Employee Enrollment Packet

"Base and Buy Up Plan Options"

Prepared Exclusively For:

Cooper County Government
Employee Benefit Plan

Prepared By:

Group Benefit Services (GBS)

www.gbs-tpa.com

"Quality People & Technology,
Delivering Best in Class Performance"

Cooper County Government Employee Benefit Plan
2021 Employee Rates

BASE	MONTHLY
Employee Only:	$40.01
Employee & Child(ren):	$407.95
Employee & Spouse Only:	$530.25
Employee & Full Family:	$902.35

BUY-UP	
Employee Only:	$142.01
Employee & Child(ren):	$596.65
Employee & Spouse Only:	$749.55
Employee & Full Family:	$1,182.85

MAXI-CARE*	
Employee Only:	$0.00
Employee & Spouse Only:	$214.29

DENTAL	
Employee Only:	$31.08
Employee & Child(ren):	$57.80
Employee & Spouse Only:	$62.91
Employee & Full Family:	$89.52

VISION	
Employee Only:	$15.50
Employee & Child(ren):	$28.65
Employee & Spouse Only:	$31.81
Employee & Full Family:	$45.13

LIFE	
Employee Only:	Employer Paid
Employee & Child(ren):	$4.80
Employee & Spouse Only:	$4.80
Employee & Full Family:	$4.80

*Maxi-Care is a Medical Expense Reimbursement Plan. Only employees, spouses, and/or dependents who meet the Plan's eligibility requirements and who have qualifying Medicare Part A, Part B, and Part D coverage.

**Employer Paid Life: $25,000

**Dependent Life amount is $10,000 for Spouse and $5,000 for each child over the age of 6 months.

See policies for additional details.

**Additional Voluntary Life is available. See Life benefit documents for details.

"Getting the Most Out of Your Health Plan"
Key Features

Preventive Care
Plan Members receive **100% coverage for Preventive Care.** Preventive Care is covered in accordance to the schedule provided by the Center for Medicare Services (CMS). More information can be found at: https://www.healthcare.gov/preventive-care-benefits

Quest Diagnostics Lab Card & LabCorp
Plan Members can have their **lab work covered at 100%.** Plan Members must request that their physician use Lab Card or LabCorp at the time their lab work is prescribed.

HOMELINK DME Program
Plan Members can **receive Durable Medical Equipment (DME) at no cost to them (100% covered)** from HOMELINK. DME includes equipment such as CPAP machines and wheelchairs. Members must call the pre-certification number listed on their plan ID card to get pre-certified and order equipment.

Relevant Healthcare for Radiology
Plan Members can have their **prescribed radiology event (MRI, PET, or CT scan) covered at 100%** by Relevant Healthcare. Members must call the pre-certification number listed on their plan ID card to get pre-certified prior to service. Once pre-certified, the pre-certification representative will work with Relevant to find a convenient location for the member and schedule the radiology event.

Diabetic Management Program
Plan Members can **use the Livongo diabetic management program at no cost to them (100% covered).** The program includes a free glucometer and regular shipments of test strips. Members can also receive nutrition and lifestyle guidance anytime, anywhere from Livongo coaches who are Certified Diabetes Educators.

Flu, Pneumonia, and Shingles Vaccinations
Plan Members can **receive flu, pneumonia, and shingles vaccinations at no cost to them (100% covered)**. Members can use this benefit at any CVS-participating pharmacy that provides these immunizations—they simply have the cost charged to their Rx card.

Vision and Hearing Exams
Plan Members can have **both their annual vision and annual hearing exam covered at 100%, up to $100 each.** Members can use any vision or hearing clinic—there are no network providers required.

CVS MinuteClinic
Plan Members can **use any CVS MinuteClinic at no cost to them (100% covered),** though prescription copays may still apply.

Additional Benefits
There are several additional benefits that Plan Members can receive, including:

- $5 allergy shots
- Reimbursable Deductible Allowance (RDA)
- Access to the Plan Member web portal at https://gbs-tpa.com
- Access to multiple national Preferred Provider Organization (PPO) and discount programs
- Access to a 24/7, toll-free care concierge line at (866) 751-2723
- Access to the LifeTrac Transplant Program

*Not all Plans include these Preferred Plan Benefits. Review your Plan Document to ensure eligibility prior to receiving services.

©2017-2020 Group Benefit Services

Summary of Base Plan Medical Benefits

The following benefits are per Plan Participant per Calendar Year:

Major Medical Cost Sharing Descriptions	In-Network	Non-Network
Annual Major Medical Deductible • Single • Family Unit	**$1,000** **x 2**	**$2,000** **x 2**
Coinsurance Levels *(after the Annual Deductible has been met)*	**80 / 20**	**50 / 50**
Maximum Annual Out-of-Pocket[1] *(Including Deductibles)* • Single • Family Unit	**$5,500** **x 2**	**$12,000** **x 2**
Major Medical deductible and out-of-pocket limits for in-network and out-of-network providers accumulate separately.		
Annual Reimbursable Deductible Allowance[2] (RDA) • Single • Family Unit	**$500** **x 2**	Not Available Not Available
Maximum Annual Major Medical Benefit Limit	**Unlimited**	**Unlimited**
Lifetime Major Medical Benefit Limit	**Unlimited**	**Unlimited**

Major Medical Expense Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
1. Acupuncture	80 / 20	50 / 50	12 Visit Limit Per Year
2. Allergy Injections *(GP / Specialists)*	$5 Co-pay	50 / 50	
3. Allergy Testing	80 / 20	50 / 50	
4. Ambulance *(Air[3] & Ground)*	80 / 20	50 / 50	Essential Health Benefits
5. Ambulatory Surgical Center	80 / 20	50 / 50	Essential Health Benefits
6. Anesthesia	80 / 20	50 / 50	Essential Health Benefits
7. Birthing Center	80 / 20	50 / 50	
8. Birth Control Devices *(Implants, IUDs, etc.)*	100%	50 / 50	
9. Blood & Plasma	80 / 20	50 / 50	Essential Health Benefits
10. Chiropractic Care Over 5 years of Age	80 / 20	50 / 50	30 Visit Limit Per Year **Medically Necessary** X-rays up to $60 per visit
11. Dialysis	80 / 20	50 / 50	6 Month Benefit Limit
12. Durable Medical Equipment	80 / 20	50 / 50	**Must be Pre-certified**
13. Hearing Examination (Annual)	100%	100%	Basic Hearing Exam
14. Home Health Care	80 / 20	50 / 50	120 Day Annual Visit Limit
15. Hospice Care • Inpatient Treatment • Outpatient Treatment • Family Bereavement Counseling	 80 / 20 80 / 20 80 / 20	 50 / 50 50 / 50 50 / 50	180 Day Benefit Limit Combined for all Hospice Care Services.
16. Hospital • Inpatient Treatment • Outpatient Treatment	 80 / 20 80 / 20	 50 / 50 50 / 50	**Must be Pre-certified** Essential Health Benefits

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

[2] The Reimbursable Deductible Allowance (RDA) is a portion of the deductible that is reimbursed back to the Plan Member at a rate of 100% for eligible expenses that are incurred and paid when the Plan Member utilizes Network. There is no RDA available for Non-Network providers.

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

17. Infusion Therapy Non-Orphan Drugs Only Covered Through PBM	80 / 20 Through PBM	50 / 50 Through PBM	**Must be Pre-certified** Medication must be provided through the PBM
18. Mental Health, Substance & Chemical Dependency: • Inpatient Physician Services • Partial Day Program • Outpatient Physician Services • Residential Treatment Program	 80 / 20 80 / 20 80 / 20 80 / 20	 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits **Must be Pre-certified** 60 Day Annual Visit Limit 60 Visit Annual Limit 60 Visit Annual Limit 60 Day Annual Limit
19. Newborn Nursery Care – while inpatient	80 / 20	50 / 50	Essential Health Benefits
20. Orthoptic training prescribed by a physician	80 / 20	50 / 50	For dependent children up to age 10 only. **Must be Pre-certified**
21. Orthotics prescribed by a physician	80 / 20	50 / 50	$300 Annual Limit $1,500 Lifetime Limit **Must be Pre-certified**
22. Outpatient Diagnostic X-ray and Lab Services	80 / 20	50 / 50	Essential Health Benefits
23. Outpatient Emergency Room Services – ER • Emergency • Physicians	 80 / 20 80 / 20	 80 / 20 80 / 20	Essential Health Benefits
24. Physician Services • General Practitioner • Specialist • Urgent Care • Lab, X-ray, and Surgery	 80 / 20 80 / 20 80 / 20 80 / 20	 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits
25. **Preferential Provider Benefits** • Preferred Lab Benefits *(Quest - LabCard)* • Preferred Lab Benefits - LabCorp • Preferred DME Program • CVS - Walk in Clinic Benefit • Mizzou Quick Care - Walk in Clinic Benefit • Livongo Diabetic Testing Program • Preferred Radiology Benefit • Telehealth Services – 24/7 Access • Preferred Surgical Network	 *Quest/LabCard* LabCorp **HOMELINK** minute clinic MU Quick Care Livongo **Relevant** **Teladoc** PRICEMDs	 N/A N/A N/A N/A N/A N/A N/A N/A N/A	 100% - *Quest/LabCard* 100% - LabCorp 100% - **HOMELINK** 100% at minute clinic 100% at MU Quick Care 100% through Livongo 100% through **Relevant** 100% through Teladoc 100% through PriceMDs
26. Pregnancy Expenses	80 / 20	50 / 50	Essential Health Benefits
27. Preventive Care • Routine Physical Exam • Mammograms – *must be over age 40* • Pap Smears • Prostate Exam – *must be over age 50* • Routine Immunizations • Well Child Care Exam	 100% 100% 100% 100% 100% 100%	 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits For a complete listing of covered wellness benefits see: https://www.healthcare.gov/coverage/preventive-care-benefits/
28. Private Duty Nursing	80 / 20	50 / 50	
29. Prosthetics	80 / 20	50 / 50	**Must be Pre-certified**
30. Routine Patient Costs *(Approved Clinical Trials)*	80 / 20	50 / 50	
31. Second Surgical Opinions	100%	50 / 50	
32. Skilled Nursing Facility	80 / 20	50 / 50	120 Day Annual Limit
33. Sleep Apnea Appliance (CPAP)	80 / 20	50 / 50	**Must be Pre-certified**
34. Smoking Cessation	100%	Not Covered	120 Day Annual Limit
35. Surgery	80 / 20	50 / 50	Essential Health Benefits
36. Temporomandibular Joint Disorder (TMJ)	80 / 20	50 / 50	$2,500 Annual Limit **Must be Pre-certified**

37. Therapy			
• Chemotherapy	80 / 20	50 / 50	Essential Health Benefits
• Occupational Therapy	80 / 20	50 / 50	60 Day Annual Visit Limit
• Physical Therapy	80 / 20	50 / 50	60 Day Annual Visit Limit
• Radiation Therapy	80 / 20	50 / 50	Essential Health Benefits
• Respiration Therapy	80 / 20	50 / 50	Essential Health Benefits
• Speech Therapy	80 / 20	50 / 50	60 Day Annual Visit Limit
38. Transplants – LifeTrac Transplant Network	80 / 20	50 / 50	Essential Health Benefits
39. Vision Examination (Annual)	100%	100%	Basic Vision Care
40. Weight Loss Counseling (No procedures)	100%	100%	1 Annual Visit
41. All Other Eligible Services *(Not Specifically Listed)*	80 / 20	50 / 50	**See Plan Document**

Summary of Voluntary Dental Benefits if Elected by Plan Member

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

Dental Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant *(Deductible waived for Class 1 Services)*	**$25**
Maximum Number of Deductibles for Family	**x 2**
Maximum Annual Benefit Limit for Class 1, 2 and 3 Services	**$1,000**
Maximum Lifetime Benefit Limit for Class 4 Services *(Orthodontia)*	**$1,000**

Dental Benefit Coinsurance Levels Based Upon Class:	Benefits	Benefit Type
Class 1 Services	**100%**	Preventive Care
Class 2 Services	**90%**	Repair and Restoration
Class 3 Services	**60%**	Major Dental Repair
Class 4 Services	**60%**	Orthodontics
All charges except preventive care are limited to Usual and Customary Fees calculated at the 90th percentile.		

Dental program includes the use of the Aetna Dental network. A dental network provider is not required.

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	**$25**
Maximum Number of Deductibles for Family	**x 2**
Vision Coinsurance	**90%**
Maximum Annual Benefit Limit per Participant	**$600**

Vision Expense Benefit Descriptions:	Benefits	Limits[4]
Eye exam[5], per participant	**$100 Maximum**	12 – Month Period
Frame-type lenses, per pair – Single Vision	**$120 Maximum**	12 – Month Period
Frame-type lenses, per pair – Bi-focal	**$130 Maximum**	12 – Month Period
Frame-type lenses, per pair – Tri-focal	**$140 Maximum**	12 – Month Period
Frame-type lenses, per pair – Lenticular	**$150 Maximum**	12 – Month Period
Frames, per pair	**$130 Maximum**	24 – Month Period
Contact Lenses	**90 / 10 *(Plan Limit)***	12 – Month Period

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

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

[5] If the member has the major medical plan and the vision program, eye exams will be paid by the medical plan.

Summary of Prescription Drug Card Benefits

The following benefits levels are per Plan Participant:

Covered Retail Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Prescription Drug Annual Deductible	**$100**

Retail Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Retail Prescription Co-payment Options *(30 day supply)*	The copayments shown are applied to each prescription
Copayment, per new prescription or refill, for Generic[6]	**$12**
Copayment, per new prescription or refill, for Preferred Name Brand	**$50**
Copayment, per new prescription or refill, for Non-Preferred Name Brand	**50 / 50**

Mail Order or Retail Maintenance Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Mail Order or Retail Maintenance Prescription Co-payment Options *(90 day supply[7])*:	The copayments shown are applied to each prescription
Copayment, per new maintenance prescription or refill, for Generic[8]	**$18**
Copayment, per new maintenance prescription or refill, for Preferred Name Brand	**$100**
Copayment, per new maintenance prescription or refill, for Non-Preferred Name Brand	**50 / 50**

Specialty Drug Expenses:	Participating Pharmacy
Retail Specialty[9] Card Co-payment Options *(30 day supply)*:	The copayments shown are applied to each prescription
Copayment, per new Specialty prescription or refill, for Generic	**80 / 20**
Copayment, per new Specialty prescription or refill, for Preferred Name Brand	**80 / 20**
Copayment, per new Specialty prescription or refill, for Non-Preferred Name Brand	**70 / 30**

Note:

When a Generic Drug is available, but the pharmacy dispenses a Name Brand Drug per the member's or physician's request, the plan member will pay the difference between the cost of the Name Brand Drug and the Generic Drug in addition to the difference between the specified copays.

Specialty Drug 30 Day Retail Lock:

The first Specialty prescription *(30 day maximum fill amount)* can be filled at any retail pharmacy. Subsequent fills must be obtained through the **CVS / Caremark** Specialty Drug Program. The **CVS / Caremark** phone number is located on the actual Pharmacy Benefit Card (Rx).

Participating pharmacies *("Participating Pharmacies")* have contracted with the Plan to charge Participants reduced fees for covered Drugs. **CVS / Caremark** is the administrator of the prescription drug program for your Plan. Participants will be issued an identification card to use at any pharmacy at the time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card usage after the termination date of your coverage. The Plan has the right to charge you for any prescriptions you purchase beyond your termination date.

The Mail Order and Retail Maintenance Options are available for maintenance medications *(medications that are taken for longer periods of time, such as drugs that are prescribed for heart disease, high blood pressure, asthma, etc.).* Because of volume buying, when you utilize the **CVS / Caremark** mail order pharmacy or the retail maintenance programs at select pharmacies, you are able to help achieve significant savings for you and the prescription drug plan.

[6] Formulary Generic Prescriptions for a 30 day supply of FDA approved Women's Contraceptives, are covered at 100%.
[7] Some medications such as narcotics are not available for the 90 day mail order or retail maintenance program.
[8] Formulary Generic Prescriptions for a 90 day supply of FDA approved Women's Contraceptives, are covered at 100%.
[9] Specialty medications and infusion therapy must be pre-certified. Orphan drugs are not covered.

Summary of Buy Up Plan Medical Benefits

The following benefits are per Plan Participant per Calendar Year:

Major Medical Cost Sharing Descriptions	In-Network	Non-Network
Annual Major Medical Deductible • Single • Family Unit	**$1,000** **x 2**	**$1,000** **x 2**
Coinsurance Levels *(after the Annual Deductible has been met)*	**90 / 10**	**50 / 50**
Maximum Annual Out-of-Pocket[1] *(Including Deductibles)* • Single • Family Unit	**$3,000** **x 2**	**$10,000** **x 2**
Major Medical deductible and out-of-pocket limits for in-network and out-of-network providers accumulate separately.		
Annual Reimbursable Deductible Allowance[2] (RDA) • Single • Family Unit	**$500** **x 2**	Not Available Not Available
Maximum Annual Major Medical Benefit Limit	**Unlimited**	**Unlimited**
Lifetime Major Medical Benefit Limit	**Unlimited**	**Unlimited**

Major Medical Expense Benefit Descriptions:	In-Network Coinsurance	Non-Network Coinsurance	Benefit Limit Descriptions
1. Acupuncture	90 / 10	50 / 50	12 Visit Limit Per Year
2. Allergy Injections *(GP / Specialists)*	$5 Co-pay	50 / 50	
3. Allergy Testing	90 / 10	50 / 50	
4. Ambulance *(Air[3] & Ground)*	90 / 10	50 / 50	Essential Health Benefits
5. Ambulatory Surgical Center	90 / 10	50 / 50	Essential Health Benefits
6. Anesthesia	90 / 10	50 / 50	Essential Health Benefits
7. Birthing Center	90 / 10	50 / 50	
8. Birth Control Devices *(Implants, IUDs, etc.)*	100%	50 / 50	
9. Blood & Plasma	90 / 10	50 / 50	Essential Health Benefits
10. Chiropractic Care Over 5 years of Age	90 / 10	50 / 50	30 Visit Limit Per Year **Medically Necessary** X-rays up to $60 per visit
11. Dialysis	90 / 10	50 / 50	6 Month Benefit Limit
12. Durable Medical Equipment	90 / 10	50 / 50	**Must be Pre-certified**
13. Hearing Examination (Annual)	100%	100%	Basic Hearing Exam
14. Home Health Care	90 / 10	50 / 50	120 Day Annual Visit Limit
15. Hospice Care • Inpatient Treatment • Outpatient Treatment • Family Bereavement Counseling	90 / 10 90 / 10 90 / 10	50 / 50 50 / 50 50 / 50	180 Day Benefit Limit Combined for all Hospice Care Services.
16. Hospital • Inpatient Treatment • Outpatient Treatment	90 / 10 90 / 10	50 / 50 50 / 50	**Must be Pre-certified** Essential Health Benefits

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

[2] The Reimbursable Deductible Allowance (RDA) is a portion of the deductible that is reimbursed back to the Plan Member at a rate of 100% for eligible expenses that are incurred and paid when the Plan Member utilizes Network. There is no RDA available for Non-Network providers.

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

17. Infusion Therapy Non-Orphan Drugs Only Covered Through PBM	90 / 10 Through PBM	50 / 50 Through PBM	**Must be Pre-certified** Medication must be provided through the PBM
18. Mental Health, Substance & Chemical Dependency: • Inpatient Physician Services • Partial Day Program • Outpatient Physician Services – Encounter Co-pay • Residential Treatment Program	 90 / 10 90 / 10 $20 Dr. Co-pay 90 / 10	 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits **Must be Pre-certified** 60 Day Annual Visit Limit 60 Visit Annual Limit 60 Visit Annual Limit 60 Day Annual Limit
19. Newborn Nursery Care – while inpatient	90 / 10	50 / 50	Essential Health Benefits
20. Orthoptic training prescribed by a physician	90 / 10	50 / 50	For dependent children up to age 10 only. **Must be Pre-certified**
21. Orthotics prescribed by a physician	90 / 10	50 / 50	$300 Annual Limit $1,500 Lifetime Limit **Must be Pre-certified**
22. Outpatient Diagnostic X-ray and Lab Services	90 / 10	50 / 50	Essential Health Benefits
23. Outpatient Emergency Room Services – ER • Emergency • Physicians	 $200 Co-pay[4] 90 / 10	 $200 Co-pay[5] 90 / 10	Essential Health Benefits
24. Physician Services • General Practitioner – Encounter Co-pay • Specialist – Encounter Co-pay • Urgent Care • Lab, X-ray, and Surgery	 $20 Dr. Co-pay $40 Dr. Co-pay $75 Dr. Co-pay 90 / 10	 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits
25. **Preferential Provider Benefits** • Preferred Lab Benefits *(Quest - LabCard)* • Preferred Lab Benefits - LabCorp • Preferred DME Program • CVS - Walk in Clinic Benefit • Mizzou Quick Care - Walk in Clinic Benefit • Livongo Diabetic Testing Program • Preferred Radiology Benefit • Telehealth Services – 24/7 Access • Preferred Surgical Network	 *Quest/LabCard* LabCorp **HOMELINK** minute clinic MU Quick Care Livongo **Relevant** **Teladoc** PRICEMDs	 N/A N/A N/A N/A N/A N/A N/A N/A N/A	 100% - *Quest/LabCard* 100% - LabCorp 100% - **HOMELINK** 100% at minute clinic 100% at MU Quick Care 100% through Livongo 100% through **Relevant** 100% through Teladoc 100% through PriceMDs
26. Pregnancy Expenses	90 / 10	50 / 50	Essential Health Benefits
27. Preventive Care • Routine Physical Exam • Mammograms – *must be over age 40* • Pap Smears • Prostate Exam – *must be over age 50* • Routine Immunizations • Well Child Care Exam	 100% 100% 100% 100% 100% 100%	 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits For a complete listing of covered wellness benefits see: https://www.healthcare.gov/coverage/preventive-care-benefits/
28. Private Duty Nursing	90 / 10	50 / 50	
29. Prosthetics	90 / 10	50 / 50	**Must be Pre-certified**
30. Routine Patient Costs *(Approved Clinical Trials)*	90 / 10	50 / 50	
31. Second Surgical Opinions	100%	50 / 50	
32. Skilled Nursing Facility	90 / 10	50 / 50	120 Day Annual Limit
33. Sleep Apnea Appliance (CPAP)	90 / 10	50 / 50	**Must be Pre-certified**
34. Smoking Cessation	100%	Not Covered	120 Day Annual Limit
35. Surgery	90 / 10	50 / 50	Essential Health Benefits

[4] After the co-pay the appropriate major medical coinsurance is applied.
[5] After the co-pay the appropriate major medical coinsurance is applied.

36. Temporomandibular Joint Disorder (TMJ)	90 / 10	50 / 50	$2,500 Annual Limit **Must be Pre-certified**
37. Therapy			
• Chemotherapy	90 / 10	50 / 50	Essential Health Benefits
• Occupational Therapy	90 / 10	50 / 50	60 Day Annual Visit Limit
• Physical Therapy	90 / 10	50 / 50	60 Day Annual Visit Limit
• Radiation Therapy	90 / 10	50 / 50	Essential Health Benefits
• Respiration Therapy	90 / 10	50 / 50	Essential Health Benefits
• Speech Therapy	90 / 10	50 / 50	60 Day Annual Visit Limit
38. Transplants – LifeTrac Transplant Network	90 / 10	50 / 50	Essential Health Benefits
39. Vision Examination (Annual)	100%	100%	Basic Vision Care
40. Weight Loss Counseling (No procedures)	100%	100%	1 Annual Visit
41. All Other Eligible Services *(Not Specifically Listed)*	90 / 10	50 / 50	**See Plan Document**

Summary of Voluntary Dental Benefits if Elected by Plan Member

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

Dental Benefit Deductible and Benefit Limit Summary:	Amount
Annual Deductible per Participant *(Deductible waived for Class 1 Services)*	**$25**
Maximum Number of Deductibles for Family	**x 2**
Maximum Annual Benefit Limit for Class 1, 2 and 3 Services	**$1,000**
Maximum Lifetime Benefit Limit for Class 4 Services *(Orthodontia)*	**$1,000**

Dental Benefit Coinsurance Levels Based Upon Class:	Benefits	Benefit Type
Class 1 Services	**100%**	Preventive Care
Class 2 Services	**90%**	Repair and Restoration
Class 3 Services	**60%**	Major Dental Repair
Class 4 Services	**60%**	Orthodontics
All charges except preventive care are limited to Usual and Customary Fees calculated at the 90th percentile.		

Dental program includes the use of the Aetna Dental network. A dental network provider is not required.

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	**$25**
Maximum Number of Deductibles for Family	**x 2**
Vision Coinsurance	**90%**
Maximum Annual Benefit Limit per Participant	**$600**

Vision Expense Benefit Descriptions:	Benefits	Limits[6]
Eye exam[7], per participant	**$100 Maximum**	12 – Month Period
Frame-type lenses, per pair – Single Vision	**$120 Maximum**	12 – Month Period
Frame-type lenses, per pair – Bi-focal	**$130 Maximum**	12 – Month Period
Frame-type lenses, per pair – Tri-focal	**$140 Maximum**	12 – Month Period
Frame-type lenses, per pair – Lenticular	**$150 Maximum**	12 – Month Period
Frames, per pair	**$130 Maximum**	24 – Month Period
Contact Lenses	**90 / 10 *(Plan Limit)***	12 – Month Period

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

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

[7] If the member has the major medical plan and the vision program, eye exams will be paid by the medical plan.

Summary of Prescription Drug Card Benefits

The following benefits levels are per Plan Participant:

Covered Retail Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Prescription Drug Annual Deductible	**$50**

Retail Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Retail Prescription Co-payment Options *(30 day supply)*	The copayments shown are applied to each prescription
Copayment, per new prescription or refill, for Generic[8]	**$8**
Copayment, per new prescription or refill, for Preferred Name Brand	**$40**
Copayment, per new prescription or refill, for Non-Preferred Name Brand	**50 / 50**

Mail Order or Retail Maintenance Pharmacy Prescription Drug Expenses:	Participating Pharmacy
Mail Order or Retail Maintenance Prescription Co-payment Options *(90 day supply[9])*:	The copayments shown are applied to each prescription
Copayment, per new maintenance prescription or refill, for Generic[10]	**$12**
Copayment, per new maintenance prescription or refill, for Preferred Name Brand	**$80**
Copayment, per new maintenance prescription or refill, for Non-Preferred Name Brand	**50 / 50**

Specialty Drug Expenses:	Participating Pharmacy
Retail Specialty[11] Card Co-payment Options *(30 day supply)*:	The copayments shown are applied to each prescription
Copayment, per new Specialty prescription or refill, for Generic	**80 / 20**
Copayment, per new Specialty prescription or refill, for Preferred Name Brand	**80 / 20**
Copayment, per new Specialty prescription or refill, for Non-Preferred Name Brand	**70 / 30**

Note:

When a Generic Drug is available, but the pharmacy dispenses a Name Brand Drug per the member's or physician's request, the plan member will pay the difference between the cost of the Name Brand Drug and the Generic Drug in addition to the difference between the specified copays.

Specialty Drug 30 Day Retail Lock:

The first Specialty prescription *(30 day maximum fill amount)* can be filled at any retail pharmacy. Subsequent fills must be obtained through the **CVS / Caremark** Specialty Drug Program. The **CVS / Caremark** phone number is located on the actual Pharmacy Benefit Card (Rx).

Participating pharmacies *("Participating Pharmacies")* have contracted with the Plan to charge Participants reduced fees for covered Drugs. **CVS / Caremark** is the administrator of the prescription drug program for your Plan. Participants will be issued an identification card to use at any pharmacy at the time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card usage after the termination date of your coverage. The Plan has the right to charge you for any prescriptions you purchase beyond your termination date.

The Mail Order and Retail Maintenance Options are available for maintenance medications *(medications that are taken for longer periods of time, such as drugs that are prescribed for heart disease, high blood pressure, asthma, etc.).* Because of volume buying, when you utilize the **CVS / Caremark** mail order pharmacy or the retail maintenance programs at select pharmacies, you are able to help achieve significant savings for you and the prescription drug plan.

[8] Formulary Generic Prescriptions for a 30 day supply of FDA approved Women's Contraceptives, are covered at 100%.
[9] Some medications such as narcotics are not available for the 90 day mail order or retail maintenance program.
[10] Formulary Generic Prescriptions for a 90 day supply of FDA approved Women's Contraceptives, are covered at 100%.
[11] Specialty medications and infusion therapy must be pre-certified. Orphan drugs are not covered.

SAMPLE ONLY

BASE & BUY UP ID CARDS

Member

GBS

Toll Free: (800) 995-3569
24/7 IVR: (417) 799-0090
www.gbs-tpa.com

Cooper County Government
Group #: 70100
Base Plan

Member: JOAN SAMPLE
Member ID: 123456789

HealthLink OAII | UniCare Affiliate

Medical Plan

In-Network Plan Benefits:
Deductible: $1,000
Coinsurance: 80 / 20
Max Out-of-Pocket: $5,500
Mizzou Quick Care Visit: $0

Pharmacy Plan

CVS/caremark
Customer Care
1-866-475-0056
www.caremark.com

RxBIN: 004336
RxPCN: ADV
RxGRP: RX2602
Issuer (80840)

$100 Calendar Year Deductible
Rx Co-pay (30 Day Supply):
Generic: $12
Preferred Name Brand: $50
Non-Preferred Name Brand: 50 / 50

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Member

GBS

Toll Free: (800) 995-3569
24/7 IVR: (417) 799-0090
www.gbs-tpa.com

Cooper County Government
Group #: 70100
Buy Up Plan

Member: Joan Sample
Member ID: 123456789

HealthLink OAII | UniCare Affiliate

Medical Plan

In-Network Plan Benefits:
GP Office Visit: $20
Specialist Office Visit: $40
Mizzou Quick Care Visit: $0
Urgent Care Visit: $75
Emergency Room Visit: $200 / 10%

Pharmacy Plan

CVS/caremark
Customer Care
1-866-475-0056
www.caremark.com

RxBIN: 000000
RxPCN: TEST
RxGRP: RX0000
Issuer (00000)

$50 Calendar Year Deductible
Rx Co-pay (30 Day Supply):
Generic: $8
Preferred Name Brand: $40
Non-Preferred Name Brand: 50 / 50

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Eligibility and Benefits

To Verify Eligibility and Benefits Contact:
Group Benefit Services (GBS)
Toll Free: (800) 995-3569 / IVR: (417) 799-0090
Monday-Friday: 8:00am - 5:00pm (CT)
www.gbs-tpa.com

For Pre-Certification Call:
Managed Care Concepts (866) 750-2723

Medical Claims

Send Medical Claims To HealthLink:
PO Box 419104
St. Louis, MO 63141-9104
Electronic Claims Payer ID: #90001
EDI Clearinghouse WebMD

For HealthLink Customer Service and
Provider Inquiries Call: (800) 624-2356
www.healthlink.com

Additional Discounts

Preferred Lab 100% Coverage:

Quest Diagnostics

LabCard
www.LabCard.com
1.800.646.7788

Outside the HealthLink Service Area:

PHCS
Out of Area

MultiPlan
Complementary Network
multiplan.com, 800-678-7427

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Eligibility and Benefits

To Verify Eligibility and Benefits Contact:
Group Benefit Services (GBS)
Toll Free: (800) 995-3569 / IVR: (417) 799-0090
Monday-Friday: 8:00am - 5:00pm (CT)
www.gbs-tpa.com

For Pre-Certification Call:
Managed Care Concepts (866) 750-2723

Medical Claims

Send Medical Claims To HealthLink:
PO Box 419104
St. Louis, MO 63141-9104
Electronic Claims Payer ID: #90001
EDI Clearinghouse WebMD

For HealthLink Customer Service and
Provider Inquiries Call: (800) 624-2356
www.healthlink.com

Additional Discounts

Preferred Lab 100% Coverage:

Quest Diagnostics

LabCard
www.LabCard.com
1.800.646.7788

Outside the HealthLink Service Area:

PHCS
Out of Area

MultiPlan
Complementary Network
multiplan.com, 800-678-7427

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

SAMPLE ONLY – DENTAL & VISION ID CARDS

Member

GBS

Toll Free: (800) 995-3569
24/7 IVR: (417) 799-0090
www.gbs-tpa.com

Cooper County Government
Group #: 70100
Dental/Vision Card

Member: JOAN SAMPLE
Member ID: 123456789

See back of card for Eligibility/Benefits and Claims Submissions.

Dental Benefits

Annual Deductible: $25
Annual Max: $1,000
Ortho Lifetime Max: $1,000
Basic Services: 90%
Major Services: 60%

To find a participating dentist go to the website or call:
www.aetna.com/docfind/custom/aetnadentalaccess/
1-800-513-7177, Option 7
Aetna participating dentists are independent providers and are neither agents nor employees of Aetna

Vision Benefits

Annual Deductible: $25
Annual Max: $600
Coinsurance: 90%

You can visit any Vision provider of your choice, there is no network with GBS Vision plans.

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Eligibility and Benefits

To Verify Eligibility and Benefits:

Group Benefit Services (GBS)
Toll Free: (800) 995-3569
24/7 IVR: (417) 799-0090
Monday-Friday: 8:00am - 5:00pm (CST)
www.gbs-tpa.com

Claims Submissions

Aetna Dental® Administrators

NovaNet Customer Service: 800-513-7177

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

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

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Member

GBS

Toll Free: (800) 995-3569
24/7 IVR: (417) 799-0090
www.gbs-tpa.com

Cooper County
Group #: 70100
Dental Card

Member: JOAN SAMPLE
Member ID: 123456789

See back of card for Eligibility/Benefits and Claims Submissions.

Dental Benefits

Annual Deductible: $25
Annual Max: $1,000
Ortho Lifetime Max: $1,000
Basic Services: 90%
Major Services: 60%

Dental Network

To find a participating dentist go to the website or call:
www.aetna.com/docfind/custom/aetnadentalaccess/
1-800-513-7177, Option 7

Aetna participating dentists are independent providers and are neither agents nor employees of Aetna

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Eligibility and Benefits

To Verify Eligibility and Benefits:

Group Benefit Services (GBS)
Toll Free: (800) 995-3569
IVR: (417) 799-0090
Monday-Friday: 8:00am - 5:00pm (CT)
www.gbs-tpa.com

Claims Submissions

Aetna Dental® Administrators

NovaNet Customer Service: 800-513-7177

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

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

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

20150630T09 Sh: 0 Bin 2
J186 Env [2] BlkPck 1 CSets 1 of 1

Member

GBS

Toll Free: (800) 995-3569
24/7 IVR: (417) 799-0090
www.gbs-tpa.com

Cooper County Government
Group #: 70100
Vision Card

Member: JOAN SAMPLE
Member ID: 123456789

To verify eligibility and benefits contact:
Group Benefit Services (GBS)
Toll Free: (800) 995-3569 / IVR: (417) 799-0090
Monday-Friday: 8:00am-5:00pm (CT)
www.gbs-tpa.com

Vision Benefits

Annual Deductible: $25
Annual Max: $600
Coinsurance: 90%

You can visit any Vision provider of your choice, there is no network with GBS Vision plans.

Claims Submissions

If your provider does not bill insurance, you will need to pay the provider at the time of service and file a paper claim with GBS.

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

Submit Itemized Statements and Assignments to GBS:
P.O. Box 211547
Eagan, MN 55121-2747
GBS EDI# 80241

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

Plan Highlights

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

Cooper 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*
Birth to 26 years.
*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 and AD&D

$25,000

Dependent Life

Spouse $10,000

Dependent Child(ren)
Birth to 6 Months : $500
6 Months to age 26 : $5,000

CONTRIBUTION REQUIREMENTS

Basic Life (and AD&D):
Coverage is 100% employer paid.

Dependent Life:

Spouse: Coverage is 100% employee paid.

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

AD&D SCHEDULE

For Accidental Loss of:	Amount Payable:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Speech and hearing	100%
One hand or One foot	50%
Sight of one eye	50%
Speech or Hearing	50%

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)
- 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

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

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
Voluntary Group Term Life Insurance

Cooper 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 or your spouse must be insured in order for Dependent children to be covered.
Dependents are:
• Your legal spouse under age 70.
• Your unmarried financially dependent children* Birth to 26 years.
*natural and adopted children upon finalization of adoption; stepchildren and foster children living with you.
Upper age limits do 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

Employee and Spouse: Choose from a minimum of $10,000 to a maximum of $300,000 (in $10,000 increments) for yourself and/or your spouse. The benefit amounts chosen need not be the same.

Eligible Dependent Child(ren): Age 14 days to 6 months: $1,000
Age 6 months to 26 years of age
$2,500, $5,000; $7,500 or $10,000

Choose one benefit amount for all eligible children in family.

GUARANTEE ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee:
Under age 60: $100,000
Age 60 but under age 70: $10,000
Age 70 or older: none
Spouse:
Under age 60: $50,000
Age 60 or older: none
Guarantee Issue is subject to underwriting rules and is not available in all circumstances.

CONTRIBUTION REQUIREMENTS

Coverage is employee paid.

BENEFIT REDUCTION DUE TO AGE

Age	Original Benefit Reduced to:
75	60%
80	35%
85	27.5%
90	20%
95	7.5%
100	5%

RATE

See attached Rate Sheet.

FEATURES

• Conversion Privilege
• FMLA/MSLA Continuation
• Portability
• Waiver of Premium

EXCLUSIONS

Death by suicide is not covered during the first two years an insured's insurance is in force. Insurance coverage is incontestable after it has been in force two years during the insured's lifetime, except for non-payment of premium.

Death by suicide is not covered if it can be shown the insured intended suicide when application for this insurance was made. Insurance coverage is incontestable after it has been in force two years during the insured's lifetime, except for non-payment of premium.

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. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-8349, et al.

Reliance Standard Voluntary Plans
Voluntary Group Term Life Insurance
Premium Table
Plan Holder: Cooper County Government - VG # 184094

Scheduled Benefit: Each eligible employee may elect for himself and/or his eligible spouse an amount of insurance shown in the Table below.
For employees age 75 and older:
Benefit amounts are reduced according to the age-based reduction chart shown in the Voluntary Term Life brochure. When selecting an amount of insurance, you must select a pre-age 75 benefit amount.
Employee/Spouse Premiums:

To find you and your spouse's premium -

- Determine your age band: Your age = your age at your last birthday.
- Select a benefit amount (employees age 75 and older: see above comment - **do not select a calculated reduced amount**).
- Spouse premium: Repeat the steps above for your spouse at his/her age at his/her last birthday. Your spouse must be under age 70 to be enrolled.
- Employee and spouse rates change as insured moves from one age bracket to the next.

Monthly Premiums

Benefit Amount	Age 00-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$10,000	$0.98	$0.94	$1.35	$2.21	$3.73	$6.09	$10.41	$12.77	$19.22	$37.05
$20,000	$1.96	$1.88	$2.70	$4.42	$7.46	$12.18	$20.82	$25.54	$38.44	$74.10
$30,000	$2.94	$2.82	$4.05	$6.63	$11.19	$18.27	$31.23	$38.31	$57.66	$111.15
$40,000	$3.92	$3.76	$5.40	$8.84	$14.92	$24.36	$41.64	$51.08	$76.88	$148.20
$50,000	$4.90	$4.70	$6.75	$11.05	$18.65	$30.45	$52.05	$63.85	$96.10	$185.25
$60,000	$5.88	$5.64	$8.10	$13.26	$22.38	$36.54	$62.46	$76.62	$115.32	$222.30
$70,000	$6.86	$6.58	$9.45	$15.47	$26.11	$42.63	$72.87	$89.39	$134.54	$259.35
$80,000	$7.84	$7.52	$10.80	$17.68	$29.84	$48.72	$83.28	$102.16	$153.76	$296.40
$90,000	$8.82	$8.46	$12.15	$19.89	$33.57	$54.81	$93.69	$114.93	$172.98	$333.45
$100,000	$9.80	$9.40	$13.50	$22.10	$37.30	$60.90	$104.10	$127.70	$192.20	$370.50
$110,000	$10.78	$10.34	$14.85	$24.31	$41.03	$66.99	$114.51	$140.47	$211.42	$407.55
$120,000	$11.76	$11.28	$16.20	$26.52	$44.76	$73.08	$124.92	$153.24	$230.64	$444.60
$130,000	$12.74	$12.22	$17.55	$28.73	$48.49	$79.17	$135.33	$166.01	$249.86	$481.65
$140,000	$13.72	$13.16	$18.90	$30.94	$52.22	$85.26	$145.74	$178.78	$269.08	$518.70
$150,000	$14.70	$14.10	$20.25	$33.15	$55.95	$91.35	$156.15	$191.55	$288.30	$555.75
$160,000	$15.68	$15.04	$21.60	$35.36	$59.68	$97.44	$166.56	$204.32	$307.52	$592.80
$170,000	$16.66	$15.98	$22.95	$37.57	$63.41	$103.53	$176.97	$217.09	$326.74	$629.85
$180,000	$17.64	$16.92	$24.30	$39.78	$67.14	$109.62	$187.38	$229.86	$345.96	$666.90
$190,000	$18.62	$17.86	$25.65	$41.99	$70.87	$115.71	$197.79	$242.63	$365.18	$703.95
$200,000	$19.60	$18.80	$27.00	$44.20	$74.60	$121.80	$208.20	$255.40	$384.40	$741.00
$210,000	$20.58	$19.74	$28.35	$46.41	$78.33	$127.89	$218.61	$268.17	$403.62	$778.05
$220,000	$21.56	$20.68	$29.70	$48.62	$82.06	$133.98	$229.02	$280.94	$422.84	$815.10
$230,000	$22.54	$21.62	$31.05	$50.83	$85.79	$140.07	$239.43	$293.71	$442.06	$852.15
$240,000	$23.52	$22.56	$32.40	$53.04	$89.52	$146.16	$249.84	$306.48	$461.28	$889.20
$250,000	$24.50	$23.50	$33.75	$55.25	$93.25	$152.25	$260.25	$319.25	$480.50	$926.25

Monthly Premiums

Benefit Amount	Age 00-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$260,000	$25.48	$24.44	$35.10	$57.46	$96.98	$158.34	$270.66	$332.02	$499.72	$963.30
$270,000	$26.46	$25.38	$36.45	$59.67	$100.71	$164.43	$281.07	$344.79	$518.94	$1,000.35
$280,000	$27.44	$26.32	$37.80	$61.88	$104.44	$170.52	$291.48	$357.56	$538.16	$1,037.40
$290,000	$28.42	$27.26	$39.15	$64.09	$108.17	$176.61	$301.89	$370.33	$557.38	$1,074.45
$300,000	$29.40	$28.20	$40.50	$66.30	$111.90	$182.70	$312.30	$383.10	$576.60	$1,111.50
$310,000	$30.38	$29.14	$41.85	$68.51	$115.63	$188.79	$322.71	$395.87	$595.82	$1,148.55
$320,000	$31.36	$30.08	$43.20	$70.72	$119.36	$194.88	$333.12	$408.64	$615.04	$1,185.60
$330,000	$32.34	$31.02	$44.55	$72.93	$123.09	$200.97	$343.53	$421.41	$634.26	$1,222.65
$340,000	$33.32	$31.96	$45.90	$75.14	$126.82	$207.06	$353.94	$434.18	$653.48	$1,259.70
$350,000	$34.30	$32.90	$47.25	$77.35	$130.55	$213.15	$364.35	$446.95	$672.70	$1,296.75
$360,000	$35.28	$33.84	$48.60	$79.56	$134.28	$219.24	$374.76	$459.72	$691.92	$1,333.80
$370,000	$36.26	$34.78	$49.95	$81.77	$138.01	$225.33	$385.17	$472.49	$711.14	$1,370.85
$380,000	$37.24	$35.72	$51.30	$83.98	$141.74	$231.42	$395.58	$485.26	$730.36	$1,407.90
$390,000	$38.22	$36.66	$52.65	$86.19	$145.47	$237.51	$405.99	$498.03	$749.58	$1,444.95
$400,000	$39.20	$37.60	$54.00	$88.40	$149.20	$243.60	$416.40	$510.80	$768.80	$1,482.00
$410,000	$40.18	$38.54	$55.35	$90.61	$152.93	$249.69	$426.81	$523.57	$788.02	$1,519.05
$420,000	$41.16	$39.48	$56.70	$92.82	$156.66	$255.78	$437.22	$536.34	$807.24	$1,556.10
$430,000	$42.14	$40.42	$58.05	$95.03	$160.39	$261.87	$447.63	$549.11	$826.46	$1,593.15
$440,000	$43.12	$41.36	$59.40	$97.24	$164.12	$267.96	$458.04	$561.88	$845.68	$1,630.20
$450,000	$44.10	$42.30	$60.75	$99.45	$167.85	$274.05	$468.45	$574.65	$864.90	$1,667.25
$460,000	$45.08	$43.24	$62.10	$101.66	$171.58	$280.14	$478.86	$587.42	$884.12	$1,704.30
$470,000	$46.06	$44.18	$63.45	$103.87	$175.31	$286.23	$489.27	$600.19	$903.34	$1,741.35
$480,000	$47.04	$45.12	$64.80	$106.08	$179.04	$292.32	$499.68	$612.96	$922.56	$1,778.40
$490,000	$48.02	$46.06	$66.15	$108.29	$182.77	$298.41	$510.09	$625.73	$941.78	$1,815.45
$500,000	$49.00	$47.00	$67.50	$110.50	$186.50	$304.50	$520.50	$638.50	$961.00	$1,852.50

DEPENDENT CHILD(REN) Monthly PREMIUMS:

Benefit Amount	Premium
$2,500	$0.45
$5,000	$0.88
$7,500	$1.31
$10,000	$1.74

(One rate for all eligible children in family, regardless of number)

PREMIUM CALCULATION (Add your elections here):

Employee Premium	
Spouse Premium	
Dependent Children Premium	
Total Premium	

(Rates are calculated as of coverage effective date and are based on insured's age in relation to Plan anniversary date. Billed rates may be higher if, at application, the person is at the highest age in an age band).

Please read this important information:

- You may not have coverage as both an employee and as a dependent.
- Only one insured spouse may cover the eligible dependent children.
- Neither you nor your spouse may hold more than a total of $500,000 of group term life insurance with Reliance Standard under the master Group Policy. Insurance over that amount will be void and the premium refunded.

Rates are subject to change.

Plan Highlights
Voluntary Group Long Term Disability Insurance

Cooper County Government

COVERAGE

Disability income protection insurance provides a benefit for "long term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY

Each Active, Full-time employee working 30 or more hours per week, and earning an annual salary of at least $15,000, except any person working on a temporary or seasonal basis.

BENEFIT AMOUNT

You may elect a monthly benefit equal to 60% of your covered earnings, up to a maximum benefit of $5,000 per month.

ELIMINATION PERIOD

90 consecutive days of total disability

MAXIMUM BENEFIT DURATION

Benefits will not extend beyond the longer of: Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
Prior to age 62	To age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	20 months
67	18 months
68	15 months
69 and over	12 months

Or to Social Security Normal Retirement Age

CONTRIBUTION REQUIREMENTS

Coverage is 100% employee paid.

RATES

See attached Rate Sheet.

FEATURES

- FMLA Continuation
- Limited Benefit Period for Other Specific Conditions – 24 months
- Mental/Nervous Illness Limitation – 24 month out-patient
- Minimum Benefit Payable – $50
- Own Occupation Coverage – 24 months
- Pre-Existing Condition Limitation – 3/12
- Rehabilitation provision
- Residual and Partial Disability
- Specific Indemnity Benefit
- Substance Abuse Limitation – 24 months
- Survivor Benefit – 3 months
- Work Incentive & Child Care provisions

VALUE ADDED SERVICES

- Travel Assistance Service

EXCLUSIONS

Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; injury or sickness occurring while confined in any penal or correctional institution.

For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, 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-6564, et al.

Premium Worksheet
Voluntary Group Long Term Disability

Cooper County Government

Scheduled Benefit: Each eligible employee may elect 60% of their monthly earnings, up to $5,000 per month benefit maximum.

To calculate your monthly payroll deduction, use the formula indicated below:
(Round all numbers to the nearest whole number)

1. Enter your **Annual Earnings.** 1. $_____

2. **Divide** your annual earnings by 12 (monthly earnings). Average monthly income cannot exceed $8,333 2. $_____

3. Find your rate from the age table displayed. 3. $_____

4. **Multiply** the amount on Line 2 by the appropriate rate for your age entered on Line 3. 4. $_____

5. **Divide** the amount on Line 4 by 100 and enter the amount on Line 5 to get your monthly payroll deduction. 5. $_____

Age	Rate per $100 of covered payroll
18-24	.13
25-29	.20
30-34	.37
35-39	.59
40-44	1.02
45-49	1.33
50-54	1.89
55-59	2.44
60-64	1.88
65-69	1.27
70+	.92

Example Calculation: Jane Smith is Age 35.

1. Enter your **Annual Earnings** 1. $ 50,000

2. **Divide** your annual earnings by 12 (monthly earnings). Average monthly income cannot exceed $8,333 2. $ 4,167 (monthly earnings)

3. Find your rate from the age table displayed. 3. $ .59 (rate for age 35-39)

4. **Multiply** the amount on Line 2 by the appropriate rate for your age entered on Line 3. 4. $ 2,458.53

5. **Divide** the amount on Line 4 by 100 and enter the amount on Line 5 to get your monthly payroll deduction. 5. $ 24.59 (monthly payroll deduction)

Reimbursable Deductible Allowance FAQs

What is the Reimbursable Deductible Allowance (RDA)?

RDA is part of the deductible that is reimbursable back to the Plan Member after he/she has submitted proof to Group Benefit Services (GBS) that payment has been made to the Network Provider for eligible medical expenses. There is no RDA available for Non-Network providers.

How do I utilize the RDA benefit for doctor visits, out-patient surgeries, in-patient stays, emergency room visits, and other allowable situations?

There's no co-pay required, however, the doctor may require that you pay a minimal amount down at the time of service. If the doctor requires that you pay a small amount down, **be sure that you ask for an itemized receipt.**

After you've received treatment, the provider will send the claim to your Preferred Provider Organization (PPO) to be discounted. Once the PPO has re-priced the claim, they will send the claim directly to GBS to be processed. An Explanation of Benefits (EOB) will be sent to you once the claim has been processed. This EOB will outline your financial responsibility.

Once you have paid the amount that was applied to your deductible, you will need to request a receipt from the Provider proving that you have made payment. Once the receipt has been received by Group Benefit Services, you will be reimbursed for eligible expenses.

Can I use my Flexible Spending Account (FSA - Section 125) before I use my RDA?

No, the RDA must be exhausted before FSAs can be used. This guideline is in accordance to IRS regulations that govern Flexible Spending Account (FSA) distribution.

Can I use the RDA to be reimbursed for prescriptions?

No, prescription drugs cannot be reimbursed through the RDA. The RDA is only for eligible expenses under the medical program contained herein, not pharmacy, dental, vision, or other claims.

Can I use the RDA to be reimbursed for wellness benefits?

Wellness benefits that are paid at 100% cannot be reimbursed. Any wellness benefits that exceed the 100% benefit level that count toward your deductible can be reimbursed to you through the RDA.

Can I use the RDA to be reimbursed for preferred lab services?

No, if a Preferred Lab performs the services, the eligible claims will be paid at 100% with no deductible, so you will not have a responsibility to be reimbursed for.

Can I use the RDA to be reimbursed for Durable Medical Equipment (DME) through the preferred Durable Medical Equipment Company?

No, if DME is purchased through the Preferred Durable Medical Equipment Company, benefits will be paid at 100% with no deductible, so you will not have a responsibility to be reimbursed for.

Can I use the RDA to pay for my co-insurance amounts under the medical plan?

No, any co-insurance is your responsibility and is not reimbursable under the RDA.

Can I use the RDA if I go to a non-network provider?

No, the RDA can only be used if you go to a PPO provider.

How long do I have to make a claim for reimbursement for eligible expenses under the RDA benefit?

If your employment ends with your employer during the Plan Year, you will have until the 90th day after your last day of employment in which to turn in your claim forms with paid receipts for reimbursement under the RDA benefit.

After the Plan Year for the entire group has ended, you will have three (3) months to submit any eligible claims for reimbursement for the previous Plan Year.

The RDA benefit is a part of the benefit program and provides reimbursement for expenses under the Plan. Once you leave employment, any amounts accrued under the RDA are forfeited. Only claims incurred during the time you were eligible to receive benefits will be considered for reimbursement under this provision. The RDA benefit is not a savings or investment program. The RDA benefit only provides reimbursement for eligible expenses as explained herein.

If you have any additional questions about the RDA or any of your other health insurance benefits, contact your Human Resources Department or GBS.

www.gbs-tpa.com

FAX: 417-883-8261

Cooper County Government

Reimbursable Deductible Allowance Claim Form

⇒ PART I COMPLETE FOR ALL REIMBURSABLE DEDUCTIBLE ALLOWANCE
(TO BE COMPLETED BY EMPLOYEE ONLY)

Employee's Name:_____

Social Security#:_____ Date of Birth: _____/_____/_____

Home Address: _____
(Number) (Street/Apt#) (City) (State) (Zip)

⇒ PART II COMPLETE FOR DEPENDENT REIMBURSABLE DEDUCTIBLE ALLOWANCE

Dependent's Name: _____ Date of Birth: ____/____/____ ☐Male ☐Female

Relationship: ☐Spouse ☐Son ☐Daughter ☐Other: _____

⇒ PART III COMPLETE FOR ALL REIMBURSABLE DEDUCTIBLE CLAIMS

Date of Service: _____ Amount of Claim: $_____

Physician / Hospital / Facility name where services were rendered: _____

_____

_____

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

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

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

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

NOTICE: The information contained on this claim form, may be legally privileged and/or confidential 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 an 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 in error, please notify the sender immediately, by telephone or fax, to advise of wrongful receipt and confirm your understanding of this Notice. Thank You.

Group Benefit Services

Third-Party Administration • Project Based Services • Outsourcing Services

Plaza Towers Building • 1736 E. Sunshine Suite 200 • Springfield, Missouri 65804
(800) 995-3569 • (417) 883-8088 • Fax (417) 883-8261

AUTHORIZATION AGREEMENT FOR EFT
AUTOMATIC DEPOSITS (ACH CREDITS)

I hereby authorize Group Benefit Services (GBS) to initiate deposits (ACH credits) into my account for all employee claim payments – including reimbursements for Flexible Spending Accounts (medical and/or childcare), reimbursements for HRA (RDA), and member and provider filed claims payable to member. I further authorize GBS to initiate debit entries, if necessary, to adjust for any credit entries made to my account in error.

TYPE OF ACCOUNT (circle one) Checking Savings

DEPOSITORY (BANK)
NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA No. _____ ACCOUNT _____

This authority is to remain in full force until GBS and DEPOSITORY (BANK) has received written notification from me (or either of us) of its termination, in such time and in such manner as to afford GBS and DEPOSITORY (BANK) a reasonable opportunity to act on it.

Date: _____

Printed Name: _____

Signature: _____

NOTICE: The information contained in this document, and any attachments accompanying this transmission, may be legally privileged and/or confidential and protected health information. This information is intended 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 an employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, print, 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 fax, to advise of wrongful receipt and confirm your understanding of this Notice. Thank You.

WHERE SHOULD YOU GO FOR MEDICAL CARE?

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

NO COPAY

TELEHEALTH*

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

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

NO COPAY

WALK-IN CLINIC†

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

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

$

PRIMARY CARE

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

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

$ $

URGENT CARE

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

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

$ $ $

EMERGENCY ROOM

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

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

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

Need help?

800.995.3569
info@gbsitpa.com

©2019 Group Benefit Services

gbs-tpa.com

GBS

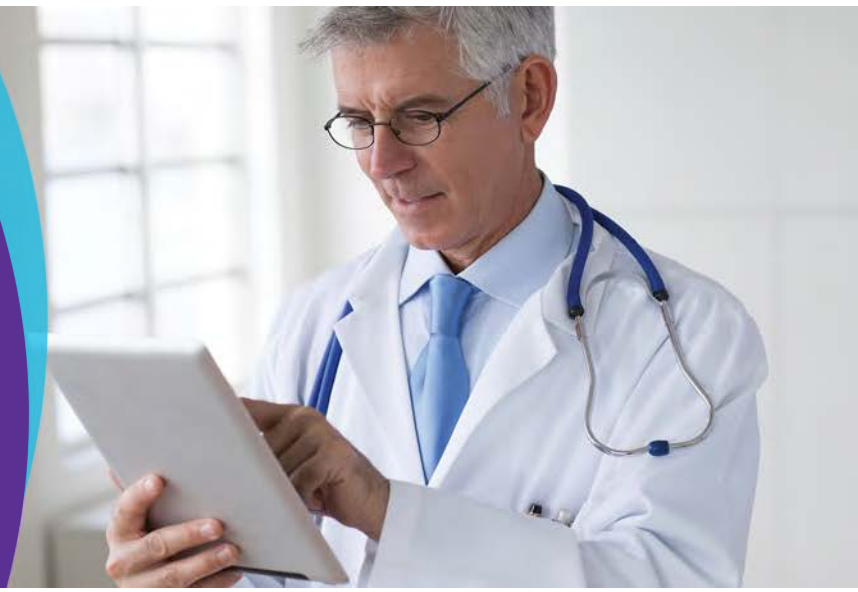
GIM.crt | 05.01.19

GBS

TELADOC®

AVAILABLE NOW:

Access to a doctor anytime, anywhere



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

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

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

WHY TELADOC?

It is a convenient and affordable option for quality care.

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

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

To log into Teladoc:

1. Go to **www.gbs-tpa.com,** then click the **Member Services Login** button beneath the yellow navigation menu.
2. Enter your username and password, then click **Submit.**
3. On the right-hand **Quick Links** sidebar, click **Telehealth.**
4. Follow the onscreen prompts to log in to Teladoc.

Support

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

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

© 2018 Teladoc, Inc. All rights reserved. Teladoc and the Teladoc logo are registered trademarks of Teladoc, Inc. and may not be used without written permission. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

04052016
10E-137B

EASY ONLINE ACCESS: GBS MEMBER PORTAL

Did you know your benefit plan includes access to a central hub online that includes coverage and claims information and secure messaging to ask questions? The GBS Member Portal does this and more—just check it out below!

Visit **mygbshealth.com** today to get started!

CVS RX REFILL REQUESTS

View your CVS prescription history, check co-pay amounts, and request CVS refills.

PROVIDER LOCATOR

Time to see a medical provider? Find one that's in-network and conveniently located.

TELEHEALTH SERVICE

Request a Teladoc visit and update your medical history.

MINUTECLINIC® LOCATOR

Find a CVS MinuteClinic near you and hold your place in line.

REIMBURSEMENT REQUESTS

Request reimbursements for RDA and FSA claims.

PLAN ID CARD REQUESTS

Request a new plan ID card be mailed to you, and print a temporary card while you wait.

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GBS

©2019 Group Benefit Services

GIM.crt| 09.04.19

MEMBER PORTAL REGISTRATION GUIDE

The GBS Member Portal gives you the ability to review claims, request a new ID card, or send a secure message to GBS support online. You can also access several services, including 24/7 Telehealth, a walk-in clinic locator, and a lab services booker.

To access the Member Portal, you'll first need to register as a user.*

To register as a user in the GBS Member Portal:

1. Navigate to **mygbshealth.com**, then beneath the **Submit** button select **Register Account.**
2. Read the License Agreement, select the **Accept** check box, and then select **Next.**
3. Enter your Member ID or Social Security Number (SSN), last name, and date of birth in the fields provided, then select **Next.**

   NOTE: If you are a dependent 18 years or older†, select the checkbox next to **Are you a dependent?** and fill out the fields accordingly.
4. Enter your username, password, security questions, and security answers in the fields provided, then select **Next.**
5. Review the information displayed and if it is correct select **Finish.**
6. In the dialog box that appears, select either the **Paperless** or **Paper** Explanation of Benefits (EOB) option.
7. Select **Continue** to complete the registration process and enter the Member Portal.

*Dependents must be 18 years or older to register for the portal. Though minor dependents cannot register for the portal, their claim information can be found in the primary policyholder's account.

†Primary policyholders will not have access to an adult dependent's account unless they are granted access by said dependent.

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GBS

©2019-2020 Group Benefit Services

GET TO KNOW YOUR PREFERRED PLAN BENEFITS

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

24/7 TELEHEALTH

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

WALK-IN CLINICS

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

PRESCRIBED LAB WORK

At the time your lab work is prescribed, request your physician use Lab Card or LabCorp to have your lab work covered.

PRESCRIBED RADIOLOGY

Call MCC to precertify your prescribed radiology event (MRI, PET, or CT scan), find a convenient location, and schedule the event.

DME

Need durable medical equipment (DME), such a CPAP machine? Call MCC to get precertified and order equipment.

DIABETIC MANAGEMENT

Use the Livongo Diabetic Management Program to receive a free glucometer and regular shipments of test strips.

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

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GBS

©2019-2020 Group Benefit Services

WHAT IS A PPB CARD?

The Preferred Plan Benefits (PPBs) are a set of premium benefits for use by GBS health plan* members. The PPB Card serves as your quick reference guide for these benefits and provides you with essential information on how and when to use them. Keep this card with your Plan Member ID card to ensure you get the most out of your 100%† covered benefits.

FRONT

100% COVERED BENEFITS

GBS

LAB SERVICES

Quest Diagnostics LabCard LabCorp

Request your physician use either service when your lab work is prescribed.

Lab Card: 800.646.7788
LabCorp: 888.522.2677

MRI, CT, OR PET

RELEVANT HEALTHCARE

Pre-certify your MRI, CT, or PET scan.

MCC: 866.750.2723

*See Plan Document for benefit details.

GIM.crtV1 | 09.01.2020

SAMPLE

BACK

DME

HOMELINK

Pre-certify and order your Durable Medical Equipment.

MCC: 866.750.2723

DIABETIC MANAGEMENT

Call to learn how to receive a free meter and test strips.

GBS: 800.995.3569

24/7 TELEHEALTH

TELADOC

800.835.2362

WALK-IN CLINICS

minute clinic

800.995.3569

Some services can be accessed at: mygbshealth.com

GBS

SAMPLE

*HDHP plan members can use these benefits before deductible by receiving specially negotiated rates, but there may be a cost associated with use.

†Not all health plans cover the Preferred Plan Benefits (PPBs) at 100%. Refer to your Plan Document for benefit details prior to receiving service.

Need help?

800.995.3569
info@gbsitpa.com

gbs-tpa.com

GBS

©2019-2020 Group Benefit Services

GIM.crt | 09.01.2020

HOW TO USE YOUR PRICEMDS BENEFIT

SAMPLE FLYER

Ready to save on your non-emergency surgical and medical procedures? Use PriceMDs! Your PriceMDs benefit covers the entire cost of your non-emergency surgery/procedure—there are no deductibles, no copays, and no coinsurance. Learn more below!

WHAT IS PRICEMDS?

The PriceMDs Surgical Program is your preferred health plan benefit for your non-emergency surgery/procedure. There are no deductibles, no copays, and no coinsurance! Your PriceMDs benefit **covers the entire cost (100%)* of your surgery/procedure,** including:

- The initial consultation
- Pre-op lab work
- Anesthesiologist
- Pathologist
- The surgery/procedure itself
- Post-op
- Any durable medical equipment needed

You'll often have a selection of surgeons/specialists and facilities to choose from for your care.

HOW DO I USE PRICEMDS?

Using your PriceMDs benefit for your surgery/procedure can be done in two (2) easy steps!

1. ***CONTACT YOUR PRICEMDS RN***

***Before* you schedule your consultation for your surgery/procedure,** contact one of your PriceMDs Registered Nurses (RN):

Rachel Kirkham
P 813.833.3267
E rachelkirkhamRN@pricemds.com

Caitlin Quinn
P 813.833.7158
E caitlinquinnRN@pricemds.com

2. ***MAKE YOUR SELECTION***

Your PriceMDs RN will explain the program and locate the right facilities and surgeons/specialists near you for your consultation. You will then make your selection from the available options.† After that, your RN will handle all of the scheduling needed—the initial consult, any lab work, the surgery/procedure itself, etc.

*100% coverage is subject to the provisions set by the Plan. Refer to your Plan Document for details.
†Multiple options may not be available in all areas.

Need help?
Your PriceMDs RN
813.833.3267

gbs-tpa.com

GBS

©2020 Group Benefit Services