



Inpatient Benefit • Outpatient Benefit • Benefits Paid Directly to You • [Learn More »](#)

Hospital GAP PLAN Choice[®] Insurance

This is a supplemental limited benefit medical expense insurance policy. This product is inappropriate for people who are eligible for Medicaid coverage. This brochure highlights important features of the policy. Please refer to your certificate for complete details.



How Would You Cover Your Out-of-Pocket Costs??

CONSIDER THE FACTS



Hospital costs average \$2,447 per person per day.¹

American Fidelity's Hospital GAP

PLAN Choice® Insurance provides coverage for you and your family to help with your share of unforeseen medical expenses.

¹ AHRQ Healthcare Cost and Utilization Project, National Inpatient Sample as of November 10, 2017.

Rising health care costs can be a financial concern. *When faced with a hospital expense, how would you manage to pay your share, including the deductible and co-pays?* Hospital GAP PLAN Choice® Insurance can help!

American Fidelity Assurance Company's Hospital GAP PLAN Choice® Insurance is a supplemental, limited benefit medical expense policy that is designed to help pay the deductible and co-insurance when you or a family member are confined in the hospital.

See How the Plan Works!

Let's assume your major medical plan deductible is \$1,500 and your co-insurance is 80/20 with a total out-of-pocket maximum of \$2,500. Our hypothetical example is based on a \$2,000 Inpatient Benefit and \$800 for our Outpatient Benefit.

Example: Hospital Stay and Surgery, totaling \$10,000

Inpatient Benefit Payment Example*	Without Hospital GAP PLAN Choice® Insurance Coverage	WITH Hospital GAP PLAN Choice® Insurance Coverage
Deductible:	\$1,500	\$1,500
Coinsurance:	\$1,000	\$1,000
Total Out-of-Pocket:	\$2,500	\$2,500
Hospital GAP PLAN Choice® Insurance:	\$0	\$2,000
Your Out-of-Pocket Cost:	\$2,500	\$500

Example: One week of radiation, totaling \$10,000

Outpatient Benefit Payment Example*	Without Hospital GAP PLAN Choice® Insurance Coverage	WITH Hospital GAP PLAN Choice® Insurance Coverage
Deductible:	\$1,500	\$1,500
Coinsurance:	\$1,000	\$1,000
Total Out-of-Pocket:	\$2,500	\$2,500
Hospital GAP PLAN Choice® Insurance:	\$0	\$800
Your Out-of-Pocket Cost:	\$2,500	\$1,700

**These are hypothetical examples and are for illustrative purposes only.*

INPATIENT HOSPITAL BENEFIT

What it Covers:

- Inpatient hospital stays
- Inpatient surgery
- Physician expenses from inpatient stay
- Lab expenses from inpatient stay

How it Pays:

The Inpatient Hospital Benefit pays the difference between the actual hospital expenses you incur as an inpatient and the amount your primary medical plan covers.

OUTPATIENT BENEFIT

What it Covers:

- Treatment in a hospital emergency room
- Outpatient surgery
- Treatment in a hospital
- Free standing outpatient surgery center
- Outpatient diagnostic testing

Repeat visits for the same or related conditions will be subject to a single maximum outpatient benefit. After 90 consecutive days without a related condition, a new maximum outpatient benefit will apply.

How it Pays:

The Outpatient Benefit pays the difference between the actual outpatient expenses incurred and the amount paid by your primary medical plan.

PHYSICIAN OFFICE VISIT BENEFIT

What it Covers:

Qualified visits are for outpatient treatment due to sickness, or outpatient emergency care for an injury. The covered person must be covered by a primary medical plan, when such charges are incurred at a Hospital outpatient clinic, free-standing emergency care clinic, or Physician's office.

ADDITIONAL PLAN INFORMATION

Effective Date of Coverage:

This plan will take effect on the application's requested effective date, or on an adjusted effective date as assigned by American Fidelity upon application approval, whichever is later, if:

- underwriting rules are met;
- such person is on active employment;
- such person is covered under a Major Medical Plan; and
- premium has been paid.

Important Plan Details:

- Benefits are paid directly to you and you are responsible for paying the providers.
- The policy does not cover 100% of out-of-pocket costs.
- This is not Major Medical Coverage.
- This coverage cannot be used with a Health Savings Account.
- Actual expense means after any discounts or reductions take place as negotiated between the primary medical carrier and the service provider.

Coverage Available For:

- Employee
- Spouse, and/or
- Children

Your Maximum Reimbursement:

Benefit amounts available range from \$1,000, \$2,000, and \$3,000 per confinement for qualified out-of-pocket expenses for injury or sickness. Your reimbursement can not exceed the benefit amount you initially select under this plan.

How Long of a Hospital Stay is Required?

A hospital stay of 18 consecutive hours or over is considered an Inpatient Benefit. Anything under 18 hours is considered an Outpatient Benefit (see below).

Your Maximum Reimbursement:

- The plan covers qualified out-of-pocket expenses for injury or sickness (depending upon the plan selected) up to a maximum outpatient benefit of:
- \$800 or \$1,200 for outpatient surgery or treatment performed in a Hospital or a Free-Standing Outpatient Surgery Center;
- \$200 or \$300 for outpatient diagnostic testing procedure performed in a hospital or a Free-Standing Magnetic Resonance Imaging (MRI) Facility; or
- \$100 or \$150 for outpatient treatment in a Hospital Emergency Room, without the covered person subsequently being considered an inpatient.

How it Pays:

The Physician Outpatient Treatment Benefit provides reimbursements for physician visits at \$25.00 per visit, for up to five visits (\$125.00) per family per calendar year for out-of-pocket covered charges. See your certificate for benefit amounts

Plan Eligibility:

To be eligible for this coverage, you must be an active permanent full-time employee:

- Working 18 hours or more per week.
- Covered under another Major Medical Plan.
- Under the age of 70 (This limit does not apply if you work for an employer employing 20 or more employees on a typical work day in the preceding calendar year).

Hospital:

The term "Hospital" shall not include an institution, or part thereof, used by you as:

- a place for rehabilitation;
- a place for rest or for the aged;
- a nursing or convalescent home;
- a long-term nursing unit or geriatrics ward; or
- an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Benefits excluded or not covered:

Only charges approved by the group major medical carrier or the comprehensive carrier maybe considered under this plan. If this plan is Employer Paid, the pre-existing condition exclusion will not apply. For a list of all exclusions, please refer to your certificate.

Exclusions include:

- suicide or any attempt, thereat, while sane or insane);
- any intentionally self-inflicted injury or sickness;
- rest care or rehabilitative care and treatment;
- routine newborn care during the initial hospital confinement period, including routine nursery charges;
- voluntary abortion except, with respect to you or your covered dependent spouse, where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from abortion;
- pregnancy of a dependent child;
- participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- commission of a felony;
- participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
- air travel, except:
 - as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - as a passenger for transportation only and not as a pilot or crew member;
- intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
- alcoholism or drug use, unless such drugs were taken on the advice of a physician and taken as prescribed;
- sex changes;
- elective surgery, including complications of elective surgery;
- experimental treatment, drugs, or surgery;
- pre-existing conditions, unless the covered person has satisfied the 12-month pre-existing condition exclusion period; **"Pre-Existing Condition"** means a disease, Injury, Sickness, or physical condition for which the Covered Person: had treatment; incurred expense; took medication; or received a diagnosis or advice from a Physician, during the 12 month period of time immediately before the Covered Person's Effective Date of coverage. The term "Pre-Existing Condition" will also include conditions which are related to such disease, Injury, Sickness or physical condition. See rate insert for applicability.
- performance of military, naval, or air force service of any country;
- injury or sickness arising out of and in the course of any occupation for compensation, wage or profit (This does not apply to those sole proprietors or partners not covered by Workers' Compensation.);
- dental or routine vision services, unless:
 - resulting from an Injury occurring while the covered person's coverage is in force and if performed within 12 months of the date of such Injury; or
 - due to congenital disease or anomaly of a covered newborn child;
- routine examinations, such as health exams, periodic check-ups, or routine physicals;
- air or ground ambulance; or
- any expense for which benefits are not payable under the covered person's other medical plan.

The Hospital GAP PLAN Choice® Insurance policy may exclude expenses that are covered under the underlying major medical plan. In those instances, there may be out-of-pocket expenses that are not covered under Hospital GAP PLAN Choice® Insurance. Coverage will continue as long as the group policy remains in force, the premiums are paid and the insured remains eligible for coverage under the policy. Your coverage will end when you no longer qualify as an Insured, you retire, you are not on Active Service, or your coverage under Another Medical Plan ends. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.



View and print your policies plus file a claim at americanfidelity.com.

American Fidelity's Online Service Center provides you convenient, secure 24/7 access to manage your account or file a claim. All you need is the EOB (Explanation of Benefits) and itemized bill from your major medical provider!

This policy is endorsed/sponsored by an association or issued through a trust in which the employer is a member, is intended to be covered by ERISA, and will be administered and enforced in accordance with ERISA. If you reside in a state other than your employer's state of domicile, where required by law, policy provisions and benefits may vary.



9000 Cameron Parkway • Oklahoma City, Oklahoma 73114 • 800-654-8489
www.americanfidelity.com

Hospital GAP PLAN Choice[®] Insurance

Monthly Rates with PHYSICIAN OFFICE VISIT BENEFIT

VOLUNTARY INPATIENT HOSPITAL PLAN MAXIMUM

	Hospital GAP PLAN Choice [®] Insurance		
	\$1,000	\$2,000	\$3,000
Under 55:			
Employee Only	\$29.00	\$38.50	\$56.50
Employee and Spouse	\$49.40	\$66.50	\$98.90
Employee and Child(ren)	\$44.50	\$59.70	\$88.50
Employee and Family	\$64.90	\$87.70	\$130.90
Ages 55-59:			
Employee Only	\$41.40	\$55.70	\$82.70
Employee and Spouse	\$71.80	\$97.50	\$146.10
Employee and Child(ren)	\$56.90	\$76.90	\$114.70
Employee and Family	\$87.30	\$118.70	\$178.10
Ages 60 and Over:			
Employee Only	\$66.20	\$90.00	\$135.00
Employee and Spouse	\$116.40	\$159.20	\$240.20
Employee and Children	\$81.70	\$111.20	\$167.00
Employee and Family	\$131.90	\$180.40	\$272.20
	Outpatient Benefits		Outpatient Benefits
Emergency Room	\$100.00		\$150.00
Diagnostic X-Ray & Lab	\$200.00		\$300.00
Outpatient Surgery	\$800.00		\$1,200.00

Hospital GAP PLAN Choice[®] Insurance Premium \$ _____

Your Payroll Deduction Amount Per Paycheck is \$ _____

This is a supplemental limited benefit medical expense insurance policy. Pre-existing conditions will not be covered for the first 12 months from your effective date. This insert must be used in conjunction with SB-30111 and any state specific deviations thereof. This brochure highlights important features of the plan. Please refer to your certificate for complete details. If you reside in a state other than your employer's state of domicile, where required by law, policy provisions and benefits may vary. Rates are guaranteed not to increase during the initial term period. However, they will increase upon renewal. For actual benefits, limitations, exclusions and other provisions, please refer to the policy.



9000 Cameron Parkway • Oklahoma City, Oklahoma 73114 • 800-654-8489
www.americanfidelity.com