ZURICH

Supplemental Gap Medical Insurance

Helping employers and employees bridge gaps in health coverage

Higher premiums, higher deductibles and higher copays…

It's become an undeniable fact that, for many individuals, even strong, comprehensive health insurance may not be enough to manage rising medical costs. According to a survey, nearly half of U.S. adults say "it is very or somewhat difficult for them to afford their healthcare costs."[1] Additionally, more than a third of respondents said they are worried about being able to afford their monthly health insurance premium.[1]

Of course, responsible employers who offer healthcare insurance to employees work hard to find the best available plan, balancing coverage needs and expenses. But many health insurance plans still require high deductibles. Fortunately, there is a way to help bridge the gap in coverage.

Zurich's Supplemental Gap Medical Insurance is designed to help limit exposure to out-of-pocket medical expenses by providing coverage when employees have not met their healthcare deductible. With flexible plans to help meet the needs of different employer groups, Supplemental Gap Medical Insurance can give companies and the people who work for them greater peace of mind.

The Zurich Advantage

Zurich's Supplemental Gap Medical Insurance offers many efficiencies and conveniences that add to the value of your organization when offering it as an option for employees:

- A gap plan reduces an insured's exposure to deductible and coinsurance charges.
- New plan versions include coverage for mental/nervous conditions, substance abuse treatment, newborn nursery care and durable medical equipment.
- Spreadsheet enrollments are accepted
- Composite rates are available for all groups
- Minimum enrollment is two lives. No participation requirements (unless required by state law).
- **Claim form is not required.**

Key features

- Coverage provided for most inpatient and outpatient services covered by the underlying primary healthcare plan and applied to the deductible or coinsurance provision.
- Benefits are paid directly to the medical service provider when an assignment of benefits exists.
- Employers can choose a variety of coverage options. Inpatient and outpatient benefits can be different, or a combined benefit covering both inpatient and outpatient benefits can be requested. Deductibles can be added to the plan to manage premium costs.
- Plans can also include benefits for doctor's office visits.
- Employer-paid, voluntary, and dependent buy-up options are available. Monthly premiums can be based on the employee's attained age or a composite rating for the group can be provided.
- Coverage can be tailored to be compatible with high-deductible health plans using health savings accounts. (Plan must include a minimum deductible determined by the IRS).
- Coverage can be layered with other Zurich Accident & Health benefits including Critical Illness Insurance, Group Personal Accident coverage, and Hospital Indemnity Insurance.
- Guaranteed Issue and no pre-existing condition limitations.

Plan features

- Inpatient benefits up to $10,000 per covered person per benefit year (family limit options: 2x or 3x).
- Outpatient benefit type I is available for up to $5,000 per occurrence (limited to 2 occurrences per person and 4 occurrences per family per benefit year).
- Outpatient benefit type II is available for up to $5,000 per covered person per benefit year (family limit options: 2x or 3x).
- Plans may include an optional Outpatient Doctor's Office Visit Benefit for maximum coverage
- Plans may include a Deductible Option (Traditional and Health Savings Account compatible options).
- Dual plan options and buy-up options are available.

Inpatient hospital benefit

Supplemental Gap Medical Insurance from Zurich coverage pays benefits for eligible charges an insured person incurs while confined in a hospital as a registered bed patient due to an injury or sickness. The expenses must be covered by the insured person's primary medical plan and applied to the deductible, copayment or coinsurance. (Covered charges are subject to the Inpatient Hospital Maximum Benefit.) Coverage is automatically included for an insured person's newborn child from the moment of birth until the next premium due date or 31 days, whichever is later if the charges are covered under the Medical Plan.

Covered expenses include:

- Inpatient hospital stays
- Inpatient surgeries
- Physician's in-hospital charges
- Pregnancy, including doctor's global fee
- Treatment for mental/nervous conditions
- Routine newborn care
- Durable medical equipment (dispensed while hospital confined)

The Inpatient benefit maximum selected by the employer may not exceed the insured person's total in-network, out-of-pocket exposure under the employer's medical plan (including deductible, coinsurance and copays).

Example - Covered Hospital Confinement		
A Hospital Stay & Surgery = $15,000 Total Expenses		
	Without GAP	With 5,000 Inpatient GAP Benefit
Deductible	$3,000	$3,000
Coinsurance (20%)	$2,400	$2,400
Total Out-of-Pocket	$5,400	$5,400
Inpatient Benefit	$0	$5,000
Total Out-of-Pocket	**$5,400**	**$400**

Outpatient benefits (Employer may elect Outpatient I or II)

This optional benefit pays the deductible and coinsurance up to the selected Benefit Year maximum for medically necessary 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 can only be paid if the Doctor's Office Visit Benefit is also elected by the employer.

Benefits are limited to the difference between the benefit paid by the group Major Medical/Health Benefit Plan and the actual covered outpatient expenses incurred, up to the maximum plan design limits. The Outpatient Benefit maximum may not exceed the Inpatient Benefit maximum selected.

Covered charges include, but are not limited to:

- Surgery in an outpatient facility or a physician's office
- Emergency room treatment of injury or sickness
- Diagnostic testing, lab and X-ray at a diagnostic or hospital outpatient facility or at a physician's office, if the cost is not included in the global office visit fee and is not part of wellness/preventive care
- Outpatient radiation therapy or chemotherapy
- Physical therapy or chiropractic care
- Durable medical equipment
- Ambulance
- Infusion therapy

Outpatient benefit type I

This benefit pays on a "per person per sickness or injury" basis, up to a maximum of two occurrences per person and four occurrences per family per benefit year. This maximum applies to the entire family unit, regardless of the number of insured 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 benefit year period. However, if an insured person is treatment-free, at any time for a least 90 consecutive days, they may qualify for an additional outpatient maximum benefit if the per person or per family maximum per benefit year has not been met.

Example - Outpatient Benefit I

Example demonstrates the total out-of-pocket cost with and without a GAP plan. The example assumes the employee has family coverage and a $2,500 Outpatient I benefit that includes 4 occurrences.

Occurrences	Out-of-Pocket Cost	Benefit Amount
Occurrence #1 – concussion	$2,750	$2,500
Occurrence #2 – broken leg	$2,000	$2,000
Occurrence #3 – busted chin	$1,000	$1,000
Occurrence #4 – bursitis	$500	$500
Occurrence #5 – diabetes	$500	$0
Total	$6,750	$6,000

Total paid by Insured after plan benefit is paid = $750

Outpatient benefit type II

This benefit pays on a "per-person per-benefit year" basis. A family maximum limit may be selected at either two (2) times or three (3) times the "per-person" limit. This maximum applies to the entire family unit, regardless of the number of insured persons within the family unit. However, the benefit payable for no one person within the family unit can exceed the "per-person" limit.

Example - Outpatient Benefit II

Example demonstrates the total out-of-pocket cost with and without a GAP plan. Employee has family coverage and a major medical plan with a $3,000 deductible.

Example assumes a $2,500 Outpatient II Benefit.

	Out-of-Pocket Cost	Benefit Amount
Employee's outpatient expenses	$2,750	$2,500
Child's outpatient expenses	$1,000	$1,000
Spouse's outpatient expenses	$500	$500
Total	$4,250	$4,000

Total paid by Insured after plan benefit is paid = $250

Combined Inpatient/Outpatient benefit ("One Bucket")

In place of separate benefits for inpatient and outpatient expenses, plans may include a Combined Single Limit benefit amount, providing a simplified structure by combining inpatient and outpatient benefits. All eligible inpatient and outpatient charges accumulate to the Combined Benefit Maximum. This simplifies the claims process, and the insured person will not have to track separate expenses.

This benefit does not cover expenses incurred for examination by a doctor, which can only be paid if the Doctor's Office Visit Benefit is also elected by the employer.

Doctor's office visit benefit

This optional benefit pays for covered charges for an injury or sickness for the examination of the Insured Person by a physician in the physician'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 physician'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 for benefits to be paid under this benefit.

Note: The benefit is not available with a Health Savings Account (HSA). This benefit is not subject to a deductible.

Deductible options

All plans have the option to include a Traditional (non-HSA) or High (HSA) deductible.

Traditional (non-HSA) per person deductible with an optional family deductible

Benefits are payable for an insured person after they have satisfied either the "per insured person" deductible or the "per family" deductible, whichever is satisfied first.

High (HSA) per person deductible

- Per insured: $1,400 or $5,000 per benefit year (subject to the IRS minimum deductible)
- Per family: 2 times the per insured amount

When dependent coverage is elected, benefits are payable only after the entire family deductible has been satisfied. The family deductible may be satisfied by one or more insured persons. To be HSA-compatible, the minimum per insured and family deductibles required by the IRS must be issued. The 2023 minimum HSA deductible is $1,500. This is subject to change by the IRS in future years. Additionally, the Doctor Office Visit Benefit may not be offered.

Ease of use for employees

Zurich's Supplemental Gap Medical Insurance is designed to benefit employees as well as their employers. Here's how it works for covered employees:

- Insureds will receive a Certificate of Insurance outlining their plan of benefits and the terms, conditions and limitations of the coverage.
- Each covered employee will also receive an ID card that can be presented to medical providers along with the primary medical plan's ID card. Payment of benefits will be made to the medical provider when an assignment of benefits exists. Employees may have little or no up-front, out-of-pocket costs when they present their gap ID card to a provider.
- Claiming benefits is an easy process. The covered person or the provider must submit copies of fully itemized bills and copies of the corresponding EOBs (Explanation of Benefits) from the underlying major medical carrier. (Claims may be filed at any time but must be filed no longer than 12 months from the date of service to be eligible for coverage.)

Supplemental Gap Medical Insurance can help companies:

- Recruit and retain top talent
- Decrease healthcare expenses by supplementing higher-deductible plans.

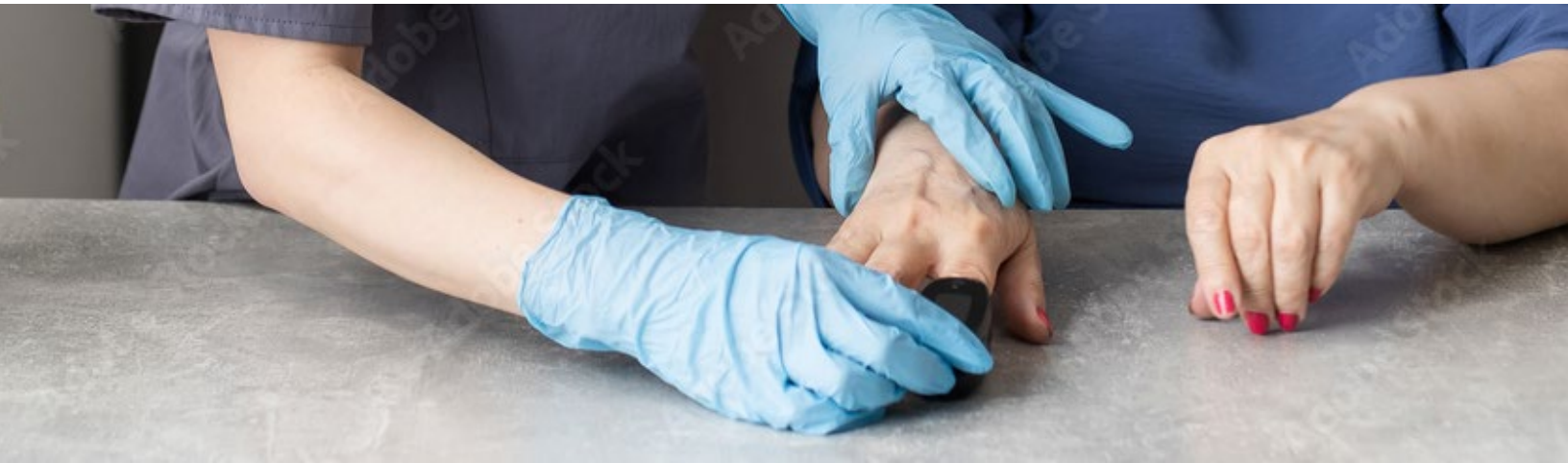
Additional details

- Expenses must be the result of medically necessary treatment for a covered injury or sickness.
- Expenses must be covered by the insured person's major medical plan and be applied to an out-of-pocket expense (deductible, coinsurance or copay).
- The major medical plan's EOB (explanation of benefits) is used as a basis for determining the eligible out-of-pocket expense, along with an itemized bill that includes procedures 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.

Plan exclusions

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. 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
7. 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
    c. Performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft
8. Skydiving, parasailing, parachuting, hang-gliding, bungee-jumping and participation in a contest of speed in power-driven vehicles
9. 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
10. Treatment or services for injury and sickness provided outside the United States
11. Rest care or rehabilitative care and treatment (this does not include rehabilitation for treatment of physical disability)
12. 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 an abortion
13. Elective cosmetic surgery (except newborn circumcision)
14. Sterilization and reversal of sterilization
15. Any expense which is not medically necessary
16. Prescription drugs
17. 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
18. Any expense or benefit that is excluded under the Covered Person's Health Benefit Plan



Underwritten by Zurich American Insurance Company

To learn more about Zurich Supplemental Gap Medical Insurance, contact your broker or your Zurich representative, or visit us online at www.zurichna.com/insurance/accident/gap-health-insurance or send us an email at usz.lifeaccidenthealth.com.

Reference:

1. Montero, Alex, et al. "Americans' Challenges with Health Care Costs." KFF (Kaiser Family Foundation). 14 July 2022.

Zurich

1299 Zurich Way, Schaumburg, IL 60196-1056

800 982-5964 www.zurichna.com

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