

Gap Summary of Benefits



Plan Year Benefit Amounts Available.

Employee Only: \$500 - \$10,000

Employee plus Spouse or Employee plus Child(ren): \$1,000 - \$20,000

Employee plus Family: \$1,500 - \$30,000

Plan Type	Definition of Covered Fees
HMO	Inpatient and Outpatient Copayments up to Coverage Limit
EPO	Deductible & Co-Insurance up to the Coverage Limit
High Deductible Health Plans	HDHP minimum individual deductible of \$1,600/Family \$3,200
	After GAP Deductible, Inpatient and Outpatient expenses up to the Coverage Limit

HOSPITAL IN-PATIENT BENEFITS

We will pay Hospital Inpatient Benefits equal to 100% of any deductibles or coinsurance for which You are responsible under Your Primary Medical Policy, up to the Maximum Annual Inpatient Benefit each Plan Year, for You or a Covered Person's Inpatient Hospital Stay covered under Your a Plan Year Deductible, if any.

Expenses incurred during an Inpatient Hospital Stay are covered under the Hospital Inpatient Benefit, including:

- Hospital charges for room and board
- Hospital miscellaneous charges including operating room, equipment, supplies, and drugs
- Intensive Care unit charges
- Physician charges incurred during the stay

When filing a claim – if you have already paid the provider, it is necessary to submit the Explanation of Benefits provided by Your Primary Medical Policy, or other documentation showing amounts for which You are responsible for under Your Primary Medical Policy.

OUTPATIENT BENEFITS

The Plan will reimburse Outpatient expenses equal to 100% of any deductibles or coinsurance as outlined below for which You are responsible under Your Primary Medical Policy and not covered under the Health Screening and Diagnostic Benefit or the Health Treatment Benefit, up to the Maximum Annual Outpatient Benefit each Plan Year, for You or other Covered Persons who are covered under the Primary Medical Policy.

Expenses for Outpatient Benefits include:

- Facility and Physician expenses for outpatient surgery in a Hospital or free-standing outpatient surgery center
- Facility and Physician expenses for outpatient diagnostic testing in a Hospital or free-standing imaging facility or free-standing laboratory
- Hospital and Physician expenses for treatment in an emergency room Hospital and Physician expenses for other outpatient treatment in a Hospital
- Pays the out-of-pocket (deductible and co-insurance) amount for these physicians' covered charges.
- Diagnostic lab work, Diagnostic Radiology, and Minor Surgical procedures performed in covered settings,
- including office. Diagnostic testing (i.e., allergy, cardiology, and pulmonary testing) are not covered when performed in an office setting. This coverage will not pay any benefit for the physician's office visit fee charged by a physician or specialist.

When filing a claim- if you have already paid the provider, it is necessary to submit the Explanation of Benefits provided by Your Primary Medical Policy, or other documentation showing amounts for which You are responsible for under Your Primary Medical Policy.



AMETRUST® GAP EXCLUSIONS

No benefits are payable under the coverage for any expenses

- a) incurred during ant period, Covered Person does not have coverage under a Primary Medical Policy.}
- b) for benefits excluded under the Covered Person's Primary Medical Policy.}
- c) for Co-payment amounts charged under the Employer's Other Plan including Doctor Office and Prescription Copays.}
- d) for additional services provided in a primary care physician's office unless the service is specifically covered under the outpatient diagnostic schedule of benefits.
- e) Non-Covered Physicians or Equipment (without a rider)
 - o Therapist (Physical, Speech, and Occupational)
 - o Psychiatrist
 - o Podiatrist
 - o Optometrist
 - o Hearing Aid Specialist
 - o Chiropractors
 - o Durable Medical Equipment (DME)
- f) for non-prescription drug or Outpatient prescription drug charges;}
- g) outpatient routine newborn care (except newborn circumcision;}
- h) rest care or rehabilitative care and treatment;}
- i) voluntary abortion except, with respect to the covered member or covered eligible dependent: where the covered member or dependent's life would be endangered if the fetus were carried to term or where medical complications have arisen from abortion;}
- j) sex changes;}
- k) experimental treatment, drugs, or surgery;}
- l) dental or vision services, including treatment, surgery, extractions, or x-rays, unless 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 due to congenital disease or anomaly of a covered newborn child;}
- m) elective cosmetic surgery;}
- n) sterilization or reversal of sterilization;}
- o) for charges that are not eligible for reimbursement under the Employer's Other Plan;}
- p) charges for medical care, treatment and services, or portions thereof, that are in excess of what is deemed allowable by the Employer's Other Plan;}
- q) for charges for medical care, treatment and services that are incurred at a provider that is not included in the provider network of the Employer's Other Plan, unless otherwise covered under the Employer's Other Plan.}
- r) with respect to Late Enrollees only, during the first 30 days of coverage under the coverage.}
- s) during any period, Covered Person does not have coverage under a Primary Medical Policy.}
- t) for benefits excluded under the Covered Person's Primary Medical Policy.}
- u) due to intentionally self-inflicted injuries, suicide, or any attempt thereat while sane or insane;}
- v) due to declared or undeclared war or any act thereof;}
- w) due to the Covered Person's commission of a felony;}
- x) due to work-related Injury or Sickness;}
- y) from the Covered Person's voluntary participation in a riot, civil commotion or disobedience, or unlawful assembly.}
- z) out of Network services are not included