Employee Enrollment Packet

Base and Buy Up Plan Options

Prepared For:

Adair County Government

Employee Benefit Plan

Prepared By:

Group Benefit Services

Innovative Solutions | Customized Benefits | Sustainable Plans

gbs-tpa.com | 800.995.3569

Adair County Government Employee Benefit Plan
2024 Employee Monthly Rates

	Base Plan		BuyUp Plan	
	Monthly	**Bi-Monthly**	**Monthly**	**Bi-Monthly**
Employee	$25.00	$12.50	$100.00	$50.00
EE & CH	$365.00	$182.50	$500.00	$250.00
EE & SP	$515.00	$257.50	$670.00	$335.00
EE & FAM	$865.00	$432.50	$1,070.00	$535.00

Please note the following changes to your plan this year:

Effective 1.1.2024 - Durable Medical Equipment Vendor will be changing to Carelink

Effective 1.1.2024 - Pharmacy Vendor will be changing to Drexi

ID Cards - you will receive a new Medical ID card

	MAXI-CARE*		
	Monthly	**Bi-Monthly**	
Employee	$0.00	$0.00	*Maxi-Care is a Medical Expense Reimbursement Plan. Only employees, spouses, and/or dependents who meet the Plan's eligibility requirements and who have qualifying Medicare Part A, Part B, and Part D coverage.
EE & SP	$214.28	$107.14	

	Dental Plan		Vision Plan	
	Monthly	**Bi-Monthly**	**Monthly**	**Bi-Monthly**
Employee	$33.00	$16.50	$7.62	$3.81
EE & CH	$59.00	$29.50	$15.56	$7.78
EE & SP	$69.00	$34.50	$18.46	$9.23
EE & FAM	$87.00	$43.50	$24.00	$12.00

	Group Life		
	Monthly	**Bi-Monthly**	**(Life Volume)**
Employee	$0.00	$0.00	25K
EE & CH	$4.00	$2.00	5K*
EE & SP	$4.00	$2.00	10K
EE & FAM	$4.00	$2.00	*see policy

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

"BASE PLAN"

PREPARED EXCLUSIVELY FOR:

ADAIR COUNTY GOVERNMENT

PREPARED BY:

GROUP BENEFIT SERVICES, INC. (GBS)

www.gbs-tpa.com

"Innovative Solutions | Customized Benefits | Sustainable Plans"

Schedule of Benefits

This page, called a Schedule of Benefits, provides a description about the benefits available through your plan. This Schedule of Benefits is included in your Plan Document (PD) and can be found in your GBS member portal at: mygbshealth.com

Group Name / Plan Sponsor	Adair County Government

Benefit Period – Deductible & Out-of-Pocket Accumulation Period:	January 1 through December 31

Preferred Provider Organization (PPO) Network:	Healthlink Open Access II PPO Network

TIP: To locate a PPO provider, log in to your GBS member portal at **mygbshealth.com** and in the right-hand sidebar select **PPO Provider Locator**.

Major Medical Deductible / Member Cost Share	In-Network	Non-Network
Single Deductible per Accumulation Period:	$3,000	$6,000
Family Deductible per Accumulation Period:	$6,000	$12,000

Coinsurance Levels / Member Cost Share	In-Network	Non-Network
Coinsurance percentage after annual deductible has been met:	80 / 20	50 / 50

Out-of-Pocket[1] Limit Including Deductible	In-Network	Non-Network
Single Annual Out-of-Pocket Limit per Accumulation Period:	$5,000	$10,000
Family Annual Out-of-Pocket Limit per Accumulation Period:	$10,000	$20,000

IMPORTANT: The **Major Medical deductible** and the **out-of-pocket limit(s)** for In-Network and Out-of-Network providers **accumulate separately.**

Cost Share Amount for Medical Services	In-Network	Non-Network
General Practitioner (GP) / Primary Care Physician (PCP)	$25 Office Visit Copay	50 / 50

The copay applies to the office visit with your physician but **does not** include any additional services performed by the physician (example: labs or x-rays). See Enhanced Plan Benefit features for **no cost options**.

IMPORTANT: For the purposes of this Plan, Physicians classified as a Primary Care Physician (PCP) are Family Practitioners, General Practitioners (GP), Internist, Pediatrician, and OB/GYN. All other Physicians are considered Specialists. A referral from a GP / PCP is not required to visit a Specialist.

Cost Share Amount for Medical Services	In-Network	Non-Network
Specialist[2]	$25 Office Visit Copay	50 / 50

The copay (encounter fee) applies to the office visit with your Specialist but **does not** include other services performed by the physician (example: labs or x-rays). No referral is required to see a Specialist. See Enhanced Plan Benefit features for **no cost options.**

Cost Share Amount for Medical Services	In-Network	Non-Network
Urgent Care	$75 Event Copay	50 / 50

The copay applies for **all services** performed during an urgent care visit.

Cost Share Amount for Medical Services	In-Network	Non-Network
Emergency Room	$200 ER Copay	$200 ER Copay

After the copay, the **In-Network** (even at an Out-of-Network facility) major medical coinsurance is applied (See ACA Rules).

	In-Network	Non-Network
Lifetime Limit for Essential Health Benefits:	Unlimited	Unlimited

[1] ACA Maximum Annual Out-of-Pocket Limit includes In-Network Major Medical and Generic & Preferred Name Brand Pharmacy Deductibles, Coinsurance, and Copays. The actual Out-of-Pocket limit each year changes based upon cost-of-living adjustments that is consistent with ACA guidelines for the Plan Year for which claims are incurred. Contact Third Party Administrator for additional details.

[2] A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Enhanced Plan Benefit Features

This page provides a brief description of the many enhanced benefits available to you through your benefit plan.

Reimbursable Deductible Allowance

The **Reimbursable Deductible Allowance (RDA)** is a portion of your Plan Deductible that can be reimbursed back to you at a rate of 100% for eligible In-Network expenses. Eligible In-Network expenses must be **Incurred** during the benefit year to qualify for reimbursement. RDA funds can only be used for Deductibles & Copays and cannot be used for Coinsurance. Current available RDA balances can be reviewed and submissions for reimbursement can be made in the GBS member portal located at: mygbshealth.com

Reimbursable Deductible Allowance (RDA) Amounts	In-Network	Non-Network
RDA Single Amount	**$1,000**	**Not Available**

Preferential Plan Providers

Preferential Plan Providers are providers that have agreed to make their goods and/or services available to GBS plan members at greatly reduced rates. If the plan member seeks eligible goods and/or services from the providers listed below, said goods and/or services will be provided at no cost (covered at 100%) to the plan member. Precertification and medical necessity are required for some of the goods and/or services listed. Likewise, some services require a prescription from your medical provider. Additional details about these benefits can be found in the provisions of your PD. To access the entire PD and review tutorials about each of the below benefits, log in to your GBS member portal located at: mygbshealth.com

Preferential Benefit	Preferential Provider(s)	Benefit Level
Lab Services	**QuestSelect**	**100% ☺**
TIP: Lab appointments can be scheduled through the Quest Diagnostics or LabCorp web site which can also be accessed at: mygbshealth.com	**Find a Location:** www.questselect.com	
	LabCorp	**100% ☺**
	Find a Location: https://www.labcorp.com/labs-and-appointments	
Durable Medical Equipment (DME)	**Carelink DME**	**100% ☺**
IMPORTANT: Carelink is the Preferential Provider for your benefit plan. Precertification is required on items over $150. CARELINK	**Phone:** (888) 604-DMED	
Walk-in Clinics	**CVS MinuteClinic®**	**100% ☺**
TIP: CVS MinuteClinic® appointments can be scheduled through their website which can also be accessed at: mygbshealth.com	**Find a Location:** www.cvs.com/minuteclinic	
Diabetic Management Program and Service	**Livongo**	**100% ☺**
IMPORTANT: Livongo is the exclusive diabetic management service provider. Livongo will supply you with a glucometer and test strips at no charge.	**Phone:** (800) 945-4355 **Website:** welcome.livongo.com/GBS **Registration Code:** GBS	
TIP: All of your glucose readings will be posted on the Livongo's secure website which can also be accessed at: mygbshealth.com		
Telemedicine	**Teladoc**	**100% ☺**
IMPORTANT: Teladoc is the exclusive telemedicine service provider for your benefit plan. There is no visit limit when using this service. **TIP:** Members can access Teladoc via dial up phone service, or a video visit. The video service can be accessed at: mygbshealth.com	**Phone:** (800) 835-2362 **Website:** www.teladoc.com	

Enhanced Plan Benefit Features – Continued

Preferred Place-of-Service Benefits

Preferred Place-of-Service Benefits provide Plan Members with specific medical services at lower-cost when receiving services at a specified place-of-service. If the Plan Member follows the guidelines regarding these Place-of-Service Benefits, the Plan will waive the Member's deductible and coinsurance for the In-Network services listed below. Precertification and medical necessity are required for some of the benefits listed.

Medical Service Categories	Preferred Place-of-Service	Benefit Level
Radiology	**Free-Standing Imaging Facility**	**100% ☺**
Enhanced imaging services (radiology) at **independent, non-hospital** facilities can be provided from one-half (½) to one-third (⅓) of the normal charges billed by hospital facilities. By selecting an independent network facility for your next MRI, CT scan, or PET scan, your plan will pay 100% of the contract rate through your PPO network. By taking charge of where you receive your enhanced imaging services, you are not only saving money, but you are also helping your plan keep the cost of health insurance sustainable. **Precertification and medical necessity determination are required prior to receiving service.**		
Sleep Study	**Home Sleep Study**	**100% ☺**
According to Johns Hopkins Medicine[3], home sleep studies provide a more accurate reading of how you sleep and are usually one-third (⅓) to one-fifth (⅕) of the cost of doing an in-lab study. Choosing to have your sleep study at home will provide a better diagnosis and you save money. Choosing this option also helps your plan keep health insurance costs lower. If durable medical equipment (DME) is needed, please see Carelink for additional member savings.		
Surgical Services	**Ambulatory Surgical Center**	**100% ☺**
According to Johns Hopkins Medicine[4], some of the advantages of having your procedures performed at an Ambulatory Surgical Center (ASC) on an outpatient basis include convenience, lower costs, reduced stress, and more predictable scheduling. Likewise, according to the American Medical Association[5], infection rates after procedures performed at ASCs are less likely. By selecting an ASC for your next procedure, you will not only benefit from the advantages listed previously, but you will also save money while helping your insurance plan keep costs down. **Precertification and medical necessity determination are required prior to receiving service.**		
Walk-in Clinics	**CVS MinuteClinic®**	**100% ☺**
Walk-in clinics are the best option when your general doctor is not available and is typically the most realistic choice for non-life-threatening and/or minor issues. Your health plan has contracted with CVS MinuteClinic® to provide you with immediate access to care when you cannot get in to see your general practitioner. MinuteClinic® costs 40% less than urgent care,[6] so when you choose MinuteClinic® over Urgent Care or the Emergency Room, you are helping to keep the cost of healthcare lower for your plan while you're saving money. Your plan will cover the cost of your MinuteClinic® visit 100%. The only cost associated with your visit may be a copay for a prescription if one is prescribed.		

[3] Johns Hopkins Medicine website: https://www.hopkinsmedicine.org/health/wellness-and-prevention/what-to-know-about-an-at-home-sleep-test#:~:text=Most%20at%2Dhome%20sleep%20tests,by%20insurance%2C%E2%80%9D%20he%20says.

[4] Johns Hopkins Medicine website: https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/outpatient-surgery

[5] American Medical Association website: https://jamanetwork.com/journals/jama/fullarticle/1829988#:~:text=Our%20findings%20affirmed%20that%20the,of%20infections%20following%20inpatient%20operations

[6] Source: Urgent Care Association, "2018 Benchmark Report." Save up to 85% at MinuteClinic® vs. the ER for comparable services. 2020 independent market research study comparing patient out-of-pocket costs for an emergency room visit versus a MinuteClinic® visit for the same presenting condition.

General Description of Benefits

Major Medical Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Acupuncture – Licensed Physician	80 / 20	50 / 50	12 Visit Limit Per Year
Allergy Injections	$5 Copay	50 / 50	
Allergy Testing	80 / 20	50 / 50	
Ambulance – Air[7] & Ground Services	80 / 20	50 / 50	**For Emergency Use Only**
Ambulatory Surgical Center (ASC)	100% ☺	50 / 50	Must be Pre-certified
Anesthesia	80 / 20	50 / 50	
Birthing Center	80 / 20	50 / 50	
Blood & Plasma	80 / 20	50 / 50	
Chiropractic Care - Over 5 Years of Age	80 / 20	50 / 50	30 Visit Limit Per Year
Dialysis – 6 Month Benefit Limit	80 / 20	50 / 50	Must be Pre-certified
Durable Medical Equipment (DME) – Non Carelink	80 / 20	50 / 50	Must be Pre-certified
Hearing Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Hearing Exam
Home Health Care – 120 Day Annual Limit	80 / 20	50 / 50	Must be Pre-certified
Hospice Care	180 Day Benefit Limit		Must be Pre-certified
Inpatient Treatment	80 / 20	50 / 50	
Outpatient Treatment	80 / 20	50 / 50	
Family Bereavement Counseling	80 / 20	50 / 50	
Hospital			Must be Pre-certified
Inpatient Treatment	80 / 20	50 / 50	
Outpatient Treatment	80 / 20	50 / 50	
Infusion Therapy			Must be Pre-certified
Non-Orphan Drugs Only Covered Through PBM	**See Pharmacy Benefit Card for Copays**		**Only Through the PBM**
Lab Services – (Non-Quest or LabCorp)	80 / 20	50 / 50	See Enhanced Plan Benefits
Maternity Program			
Maternity – Hospital or Midwife Delivery	80 / 20	50 / 50	
Maternity – Happy Beginnings Pre-Natal Delivery Well Care	100% ☺	50 / 50	Mother Routine Care Visits
Mental Health, Substance & Chemical Dependency			Must be Pre-certified
Inpatient Physician Services	80 / 20	50 / 50	60 Day Annual Limit
Partial Day Program	80 / 20	50 / 50	60 Visit Annual Limit
Outpatient Physician Services	80 / 20	50 / 50	60 Visit Annual Limit
Residential Treatment Program	80 / 20	50 / 50	60 Day Annual Limit
Newborn Nursery Care – While Inpatient	80 / 20	50 / 50	
Orthoptic Training			Must be Pre-certified
Only when Prescribed by a Physician	80 / 20	50 / 50	Dependents up to age 10
Orthotics - Only when Prescribed by a Physician	80 / 20	50 / 50	Must be Pre-certified
Outpatient Emergency Services (ER)	For non-emergency services see Telemedicine & Walk-in Clinics		
Emergency Room - **For Emergency Use Only**	$200 Copay[8]	$200 Copay[9]	Non-Emergency Services Could Be Denied
Physicians - **For Emergency Use Only**	80 / 20	80 / 20	

[7] Eligible Air Ambulance charges are limited to Reasonable, Usual & Customary, or a percentage of Medicare Allowable, whichever is appropriate. Benefits can be limited based on other coverage or services previously purchased by Plan Members through an association, group, and/or a specific air ambulance company program. Contact Third Party Administrator for additional details.

[8] After the copay, the **in-network** major medical coinsurance is applied.

[9] After the copay, the **in-network** major medical coinsurance is applied.

General Description of Benefits - Continued

Major Medical Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Physician Services[10] (See Below; GP, Specialists, etc.)			
General Practitioner (GP) / Primary Care Physician (PCP)	$25 Dr. Copay	50 / 50	Office Visit Copay[11]
Specialist[12] – Encounter Copay	$25 Dr. Copay	50 / 50	Office Visit Copay[13]
Telehealth Services – **Teladoc**	100% ☺	Not Available	100% covered using Teladoc
Urgent Care	$75 Event Copay	50 / 50	Event Copay[14]
CVS MinuteClinic®	100% ☺	Not Available	All Eligible Charges Covered[15]
Lab and X-ray Services	80 / 20	50 / 50	See Enhanced Plan Benefits
Preferred Place-of-Service Benefits	100% ☺	50 / 50	See Enhanced Plan Benefits
Preferential Plan Provider Benefits	100% ☺	Not Available	See Enhanced Plan Benefits
Preventive Care	https://www.healthcare.gov/coverage/preventive-care-benefits/		
Routine Physical Exam	100% ☺	50 / 50	Annually
Mammograms	100% ☺	50 / 50	Must be over age 40
Pap Smears	100% ☺	50 / 50	Annually
Prostate Exam	100% ☺	50 / 50	Must be over age 50
Routine Immunizations	100% ☺	50 / 50	
Well Child Care Exam	100% ☺	50 / 50	
Private Duty Nursing	80 / 20	50 / 50	
Prosthetics	80 / 20	50 / 50	Must be Pre-certified
Radiology – Enhanced Imaging[16] MRI, CT scan, or PET scan	80 / 20	50 / 50	Must be Pre-certified
Routine Patient Costs – Approved Clinical Trials	80 / 20	50 / 50	Must be Pre-certified
Second Surgical Opinions	100% ☺	50 / 50	
Skilled Nursing Facility – 120 Day Annual Limit	80 / 20	50 / 50	Must be Pre-certified
Sleep Apnea Appliance (CPAP) – See Carelink	80 / 20	50 / 50	Must be Pre-certified
Smoking Cessation – 120 Day Annual Limit	100% ☺	Not Covered	See PBM Program
Surgery – See Enhanced Plan Benefits for Additional Benefits	80 / 20	50 / 50	Must be Pre-certified
Telehealth Services – **Non-Teladoc**	$25 Dr. Copay	50 / 50	Limits[17] will apply
Temporomandibular Joint Disorder (TMJ)	80 / 20	50 / 50	Must be Pre-certified
Therapy			Must be Pre-certified
Chemotherapy	80 / 20	50 / 50	
Occupational Therapy	80 / 20	50 / 50	60 Day Annual Visit Limit
Physical Therapy	80 / 20	50 / 50	60 Day Annual Visit Limit
Radiation Therapy	80 / 20	50 / 50	
Respiration Therapy	80 / 20	50 / 50	
Speech Therapy	80 / 20	50 / 50	60 Day Annual Visit Limit
Transplants – ETS[18] Transplant Network	80 / 20	50 / 50	Must be Pre-certified
Walk-in Clinic Visit – See Enhanced Plan Benefits for no Copay	$25 Dr. Copay	50 / 50	Office Visit Copay[19]
Vision Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Vision Exam
Weight Loss Counseling – No Procedures	100% ☺	100% ☺	1 Annual Counseling Visit
All Other Eligible Services – Not Specifically Listed	80 / 20	50 / 50	See Plan Details

[10] **Note:** For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is **not** required.

[11] **Note:** The copay applies to the office visit with your physician but **does not** include any additional services performed by the physician (example: labs or x-rays).

[12] A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

[13] **Note:** The copay (encounter fee) applies to the office visit with your Specialist but **does not** include other services performed by the physician (example: labs or x-rays). No referral is required to see a Specialist.

[14] **Note:** The copay applies for **all services** performed during an urgent care visit.

[15] **Note:** The member may be responsible for a prescription copay if a prescription is prescribed during the clinic visit.

[16] **Note:** Using a Preferred Place-of-Service will provide a no cost benefit to the member. See Preferred Place-of-Service section above for details.

[17] A telehealth visit charge can be **no more** than a face-to-face office visit.

[18] **Note:** ETS is Emerging Therapy Solutions, Inc.

[19] **Note:** The copay applies to the office visit with your physician but **does not** include any additional services performed by the physician (example: labs or x-rays).

Summary of Prescription Drug (Rx) Benefits

The following benefits levels are per Plan Participant:

Mail Order or Retail Maintenance Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Retail Prescription Copayment Options – 30-day supply	The copayments shown are applied to each prescription.
ACA Preventive Services – These medications fall under ACA wellness – covered @ 100%	**$0 – No Copay ☺**
Tier 1 - Copayment per new or refill prescription – Generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs.	**$10 Copay**
Tier 2 - Copayment per new or refill prescription - means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs.	**$25 Copay**
Tier 3 - Copayment per new or refill prescription - means a category of prescription drugs that generally includes all non-preferred drugs.	**50 / 50 Cost Share**
For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact GBSRx at (888) 364-3580.	

Mail Order or Retail Maintenance Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Mail Order or Retail Maintenance Prescription Copayment Options – 90-day supply[20]	The copayments shown are applied to each prescription.
ACA Preventive Services – These medications fall under ACA wellness – covered @ 100%	**$0 – No Copay ☺**
Tier 1 - Copayment per new or refill prescription – Generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs.	**$10 Copay**
Tier 2 - Copayment per new or refill prescription - means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs.	**$50 Copay**
Tier 3 - Copayment per new or refill prescription - means a category of prescription drugs that generally includes all non-preferred drugs.	**50 / 50 Cost Share**
For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact GBS Rx at (888) 364-3580.	

Specialty Drug Expenses (Non-Orphan Drugs):	Participating Pharmacy
Retail Specialty[21] **Card Copayment Options – No more than a 30-day supply**	The copayments shown are applied to each prescription.
Copayment per new or refill Specialty prescription - Generic	**$30 Copay**
Copayment per new or refill Specialty prescription - Preferred Name Brand	**$60 Copay**
Copayment per new or refill Specialty prescription - Non-Preferred Name Brand	**50 / 50 Cost Share**
Copayment per new or refill Specialty prescription through GBS Rx Specialty Drug Program	**No Copay (See Below)**

Note:
In accordance with applicable law, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as medical Deductibles or prescription drug co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact Drexi Rx at 833-306-4092 at the telephone number on the health plan identification card.

Immunizations through the Pharmacy:
Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no prescription drug co-payment or medical Deductible will be applied). Covered Persons can contact Drexi Rx for more information on how to find a pharmacy within the designated network that administers these immunizations.

Drug Manufacturer Assistance Programs:
Any amounts paid toward plan member responsibility which were paid or reimbursed by manufacturer assistance programs, which includes copay cards, or similar patient assistance programs from a third party, do not accrue toward the deductible or annual out-of-pocket maximum.

Step Therapy Protocol:
When it comes to medicines to treat long-term health conditions, people and doctors have more choices than ever. Cost is often a big difference between the choices. Brand-name medicines usually are highest-cost and generic medicines are usually the lowest-cost.

One way to make sure you get safe, effective, and reasonably-priced medicine is by using programs like step therapy. Step therapy programs are created using U.S. Food and Drug Administration (FDA) guidelines, clinical evidence, and research.
These programs encourage you and your doctors to start treatment with an appropriate generic medicine with the lowest copay rather than a higher-cost medicine.

[20] Some medications such as narcotics and specialty medications are not available for the 90-day mail order or retail maintenance program.

[21] Specialty medications and infusion therapy must be pre-certified. Orphan drugs are not covered.

Step therapy protocol means that an individual may need to use one type of medication before another. Your plan monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help an individual access high quality yet cost-effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the prior authorization process is applied.

Generic medicines are an important step you can take to spend less for your prescriptions:
A lower-cost option that is as safe and effective as brand-name medicines.[22] 2 out of 3 prescriptions filled today are for generic medicines and that number is growing.[23] The FDA approve generic medicines to be just as safe and effective as their Brand-name counterparts.

There are generic medicine options to treat many conditions – your doctor can help you choose the right one for you. The step therapy program makes prescriptions more affordable for many people who participate. It also helps keep your prescription benefit plan priced right and helps control the rising cost of medicines by encouraging the use of lower-cost generic medicines that are as safe and effective as brand-name medicines.

[22] Generic Pharmaceutical Association's Website: http://www.gphaonline.org/Content/NavigationMenu/AboutGenerics/Statistics/Statistics.htm
[23] Generic Pharmaceutical Association's Website: http://www.gphaonline.org/about-gpha/about-generics/case

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

"BUY UP PLAN"

PREPARED EXCLUSIVELY FOR:

ADAIR COUNTY GOVERNMENT

PREPARED BY:

GROUP BENEFIT SERVICES, INC. (GBS)

www.gbs-tpa.com

"Innovative Solutions | Customized Benefits | Sustainable Plans"

Schedule of Benefits

This page, called a Schedule of Benefits, provides a description about the benefits available through your plan. This Schedule of Benefits is included in your Plan Document (PD) and can be found in your GBS member portal at: mygbshealth.com

Group Name / Plan Sponsor	Adair County Government

Benefit Period – Deductible & Out-of-Pocket Accumulation Period:	January 1 through December 31

Preferred Provider Organization (PPO) Network:	Healthlink Open Access II PPO Network

TIP: To locate a PPO provider, log in to your GBS member portal at **mygbshealth.com** and in the right-hand sidebar select **PPO Provider Locator**.

Major Medical Deductible / Member Cost Share	In-Network	Non-Network
Single Deductible per Accumulation Period:	$2,000	$4,000
Family Deductible per Accumulation Period:	$4,000	$8,000

Coinsurance Levels / Member Cost Share	In-Network	Non-Network
Coinsurance percentage after annual deductible has been met:	90 / 10	50 / 50

Out-of-Pocket[1] Limit Including Deductible	In-Network	Non-Network
Single Annual Out-of-Pocket Limit per Accumulation Period:	$3,000	$6,000
Family Annual Out-of-Pocket Limit per Accumulation Period:	$6,000	$12,000

IMPORTANT: The **Major Medical deductible** and the **out-of-pocket limit(s)** for In-Network and Out-of-Network providers **accumulate separately.**

Cost Share Amount for Medical Services	In-Network	Non-Network
General Practitioner (GP) / Primary Care Physician (PCP)	$20 Office Visit Copay	50 / 50

The copay applies to the office visit with your physician but **does not** include any additional services performed by the physician (example: labs or x-rays). See Enhanced Plan Benefit features for **no cost options**.

IMPORTANT: For the purposes of this Plan, Physicians classified as a Primary Care Physician (PCP) are Family Practitioners, General Practitioners (GP), Internist, Pediatrician, and OB/GYN. All other Physicians are considered Specialists. A referral from a GP / PCP is not required to visit a Specialist.

Cost Share Amount for Medical Services	In-Network	Non-Network
Specialist[2]	$25 Office Visit Copay	50 / 50

The copay (encounter fee) applies to the office visit with your Specialist but **does not** include other services performed by the physician (example: labs or x-rays). No referral is required to see a Specialist. See Enhanced Plan Benefit features for **no cost options.**

Cost Share Amount for Medical Services	In-Network	Non-Network
Urgent Care	$50 Event Copay	50 / 50

The copay applies for **all services** performed during an urgent care visit.

Cost Share Amount for Medical Services	In-Network	Non-Network
Emergency Room	$150 ER Copay	$150 ER Copay

After the copay, the **In-Network** (even at an Out-of-Network facility) major medical coinsurance is applied (See ACA Rules).

	In-Network	Non-Network
Lifetime Limit for Essential Health Benefits:	Unlimited	Unlimited

[1] ACA Maximum Annual Out-of-Pocket Limit includes In-Network Major Medical and Generic & Preferred Name Brand Pharmacy Deductibles, Coinsurance, and Copays. The actual Out-of-Pocket limit each year changes based upon cost-of-living adjustments that is consistent with ACA guidelines for the Plan Year for which claims are incurred. Contact Third Party Administrator for additional details.

[2] A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Enhanced Plan Benefit Features

This page provides a brief description of the many enhanced benefits available to you through your benefit plan.

Reimbursable Deductible Allowance

The **Reimbursable Deductible Allowance (RDA)** is a portion of your Plan Deductible that can be reimbursed back to you at a rate of 100% for eligible In-Network expenses. Eligible In-Network expenses must be **Incurred** during the benefit year to qualify for reimbursement. RDA funds can only be used for Deductibles & Copays and cannot be used for Coinsurance. Current available RDA balances can be reviewed and submissions for reimbursement can be made in the GBS member portal located at: mygbshealth.com

Reimbursable Deductible Allowance (RDA) Amounts	In-Network	Non-Network
RDA Single Amount	**$1,000**	**Not Available**

Preferential Plan Providers

Preferential Plan Providers are providers that have agreed to make their goods and/or services available to GBS plan members at greatly reduced rates. If the plan member seeks eligible goods and/or services from the providers listed below, said goods and/or services will be provided at no cost (covered at 100%) to the plan member. Precertification and medical necessity are required for some of the goods and/or services listed. Likewise, some services require a prescription from your medical provider. Additional details about these benefits can be found in the provisions of your PD. To access the entire PD and review tutorials about each of the below benefits, log in to your GBS member portal located at: mygbshealth.com

Preferential Benefit	Preferential Provider(s)	Benefit Level
Lab Services	**QuestSelect**	**100% ☺**
TIP: Lab appointments can be scheduled through the Quest Diagnostics or LabCorp web site which can also be accessed at: mygbshealth.com	**Find a Location:** www.questselect.com	
	LabCorp	**100% ☺**
	Find a Location: https://www.labcorp.com/labs-and-appointments	
Durable Medical Equipment (DME)	**Carelink DME**	**100% ☺**
IMPORTANT: Carelink is the Preferential Provider for your benefit plan. Precertification is required on items over $150. CARELINK	**Phone:** (888) 604-DMED	
Walk-in Clinics	**CVS MinuteClinic®**	**100% ☺**
TIP: CVS MinuteClinic® appointments can be scheduled through their website which can also be accessed at: mygbshealth.com	**Find a Location:** www.cvs.com/minuteclinic	
Diabetic Management Program and Service	**Livongo**	**100% ☺**
IMPORTANT: Livongo is the exclusive diabetic management service provider. Livongo will supply you with a glucometer and test strips at no charge.	**Phone:** (800) 945-4355 **Website:** welcome.livongo.com/GBS **Registration Code:** GBS	
TIP: All of your glucose readings will be posted on the Livongo's secure website which can also be accessed at: mygbshealth.com		
Telemedicine	**Teladoc**	**100% ☺**
IMPORTANT: Teladoc is the exclusive telemedicine service provider for your benefit plan. There is no visit limit when using this service. **TIP:** Members can access Teladoc via dial up phone service, or a video visit. The video service can be accessed at: mygbshealth.com	**Phone:** (800) 835-2362 **Website:** www.teladoc.com	

Enhanced Plan Benefit Features – Continued

Preferred Place-of-Service Benefits

Preferred Place-of-Service Benefits provide Plan Members with specific medical services at lower-cost when receiving services at a specified place-of-service. If the Plan Member follows the guidelines regarding these Place-of-Service Benefits, the Plan will waive the Member's deductible and coinsurance for the In-Network services listed below. Precertification and medical necessity are required for some of the benefits listed.

Medical Service Categories	Preferred Place-of-Service	Benefit Level
Radiology	**Free-Standing Imaging Facility**	**100% ☺**
Enhanced imaging services (radiology) at **independent, non-hospital** facilities can be provided from one-half (½) to one-third (⅓) of the normal charges billed by hospital facilities. By selecting an independent network facility for your next MRI, CT scan, or PET scan, your plan will pay 100% of the contract rate through your PPO network. By taking charge of where you receive your enhanced imaging services, you are not only saving money, but you are also helping your plan keep the cost of health insurance sustainable. **Precertification and medical necessity determination are required prior to receiving service.**		
Sleep Study	**Home Sleep Study**	**100% ☺**
According to Johns Hopkins Medicine[3], home sleep studies provide a more accurate reading of how you sleep and are usually one-third (⅓) to one-fifth (⅕) of the cost of doing an in-lab study. Choosing to have your sleep study at home will provide a better diagnosis and you save money. Choosing this option also helps your plan keep health insurance costs lower. If durable medical equipment (DME) is needed, please see Carelink for additional member savings.		
Surgical Services	**Ambulatory Surgical Center**	**100% ☺**
According to Johns Hopkins Medicine[4], some of the advantages of having your procedures performed at an Ambulatory Surgical Center (ASC) on an outpatient basis include convenience, lower costs, reduced stress, and more predictable scheduling. Likewise, according to the American Medical Association[5], infection rates after procedures performed at ASCs are less likely. By selecting an ASC for your next procedure, you will not only benefit from the advantages listed previously, but you will also save money while helping your insurance plan keep costs down. **Precertification and medical necessity determination are required prior to receiving service.**		
Walk-in Clinics	**CVS MinuteClinic®**	**100% ☺**
Walk-in clinics are the best option when your general doctor is not available and is typically the most realistic choice for non-life-threatening and/or minor issues. Your health plan has contracted with CVS MinuteClinic® to provide you with immediate access to care when you cannot get in to see your general practitioner. MinuteClinic® costs 40% less than urgent care,[6] so when you choose MinuteClinic® over Urgent Care or the Emergency Room, you are helping to keep the cost of healthcare lower for your plan while you're saving money. Your plan will cover the cost of your MinuteClinic® visit 100%. The only cost associated with your visit may be a copay for a prescription if one is prescribed.		

[3] Johns Hopkins Medicine website: https://www.hopkinsmedicine.org/health/wellness-and-prevention/what-to-know-about-an-at-home-sleep-test#:~:text=Most%20at%2Dhome%20sleep%20tests,by%20insurance%2C%E2%80%9D%20he%20says.

[4] Johns Hopkins Medicine website: https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/outpatient-surgery

[5] American Medical Association website: https://jamanetwork.com/journals/jama/fullarticle/1829988#:~:text=Our%20findings%20affirmed%20that%20the,of%20infections%20following%20inpatient%20operations

[6] Source: Urgent Care Association, "2018 Benchmark Report." Save up to 85% at MinuteClinic® vs. the ER for comparable services. 2020 independent market research study comparing patient out-of-pocket costs for an emergency room visit versus a MinuteClinic® visit for the same presenting condition.

General Description of Benefits

Major Medical Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Acupuncture – Licensed Physician	90 / 10	50 / 50	12 Visit Limit Per Year
Allergy Injections	$5 Copay	50 / 50	
Allergy Testing	90 / 10	50 / 50	
Ambulance – Air[7] & Ground Services	90 / 10	50 / 50	**For Emergency Use Only**
Ambulatory Surgical Center (ASC)	100% ☺	50 / 50	Must be Pre-certified
Anesthesia	90 / 10	50 / 50	
Birthing Center	90 / 10	50 / 50	
Blood & Plasma	90 / 10	50 / 50	
Chiropractic Care - Over 5 Years of Age	90 / 10	50 / 50	30 Visit Limit Per Year
Dialysis – 6 Month Benefit Limit	90 / 10	50 / 50	Must be Pre-certified
Durable Medical Equipment (DME) – Non Carelink	90 / 10	50 / 50	Must be Pre-certified
Hearing Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Hearing Exam
Home Health Care – 120 Day Annual Limit	90 / 10	50 / 50	Must be Pre-certified
Hospice Care	180 Day Benefit Limit		Must be Pre-certified
Inpatient Treatment	90 / 10	50 / 50	
Outpatient Treatment	90 / 10	50 / 50	
Family Bereavement Counseling	90 / 10	50 / 50	
Hospital			Must be Pre-certified
Inpatient Treatment	90 / 10	50 / 50	
Outpatient Treatment	90 / 10	50 / 50	
Infusion Therapy			Must be Pre-certified
Non-Orphan Drugs Only Covered Through PBM	**See Pharmacy Benefit Card for Copays**		**Only Through the PBM**
Lab Services – (Non-Quest or LabCorp)	90 / 10	50 / 50	See Enhanced Plan Benefits
Maternity Program			
Maternity – Hospital or Midwife Delivery	90 / 10	50 / 50	
Maternity – Happy Beginnings Pre-Natal Delivery Well Care	100% ☺	50 / 50	Mother Routine Care Visits
Mental Health, Substance & Chemical Dependency			Must be Pre-certified
Inpatient Physician Services	90 / 10	50 / 50	60 Day Annual Limit
Partial Day Program	90 / 10	50 / 50	60 Visit Annual Limit
Outpatient Physician Services	90 / 10	50 / 50	60 Visit Annual Limit
Residential Treatment Program	90 / 10	50 / 50	60 Day Annual Limit
Newborn Nursery Care – While Inpatient	90 / 10	50 / 50	
Orthoptic Training			Must be Pre-certified
Only when Prescribed by a Physician	90 / 10	50 / 50	Dependents up to age 10
Orthotics - Only when Prescribed by a Physician	90 / 10	50 / 50	Must be Pre-certified
Outpatient Emergency Services (ER)	For non-emergency services see Telemedicine & Walk-in Clinics		
Emergency Room - **For Emergency Use Only**	$150 Copay[8]	$150 Copay[9]	Non-Emergency Services Could Be Denied
Physicians - **For Emergency Use Only**	90 / 10	90 / 10	

[7] Eligible Air Ambulance charges are limited to Reasonable, Usual & Customary, or a percentage of Medicare Allowable, whichever is appropriate. Benefits can be limited based on other coverage or services previously purchased by Plan Members through an association, group, and/or a specific air ambulance company program. Contact Third Party Administrator for additional details.

[8] After the copay, the **in-network** major medical coinsurance is applied.

[9] After the copay, the **in-network** major medical coinsurance is applied.

General Description of Benefits - Continued

Major Medical Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Physician Services[10] (See Below; GP, Specialists, etc.)			
General Practitioner (GP) / Primary Care Physician (PCP)	$20 Dr. Copay	50 / 50	Office Visit Copay[11]
Specialist[12] – Encounter Copay	$25 Dr. Copay	50 / 50	Office Visit Copay[13]
Telehealth Services – **Teladoc**	100% ☺	Not Available	100% covered using Teladoc
Urgent Care	$50 Event Copay	50 / 50	Event Copay[14]
CVS MinuteClinic®	100% ☺	Not Available	All Eligible Charges Covered[15]
Lab and X-ray Services	90 / 10	50 / 50	See Enhanced Plan Benefits
Preferred Place-of-Service Benefits	100% ☺	50 / 50	See Enhanced Plan Benefits
Preferential Plan Provider Benefits	100% ☺	Not Available	See Enhanced Plan Benefits
Preventive Care	https://www.healthcare.gov/coverage/preventive-care-benefits/		
Routine Physical Exam	100% ☺	50 / 50	Annually
Mammograms	100% ☺	50 / 50	Must be over age 40
Pap Smears	100% ☺	50 / 50	Annually
Prostate Exam	100% ☺	50 / 50	Must be over age 50
Routine Immunizations	100% ☺	50 / 50	
Well Child Care Exam	100% ☺	50 / 50	
Private Duty Nursing	90 / 10	50 / 50	
Prosthetics	90 / 10	50 / 50	Must be Pre-certified
Radiology – Enhanced Imaging[16] MRI, CT scan, or PET scan	90 / 10	50 / 50	Must be Pre-certified
Routine Patient Costs – Approved Clinical Trials	90 / 10	50 / 50	Must be Pre-certified
Second Surgical Opinions	100% ☺	50 / 50	
Skilled Nursing Facility – 120 Day Annual Limit	90 / 10	50 / 50	Must be Pre-certified
Sleep Apnea Appliance (CPAP) – See Carelink	90 / 10	50 / 50	Must be Pre-certified
Smoking Cessation – 120 Day Annual Limit	100% ☺	Not Covered	See PBM Program
Surgery – See Enhanced Plan Benefits for Additional Benefits	90 / 10	50 / 50	Must be Pre-certified
Telehealth Services – **Non-Teladoc**	$20 Dr. Copay	50 / 50	Limits[17] will apply
Temporomandibular Joint Disorder (TMJ)	90 / 10	50 / 50	Must be Pre-certified
Therapy			Must be Pre-certified
Chemotherapy	90 / 10	50 / 50	
Occupational Therapy	90 / 10	50 / 50	60 Day Annual Visit Limit
Physical Therapy	90 / 10	50 / 50	60 Day Annual Visit Limit
Radiation Therapy	90 / 10	50 / 50	
Respiration Therapy	90 / 10	50 / 50	
Speech Therapy	90 / 10	50 / 50	60 Day Annual Visit Limit
Transplants – ETS[18] Transplant Network	90 / 10	50 / 50	Must be Pre-certified
Walk-in Clinic Visit – See Enhanced Plan Benefits for no Copay	$20 Dr. Copay	50 / 50	Office Visit Copay[19]
Vision Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Vision Exam
Weight Loss Counseling – No Procedures	100% ☺	100% ☺	1 Annual Counseling Visit
All Other Eligible Services – Not Specifically Listed	90 / 10	50 / 50	See Plan Details

[10] **Note:** For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is **not** required.

[11] **Note:** The copay applies to the office visit with your physician but **does not** include any additional services performed by the physician (example: labs or x-rays).

[12] A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

[13] **Note:** The copay (encounter fee) applies to the office visit with your Specialist but **does not** include other services performed by the physician (example: labs or x-rays). No referral is required to see a Specialist.

[14] **Note:** The copay applies for **all services** performed during an urgent care visit.

[15] **Note:** The member may be responsible for a prescription copay if a prescription is prescribed during the clinic visit.

[16] **Note:** Using a Preferred Place-of-Service will provide a no cost benefit to the member. See Preferred Place-of-Service section above for details.

[17] A telehealth visit charge can be **no more** than a face-to-face office visit.

[18] **Note:** ETS is Emerging Therapy Solutions, Inc.

[19] **Note:** The copay applies to the office visit with your physician but **does not** include any additional services performed by the physician (example: labs or x-rays).

Summary of Prescription Drug (Rx) Benefits

The following benefits levels are per Plan Participant:

Mail Order or Retail Maintenance Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Retail Prescription Copayment Options – 30-day supply	The copayments shown are applied to each prescription.
ACA Preventive Services – These medications fall under ACA wellness – covered @ 100%	**$0 – No Copay ☺**
Tier 1 - Copayment per new or refill prescription – Generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription - means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs.	**$20 Copay**
Tier 3 - Copayment per new or refill prescription - means a category of prescription drugs that generally includes all non-preferred drugs.	**50 / 50 Cost Share**
For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact GBS Rx at (888) 364-3580.	

Mail Order or Retail Maintenance Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Mail Order or Retail Maintenance Prescription Copayment Options – 90-day supply[20]	The copayments shown are applied to each prescription.
ACA Preventive Services – These medications fall under ACA wellness – covered @ 100%	**$0 – No Copay ☺**
Tier 1 - Copayment per new or refill prescription – Generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription - means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs.	**$30 Copay**
Tier 3 - Copayment per new or refill prescription - means a category of prescription drugs that generally includes all non-preferred drugs.	**50 / 50 Cost Share**
For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact GBSRx at (888) 364-3580.	

Specialty Drug Expenses (Non-Orphan Drugs):	Participating Pharmacy
Retail Specialty[21] **Card Copayment Options – No more than a 30-day supply**	The copayments shown are applied to each prescription.
Copayment per new or refill Specialty prescription - Generic	**$30 Copay**
Copayment per new or refill Specialty prescription - Preferred Name Brand	**$60 Copay**
Copayment per new or refill Specialty prescription - Non-Preferred Name Brand	**50 / 50 Cost Share**
Copayment per new or refill Specialty prescription through GBS Rx Specialty Drug Program	**No Copay (See Below)**

Note:
In accordance with applicable law, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as medical Deductibles or prescription drug co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact Drexi Rx at 833-306-4092 at the telephone number on the health plan identification card.

Immunizations through the Pharmacy:
Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no prescription drug co-payment or medical Deductible will be applied). Covered Persons can contact Drexi Rx for more information on how to find a pharmacy within the designated network that administers these immunizations.

Drug Manufacturer Assistance Programs:
Any amounts paid toward plan member responsibility which were paid or reimbursed by manufacturer assistance programs, which includes copay cards, or similar patient assistance programs from a third party, do not accrue toward the deductible or annual out-of-pocket maximum.

Step Therapy Protocol:
When it comes to medicines to treat long-term health conditions, people and doctors have more choices than ever. Cost is often a big difference between the choices. Brand-name medicines usually are highest-cost and generic medicines are usually the lowest-cost.

One way to make sure you get safe, effective, and reasonably-priced medicine is by using programs like step therapy. Step therapy programs are created using U.S. Food and Drug Administration (FDA) guidelines, clinical evidence, and research.
These programs encourage you and your doctors to start treatment with an appropriate generic medicine with the lowest copay rather than a higher-cost medicine.

[20] Some medications such as narcotics and specialty medications are not available for the 90-day mail order or retail maintenance program.

[21] Specialty medications and infusion therapy must be pre-certified. Orphan drugs are not covered.

Step therapy protocol means that an individual may need to use one type of medication before another. Your plan monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help an individual access high quality yet cost-effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the prior authorization process is applied.

Generic medicines are an important step you can take to spend less for your prescriptions:
A lower-cost option that is as safe and effective as brand-name medicines.[22] 2 out of 3 prescriptions filled today are for generic medicines and that number is growing.[23] The FDA approve generic medicines to be just as safe and effective as their Brand-name counterparts.

There are generic medicine options to treat many conditions – your doctor can help you choose the right one for you. The step therapy program makes prescriptions more affordable for many people who participate. It also helps keep your prescription benefit plan priced right and helps control the rising cost of medicines by encouraging the use of lower-cost generic medicines that are as safe and effective as brand-name medicines.

[22] Generic Pharmaceutical Association's Website: http://www.gphaonline.org/Content/NavigationMenu/AboutGenerics/Statistics/Statistics.htm
[23] Generic Pharmaceutical Association's Website: http://www.gphaonline.org/about-gpha/about-generics/case

ABOUT THE GBS NURSE NAVIGATORS PROGRAM

You now have access to GBS Nurse Navigators through your health plan! Nurse Navigators connect you to high-quality care at affordable prices.

Expert Guidance, Essential Support

Your GBS Nurse Navigator ("Nurses") team doesn't just connect you to affordable, high-quality care. Learn more about the other services your Nurse Navigator team provides below.

Appointment Scheduling

Nurses can assist you with scheduling appointments as part of your prescribed treatment plan.

Education and Support

Nurses can provide education and support to you, your family, and your care support system.

Locating Specialists

Nurses can help you locate qualified specialists for second opinions on diagnosis or treatments.

Referrals to Enhanced Benefit Programs

Nurses can refer you to an available cost-saving program that is applicable to your care needs.

Help Understanding Diagnosis/Treatment(s)

Nurses can assist you in understanding a diagnosis or proposed treatment(s) for a variety of health conditions.

GBS Nurse Navigators

Monday-Friday, 8 a.m.–5 p.m. CT
1-888-364-3580

HOW TO READ YOUR PLAN ID CARD

A POCKET-SIZED BENEFIT GUIDE

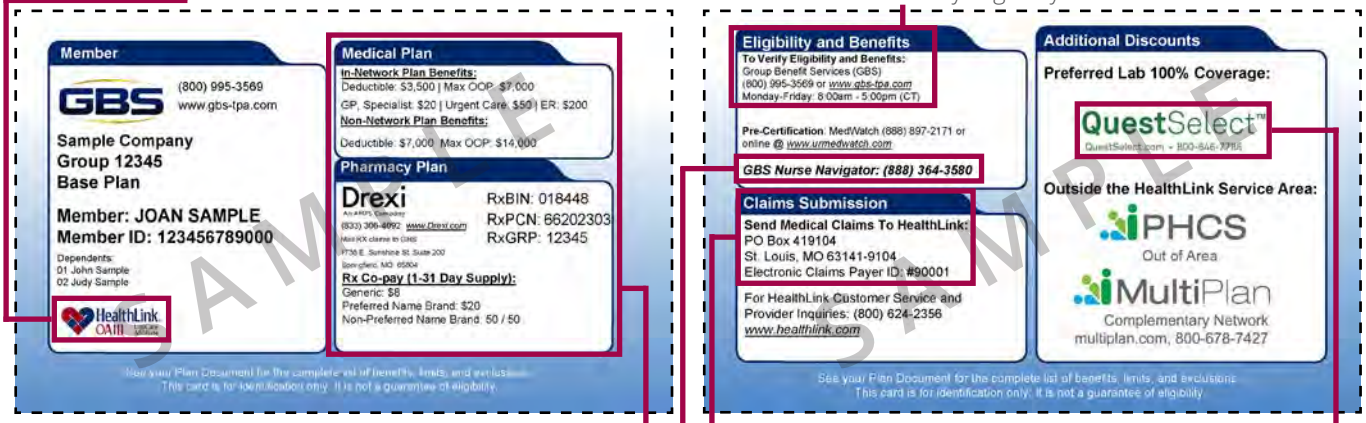
Your plan ID card is a small but mighty piece of your benefit toolkit. Discover the most significant parts of your card and the information each one provides below!

NOTE: *The* ***below cards*** *are for* ***example only.*** *Your actual plan ID cards may differ in layout and/or information.*

MEDICAL

PPO Network: *HealthLink Open Access III* is your medical PPO network.

Benefit Verification and Eligibility: Group Benefit Services (GBS) is your insurance administrator. Contact GBS to verify eligibility and benefits.



Deductibles and Copays: These are your deductibles and/or copays for covered services. Your copay may be due at time of service.

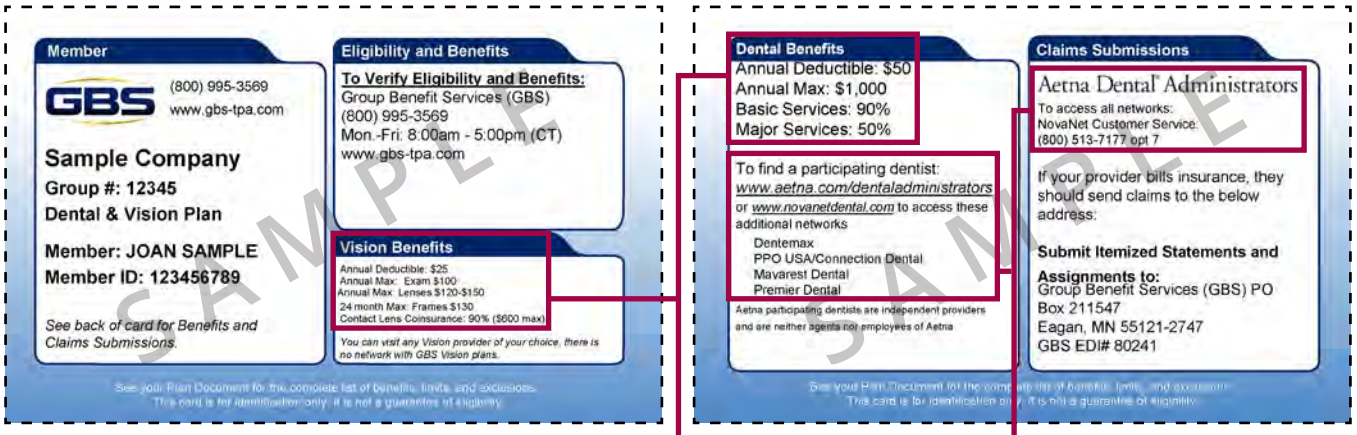
Nurse Navigators: *GBS Nurse Navigators* (included in your medical plan) can help you access your specialty medication(s) with no copay.*

Claims Submissions Address: Claims should be mailed to GBS at this address.

No-Cost Lab Services: QuestSelect is a preferred lab services provider. Use QuestSelect to have your lab services covered at 100%.

DENTAL + VISION

Note: If you elect only dental or vision (not both), you'll receive an ID card with info only for that benefit.



Deductibles and Copays: These are your deductibles and/or copays for covered services. Your copay may be due at time of service.

PPO Networks: Using an in-network provider lowers your **out-of-pocket cost(s)** but *is not required* to use your dental or vision benefits.

*Not all plans cover these benefits at 100%. Review your Plan Document prior to receiving service(s).

Need help?

800.995.3569
info@gbsitpa.com

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

"VOLUNTARY DENTAL BENEFIT PLAN"

PREPARED EXCLUSIVELY FOR:

ADAIR COUNTY GOVERNMENT

PREPARED BY:

GROUP BENEFIT SERVICES

www.gbs-tpa.com

"Innovative Solutions | Customized Benefits | Sustainable Plans"

VOLUNTARY DENTAL BENEFITS

Summary of Voluntary Dental Benefits if Elected by Plan Member

The following Deductibles, Benefits, and Plan Maximums are per Plan Participant, per Plan Year:

Dental Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant – Deductible waived for Class 1 Services	**$25**
Annual Deductible per Family – Deductible waived for Class 1 Services	**$50**
Maximum Annual Benefit Limit for Class 1, 2 and 3 Services	**$1,000**
Maximum Lifetime Benefit Limit for Class 4 Services – Orthodontia	**Not Covered**

Dental Benefit Coinsurance Levels Based Upon Class:	Benefit Coverage	Benefit Type
Class 1 Services	**100% One Hundred Percent ☺**	*Preventive Care
Class 2 Services	**90% Ninety Percent**	Repair and Restoration
Class 3 Services	**60% Sixty Percent**	Major Dental Repair
Class 4 Services	**Not Covered**	Orthodontics
All charges except **preventive care are limited to Usual and Customary Fees calculated at the 90th percentile.*		

Dental PPO Network: The dental program includes the **Aetna Dental Signature Administrators PPO** Network. Use of network providers are optional.

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Plan Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and Exclusions set forth in this section.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a Participant chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the Participant and the Dentist decide to use a gold filling, the Plan will base its reimbursement on Maximum Allowable Charge for an amalgam filling. The patient will pay the difference in cost.

Pre-Determination of Dental Benefits

If a planned dental service or Participant's proposed course of treatment can be reasonably expected to involve dental charges of $300 or more, a Participant may submit a description of the procedures to be performed and an estimate of the charges to the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.**

Dental Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to the Maximum Allowable Charge.

Class 1 Services (Preventive Care)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than once in any period of 6 consecutive months.
2. Periapical x-rays, as required, and bitewing x-rays once in any period of 6 consecutive months.
3. Full mouth x-rays, but not more than once in any period of 60 consecutive months, or
4. Panoramic x-rays, but not more than once in any period of 60 consecutive months (only Panoramic **or** Full mouth x-rays, but not both).
5. Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children under age 16, but not more than once in any period of 36 consecutive months.
6. Topical application of fluoride for Dependent Children under age 14, but not more than once in any period of 6 consecutive months.
7. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age 16. No payment will be made for duplicate space maintainers.
8. Palliative emergency treatment of an acute condition requiring immediate care.

Class 2 Services (Repair and Restoration)

1. All Medically Necessary x-rays not covered under another class.
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.
3. Simple extractions.
4. Endodontics, including pulpotomy, direct pulp capping and root canal treatment.
5. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant upon demonstration of Medical Necessity.
6. Periodontal examinations, treatment and Surgery.
7. Consultations.

Class 3 Services (Major Dental Repair)

Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth.
2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures.
3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable.
    b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within12 months.
4. Osseous Surgery.
5. Periodontal scaling.
6. Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.
7. Post and core.
8. Relines.
9. Stainless steel crowns.

Class 4 Services (Orthodontics) Only available if depicted in the Benefit Summary

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth. Orthodontic services will be eligible only when provided to covered Dependents who are under age 19 when treatment is received.

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan.
2. Interceptive, interventive or preventive orthodontic services.

3. Fixed and removable appliance placement, and active treatment per month after the first month.
4. Extractions in connection with orthodontic services.

Dental Exclusions and Limitations

The following Exclusions and limitations are in addition to those set forth in the sections entitled "General Limitations and Exclusions," and "Summary of Benefits".

Adjustments. Charges arising from alteration of dimension or occlusion; to address damage arising from abrasion or attrition; splinting and/or temporomandibular joint disturbances.

Administrative Costs. For administrative costs of completing claim forms or reports or for providing dental records.

After the Termination Date. The Plan will not pay for services or supplies furnished after the date coverage terminates. Predetermination of an allowable course of treatment and eligible services (claims for which coverage would be in effect had coverage not terminated) will not extend coverage beyond termination. The Plan will pay for a prosthetic device, crown, such as full or partial dentures, if the preparatory steps (such as an impression) had already initiated and/or been prepared for said device or crown, while the patient was a Participant in the Plan; so long as the device or crown is delivered and installed within two months following termination of coverage, as well as root canal therapy if the Dentist opened the tooth while the patient was a Participant, and treatment is completed within two months of coverage termination.

Anesthetic. Local infiltration anesthetic when billed for separately by a Dentist.

Cosmetic. Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations.

This exclusion will not apply to cosmetic work needed as a result of Accidental Injury. Damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered orthodontic treatment.

Crowns. For crowns for the purpose of periodontal splinting.

Duplicate X-Rays. Charges for duplicate copies or replication of x-ray or other imaging.

Education. Charges solely arising from instruction provided regarding oral health and/or diet, including a plaque control program.

Experimental. Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association.

Hygiene. For oral hygiene, plaque control programs or dietary instructions.

Implants. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants, except first-time non-cosmetic dental implants.

Late Enrollee. Charges Incurred during the first 24 months of coverage applicable to a late enrollee. This Exclusion shall not apply to such claims arising from or due to an Accidental Injury sustained by the Participant. "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

Medical Benefits. For charges covered under the "Medical Benefits" section of the Plan.

Miscellaneous. The Plan does not cover any dental charge, service or supply not provided by a Dentist or Physician unless it is: (1) specifically for non-Experimental services performed at a dental school under the supervision of a Dentist, and only if the school customarily charges patients for its services, or (2) specifically for cleaning, scaling and/or application of fluoride, and is performed by a licensed dental hygienist under the supervision of a Dentist.

Missing Appliances. The cost of replacing lost, missing or stolen supplies, including implants, appliances, and prosthetics.

More Expensive Course of Treatment. The aforementioned rules regarding Medical Necessity, Maximum Allowable Charge, and the least costly yet equally effective treatments shall apply here as well.

If a Participant chooses a more expensive treatment than is needed according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment at the most cost-effective level.

Mouth Guards. For athletic guards and/or occlusal guards.

Not Recommended. Charges for services or supplies which are not recommended and approved by a Dentist or Physician.

Orthognathic Surgery. For Surgery to correct malpositions in the bones of the jaw.

Personalization. For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

Replacements. Charges for replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge, made within five years after the last placement, exclusive of replacement necessitated by damages caused by an Accidental Injury sustained by the Participant, resulting in damages that are beyond repair. Damage resulting from biting or chewing is not considered an Accidental Injury.

Single Provider Care. Charges arising from solely the transfer from one Provider's care to another, that would not have been Incurred had one Provider been utilized, and thereby in accordance with the Maximum Allowable Charge.

Splinting. For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

TMJ. Treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint, and appliances.

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

"VOLUNTARY VISION BENEFIT PLAN"

PREPARED EXCLUSIVELY FOR:

ADAIR COUNTY GOVERNMENT

PREPARED BY:

GROUP BENEFIT SERVICES

www.gbs-tpa.com

"Innovative Solutions | Customized Benefits | Sustainable Plans"

VOLUNTARY VISION BENEFITS

Summary of Voluntary Vision Benefits if Elected by Plan Member

The following Deductibles, Copayments, and Benefits are per Plan Participant, per Plan year:

Vision Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant	**$50**
Annual Deductible per Family	**$100**
Vision Coinsurance	**90% Ninety Percent**
Maximum Annual Vision Plan Benefit Limit per Participant	**$600**

Vision Expense Benefit Descriptions:	Benefit Limits[1]	Annual Benefit Maximum
1 Eye Exam[2], Per Participant (No deductible applies to eye exam)	1 every 12 months	**$100 Maximum**
1 Set of Frame-type Single Vision Lenses	1 every 12 months	**$120 Maximum**
1 Set of Frame-type Bi-focal Lenses	1 every 12 months	**$130 Maximum**
1 Set of Frame-type Tri-focal Lenses	1 every 12 months	**$140 Maximum**
1 Set of Frame-type Lenticular Lenses	1 every 12 months	**$150 Maximum**
1 Set of Frames	1 every 24 months	**$130 Maximum**
Contact Lenses	Subject to Vision Limit	**90 / 10 to Benefit Limit**

Benefit Limitation: A Participant can use the vision benefit program to secure either eyeglasses with frames (subject to plan limitations) **or** contact lenses within a 12-month period (**not both**).Network. Use of network providers are optional.

Vision Covered Expenses

Subject to the limits in the Summary of Benefits, the Plan pays the Maximum Allowable Charge for vision care services, as follows:

Enrolled in a Training Program. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program.

Eye Refractions. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Injury).

Radial Keratotomy. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Recommended. Recommended and approved by a Physician or optometrist.

Vision Exclusions and Limitations

The following Exclusions and limitations are in addition to those set forth in the sections entitled “General Limitations and Exclusions,” and “Summary of Benefits”:

Benefit Limitations. A Participant can use the benefit to secure either eye glasses with frames or contact lenses, but not both within the same Plan year.

Glaucoma and Cataracts. Treatment of glaucoma, cataract surgery and one set of lenses (contacts or frame-type) for these conditions are covered under Medical Benefits.

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[1] These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the entire Plan Document carefully to determine available benefits.

[2] If the member has the major medical plan and the vision program, eligible eye exam expenses will be paid by the medical plan.

Greater Coverage. Any charges that are covered under a medical or health plan that reimburses a greater amount than this Plan.

Missed Consultations. Missed consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

Non Prescription Lenses. Charges for lenses ordered without a prescription or lenses that do not require a prescription.

Orthoptics. Charges for orthoptics (eye muscle exercises).

Safety Goggles. Charges for eyewear not meant to address any medical purpose including but not limited to plain safety glasses or goggles.

Sunglasses. Charges for sunglasses not meant to address any medical purpose including prescription type.

Vision Training. Charges for vision training or subnormal vision aids.

Plan Highlights

Group Basic Life and AD&D, and Dependent Life Insurance

Adair County Government

ELIGIBILITY

Employees: Each Active, Full-time employee working 30 or more hours per week, except any person working on a temporary or seasonal basis.

Dependents: You must be insured in order for Dependents to be covered.
Dependents are:

- your legal spouse not legally separated or divorced from you
- your unmarried financially dependent children* age 14 days to 20 years (to 26 years if full-time student).

*natural and adopted children; stepchildren and foster children in your custody.
Age limit does not apply to handicapped children.

- A person may not have coverage as both an Employee and Dependent.
- Only one insured spouse may cover Dependent children.

BENEFIT AMOUNT

Basic Life

$25,000

Amounts of life insurance equal to $150,000 or more may be subject to an earnings cap.

Dependent Life

Spouse $10,000
(spouse amount may not exceed 100% of employee amount)

Dependent Child(ren)
Birth to age 19 : $500
Age 20 to age 23 : $5,000
(up to age 26 if a full-time student)

GUARANTEED ISSUE

Employee: $25,000
Spouse: $10,000
Child: all child amounts are guaranteed issue

CONTRIBUTION REQUIREMENTS

Basic Life:
Coverage is 100% employer paid.

Dependent Life:

Spouse: Coverage is 100% employee paid.

Dependent Child(ren): Coverage is 100% employee paid.

BENEFIT REDUCTION DUE TO AGE (applicable to employee/spouse coverage)

Age	Original Benefit Reduced To
65	65%
70	40%
75	20%

FEATURES

- Living Benefit Rider(expressed as Accelerated Death Benefit in some states and Imminent Death Benefit in PA)
- Conversion Privilege
- FMLA/MSLA Continuation
- Waiver of Premium with Critical Illness

VALUE ADDED SERVICES

- Bereavement Counseling Service
- Travel Assistance Service

EXCLUSIONS

AD&D EXCLUSIONS:
AD&D benefits will not be payable for a loss: caused by suicide or intentionally self-inflicted injuries; caused by or resulting from war or any act of war, declared or undeclared; to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor;
sustained during an insured's commission or attempted commission of an assault or felony; to which the insured's acute or chronic intoxication is a contributing factor; or to which the insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.
For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6422, et al.

EAP
employee assistance

ACI SPECIALTY BENEFITS

ACI's Employee Assistance Program (EAP) provides professional and confidential services to help employees and family members address a variety of personal, family, life, and work-related issues.

Confidential and professional assessment and referral services for employees and their family members

EAP and Work-Life Benefits:

From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- Unlimited Telephonic Clinical Assessment and Referral
- Up to 5 Sessions of Professional Assessment* for Employees and Family Members
- Unlimited Child Care and Elder Care Referrals
- Legal Consultation for Unlimited Number of Issues per Year
- Financial Consultation for Unlimited Number of Issues per Year
- Unlimited Pet Care Consultation
- Unlimited Education Referrals and Resources
- Unlimited Referrals and Resources for any Personal Service
- Unlimited Community-based Resource Referrals
- Online Legal Resource Center
- *Affinity*™ Online Work-Life Website
- myACI App for Mobile Access
- Multicultural and Multilingual Providers Available Nationwide

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

EAP services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

*3 Sessions per Six Months for California Employees

Additional Questions?

Contact Human Resources or contact ACI Specialty Benefits toll-free at

855-RSL-HELP
(855-775-4357)
rsli@acieap.com
http://rsli.acieap.com

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

RS-2507 (07/2016)

Reimbursable Deductible Allowance FAQs

What is the Reimbursable Deductible Allowance?

The Reimbursable Deductible Allowance (RDA) is a benefit built into your medical plan that reimburses you for payments you make toward your in-network medical deductible.

What expenses are not eligible for reimbursement under the RDA?

The following expenses are ineligible for reimbursement under the RDA:

- Medical copays
- Prescription copays
- Coinsurance
- Out-of-network expenses, including copays
- Services not covered by the medical plan

How do I use the RDA benefit?

After you've received treatment, your provider will send the claim to GBS to be processed. Once GBS has processed the claim, you will be sent an Explanation of Benefits (EOB) that outlines your financial responsibility.

After you've paid the amount that was applied to your deductible, collect your proof of payment in the form of:

- A cancelled check
- A credit card statement
- A bank statement
- An itemized paid invoice or receipt

Next, complete an RDA claim form and submit both the form and your proof of payment to GBS in one of the following ways:

- **Fax:** (417) 883-8261
- **Email:** claims@gbsitpa.com
- **Online:** www.mygbshealth.com
- **Mail:** Group Benefit Services
  3810 E. Sunshine St., STE 200
  Springfield, MO 65809

When using the online option (above), select Contact Us (top of the page) to submit your documents via a secure message.

Can I use my Flexible Spending Account before I use my RDA?

No, your RDA must be exhausted before you can use your Flexible Spending Account (FSA). This guideline is in accordance with Internal Revenue Service (IRS) regulations that govern FSA (Section 125) distribution.

How long do I have to submit a claim for reimbursement under the RDA benefit?

The deadline to submit RDA claims is 90 days from the end of your benefit period. For example, if your medical plan deductible restarts on January 1 of each year, then you will have until March 31 to submit RDA claims from last year.

If your employment ends with your employer during the benefit period, you will have 90 days from your last day of employment to submit your RDA claim form(s) with proof(s) of payment for reimbursement under the RDA benefit.

Who can I contact if I have questions about the RDA that are not listed here?

If you have any additional questions about the RDA, contact GBS M-F 8 a.m.-5 p.m. CT.

Phone: (800) 995-3569 | **Email:** claims@gbsitpa.com | **Online:** www.mygbshealth.com

ABOUT THE RDA: REIMBURSEMENT

The **Reimbursable Deductible Allowance (RDA)** is a benefit built into your medical plan that **reimburses** you for **payments** you **make toward your in-network medical deductible.** Let's say your medical plan includes the following RDA benefit amount:

Reimbursable Deductible Allowance (RDA) Amounts	In-Network	Non-Network
RDA Single Amount	$1,000	Not Available

The above table indicates that **each individual member** ("RDA Single Amount") on the medical plan can receive **up to $1,000*** in reimbursement during the plan year. If you select **coverage** that **includes** your **spouse and/or child(ren),** each individual family member can also receive **up to $1,000*** in reimbursement.

MAXIMUM FAMILY REIMBURSEMENT AMOUNT

If you select coverage that includes your spouse and/or child(ren), the **total reimbursement amount** your **family** can receive **as a whole is limited.** This is called the Total Maximum Family Reimbursement Amount, and can be calculated in a few simple steps.

HOW TO CALCULATE THE TOTAL MAX. FAMILY REIMBURSEMENT AMOUNT

1. Determine how much your **in-network family deductible** is by reviewing your Summary Plan Document (SPD). Below is a snippet we'll use for our example.

Major Medical Deductible / Member Cost Share	In-Network
Single Deductible per Accumulation Period:	$4,000
Family Deductible per Accumulation Period:	$8,000

2. Remove the zeros from each deductible, then **divide** the **family deductible** by the **single deductible.** The result is your multiplier. In this example, the equation would be: 8 ÷ 4 = 2
3. Finally, **multiply** the **RDA Single Amount** by your **multiplier** (determined in Step 2). This final result is the total maximum family reimbursement amount for the plan year. In this example, the equation would be: 2 x $1,000 = $2,000

EXAMPLE: HOW MAX. FAMILY REIMBURSEMENT WORKS

No 2022 Rollover: Since this is the family's first year on the plan, they had no rollover from the previous plan year (2022).

Single Reimbursement Limit: Even though Ben had $1,750 in claims eligible for reimbursement, he could only receive up to the RDA Single Amount of $1,000 in reimbursement.

	Single RDA Amount	Claim Date of Service	Eligible Claims Totals	Total Amount Reimbursed	2023 Family RDA Remaining	2023 Single RDA Remaining	2024 Rollover Amount
Amy	$1,000	Feb. 1	$1,000	$1,000	$1,000	$0	$0
Ben	$1,000	July 18	$1,750	$1,000	$0	$0	$0
Lea	$1,000	Oct. 4	$1,000	$0	$0	$1,000	$500

Family Reimbursement Limit: Since the other family members had already received reimbursements that (when combined) met the RDA Family Amount of $2,000, Lea could not receive any reimbursement for her eligible claims.

2024 Rollover: Since the other family members used the entire RDA Family Amount, Lea could not receive any reimbursement for her claims. Thus, 50% of her unused $1,000 2023 RDA Single Amount will rollover to plan year 2024.

*The Single Amount used in this flyer is for example only. Your RDA benefit amount may vary. Review your Summary Plan Document (SPD) for benefit details.

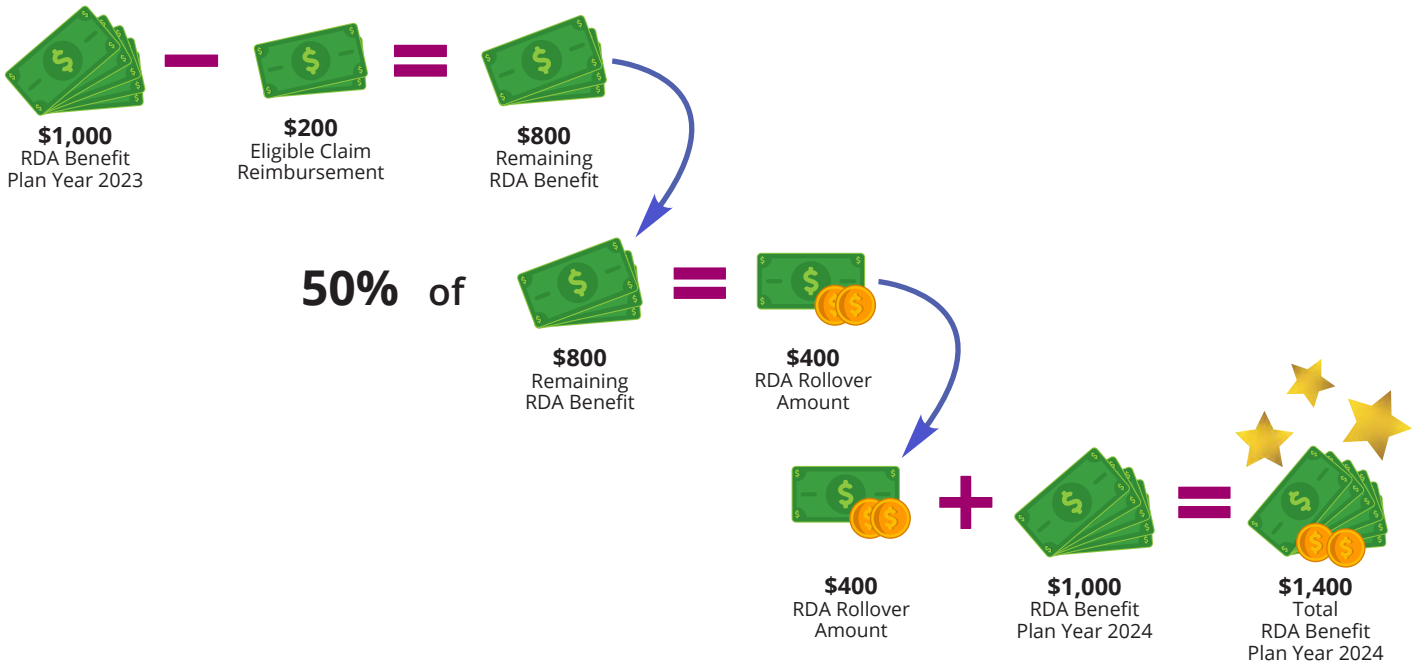
ABOUT THE RDA: ANNUAL ROLLOVER

HOW ANNUAL ROLLOVER WORKS

If there are **any unused RDA** benefit **amounts left** at the **end of the plan year, 50% will roll over** for use during the **next plan year. Rollover occurs after** the **filing deadline** has passed, which is **typically 90 calendar days** from the **last day of the plan year.** For example, if Plan Year 2023 ends on December 31, 2023 then the 2023 RDA filing deadline would be March 31, 2024.

EXAMPLE: *EMPLOYEE ONLY COVERAGE*

Sue **used $200** of her **$1,000 RDA benefit** in **Plan Year 2023.** This **leaves $800** of Sue's RDA Plan Year 2023 benefit. So, when the next plan year begins **(Plan Year 2024) $400 will roll over** and be **added to** her **yearly $1,000** for a **total** of **$1,400** for **Plan Year 2024.**



Need help?

800.995.3569
info@gbsitpa.com

REIMBURSABLE DEDUCTIBLE ALLOWANCE CLAIM FORM

RDA Submission Options

Fax: (417) 883-8261 | **Email:** claims@gbsitpa.com | **Online:** mygbshealth.com

EMPLOYEE INFORMATION

*This section **must be completed for all Reimbursable Deductible Allowance (RDA) claim submissions.***
*This section must be **completed by the employee only.***

Name: _____ **Employer:** _____

Last 4 of SSN:_____ **Date of Birth:** _____

Home Address:_____

Street Address *City* *State* *Zip*

DEPENDENT INFORMATION

Only complete** this section **for a dependent RDA claim submission.

Dependent's Name:_____ **Date of Birth:** _____

CLAIM INFORMATION

Complete** this section **for all RDA claim submissions.

Date of Service: _____ **Claim Amount:** $ _____

Name of provider where services were received: _____

*****Please Attach a Copy of the Paid Claim(s) with a Paid Receipt(s) *****

AGREEMENT AND SIGNATURE

I/We certify that the above information is true and correct. I/We authorize the release of any medical or other information necessary to evaluate and complete the review and processing of any claims for reimbursement. A photocopy of this authorization shall be considered as valid as the original.

Signature of Employee: _____ **Date:**_____

Signature of Spouse (if patient):_____ **Date:**_____

AUTHORIZATION FOR EFT AUTOMATIC DEPOSITS (ACH CREDITS)

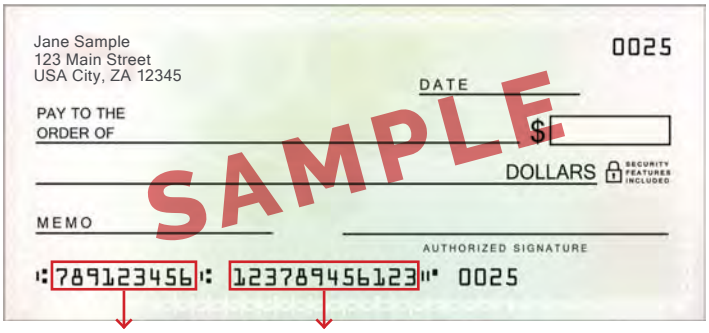
Complete and submit this form to have your claim-related reimbursements automatically deposited into your selected checking or savings account.

Employee Name: _____ **Employer:** _____
Last First Middle Initial

BANK + ACCOUNT INFORMATION

Account Type: Checking Account
Savings Account

Name on Account: _____



Routing Number

Account Number

Bank Name

Bank Address

Bank City **State** **Zip**

AUTHORIZATION AND SIGNATURE

I (the Undersigned) hereby authorize Group Benefit Services (GBS) to initiate deposits (ACH credits) into my account for all employee claim payments, including:

- Flexible Spending Account (FSA) reimbursements for healthcare and/or dependent care assistance
- HRA (RDA) reimbursements
- Claims payable to me (the member) that were filed by a provider or myself (the member).

I (the Undersigned) further authorize GBS to initiate debit entries (ACH withdrawals) if/when necessary to adjust for any credit entries made to my account in error.

I (the Undersigned) understand and agree that this authorization will remain in force (active) until GBS receives a written notification from me of the authorization's termination.

Employee Signature: _____ **Date:** _____

SUBMISSION OPTIONS
Mail: Group Benefit Services, **ATTN:** Accounting Dept., 3810 E. Sunshine, #200, Springfield, MO 65809
Fax: (417) 883-8261 **| Email*:** accounting@gbsitpa.com
Please *only send this form via secure (encrypted) email. If you require assistance, please contact your HR Department.

WHERE SHOULD YOU GO FOR MEDICAL CARE?

Sometimes healthcare choices can be confusing, but understanding your options ahead of time can help. Knowing when to get care and where to go can ensure you make the best possible decision for not only your health, but also for your wallet and schedule.

TELEHEALTH*

Call Teladoc 24/7/365 for a variety of non-emergency conditions including:

- Cold and flu
- Ear infection
- Respiratory infection
- Skin conditions
- Urinary tract infection

WALK-IN CLINIC†

Visit a nearby GBS-contracted walk-in clinic to receive treatment for non-emergency illnesses or injuries and services such as:

- Cold and flu
- Sore throat
- Minor rashes
- Coughs
- Congestion
- Minor cuts
- Vaccinations

PRIMARY CARE

Visit your Primary Care Physician for non-emergency conditions and services, including:

- Cold and flu
- Ear infection
- Back pain
- Vaccinations
- Annual exams and screenings

URGENT CARE

Offering extended hours and services on a walk-in basis, visit an Urgent Care for urgent health concerns like:

- Mild burns
- Mild fractures
- Severe vomiting
- Abdominal pain
- Severe headaches
- Cuts requiring stitches

EMERGENCY ROOM

The most expensive option, call 911 or go to the Emergency Room for life-threatening health issues such as:

- Apparent heart attack
- Major fractures, broken bones, and burns
- Head or spinal injuries
- Difficulty breathing

*For even faster service, book a visit online via the Telehealth link inside the GBS Member Portal at mygbshealth.com.
†Not all walk-in clinics are contracted with GBS, and not all plans cover walk-in clinic services at no copay. Review your Plan Document to ensure coverage prior to receiving services.

Need help?

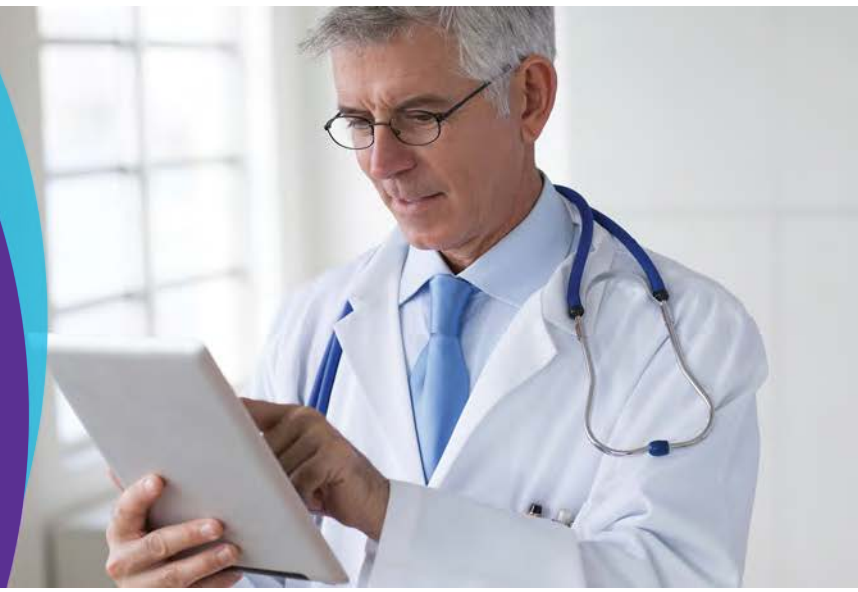
800.995.3569
info@gbsitpa.com

gbs-tpa.com

GIM.crt| 05.01.19

AVAILABLE NOW:

Access to a doctor anytime, anywhere



Log in to the GBS web portal and click the "Teladoc link for setting up your Teladoc account, completing your medical history, and requesting a consult. Once you're set up, a **Teladoc doctor is always just a click or call away.**

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Acid reflux
- Asthma
- Backache
- Blood Pressure issues
- Cough
- Eye Infection/Irritation
- Fever
- Headache/Migraine
- Joint Pain/Swelling
- Laryngitis
- Pink Eye
- Sore Throat
- Sprains and Strains
- And more!

WHY TELADOC?

It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Talk to a doctor anytime for **free!**

To log into Teladoc:

1. Log in to the GBS Member Portal **(mygbshealth.com).**
2. On your portal account homepage, in the **Other Links** section near the bottom on the right-hand side, select **Teladoc.**
3. Follow the on-screen prompts to log in to Teladoc.

Support

GBS member portal:
800-995-3569
customercare@mygbshealth.com

Teladoc:
1-800-835-2362
help@teladoc.com

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REGISTRATION GUIDE: GBS MEMBER PORTAL

All GBS plan members **can register** for the **GBS MediConnX** portal. GBS **medical plan members** can **also register** for the **GBS MediConnX 360** if they'd like to use the new **medical cost comparison tool.**

To register as a user in the GBS MediConnX portal:

1. Using your preferred internet browser, navigate to **mygbshealth.com** and on the page that appears, beneath the **Log In** button, select the **Register** button.
2. In the **I am a/an:** dropdown box, select **Employee/Insured,** then in the **Administrator** dropdown box select **Group Benefit Services, Inc.**
3. On the same page, select the **Click here to read the Statement of Understanding** text to review the Statement, then select the **I Accept** option and select the **Next** button.
4. On final two (2) pages, complete the below fields, and then select the **Create User** button.
   - ***a.*** First Name
   - ***b.*** Last Name
   - ***c.*** Date of Birth
   - ***d.*** Social Security Number
   - ***e.*** Desired User Name
   - ***f.*** Desired Password
   - ***g.*** E-mail address
   - ***h.*** Security Questions and Answers
   - ***i.*** Coverages

Only medical plan members can register for the **GBS MediConnX 360 portal** to use the MyMedicalShopper Tool.

To register as a user in the GBS MediConnX 360 portal:

1. Using your preferred internet browser, navigate to **mygbshealth.com** and enter your **User Name** and **Password,** then select the **Log In** button.
2. In the **Other Links** section, select the **MyMedicalShopper Tool,** and then (on the MediConnX 360 page) select the **Get Started** button.
3. Enter your **Member ID** (listed on your Plan ID Card), **Email Address, Date of Birth, and First and Last Name,** then select the **Proceed** button.
4. Answer each **Security Question** presented with the correct response, then (on the next page) enter your desired **Password** in the fields provided and select the **Complete Account** button.

Need help?

800.995.3569
info@gbsitpa.com

GET TO KNOW YOUR ENHANCED BENEFITS

PREFERENTIAL PROVIDERS

Want to save money on your medical expenses? Get the most out of your health plan by utilizing the 100% covered* benefits below:

24/7 TELEHEALTH

Call Teladoc 24/7/365 for a variety of conditions, including cold and flu, ear infection, respiratory infection, and skin conditions.

WALK-IN CLINICS

Visit a nearby GBS-contracted walk-in clinic to receive in-person care for conditions like cold and flu, sore throat, and minor rashes.

DURABLE MEDICAL EQUIPMENT

Need durable medical equipment (DME), such as a CPAP machine? **Call Carelink at 888.604.DMED (3633) to get precertified** and order equipment.

PRESCRIBED LAB WORK

At the time your lab work is prescribed, ask your doctor to use QuestSelect or LabCorp to have your lab work covered.†

DIABETIC MANAGEMENT

Join Livongo‡ to receive a free glucometer, free regular test strip shipments, and get help managing your diabetes from Certified Diabetes Educators.

*Not all plans cover these benefits at 100%. Review your Plan Document prior to receiving services.

†To avoid a potential draw fee at your physician's office, take your lab order directly to a QuestSelect or LabCorp location for draw and testing. Your lab results will be sent directly to your physician once complete.

‡To learn more and/or join Livongo, visit **welcome.livongo.com/GBS** or call Livongo Member Support at **(800) 945-4355** and mention registration code **GBS.**

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GET TO KNOW YOUR ENHANCED BENEFITS

PREFERENTIAL PLACES-OF-SERVICE

REQUIRE PRECERTIFICATION

Precertification is required prior to receiving any of the following services. Please call, or have your provider call, the precertification number on the back of your GBS plan ID card to obtain precertification prior to receiving service.

MRI, CT, + PET Scans

Use an independent, non-hospital imaging facility to have your prescribed MRI, CT, or PET scan 100% covered.*

SURGICAL SERVICES

Use an Ambulatory Surgical Center (ASC) for your outpatient procedure to have it covered at 100%.*

NO PRECERTIFICATION

Precertification is not required prior to using/receiving the below services. The below **walk-in clinic service** is **covered at 100%,*** but **any prescription copays** will **still apply.**

HOME SLEEP STUDY

Choose to have your prescribed sleep study at home and it's 100% covered.*

WALK-IN CLINICS

Visit a nearby GBS-contracted walk-in clinic to receive in-person care for conditions like cold and flu, sore throat, and minor rashes.

*Not all plans cover these benefits at 100%. Review your Plan Document prior to receiving services.

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WHAT ARE AMBULATORY SURGICAL CENTERS?

Ambulatory Surgical Centers (ASCs) are medical facilities that only perform selected outpatient surgeries and procedures. Surgeries and procedures performed at **any in-network ASC are covered at 100%*** for GBS health plan members. Besides the financial incentive, using an ASC for an outpatient surgery or procedure instead of a hospital can also be beneficial in the following ways:

LESS RISK OF INFECTION

Outpatient surgeries and procedures performed at ASCs have a **lower rate of infection** than those performed inpatient at hospitals.‡

QUICKER RECOVERY

Less invasive techniques means patients spend less time under anesthesia, recover faster, and have better clinical outcomes.†

LESS STRESS

Same-day discharge (meaning no expenses for overnight hospital stays) and **recovery at home** provides patients with a less stressful experience overall.†

FLEXIBLE SCHEDULING

Not handling emergencies like hospitals means **ASCs typically stay on schedule** more often. Likewise, ASCs can **work around the patient's schedule** and can usually **book their appointments sooner.**†

LOCATING AN IN-NETWORK ASC

To find an in-network ASC, login to the GBS Member Portal at **mygbshealth.com** and on the right-hand sidebar select **PPO Locator**. Once on your PPO's lookup page, select **Ambulatory Surgical Center** as the type. Likewise, you can always call the GBS team M-F 8 a.m.-5 p.m. CT at **800.995.3569**.

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*Precertification and medical necessity determination are required prior to receiving service. Not all plans cover these benefits at 100%. Review your Plan Document prior to receiving services.

†**Source:** https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/outpatient-surgery

‡**Source:** https://jamanetwork.com/journals/jama/fullarticle/1829988#:~:text=Our%20findings%20affirmed%20that%20the,of%20infections%20following%20inpatient%20operations

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info@gbsitpa.com

gbs-tpa.com

RECEIVING AN MRI(s), CT Scan(s), and PET Scan(s) JUST GOT EASIER

Hospitals often charge 3 to 10 times more* for enhanced imaging services than non-hospital imaging centers charge. So how can you (and your health plan!) avoid these excessive charges?

100% COVERED†

When your provider indicates you will need an **MRI, CT scan, or PET scan,** tell them that your health plan **covers these services at 100%†** when an **in-network, freestanding imaging facility** is used.

KEY TERM Freestanding means that the facility is **independent** or, in other words, **not owned by a hospital.**

HOW TO SAVE ON IMAGING SERVICES

1 LOCATE A FACILITY

To find a facility, login to the GBS Member Portal at **mygbshealth.com** and on the right-hand **Member Resources** sidebar select **PPO Locator.** Once on your PPO's lookup page, select **Radiology** or **Imaging** as the type‡.

NEED HELP? If you need assistance locating a facility, you can always call your GBS team M-F, 8 a.m.-5 p.m. CT at **800.995.3569.**

2 SCHEDULE AND PRECERTIFY

Once you have located an imaging facility, simply **call the facility to schedule your appointment**. During the call, be sure to tell them that **your service must be precertified** and (if needed) provide them with the precertification phone number on the back of your GBS plan ID card.

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*This statistic is based upon pricing information provided to GBS by medical providers.

†Other imaging services, such as x-rays and ultrasounds, are not eligible. Precertification and medical necessity determination are required prior to receiving service(s). Not all plans cover these benefits at 100%. Review your Plan Document prior to receiving service(s).

‡These instructions are general. The labels and/or prompts to search for enhanced imaging facilities on your specific PPO's website may differ than those mentioned here.

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

USE A PREFERRED LAB SERVICE AND DISCOVER SAVINGS

KEY CONCEPT

When you use either **QuestSelect (formerly Lab Card)** or **Labcorp** for your prescribed outpatient lab work, you can have your lab work covered at 100%.*

HOW TO USE THE BENEFIT

Using this benefit can be done in two (2) easy steps:

1. **Doctor's Appointment.** When your doctor orders lab work for you, ask your doctor to use either QuestSelect ("Quest") or Labcorp for your lab work and to note your chart for any future lab work ordered.
2. **Specimen Collection.** Your specimen can be collected by either:

-OR-

a. **Your Doctor.** If your doctor participates in either lab services program, they can collect your specimen and have it sent to either Quest or Labcorp for testing. If the specimen is **collected at the doctor's office,** there **might be a draw fee** that's subject to your plan benefit.

b. **A Quest/Labcorp Location.** If your doctor does not participate in either program (or you want to avoid a potential draw fee), request a copy of your lab work order and visit a Quest or Labcorp location. When you arrive, **give** the staff your **lab work order** and **show** them **your plan ID card.** When showing your ID card, ask them to file the claim to the address on the back of your card. If your plan ID card does not have the QuestSelect or Labcorp logo on the back, your benefit will still apply.

* This benefit is available on HDHP plans only after the member's deductible has been met. Review your plan document prior to receiving service.