared with employees other than representatives of employers who are making decisions about which plan designs to offer.

HMO Plan Design

Provision	2024	
	HMO 90	HMO 80
Individual Deductible Options	$250	$500
Family Deductible	$750	$1,500
Coinsurance	10%, Plan pays 90% after Deductible	20%, Plan pays 80% after Deductible
Individual Out-of-Pocket Maximum	$1,500	$2,650
Family Out-of-Pocket Maximum	$3,000	$5,300
Primary Care Office Visit	$20	$25
Specialist Office Visit	$30	$35
Emergency Room	$200	$200
No Out – Of – Network Coverage [except for emergency room]		

Note: Out-of-Pocket Maximums include Deductible

PPO [80/60] Plan Designs

Provision	2024				
	PPO 80/60 - 500	PPO 80/60 - 750	PPO 80/60 - 1000	PPO 80/60 - 1500	PPO 80/60 - 2000
Individual Deductible Options	$500	$750	$1,000	$1,500	$2,000
Family Deductible	$1,500	$2,250	$3,000	$4,500	$6,000
Coinsurance	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible
Individual Out-of-Pocket Maximum [medical]	$3,000	$3,500	$4,000	$5,000	$5,500
Family Out-of-Pocket Maximum [medical]	$6,000	$7,000	$8,000	$10,000	$11,000
Physician Office Visit Copayment	$30	$30	$40	$40	$40
Specialist Office Visit Copayment	$40	$40	$50	$50	$50
Emergency Room Copayment	$200	$200	$200	$200	$200
Out-Of-Network Individual Deductible	$1,000	$1,500	$2,000	$3,000	$4,000
Out-of-Network Family Deductible	$3,000	$4,500	$6,000	$9,000	$12,000
Out-of-Network Coinsurance	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible
Individual Out-of-Network Out-of-Pocket Maximum [medical]	$5,500	$6,500	$7,500	$9,500	$10,500
Family Out-of-Network Out-of-Pocket Maximum [medical]	$6,000	$13,000	$15,000	$19,000	$21,000

FOR USE BY EMPLOYERS WHEN CONSIDERING WHICH PLAN DESIGNS TO OFFER. TERMS AND CONDITIONS OF PLANS ARE SET FORTH IN BENEFITS BOOKLETS AND SCHEDULE OF BENEFITS. DO NOT USE THIS PRESENTATION
(OR ANY PORTION OF IT) TO PROVIDE INFORMATION ABOUT THE PLANS TO EMPLOYEES.

PPO [90/70] Plan Designs

Provision	2024			
	PPO 90/70 - 500	PPO 90/70 - 750	PPO 90/70 - 1000	PPO 90/70 - 1500
Individual Deductible Options	$500	$750	$1,000	$1,500
Family Deductible	$1,500	$2,250	$3,000	$4,500
Coinsurance	10%; Plan pays 90% after Deductible	10%; Plan pays 90% after Deductible	10%; Plan pays 90% after Deductible	10%; Plan pays 90% after Deductible
Individual Out-of-Pocket Maximum [medical]	$2,000	$2,500	$3,000	$4,000
Family Out-of-Pocket Maximum [medical]	$4,000	$5,000	$6,000	$8,000
Physician Office Visit Copayment	$25	$25	$35	$35
Specialist Office Visit Copayment	$35	$35	$45	$45
Emergency Room Copayment	$200	$200	$200	$200
Out-Of-Network Individual Deductible	$1,000	$1,500	$2,000	$3,000
Out-of-Network Family Deductible	$3,000	$4,500	$6,000	$9,000
Out-of-Network Coinsurance	30%; Plan pays 70% after Deductible	30%; Plan pays 70% after Deductible	30%; Plan pays 70% after Deductible	30%; Plan pays 70% after Deductible
Individual Out-of-Network Out-of-Pocket Maximum [medical]	$3,500	$4,500	$5,500	$7,500
Family Out-of-Network Out-of-Pocket Maximum [medical]	$7,000	$9,000	$11,000	$15,000

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POS [80/60] Plan Designs

Provision	2024						
	POS 80/60 - 500	POS 80/60 - 750	POS 80/60 – 1000	POS 80/60 - 1500	POS 80/60 - 2000	POS 80/60 - 3000	POS 80/60 - 5000
Individual Deductible Options	$500	$750	$1,000	$1,500	$2,000	$3,000	$5,000
Family Deductible	$1,500	$2,250	$3,000	$4,500	$6,000	$9,000	$12,500
Coinsurance	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible	20%; Plan pays 80% after Deductible
Individual Out-of-Pocket Maximum [medical]	$3,000	$3,500	$4,000	$5,000	$5,500	$6,500	$7,000
Family Out-of-Pocket Maximum [medical]	$6,000	$7,000	$8,000	$10,000	$11,000	$13,000	$14,000
Physician Office Visit Copayment	$30	$30	$40	$40	$40	$40	$40
Specialist Office Visit Copayment	$40	$40	$50	$50	$50	$50	$50
Emergency Room Copayment	$200	$200	$200	$200	$200	$200	$200
Out-Of-Network Individual Deductible	$1,000	$1,500	$2,000	$3,000	$4,000	$6,000	$10,000
Out-of-Network Family Deductible	$3,000	$4,500	$6,000	$9,000	$12,000	$18,000	$25,000
Out-of-Network Coinsurance	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible	40%; Plan Pays 60% after Deductible
Individual Out-of-Network Out-of-Pocket Maximum [medical]	$5,500	$6,500	$7,500	$9,500	$10,500	$12,500	$13,500
Family Out-of-Network Out-of-Pocket Maximum [medical]	$11,000	$13,000	$15,000	$19,000	$21,000	$25,000	$27,000

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POS [90/70] Plan Designs

Provision	2024			
	POS 90/70 - 500	POS 90/70 – 750	POS 90/70 - 1000	POS 90/70 - 1500
Individual Deductible Options	$500	$750	$1,000	$1,500
Family Deductible	$1,500	$2,250	$3,000	$4,500
Coinsurance	10%, Plan pays 90% after Deductible	10%, Plan pays 90% after Deductible	10%, Plan pays 90% after Deductible	10%, Plan pays 90% after Deductible
Individual Out-of-Pocket Maximum [medical]	$2,000	$2,500	$3,000	$4,000
Family Out-of-Pocket Maximum [medical]	$4,000	$5,000	$6,000	$8,000
Physician Office Visit Copayment	$25	$25	$35	$35
Specialist Office Visit Copayment	$35	$35	$45	$45
Emergency Room Copayment	$200	$200	$200	$200
Out-Of-Network Individual Deductible	$1,000	$1,500	$2,000	$3,000
Out-of-Network Family Deductible	$3,000	$4,500	$6,000	$9,000
Out-of-Network Coinsurance	30%, Plan pays 70% after Deductible	30%, Plan pays 70% after Deductible	30%, Plan pays 70% after Deductible	30%, Plan pays 70% after Deductible
Individual Out-of-Network Out-of-Pocket Maximum [medical]	$3,500	$4,500	$5,500	$7,500
Family Out-of-Network Out-of-Pocket Maximum [medical]	$7,000	$9,000	$11,000	$15,000

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HSA-Eligible High Deductible Plan Design

Provision	2024	
	HSA-Eligible HDHP 3200	HSA-Eligible HDHP 4000
Individual Deductible Options	$3,200	$4,000
Family Deductible	$6,400	$8,000
Coinsurance	10%; Plan pays 90% after Deductible	20%; Plan pays 80% after Deductible
Individual Out-of-Pocket Maximum [medical]	$4,500	$13,500
Family Out-of-Pocket Maximum [medical]	$9,000	$27,000
Preventative Care	Plan Pays 100%, no Deductible	Plan Pays 100%, no Deductible
Primary Care Office Visit Coinsurance	10%; Plan pays 90% after Deductible	20%; Plan pays 80% after Deductible
Specialist Office Visit Coinsurance	10%; Plan pays 90% after Deductible	20%; Plan pays 80% after Deductible
Emergency Room Coinsurance	10%; Plan pays 90% after Deductible	20%; Plan pays 80% after Deductible
Out-Of-Network Individual Deductible	$6,400	$8,000
Out-of-Network Family Deductible	$12,800	$16,000
Out-of-Network Coinsurance	30%; Plan pays 70% after Deductible	40%; Plan pays 60% after Deductible
Individual Out-of-Network Out-of-Pocket Maximum [medical]	$8,500	$13,500
Family Out-of-Network Out-of-Pocket Maximum [medical]	$17,000	$27,000

Note: Out-of-Pocket Maximums include Deductible

FOR USE BY EMPLOYERS WHEN CONSIDERING WHICH PLAN DESIGNS TO OFFER. TERMS AND CONDITIONS OF PLANS ARE SET FORTH IN BENEFITS BOOKLETS AND SCHEDULE OF BENEFITS. DO NOT USE THIS PRESENTATION
(OR ANY PORTION OF IT) TO PROVIDE INFORMATION ABOUT THE PLANS TO EMPLOYEES.

Pharmacy Plan Designs

	2024		
	HMO	**PPO**	**POS**
	Notes: **1.After first fill, specialty drugs must be filled at Aetna specialty pharmacy** **2.Out-of-Network Must File Claim Form for Reimbursement**		
In network : Generic [retail/mail order] ---- **Out of Network**: Generic [retail]	$10 / $20 --- ---	$10 / $20 ---- $10 Copayment + cost difference	$10 / $20 ---- $10 Copayment + cost difference
In network : Formulary Brand [retail/mail order] --- **Out of Network:** Formulary [retail]	$35 / $70 --- ---	$35 / $70 --- $35 + cost difference	$35 / $70 --- $35 + cost difference
In network : Non-Formulary Brand [retail/mail order] --- **Out of Network:** Non-Formulary [retail]	$60 / $120 --- ---	$60 / $120 --- $60 + cost difference	$60 / $120 --- $60 + cost difference
Individual RX Out-Of-Pocket Maximum [In network/Out of Network]	$4,450	$1,600/$3,200	$1,600/$3,200
Family RX Out-Of-Pocket Maximum [In network/Out of Network]	$8,900	$3,200/$6,400	$3,200/$6,400

FOR USE BY EMPLOYERS WHEN CONSIDERING WHICH PLAN DESIGNS TO OFFER. TERMS AND CONDITIONS OF PLANS ARE SET FORTH IN BENEFITS BOOKLETS AND SCHEDULE OF BENEFITS. DO NOT USE THIS PRESENTATION
(OR ANY PORTION OF IT) TO PROVIDE INFORMATION ABOUT THE PLANS TO EMPLOYEES.

Pharmacy Plan Design: HSA – eligible HDHP

	2024
	HSA – eligible HDHP
	Note: Out-of-Network Must File Claim Form for Reimbursement
In Network : Tier 1 [retail/mail order] ---- **Out of Network**: Tier 1 [retail/mail order]	$10 Copayment after Deductible/ $20 Copayment after Deductible --- *** $10 Copayment / *** $20 Copayment
In Network : Tier 2 [retail/mail order] --- **Out of Network**: Tier 2 [retail/mail order]	$35 Copayment after Deductible / $70 Copayment after Deductible --- *** $35 Copayment / *** $70 Copayment
In Network : Tier 3 [retail/mail order] --- **Out of Network**: Tier 3 [retail/mail order]	$60 after Deductible / $120 Copayment after Deductible --- *** $60 Copayment / *** $120 Copayment
In Network : Preventative Medicine	Plan pays 100%, no Deductible
Individual RX Out-Of-Pocket Maximum	Combined with Medical
Family RX Out-Of-Pocket Maximum	Combined with Medical

*** After Deductible, reimburses up to MAA, minus Tier's Copayment

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