Supplemental GAP Medical Plan
Zurich American Insurance Company

The Zurich GAP Plan is designed to help you cover the out-of-pocket costs of medical treatment, whether it be expenses for an inpatient hospital stay, surgery or outpatient medical care for an injury or an illness.

Your employer has chosen a plan design that offers you an optimal offset of expenses due to high deductibles and high out-of-pocket maximums applied under your major medical plan.

Plan of Benefits offered to employees of Denison Independent School District:

- **Hospital Confinement Benefit*** - This benefit is designed to offset the cost you incur as an in-patient in the hospital when your primary major medical policy applies such expenses to your deductible or coinsurance maximum, up to the $1,500 benefit year maximum per insured person.

- **Out-Patient Benefit*** - This benefit offsets the cost you incur for out-patient treatment when your primary major medical policy applies such expenses to your deductible or coinsurance maximum, up to the 1,500 benefit limit. This benefit is a "per person per benefit year" maximum and is subject to a family benefit year maximum limitation that is equal to four (4) times the individual benefit. Expenses related to physician office visits are not included in this benefit. Covered expenses include:

    - Surgery in an Out-Patient Facility or a Physician's Office
    - Emergency Room visits
    - Diagnostic testing, Lab & X-ray at a diagnostic or hospital out-patient 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

*For expenses to be eligible under this plan they must be medically necessary for the treatment of an injury or illness. Expenses not covered by your primary major medical plan are not covered.

How to File a Claim

When you enroll in this plan, you will receive a certificate of insurance and an ID card, along with specific instructions on how to file a claim. This form outlines the procedures you should follow and where you should send your claim. Simply stated, you will need to submit itemized bills (NOT balance due statements) and EOB's that correspond to the itemized bills.

Claims may be filed at any time, but must be filed no longer than 12 months from the date of service in order to be eligible for coverage.

The insurance benefits described above are underwritten by Zurich American Insurance Company, 1299 Zurich Way, Schaumburg, IL 60196, 1-800-987-3373. This document provides a general description of certain provisions and features of this insurance program and does not revise or amend the applicable policies. In the event of a discrepancy between this document and your certificate of insurance or the group policy, the terms of the group policy shall apply. All benefits are subject to the terms and conditions of the group policy. Please refer to your Certificate of Insurance for a detailed description of the insurance coverage, including the exclusions, limitations, reductions, and termination.

Coverage may not be available in all states or certain terms, conditions, and exclusions may be different where required by state law. This insurance provides limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative, it is intended to help supplement Comprehensive coverage. This insurance does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not a minimum essential benefit as set forth under the Patient Protection and Affordable Care Act.

DENISON INDEPENDENT SCHOOL DISTRICT
1201 South Rusk Avenue
Denison, Texas 75020
Phone: (903)462-7000
Fax:(903) 462 7002

IT'S G REAT TO BE A YELLOW *JACKET!"*

Supplemental GAP Medical Plan
Zurich American Insurance Company

RE: GAP COVERAGE

	Monthly Rate	Admin. Fee	Total Monthly Cost
Under Age 40:			
Insured Only	$27.28	$0.96	$28.24
Insured & Spouse	$50.15	$1.76	$51.91
Insured & Child(ren)	$65.57	$2.30	$67.87
Insured & Family	$87.82	$3.08	$90 .90
Ages 40 - 49:			
Insured Only	$35.92	$1.26	$37.18
Insured & Spouse	$65.99	$ 2.31	$68 .30
Insured & Child(ren)	$70.58	$2.48	$73.06
Insured & Family	$99.87	$3.50	$103. 37
Ages 50 & Above:			
Insured Only	$75.44	$2.65	$78.09
Insured & Spouse	$138.62	$4.86	$143.48
Insured & Child(ren)	$130.00	$4.56	$134.56
Insured & Family	$191.53	$6.71	$198.24

$1,5 00 Hospital Confinement Benefit
$1,5 00 Outpatient I Benefit

This insurance is underwritten by Zurich American Insurance Company, 1299 Zurich Way, Schaumburg, IL 60196, 1-800-987-3373.

DATA COLLECTION FORM

for Group Supplemental Medical Expense Insurance

Arranged by Special Insurance Services, Inc.

In order for Special Insurance Services to administer your employer-sponsored supplemental medical coverage and process any claims you might have accordingly, we will need the following information from you:

☐ NEW ☐ TERMINATION ☐ CHANGE

PLAN DATA

If your employer offered more than one supplemental medical plan design, which plan did you choose:

☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4

Please indicate which coverage level you elected under your employer-sponsored supplemental medical coverage:

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

EMPLOYEE INFORMATION

Last Name : _____ First Name: _____ M.I.: _____

Social Security #: _____ Gender: ☐ Female ☐ Male Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

Employer: _____ Date of Hire: _____

Occupation/Job Title: _____ If retiree, Date of Retirement: _____

DEPENDENT INFORMATION (only those eligible may be enrolled)

A=Add T=Termination C=Change

A/T/C	Name (last, first, MI)	Relationship	Date of Birth	Gender	Social Security #
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	

(Use reverse side of form if additional space is needed)

Requested Effective Date of Coverage/Change: _____

☐ I waived enrollment under my employer's sponsored supplemental medical plan at the time I was initially eligible to participate in the plan. I understand that I can only enroll in the plan during an employer-sponsored annual open enrollment period, or upon provision of satisfactory documentation evidencing my status as a special enrollee due to a qualifying event as determined by law.

Employee's Signature: _____ Date: _____

At Special Insurance Services, we understand the importance of maintaining the confidentiality of our customers' nonpublic personal information It is our policy not to disclose personal information about our customers except to our affiliates, or others as may be permitted by law. We have policies and procedures to safeguard nonpublic personal information about our customers which include (1) restricting access to nonpublic personal information, and (2) maintaining physical, electronic and procedural safeguards that comply with legal requirements to safeguard such nonpublic personal information.