OptiMed GAP Plans

The GAP Plans

With the slowing economy and employers finding it increasingly difficult to afford traditional health insurance premiums, OptiMed GAP fills a rapidly growing niche in the group health insurance marketplace by assisting employers to provide affordable health coverage to their employees.

OptiMed Gap is specifically designed to help save direct health insurance premium costs by allowing employers and employees greater freedom in selecting lower cost high deductible health plans. Simply put, by plugging in OptiMed Gap, employers may be able to raise deductibles and coinsurance to obtain lower cost coverage. OptiMed GAP helps to fill the gap in coverage for higher deductible health plans in relation to eligible expenses for deductibles, coinsurance and copays if hospital confined.

OptiMed GAP is a guaranteed issue insurance product with multiple plan options available, allowing employers to pick and choose the best fit.

OptiMed Gap is only available on an employer group basis to employees who have an underlying employer sponsored comprehensive major medical plan. Employees who are not covered under the employer's major medical plan may not enroll in OptiMed Gap.

OptiMed GAP Features

- Expenses must be covered by the insured person's major medical or comprehensive medical plan to be covered under this policy.
- Covers certain portions of the insured person's cost sharing under their major medical or comprehensive medical plan (co-insurance, co-pays and deductibles) up to the maximum benefit selected if hospital confined.
- Each plan of insurance includes benefits for In-Hospital expenses. Optional Outpatient, Physician Office Visit Benefits may be added, if elected by the employer.
- OptiMed GAP will not pay benefits toward office visit copays unless quoted by OptiMed and elected by the employer.
- Uses the primary medical plan's EOB (explanation of benefits) as a basis for determining what is covered.
- Up to two OptiMed GAP plans may be sold per comprehensive major medical plan maintained by the employer (one employer-paid plan and one voluntary buy-up plan). Employers who purchase an employer-paid plan for which the maximum inpatient benefit amount is less than the total major medical plan out-of-pocket expense may also include a buy-up option for the employees.

  The employer must pay the entire premium for a minimum $500 inpatient benefit for all employees covered by the employer's group medical plan. The employer may select additional Inpatient Hospital benefit amounts to make available for employees to purchase. This amount, when combined with the employer-paid plan's maximum benefit amount, may not exceed the insured person's total out-of-pocket exposure under the major medical plan.

  The buy-up amount selected by the employer applies to each employee; it cannot vary by individual within the group.
- Please note that OptiMed GAP plans with in-patient benefit amounts of $6,000 or more will require mandatory employer contribution.

OptiMed GAP Benefit Summary

How Does It Work?

The insured submits a claim form with an EOB. As long as the claim is an eligible expense under the underlying major medical plan OptiMed pays the insured the appropriate amount, subject to the exclusions, limitations and other provisions of the policy.

Inpatient Benefit

If, as a result of a covered injury or sickness an insured person is hospital confined, under the regular care and attendance of a physician and the expenses are covered by the insured person's major medical/comprehensive policy, OptiMed will pay up to the maximum indemnity benefit per calendar year. Hospital confinement must begin after the effective date of coverage.

Benefits are limited to:

- The deductible the insured person is required to pay under the major medical/ comprehensive Policy.
- Copays and the coinsurance amount the insured person is required to pay under the major medical/comprehensive Policy.

Benefits also will be payable for a covered Hospital emergency room treatment as follows:

- Injury – up to the Maximum Benefit, subject to Exclusions & Limitations.
- Sickness – up to the Maximum Benefit subject to Exclusions and Limitations, if the sickness results in Hospital Confinement within 24 hours of the Hospital emergency room treatment.

Optional Outpatient Benefit

Outpatient benefits include treatment under the regular care and attendance of a physician at a hospital, physician's office, outpatient surgical or emergency facility or a diagnostic testing facility or similar facility that is licensed to provide outpatient treatment.

The benefits are limited to the difference between the benefit paid by the underlying major medical/ comprehensive policy and the actual outpatient expenses incurred, which includes any out-of-pocket expenses such as deductible, co-pays and coinsurance.

Benefits are payable per person for outpatient treatment for a covered Injury or Sickness up to the maximum Outpatient benefit with a family maximum of 2 times the per person Outpatient benefit. Example: $250 Outpatient benefit for any coverage level above employee only = $500 calendar year maximum.

Expenses incurred means the charges for a service or supply that is covered by this Rider and given to an insured person due to an injury or sickness. The expense incurred must be medically necessary for the condition being treated. An expense or charge is deemed to be incurred on the date the service or supply that causes the expense or charge is given or obtained.