GAP COVERAGE - PARTICIPANT FREQUENTLY ASKED QUESTIONS

1. What is the purpose of Gap coverage: Gap coverage is an insured out of pocket medical expense funding mechanism that is designed to:
    a. Provide the dollars needed to help health insurance plan participants pay out of pocket medical expenses included in most health insurance plans, i.e. Deductibles, co-insurance percentages, and some co-payments.
    2.
3. Does Gap coverage pay a benefit for all types of out of pocket medical expenses?
    a. No! In order to receive benefits the medical out of pocket expense must be:
        i. Medically necessary treatment of an injury or sickness; and
        ii. Covered by an underlying health insurance plan and applied to the deductible, coinsurance or co-pay provisions of such plan; and
        iii. An eligible expense under the gap plan
        4.
5. Is Gap coverage designed to relieve the participant of all out of pocket medical expense responsibility/liability?
    a. No! Gap coverage is designed, primarily, to protect participants against:
        i. Major out of pocket medical expense events.
            1. Events such as in-patient hospital expenses, out-patient surgical expenses, out-patient radiological diagnostic tests, etc.
            2. Typical plan designs DO NOT include payment for routine out-patient office visits charges, and prescriptions.
    6.
7. How does Gap coverage differ from other out of pocket medical expense funding mechanisms, like H.S.A's, H.R.A's, and F.S.A's?
    a. Gap plans are an insurance product. Participants pay a premium to the insurance company to cover a pre-determined benefit amount. The premiums paid for the coverage level are usually less than the actual benefit paid out by the insurance company for the expense incurred.
    b. H.S.A.'s, H.R.A's, and F.S.A's are tax-favored accounts funded, either fully or partially, by the participant or the plan sponsor (employer).
    8.
9. Can Gap coverage be implemented in a group with an H.S.A, H.R.A., or F.S.A.?
    a. Yes! However, H.S.A. regulations do not allow an H.S.A participant to make contributions to an H.S.A if the participant has an insurance plan that will pay specifically for deductibles, co-insurance and co-payments. When implementing Gap coverage in an H.S.A. case, the employee will have to choose between the H.S.A. and the Gap plan as their preferred out of pocket medical expense funding mechanism.

10.

11. May an employee that is not covered by the employer's health insurance plan, but is covered by another health insurance plan, participate in the employer's Gap coverage, even though that employee is not covered by the employer's health insurance plan?
    a. Yes! As long as they are covered by a group medical plan and their employer does not limit participation to only those covered by the employer's plan.
    b. Benefits received will be based on the Gap plan design elected by the employer.

12.

13. Is the Gap coverage tier the participant elects required to match their health insurance plan tier election?
    a. No! An employee may elect a different coverage tier.
        i. Example, employee covers family under the health insurance plan, but elects to cover employee and child(ren) under the Gap coverage.

14.

15. Are there some types of out of pocket medical expense treatments we think are covered by a Gap plan that are not covered?
    a. Yes! Some examples include but are not limited to:
        i. Examples of treatments we think are covered but are probably not covered:
            1. Dependent "Child" Pregnancy:
                a. Benefits for Pregnancy and termination of Pregnancy under this provision are limited to an Insured or an Insured dependent spouse.
            2. Post-delivery Well Baby Care:
                a. No complications: if the baby is born healthy (no complications, injury, or illness etc...) regardless if its charges were applied to a separate deductible or coinsurance, the charges are NOT covered.
                b. Complications: If the baby was NOT born without complications please provide documentation, a bill with a sick baby diagnosis. Claim will be reviewed.
            3. Out of Network – Balance Billed Charges
                a. "Balance Billed" amounts are billed by the health insurance company as "Non-covered" medical treatments, so the "Must be covered by the underlying health insurance plan" rule would apply.

16. Are there some types of out of pocket medical expense treatments we think are NOT covered by a Gap plan that may be covered?
    a. Yes! An example:
        i. **Out-patient Doctor's Office "Procedure Charge":** While the "Visit Charge" is not covered, a charge for a "Procedure" performed by the physician during an office visit may be covered.

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GAP COVERAGE - PARTICIPANT FREQUENTLY ASKED QUESTIONS (CONTINUED)

17. Are dental and vision treatments covered under the Gap plan?

a. **Routine** dental and vision treatments that are typically covered under dental and vision insurance plans are typically not covered by the Gap plan.
b. **Medical** treatments for dental or vision conditions caused by illness or accident that are subject to payments under the group health insurance plan may be covered by the Gap plan.

18. How does the Gap Plan Out-patient benefit work?
    a. Each covered family unit has a maximum of 4 out-patient benefits per occurrence per calendar year. This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit. If you have employee only coverage, you have 4 occurrences to use in a calendar year. If you have dependent coverage, there are 4 occurrences to be used in the calendar year for the entire family unit. It is not a "per person per occurrence" maximum.
    b. An "Occurrence" happens when you are treated on an out-patient basis for an eligible medical expense. It does not matter how many doctors you see or what period of time the treatments span; all expenses related to the treatment of the condition you are diagnosed with will accrue towards your out-patient maximum for one occurrence. If, however, at any time you go treatment-free for 90 consecutive days or more *for that condition*, then resume treatments, the new round of treatments will be considered a new occurrence.
19. Is Durable Medical Equipment a covered expense?
    a. If dispensed by the provider as part of their everyday practice, Yes.
        i. Example: An ER department issuing crutches.
    b. If a prescription is issued for the equipment, No.
        i. Example: A prescription written for a C-PAP machine.

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GAP CLAIMS PROCEDURES

ASSIGNMENT OF BENEFITS

Insured and the Provider combined will send the required information to administrator.

1. PRESENT GAP ID CARD TO PROVIDER at time of treatment
    a. Note: Provider may not recognize this secondary coverage. If that happens ask the provider to call the 800# on the card for an explanation of coverage.
    20.
2. INFORMATION REQUIRED to assure timely claims payment
    a. Billing Invoice(s): what the provider submits to the health plan
        i. This provides diagnosis and procedure codes required by administrator.
    b. Health Insurance Co. Explanation of Benefits (EOB): accessible at carrier portal
        i. This provides information regarding what is being applied to the deductible and co-insurance.
    c. Claim Form: One time per calendar year, per covered person
        i. This provides updated insured data and the authorization to release medical information required by HIPAA.

MANUAL CLAIM

Insured will send the required information to administrator.

1. FOR REIMBURSEMENT PURPOSES at end of claim calendar year
    a. Note: to be used when card is not presented
    21.
2. INFORMATION REQUIRED to assure timely claims payment
    a. Billing Invoice(s): what the provider submits to the health plan
        i. This provides diagnosis and procedure codes required by administrator.
    b. Health Insurance Co. Explanation of Benefits (EOB): accessible at carrier portal
        i. This provides information regarding what is being applied to the deductible and co-insurance.
    c. Claim Form: One time per calendar year, per covered person
        i. This provides updated insured data and the authorization to release medical information required by HIPAA.
    d. Proof of Payment:
        i. Please retain all receipts of payment from services for submission.