

# 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/>



**Group Benefit Services, Inc.**  
Innovative Solutions | Customized Benefits | Sustainable Plans

*gbs-tpa.com | 800.995.3569*





## Adair County Government Plan Year 2026



### ATTENTION

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

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-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly
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
*Bi-Weekly payroll (26) withholdings are Bi-Monthly (24)							
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		20%	50%	20%	50%	20%	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
Family		\$2,000	N/A	\$2,000	N/A	\$2,000	N/A
MEDICAL SERVICES							
Primary Care Physician		20%	50%	\$20 Copay	50%	\$20 Copay	50%
Specialist		20%	50%	\$20 Copay	50%	\$20 Copay	50%
Urgent Care		20%	50%	\$50 Copay	50%	\$50 Copay	50%
Emergency Room		20%	20%	\$200 Copay + 20%		\$200 Copay + 20%	

**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	20%
90-day		\$0 Copay	\$8 Copay	\$30 Copay	20%
SPECIALTY**		N/A	20%	20%	20%
GBS Rx Drug Program		N/A	0%	0%	0%

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

\*\*Orphan drugs are excluded.

**Adair County Government**

Group Number: 40500  
Member ID: 123456789000  
Member: JOHN SAMPLE  
Dependent: 01 Judy Sample  
02 Jason Sample  
Plan Type: Bronze Plan  
Network: PPO

Precertification: AHH (866) 898-9356  
[www.Americanhealthholding.com](http://www.Americanhealthholding.com)

Aetna Signature Administrators\*  
PPO

**Medical Claims Mailing Address:**  
**Group Benefit Services, Inc. (GBS)**  
 PO Box 211547  
 Eagan, MN 55121-2747  
 EDI 80241  
 Online Provider Directory: [aetna.com/asa](http://aetna.com/asa)

**To Verify Eligibility and Benefits:**  
**Group Benefit Services, Inc. (GBS)**  
 24/7: [www.gbs-tpa.com](http://www.gbs-tpa.com)  
 M-F 8-5: (800) 995-3569

**GBS Nurse Navigator: (888) 364-3580**

**In-Network Benefits:**  
 Deductible: \$6,000 | Max OOP: \$8,000  
 GP, Specialist, Urgent Care, & ER: 20%

**Non-Network Benefits:**  
 Deductible: \$12,000 | Max OOP: \$16,000  
 GP, Specialist, & Urgent Care: 50% | ER: 20%

Rx Copay (30 Day Supply): Tier 1: \$8 | Tier 2: \$20 | Tier 3: 20%  
 Specialty Rx Copay (30 DS): 20%  
 Rx Copay (90 Day Supply): Tier 1: \$8 | Tier 2: \$30 | Tier 3: 20%

**Drexil**  
An AMPS Company  
[www.Drexil.com](http://www.Drexil.com) (844) 728-3479  
 RxBIN: 018448  
 RxPCN: 66202303  
 RxGRP: 40500

Preferred Lab 100% Coverage:

Mail Rx claims to: GBS  
 2810 E. Sunshine Drive 200, Springfield, MO. 65804



**Adair County Government**  
Plan Year 2025



**ATTENTION**

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

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

EMPLOYEE CONTRIBUTION BY TIER	DENTAL PLAN		VISION PLAN	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
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

\*Bi-Weekly payroll (26) withholdings are Bi-Monthly (24)

ANNUAL DEDUCTIBLE	DENTAL PLAN	VISION PLAN
	Single	Waived for Class 1 Services. \$25
Family	\$50	\$100

ANNUAL BENEFIT LIMIT	DENTAL PLAN	VISION PLAN
Per Participant	\$1,000 (Class 1, 2, and 3)	\$600

MAXIMUM LIFETIME BENEFIT	DENTAL PLAN	COINSURANCE	VISION PLAN
	Orthodontics (Class 4)		N/A

BENEFITS (See below conditions)	DENTAL PLAN	12-MONTH BEN. PERIOD	VISION PLAN
	Preventive Care (Class 1)		
Repair + Restoration (Class 2)	90/10	Single Vision Lenses <sup>‡</sup>	90/10 up to \$120 Max.
Major Dental Repair <sup>*</sup> (Class 3)	60/40	Bi-focal Lenses <sup>‡</sup>	90/10 up to \$130 Max.
Orthodontics under age 19 (Class 4)	60/40	Tri-focal Lenses <sup>‡</sup>	90/10 up to \$140 Max.
		Lenticular Lenses <sup>‡</sup>	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.

**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.

NETWORKS	
DENTAL	VISION
Aetna Dental Administrators, Zelis Dental, Dentemax, GEHA Solutions/Connection Dental	No Network Required

**Member**

**GBS** (800) 955-3569  
www.gbs-tpa.com

Adair County Government  
Group #: 40500  
Dental & Vision Plan  
Member: JOAN SAMPLE  
Member ID: 40500000000  
Dependents: John Sample  
Judy Sample

See back of card for benefits and claims instructions.

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**Eligibility and Benefits**

To Verify Eligibility and Benefits:  
Group Benefit Services, Inc.

24/7: www.gbs-tpa.com  
M-F 8-5: (800) 995-3569

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**Vision Benefits**

Annual Deductible: \$25  
Annual Max. Exam: \$100  
Annual Max. Lenses: \$120-\$150  
24 month Max. Frames: \$130  
Contact Lens Co-insurance: 10% (\$500 max)  
You cannot use any Vision provider of your choice.  
There is no network with GBS Vision plans.

**Dental Benefits**

Annual Deductible: \$25  
Annual Max: \$1,500  
Ortho Annual Max: \$1,500  
Basic Services: 10%  
Major Services: 40%

To find a participating dental:  
[www.aetna.com/healthandretirement](http://www.aetna.com/healthandretirement)  
[www.dentemax.com](http://www.dentemax.com) or [zelis.com](http://zelis.com)  
To access these additional networks:

Unitedent  
GEHA/Connection Dental  
Zelis Dental

All participating dentists are independent providers and are not agents or employees of Aetna.

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**Claims Submissions**

Aetna Dental Administrators  
To access all member's  
NewNet Customer Service  
800-533-7177 ext. 7

If your provider bills insurance, they should send claims to the below address:

Submit Itemized Statements and Assignments to:  
Group Benefit Services, Inc. (GBS)  
PO Box 211547  
Eagan, MN 55121-2747  
GBS EDIF 80241

See your Plan Document for the complete list of benefits, limits, and conditions. This card is for identification only. It is not a guarantee of eligibility.

\*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, lenticular) or contact lenses, within a 12-month period (not both).



## Summary Plan Description

The Summary Plan Description (SPD) describes the information contained within the Plan Document (PD). SPD and PD are available at: [mygbshealth.com](http://mygbshealth.com)

<b>Group Name / Plan Sponsor</b>	<b>Adair County Government</b>
<b>Plan Name</b>	<b>Gold Plan</b>
<b>Accumulation / Benefit Period</b>	<b>January 1 through December 31</b>
<b>PPO Network</b>	<b>Aetna Signature Administrators (ASA) PPO Network</b>

	<b>In-Network</b>	<b>Non-Network</b>
<b>Major Medical Deductible<sup>1</sup></b>		
<b>Single</b>	<b>\$2,000</b>	<b>\$4,000</b>
<b>Family</b>	<b>\$4,000</b>	<b>\$8,000</b>
<b>Coinsurance / Member Responsibility</b>		
<b>% after deductible has been met</b>	<b>20%</b>	<b>50%</b>
<b>Out-of-Pocket<sup>1</sup> Limit</b>		
<b>Single</b>	<b>\$4,000</b>	<b>\$8,000</b>
<b>Family</b>	<b>\$8,000</b>	<b>\$16,000</b>
<b>Medical Services</b>		
<b>Primary Care Physician (PCP, GP, OB/GYN)</b>	<b>\$20 Office Visit Copay<sup>3</sup></b>	<b>50%</b>
<b>Specialist<sup>2</sup></b>	<b>\$20 Office Visit Copay<sup>3</sup></b>	<b>50%</b>
<b>Urgent Care</b>	<b>\$50 Event Copay<sup>4</sup></b>	<b>50%</b>
<b>Emergency Room</b>	<b>\$200 Facility Copay + 20% Coinsurance</b>	

<b>Reimbursable Deductible Allowance (RDA)</b>	<b>In-Network</b>	<b>Non-Network</b>
<b>RDA Single Amount*</b>	<b>\$1,000</b>	<b>Not available</b>
<b>Family Annual Reimbursement Limit</b>	<b>\$2,000</b>	<b>Not available</b>

The RDA (Reimbursable Deductible Allowance) is a portion of your Deductible that you have paid to a Provider and/or Hospital that can be reimbursed at 100%. Eligible expenses are invoices from Providers and Hospitals that you have paid towards your in-network deductible in the current plan year. Submission of an invoice and payment receipt are required as Proof of Payment in order to receive RDA reimbursement. This Proof of Payment must be received by GBS within 90 days of the end of the plan year. Please Note: Amounts applied to Copays and Coinsurance are not eligible for RDA reimbursement.

How to submit: Claims may be submitted through [mygbshealth.com](http://mygbshealth.com) or emailed to [claims@gbsitpa.com](mailto:claims@gbsitpa.com).

\*50% of the unused RDA benefit amount(s) will roll over into the next plan year not to exceed the in-network Single deductible.

<sup>1</sup>In-Network and Non-Network Major Medical Deductible & Out-of-Pocket limit(s) **accumulate separately**.

<sup>2</sup>A referral from a PCP is not required to visit a Specialist.

<sup>3</sup>All other services performed in the Physician's office apply to Deductible and Coinsurance unless otherwise noted.

<sup>4</sup>Includes all services performed.



## Enhanced Plan Benefits

**\$0 Out-of-Pocket cost when using In-Network providers for the services listed below. Call a GBS Nurse Navigator at 888.364.3580 for the current provider (regional / nationwide) options and services available.**

Precertification and medical necessity determination may be required for some of the benefits listed. See Precertification section for requirements.

<b>Benefit Level</b>	<b>No Member Cost Options</b>
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Medical Service Categories	Preferred Provider	Find a Location
Diabetes Management Program & Service	Livongo	welcome.livongo.com/GBS      800.945.4355 Registration Code: <b>GBS</b>
Durable Medical Equipment (DME)	Carelink DME	CarelinkDME.com      888.604.3633
Lab Services	QuestSelect	questselect.com
Lab Services	Labcorp	labcorp.com
Radiology	Freestanding imaging facility	GBS Nurse Navigator 888.364.3580 Independent, non-hospital facilities
Sleep Study	Home sleep study	GBS Nurse Navigator 888.364.3580
Surgical Services	Ambulatory Surgical Center (ASC)	GBS Nurse Navigator 888.364.3580
Telemedicine	Teladoc	teladoc.com      800.835.2362
Walk-in Clinics	CVS MinuteClinic®	cvs.com/minuteclinic
Walk-in Clinics	Mizzou Quick Care	<a href="https://www.muhealth.org/conditions-treatments/quick-care">https://www.muhealth.org/conditions-treatments/quick-care</a>



## General Description of Benefits

Major Medical Benefit Descriptions	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
ABA Therapy	\$20 Office Visit Copay <sup>5</sup>	50%	
Acupuncture	\$20 Office Visit Copay <sup>5</sup>	50%	12 visit maximum per year
Allergy Injections / Serum	\$5 Copay	50%	
Allergy Testing	20%	50%	
Ambulance – Air <sup>6</sup> & Ground Services	20%		<b>For Emergency Use Only</b>
Ambulatory Surgical Center (ASC)	0%	50%	
Anesthesia	20%	50%	
Chemotherapy	\$20 Office Visit Copay <sup>5</sup>	50%	
Chiropractic Care	\$20 Office Visit Copay <sup>5</sup>	50%	30 visit maximum per year
Dialysis	20%	50%	6 month lifetime maximum
Durable Medical Equipment (DME) Preferred	0%	n/a	Carelink DME
Durable Medical Equipment (DME) Non-Preferred	20%	50%	Non-Carelink DME
Emergency Room	\$200 Facility Copay + 20% Coinsurance		<b>For Emergency Use Only.</b>
Emergency Room Physicians	20%		Non-Emergency Services Could Be Denied
Hearing Exam	0%		1 annual - basic hearing exam
Home Health Care	20%	50%	120 day annual maximum
Hospice Care Inpatient	20%	50%	
Hospice Care Outpatient	20%	50%	180 day annual maximum
Hospital Inpatient	20%	50%	
Hospital Outpatient	20%	50%	
Infusion Therapy	20%	50%	<b>Precertification may be required, orphan drugs are not covered. See Plan document for details.</b>
Lab Services - Preferential Plan Providers	0%	n/a	Quest & Labcorp
Lab Services - Non-Preferential Plan Providers	20%	50%	Non-Quest and Labcorp
Maternity Hospital Delivery	20%	50%	
Maternity Prenatal Services	0%	50%	Includes ultrasounds
Mental Health / Substance Abuse Inpatient Services	20%	50%	
Mental Health / Substance Abuse Group Therapy	20%	50%	
Mental Health / Substance Abuse Partial Day	20%	50%	
Mental Health / Substance Abuse Intensive Outpatient	20%	50%	
Mental Health / Substance Abuse Residential Treatment	20%	50%	
Newborn Nursery Care	20%	50%	
Nutritional Education (Diabetic / Weight Loss)	0%	50%	10 visit maximum per year
Occupational Therapy	\$20 Office Visit Copay <sup>5</sup>	50%	60 day Annual limit
Office Visit Mental Health / Substance Abuse	\$20 Office Visit Copay <sup>7</sup>	50%	In-office or telehealth <sup>8</sup>
Office Visit PCP, GP, OB/GYN	\$20 Office Visit Copay <sup>7</sup>	50%	In-office or telehealth <sup>8</sup>
Office Visit Specialist <sup>9</sup>	\$20 Office Visit Copay <sup>7</sup>	50%	In-office or telehealth <sup>8</sup>

<sup>5</sup> Includes all services performed.

<sup>6</sup> Eligible Air Ambulance 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.

<sup>7</sup> All other services performed in the Physician's office apply to deductible and coinsurance unless otherwise noted.

<sup>8</sup> A telehealth visit charge can be no more than a face-to-face office visit.

<sup>9</sup> A referral from a PCP is not required to visit a Specialist.



## General Description of Benefits - Continued

Major Medical Benefit Descriptions	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Orthoptic Training / Vision Training	20%	50%	Dependents up to age 10 (requires MD order)
Orthotics	20%	50%	
Preventive / Wellness Care	0%	50%	Full list <sup>10</sup>
Physical Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	60 day annual maximum
Private Duty Nursing	20%	50%	60 day annual maximum
Prosthetics	20%	50%	
Radiation Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	
Radiology - Preferred	0%	n/a	MRI, CT & PET Scans at preferred providers
Radiology - Non-Preferred	20%	50%	
Respiration Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	
Skilled Nursing Facility	20%	50%	120 day annual maximum (requires MD order)
Smoking Cessation	0%	n/a	10 visit maximum per year
Speech Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	60 day annual maximum
Teladoc	0%	n/a	100% covered using Teladoc
Temporomandibular Joint Disorder (TMJ)	20%	50%	
Transplant - IOE Transplant Network	20%	50%	
Urgent Care	\$50 Event Copay <sup>12</sup>	50%	
Vision Examination	0%		1 annual - basic vision exam
Walk-In Clinic - Preferred	0%	n/a	MinuteClinic
Walk-In Clinic - Non-Preferred	\$20 Office Visit Copay <sup>12</sup>	50%	
All Other Eligible Services - Not Specifically Listed	20%	50%	See Plan Document for Details

<sup>10</sup> For a full list visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>. Includes annual wellness exam, routine mammograms (over age 40), routine pap smears, routine prostate exam (over age 50), routine immunizations.

<sup>11</sup> Includes all services performed.

<sup>12</sup> All other services performed in the Physician's office apply to deductible and coinsurance unless otherwise noted.



## PRE-CERTIFICATION REQUIREMENTS

Call AHH at 866.898.9356 [www.Americanhealthholding.com](http://www.Americanhealthholding.com)

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced or penalty may apply):

1. Dialysis
2. Durable Medical Equipment, rental greater than two months, or purchase in excess of \$500.00 billed per date of service. Precertification not required for DME through Carelink (Enhanced Plan Benefits)
3. High-Tech Radiology – the use of radioactive tracers including but not limited to nuclear medicine
4. Implantable devices – including but not limited to pacemakers, neurostimulators, cardioverter-defibrillators
5. Infusion Therapy services
6. Inpatient Hospice
7. Inpatient hospitalization – including surgical procedures
8. Inpatient Skilled Nursing Facility
9. Intensive Outpatient & Partial Day
10. MRI / PET Scans / CT Scans
11. Non-emergency care at a non-USA Provider
12. Outpatient surgical facility – including Ambulatory Surgical Center
13. Participation in Approved Clinical Trial
14. Pregnancy stays that exceed:
  - a. 48 hours for vaginal delivery
  - b. 96 hours for caesarean delivery
15. Prescription Specialty Drugs - **CALL GBS Nurse Navigator 888.364.3580**
16. Prosthetics - purchase in excess of \$500.00 billed per date of service
17. Rehab program (such as cardiac, pain management, pulmonary)
18. Residential Treatment Facility program
19. Temporomandibular Joint Disorder (TMJ) treatment
20. Therapy services:
  - a. ABA therapy
  - b. Cardiac therapy
  - c. Chemotherapy
  - d. Cognitive therapy
  - e. Hyperbaric oxygen therapy
  - g. Orthoptic training – vision therapy
  - h. Radiation therapy
  - j. Speech therapy
21. Transplant candidacy evaluation and transplant (organ and/or tissue)

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. **This does not verify eligibility for benefits nor guarantee benefit payments under the Plan.** It is the Participant's responsibility to verify that the above services have been pre-certified as outlined above.



### Prescription Drug (Rx) Benefits

The following benefit levels are per member for each prescription: **All prescriptions over \$700 require prior authorization.**

For additional information about Rx coverage - tier category of a drug, quantity, age limits, and/or prior authorization requirements, the member can contact GBS Nurse Navigator at 888.364.3580.

<b>No Cost Options</b>	<b>Participating Pharmacy</b>
ACA Preventive Services	0%
Smoking Deterrents	0%
GBS Rx Drug Program (Includes maintenance & speciality Rx based upon availability)	0%
<b>Retail Prescription 30-day supply</b>	<b>Participating Pharmacy</b>
Tier 1 - Prescription Cost \$0 - \$250	\$8 Copay
Tier 2 - Prescription Cost \$251 - \$700	\$20 Copay
Tier 3 - Prescription Cost \$701+	20% Copay
<b>Mail Order or Retail Prescription 90-day supply<sup>13</sup></b>	<b>Participating Pharmacy</b>
Tier 1 - Prescription Cost \$0 - \$250	\$8 Copay
Tier 2 - Prescription Cost \$251 - \$700	\$30 Copay
Tier 3 - Prescription Cost \$701+	20% Copay
<b>Retail Specialty Drug Expenses (Non-Orphan Drugs) 30-day or 90-day supply</b>	<b>Participating Pharmacy</b>
Specialty <sup>14</sup>	20% Copay
<b>ACA Maximum Annual Out-Of-Pocket<sup>15</sup></b>	<a href="https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/">https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/</a>

GBS Rx Program: This program provides cost savings for both prescribed maintenance and specialty drugs.

Call a GBS Nurse Navigator at 888.364.3580 from 8 am - 5 pm CST, M-F to see if a no-cost option is available.

When a specialty medicine is available through the GBS Rx Drug Program, you are REQUIRED to fill the prescription through this program. You will not be able to fill the prescription at a local pharmacy.

STEP THERAPY PROTOCOL: Step therapy requires the use of lower-priced medications before "stepping up" to medications that cost more. If a Physician determines that a higher cost medication is needed, a prior authorization is required.

DRUG EXCLUSIONS - For drug exclusions contact Drex @ 844.728.3479 www.Drex.com. May include prescriptions for treatment of Acne, Anabolic Steroids, Anti-aging, Fertility, Sexual Dysfunction, and Weight Loss. ALL ORPHAN DRUGS ARE EXCLUDED.

Formulary Drugs - For current formulary drug list contact Drex @ 844.728.3479 www.Drex.com

<sup>13</sup> Some medications such as narcotics and specialty medications are not available for the 90-day mail order or retail maintenance program.

<sup>14</sup> Specialty medications and infusion therapy must be pre-certified. **Orphan drugs are not covered.**

<sup>15</sup> 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. When the ACA Maximum Annual Out-of-Pocket has been met, Deductibles, Coinsurance, and Copays no longer apply.



## Summary Plan Description

The Summary Plan Description (SPD) describes the information contained within the Plan Document (PD). SPD and PD are available at: [mygbshealth.com](http://mygbshealth.com)

<b>Group Name / Plan Sponsor</b>	<b>Adair County Government</b>
<b>Plan Name</b>	<b>Silver Plan</b>
<b>Accumulation / Benefit Period</b>	<b>January 1 through December 31</b>
<b>PPO Network</b>	<b>Aetna Signature Administrators (ASA) PPO Network</b>

	In-Network	Non-Network
<b>Major Medical Deductible<sup>1</sup></b>		
Single	\$4,000	\$8,000
Family	\$8,000	\$16,000
<b>Coinsurance / Member Responsibility</b>		
% after deductible has been met	20%	50%
<b>Out-of-Pocket<sup>1</sup> Limit</b>		
Single	\$6,000	\$12,000
Family	\$12,000	\$24,000
<b>Medical Services</b>		
Primary Care Physician (PCP, GP, OB/GYN)	\$20 Office Visit Copay <sup>3</sup>	50%
Specialist <sup>2</sup>	\$20 Office Visit Copay <sup>3</sup>	50%
Urgent Care	\$50 Event Copay <sup>4</sup>	50%
Emergency Room	\$200 Facility Copay + 20% Coinsurance	
<b>Reimbursable Deductible Allowance (RDA)</b>		
RDA Single Amount*	\$1,000	Not available
Family Annual Reimbursement Limit	\$2,000	Not available

The RDA (Reimbursable Deductible Allowance) is a portion of your Deductible that you have paid to a Provider and/or Hospital that can be reimbursed at 100%. Eligible expenses are invoices from Providers and Hospitals that you have paid towards your in-network deductible in the current plan year. Submission of an invoice and payment receipt are required as Proof of Payment in order to receive RDA reimbursement. This Proof of Payment must be received by GBS within 90 days of the end of the plan year. Please Note: Amounts applied to Copays and Coinsurance are not eligible for RDA reimbursement.

How to submit: Claims may be submitted through [mygbshealth.com](http://mygbshealth.com) or emailed to [claims@gbsitpa.com](mailto:claims@gbsitpa.com).

\*50% of the unused RDA benefit amount(s) will roll over into the next plan year not to exceed the in-network Single deductible.

<sup>1</sup>In-Network and Non-Network Major Medical Deductible & Out-of-Pocket limit(s) **accumulate separately**.

<sup>2</sup>A referral from a PCP is not required to visit a Specialist.

<sup>3</sup>All other services performed in the Physician's office apply to Deductible and Coinsurance unless otherwise noted.

<sup>4</sup>Includes all services performed.



## Enhanced Plan Benefits

**\$0 Out-of-Pocket cost when using In-Network providers for the services listed below. Call a GBS Nurse Navigator at 888.364.3580 for the current provider (regional / nationwide) options and services available.**

Precertification and medical necessity determination may be required for some of the benefits listed. See Precertification section for requirements.

<b>Benefit Level</b>	<b>No Member Cost Options</b>
----------------------	-------------------------------

Medical Service Categories	Preferred Provider	Find a Location
Diabetes Management Program & Service	Livongo	welcome.livongo.com/GBS      800.945.4355 Registration Code: <b>GBS</b>
Durable Medical Equipment (DME)	Carelink DME	CarelinkDME.com      888.604.3633
Lab Services	QuestSelect	questselect.com
Lab Services	Labcorp	labcorp.com
Radiology	Freestanding imaging facility	GBS Nurse Navigator 888.364.3580 Independent, non-hospital facilities
Sleep Study	Home sleep study	GBS Nurse Navigator 888.364.3580
Surgical Services	Ambulatory Surgical Center (ASC)	GBS Nurse Navigator 888.364.3580
Telemedicine	Teladoc	teladoc.com      800.835.2362
Walk-in Clinics	CVS MinuteClinic®	cvs.com/minuteclinic
Walk-in Clinics	Mizzou Quick Care	<a href="https://www.muhealth.org/conditions-treatments/quick-care">https://www.muhealth.org/conditions-treatments/quick-care</a>



## General Description of Benefits

Major Medical Benefit Descriptions	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
ABA Therapy	\$20 Office Visit Copay <sup>5</sup>	50%	
Acupuncture	\$20 Office Visit Copay <sup>5</sup>	50%	12 visit maximum per year
Allergy Injections / Serum	\$5 Copay	50%	
Allergy Testing	20%	50%	
Ambulance – Air <sup>6</sup> & Ground Services	20%		<b>For Emergency Use Only</b>
Ambulatory Surgical Center (ASC)	0%	50%	
Anesthesia	20%	50%	
Chemotherapy	\$20 Office Visit Copay <sup>5</sup>	50%	
Chiropractic Care	\$20 Office Visit Copay <sup>5</sup>	50%	30 visit maximum per year
Dialysis	20%	50%	6 month lifetime maximum
Durable Medical Equipment (DME) Preferred	0%	n/a	Carelink DME
Durable Medical Equipment (DME) Non-Preferred	20%	50%	Non-Carelink DME
Emergency Room	\$200 Facility Copay + 20% Coinsurance		<b>For Emergency Use Only.</b> Non-Emergency Services Could Be Denied
Emergency Room Physicians	20%		
Hearing Exam	0%		1 annual - basic hearing exam
Home Health Care	20%	50%	120 day annual maximum
Hospice Care Inpatient	20%	50%	
Hospice Care Outpatient	20%	50%	180 day annual maximum
Hospital Inpatient	20%	50%	
Hospital Outpatient	20%	50%	
Infusion Therapy	20%	50%	<b>Precertification may be required, orphan drugs are not covered. See Plan document for details.</b>
Lab Services - Preferential Plan Providers	0%	n/a	Quest & Labcorp
Lab Services - Non-Preferential Plan Providers	20%	50%	Non-Quest and Labcorp
Maternity Hospital Delivery	20%	50%	
Maternity Prenatal Services	0%	50%	Includes ultrasounds
Mental Health / Substance Abuse Inpatient Services	20%	50%	
Mental Health / Substance Abuse Group Therapy	20%	50%	
Mental Health / Substance Abuse Partial Day	20%	50%	
Mental Health / Substance Abuse Intensive Outpatient	20%	50%	
Mental Health / Substance Abuse Residential Treatment	20%	50%	
Newborn Nursery Care	20%	50%	
Nutritional Education (Diabetic / Weight Loss)	0%	50%	10 visit maximum per year
Occupational Therapy	\$20 Office Visit Copay <sup>5</sup>	50%	60 day Annual limit
Office Visit Mental Health / Substance Abuse	\$20 Office Visit Copay <sup>7</sup>	50%	In-office or telehealth <sup>8</sup>
Office Visit PCP, GP, OB/GYN	\$20 Office Visit Copay <sup>7</sup>	50%	In-office or telehealth <sup>8</sup>
Office Visit Specialist <sup>9</sup>	\$20 Office Visit Copay <sup>7</sup>	50%	In-office or telehealth <sup>8</sup>

<sup>5</sup> Includes all services performed.

<sup>6</sup> Eligible Air Ambulance 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.

<sup>7</sup> All other services performed in the Physician's office apply to deductible and coinsurance unless otherwise noted.

<sup>8</sup> A telehealth visit charge can be no more than a face-to-face office visit.

<sup>9</sup> A referral from a PCP is not required to visit a Specialist.



## General Description of Benefits - Continued

Major Medical Benefit Descriptions	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Orthoptic Training / Vision Training	20%	50%	Dependents up to age 10 (requires MD order)
Orthotics	20%	50%	
Preventive / Wellness Care	0%	50%	Full list <sup>10</sup>
Physical Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	60 day annual maximum
Private Duty Nursing	20%	50%	60 day annual maximum
Prosthetics	20%	50%	
Radiation Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	
Radiology - Preferred	0%	n/a	MRI, CT & PET Scans at preferred providers
Radiology - Non-Preferred	20%	50%	
Respiration Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	
Skilled Nursing Facility	20%	50%	120 day annual maximum (requires MD order)
Smoking Cessation	0%	n/a	10 visit maximum per year
Speech Therapy	\$20 Office Visit Copay <sup>11</sup>	50%	60 day annual maximum
Teladoc	0%	n/a	100% covered using Teladoc
Temporomandibular Joint Disorder (TMJ)	20%	50%	
Transplant - IOE Transplant Network	20%	50%	
Urgent Care	\$50 Event Copay <sup>12</sup>	50%	
Vision Examination	0%		1 annual - basic vision exam
Walk-In Clinic - Preferred	0%	n/a	MinuteClinic
Walk-In Clinic - Non-Preferred	\$20 Office Visit Copay <sup>12</sup>	50%	
All Other Eligible Services - Not Specifically Listed	20%	50%	See Plan Document for Details

<sup>10</sup> For a full list visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>. Includes annual wellness exam, routine mammograms (over age 40), routine pap smears, routine prostate exam (over age 50), routine immunizations.

<sup>11</sup> Includes all services performed.

<sup>12</sup> All other services performed in the Physician's office apply to deductible and coinsurance unless otherwise noted.



## PRE-CERTIFICATION REQUIREMENTS

Call AHH at 866.898.9356 [www.Americanhealthholding.com](http://www.Americanhealthholding.com)

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced or penalty may apply):

1. Dialysis
2. Durable Medical Equipment, rental greater than two months, or purchase in excess of \$500.00 billed per date of service. Precertification not required for DME through Carelink (Enhanced Plan Benefits)
3. High-Tech Radiology – the use of radioactive tracers including but not limited to nuclear medicine
4. Implantable devices – including but not limited to pacemakers, neurostimulators, cardioverter-defibrillators
5. Infusion Therapy services
6. Inpatient Hospice
7. Inpatient hospitalization – including surgical procedures
8. Inpatient Skilled Nursing Facility
9. Intensive Outpatient & Partial Day
10. MRI / PET Scans / CT Scans
11. Non-emergency care at a non-USA Provider
12. Outpatient surgical facility – including Ambulatory Surgical Center
13. Participation in Approved Clinical Trial
14. Pregnancy stays that exceed:
  - a. 48 hours for vaginal delivery
  - b. 96 hours for caesarean delivery
15. Prescription Specialty Drugs - **CALL GBS Nurse Navigator 888.364.3580**
16. Prosthetics - purchase in excess of \$500.00 billed per date of service
17. Rehab program (such as cardiac, pain management, pulmonary)
18. Residential Treatment Facility program
19. Temporomandibular Joint Disorder (TMJ) treatment
20. Therapy services:
  - a. ABA therapy
  - b. Cardiac therapy
  - c. Chemotherapy
  - d. Cognitive therapy
  - e. Hyperbaric oxygen therapy
  - g. Orthoptic training – vision therapy
  - h. Radiation therapy
  - j. Speech therapy
21. Transplant candidacy evaluation and transplant (organ and/or tissue)

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. **This does not verify eligibility for benefits nor guarantee benefit payments under the Plan.** It is the Participant's responsibility to verify that the above services have been pre-certified as outlined above.



### Prescription Drug (Rx) Benefits

The following benefit levels are per member for each prescription: **All prescriptions over \$700 require prior authorization.**

For additional information about Rx coverage - tier category of a drug, quantity, age limits, and/or prior authorization requirements, the member can contact GBS Nurse Navigator at 888.364.3580.

<b>No Cost Options</b>	<b>Participating Pharmacy</b>
ACA Preventive Services	0%
Smoking Deterrents	0%
GBS Rx Drug Program (Includes maintenance & speciality Rx based upon availability)	0%
<b>Retail Prescription 30-day supply</b>	<b>Participating Pharmacy</b>
Tier 1 - Prescription Cost \$0 - \$250	\$8 Copay
Tier 2 - Prescription Cost \$251 - \$700	\$20 Copay
Tier 3 - Prescription Cost \$701+	20% Copay
<b>Mail Order or Retail Prescription 90-day supply<sup>13</sup></b>	<b>Participating Pharmacy</b>
Tier 1 - Prescription Cost \$0 - \$250	\$8 Copay
Tier 2 - Prescription Cost \$251 - \$700	\$30 Copay
Tier 3 - Prescription Cost \$701+	20% Copay
<b>Retail Specialty Drug Expenses (Non-Orphan Drugs) 30-day or 90-day supply</b>	<b>Participating Pharmacy</b>
Specialty <sup>14</sup>	20% Copay
<b>ACA Maximum Annual Out-Of-Pocket<sup>15</sup></b>	<a href="https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/">https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/</a>

GBS Rx Program: This program provides cost savings for both prescribed maintenance and specialty drugs.

Call a GBS Nurse Navigator at 888.364.3580 from 8 am - 5 pm CST, M-F to see if a no-cost option is available.

When a specialty medicine is available through the GBS Rx Drug Program, you are REQUIRED to fill the prescription through this program. You will not be able to fill the prescription at a local pharmacy.

STEP THERAPY PROTOCOL: Step therapy requires the use of lower-priced medications before "stepping up" to medications that cost more. If a Physician determines that a higher cost medication is needed, a prior authorization is required.

DRUG EXCLUSIONS - For drug exclusions contact Drex @ 844.728.3479 www.Drex.com. May include prescriptions for treatment of Acne, Anabolic Steroids, Anti-aging, Fertility, Sexual Dysfunction, and Weight Loss. ALL ORPHAN DRUGS ARE EXCLUDED.

Formulary Drugs - For current formulary drug list contact Drex @ 844.728.3479 www.Drex.com

<sup>13</sup> Some medications such as narcotics and specialty medications are not available for the 90-day mail order or retail maintenance program.

<sup>14</sup> Specialty medications and infusion therapy must be pre-certified. **Orphan drugs are not covered.**

<sup>15</sup> 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. When the ACA Maximum Annual Out-of-Pocket has been met, Deductibles, Coinsurance, and Copays no longer apply.



## Summary Plan Description

The Summary Plan Description (SPD) describes the information contained within the Plan Document (PD). SPD and PD are available at: [mygbshealth.com](http://mygbshealth.com)

<b>Group Name / Plan Sponsor</b>	<b>Adair County Government</b>
<b>Plan Name</b>	<b>Bronze Plan</b>
<b>Accumulation / Benefit Period</b>	<b>January 1 through December 31</b>
<b>PPO Network</b>	<b>Aetna Signature Administrators (ASA) PPO Network</b>

	<b>In-Network</b>	<b>Non-Network</b>
<b>Major Medical Deductible<sup>1</sup></b>		
<b>Single</b>	<b>\$6,000</b>	<b>\$12,000</b>
<b>Family</b>	<b>\$12,000</b>	<b>\$24,000</b>
<b>Coinsurance / Member Responsibility</b>		
<b>% after deductible has been met</b>	<b>20%</b>	<b>50%</b>
<b>Out-of-Pocket<sup>1</sup> Limit</b>		
<b>Single</b>	<b>\$8,000</b>	<b>\$16,000</b>
<b>Family</b>	<b>\$16,000</b>	<b>\$32,000</b>
<b>Medical Services</b>		
<b>Primary Care Physician (PCP, GP, OB/GYN)</b>	<b>20%</b>	<b>50%</b>
<b>Specialist<sup>2</sup></b>	<b>20%</b>	<b>50%</b>
<b>Urgent Care</b>	<b>20%</b>	<b>50%</b>
<b>Emergency Room</b>	<b>20%</b>	

<b>Reimbursable Deductible Allowance (RDA)</b>	<b>In-Network</b>	<b>Non-Network</b>
<b>RDA Single Amount*</b>	<b>\$1,000</b>	<b>Not available</b>
<b>Family Annual Reimbursement Limit</b>	<b>\$2,000</b>	<b>Not available</b>

The RDA (Reimbursable Deductible Allowance) is a portion of your Deductible that you have paid to a Provider and/or Hospital that can be reimbursed at 100%. Eligible expenses are invoices from Providers and Hospitals that you have paid towards your in-network deductible in the current plan year. Submission of an invoice and payment receipt are required as Proof of Payment in order to receive RDA reimbursement. This Proof of Payment must be received by GBS within 90 days of the end of the plan year. Please Note: Amounts applied to Copays and Coinsurance are not eligible for RDA reimbursement.

How to submit: Claims may be submitted through [mygbshealth.com](http://mygbshealth.com) or emailed to [claims@gbsitpa.com](mailto:claims@gbsitpa.com).

\*50% of the unused RDA benefit amount(s) will roll over into the next plan year not to exceed the in-network Single deductible.

<sup>1</sup>In-Network and Non-Network Major Medical Deductible & Out-of-Pocket limit(s) **accumulate separately**.

<sup>2</sup>A referral from a PCP is not required to visit a Specialist.



## Enhanced Plan Benefits

**\$0 Out-of-Pocket cost when using In-Network providers for the services listed below. Call a GBS Nurse Navigator at 888.364.3580 for the current provider (regional / nationwide) options and services available.**

Precertification and medical necessity determination may be required for some of the benefits listed. See Precertification section for requirements.

<b>Benefit Level</b>	<b>No Member Cost Options</b>
----------------------	-------------------------------

Medical Service Categories	Preferred Provider	Find a Location
Diabetes Management Program & Service	Livongo	welcome.livongo.com/GBS 800.945.4355 Registration Code: <b>GBS</b>
Durable Medical Equipment (DME)	Carelink DME	CarelinkDME.com 888.604.3633
Lab Services	QuestSelect	questselect.com
Lab Services	Labcorp	labcorp.com
Radiology	Freestanding imaging facility	GBS Nurse Navigator 888.364.3580 Independent, non-hospital facilities
Sleep Study	Home sleep study	GBS Nurse Navigator 888.364.3580
Surgical Services	Ambulatory Surgical Center (ASC)	GBS Nurse Navigator 888.364.3580
Telemedicine	Teladoc	teladoc.com 800.835.2362
Walk-in Clinics	CVS MinuteClinic®	cvs.com/minuteclinic
Walk-in Clinics	Mizzou Quick Care	<a href="https://www.muhealth.org/conditions-treatments/quick-care">https://www.muhealth.org/conditions-treatments/quick-care</a>



## General Description of Benefits

Major Medical Benefit Descriptions	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
ABA Therapy	20%	50%	
Acupuncture	20%	50%	12 visit maximum per year
Allergy Injections / Serum	20%	50%	
Allergy Testing	20%	50%	
Ambulance – Air <sup>3</sup> & Ground Services	20%		<b>For Emergency Use Only</b>
Ambulatory Surgical Center (ASC)	0%	50%	
Anesthesia	20%	50%	
Chemotherapy	20%	50%	
Chiropractic Care	20%	50%	30 visit maximum per year
Dialysis	20%	50%	6 month lifetime maximum
Durable Medical Equipment (DME) Preferred	0%	n/a	Carelink DME
Durable Medical Equipment (DME) Non-Preferred	20%	50%	Non-Carelink DME
Emergency Room	20%		<b>For Emergency Use Only.</b> Non-Emergency Services Could Be Denied
Emergency Room Physicians	20%		
Hearing Exam	0%		1 annual - basic hearing exam
Home Health Care	20%	50%	120 day annual maximum
Hospice Care Inpatient	20%	50%	
Hospice Care Outpatient	20%	50%	180 day annual maximum
Hospital Inpatient	20%	50%	
Hospital Outpatient	20%	50%	
Infusion Therapy	20%	50%	<b>Precertification may be required, orphan drugs are not covered. See Plan document for details.</b>
Lab Services - Preferential Plan Providers	0%	n/a	Quest & Labcorp
Lab Services - Non-Preferential Plan Providers	20%	50%	Non-Quest and Labcorp
Maternity Hospital Delivery	20%	50%	
Maternity Prenatal Services	0%	50%	Includes ultrasounds
Mental Health / Substance Abuse Inpatient Services	20%	50%	
Mental Health / Substance Abuse Group Therapy	20%	50%	
Mental Health / Substance Abuse Partial Day	20%	50%	
Mental Health / Substance Abuse Intensive Outpatient	20%	50%	
Mental Health / Substance Abuse Residential Treatment	20%	50%	
Newborn Nursery Care	20%	50%	
Nutritional Education (Diabetic / Weight Loss)	0%	50%	10 visit maximum per year
Occupational Therapy	20%	50%	60 day Annual limit
Office Visit Mental Health / Substance Abuse	20%	50%	In-office or telehealth <sup>4</sup>
Office Visit PCP, GP, OB/GYN	20%	50%	In-office or telehealth <sup>4</sup>
Office Visit Specialist <sup>5</sup>	20%	50%	In-office or telehealth <sup>4</sup>

<sup>3</sup> Eligible Air Ambulance 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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## General Description of Benefits - Continued

Major Medical Benefit Descriptions	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
Orthoptic Training / Vision Training	20%	50%	Dependents up to age 10 (requires MD order)
Orthotics	20%	50%	
Preventive / Wellness Care	0%	50%	Full list <sup>6</sup>
Physical Therapy	20%	50%	60 day annual maximum
Private Duty Nursing	20%	50%	60 day annual maximum
Prosthetics	20%	50%	
Radiation Therapy	20%	50%	
Radiology - Preferred	0%	n/a	MRI, CT & PET Scans at preferred providers
Radiology - Non-Preferred	20%	50%	
Respiration Therapy	20%	50%	
Skilled Nursing Facility	20%	50%	120 day annual maximum (requires MD order)
Smoking Cessation	0%	n/a	10 visit maximum per year
Speech Therapy	20%	50%	60 day annual maximum
Teladoc	0%	n/a	100% covered using Teladoc
Temporomandibular Joint Disorder (TMJ)	20%	50%	
Transplant - IOE Transplant Network	20%	50%	
Urgent Care	20%	50%	
Vision Examination	0%		1 annual - basic vision exam
Walk-In Clinic - Preferred	0%	n/a	MinuteClinic
Walk-In Clinic - Non-Preferred	20%	50%	
All Other Eligible Services - Not Specifically Listed	20%	50%	See Plan Document for Details

<sup>6</sup> For a full list visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>. Includes annual wellness exam, routine mammograms (over age 40), routine pap smears, routine prostate exam (over age 50), routine immunizations.



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4. Implantable devices – including but not limited to pacemakers, neurostimulators, cardioverter-defibrillators
5. Infusion Therapy services
6. Inpatient Hospice
7. Inpatient hospitalization – including surgical procedures
8. Inpatient Skilled Nursing Facility
9. Intensive Outpatient & Partial Day
10. MRI / PET Scans / CT Scans
11. Non-emergency care at a non-USA Provider
12. Outpatient surgical facility – including Ambulatory Surgical Center
13. Participation in Approved Clinical Trial
14. Pregnancy stays that exceed:
  - a. 48 hours for vaginal delivery
  - b. 96 hours for caesarean delivery
15. Prescription Specialty Drugs - **CALL GBS Nurse Navigator 888.364.3580**
16. Prosthetics - purchase in excess of \$500.00 billed per date of service
17. Rehab program (such as cardiac, pain management, pulmonary)
18. Residential Treatment Facility program
19. Temporomandibular Joint Disorder (TMJ) treatment
20. Therapy services:
  - a. ABA therapy
  - b. Cardiac therapy
  - c. Chemotherapy
  - d. Cognitive therapy
  - e. Hyperbaric oxygen therapy
  - g. Orthoptic training – vision therapy
  - h. Radiation therapy
  - j. Speech therapy
21. Transplant candidacy evaluation and transplant (organ and/or tissue)

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. **This does not verify eligibility for benefits nor guarantee benefit payments under the Plan.** It is the Participant's responsibility to verify that the above services have been pre-certified as outlined above.



### Prescription Drug (Rx) Benefits

The following benefit levels are per member for each prescription: **All prescriptions over \$700 require prior authorization.**

For additional information about Rx coverage - tier category of a drug, quantity, age limits, and/or prior authorization requirements, the member can contact GBS Nurse Navigator at 888.364.3580.

<b>No Cost Options</b>	<b>Participating Pharmacy</b>
ACA Preventive Services	0%
Smoking Deterrents	0%
GBS Rx Drug Program (Includes maintenance & speciality Rx based upon availability)	0%
<b>Retail Prescription 30-day supply</b>	<b>Participating Pharmacy</b>
Tier 1 - Prescription Cost \$0 - \$250	\$8 Copay
Tier 2 - Prescription Cost \$251 - \$700	\$20 Copay
Tier 3 - Prescription Cost \$701+	20% Copay
<b>Mail Order or Retail Prescription 90-day supply<sup>7</sup></b>	<b>Participating Pharmacy</b>
Tier 1 - Prescription Cost \$0 - \$250	\$8 Copay
Tier 2 - Prescription Cost \$251 - \$700	\$30 Copay
Tier 3 - Prescription Cost \$701+	20% Copay
<b>Retail Specialty Drug Expenses (Non-Orphan Drugs) 30-day or 90-day supply</b>	<b>Participating Pharmacy</b>
Specialty <sup>8</sup>	20% Copay
<b>ACA Maximum Annual Out-Of-Pocket<sup>9</sup></b>	<a href="https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/">https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/</a>

**GBS Rx Program:** This program provides cost savings for both prescribed maintenance and specialty drugs.

Call a GBS Nurse Navigator at 888.364.3580 from 8 am - 5 pm CST, M-F to see if a no-cost option is available.

When a specialty medicine is available through the GBS Rx Drug Program, you are REQUIRED to fill the prescription through this program. You will not be able to fill the prescription at a local pharmacy.

STEP THERAPY PROTOCOL: Step therapy requires the use of lower-priced medications before "stepping up" to medications that cost more. If a Physician determines that a higher cost medication is needed, a prior authorization is required.

DRUG EXCLUSIONS - For drug exclusions contact Drexii @ 844.728.3479 www.Drexii.com. May include prescriptions for treatment of Acne, Anabolic Steroids, Anti-aging, Fertility, Sexual Dysfunction, and Weight Loss. ALL ORPHAN DRUGS ARE EXCLUDED.

Formulary Drugs - For current formulary drug list contact Drexii @ 844.728.3479 www.Drexii.com

<sup>7</sup> Some medications such as narcotics and specialty medications are not available for the 90-day mail order or retail maintenance program.

<sup>8</sup> Specialty medications and infusion therapy must be pre-certified. **Orphan drugs are not covered.**

<sup>9</sup> 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. When the ACA Maximum Annual Out-of-Pocket has been met, Deductibles, Coinsurance, and Copays no longer apply.



# SUMMARY PLAN DESCRIPTION

ADAIR COUNTY  
EMPLOYEE BENEFIT PLAN

“VOLUNTARY VISION BENEFIT PLAN”

PREPARED EXCLUSIVELY FOR:  
ADAIR COUNTY GOVERNMENT

PREPARED BY:  
GROUP BENEFIT SERVICES

[www.gbs-tpa.com](http://www.gbs-tpa.com)

*“Innovative Solutions | Customized Benefits | Sustainable Plans”*

## 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	<b>\$50</b>
Annual Deductible per Family	<b>\$100</b>
Vision Coinsurance	<b>90/10</b>
Maximum Annual Vision Plan Benefit Limit per Participant	<b>\$600</b>

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

**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.

<sup>1</sup> 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.

<sup>2</sup> If the member has the major medical plan and the vision program, eligible eye exam expenses will be paid by the medical plan.



# 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](http://www.gbs-tpa.com)

*“Innovative Solutions | Customized Benefits | Sustainable Plans”*

## 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	<b>\$25</b>
Annual Deductible per Family – Deductible waived for Class 1 Services	<b>\$50</b>
Maximum Annual Benefit Limit for Class 1, 2 and 3 Services	<b>\$1,000</b>
Maximum Lifetime Benefit Limit for Class 4 Services – Orthodontia	<b>Not Covered</b>

Dental Benefit Coinsurance Levels Based Upon Class:	Benefit Coverage	Benefit Type
Class 1 Services	<b>100/0</b>	Preventive Care
Class 2 Services	<b>90/10</b>	Repair and Restoration*
Class 3 Services (12 month waiting period for dentures and bridgework)	<b>60/40</b>	Major Dental Repair*
Class 4 Services	<b>Not Covered</b>	Orthodontics* underage 19

**PPO Network:**

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

**\*Non-PPO Network:** Covered charges are limited to Usual and Customary fees calculated at the 90<sup>th</sup> percentile. If the Provider bills in excess of the 90<sup>th</sup> 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 not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment.

In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.**



# Employee Enrollment Packet

## FSA Plan Option

### 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/>



**Group Benefit Services, Inc.**  
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*gbs-tpa.com | 800.995.3569*





# FSA ENROLLMENT FORM

2026

## 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
<b>Medical Care Reimbursement:</b> (Annual Maximum: \$3,400.00)	_____	÷	_____	=	_____
<b>Dependent Care Reimbursement:</b> (Annual Maximum: \$7,500.00)	_____	÷	_____	=	_____

## 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@gsbitpa.com

**NOTICE:** The information contained in this claim form, and any attachments accompanying this transmission, may be legally privileged and/or confidential and protected health information. This information is intended only for use of the individual(s) and/or entity identified above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to protect the information after its stated need has been fulfilled. If you are not the intended recipient, or any employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, printing, copying, forwarding, or distributing of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately, by telephone or return email, to advise of wrongful receipt and confirm your understanding of this Notice. Thank you.





# 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.

$$\begin{array}{c}
 \$ \underline{\hspace{2cm}} \\
 \text{Total (above)}
 \end{array}
 \div
 \begin{array}{c}
 \underline{\hspace{2cm}} \\
 \text{Number of pay} \\
 \text{periods in the} \\
 \text{Plan Year}
 \end{array}
 = \$ \underline{\hspace{2cm}} \text{ per paycheck contributed to your FSA.}$$

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





# 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: _____	\$ _____
<b>TOTAL: \$ _____</b>	

### 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.

$$\$ \frac{\text{Total (above)}}{\text{Number of pay periods in the Plan Year}} = \$ \text{_____} \text{ per paycheck contributed to your FSA.}$$



# FSA REIMBURSABLE EXPENSES 2026

## 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?

<b>Abortion:</b>	✓ Reimbursable
<b>Acupuncture:</b>	✓ Reimbursable
<b>Ambulance:</b>	✓ Reimbursable
<b>Braille Books and Magazines:</b>	<p>! Reimbursable, but only the cost difference of braille books and/or magazines and the price for regular books and/or magazines.</p> <p><i>Example:</i> 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 (<math>\\$35 - \\$15 = \\$20</math>). Therefore, the total reimbursable amount is \$20.</p>
<b>Breast Augmentation:</b>	! Reimbursable, but only if the costs are related to the removal of breast implants that are defective and/or are causing a medical problem.
<b>Breast Reduction or Reconstruction Surgery:</b>	! Reimbursable, but only for medically necessary, non-cosmetic purposes.
<b>Capital Expenses:</b>	! Reimbursable, but only for medical care.
<b>Car Accessibility Modifications:</b>	! 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.
<b>Childbirth Classes:</b>	! Reimbursable, but only classes related to the process of childbirth attended by the mother-to-be.
<b>Chiropractor:</b>	✓ Reimbursable

## WHAT EXPENSES ARE REIMBURSABLE? CONT.

<b>Christian Science Practitioners:</b>	✓ Reimbursable
<b>Coinsurance Amounts:</b>	✓ Reimbursable
<b>Cord Blood Storage:</b>	! Reimbursable, but only if a child(ren) has a medical condition(s) the cord blood treats.
<b>Cosmetic Surgery:</b>	<p>! Reimbursable, but only if the surgery is necessary to improve a deformity arising from or directly related to:</p> <ul style="list-style-type: none"><li>• A congenital abnormality,</li><li>• A personal injury resulting from an accident or trauma, or</li><li>• A disfiguring disease.</li></ul> <p>The cost of cosmetic surgery to improve a facial deformity caused by prior surgeries to correct congenital abnormalities is also reimbursable.</p> <p><b>X Not Reimbursable:</b> Medical expenses paid for any other cosmetic surgery that are not deductible medical expenses (example: gender reassignment surgery).</p> <p>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.</p>
<b>Deductibles (Medical, Dental, and Vision):</b>	✓ Reimbursable.
<b>Dental Treatment:</b>	✓ Reimbursable
<b>Dependent Care Expenses:</b>	! Not Reimbursable but may be reimbursable under a dependent care FSA.
<b>Divorce Expenses:</b>	<b>X Not Reimbursable</b> , even if a doctor or psychiatrist recommends it.
<b>Egg Donor Fees and Expenses:</b>	✓ Reimbursable
<b>Employment-Related Expenses:</b>	<b>X Not Reimbursable</b> , including employment-related physicals.

## WHAT EXPENSES ARE REIMBURSABLE? CONT.

<b>Exercise- / Fitness-Related Expenses:</b>	<b>!</b> 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: <ul style="list-style-type: none"><li>• Exercise Equipment</li><li>• Fitness/Exercise Classes</li><li>• Health Club Dues</li><li>• Personal Trainer</li><li>• Weight-Loss Program</li></ul>
<b>Fertility:</b>	<b>!</b> Reimbursable, but not for a single father of natural health for fertilization of an anonymous donor's eggs.
<b>Formula, Infant:</b>	<b>X</b> Not Reimbursable even if the mother is unable to breast feed. Formula is considered food that satisfies normal nutritional requirements.
<b>Funeral Expenses:</b>	<b>X</b> Not Reimbursable
<b>Hospital Expenses:</b>	<b>✓</b> Reimbursable
<b>Household Help:</b>	<b>!</b> Reimbursable, but only for certain expenses paid to an attendant providing nursing-type services.
<b>Human Guide:</b>	<b>✓</b> Reimbursable
<b>Impotence or Sexual Inadequacy:</b>	<b>✓</b> Reimbursable
<b>Insurance Premiums and Supplemental Policies:</b>	<b>X</b> Not Reimbursable
<b>Laboratory Fees:</b>	<b>✓</b> Reimbursable
<b>LASIK:</b>	<b>✓</b> Reimbursable
<b>Lead-Based Paint (Removal and Repainting):</b>	<b>✓</b> Reimbursable: Expenses related to removal of the paint. <b>X</b> Not Reimbursable: Expenses related to repainting the scraped area.
<b>Learning Disability:</b>	<b>!</b> Reimbursable, but only: <ul style="list-style-type: none"><li>• Tuition payments to a special school and</li><li>• Tutoring fees to overcome learning disabilities.</li></ul>

## 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:

X Not Reimbursable

### Marriage Counseling:

X Not Reimbursable

### Massage:

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

### Maternity Clothes:

X Not Reimbursable

### Medical Alert Devices:

X 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.

X **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:** **X** 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.

<b>Trips:</b>	<ul style="list-style-type: none"><li>! Reimbursable, but only if the trip is primarily for and essential to receiving medical services.</li><li>X Not Reimbursable: Commuting to a job not explicitly prescribed as therapy for a medical condition.</li></ul>
<b>Tuition:</b>	! Reimbursable, but only if charges are separately stated in the tuition bill.
<b>Unscheduled Office Visits:</b>	! 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.
<b>Vaccines:</b>	✓ Reimbursable
<b>Vacuum Cleaners:</b>	X Not Reimbursable. Per the IRS, vacuums are not a qualified expense for treatment of allergies.
<b>Vasectomy:</b>	✓ Reimbursable
<b>Vision Care:</b>	<ul style="list-style-type: none"><li>! Reimbursable, but only:<ul style="list-style-type: none"><li>• Eyeglasses and lenses for medical reasons</li><li>• Eye exams and expenses for contact lens solutions.</li></ul></li><li>X Not Reimbursable: premiums for contact lens replacement insurance.</li></ul>
<b>Wigs:</b>	! 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.

\* 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.")

Need help?

800.995.3569  
info@gsbitpa.com

Page 2 of 2

gbs-tpa.com

**GBS**

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GIM.crt | 11.24.2021

# Employee Enrollment Packet

## Maxi-Care Plan Option

### 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/>



**Group Benefit Services, Inc.**  
Innovative Solutions | Customized Benefits | Sustainable Plans

*[gbs-tpa.com](https://gbs-tpa.com) | 800.995.3569*





**Adair County Government**  
Benefit Period: January 1 through December 31



**ATTENTION**

ID Cards - Please see the temporary ID card below  
Please log into the Member Portal to review the full Summary Plan Description (SPD)

EMPLOYEE CONTRIBUTION BY TIER	MAXI-CARE*	
	Monthly	Bi-Weekly
Employee only	\$0.00	\$0.00
Employee + Spouse (Bronze Plan)	\$285.05	\$142.53
Employee + Spouse (Silver Plan)	\$361.55	\$180.78
Employee + Spouse (Gold Plan)	\$439.15	\$219.57

\*Bi-Weekly payroll (26) withholdings are Bi-Monthly (24)

ANNUAL MAXIMUM BENEFIT AMOUNT <sup>†</sup>
\$50,000

COMMONLY REIMBURSED BENEFITS		
<b>100% OF THE BALANCE<sup>†</sup></b>	Anesthesia	Vision Exam
	Diagnostic X-Ray and Lab	Hearing Exam
	Emergency Room (Illness or Accident)	Maternity
	Hospital	Occupational Therapy
	Outpatient Treatment	Physical Therapy
	Inpatient Treatment	Second Surgical Opinions
	Physician Office Services	Specialist – Physician Speech Therapy
	Chiropractic Care	Urgent Care
<b>ADDITIONAL COVERED BENEFITS<sup>††</sup></b>	<b>Benefit Limit Description</b>	
	Annual Wellness Visit	\$150/calendar year
	Hospital Daily Room Benefit	\$100/day, max. 10 days/calendar year
	Intensive Care Daily Room Benefit	\$200/day, max. 10 days/calendar year

Please log into the **Member Portal** to review the full Maxi-Care Schedule of Benefits, Frequently Asked Questions, and Call Guide.

<p><b>Member</b></p> <p align="center"><b>GBS</b> (800) 995-3669 www.gbs-tpa.com</p> <p><b>Adair County Government</b> Group #: 40500 Maxi-Care Plan</p> <p><b>Member: JOAN SAMPLE</b> Member ID: 123456789</p>	<p><b>Provider Submissions</b></p> <p>Providers submit secondary itemized statements and EOBs to: GBS-Supplemental Insurance Plan Division P.O. Box 211547 Eagan, MN 55121-2747 GBS EDI #80241</p> <p><b>Eligibility and Benefits</b></p> <p>To verify eligibility and benefits contact: Group Benefit Services (GBS) (800) 995-3569 Monday-Friday: 8:00am-5:00pm (CT) www.gbs-tpa.com</p>
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This card is for identification only. It is not a guarantee of eligibility.

\*Maxi-Care is a Medical Expense Reimbursement Plan, not a Medicare supplement plan. Maxi-Care is also not considered a major medical plan nor is it designed to replace such a plan. Maxi-Care does not reimburse Medicare Part D (prescription) deductibles, coinsurance, or copays. Maxi-Care reimburses for what Medicare approves but doesn't pay. Only employees, spouses, and/or dependents who meet the Plan's eligibility requirements and who have qualifying Medicare Part A, Part B, and Part D coverage are eligible for Maxi-Care.

†All benefit reimbursements are subject to the Annual Maximum Benefit Amount.

‡These benefits will be paid in addition to the Medicare deductible, coinsurance, and copay reimbursement(s).



**Adair County Government**  
Plan Year 2025



**ATTENTION**

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

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

EMPLOYEE CONTRIBUTION BY TIER	DENTAL PLAN		VISION PLAN	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
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

\*Bi-Weekly payroll (26) withholdings are Bi-Monthly (24)

ANNUAL DEDUCTIBLE	DENTAL PLAN	VISION PLAN
	Single	Waived for Class 1 Services. \$25
Family	\$50	\$100

ANNUAL BENEFIT LIMIT	DENTAL PLAN	VISION PLAN
Per Participant	\$1,000 (Class 1, 2, and 3)	\$600

MAXIMUM LIFETIME BENEFIT	DENTAL PLAN	COINSURANCE	VISION PLAN
	Orthodontics (Class 4)		N/A

BENEFITS (See below conditions)	DENTAL PLAN	12-MONTH BEN. PERIOD	VISION PLAN
	Preventive Care (Class 1)		
Repair + Restoration (Class 2)	90/10	Single Vision Lenses <sup>‡</sup>	90/10 up to \$120 Max.
Major Dental Repair* (Class 3)	60/40	Bi-focal Lenses <sup>‡</sup>	90/10 up to \$130 Max.
Orthodontics under age 19 (Class 4)	60/40	Tri-focal Lenses <sup>‡</sup>	90/10 up to \$140 Max.
		Lenticular Lenses <sup>‡</sup>	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.

**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.

NETWORKS	
DENTAL	VISION
Aetna Dental Administrators, Zelis Dental, Dentemax, GEHA Solutions/Connection Dental	No Network Required

**Member**

**GBS** (800) 955-3569  
www.gbs-tpa.com

Adair County Government  
Group #: 40500  
Dental & Vision Plan  
Member: JOAN SAMPLE  
Member ID: 405000000000  
Dependents: John Sample  
Judy Sample

See back of card for Details and Claims Submissions

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**Eligibility and Benefits**

To Verify Eligibility and Benefits:  
Group Benefit Services, Inc.

24/7: www.gbs-tpa.com  
M-F 8-5: (800) 995-3569

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**Vision Benefits**

Annual Deductible: \$25  
Annual Max. Exam: \$100  
Annual Max. Lenses: \$120-\$150  
24 month Max. Frames: \$130  
Contact Lens Coinsurance: 10% (\$500 max)  
You can visit any Vision provider of your choice.  
There is no network for GBS Vision plans.

See your Plan Document for the complete list of benefits, terms, and conditions.  
This card is for identification only. It is not a guarantee of eligibility.

**Dental Benefits**

Annual Deductible: \$25  
Annual Max: \$1,500  
Ortho Annual Max: \$1,500  
Basic Services: 10%  
Major Services: 40%

To find a participating dental:  
[www.aetna.com/locateadentalprovider](http://www.aetna.com/locateadentalprovider)  
[www.dentemax.com](http://www.dentemax.com) or [www.zelis.com](http://www.zelis.com)  
to access these additional networks:

Dentemax  
GEHA/Connection Dental  
Zelis Dental

Aetna participating dentists are independent providers  
and are not agents for employees of Aetna

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**Claims Submissions**

Aetna Dental Administrators  
To access all services:  
NoviNet Customer Service  
800-955-3569 ext. 7

If your provider bills insurance, they should send claims to the below address:

**Submit Itemized Statements and Assignments to:**  
Group Benefit Services, Inc. (GBS)  
PO Box 211547  
Eagan, MN 55121-2747  
GBS EDI# 80241

See your Plan Document for the complete list of dental, vision, and exclusions.  
This card is for identification only. It is not a guarantee of eligibility.

\*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, lenticular) 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.



## 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.



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

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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.



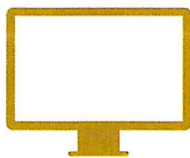
## Education and Support

Providing education and support to you and your family.

## REGISTER FOR THE MEMBER PORTAL AT [MYGBSHEALTH.COM](https://mygbshealth.com)

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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

### REQUEST/SUBMIT

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

### REVIEW

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

### 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](https://gbs-tpa.com)

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# 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](https://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](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?

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