AMERICAN FIDELITY ASSURANCE COMPANY

Inpatient Benefit • Outpatient Benefit • Benefits Paid Directly to You • Learn More »

Hospital GAP PLAN®

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.*

AMERICAN FIDELITY
a different opinion

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

CONSIDER THE FACTS

A day spent as an inpatient at an American hospital costs on average more than $4,000.[1]

American Fidelity's Hospital GAP PLAN® provides coverage for you and your family to help with your share of unforeseen medical expenses.

[1] *International Federation of Health Plans: 2013 Comparative Price Report, p.15; April 2014.*

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?*** The Hospital GAP PLAN® can help!

American Fidelity Assurance Company's Hospital GAP PLAN® 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® Coverage	WITH Hospital GAP PLAN® Coverage
Deductible:	$1,500	$1,500
Coinsurance:	$1,000	$1,000
Total Out-of-Pocket:	$2,500	$2,500
Selected GAP PLAN® Benefit:	$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® Coverage	WITH Hospital GAP PLAN® Coverage
Deductible:	$1,500	$1,500
Coinsurance:	$1,000	$1,000
Total Out-of-Pocket:	$2,500	$2,500
Selected GAP PLAN® Benefit:	$0	$200
Your Out-of-Pocket Cost:	**$2,500**	**$2,300**

**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.

Your Maximum Reimbursement:

Benefit amounts available range from $1,000 to $5,000 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. (Our plan is for $2000)

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).

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.

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 $200.00.

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.

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. See your certificate for benefit amounts

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

Plan Eligibility:

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

- Working18 hours or more per week.
- Covered under your employer's 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).

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;
- 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 except for medical complications due to pregnancy;
- 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® 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®. 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.

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

AMERICAN FIDELITY ASSURANCE COMPANY

Hospital GAP PLAN®

Monthly Rates

VOLUNTARY INPATIENT HOSPITAL PLAN MAXIMUM

	Hospital Gap Plan® Benefits	
	$2,000	Our plan is for $2000 maximum in-patient benefit. These are monthly premium amounts. For bi-weekly payroll deductions, please see the Payroll Deduction Sheet.
Under 55:		
Employee Only	$28.54	
Employee and Spouse	$51.42	
Employee and Child(ren)	$42.74	
Employee and Family	$65.62	
Ages 55-59:		
Employee Only	$35.60	
Employee and Spouse	$64.10	
Employee and Child(ren)	$49.80	
Employee and Family	$78.30	
Ages 60 and Over:		
Employee Only	$59.30	
Employee and Spouse	$106.70	
Employee and Children	$73.50	
Employee and Family	$120.90	
	Outpatient Benefits	
Emergency Room	$200.00	
Diagnostic X-Ray & Lab	$200.00	
Outpatient Surgery	$200.00	
Physician Treatment	$25.00	

Figures above are monthly premiums. Please see the deduction sheet for bi-weekly payroll deduction amounts.

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-30116 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.

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SB-30121(AR)(HI)(IA)(ME)(MT)(SC)(RATE INSERT)(VOLUNTARY)(CLASSIC)-0516

G923 Series
AWD BROK

GAP APPLICATION

GROUP APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

1. PROPOSED INSURED INFORMATION:

Last Name | First Name | Full Middle Name | Suffix

Age | Date of Birth MM/DD/YYYY | Sex M ☐ F ☐ | SSN | Requested Effective Date MM/DD/YYYY | Date of Employment MM/DD/YYYY

Residence Address: Number & Street (Not a P.O. Box) | Work Phone # ( ) | Home Phone # ( )

City | State | Zip | Country of Citizenship

Mailing Address (if different than Residence) | City | State | Zip

Employer Name | Employer/MCP # | Salary: $ _____ | Occupation

Southeast Restaurants Corp | 85555 | Annual ☐ Monthly ☐

Are you currently able to perform the duties of your occupation? Yes ☐ No ☐

Spouse Last Name | First Name | Middle Initial | SSN | Date of Birth | Country of Citizenship

Has any adult to be covered used any form of nicotine in the last 12 months? Applicant Yes ☐ No ☐ Spouse Yes ☐ No ☐

Applicant's Email Address:

2. BENEFITS APPLIED FOR:

Product	New/Chg	Billing Distribution ID	MCH	Persons Covered[1]	Plan Code	Plan Amount	PREMIUM: Employee	Employer	Mode	Total
GAP	☐ ☐		9345		018094-G6	$2,000	$			$
GAP	☐ ☐		9345	Our plan is	018094-G6	$2,000	$			$
GAP	☐ ☐		9345		018094-G6	$2,000	$			$
GAP	☐ ☐		9345		018094-G6	$2,000	$			$
GAP	☐ ☐		9345		018094-G6	$2,000	$			$
	☐ ☐									
	☐ ☐									
	☐ ☐									
	☐ ☐									

[1]z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse TOTAL

3. BENEFICIARY: Last Name | First Name | Middle Initial | Relationship | Country of Citizenship

NO BENEFICIARY INFO IS NEEDED ----------

4. ELECTION: I hereby enroll, add or change, as selected above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay.

5. ACKNOWLEDGMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
- If applying for disability income coverage, **OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**
- "Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any. I further understand that any increase in coverage must be applied for and approved by the company, and as explained in my Certificate, a new Pre-Existing Condition period will apply with respect to the increase.

6. FRAUD NOTICE: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud.

[BROCHURE(S) # SB-6736T(SC) **HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S).]**

Applicant Signature or PIN _____ Date _____

Agent # _____ Agent Signature or PIN (where required by law) _____

Help Us Help the Environment

Electronic delivery of policy documents can offer you access to the most up-to-date documents keeping them safe so that you can have access to them at any time.

If you would like to receive and manage your American Fidelity Assurance Company Policy Documents online electronically, please read the Consent to Electronic Delivery of Policy Documents and place your initials in the space provided below.

Consent to Electronic Delivery of Policy Documents

I hereby request and agree to Electronic Delivery of Policy Documents ("Consent"), if available, by American Fidelity Assurance Company (AFA).

Policy Documents
I understand that: (1) Policy Documents will be hosted on a secure Web site; (2) I will receive an e-mail from AFA to the e-mail address that I have designated below containing instructions and AFA's web address; (3) Electronic Delivery is in lieu of regular U.S. Mail delivery; (4) Electronic Delivery is sufficient to meet all requirements under the Policy; (5) paper copies of any and all electronically delivered Policy Documents are available to me upon my request; and (6) if I have executed more than one Consent, only my last election will be in effect.

Systems Requirements
I understand that in order to receive Policy Documents electronically, I must use a valid e-mail address, an Internet connection, and a computer that meets the following minimum requirements: Internet Explorer 6.0 or later and Adobe® Reader® 8.0 or newer, available free on www.afadvantage.com or www.adobe.com.

Revocation of Consent
I understand that either party may revoke this Consent unilaterally at any time with ten (10) days prior notice to the other party. The Certificateholder/Policy Owner may revoke by calling, toll-free: 1-800-654-8489; or by writing to: American Fidelity Assurance Company, 2000 N. Classen Blvd., Oklahoma City, Oklahoma 73106. Upon revocation of this Consent, AFA will communicate all future Policy Documents via regular U.S. Mail to the last known designated address of the Certificateholder/Policy Owner.

Transmittal of Policy Documents
I understand that I am responsible at all times, as the Certificateholder/Policy Owner, to notify AFA in writing of any and all changes associated with the transmittal of Policy Documents. That I, as the Certificateholder/Policy Owner, agree that I will hold AFA harmless with respect to any and all delivery errors caused by my failure to provide current and valid information for the receipt of Policy Documents.

By initialing in the box below, I ☐ **agree** ☐ **do not agree** to the Electronic Delivery of my Policy Documents.

INITIAL ABOVE	DATE

Name and designated electronic transmittal e-mail address of the Certificateholder/Policy Owner:

PRINTED NAME	E-MAIL ADDRESS