MEDlink® 9 Gap Insurance

Group Supplemental Limited Benefit Medical Expense Insurance

Summary of Benefits‡ for Columbus Hospitality Management

	Plan 2
Funding	Voluntary
Plan Type	Separate Inpatient and Separate Outpatient
Policy Period	Calendar Year
Benefits	
Inpatient Benefit Maximum	$1,000 per covered person per calendar year. Maximum of $3,000 per calendar year for all covered persons combined.
Inpatient Benefits	Treatment incurred while confined as an inpatient. Treatment of a mental or emotional disorder while confined as an inpatient. Treatment for substance use disorders while confined as an inpatient. Ambulance service resulting with a covered person's confinement as an inpatient.
Outpatient Benefit Maximum	$500 per covered person per calendar year. Maximum of $1,500 per calendar year for all covered persons combined.
Outpatient Benefits	Treatment in a hospital outpatient facility not resulting with a covered person's confinement as an inpatient. Treatment in an urgent care facility. Emergency Services and Treatment in an emergency room. Kidney dialysis in a kidney dialysis center or hospital outpatient facility or a physician's office. Infusion therapy in an infusion therapy center or hospital outpatient facility or a physician's office. Physical therapy in a physical therapy facility or a physician's office. Occupational therapy in an occupational therapy facility or a physician's office. Speech therapy in a speech therapy facility or a physician's office. Surgery in a hospital outpatient facility or a freestanding outpatient surgery center or a physician's office. Diagnostic testing performed in a hospital outpatient facility or an MRI facility or a physician's office. Sleep study in a hospital outpatient facility or a sleep study center or the covered person's home. Cancer treatment performed in a cancer treatment facility or a physician's office. Treatment for substance use disorders in a hospital outpatient facility or an outpatient substance abuse treatment facility or a physician's office. Treatment of a mental or emotional disorder performed in a hospital outpatient facility or outpatient psychiatric treatment facility or a physician's office. Ambulance service not resulting with a covered person's confinement as an inpatient. If the covered person is confined as an inpatient, this benefit will be payable under the inpatient benefit. Other treatment in a physician's office (not including the physician's office visit fee). Diagnostic testing in an independent lab facility. Durable medical equipment when recommended by a physician.

‡The benefit amounts vary dependent upon the Plan selected at time of application.

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After satisfaction of any applicable certificate or emergency room deductibles, benefits are payable for eligible out-of-pocket covered charges incurred by a covered person under the other medical plan. A covered person is you and any dependents covered under the policy and the certificate. A dependent is any person who is covered under the other medical plan and is your spouse and/or natural child, legally adopted child, foster child for whom you have been appointed legal guardian or stepchild who is under 26 years of age if applicable to your plan. Dependent may also include any minor under your charge, care and control, who has been placed for adoption and is under 26 years of age if applicable to your plan. Dependent does not include a grandchild unless required by law.

Other medical plan includes any basic major medical, comprehensive medical or managed care policy provided through the policyholder or subsidized by the policyholder and through which a covered person has coverage. Other medical plans do not include any limited medical program, TRICARE, Medicare or Medicaid.

A hospital is not an institution, or part thereof, used as: a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long-term nursing unit or geriatrics ward or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Inpatient Benefits

APL does not pay for any expense for which benefits are not payable under the other medical plan.

Outpatient Benefits

APL does not pay for any expense for which benefits are not payable under the other medical plan. Only applicable if outpatient benefits are included in the plan.

Limitations and Exclusions

No benefits will be payable for expenses incurred during any period the covered person does not have coverage under the other medical plan. If APL receives a claim after coverage under the other medical plan has terminated, our liability will be limited to a refund of any premium paid since coverage terminated.

No benefits will be payable for expenses incurred which result from or are caused by, whether directly or indirectly: war or any act of war, whether declared or undeclared, or any act related to war while serving in the military forces or any auxiliary unit thereto (the pro-rata portion of any premium paid for any such covered person will be refunded upon receipt of your written request); outpatient routine newborn care (except newborn circumcision); voluntary abortion except, with respect to you or your covered dependent, if dependent coverage is applicable to the plan, where you or the dependent's life would be endangered if the fetus were carried to term; or where medical complications have arisen from abortion; committing or attempting to commit a felony, or active participation in a riot, insurrection or terrorist activity; 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; gender reassignment, except when a physician determines it is medically necessary treatment including gender affirmation surgery for gender dysphoria and related health conditions; experimental treatment, drugs or surgery; accident or sickness arising out of and in the course of any occupation for compensation, wage or profit (not applicable to those sole proprietors or partners not covered by workers' compensation); 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; elective cosmetic surgery (except newborn circumcision); drugs (prescription and non-prescription for use outside of a covered facility as defined in the certificate or any attached rider); physician's office visit fee; home health care; sterilization reversal procedures; an expense or service that exceeds any of the maximum benefits, as shown on your certificate schedule; any expense for which benefits are not payable under the other medical plan.

No benefits will be payable for incurred inpatient expenses for rest care or rehabilitative care and treatment, or for incurred outpatient expenses for rest care or rehabilitative care and treatment, except for physical therapy performed in a physical therapy facility or physician's office, occupational therapy performed in an occupational therapy facility or physician's office or speech therapy performed in a speech therapy facility or physician's office if outpatient benefits are included in the plan.

No benefits will be payable for incurred inpatient expenses that do not meet the definition of inpatient covered charges, if the benefit is not included in the inpatient benefits listed in the summary of benefits of the plan.

No benefits will be payable for incurred outpatient expenses that do not meet the definition of outpatient covered charges, treatment in an emergency room, diagnostic testing in an independent lab facility or durable medical equipment if the benefit is not included in the outpatient benefits listed in the summary of benefits of the plan.

No benefits will be payable for outpatient expenses incurred in a physician's office unless the outpatient benefit "other treatment in a physician's office (not including the physician's office visit fee)" is included in the outpatient benefits listed in the summary of benefits of the plan. Cancer treatment performed in a cancer treatment facility or physician's office will only be payable if included in the outpatient benefits listed in the summary of benefits of the plan.

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Termination of Coverage

Your coverage ends on the earliest of: the date you leave an eligible class under the certificate; any premium due date, if full payment for your coverage is not made within 45 days following the premium due date; the date the policy terminates; or the date you are no longer covered under the other medical plan; or the date the participating policyholder's coverage under the policy terminates. Coverage for a dependent ends on the earliest of: your termination date; the last day of the month during which the dependent is no longer eligible for coverage due to a change to the policy; or the last day of the month during which a dependent no longer satisfies the definition of a dependent. Termination will not affect a claim that occurred while a covered person was covered by the policy.

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Underwritten by American Public Life Insurance Company. This is a brief description of the coverage. This product contains limitations and exclusions. For complete benefits and other provisions, please refer to the policy/certificate. This coverage does not replace Workers' Compensation Insurance. This is not a Medicare Supplement Policy. **This product is inappropriate for people who are eligible for Medicaid coverage.** | This policy is considered an employee welfare benefit plan established and/or maintained by an association, union or employer intended to be covered by ERISA, and will be administered and enforced under ERISA. Group policies issued to governmental entities and municipalities may be exempt from ERISA. | Policy Form GML921APL MEDlink® 9 Group Supplemental Limited Benefit Medical Expense Insurance Series | Ohio | 11/24