# Underwriting Guidelines and Agent Guide

GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

Underwritten by Zurich American Insurance Company

**For agent training purposes only.**
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# SECTION 1: PRODUCT DESCRIPTION

This is an optionally renewable group supplemental medical expense product, commonly known as GAP. It provides supplemental benefits to an employer's group major medical insurance plan, by helping cover certain portions of the out-of-pocket expenses that employees and their families incur under their medical plan due to the application of deductibles, coinsurance, and co-payments.

The Zurich GAP plan (GAP) is designed to complement comprehensive major medical insurance plans by filling the gap in primary medical plans (deductibles, coinsurance, and co-pays). However, this product does not cover 100% of out-of-pocket expenses.

GAP may be sold to any employer group that has a major medical or comprehensive health insurance plan in place for their employees. An underlying major medical insurance plan is required.

**Product Features**

- All plans include coverage for Inpatient Hospital expenses
- Optional Outpatient Benefit available for medical treatment received on an outpatient basis
- Combined Inpatient/Outpatient Benefit "One Bucket" option available, providing a simplified benefit structure by combining inpatient and outpatient benefits
- Includes a range of benefit maximums designed to correspond with the major medical insurance plan's out-of-pocket expenses
- Plans may include an optional Outpatient Doctor's Office Visit Benefit, if elected by the employer
- Plans may include a Deductible Option, if elected by the employer
- HSA compatible with appropriate plan design
- Dual plan options and buy-up options available
- Guaranteed Issue and No Pre-Existing Condition Limitations
- Expenses must be covered by the covered person's major medical insurance plan and applied to an out-of-pocket expense (deductible, coinsurance or co-pay)
- Expenses must be the result of treatment for a covered injury or sickness
- Uses primary medical plan's EOB (explanation of benefits) as a basis for determining the eligible out-of-pocket expense, along with an itemized bill that includes procedure and diagnosis codes

**This product does not pay 100% of out-of-pocket expenses. Please refer to the policy or certificate for benefit descriptions, a full list of exclusions, and other limitations.**

# SECTION 2: BASE POLICY (must choose between Benefit Type 1B or 2B)

## BENEFIT TYPE 1B:

### Combined Inpatient/Outpatient Benefit Amount

### COMBINED INPATIENT AND OUTPATIENT BENEFIT

Plans include a Combined Single Limit benefit amount, providing a simplified benefit structure by combining inpatient and outpatient benefits. All eligible inpatient and outpatient charges accumulate to the Combined Benefit Maximum.

Benefit amount options range from $250 to $15,000 but may not exceed the covered person's total in-network out-of-pocket exposure under the employer's primary medical plan (deductible + coinsurance + co-pays).

**The Combined Benefit does not cover physician office visit charges**. To have this type of charge covered, the Doctor's Office Visit Benefit would need to be elected by the employer and issued with the Policy.

Covered Charges include, but are not limited to:

- Inpatient hospital confinements and surgeries
- Physician's In-Hospital charges
- Emergency Room treatment
- Ambulance Transportation
- Routine newborn nursery care
- Surgery in an Outpatient Facility or Physician's office
- Diagnostic Testing, Labs, X-Ray, Advanced Imaging
- Outpatient Radiation Therapy or Chemotherapy
- Physical Therapy or Chiropractic Care
- Durable Medical Equipment, regardless of where it is dispensed

### Pregnancy benefits

Eligible charges for outpatient care and hospital confinement due to pregnancy are covered the same as any other illness for insured employees and their insured dependents if it is covered under their medical plan.

## BENEFIT TYPE 2B:

**Split Limit Benefit Amounts – Separate benefit maximums for Inpatient and Outpatient treatment**

### INPATIENT HOSPITAL BENEFIT

Benefits are payable for covered charges if the covered person is hospital confined as an overnight bed patient due to an injury or sickness (under the regular care and attendance of a physician) and the expenses must be covered by the covered person's Health Benefit Plan and applied to the deductible, co-pay, or coinsurance. Coverage is automatically included for a covered person's newborn child from the moment of birth until discharged from the hospital if the charges are covered under the Health Benefit Plan.

Hospital confinement must begin after the covered person's effective date of coverage.

Inpatient Hospital Benefit amount options range from $250 to $15,000 but may not exceed the covered person's total in-network out-of-pocket exposure under the employer's primary medical plan (deductible + coinsurance + co-pays).

Covered Charges include, but are not limited to:

- Inpatient hospital confinements and surgeries
- Physician's In-Hospital charges
- Routine newborn nursery care

### Emergency Room Treatment

Benefits are also payable for covered charges in a hospital emergency room for treatment of an Injury if the expenses are incurred within 48 hours of an accident.

Benefits are also payable for covered charges in a hospital emergency room for treatment of a Sickness if the Sickness results in hospital confinement with 24 hours of the hospital emergency room treatment.

### Durable Medical Equipment

Benefits are payable for covered charges for durable medical equipment received by the covered person while hospital confined.

### Pregnancy Benefits

Hospital confinement due to pregnancy is covered the same as any other illness for insured employees and their insured dependents if it is covered under their medical plan.

### OUTPATIENT BENEFIT

The outpatient benefit pays up to the maximum benefit selected for deductibles, coinsurance and co-pays for outpatient treatment of an injury or sickness under the regular care and attendance of a physician at a hospital, physician's office, outpatient surgical, emergency facility, or diagnostic testing facility licensed to provide outpatient treatment. It covers treatment, supplies and other non-physician related outpatient charges. It does not cover expenses incurred for examination, which is included in the Doctor's Office Visit Benefit.

Covered Charges include, but are not limited to:

- Emergency Room treatment, unless it qualifies under the Inpatient Benefit
- Ambulance Transportation
- Surgery in an Outpatient Facility or Physician's office
- Diagnostic Testing, Labs, X-Ray, Advanced Imaging
- Outpatient Radiation Therapy or Chemotherapy
- Physical Therapy or Chiropractic Care
- Durable Medical Equipment, regardless of where it is dispensed

# SECTION 3: OPTIONAL OUTPATIENT BENEFITS

(If elected, must choose between Benefit Type OP1 or OP2)

**OUTPATIENT BENEFIT I (OP1)**

Outpatient I benefits range from a minimum of $250 to a maximum of $5,000 per sickness or injury, provided the maximum benefit selected is not greater than the amount of Inpatient Benefit selected.

The Outpatient I benefit pays on a "per person per Sickness or Injury" basis, up to a maximum of two "occurrences" per person per plan year and four "occurrences" per family per plan year. This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit. An "occurrence" is the treatment, or series of treatments, for a specific sickness or injury. All expenses related to the treatment of the same or related sickness or injury will accrue toward the outpatient maximum for one occurrence, regardless of whether such treatment is received in more than one plan year period. If, however, a Covered Person is treatment-free, at any time, for at least 90 consecutive days, they may qualify for an additional outpatient maximum benefit if the individual or family maximum per plan year has not been met.

**The Outpatient Benefit I does not cover physician office visit charges**. In order to have this type of charge covered, the Doctor's Office Visit Benefit would need to be issued with the Policy.

**OUTPATIENT BENEFIT I (Claim Scenarios)**

The outpatient benefit will pay, up to the maximum benefit elected, for covered expenses applied to your major medical deductible (including co-pays) or coinsurance percentage. This benefit is a "per occurrence" benefit with a plan year limit of 2 occurrences per person and 4 occurrences per family unit. If you, or your covered dependent have an outpatient lab procedure that, in the absence of this benefit, would cause you to be out of pocket a fairly small amount, you might want to consider not having the provider bill us, and pay the provider yourself. This way, you will not use all of your occurrences or events up early in the calendar year for small items, then realize you do not have anything left to help offset that large item you may need it for at the end of the year. If you do not have any large items come up, you can always file for reimbursement of your previous items at the end of the calendar year. The following illustration, which is based on an outpatient benefit of $1,000, may help you understand this benefit better:

In January - you go to the doctor for the flu. You have $100 in x-ray charges assessed, all of which are applied to your deductible.

In March – your child goes to the doctor for strep throat. You have $80 in lab charges assessed, all of which are applied to your deductible.

In August – your child goes to doctor because they have an eye irritation. The doctor runs a lab culture to rule out pink-eye. The out-of-pocket costs is $20 for this service.

In October – your spouse goes to the doctor because they are feeling tired, and the doctor runs blood work. The out-of-pocket costs is $30 for this service.

If at this point, either you, or your provider, file for reimbursement of the January, March, August and October events, as they occur, you will have used all four of your occurrences for the year.

If you then injure your knee in December and have an MRI totaling $1,000, you would have no further outpatient benefit to assist you with the large bill. Had you waited on filing the original four items, you would have had $1,000 of this expense paid by the plan, and you could have then filed three of the other events at your choosing. See the following table:

| **Events filed as they occur:** | | | **Events filed at end of year after Dec. event:** | | |
|---|---|---|---|---|---|
| EE Portion | GAP Pd | EE Balance | EE Portion | GAP Pd | EE Balance |
| $100 | $100 | $0 | $1,000 | $1,000 | $0 |
| $80 | $80 | $0 | $100 | $100 | $0 |
| $20 | $20 | $0 | $80 | $80 | $0 |
| $30 | $30 | $0 | $30 | $30 | $0 |
| $1,000 | $0 | $1,000 | $20 | $0 | $20 |
| $1,230 | $230 | $1,000 | $1,230 | $1,210 | $20 |

**In the above example, your wise use of your benefit would have meant the difference between being out of pocket $1,000 or $20.**

## OUTPATIENT BENEFIT II (OP2)

The outpatient benefit pays up to the maximum benefit selected per person per plan year for deductibles, coinsurance and co-pays applied under the primary medical plan for outpatient medical treatment of an injury or sickness.

**Outpatient Maximum Benefit**

- Per Covered Person: From $250 to $5,000 per Plan Year
- Per Family options: No maximum or 2 to 3 times the Per Covered Person Outpatient Maximum Benefit

**The Outpatient Benefit II does not cover physician office visit charges**. In order to have this type of charge covered, the Doctor's Office Visit Benefit would need to be issued with the Policy.

## OUTPATIENT BENEFIT II (Claim Examples)

These examples are only for illustrative purposes. The example assumes a $2,000 outpatient benefit, a 2x family maximum, and a calendar year benefit period (without a gap deductible).

**Employee Only** – the max this would pay is $2,000 per calendar year, regardless of how many claims submitted in the year.

**Employee plus Spouse** – the max this would pay is $2,000 per person per calendar year to a maximum of $4,000 for all covered persons, regardless of how many claims submitted in the year.

**Employee plus Children** – the max this would pay is $2,000 per person per calendar year to a maximum of $4,000 for all covered persons, regardless of how many claims submitted in the year.

**Employee plus Family** – the max this would pay is $2,000 per person per calendar year to a maximum of $4,000 for all covered persons, regardless of how many claims submitted in the year.

**Example 1**

| **Insured Person** | **Out-of-Pocket Cost** | **Benefit Amount** |
|---|---|---|
| Employee | $2,750 | $2,000 |
| Child 1 | $2,000 | $2,000 |
| Child 2 | $1,000 | $0 |
| Spouse | $500 | $0 |
| **Total** | **$6,250** | **$4,000** |
| | | **Total Paid by Insured = $2,250** |

**Example 2**

| **Insured Person** | **Out-of-Pocket Cost** | **Benefit Amount** |
|---|---|---|
| Employee | $2,250 | $2,000 |
| Child 1 | $1,500 | $1,500 |
| Spouse | $800 | $500 |
| Child 2 | $450 | $0 |
| **Total** | **$5,000** | **$4,000** |
| | | **Total Paid by Insured = $1,000** |

# SECTION 4: OPTIONAL DOCTOR'S OFFICE VISIT BENEFIT

**DOCTOR'S OFFICE VISIT BENEFIT**

Benefits are payable for covered charges for an injury or sickness for an examination of the Covered Person by a Doctor in the Doctor's office or Urgent Care Facility. Covered charges are subject to the Doctor's Office Visit maximum benefit shown in the schedule of benefits. Benefits are not payable for any other service or supply provided in the Doctor's office or Urgent Care Facility, including, but not limited to, charges for x-rays and laboratory services. The provider must use an office visit/consultation code in order for benefits to be paid under this section.

Outpatient Doctor's Office Visit Maximum:

- Per Person: The lesser of the benefit amount selected by the employer, or the actual office visit charge for physician's services for treatment of an injury or sickness. The maximum amounts range from $15 to $125 and number of visits range from 3 to 12.
- Per Family Options: No family maximum; or 2 to 3 times the Per Person Number of Visits

The Doctor's Office Visit Benefit is not available with a Health Savings Account (HSA).

The Doctor's Office Visit Benefit is not subject to any Benefit Period Deductible.

The intent of the Doctor's Office Visit Benefit is to cover the Doctor's services for the examination of the covered person (office visit), while the Outpatient or Combined Benefit is to cover treatment, supplies and other non-physician related outpatient charges.

# SECTION 5: DEDUCTIBLE OPTIONS

**Traditional Per Person Deductible with Optional Family Maximum Deductible**

- None – No Deductible
- Per Covered Person: $250 - $5,000 per plan year
- Per Family options: no family maximum; or 2 to 3 times per Covered Person Deductible

**Deductible applies to:**

- Inpatient and Outpatient or the Combined Benefit
- Accident and Sickness

*Notes:*
*• Benefits are payable for a Covered Person after they have satisfied either the "per Covered Person" deductible or the "per family" deductible has been satisfied, whichever comes first.*

**High Deductible (HSA Compatible)***

- The 2023 minimum is $1,500 and is subject to change by the IRS in future years
- Employee Only (Individual Coverage): $1,500 - $5,000 per Benefit Period
- Family (Family Coverage): $3,000 - $10,000 per Benefit Period (2x the Employee Only Deductible)

*Note: If dependent coverage is elected the entire Family Coverage Deductible must be met first before any benefits will be paid on any Covered Person. The Family Deductible may be satisfied by one or more Covered Persons.*

**To be HSA Compatible, the minimum Individual and Family Deductibles required by the IRS must be issued. The Deductible must apply to both the Inpatient and Outpatient Benefits and the Doctor's Office Visit Benefit may not be elected.*

**Health Savings Account (HSA) compatibility**

To qualify for an HSA, an individual must 1) have a High Deductible Health Plan "HDHP" and 2) have no other coverage except as permitted by regulation.

Other coverages permitted by regulation include: insurance for a specified disease or illness, insurance that pays a fixed amount per day (or other period) of hospitalization, worker's comp and coverage for accidents only, disability, dental care, vision care or long-term care. Individuals may also be covered by a second, non-HDHP health plan and remain HSA-eligible as long as the second plan has a deductible that equals or exceeds the statutory minimum HDHP deductible.

In order to be HSA Compatible, this GAP product must be sold with an Individual Coverage/Family Coverage deductible that equals or exceeds the statutory minimum HDHP deductible; and all benefits payable under the Policy must be subject to that deductible.

# SECTION 6: ELIGIBILITY AND ENROLLMENT

### Employer eligibility

Employer groups must meet these criteria in order to offer the Zurich GAP plan to their employees.

They must:

- Be situsedin or have a clearly defined division in an available state.
- Offer a Health Benefit Plan to employees that contains out-of-pocket expense responsibilities such as deductibles, coinsurance and/or copay requirements.
- Meet the product's group size and participation requirements. Minimum group size in most states is 2 enrolled employees.

### Employee eligibility

Employees are required to meet the following criteria to be eligible for coverage. They must be:

- A W-2 employee of an approved employer group. (1099 employees may be eligible with prior home office approval)
- Actively at Work
- Covered under a Health Benefit Plan (not including limited medical plans).

In order for a spouse or dependent child of an employee to be covered, he or she must:

- Meet the definition of an insured dependent.
- Be covered under a group Health Benefit Plan (not including limited medical plans).
- For a child, be under age 26, regardless of financial dependency, residency, student status, or marital status. (Dependent eligibility may vary by state.)

Employees are not eligible for coverage if the plan would exceed the overall individual inpatient out-of-pocket expenses under their Health Benefit Plan. 1099 employees of any arrangement are not eligible for coverage unless prior approval has been granted.

Coverage will automatically be extended to domestic partners if mandated by state law. In states where it is not mandated, the Employer may still choose to extend coverage to domestic partners at the time of initial group enrollment.

Newborn children, adopted children and children placed for adoption are covered on their date of birth, date of adoption or placement for adoption for a period of 31 days*. Coverage for such child may be extended beyond the initial 31-day period by notifying the Company in writing within 31 days of the child's birth, adoption or placement for adoption. The insured must pay any required additional premium.

*may vary by state

### Late enrollees

If an eligible employee does not apply for coverage on their initial eligibility date, they may not apply for coverage until the next policy anniversary date, unless: (a) they are allowed to enroll in, or change their enrollment in the employer's Health Benefit Plan because they qualify as a Special Enrollee as defined by law; or (b) they are allowed to enroll in the employer's Health Benefit Plan during an employer sponsored period of open enrollment.

### Premium payment

The Zurich GAP plan may be written to payroll groups only.

**Selective Industries*** – The following industries are considered "Selective" and require Zurich approval prior to quoting:

- Associations
- PEOs
- Non-profit groups
- Oil or Gas
- Construction
- Transportation
- Heavy Equipment Manufacturing or Repair
- First Responders
- Agriculture
- Forestry
- Textile Mills
- Logging or sawmills
- Railroads
- Trucking or warehousing
- Refuse Haulers
- Environmental Cleanup

***Requires prior carrier approval BEFORE quoting.**

**Restricted Industries** – The following industries should be automatically declined.

- Explosive, Ammunition or Gun assembly or manufacturing
- Heavy Manufacturing (blast furnaces, foundries, farm machinery, ship building)
- Armed Services - Military, Naval and/or Air Force Services or any operations actively engaged in war.
- Airline/Aircrew - Group policies for airline personnel and aircrew of commercial airlines for passengers or freight
- Nuclear Power Generation
- Underground Mining
- Ore Mining
- Professional Athletes
- Ship Building or Commercial Ship Crews
- Asbestos, Lead and Mold Abatement
- Asbestos Operations
- Black Powder Manufacturing
- Insulation Work
- Government funded organizations (not including municipalities or schools)
- MEWAs
- Employee Leasing Companies
- Non-Taft Hartley Unions
- Indian Tribes
- Cannabis Industries

# SECTION 7: ADMINISTRATIVE GUIDELINES

**Underwriting Guidelines for Referrals to Zurich home office underwriter (prior to quoting)**

- 5,000 or more eligible employees
- Any quote request that deviates from the general guidelines above
- Quote requests for Inpatient or Combined Maximums higher than $10,000 or where home office underwriting is otherwise indicated

**Policy issue guidelines**

This plan is a group product consisting of a master contract issued to the employer and certificates issued to participating employees.

**Dual plan option**

One GAP plan may be selected for each medical plan offered by the employer.

**Employee buy-up option**

If an Employer purchases a GAP plan and pays 100% of the employee only cost, they may also select an additional plan with higher benefit limits that the employee can choose to purchase as a buy-up option. The maximum inpatient or combined benefit amount for both the Employer-paid plan and the employee buy-up option may not exceed the total in-network out-of-pocket expense under the medical plan.

**Guaranteed issue**

This plan is a guaranteed-issue product. Employer groups must be covered under a Health Benefit Plan and meet participation requirements to qualify. Employers are responsible for selecting a plan that complements their Health Benefit Plan.

**Participation requirements**

Minimum group size is 2 enrolled lives, subject to state specific minimums.

For participation purposes, only employees covered under a Health Benefit Plan are considered eligible.

**Rates**

- Rates are age-banded (under 40, 40-49, and 50+) and are based on the employee's attained age on the effective date. A quoting tool/rater is available to eligible agents.
- Composite rates are also available.
- Dual Option composite rates are also available
- May be sold only to employer groups and unions (with prior approval)
- Premiums may be employer-paid, employee-paid or contributory
- Rates are reviewed on an annual basis.

Rates are based on:

- The insured employee's age
- The benefit amounts selected
- The family members covered
- Situs State*

*States with minimum loss ratio requirements that are greater than assumed for standard rates will require reduced commissions/expenses and a separate set of gross rates.

### Available Rate Structures

- 2-Tier: Employee; Employee + 1 or more
- 3-Tier: Employee; Employee + 1; Employee + 2 or more
- 4-Tier: Employee; Employee + Spouse; Employee + Child(ren); Employee + Family

### Waiver of premium

There is no waiver-of-premium provision for this product.

### Pre-existing conditions

This product does not specifically contain a pre-existing condition limitation. However, if a condition is not covered under the Health Benefit Plan, no benefit is available under the Zurich GAP plan.

### Policy effective dates

The following guidelines apply to the effective date of the policy:

- The application date must be earlier than the coverage effective date.
- All policies take effect on the first day of the month.

### Certificate effective dates

The following guidelines apply to individual certificate effective dates:

- The enrollment form date must be earlier than the coverage effective date.
- Coverage takes effect on the later of 1) the first day of the month following the acceptance of employee enrollment forms by the Company; or 2) the employee's effective date under the employer's Health Benefit Plan.
- The waiting period for employee coverage availability will match the group's Health Benefit Plan.
- In no event will coverage for any person take effect before the effective date of the group policy.

Note: An electronic census file should be submitted in lieu of enrollment forms. Certain guidelines and criteria must be met for electronic enrollment. Contact your Zurich sales rep to obtain these guidelines.

### Backdating

Coverage may not be backdated. Requests to bind coverage must be received on or before the effective date.

### Health Reimbursement Account (HRA) compatibility

The Zurich GAP plan is an HRA-compatible product. However, out-of-pocket expenses that are paid for using funds from an HRA will not be reimbursable expenses under GAP. Benefits under the GAP plan are only paid to an insured or to a provider if the benefits have been assigned.

### HIPAA & Portability

The Zurich GAP plan is not a portable product. When an employee leaves the employer, his or her coverage under the GAP plan will terminate. However, the GAP plan is COBRA eligible. If an insured continues medical coverage through their former employer under COBRA, they may continue the GAP plan as well. They must complete the appropriate COBRA enrollment form and submit it to their former employer with the required premium. The employer will forward this enrollment form with the premium to the premium administrator.

### COBRA Administration

COBRA administration of the GAP plan is the responsibility of the employer or the vendor chosen by the employer.

### Assignment of Benefits

If the covered person presents the Zurich GAP ID card to a provider and executes an "assignment of benefits", the carrier is obligated to honor that assignment of benefits and must pay the provider, whether or not the covered person paid the provider at the time of service.

Note: Assignments are global and apply to all insurance a person has. If the provider bill says benefits are assigned, we must pay the provider unless the provider indicates the bill has been paid in full and releases us from the assignment.

### Creation of advertising and marketing materials

Advertising is anything intended to generate interest in a specific insurance product, company or agent. This includes, but is not limited to, the following: web site information and other online services; product brochures; newsletters; agent recruiting materials; prospecting letters; print, radio, television and all forms of media advertising; illustration or presentation materials; and business cards and stationery.

Do not publish, advertise or promote any material concerning Zurich American Insurance Company or our contracts unless approved and authorized for such use in writing.

***Written approval from Zurich must be obtained before such material may be published or used in any way.*** Please plan sufficient time to allow for the review and approval process.

For example, you are authorized to use a comparison statement between a competitor's product and those offered by Zurich American Insurance Company only if that statement has been approved in writing by Zurich American Insurance Company prior to use.

### Marketing materials and forms usage

The insurance industry is state-regulated. For that reason, policies issued often vary by state regarding both the availability of a product and the forms required to sell the policy.

***If you have any questions regarding product availability or the differences in form requirements, please consult your Zurich sales rep.*** Under no circumstances should an agent assume that policies available in one state are available in another state, or that the required forms are the same.

## SECTION 8: SUBMITTING BUSINESS

### Enrollment requirements

We will need a New Group Set Up Sheet, the Employer Application, and the Employee Enrollment Census. Some employer applications are state specific; contact your sales rep for the appropriate forms. Once the enrollment is completed, you should submit the entire enrollment package to usz_gapmedical@zurichna.com in order for your case to be issued.

### Policy delivery

Once the group application has been processed and eligibility has been transmitted, the group master policy and employee certificates will be emailed in a PDF format with a welcome kit directly to the employer. The employer is responsible for distributing the certificates to the employees via email or hard copy.

### ID Card

GAP Medical ID cards will be issued to each insured person. This card should be presented to the medical provider along with the major medical ID card.

# SECTION 9: CLAIM INFORMATION

Claims may be filed by the insured for reimbursement or benefits may be assigned to the provider, if the provider accepts secondary or GAP-type coverage. ***Claims must be filed by submitting an itemized bill and the medical or comprehensive health insurance carrier's Explanation of Benefits to the Zurich approved claims administrator.***

Please note when an assignment of benefits exists, Zurich is legally obligated to make payment directly to the provider unless proof of payment in full is supplied by the insured.

Itemized bills must include diagnosis codes (ICD-9 or ICD-10 codes) and procedures codes (CPT codes). Balance due statements cannot be used to process claims.

The following information must be included on the EOB:
- Deductible
- Co-pay
- Coinsurance
- Dates of service

# SECTION 10: LIMITATIONS AND EXCLUSIONS

The following standard limitations and exclusions apply to the Zurich GAP product:

**Limitations**

**Health Benefit Plan.** If a Covered Person did not have a Health Benefit Plan on the Covered Person's Effective Date under the Policy, the Company's sole obligation will then be to refund all premiums paid for that Covered Person.

**Exclusions**

The Policy does not cover any loss, treatment, or services resulting from any of the following:

1. suicide or any attempt at suicide;
2. intentionally self-inflicted Injury or Sickness, while sane or insane;
3. declared or undeclared war, or any act of declared or undeclared war;
4. full-time active duty in the armed forces of any country or international authority;
5. any Injury or Sickness for which the Covered Person is entitled to benefits pursuant to any workers' compensation law or other similar legislation;
6. out-of-pocket medical expense paid or payable under any mandatory no fault automobile insurance law or mandatory basic reparations benefit of no fault;
7. the Covered Person's commission of or attempt to commit a felony, assault, sexual assault, riot or insurrection or any Injury resulting from the Covered Person's provocation of an attack against them;
8. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Covered Person is:
   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or the Covered Person;
9. skydiving, parasailing, parachuting, hang-gliding, bungee-jumping and participation in a contest of speed in power driven vehicles;
10. dental or vision services, including treatment, surgery, extractions, or x-rays, unless: (a) resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or (b) due to congenital disease or anomaly of a covered newborn child;
11. treatment or services for Injury and Sickness provided outside of the United States;
12. rest care or rehabilitative care and treatment (this does not include rehabilitation for treatment of physical

disability);
13. voluntary abortion except, with respect to the Covered Person: (a) where the Insured or the Insured's Dependent's life would be endangered if the fetus were carried to term; or (b) where medical complications have arisen from abortion;
14. elective cosmetic surgery (except newborn circumcision);
15. sterilization and reversal of sterilization;
16. any expense which is not Medically Necessary;
17. Prescription Drugs
18. any loss for which the Covered Person is not required to pay a Health Benefit Plan Deductible, co-payment and/or Health Benefit Plan Coinsurance under the Covered Person's Health Benefit Plan; and
19. any expense or benefit that is excluded under the Covered Person's Health Benefit Plan.

Note: The Zurich GAP plan is not available in all states. Some provisions, benefits and limitations or exclusions listed herein may vary by state. Contact your Zurich sales rep for a current list of available states for this GAP plan.

# SECTION 11: POLICY DEFINITIONS

The following policy definitions are used with the Zurich GAP policy. State variations may apply.

**Accident** means a sudden, unforeseen, unexpected, specific and abrupt external event that occurs by chance at an identifiable time and place while coverage is in effect under this **Policy** and that results in bodily **Injury**.
**Active** or **Actively at Work** means the **Insured** is able and available for active performance of all their regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Active at Work** provided the **Insured** is able and available for active performance of all his or her regular duties and was working the day immediately prior to the date of his or her absence.
**Benefit Period** means the period of time when benefits are payable. Unless stated otherwise on the **Schedule**, a **Benefit Period** is a **Plan Year**.
**Calendar Year** means a one-year period that begins on January 1 at 12:00 a.m. (midnight) and ends on January 1 at 12:00 a.m. (midnight) of the following year at the **Policyholder's** address.
**Certificate** means the Zurich Group Supplemental Medical Expense **Certificate**.
**Complications of Pregnancy** means a condition requiring **Hospital Confinement**, whose diagnosis is distinct from Pregnancy but adversely affected or caused by Pregnancy, such as: a) acute nephritis or nephrosis; b) cardiac decompensation; c) missed abortion; and d) similar medical and surgical conditions of comparable severity. **Complications of Pregnancy** will also include: a) non-elective cesarean section; b) termination of ectopic pregnancy; and c) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. However, the term **Complication of Pregnancy** will not include: a) false labor, occasional spotting, or morning sickness; b) **Doctor** prescribed rest; c) hyperemesis gravidarum; d) pre-eclampsia; or any similar condition associated with the management of a difficult Pregnancy not consisting of a nosologically distinct **Complication of Pregnancy**.
**Company** means Zurich American Insurance Company.
**Confined or Confinement** means a stay of 15 or more consecutive hours as a registered resident bed-patient in a **Hospital**.
**Covered Expenses** means expenses actually incurred by or on behalf of a **Covered Person** as a result of an **Accident** or **Sickness** for services or supplies covered under the **Covered Person's Health Benefit Plan**. The **Covered Expense** must be **Medically Necessary** for the condition being treated. A **Covered Expense** is deemed to be incurred on the date such service or supply that gave rise to the expense or the charge was rendered or obtained.
**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes the **Insured, Spouse** and **Dependent Child(ren)** if any.
**Dependent** means the **Insured's Spouse** and **Dependent Child(ren**).
**Dependent Child(ren)** means the **Insured's** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children from the date of the final decree of adoption or, if earlier, the date the child is placed by a court in the **Insured's** home pending such an order, any child living with the **Insured** in a regular parent-child relationship and primarily dependent on a **Covered Person** for support and maintenance, or any child for whom **We** have notice, pursuant to a medical support order, that the **Covered Person** must provide support from the date of such notice; who are:
1. under age 26; or
2. incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily

dependent on the **Covered Person** for support and maintenance as defined herein.
The **Company** may require proof of the **Dependent Child(ren)'s** incapacity and dependency within 60 days before the **Dependent Child(ren)** reached the age limit specified above. The **Company** may request that satisfactory proof of the **Dependent Child(ren)'s** continued incapacity and dependency be submitted to the **Company** on an annual basis. If the requested proof is not furnished within 31 days of the request, such child(ren) shall no longer be considered **Dependent Child(ren)** as of the end of that 31-day period.
For the purpose of this definition, "medical support order" is a valid order of a court, judicial department, or government agency at the local, state, or federal level that obligates the **Covered Person** to provide a child financial support.
**Doctor** means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a **Covered Person** that is appropriate for the conditions and locality. A **Doctor** will not include a **Covered Person** or a member of the **Covered Person's Immediate Family** or a **Household Member**.
**Durable Medical Equipment (DME)** means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of **Injury** or **Sickness** and is able to withstand repeated use;
2. Is used exclusively by the patient;
3. Is routinely used in a **Hospital** but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to the treatment of the patient's **Injury** or **Sickness**; and
5. Is prescribed by a Physician and the device is **Medically Necessary** for rehabilitation.

**DME** includes, but is not limited to: abdominal, back and arch supports; artificial limbs; diagnostic devices such as blood sugar test kits; elastic hosiery when prescribed by a Physician; wheelchairs; splints, crutches and orthopedic shoes, oxygen and oxygen equipment, fluoridation units and special beds when prescribed by a Physician. **DME** also includes wigs needed for severe hair loss due to medical treatment such as chemotherapy.
**DME** does not include: (a) comfort or convenience items; (b) equipment that can be used by **Immediate Family** or **Household Member** other than the patient; (c) health exercise equipment, corrective shoes, or exercise and sports equipment; or (d) equipment that may increase the value of the patient's residence including, but not limited to: modifications to the patient's property or automobiles, such as spas, air conditioners or vehicle hand controls. Modifications to the patient's residence such as ramps and elevators will be considered **DME** if such modifications will allow the patient to remain at home instead of being an Inpatient in a **Hospital** or skilled nursing facility.
**Eligible Employee** means an individual who, is **Actively at Work,** meets the qualification of one of the **Classes of Eligible Employees** and has completed any **Eligibility Waiting Period,** is eligible for coverage under this **Policy**. If the individual is covered by the **Company** under more than one **Policy** for the same **Accident** or **Sickness**, only one **Policy** will pay benefits, the **Policy** with the largest benefit for the same **Accident** or **Sickness**.
**Eligibility Waiting Period** means a period of continuously **Actively at Work** that an **Insured** must serve in order to qualify for coverage under this **Policy**. The length of any **Eligibility Waiting Period** is shown in the Schedule.
**Enrollment Period** means the period agreed upon by the **Policyholder** and **Us** when an **Eligible Employee** may enroll for coverage or an **Insured** may change benefit elections under this **Policy**.
**Health Benefit Plan** means the group major medical or comprehensive medical plan offered by the **Policyholder** that requires the **Covered Person** to pay a **Health Benefit Plan Deductible**, Co-Payment and/or portion of the **Health Benefit Plan Coinsurance**. **Health Benefit Plan** includes, but is not limited to, group or blanket insurance plans; group prepayment coverage plans; coverage under labor-management trusteed plans, union welfare plans, Employer organizational plans, Employee benefit organizational plans, self-funded plans, or other arrangements of benefits for persons of a group. **Health Benefit Plan** does not include any limited benefit health plans, Medicare, Medicaid, CHAMPUS, or TRICARE.
**Health Benefit Plan Coinsurance** means the dollar amount of **Covered Expenses**, after the **Health Benefit Plan Deductible** is applied, that are not payable under the **Insured's Health Benefit Plan**.
**Health Benefit Plan Deductible** means the dollar amount of **Health Benefit Plan Deductible** that applies to all the **Covered Expenses** under the **Insured's Health Benefit Plan**.
**Household Member** means a person who maintains residence at the same address as the **Insured** and is not a member of the **Immediate Family**.
**Hospital** means an institution that:
1. operates pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons;
2. provides 24-hour nursing service by Registered Nurses on duty or call;
3. has a staff of one or more licensed **Doctors** available at all times;
4. provides organized facilities for diagnosis, treatment and surgery, either:
a. on its premises; or
b. in facilities available to it, on a pre-arranged basis;
5. is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate

ward, wing or section of a **Hospital** used as such; and
6. is not a place for the aged.

**Immediate Family** means the **Insured's Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, stepparent, brother, sister, stepbrother, stepsister, child, child who has been legally adopted, or stepchild.

**Injury** means accidental bodily **Injury** caused by an **Accident**, which occurs while the **Covered Person** is covered under this **Policy** and the **Injury** must result directly and independently of all other causes. All **Injuries** sustained by the **Covered Person** in any one **Accident** shall be considered a single **Injury**.

**Insured** means an employee who is eligible for coverage under this **Policy** and who completes the enrollment material, if any.

**Life Status Change** means an event recognized by the **Policyholder** and **Us** that qualifies the **Insured** to make changes in coverage at any time other than an open **Enrollment Period**. The following events are all considered **Life Status Changes**:

1. marriage; partnership in a civil union; domestic partnership;
2. divorce, annulment or legal separation;
3. birth or adoption of a child;
4. change in a **Dependent Child's** eligibility;
5. death of a **Spouse**;
6. a change in the benefit plan or employment status of the **Insured's Spouse** that affects **Covered Person** eligibility for benefits.

**Medical Emergency** means a condition caused by an **Injury** or **Sickness** that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

**Medically Necessary** means a treatment, service or supply that is:

1. required to treat an **Injury** or **Sickness**;
2. prescribed or ordered by a **Doctor** or furnished by a **Hospital**;
3. performed in the least costly setting required by the condition; and
4. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered; and

a service or supply may not be **Medically Necessary** if a less intensive or more appropriate diagnostic or treatment alternative could have been used. **We** may consider the cost of the alternative to be the **Covered Expense**.

**Plan Year** means a consecutive 12-month period during which a **Covered Person's** coverage under this **Policy** is in force. The first **Plan Year** begins on the effective date of the **Certificate** under this **Policy** and ends after 12 consecutive months. **Dependents** will have the same **Plan Year** as the **Insured**.

**Policy** means this Group Supplemental Medical Expense Policy issued to the **Policyholder**.

**Policy Deductible** means the amount of expenses incurred each **Benefit Period** for **Covered Expenses** that a **Covered Person** must pay before benefits will be payable under this **Policy.**

**Policyholder** means the company named as **Policyholder** in the **Schedule**.

**Policy Period** means the period shown in the **Schedule**.

**Prescription Drug** means drugs dispensed by a licensed pharmacist for which the law requires a **Doctor's** written prescription. **Prescription Drugs** include insulin and the needles and syringes required for its administration, if the **Covered Person** has a **Doctor's** authorization for such supplies on record with the pharmacist.

**Sickness** means an illness, disease or condition of the **Covered Person** that causes a loss for which incurs medical expenses while covered under this **Policy**. **Sickness** includes both normal pregnancy and **Complications of Pregnancy**. All related conditions and recurrent symptoms of the same or similar condition will be considered one **Sickness.**

**Spouse** means any individual who, under applicable state law, is recognized as the husband, wife, or domestic partner of the **Insured**.

**Supplemental Medical Coinsurance** means the maximum percentage that **We** will pay under this **Policy** for **Covered Expenses** incurred by a **Covered Person**.

**Third Party** in the singular or plural means, but is not limited to, the following:

1. the party that caused the **Accident**, **Injury** or other medical condition and any insurer or indemnifier thereof;
2. the **Covered Person's** insurer (other than the **Company**) including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers, unless sponsored by the **Policyholder**; or
3. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Accident**, **Injury** or other medical condition.

**We, Our,** or **Us** means the insurance company underwriting this insurance.

**Underwritten by:**
Zurich American Insurance Company
Schaumburg, Illinois
Policy form number: USME 100 A
Zurich American Insurance Company has been rated A+ (Superior), based on an analysis of financial position and operating performance, by A. M. Best Company, an independent analyst of the insurance industry. For the latest rating, access www.ambest.com.

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