Employee Enrollment Packet

"Base Plan"

Prepared Exclusively For:

Zimmer Radio of Mid-MO, Inc. Employee Benefit Plan

Prepared By:

Group Benefit Services (GBS)

www.gbs-tpa.com

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

Summary of Medical Benefits

The following benefits are per Participant per Calendar Year:

Cost Sharing Descriptions	Network	Non-Network
Annual Deductible • Individual • Family Unit	$2,500 x 3	$5,000 x 3
Coinsurance Levels - after the Annual Deductible has been met (unless otherwise specified)	80 / 20	50 / 50
Maximum Annual Out-of-Pocket *(Including Deductibles)* • Individual • Family Unit	$3,000 x 2	$6,000 x 2
Reimbursable Deductible Allowance[1] (RDA) • Individual • Family Unit	$500 x 3	Not Available Not Available
Annual Benefit Limit Available Under this Plan	Unlimited	Unlimited
Lifetime Benefit Limit Available Under this Plan	Unlimited	Unlimited

Medical Expense Descriptions:	Network Coinsurance	Non-Network Coinsurance	Limits[2]
1. Allergy Injections *(GP / Specialists)* 2. Allergy Testing	$5 80 / 20	50 / 50 50 / 50	
3. Ambulance *(Air[3] & Ground)*	80 / 20	50 / 50	Essential Health Benefits
4. Ambulatory Surgical Center	80 / 20	50 / 50	Essential Health Benefits
5. Anesthesia	80 / 20	50 / 50	Essential Health Benefits
6. Birthing Center	80 / 20	50 / 50	
7. Birth Control Devices *(Implants, IUDs, etc.)*	80 / 20	50 / 50	
8. Blood & Plasma	80 / 20	50 / 50	Essential Health Benefits
9. Chiropractic Care	80 / 20	50 / 50	30 Visit Limit Per Year
10. Durable Medical Equipment	80 / 20	50 / 50	
11. Home Health Care	80 / 20	50 / 50	120 Day Annual Visit Limit
12. Hospice Care • Inpatient • Outpatient • 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.
13. Hospital • Inpatient Treatment • Outpatient Treatment	80 / 20 80 / 20	50 / 50 50 / 50	Essential Health Benefits
14. Newborn Care	80 / 20	50 / 50	Essential Health Benefits
15. Outpatient Diagnostic X-ray and Lab	80 / 20	50 / 50	Essential Health Benefits

[1] 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.

[2] These limits are in addition to all other Plan exclusions, limitations and provisions and the applicable lifetime maximum benefit set forth in this Plan. Please review the Plan carefully to determine benefits available.

[3] Air Ambulance eligible 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. Contact Third Party Administrator for additional details.

16. Outpatient Emergency Room Services - ER • Emergency • Physicians	 80 / 20 80 / 20	 50 / 50 50 / 50	Essential Health Benefits
17. Physician Services • General Practitioner – Encounter Co-pay • Specialist – Encounter Co-pay • 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
18. **Preferred Plan Benefits** • Preferred Lab Benefits *(Quest - LabCard)* • Preferred DME Program • CVS - Minute Clinic Benefit • Diabetic Testing Program • One Call Radiology Benefit	 Quest/LabCard Heartland DME Minute Clinic CVS Direct One Call	 N /A N /A N /A N /A N/A	 100% - Quest/LabCard 100% - Heartland DME 100% at Minute Clinic 100% through CVS Rx 100% through One Call
19. Pregnancy Expenses	80 / 20	50 / 50	Essential Health Benefits
20. Preventive Care • Well Adult Care • Routine Physical Exam • Mammograms – *must be over age 40, unless Medically Necessary* • Pap Smears • Prostate Exam – *must be over age 50, unless Medically Necessary* • Routine Immunizations • Well Child Care • Exam • Immunizations	 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%	 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50	Essential Health Benefits
21. Private Duty Nursing	80 / 20	50 / 50	
22. Prosthetics, Orthotics, Supplies and Surgical Dressings	80 / 20	50 / 50	$10,000 Annual Limit
23. Second Surgical Opinions	80 / 20	50 / 50	
24. Skilled Nursing Facility	80 / 20	50 / 50	120 Day Limit Annually
25. Surgery	80 / 20	50 / 50	Essential Health Benefits
26. Temporomandibular Joint Disorder (TMJ)	80 / 20	50 / 50	$1,000 Annual Limit
27. Therapy (Rehabilitative) • Chemotherapy • Occupational Therapy • Physical Therapy • Radiation Therapy • Respiration Therapy • Speech Therapy	 80 / 20 80 / 20 80 / 20 80 / 20 80 / 20 80 / 20	 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50 50 / 50	 Essential Health Benefits 60 Day Annual Visit Limit 60 Day Annual Visit Limit Essential Health Benefits Essential Health Benefits 60 Day Annual Visit Limit
28. Transplants	80 / 20	50 / 50	Essential Health Benefits
29. Vision Screening	100%	100%	$100 Calendar Year Max.
30. All Other Covered Services *(Not Specifically Listed in this brief Summary)*	80 / 20	50 / 50	

Summary of Psychiatric Benefits
The following benefits are per Participant, per calendar year:

Covered Psychiatric Expenses:	Network	Non-Network	Limits[4]
1. Residential Treatment	80 / 20	50 / 50	30 Day Annual Limit
2. Inpatient Physician	80 / 20	50 / 50	30 Day Annual Visit Limit
3. Partial Day Program	80 / 20	50 / 50	30 Visit Limit Per Year
4. Outpatient Physician	80 / 20	50 / 50	30 Visit Limit Per Year

Summary of Substance Abuse Benefits
The following benefits are per Participant, per calendar year:

Covered Substance Abuse Expenses:	Network	Non-Network	Limits[5]
1. Residential Treatment	80 / 20	50 / 50	30 Day Annual Limit
2. Inpatient Physician	80 / 20	50 / 50	30 Day Annual Visit Limit
3. Partial Day Program	80 / 20	50 / 50	30 Visit Limit Per Year
4. Outpatient Physician	80 / 20	50 / 50	30 Visit Limit Per Year

Summary of Prescription Drug Card Benefits
The following benefits are per Participant:

Covered Retail Pharmacy Prescription Drug Card Expenses:	Participating Pharmacy
Prescription Drug Annual Deductible	$25

Covered Retail Pharmacy Prescription Drug Card Expenses:	Participating Pharmacy
Retail Prescription Rx Card Co-payment Options *(30 day supply)*:	
Copayment, per prescription or refill, for Generic	$12
Copayment, per prescription or refill, for Preferred Name Brand	$40
Copayment, per prescription or refill, for Non-Preferred Name Brand	80 / 20

Covered Mail Order or Retail Maintenance Pharmacy Prescription Drug Card Expenses:	Participating Pharmacy
Mail Order or Retail Maintenance Prescription Rx Card Co-payment Options *(90 day supply)*:	
Copayment, per prescription or refill, for Generic	$12
Copayment, per prescription or refill, for Preferred Name Brand	$60
Copayment, per prescription or refill, for Non-Preferred Name Brand	80 / 20

CVS Specialty Drug Expenses:	Participating Pharmacy
CVS Specialty Co-payment Options *(30 day supply)*:	
Copayment, per prescription or refill, for Generic	$50
Copayment, per prescription or refill, for Preferred Name Brand	$100
Copayment, per prescription or refill, for Non-Preferred Name Brand	80 / 20

Non CVS Specialty Drug Expenses:	Participating Pharmacy
Non CVS Specialty Co-payment Options *(30 day supply)*:	
Copayment, per prescription or refill, for Generic	$70
Copayment, per prescription or refill, for Preferred Name Brand	$120
Copayment, per prescription or refill, for Non-Preferred Name Brand	80 / 20

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

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

Summary of Optional Dental Benefits if elected by Plan Member
The following Deductibles, Maximums and Benefits are per Participant, per Calendar Year:

Benefit and Cost Share Description	Benefit Limits
Annual Deductible per Participant not to exceed 3 per family *(Deductible waived for Class 1 Services)*	$25
Maximum benefit per calendar year for Class 1, 2 and 3 Services	$1,500
Maximum Lifetime benefit for Class 4 Services (Orthodontia)	$1,500

Optional Covered Dental *Benefits:	Benefit Coinsurance
Class 1 Services (Preventive Care)	100%
Class 2 Services (Repair and Restoration)	90%
Class 3 Services (Major Dental Repair)	60%
Class 4 Services (Orthodontics)	60%

**Charges are limited to Usual and Customary Fees calculated at the 90th percentile.*

Summary of Optional Vision Benefits if Elected by Plan Member
The following Deductibles, Maximums and Benefits are per Participant, per Calendar Year:

Annual Vision Deductible Per Person *(not to exceed 3 per family):*	**$25**
Vision Coinsurance (%)	**90%**
Maximum Annual Benefit per participant	**$600**

Optional Covered Vision Expenses:	Annual Benefit Limit
Eye exam, per person, in a 12 - month period	$80 Maximum
Frame-type lenses, per pair, in a 12 - month period – Single vision	$120 Maximum
Frame-type lenses, per pair, in a 12 - month period – Bi-focal	$130 Maximum
Frame-type lenses, per pair, in a 12 - month period – Tri-focal	$140 Maximum
Frame-type lenses, per pair, in a 12 - month period – Lenticular	$150 Maximum
Frames, per pair, in a 24 - month period	$130 Maximum
Contact Lenses in a 12 - month period *(90/10 co-pay until Vision Plan Maximum has been paid)*	90 / 10

Zimmer Radio Employee Benefit Plan
Employee Bi-Monthly Contribution Report
Group #8040

Available Medical Programs

Coverage Class:	Base Plan	Buy-Up Plan	*Maxi-Care Plan
Employee Only:	$99.13	$137.25	$0.00
Employee & Child(ren):	$248.70	$319.23	
Employee & Spouse Only:	$297.62	$379.59	$246.43
Employee & Full Family:	$449.18	$554.02	

*Maxi-Care is a Medical Expense Reimbursement Plan for those that have other qualifying Major Medical Coverage.

Ancillary Benefit Plan Options

Coverage Class:	Dental Plan	Vision Plan	Employee Life	Dependent Life	Voluntary Life
Employee Only:	$16.78	$6.66	Employer Paid	N/A	See Schedule
Employee & Child(ren):	$29.77	$9.91	N/A	$1.53	See Schedule
Employee & Spouse Only:	$31.95	$12.08	N/A	$1.53	See Schedule
Employee & Full Family:	$49.28	$14.20	N/A	$1.53	See Schedule

Employer Paid Life: $25,000
Dependent life amount is $10k for Spouse and $5k for each child over the age of 6 months. See policy for details.
Additional voluntary life is available for all employees and dependents. See policy and fee schedule for details.

Zimmer Radio

OPTIONAL LIFE BENEFITS SCHEDULE OF INSURANCE

<u>Dependents</u>

	Life Insurance
Spouse*	10,000
Children	
14 days but less than 6 months	500
6 months but less than 19 years (or 23 years if full-time student)	5,000

Higher age limits may apply in certain states.

*The amount of a Spouse's benefit will terminate upon the Spouse's attainment of age 70.

The monthly rate for this benefit is $3.05 per family unit.

PLEASE NOTE: Eligible dependents must satisfy the policy's non-confinement requirement. If a dependent is confined in a hospital on the date insurance would otherwise take effect, his or her insurance will become effective on the 10th day following final discharge from the hospital.

Zimmer Radio of Mid-MO, Inc.
Group #8040 – Base Plan

Customer Care
(866) 475-0056
www.caremark.com

Generic: $12 / Preferred Name Brand: $40 / Non-Preferred Brand: 80/20
30 Day Supply Maximum

RXBIN: 004336
RXGRP: RX2602
RXPCN: ADV
ISSUER: (80840)
EMPLOYEE: NAME HERE
EMPLOYEE ID: SUBMIT EMPLOYEE ID

Zimmer Radio of Mid-MO, Inc.
Group #8040 – Base Plan

To Verify Eligibility and Benefits Call:
Group Benefit Services @ (800) 995-3569
Mon – Fri: 8:00 am to 5:00 pm (Central Time)
www.gbs-tpa.com

www.healthlink.com

Send HealthLink Medical Claims To:
P.O. Box 419104, St. Louis, MO 63141-9104
Send Electronic Claims to: Vendor #90001
EDI Clearinghouse WebMD
For HealthLink Customer Service and
Providers Inquiries: Call (800) 624-2356

Outside the HealthLink Service Area

Extended PPO

In-Network Plan Benefits:

Deductible:	$2,500
Coinsurance:	80/20
Emergency Copay:	80/20
Urgent Care Copay:	80/20
Doctor Copay:	80/20

www.LabCard.com
1.800.646.7788

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

Zimmer Radio of Mid-MO, Inc.
Group #8040 – Base Plan

To Verify Eligibility and Benefits Call:
Group Benefit Services @ (800) 995-3569
Mon – Fri: 8:00 am to 5:00 pm (Central Time)
www.gbs-tpa.com

Send ALL Claims To: Group Benefit Services
P.O. Box 211547 Eagan, MN 55121-2747
AHA EDI: #01066
Locate Providers: Call (888) 685-7774

In-Network Plan Benefits:

Deductible:	$2,500
Coinsurance:	80/20
Emergency Copay:	80/20
Urgent Care Copay:	80/20
Doctor Copay:	80/20

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

Outside the AHA Service Area

Extended PPO

www.LabCard.com
1.800.646.7788

Zimmer Radio of Mid-MO, Inc.
Group #8040
Employee Benefit Card

To Verify Eligibility and Benefits Contact: GBS
(800) 995-3569 or (417) 883-8088
Mon – Fri 8am to 5pm (CST)
www.gbs-tpa.com

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

Group Benefit Services, Inc.

New Enrollee On-line Access Guide

New Enrollee: Go to the following web site: **www.gbs-tpa.com**

Click on the **"Member Services Login"** located right in the middle of the home page.

New User Registration:

1. In the middle of the screen, click the button that says **Register**.
2. Under "**Sign Up for Your New Account**", select how you are registering. Example: Employee/Insured, Dependent or Employer.
3. Once your selection has been made, the following screen will appear.
   GBS should be automatically selected as your Administrator.

   I am a/an: Employee/Insured

   Administrator: Group Benefit Services, Inc.

4. Click the **Next** button.
   Enter your personal information:
5. For Date of Birth: Enter your Date of Birth in the format of MM/DD/YYYY.
6. Enter a nine digit Social Security Number. Do not include dashes (–) or slashes (/).
7. Once all personal information has been entered, click the **Next** button.

Sign Up: Select a unique User Name and Password:

1. User Name: Create a unique User Name.
2. Password: Your Password should be a minimum length of eight characters, with at least one letter, one number and one of the following: ! @ # $ % ^ & * ( )
3. Enter your Email address.
4. Enter a Security Question and Security Answer. Note: The Security Question will be displayed as a reminder if you click on "Forgot Your Password?" When using "Forgot Your Password?", you must enter your Security Answer.
5. Click the **Create User** button.
6. Please make a record of your User Name, Password, Security Question and Security Answer. You will use the User Name and Password to access the web site. If you forget your Password, you can answer the Security Question to request a new password.

It may take up to 24 hours to confirm your online access account, but once authorized, you will be able to use this site 24 hours a day, 7 days a week.

View/Create Messages
This option allows you to communicate with Group Benefit Services via a HIPAA compliant, secure e-mail system. The e-mail system has similar features as other on-line e-mail systems.

My Account
You can change your password, e-mail, and security question from here.

Logout
The system will automatically log you out after a few minutes of inactivity, but it is safer to logout as soon as you are done.

HELPFUL HINTS
The drop-down menus are also clickable options. If you can't find the information you're looking for in a menu, click the header.
Read the items on the screen carefully, and get familiar with the site. If you feel lost, try the "Need Help?" link.
Login Codes and Passwords are CASE sensitive. If you use capital letters be sure to use them every time you login. Access will be denied if you do not use the right words and the proper case (upper or lower case letters).

You can print your Explanation of Benefits (EOB's) directly from the site under the "Claims" tab.

Plaza Towers Building ✷ 1736 East Sunshine, Suite #200 ✷ Springfield, MO 65804 ✷ 800.995.3569

www.gbs-tpa.com

EMPLOYEE ENROLLMENT FORM / REFUSAL FORM

INSTRUCTIONS FOR COMPLETING THIS FORM

1. **Misstatements, omissions, and illegible statements made on this form may cause you to lose coverage under this plan.**
2. This form must be completed by the **EMPLOYEE ONLY.**
3. Please **PRINT** clearly. **INITIAL & DATE** all corrections.
4. You must be a US Citizen or Legal Alien residing in the USA to be eligible for all coverage's under this Plan.

EMPLOYER INFORMATION

Zimmer Radio of Mid-MO, Inc. – Group: #8040

Plan Type: (Check only one) ☐Base Plan ☐Buy-Up Plan

☐Open Enrollment ☐New Hire ☐Employment Status Change:___________ Event Date:___________

EMPLOYEE INFORMATION

PLEASE PRINT CLEARLY (All fields must be completed in order to qualify for coverage) PLEASE PRINT CLEARLY

❑ Single ❑ Married ❑ Divorced **☐ I DECLINE ALL COVERAGE**

Name: ________________________ ☐ Male ☐ Female Date of Birth: ______________ Hire Date: ______________

Home Address: ________________________ City:________________ State:_____ Zip Code: __________

Social Security Number: ______________ Home Phone #: ______________ Cell Phone #: ______________

E-mail Address: ______________________ Effective Date: ______________

***IMPORTANT DISCLOSURE AND COVERAGE INFORMATION ***

Please note that by enrolling in the coverage(s) available to you, any part of the benefits that you select that is NOT employer paid, you do hereby authorize your employer to reduce your salary by the amount necessary to cover the cost of the benefits you select.

Will you or any dependents enrolling in this Plan be covered by any other Medical Insurance in addition to this Plan?: **☐Yes ☐ No**

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

Benefit Enrollment Coverage Class	Medical/Rx	Voluntary Dental	Voluntary Vision	Employee & Dependent Life
Employee Only:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Employer Paid $25,000
Employee/Children:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	$5,000 per Child ☐Yes ☐No
Employee/Spouse:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	$10,000 Spouse ☐Yes ☐No
Employee/Family:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Spouse & Child ☐Yes ☐No

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

Dep.#	Relation to Employee	First Name, M. I. Last Name (if different*),	Gender (M / F)	Social Security Number	Date of Birth
1					
2					
3					
4					
5					
6					
7					

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

LIFE INSURANCE BENEFICIARY INFORMATION

Primary:____ Relationship:___________________________
Address:____ City:_____________________St._____Zip:__________
Phone Number: (______) ______- ___________ Additional Instructions: _____________________________________

Contingent:____ Relationship:___________________________
Address:____ City:_____________________St._____Zip:__________
Phone Number: (______) ______- ___________ Additional Instructions: _____________________________________

PLEASE READ CAREFULLY

SPECIAL ENROLLMENT NOTICE:

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption.

If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health Insurance coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or your dependents' other health coverage ends, **but only if you state on the Coverage Declination Form that other health coverage is the reason for declining coverage.** The penalty for failure to state that other health coverage was the reason for declining this coverage will be a 6-month waiting period under this Plan after you apply for coverage hereunder.

ELECTRONIC WAIVER:

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

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

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

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

Employee Signature: X____ **Date Signed:** ___________________________
(PLEASE DO NOT PRINT)

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