Adair County Government #40500

EMPLOYEE ENROLLMENT/WAIVER FORM

INSTRUCTIONS FOR COMPLETING THIS FORM

1. All fields must be completed by the **EMPLOYEE.** Please **PRINT** clearly. **INITIAL & DATE** all corrections.

2. You must be a US Citizen or Legal Alien residing in the USA to be eligible for all coverage's under this Plan.

3. Misstatements, omissions, and illegible statements made on this form may cause you to lose coverage under this plan.

SECTION A

EMPLOYEE INFORMATION				
Name		DOB	SSN	
Legal Gender ☐M ☐F	Marital Status ☐Single ☐Married ☐Other_____			
Address	City	State	Zip	
Phone	Email			
Class / Occupation	Location	DOH	Annual Salary	

COVERAGE DECLINED
I hereby certify that I am **declining enrollment** in the group health plan for ☐myself and/or ☐my dependents.
☐ I (or they) currently have other health insurance coverage; or
☐ I (or they) do not currently have other health insurance coverage.
If you are **declining coverage**, please **skip** to **Section B**.

NO CHANGES TO COVERAGE
☐ I hereby certify that I am **making no changes** to my current coverage.
If your **coverage remains the same**, please **skip** to **Section B**.

If **electing new coverages** or **changing current coverages**, please complete the applicable fields below:

COVERAGE ELECTED

☐New Enrollment ☐Open Enrollment ☐Qualifying Life Event (Event Date: _____)

Coverage	Medical/Rx Plans	Dental	Vision	EE & Dep. Life
EE	▫Bronze ▫Silver ▫Gold ▫Maxi-Care ▫N	☐Y ☐N	☐Y ☐N	Employer-Paid $25,000
EE/CHILD(REN)	▫Bronze ▫Silver ▫Gold ▫Maxi-Care ▫N	☐Y ☐N	☐Y ☐N	Dep. Life $5,000 per Child
EE/SPOUSE	▫Bronze ▫Silver ▫Gold ▫Maxi-Care ▫N	☐Y ☐N	☐Y ☐N	$10,000 Spouse
EE/FAMILY	▫Bronze ▫Silver ▫Gold ▫Maxi-Care ▫N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Please attach a separate sheet of paper listing additional dependents and/or beneficiaries, if applicable.

DEPENDENT INFORMATION (Only list dependents you are enrolling on this Plan)

First Name, M. I., Last Name (if different)*	DOB	SSN	M/F	Relation to EE

*Dependents with different last names from the employee will require additional proof (Marriage License, Proof of Guardianship, Divorce Decree, etc.) in order to become active under this plan.

Will you or any dependents enrolling in this Plan be covered by any other Medical Insurance in addition to this Plan?: ☐Y ☐N

• If yes, who?: ☐Employee ☐Spouse ☐Child(ren) Please attach a **Certificate of Creditable Coverage** from that insurance company.

PRIMARY LIFE INSURANCE BENEFICIARY INFORMATION				
First Name, M. I., Last Name	**DOB**	**SSN**	**Relationship**	**LIFE (Combined total must equal 100%)**
				%
				%

SECONDARY/CONTINGENT LIFE INSURANCE BENEFICIARY INFORMATION				
First Name, M. I., Last Name	**DOB**	**SSN**	**Relationship**	**LIFE (Combined total must equal 100%)**
				%
				%

SECTION B

*****IMPORTANT DISCLOSURE AND COVERAGE INFORMATION*****

Please note that by electing any non-employer-paid benefits, you authorize your employer to reduce your salary by the amount necessary to cover the cost of your elected benefits.

IMPORTANT:

SPECIAL ENROLLMENT NOTICE:

If you decline medical, dental, and/or vision coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse, and/or your dependent(s) in medical, dental, and/or vision coverage within 30 days of your qualifying life event.

ELECTRONIC WAIVER:

GBS provides 24 hours a day, seven days a week access to your online employee benefits web portal located at: www.gbs-tpa.com. By signing this form I understand that I have electronic access to a wide variety of Plan documentation including the Summary Benefit of Coverage (SBC) at any time.

I REPRESENT:

(1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Employee Enrollment/Waiver Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on the Employee Enrollment/Waiver Form made by me and any subsequent information I provide are the basis for my coverage under my employer's Plan and coverage will not be effective until I am notified of my effective date; (4) if any controversy or claim is made arising out of or relating to a claim for benefits payable by the self-funded Plan it shall be settled by arbitration in accordance with the provisions of the Plan.

I AUTHORIZE:

(1) any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, Veteran's Administration, or other medical-related facility, insurance agent, administrator, insurance company, reinsurer, consumer reporting agency, telephone interview company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol, to Group Benefit Services; (2) Group Benefit Services to release such information to any insurance agent, insurance company, reinsurer, managed care organization, telephone interview company, other insurance support organization, or my employer; (3) my employer to deduct contributions from my earnings to be applied to the cost of this Plan; and (4) that benefits under this Plan be paid directly to any provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependent(s) and/or for me.

Employee Signature: X_____ **Date Signed:** _____

(PLEASE DO NOT PRINT)

Employee Enrollment Packet

Bronze, Silver, and Gold Plan Options

Adair County Government

Employee Benefit Plan

To view your full benefit documents, scan the QR code or visit:
https://gbs-tpa.com/adair-county-govt-oe-guide/

GBS

Group Benefit Services

Innovative Solutions | Customized Benefits | Sustainable Plans

gbs-tpa.com | 800.995.3569

Adair County Government

Plan Year 2025

ATTENTION

For questions, please call GBS 800-955-3569. M - F 8 AM - 5 PM CST

ID Cards - You will be receiving a new Medical ID card

Please log into the Member Portal to review the full Summary Plan Description (SPD)

	BRONZE PLAN		SILVER PLAN		GOLD PLAN	
EMPLOYEE CONTRIBUTION BY TIER	**Monthly**	**Bi-Monthly**	**Monthly**	**Bi-Monthly**	**Monthly**	**Bi-Monthly**
Employee only	$50.00	$25.00	$125.00	$62.50	$201.07	$100.54
Employee + Child(ren)	$455.00	$227.50	$590.00	$295.00	$730.73	$365.37
Employee + Spouse	$630.00	$315.00	$790.00	$395.00	$953.55	$476.78
Family	$1,025.00	$512.50	$1,290.00	$645.00	$1,499.19	$749.60
DEDUCTIBLE	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Major Medical - Single	$6,000	$12,000	$4,000	$8,000	$2,000	$4,000
Major Medical - Family	$12,000	$24,000	$8,000	$16,000	$4,000	$8,000
COINSURANCE						
% After Deductible	80 / 20	50 / 50	80 / 20	50 / 50	80 / 20	50 / 50
OUT-OF-POCKET LIMIT						
Single	$8,000	$16,000	$6,000	$12,000	$4,000	$8,000
Family	$16,000	$32,000	$12,000	$24,000	$8,000	$16,000
RDA*						
Single	$1,000	N/A	$1,000	N/A	$1,000	N/A
MEDICAL SERVICES						
Primary Care Physician	80 / 20	50 / 50	$20 Copay	50 / 50	$20 Copay	50 / 50
Specialist	80 / 20	50 / 50	$20 Copay	50 / 50	$20 Copay	50 / 50
Urgent Care	80 / 20	50 / 50	$50 Copay	50 / 50	$50 Copay	50 / 50
Emergency Room	80 / 20	80 / 20	$200 Copay	$200 Copay	$200 Copay	$200 Copay

IMPORTANT: Major Medical deductible(s) and out-of-pocket (OOP) limits for In-Network and Non-Network providers accumulate separately. Please review the SPD for more information.

	PRESCRIPTION DRUG PLAN*			
MAIL ORDER OR RETAIL	**ACA**	**Generic**	**Preferred**	**Non-Preferred**
30-day	$0 Copay	$8 Copay	$20 Copay	80 / 20
90-day	$0 Copay	$8 Copay	$30 Copay	80 / 20
SPECIALTY (30-Day Supply)**	N/A	80 / 20	80 / 20	80 / 20
GBS Rx Drug Program	N/A	$0 Copay	$0 Copay	$0 Copay

*Benefits may be covered differently based on the plans selected. Review the SPD for further information.

**Orphan drugs are excluded.

Adair County Government

Plan Year 2025

ATTENTION

Please log into the Member Portal to review the full Summary Plan Description (SPD)

EMPLOYEE CONTRIBUTION BY TIER	DENTAL PLAN		VISION PLAN	
	Monthly	Pay Cycle	Monthly	Pay Cycle
Employee only	$33.00	$16.50	$7.62	$3.81
Employee + Child(ren)	$59.00	$29.50	$15.56	$7.78
Employee + Spouse	$69.00	$34.50	$18.46	$9.23
Family	$87.00	$43.50	$24.00	$12.00

	DENTAL PLAN	VISION PLAN
ANNUAL DEDUCTIBLE	**Waived for Class 1 Services.**	
Single	$25	$50
Family	$50	$100
ANNUAL BENEFIT LIMIT		
Per Participant	$1,000 (Class 1, 2, and 3)	$600

	DENTAL PLAN
MAXIMUM LIFETIME BENEFIT	
Orthodontics (Class 4)	N/A
BENEFITS (See below conditions)	
Preventive Care (Class 1)	100/0
Repair + Restoration (Class 2)	90/10
Major Dental Repair* (Class 3)	60/40
Orthodontics under age 19 (Class 4)	60/40

Conditions for Classes 2-4, Non-PPO Network: Covered charges are calculated at the 90th percentile of Usual and Customary Fees. If the Provider bills in excess of the 90th percentile, members could be responsible for the difference.

	VISION PLAN
COINSURANCE	
Vision	90/10
12-MONTH BEN. PERIOD	
Eye Exam†	90/10 up to $100 Max.
Single Vision Lenses‡	90/10 up to $120 Max.
Bi-focal Lenses‡	90/10 up to $130 Max.
Tri-focal Lenses‡	90/10 up to $140 Max.
Lenticular Lenses‡	90/10 up to $150 Max.
Contact Lenses (up to 12-month supply)	90/10 to Benefit Limit
24-MONTH BEN. PERIOD	
Frames, one pair	90/10 up to $130 Max.

NETWORKS		
DENTAL		VISION
Aetna Dental Administrators, Dentemax, Premier Dental	Mavarest Dental, PPO USA/Connection Dental	No Network Required

*12-month waiting period for dentures and bridgework.

†Per participant, no deductible.

‡Choice of one type of eyeglass lenses (single vision, bi-focal, tri-focal, lentincular) **or** contact lenses, within a 12-month period (not both).

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.

CALL GBS NURSE NAVIGATORS AT 1-888-364-3580

Call your GBS Nurse Navigators **Monday-Friday, 8 a.m. - 5 p.m. CT** for the following services:

Enhanced Benefit Programs

Referring you to cost-saving programs like an Ambulatory Surgical Center (ASC) for outpatient procedures, or an independent, non-hospital imaging facility for MRI, CT, and PET scans.

Appointment Scheduling

Assisting with the scheduling of appointments, tests, and surgeries.

Locating Specialists

Helping locate qualified specialists for diagnosis/treatment.

Understanding Diagnosis/ Treatment(s)

Helping you understand a diagnosis or proposed treatment.

Education and Support

Providing education and support to you and your family.

REGISTER FOR THE MEMBER PORTAL AT MYGBSHEALTH.COM

After registering for the portal, you'll be able to:

MEMBER PORTAL

The GBS member portal is a central hub that includes coverage, claims information, a provider search, and much more.

FIND

PROVIDER LOCATOR
PREFERRED LAB SERVICES
MYMEDICALSHOPPER TOOL
MINUTECLINIC® LOCATOR

REVIEW

CLAIM INFORMATION (EOBs)
DEDUCTIBLES / ACCUMULATORS
BENEFIT FLYERS AND VIDEOS

REQUEST/SUBMIT

CLAIM REIMBURSEMENT
RDA REIMBURSEMENT
PLAN ID CARD
RX REFILL
QUESTIONS FOR GBS

ACCESS

SPD(s) AND PLAN DOCUMENT(s)
RDA CLAIM FORM
EFT FORM
LIFE, DISABILITY, AND WORKSITE POLICIES
FREQUENTLY ASKED QUESTIONS

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GIM.crt | 240829

GET TO KNOW YOUR ENHANCED BENEFITS

For all **Major Medical** health plans, **except** an **HDHP (HSA)**, the benefits listed below are **covered at 100%.*** For HDHP, while deductible and coinsurance still apply, lower-cost services and/or lower event co-pays may be available. Review your SPD for more information.

PREFERENTIAL PROVIDERS

24/7 TELEHEALTH

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

DURABLE MEDICAL EQUIPMENT

Call Carelink at 888.604.DMED (3633) to get precertified and order your DME equipment like a CPAP machine, nebulizers, or back braces.

PRESCRIBED LAB WORK

Take your lab order(s) from your physician and go to a **QuestSelect** or **LabCorp** location for draw and testing. Your lab results will be sent to your physician.

DIABETIC MANAGEMENT

Join **Livongo** to receive a free glucometer, test strips, and get help managing your diabetes. Visit **welcome.livongo.com/GBS** or call **(800) 945-4355** and mention registration code GBS.

PREFERENTIAL PLACES-OF-SERVICE

PRECERTIFICATION REQUIRED

Have your provider call the precertification number on the back of your GBS plan ID card **prior to receiving** any of the below **services.**

MRI, CT, + PET SCANS

Use an independent, non-hospital imaging facility to get your prescribed MRI, CT, or PET scan.†

SURGICAL SERVICES

Use an Ambulatory Surgical Center (ASC) for your outpatient procedure.†

NO PRECERTIFICATION REQUIRED

HOME SLEEP STUDY

Choose to have your prescribed sleep study at home.

WALK-IN CLINICS

Search for a walk-in clinic through the **member portal**, to receive in-person care for numerous conditions. **Prescription copays apply** when buying prescriptions.

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

†For HDHP (HSA) plans, a **lower event co-pay** is applied to the following: MRI, CT, PET Scan(s), and procedure(s) performed at ASCs. See the IRS minimum deductible for HDHP plans, by viewing the current revision of Publication 969 at: https://www.irs.gov/forms-pubs/about-publication-969
See prior years' Publication 969 at: https://www.irs.gov/prior-year-forms-and-instructions?find=publ%20969&items_per_page=200&order=prior_year_products_picklist_revision_date&sort=desc

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GIM.crt | 240828

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

GOLD 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:	**80 / 20**	**50 / 50**

Out-of-Pocket[1] Limit Including Deductible	In-Network	Non-Network
Single Annual Out-of-Pocket Limit per Accumulation Period:	**$4,000**	**$8,000**
Family Annual Out-of-Pocket Limit per Accumulation Period:	**$8,000**	**$16,000**

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]	**$20 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	**$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 DME is the Preferential Provider for your benefit plan. Precertification is not required for items provided by Carelink. CARELINK	**Phone:** (888) 604-DMED www.CarelinkDME.com	
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 DME 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	$20 Dr. Copay	50 / 50	12 Visit Limit Per Year
Allergy Injections (including serum)	$5 Copay	50 / 50	
Allergy Testing	80 / 20	50 / 50	
Ambulance – Air[7] & Ground Services	80 / 20	80 / 20	**For Emergency Use Only**
Ambulatory Surgical Center (ASC)	100% ☺	50 / 50	Precertification Required
Anesthesia	80 / 20	50 / 50	
Birthing Center	80 / 20	50 / 50	
Blood & Plasma	80 / 20	50 / 50	
Chiropractic Care - Over 5 Years of Age	$20 Dr. Copay	50 / 50	30 Visit Limit Per Year
Dialysis – 6 Month Benefit Limit	80 / 20	50 / 50	Precertification Required
Durable Medical Equipment (DME) – Non Carelink DME	80 / 20	50 / 50	Precertification Required for items over $500
Hearing Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Hearing Exam
Home Health Care – 120 Day Annual Limit	80 / 20	50 / 50	Precertification Required
Hospice Care	180 Day Benefit Limit		
Inpatient Treatment	80 / 20	50 / 50	Precertification Required
Outpatient Treatment	80 / 20	50 / 50	
Family Bereavement Counseling	80 / 20	50 / 50	
Hospital			
Inpatient Treatment	80 / 20	50 / 50	Precertification Required
Outpatient Treatment	80 / 20	50 / 50	See Utilization Management Section of Plan Document for Pre-cert. Requirement
Infusion Therapy			Precertification Required
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			
Inpatient Physician Services	80 / 20	50 / 50	Precertification Required
Partial Day Program / Group Therapy – 120 Visit Annual Limit In-Network and 120 Visit Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required
Outpatient Physician Services / Intensive Outpatient Program – 120 Visit Annual Limit In-Network and 120 Visit Annual Limit Non-Network	$20 Dr. Copay	50 / 50	Precertification Required for Intensive Outpatient.
Residential Treatment Program - 120 Day Annual Limit In-Network and 120 Day Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required
Newborn Nursery Care – While Inpatient	80 / 20	50 / 50	
Orthoptic Training			Precertification Required
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	Items over $500 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)	$20 Dr. Copay	50 / 50	Office Visit Copay[11]
Specialist[12] – Encounter Copay	$20 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	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	Precertification Required
Radiology – Enhanced Imaging[16] MRI, CT scan, or PET scan	80 / 20	50 / 50	Precertification Required
Routine Patient Costs – Approved Clinical Trials	80 / 20	50 / 50	Precertification Required
Second Surgical Opinions	100% ☺	50 / 50	
Skilled Nursing Facility – 120 Day Annual Limit	80 / 20	50 / 50	Precertification Required
Sleep Apnea Appliance (CPAP) – See Carelink DME	80 / 20	50 / 50	Precertification Required
Smoking Cessation – 120 Day Annual Limit	100% ☺	Not Covered	See PBM Program
Surgery – See Enhanced Plan Benefits for Additional Benefits	80 / 20	50 / 50	Precertification Required
Telehealth Services – Non-Teladoc	$20 Dr. Copay	50 / 50	Limits[17] will apply
Temporomandibular Joint Disorder (TMJ)	80 / 20	50 / 50	Precertification Required
Therapy			
ABA Therapy – 60 Visit Annual Limit			Precertification Required
Chemotherapy	$20 Event Copay	50 / 50	Precertification Required
Occupational Therapy – 60 Day Annual Visit Limit	$20 Event Copay	50 / 50	Precertification Required
Physical Therapy – 60 Day Annual Visit Limit	$20 Event Copay	50 / 50	Precertification Required
Radiation Therapy	$20 Event Copay	50 / 50	Precertification Required
Respiration Therapy	$20 Event Copay	50 / 50	Precertification Required
Speech Therapy – 60 Day Annual Visit Limit	$20 Event Copay	50 / 50	Precertification Required
Transplants – ETS Transplant Network	80 / 20	50 / 50	Precertification Required
Walk-in Clinic Visit – See Enhanced Plan Benefits for no Copay	$20 Dr. Copay	50 / 50	Office Visit Copay[18]
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:** 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 - **$0 to $250**: **Note:** All prescriptions over $700 require a prior authorization.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription – **$251 to $700**: **Note:** All prescriptions over $700 require a prior authorization.	**$20 Copay**
Tier 3 - Copayment per new or refill prescription – **$700 and Up**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill prescription through GBS Rx Drug Program	**$0 – No Copay ☺**
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[19]	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 - **$0 to $250**: **Note:** All prescriptions over $700 require a prior authorization.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription – **$251 to $700**: **Note:** All prescriptions over $700 require a prior authorization.	**$30 Copay**
Tier 3 - Copayment per new or refill prescription – **$700 and Up**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill prescription through GBS Rx Drug Program	**$0 – No Copay ☺**
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[20] **Card Copayment Options – No more than a 30-day supply**	The copayments shown are applied to each prescription.
Copayment per new or refill prescription - **Specialty prescription**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill Specialty prescription through GBS Rx Specialty Drug Program	**$0 – No Copay ☺**

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.

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** (Phone number is on your ID card) 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.

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

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

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.

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.[21] 2 out of 3 prescriptions filled today are for generic medicines and that number is growing.[22] 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.

Select Drugs and Products Program: Your Prescription Drug Plan has been enhanced to offer you the opportunity to substantially reduce your out-of-pocket cost paid for specialty drugs.

Your Plan includes a program offered through **GBS Rx**, called the Select Drugs and Products Program. This program will support Plan participants prescribed specialty drugs and products.

Participation is required of those Plan participants seeking coverage for products included on the Select Drugs and Products List. All products included in the program require prior authorization. A Case Coordinator from the program will assist you with accessing and making these high-cost specialty drugs affordable.

If you are being treated with a brand name medication for rheumatoid arthritis, cancer, multiple sclerosis, or other conditions typically treated by a specialist you should contact the Specialty Contact Center to enroll in the Select Drugs and Products Program. Additionally, the benefits office may contact you to introduce the program to facilitate your enrollment.

The Specialty Contact Center with **GBS Rx** may be reached toll-free at **(888) 364-3580** from 8 a.m. to 5 p.m. CT, Monday through Friday.

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

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

SILVER 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:	$4,000	$8,000
Family Deductible per Accumulation Period:	$8,000	$16,000

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:	$6,000	$12,000
Family Annual Out-of-Pocket Limit per Accumulation Period:	$12,000	$24,000

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]	$20 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	$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 DME is the Preferential Provider for your benefit plan. Precertification is not required for items provided by Carelink. CARELINK	**Phone:** (888) 604-DMED www.CarelinkDME.com	
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 DME 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.

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Allergy Testing	80 / 20	50 / 50	
Ambulance – Air[7] & Ground Services	80 / 20	80 / 20	**For Emergency Use Only**
Ambulatory Surgical Center (ASC)	100% ☺	50 / 50	Precertification Required
Anesthesia	80 / 20	50 / 50	
Birthing Center	80 / 20	50 / 50	
Blood & Plasma	80 / 20	50 / 50	
Chiropractic Care - Over 5 Years of Age	$20 Dr. Copay	50 / 50	30 Visit Limit Per Year
Dialysis – 6 Month Benefit Limit	80 / 20	50 / 50	Precertification Required
Durable Medical Equipment (DME) – Non Carelink DME	80 / 20	50 / 50	Precertification Required for items over $500
Hearing Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Hearing Exam
Home Health Care – 120 Day Annual Limit	80 / 20	50 / 50	Precertification Required
Hospice Care	180 Day Benefit Limit		
Inpatient Treatment	80 / 20	50 / 50	Precertification Required
Outpatient Treatment	80 / 20	50 / 50	
Family Bereavement Counseling	80 / 20	50 / 50	
Hospital			
Inpatient Treatment	80 / 20	50 / 50	Precertification Required
Outpatient Treatment	80 / 20	50 / 50	See Utilization Management Section of Plan Document for Pre-cert. Requirement
Infusion Therapy			Precertification Required
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			
Inpatient Physician Services	80 / 20	50 / 50	Precertification Required
Partial Day Program / Group Therapy – 120 Visit Annual Limit In-Network and 120 Visit Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required
Outpatient Physician Services / Intensive Outpatient Program – 120 Visit Annual Limit In-Network and 120 Visit Annual Limit Non-Network	$20 Dr. Copay	50 / 50	Precertification Required for Intensive Outpatient.
Residential Treatment Program - 120 Day Annual Limit In-Network and 120 Day Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required
Newborn Nursery Care – While Inpatient	80 / 20	50 / 50	
Orthoptic Training			Precertification Required
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	Items over $500 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.

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[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	$20 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	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	Precertification Required
Radiology – Enhanced Imaging[16] MRI, CT scan, or PET scan	80 / 20	50 / 50	Precertification Required
Routine Patient Costs – Approved Clinical Trials	80 / 20	50 / 50	Precertification Required
Second Surgical Opinions	100% ☺	50 / 50	
Skilled Nursing Facility – 120 Day Annual Limit	80 / 20	50 / 50	Precertification Required
Sleep Apnea Appliance (CPAP) – See Carelink DME	80 / 20	50 / 50	Precertification Required
Smoking Cessation – 120 Day Annual Limit	100% ☺	Not Covered	See PBM Program
Surgery – See Enhanced Plan Benefits for Additional Benefits	80 / 20	50 / 50	Precertification Required
Telehealth Services – Non-Teladoc	$20 Dr. Copay	50 / 50	Limits[17] will apply
Temporomandibular Joint Disorder (TMJ)	80 / 20	50 / 50	Precertification Required
Therapy			
ABA Therapy – 60 Visit Annual Limit			Precertification Required
Chemotherapy	$20 Event Copay	50 / 50	Precertification Required
Occupational Therapy – 60 Day Annual Visit Limit	$20 Event Copay	50 / 50	Precertification Required
Physical Therapy – 60 Day Annual Visit Limit	$20 Event Copay	50 / 50	Precertification Required
Radiation Therapy	$20 Event Copay	50 / 50	Precertification Required
Respiration Therapy	$20 Event Copay	50 / 50	Precertification Required
Speech Therapy – 60 Day Annual Visit Limit	$20 Event Copay	50 / 50	Precertification Required
Transplants – ETS Transplant Network	80 / 20	50 / 50	Precertification Required
Walk-in Clinic Visit – See Enhanced Plan Benefits for no Copay	$20 Dr. Copay	50 / 50	Office Visit Copay[18]
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:** 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 - **$0 to $250**: **Note:** All prescriptions over $700 require a prior authorization.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription – **$251 to $700**: **Note:** All prescriptions over $700 require a prior authorization.	**$20 Copay**
Tier 3 - Copayment per new or refill prescription – **$700 and Up**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill prescription through GBS Rx Drug Program	**$0 – No Copay ☺**
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[19]	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 - **$0 to $250**: **Note:** All prescriptions over $700 require a prior authorization.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription – **$251 to $700**: **Note:** All prescriptions over $700 require a prior authorization.	**$30 Copay**
Tier 3 - Copayment per new or refill prescription – **$700 and Up**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill prescription through GBS Rx Drug Program	**$0 – No Copay ☺**
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[20] Card Copayment Options – No more than a 30-day supply	The copayments shown are applied to each prescription.
Copayment per new or refill prescription - **Specialty prescription**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill Specialty prescription through GBS Rx Specialty Drug Program	**$0 – No Copay ☺**

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.

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** (Phone number is on your ID card) 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.

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

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

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.

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.[21] 2 out of 3 prescriptions filled today are for generic medicines and that number is growing.[22] 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.

Select Drugs and Products Program: Your Prescription Drug Plan has been enhanced to offer you the opportunity to substantially reduce your out-of-pocket cost paid for specialty drugs.

Your Plan includes a program offered through **GBS Rx**, called the Select Drugs and Products Program. This program will support Plan participants prescribed specialty drugs and products.

Participation is required of those Plan participants seeking coverage for products included on the Select Drugs and Products List. All products included in the program require prior authorization. A Case Coordinator from the program will assist you with accessing and making these high-cost specialty drugs affordable.

If you are being treated with a brand name medication for rheumatoid arthritis, cancer, multiple sclerosis, or other conditions typically treated by a specialist you should contact the Specialty Contact Center to enroll in the Select Drugs and Products Program. Additionally, the benefits office may contact you to introduce the program to facilitate your enrollment.

The Specialty Contact Center with **GBS Rx** may be reached toll-free at **(888) 364-3580** from 8 a.m. to 5 p.m. CT, Monday through Friday.

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

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

BRONZE 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:	$6,000	$12,000
Family Deductible per Accumulation Period:	$12,000	$24,000

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:	$8,000	$16,000
Family Annual Out-of-Pocket Limit per Accumulation Period:	$16,000	$32,000

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)	80 / 20	50 / 50

After the deductible, the applicable major medical coinsurance is applied. 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]	80 / 20	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	80 / 20	50 / 50

After the deductible, the applicable major medical coinsurance is applied. 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
Emergency Room	80 / 20	80 / 20

After the deductible, 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 DME is the Preferential Provider for your benefit plan. Precertification is not required for items provided by Carelink. CARELINK	**Phone:** (888) 604-DMED www.CarelinkDME.com	
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. **TIP:** All of your glucose readings will be posted on the Livongo's secure website which can also be accessed at: mygbshealth.com	**Phone:** (800) 945-4355 **Website:** welcome.livongo.com/GBS **Registration Code:** GBS	
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 DME 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 (including serum)	80 / 20	50 / 50	
Allergy Testing	80 / 20	50 / 50	
Ambulance – Air[7] & Ground Services	80 / 20	80 / 20	**For Emergency Use Only**
Ambulatory Surgical Center (ASC)	100% ☺	50 / 50	Precertification Required
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	Precertification Required
Durable Medical Equipment (DME) – Non Carelink DME	80 / 20	50 / 50	Precertification Required for items over $500
Hearing Examination – Annual Benefit	100% ☺	100% ☺	1 Basic Hearing Exam
Home Health Care – 120 Day Annual Limit	80 / 20	50 / 50	Precertification Required
Hospice Care	180 Day Benefit Limit		
Inpatient Treatment	80 / 20	50 / 50	Precertification Required
Outpatient Treatment	80 / 20	50 / 50	
Family Bereavement Counseling	80 / 20	50 / 50	
Hospital			
Inpatient Treatment	80 / 20	50 / 50	Precertification Required
Outpatient Treatment	80 / 20	50 / 50	See Utilization Management Section of Plan Document for Pre-cert. Requirement
Infusion Therapy			Precertification Required
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			
Inpatient Physician Services	80 / 20	50 / 50	Precertification Required
Partial Day Program / Group Therapy – 120 Visit Annual Limit In-Network and 120 Visit Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required
Outpatient Physician Services / Intensive Outpatient Program – 120 Visit Annual Limit In-Network and 120 Visit Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required for Intensive Outpatient.
Residential Treatment Program - 120 Day Annual Limit In-Network and 120 Day Annual Limit Non-Network	80 / 20	50 / 50	Precertification Required
Newborn Nursery Care – While Inpatient	80 / 20	50 / 50	
Orthoptic Training			Precertification Required
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	Items over $500 must be Pre-certified
Outpatient Emergency Services (ER)	For non-emergency services see Telemedicine & Walk-in Clinics		
Emergency Room - **For Emergency Use Only**	80 / 20	80 / 20	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.

General Description of Benefits - Continued

Major Medical Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Physician Services[8] (See Below; GP, Specialists, etc.)			
General Practitioner (GP) / Primary Care Physician (PCP)	80 / 20	50 / 50	
Specialist[9] – Encounter Copay	80 / 20	50 / 50	
Telehealth Services – **Teladoc**	100% ☺	Not Available	100% covered using Teladoc
Urgent Care	80 / 20	50 / 50	
CVS MinuteClinic®	100% ☺	Not Available	All Eligible Charges Covered[10]
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	Precertification Required
Radiology – Enhanced Imaging[11] MRI, CT scan, or PET scan	80 / 20	50 / 50	Precertification Required
Routine Patient Costs – Approved Clinical Trials	80 / 20	50 / 50	Precertification Required
Second Surgical Opinions	100% ☺	50 / 50	
Skilled Nursing Facility – 120 Day Annual Limit	80 / 20	50 / 50	Precertification Required
Sleep Apnea Appliance (CPAP) – See Carelink DME	80 / 20	50 / 50	Precertification Required
Smoking Cessation – 120 Day Annual Limit	100% ☺	Not Covered	See PBM Program
Surgery – See Enhanced Plan Benefits for Additional Benefits	80 / 20	50 / 50	Precertification Required
Telehealth Services – Non-Teladoc	80 / 20	50 / 50	Limits[12] will apply
Temporomandibular Joint Disorder (TMJ)	80 / 20	50 / 50	Precertification Required
Therapy			
ABA Therapy – 60 Visit Annual Limit	80 / 20	50 / 50	Precertification Required
Chemotherapy	80 / 20	50 / 50	Precertification Required
Occupational Therapy – 60 Day Annual Visit Limit	80 / 20	50 / 50	Precertification Required
Physical Therapy – 60 Day Annual Visit Limit	80 / 20	50 / 50	Precertification Required
Radiation Therapy	80 / 20	50 / 50	Precertification Required
Respiration Therapy	80 / 20	50 / 50	Precertification Required
Speech Therapy – 60 Day Annual Visit Limit	80 / 20	50 / 50	Precertification Required
Transplants – ETS Transplant Network	80 / 20	50 / 50	Precertification Required
Walk-in Clinic Visit – See Enhanced Plan Benefits for no Copay	80 / 20	50 / 50	
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

[8] **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.

[9] 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.

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

[11] **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.

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

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 - **$0 to $250**: **Note:** All prescriptions over $700 require a prior authorization.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription – **$251 to $700**: **Note:** All prescriptions over $700 require a prior authorization.	**$20 Copay**
Tier 3 - Copayment per new or refill prescription – **$700 and Up**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill prescription through GBS Rx Drug Program	**$0 – No Copay ☺**
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[13]	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 - **$0 to $250**: **Note:** All prescriptions over $700 require a prior authorization.	**$8 Copay**
Tier 2 - Copayment per new or refill prescription – **$251 to $700**: **Note:** All prescriptions over $700 require a prior authorization.	**$30 Copay**
Tier 3 - Copayment per new or refill prescription – **$700 and Up**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill prescription through GBS Rx Drug Program	**$0 – No Copay ☺**
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[14] **Card Copayment Options – No more than a 30-day supply**	The copayments shown are applied to each prescription.
Copayment per new or refill prescription - **Specialty prescription**: **Note:** All prescriptions over $700 require a prior authorization.	**80 / 20 Cost Share**
Copayment per new or refill Specialty prescription through GBS Rx Specialty Drug Program	**$0 – No Copay ☺**

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.

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** (Phone number is on your ID card) 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.

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

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

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.

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.[15] 2 out of 3 prescriptions filled today are for generic medicines and that number is growing.[16] 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.

Select Drugs and Products Program: Your Prescription Drug Plan has been enhanced to offer you the opportunity to substantially reduce your out-of-pocket cost paid for specialty drugs.

Your Plan includes a program offered through **GBS Rx**, called the Select Drugs and Products Program. This program will support Plan participants prescribed specialty drugs and products.

Participation is required of those Plan participants seeking coverage for products included on the Select Drugs and Products List. All products included in the program require prior authorization. A Case Coordinator from the program will assist you with accessing and making these high-cost specialty drugs affordable.

If you are being treated with a brand name medication for rheumatoid arthritis, cancer, multiple sclerosis, or other conditions typically treated by a specialist you should contact the Specialty Contact Center to enroll in the Select Drugs and Products Program. Additionally, the benefits office may contact you to introduce the program to facilitate your enrollment.

The Specialty Contact Center with **GBS Rx** may be reached toll-free at **(888) 364-3580** from 8 a.m. to 5 p.m. CT, Monday through Friday.

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

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"

_____

Signature & Date

OPTIONAL 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	**100/0**	Preventive Care
Class 2 Services	**90/10**	Repair and Restoration*
Class 3 Services (12 month waiting period for dentures and bridgework)	**60/40**	Major Dental Repair*
Class 4 Services	**Not Covered**	Orthodontics* underage 19

PPO Network:
The dental program includes the **Aetna Dental Administrators PPO** www.aetna.com/dentaladministrators.com, **Dentemax PPO USA/Connection Dental, Mavarest Dental, and Premier Dental at** www.novanetdental.com networks.

***Non-PPO Network:** Covered charges are limited to Usual and Customary fees calculated at the 90th percentile. If the Provider bills in excess of the 90th percentile member's could be responsible for the difference.

Benefits will remain the same for both PPO and Non-PPO Network Providers.

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Calendar 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 Article.

16.01. 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 Usual and Customary fees.

A. Class 1 Services *(Preventive Care)*

1. Routine oral examinations and prophylaxis *(cleaning, scaling and polishing teeth)* – limited to once in any 6-month consecutive period.
2. Periapical x-rays and bitewing x-rays – limited to once in any 6-month consecutive period.
3. Full mouth or Panoramic x-rays – limited to once in any 60-month consecutive period.
4. Sealants for Dependent Children (under age 16) - limited to once in any 36-month consecutive period.
5. Topical application of fluoride for Dependent Children (under age 14) – limited to once in any 6-month consecutive period.
6. 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.
7. Palliative Emergency treatment of an acute condition requiring immediate care.

B. Class 2 Services *(Repair and Restoration)*

1. All Medically Necessary x-rays not covered under another class.
2. Amalgam (not downgraded), 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.
6. Periodontal examinations, scaling, treatment and surgery.
7. Consultations.

C. Class 3 Services *(Major Dental Repair)*

1. Inlays, gold fillings, crowns (upon seat date), and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth. Missing tooth clause does not apply.
2. Repair or re-cementing 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 subject:
    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
    b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.
4. Osseous Surgery.
5. Oral Surgery.
6. Post and core.
7. Denture Reline.
8. Stainless steel crowns.
9. Impacted Wisdom Teeth (if not covered under medical plan).

D. Class 4 Services *(Orthodontics)*

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.

16.02. Exclusions and Limitations

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

A. Adjustments. Charges for services to alter vertical dimension *(work done or appliance used to increase the distance between nose and chin)*; to restore or maintain occlusion *(work done or appliance used to change the way the top and bottom teeth meet or mesh)*; to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;

B. After the Termination Date. The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses Incurred for the following procedures will be payable as though the coverage had continued in force:

1. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;

2. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and

3. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;

C. 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 Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;

D. Education. Charges for instruction in oral hygiene, plaque control or diet;

E. 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;

F. Miscellaneous. The Plan does not cover any charge, service or supply which is:

1. For treatment other than by a Dentist or Physician, except:
   a. Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and

   b. Non-Experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;

2. For local infiltration anesthetic when billed for separately by a Dentist;

3. For personalization or characterization of dentures or veneers or any cosmetic procedures or supplies;

4. For oral hygiene or dietary instruction;

5. For a plaque control program *(a series of instructions on the care of the teeth)*;

6. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;

7. For periodontal splinting;

8. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

9. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;

10. For replacement of a lost, missing or stolen prosthetic device;

11. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;

12. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;

13. Charges for missed appointments or completion of claim forms;

14. Covered under the "Medical Benefits" Article of the Plan; and

15. 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, except as specifically provided herein;

G. **Missing Appliances**. Charges for replacement of lost, missing or stolen appliances or prosthetic devices;

H. **More Expensive Course of Treatment.** In all cases involving covered services in which the Provider and the Participant select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the lesser procedure;

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

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

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

L. **Replacements**. Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or on lay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, on lay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Participant. *(Damage resulting from biting or chewing is not considered an Accidental Injury)*;

M. **Single Provider Care.** In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the services. An appropriate expense in this case will be the Usual and Customary fee;

N. **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.

16.03. Pre-determination of Dental Benefits

If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of $300 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However, approval is <u>not required</u> 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.**

SUMMARY PLAN DESCRIPTION

ADAIR COUNTY
EMPLOYEE BENEFIT PLAN

"VOLUNTARY VISION BENEFIT PLAN"

PREPARED EXCLUSIVELY FOR:

ADAIR COUNTY GOVERNMENT

PREPARED BY:

GROUP BENEFIT SERVICES

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_____

Signature & Date

OPTIONAL 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	**90/10**
Maximum Annual Vision Plan Benefit Limit per Participant	**$600**

Vision Benefits:	Benefit Limits[1]	Benefit Maximums
Eye Exam[2], Per Participant – no deductible	1 every 12-month period	**90/10 up to $100 Maximum**
Single Vision Lenses	1 set every 12-month period	**90/10 up to $120 Maximum**
Bi-focal Lenses	1 set every 12-month period	**90/10 up to $130 Maximum**
Tri-focal Lenses	1 set every 12-month period	**90/10 up to $140 Maximum**
Lenticular Lenses	1 set every 12-month period	**90/10 up to $150 Maximum**
Frames	1 pair every 24-month period	**90/10 up to $130 Maximum**
Contact Lenses	Up to 12-month supply	**90/10 to Benefit Limit**

Benefit Limitation: A Participant can use the vision benefit program to secure either one type of eyeglass lenses **or** contact lenses within a 12-month period (**not both, subject to plan limitations**).

17.01. Additional Covered Expenses

Subject to the limits in the Summary of Benefits, the Plan pays the Usual and Customary fees for vision care services, as follows:

A. 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;

B. 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 Disease or Injury)*;

C. Recommended. Recommended and approved by a Physician or optometrist;

17.02. Exclusions and Limitations

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

A. Benefit Limitation: A Participant can use the benefit to secure either eye glasses with frames or contact lenses (not both)

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

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

D. Non-Prescription Lenses. Charges for lenses ordered without a prescription;

E. Orthoptics. Charges for orthoptics *(eye muscle exercises)*

F. Safety Goggles or Sunglasses. Charges for safety goggles or sunglasses, including prescription type; and

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

H. Optional lens extras. Including anti-reflective, scratch-resistant and mirror coatings. Also including, UV, Transitions, lens tint and Polarization lenses. etc)

I. Corrective surgical procedures. Such as, but not limited to, Radial Keratotomy (RK), Photo-refractive Keratectomy (PRK) and LASIK surgery.

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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.

Employee Enrollment Packet

Flexible Spending Account (FSA)

Adair County Government

Employee Benefit Plan

To view your full benefit documents, scan the QR code or visit:
https://gbs-tpa.com/adair-county-govt-oe-guide/

Group Benefit Services

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gbs-tpa.com | 800.995.3569

FSA ENROLLMENT FORM

2025

EMPLOYEE INFORMATION

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

Last 4 of SSN: _____ **Email Address:**_____ *(to receive e-statements)*

ENROLLMENT OR DECLINATION

☐ **Yes, I want to enroll in a flexible savings account (FSA).**
Enrolling in an *FSA may* have a *minor effect* on your *social security and/or retirement benefits.* Please seek professional advice from appropriate parties.

☐ **No, I do not want to enroll in an FSA.**
If a change of status occurs, you may have the right to elect (enroll in) an FSA at that time if your employer allows.

REGULATIONS + PAYCHECK DEDUCTIONS

NOTE: Only complete this section if you are enrolling in an FSA.

FSA REGULATIONS

Internal Revenue Service (IRS) regulations includes four (4) primary conditions for FSAs:

1. Qualified expenses must be incurred during the plan year.
2. Any expenses incurred that are covered under another health plan do not qualify for FSA distributions.
3. To receive reimbursement, you must provide proper documentation.
4. You can change or revoke your election only if specifically allowed by law and the plan.

PAYCHECK DEDUCTIONS

I request the following amount(s) to be deducted pretax:

	Plan Year Total		# of Paychecks		$ per Paycheck
Medical Care Reimbursement: (Annual Maximum: $3,200.00)	_____	÷	_____	=	_____
Dependent Care Reimbursement: (Annual Maximum: $5,000.00)	_____	÷	_____	=	_____

AGREEMENT AND SIGNATURE

The undersigned individual ("Undersigned") understands that they alone are fully responsible for the sufficiency, accuracy, and integrity of all information provided on this form. The Undersigned also understands that the email address provided here will only be used by Group Benefit Services, Inc. (GBS) to send plan-related communications (primarily digital FSA statements) and that GBS will not sell, redistribute, or otherwise provide this email address to any other party unless when required by law.

Signature:_____ **Date:** _____

FSA CLAIM FORM

For each claim you are requesting reimbursement for, please attach a **copy of the paid claim/invoice** and **a copy of the paid receipt.**

EMPLOYEE INFORMATION

*This section **must be completed for all Flexible Spending Account (FSA) claim submissions.***

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

Last 4 of SSN: _____ **Date of Birth (DOB):** _____

Home Address: _____
Street Address City State Zip

HEALTHCARE REIMBURSEMENTS

DATE		PATIENT INFORMATION		AMOUNT REQUESTED	CLAIM INFORMATION	
Start	*End*	*Name*	*Relationship*		*Provider Name*	*Desc./Type of Service*
				$		
				$		
				$		
				$		

DEPENDENT CARE ASSISTANCE REIMBURSEMENTS

*Dependent care expenses **must** be for a **dependent that is incapable of self-care** or **under the age of 13** at the time care was provided.*

DATE		DEPENDENT INFORMATION		AMOUNT REQUESTED	PROVIDER CERTIFICATION		
Start	*End*	*Name*	*DOB*		*Provider Name*	*Tax ID #*	*Provider Signature*
				$			
				$			
				$			

AGREEMENT AND SIGNATURE

The undersigned individual ("Undersigned") certifies that all expenses for which reimbursement or payment are claimed on this form were incurred during a period while the Undersigned was covered under their employer's Flexible Spending Account (FSA) with respect to such expenses. The Undersigned also certifies that the expenses listed on this form have not already been reimbursed and reimbursement will not be sought from any other source now or in the future. The Undersigned fully understands that they alone are fully responsible for the sufficiency, accuracy, and integrity of all information provided by the Undersigned here. The Undersigned also understands that unless an expense for which payment or reimbursement is requested here is a qualified expense under the Plan, the Undersigned may be liable for payment of all related taxes (including federal, state, or local income taxes) on amounts paid from the Plan which relate to such an expense. **Any individual who knowingly files a statement of claim containing false, incomplete, or misleading information with the intent to injure, defraud, and/or deceive any insurance company, plan administrator, and/or plan service provider may be charged with and found guilty of a criminal act punishable under law.**

Employee Signature:_____ **Date:**_____

SUBMISSION OPTIONS

Mail: Group Benefit Services, ***ATTN:*** Claims Dept., 3810 E. Sunshine, #200, Springfield, MO 65809
Fax: (417) 883-8261 | **Email:** claims@gbsitpa.com

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FSA CONTRIBUTION ESTIMATE WORKSHEET

MEDICAL EXPENSES

This worksheet will help you estimate the amount of money (per paycheck) you may want to contribute to your FSA for this Plan Year's non-reimbursable medical expenses.

NON-REIMBURSABLE MEDICAL EXPENSES ESTIMATE

Using your expenses from previous years, complete this section of the worksheet to estimate the medical expenses you and your eligible dependents expect to incur during the current Plan Year. Only list expenses that will not be paid or reimbursed from another source, such as insurance.

MEDICAL

Deductibles $_____
Coinsurance $_____
Routine Exams (OB-GYN, physicals, etc.) $_____
Medical Office Copays $_____
Prescription Drugs (including birth control, allergy shots, and insulin) $_____
Hearing Aids and Exams $_____
Medical Equipment (wheelchairs, prosthetic devices, etc.) $_____
Chiropractor $_____
Other: _____ $_____

DENTAL

Deductibles $_____
Coinsurance $_____
Orthodontia (braces, retainers, etc.)* $_____
Other: _____ $_____

VISION

Eye exams $_____
Contact lenses $_____
Prescription eye wear $_____
Other: _____ $_____

TOTAL: $_____

CONTRIBUTION ESTIMATE

BEFORE YOU BEGIN: Your total annual FSA contribution for medical expenses cannot exceed the limit set by the IRS or the limit set by your employer. Your employer's limit could be less than the IRS limit. Contact your HR Department to confirm what your annual FSA contribution limit is for the current Plan Year.

To estimate the amount of money you may want to contribute to your FSA from each paycheck, **divide** your **Total** (above) **by** the **total number of pay periods** in the Plan Year.

$_____ ÷ _____ = **$**_____ per paycheck contributed to your FSA.

Total (above) | Number of pay periods in the Plan Year

*Refer to "Orthodontia" on the "FSA Reimbursable Expenses List" document for special rules regarding orthodontic care.

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FSA CONTRIBUTION ESTIMATE WORKSHEET

DEPENDENT CARE EXPENSES

This worksheet will help you estimate the amount of money (per paycheck) you may want to contribute to your FSA for this Plan Year's dependent care expenses.

DEPENDENT CARE EXPENSES ESTIMATE

Using your expenses from previous years, complete this section of the worksheet to estimate the dependent care expenses you expect your eligible dependents to incur during the current Plan Year.

TYPES OF DEPENDENT CARE

Daycare	$_____
Preschool	$_____
After School Care	$_____
Family Childcare	$_____
Nanny Services	$_____
Adult Daycare Center	$_____
Other: _____	$_____
Other: _____	$_____

TOTAL: $_____

CONTRIBUTION ESTIMATE

BEFORE YOU BEGIN: Your total annual FSA contribution for dependent care cannot exceed the limit set by the IRS or the limit set by your employer. Your employer's limit could be less than the IRS limit. Contact your HR Department to confirm what your annual FSA contribution limit is for the current Plan Year.

To estimate the amount of money you may want to contribute to your FSA from each paycheck, **divide** your **Total** (above) **by** the **total number of pay periods** in the Plan Year.

$_____ ÷ _____ = **$**_____ per paycheck contributed to your FSA.

Total (above) | Number of pay periods in the Plan Year

FSA REIMBURSABLE EXPENSES

2025

About This List

United States Internal Revenue Service (IRS) regulations govern the eligibility of expenses. This document is for **general information purposes only** and should not be considered medical reimbursement advice. For complete details, visit https://www.irs.gov/publications/p502.

What Expenses are Reimbursable?

Abortion:	✓ **Reimbursable**
Acupuncture:	✓ **Reimbursable**
Ambulance:	✓ **Reimbursable**
Braille Books and Magazines:	! **Reimbursable,** but only the cost difference of braille books and/or magazines and the price for regular books and/or magazines. ***Example:*** A braille book is $35 while the regular version of the same book is $15. To find the cost difference, subtract the price of the regular version from the cost of the braille version ($35−$15= $20). Therefore, the total reimbursable amount is $20.
Breast Augmentation:	! **Reimbursable,** but only if the costs are related to the removal of breast implants that are defective and/or are causing a medical problem.
Breast Reduction or Reconstruction Surgery:	! **Reimbursable,** but only for medically necessary, non-cosmetic purposes.
Capital Expenses:	! **Reimbursable,** but only for medical care.
Car Accessibility Modifications:	! **Reimbursable,** but only for special hand controls and other special equipment needed by a person with a physical limitation(s) (disability or disabilities) to safely operate a motor vehicle. Likewise, the cost of a car specially designed to hold a wheelchair must exceed the cost of a regular car in order to qualify for reimbursement.
Childbirth Classes:	! **Reimbursable,** but only classes related to the process of childbirth attended by the mother-to-be.
Chiropractor:	✓ **Reimbursable**

What Expenses are Reimbursable? Cont.

Christian Science Practitioners:
✓ Reimbursable

Coinsurance Amounts:
✓ Reimbursable

Cord Blood Storage:
! **Reimbursable,** but only if a child(ren) has a medical condition(s) the cord blood treats.

Cosmetic Surgery:
! **Reimbursable,** but only if the surgery is necessary to improve a deformity arising from or directly related to:

- A congenital abnormality,
- A personal injury resulting from an accident or trauma, or
- A disfiguring disease.

The cost of cosmetic surgery to improve a facial deformity caused by prior surgeries to correct congenital abnormalities is also reimbursable.

✗ **Not Reimbursable**: Medical expenses paid for any other cosmetic surgery that are not deductible medical expenses (example: gender reassignment surgery).

If there is a concern that a medical or dental surgery could be considered cosmetic, a doctor's certification should be obtained explaining how the procedure meaningfully promotes the proper function of the body and/or prevents or treats an illness or disease.

Deductibles (Medical, Dental, and Vision):
✓ Reimbursable.

Dental Treatment:
✓ Reimbursable

Dependent Care Expenses:
! **Not Reimbursable** but may be reimbursable under a dependent care FSA.

Divorce Expenses:
✗ **Not Reimbursable,** even if a doctor or psychiatrist recommends it.

Egg Donor Fees and Expenses:
✓ Reimbursable

Employment-Related Expenses:
✗ **Not Reimbursable,** including employment-related physicals.

What Expenses are Reimbursable? Cont.

Exercise- / Fitness-Related Expenses:

! **Reimbursable,** but only if purchased, attended, etc. on a doctor's recommendation and a Letter of Medical Necessity is provided by said doctor. Reimbursable expenses include:

- Exercise Equipment
- Fitness/Exercise Classes
- Health Club Dues
- Personal Trainer
- Weight-Loss Program

Fertility:

! **Reimbursable,** but not for a single father of natural health for fertilization of an anonymous donor's eggs.

Formula, Infant:

✗ **Not Reimbursable** even if the mother is unable to breast feed. Formula is considered food that satisfies normal nutritional requirements.

Funeral Expenses:

✗ **Not Reimbursable**

Hospital Expenses:

✓ Reimbursable

Household Help:

! **Reimbursable,** but only for certain expenses paid to an attendant providing nursing-type services.

Human Guide:

✓ **Reimbursable**

Impotence or Sexual Inadequacy:

✓ **Reimbursable**

Insurance Premiums and Supplemental Policies:

✗ **Not Reimbursable**

Laboratory Fees:

✓ **Reimbursable**

LASIK:

✓ **Reimbursable**

Lead-Based Paint (Removal and Repainting):

✓ **Reimbursable:** Expenses related to removal of the paint.

✗ **Not Reimbursable:** Expenses related to repainting the scraped area.

Learning Disability:

! **Reimbursable,** but only:

- Tuition payments to a special school and
- Tutoring fees to overcome learning disabilities.

WHAT EXPENSES ARE REIMBURSABLE? CONT.

Legal Fees:

❗ **Reimbursable,** except for a management fee.

Example: Legal fees related to establishing a guardianship for a spouse with Alzheimer's disease qualify because the purpose was to commit the spouse for medical treatment that could not be provided otherwise.

Lifetime Care:

❗ **Reimbursable,** but the agreement must require a specified fee payment as a condition for the home's promise to provide lifetime care that includes medical care.

Lodging and Meals:

❗ **Reimbursable.** The cost of lodging not provided in a hospital or similar institution while an employee is away from home is reimbursable if following four (4) requirements are met:

1. The lodging is primarily for and essential to medical care;
2. The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital;
3. The lodging is not lavish or extravagant under the circumstances; and
4. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

Finally, the reimbursable amount cannot exceed $50 per person per night.

Marijuana:

✗ **Not Reimbursable**

Marriage Counseling:

✗ **Not Reimbursable**

Massage:

❗ **Reimbursable,** but only if prescribed or substantiated by physician to treat a physical defect or illness.

Maternity Clothes:

✗ **Not Reimbursable**

Medical Alert Devices:

✗ **Not Reimbursable**

Medical Information Plan:

✓ **Reimbursable**

What Expenses are Reimbursable? Cont.

Medical Savings Accounts (MSAs):	✗ Not Reimbursable
Medical Equipment/Devices	✓ Reimbursable
Medicines, Rx and Over-the-Counter:	✓ Reimbursable
Missed-Appointment Fees:	✗ Not Reimbursable
Nursing Home:	✓ Reimbursable
Nursing Services:	! **Reimbursable** but only if services are generally performed by a nurse. ✗ **Not Reimbursable** if services are for a baby that is normal and healthy.
Orthodontia:	! **Reimbursable** except for cosmetic purposes.
Osteopath:	✓ Reimbursable
Physical Exams:	! **Reimbursable,** but only if the physical exam is not employment-related.
Pilates:	✗ Not Reimbursable
Pre-Existing Conditions:	✓ Reimbursable
Prosthesis:	✓ Reimbursable
Psychiatric Care:	✓ Reimbursable
Radial Keratotomy:	✓ Reimbursable
Scientology "Audits":	✗ Not Reimbursable
Service Animals (such as Guide Dogs):	! **Reimbursable,** but only if the animal is primarily for medical care to alleviate a mental or physical defect or illness. Expenses incurred to maintain the animal's health and vitality so it may perform its duties are also reimbursable.
Sexual Counseling:	! **Reimbursable,** but only if the counseling is provided by psychiatrist.
Smoking Cessation Program:	✓ Reimbursable
Spa or Resort:	! **Reimbursable,** but only the medical services costs.

What Expenses are Reimbursable? Cont.

Special

Foods:

❗ **Reimbursable,** but only the cost difference between the price of special foods and/or beverages and the price of regular ones. Likewise, cost difference(s) are only reimbursable if they are:

- Consumed primarily to alleviate or treat illness or disease,
- Substantiated by a physician, and
- Are not part of normal nutritional needs.

Example: A special food is $5 while the regular version of the same food is $1. To find the cost difference, subtract the price of the regular food from the cost of the special food ($5−$1= $4). Therefore, the total reimbursable amount is $4.

✗ **Not Reimbursable:** special foods purchased as part of a weight-loss program are not reimbursable expenses as reduced-calorie foods are substitutes for the food individuals would normally eat.

Home for the Mentally Handicapped:

✓ **Reimbursable**

Schools:

❗ **Reimbursable,** but only if school uses its resources for treating the disability. This includes the cost of a school that:

- Teaches braille to a visually impaired child,
- Teaches lip-reading to a hearing-impaired child, and/or
- Provides remedial language training to correct a condition caused by a birth defect.

Sterilization:

✓ **Reimbursable**

Substance Abuse:

❗ **Reimbursable,** but only medical expenses paid to a treatment center.

Sunglasses:

✓ **Reimbursable:** prescription sunglasses.

❗ **Reimbursable:** Non-prescription sunglasses, but only if they meet definition of medical care.

Taxes:

❗ **Reimbursable,** but only medical-related taxes.

What Expenses are Reimbursable? Cont.

Telephone:

❗ **Reimbursable,** but only special equipment that lets a hearing-impaired person communicate over a telephone.

Television:

❗ **Reimbursable,** but only special equipment that displays the audio part of TV programs as subtitles for the hearing-impaired.

Tests:

❗ **Reimbursable,** but only if diagnostic or screening tests have a direct relationship between the test and a medical diagnosis.

Therapy:

❗ **Reimbursable,** but only when performed by a qualified therapist for a medical condition.

Toiletries:

✗ **Not Reimbursable**

Transplants:

❗ **Reimbursable,** but only for surgical, hospital, laboratory, and/or transportation expenses for a prospective or actual donor.

Transportation:

❗ **Reimbursable,** but only the medical care-related transportation expenses:

- Of a parent who must accompany a child who needs medical care.
- Of a nurse or other person who can give injections, medications, or other treatment a patient requires who is traveling to get medical care and is unable to travel alone.
- For regular visits to see a mentally ill dependent if these visits are recommended as a part of treatment.
- To attend doctor-recommended outpatient meetings (such as Alcoholics Anonymous).
- To attend a medical conference on a chronic disease of the employee or a dependent. This includes registration fees, but not meals or lodging expenses.

Instead of using actual expenses the medical or moving expense mileage rate can be used. This flat rate only considers out-of-pocket variable expenses (such as gasoline and oil), not fixed expenses (such as license and registration fees). The year's current rate can be found at:
https://www.irs.gov/tax-professionals/standard-mileage-rates

What Expenses are Reimbursable? Cont.

Trips:

❗ **Reimbursable,** but only if the trip is primarily for and essential to receiving medical services.

✗ **Not Reimbursable:** Commuting to a job not explicitly prescribed as therapy for a medical condition.

Tuition:

❗ **Reimbursable,** but only if charges are separately stated in the tuition bill.

Unscheduled Office Visits:

❗ **Reimbursable,** the fee charged for a visit being an unscheduled visit can be considered a qualified medical expense that can be reimbursed through FSA funds, as long a qualified services were rendered at that visit.

Vaccines:

✓ **Reimbursable**

Vacuum Cleaners:

✗ **Not Reimbursable.** Per the IRS, vacuums are not a qualified expense for treatment of allergies.

Vasectomy:

✓ **Reimbursable**

Vision Care:

❗ **Reimbursable,** but only:

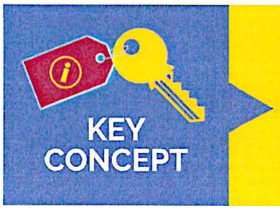
- Eyeglasses and lenses for medical reasons
- Eye exams and expenses for contact lens solutions.

✗ **Not Reimbursable:** premiums for contact lens replacement insurance.

Wigs:

❗ **Reimbursable,** but only when all hair is lost due to disease.

DISCOVER SAVINGS WITH A DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT



A Dependent Care Flexible Spending Account (FSA) can be a great way to **pay less taxes on your income.** Money placed into a dependent care FSA is taken directly from your paycheck. This lowers your total pretax pay, which reduces the amount of taxes you pay on your income. These **tax savings** are often **called "pretax savings"** or a **"pretax advantage."**

INFO BITES

TERM: QUALIFYING PERSON
A qualifying person is a **child(ren), disabled spouse,** or **parent(s)** who depend on you for care. To determine if the individual you care for is a qualifying person, review the definitions of qualifying persons **in IRS Publication 503 (2020), page 3.**

TIP: USE ALL OF YOUR FUNDS
All funds in your Dependent Care FSA **must be used by the end of the plan year** as any **remaining funds will be forfeited** in compliance with IRS regulations.

TIP: KEEP ALL OF YOUR RECEIPTS
The IRS requires all FSA expenses be verified as eligible. In order for GBS to verify your expenses, **you'll need to include a receipt (or other proof of payment) when you submit your FSA Claim Form** to GBS for reimbursement. So, be sure to **save all of your receipts!**

HOW DO I KNOW IF I CAN PARTICIPATE?

To be eligible to participate in a Dependent Care FSA:

- You (and your spouse, if applicable) must work full-time or attend school full-time*.
- You must be eligible† to participate in your employer's health plan‡.
- You must be receiving a paycheck from which deductions can be taken.
- You (and your spouse, if applicable) must be unavailable to care for your qualifying person.

In addition to the above eligibility requirements, if you have a spouse they must either be:

1. Gainfully employed;
2. A full-time* student;
3. Disabled and incapable of self-care; or
4. Seeking employment and have income for the year.

HOW DOES IT WORK?

To use your Dependent Care FSA, follow these steps:

1. **Decide how much** you want **to set aside** per year (up to $5,000/year§).
2. **Pay** for your **dependent care expenses as normal.**
3. **Submit** an **FSA Claim Form and proof of payment** for your eligible dependent care expense(s) **to GBS** for reimbursement.

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* Full-time students are considered to be working if they remain full-time for some part of each of five (5) calendar months during the year. The months do not need to be consecutive. IRS Publication 503 (2020), page 6, column 1, paragraph 4.

† You do not have to be enrolled in one (1) of your employer's health plans, you just have to be eligible to enroll.

‡ If your employer offers more than one (1) health plan, you must be eligible for at least one (1) of the plans offered.

§ The IRS states you can contribute a maximum of $5,000 per year, but your employer may set a lower maximum contribution.

ABOUT DEPENDENT CARE EXPENSES

Dependent Care FSA funds reimburse you for care expenses you must pay in order for you to work or look for work. These expenses must be for the care of a qualifying person(s).

EXAMPLES OF ELIGIBLE EXPENSES

An **expense may be eligible** if you **pay** an individual or organization **to care for your dependent** who is **under 13 years old** or for **your spouse or parent who is unable to care for themselves (i.e. a qualifying person[s]).**

- Adult day care
- Au pair services (only the amounts paid for the actual care)
- Babysitting services (both inside and outside the home)
- Before- and after-school care (not tuition)
- Care at a licensed day care center
- Elder day care
- Extended day programs (such as summer day camp) for a child(ren) under 13 years old
- Nanny services (only the amounts paid for the actual care)
- Nursery school, preschool, or similar programs

EXAMPLES OF INELIGIBLE EXPENSES

According to the IRS* "**Expenses for care don't include** amounts you pay for **food, lodging, clothing, education, and entertainment.** However, you **can include small amounts paid for these items if** they are **incidental** to and **can't be separated** from **the cost of caring** for a qualifying person." Refer to IRS Publication 503 (2020), page 7, "Expenses not for care." for details.

- Educational expenses (such as summer school, tutoring programs, and tuition fees)
- Overnight camp
- Extra expenses for items such as food, clothing, supplies, special events, sports lessons, or activities (unless inseparable from care)
- Care expenses for a qualifying person living outside your household
- Care expenses paid to:
  - A person you (or your spouse, if filing jointly) can claim as a dependent
  - Your child who is under age 19 at the end of the year, even if he or she isn't your dependent
  - A person who was your spouse any time during the year
  - The parent of your qualifying person if said person is your child and under 13 years old

ABOUT THIS FLYER

United States Internal Revenue Service (IRS) regulations govern the eligibility of expenses. This document is for general information purposes only and should not be considered dependent care reimbursement advice. For complete details, visit https://www.irs.gov/pub/irs-pdf/p503.pdf.

* IRS Publication 503 (2020), page 7, column 1, paragraph 4. ("Expenses not for care.")

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)

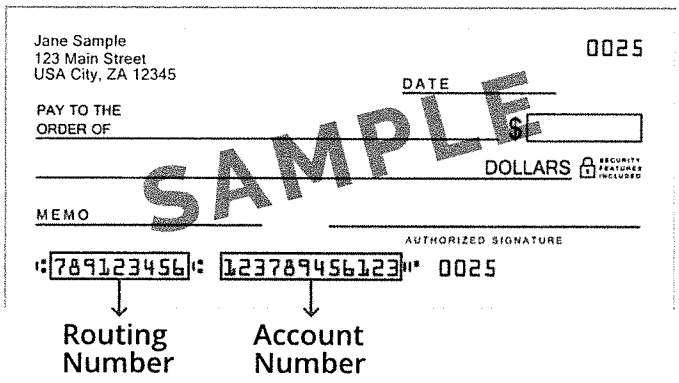
Complete and submit this form to have your claim-related reimbursements automatically deposited into your selected checking or savings account.

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., 1736 E. Sunshine, #200, Springfield, MO 65804
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.

EMPLOYEE DEPENDENT CLAIM FORM

Submission Options

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

EMPLOYEE INFORMATION

*This section **must be completed for all 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 claim submission.

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

CLAIM INFORMATION

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

Do you and/or your dependent have medical coverage other than GBS? Y / N

What type of claim is being submitted? Medical / Dental / Vision

If you're ***submitting a medical claim,*** attach the following information on the service provider's letterhead:

☐ Provider's federal tax ID number ☐ Diagnosis codes ☐ Description of service(s) ☐ Date(s) of service

If you're ***submitting a dental or vision claim,*** attach the following information on the service provider's letterhead:

☐ An itemized list of service(s) received with cost per service ☐ Name of the provider where service(s) were received ☐ Date(s) of service

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:** _____

GBS' ENHANCEMENTS TO OPEN ENROLLMENT

Starting this year, GBS is making changes that will help to streamline your group's open enrollment process.

ENROLLMENT MATERIALS

We've **simplified** your **open enrollment packet**.

COVER PAGE
Includes a URL and QR code to your custom OE webpage (see below).

AT-A-GLANCE
Includes employee contribution rates, SPD highlights, and a sample ID card by plan.*

CONDENSED FLYERS
Adapted benefit flyers, focusing on our core benefits.

COMBINED FORMS
Enrollment and Event Change forms have been revised into a single form, with the option to waive coverage.

NEW! CUSTOM WEBPAGE

Tailored to your group's branding, this webpage will be available year-round so that both **current employees** and **new hires can view their benefits 24/7/365.**

SPDs, AAGs, and Ancillary Highlights
View the full SPD(s) and benefits offered through your plan.

ONLINE OE APPLICATION
A link to the portal where members can complete enrollment, if applicable.

BENEFIT FLYERS
Full versions of all benefit flyers, available for members to view/ download at their convenience.

FORMS
Enrollment/Event Change and EFT forms; FSA and RDA forms, if applicable.

*Ancillary highlight sheets included for applicable Life, Disability, and/or Worksite products.

Want more info?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GGI.crt| 241025