GBG
Insurance Without Borders℠

Global Advantage

INTERNATIONAL GROUP MEDICAL INSURANCE PLAN

EMPLOYEE BENEFIT GUIDE

RELIANT MISSION

POLICY PERIOD: 01 JANUARY 2019 through 31 DECEMBER 2019

POLICY #: GAWN - 18321

Worldwide

Welcome

Your employer has selected **GBG Insurance Limited (GBG)** as your medical insurance coverage provider.[1] We look forward in providing you with valuable medical insurance protection while you are living and working outside your Home Country. The Employee Benefit Guide[2] is intended to provide you with an overview of this group insurance plan. However, do not hesitate to contact GBG should you require further clarification.

In this guide you will find:

- **Schedule of Benefits –** summarizing your coverage and benefits.
- **Provider Choice –** describing your options for choosing an in-network doctor.
- **Pre-Authorization –** describing treatment and services that require pre-approval by GBG in order to maximize your benefits.
- **Claims –** outlining the procedure for benefit reimbursement.
- **Exclusions –** that outlining services not covered under this Policy.
- **Definition –** describing key terms.

How to contact GBG and GBG Assist

Claims Inquiries

- Toll Free: +1.877.916.7920 (within the U.S. and Canada)
- Phone: +1.949.916.7941 (outside the U.S. and Canada)
- Email: customerservice@gbg.com

Pre-Authorization, Benefits, and other Medical Insurance Assistance

- Toll Free: +1.866.914.5333 (within the U.S. and Canada)
- Phone: +1.905.669.4920 (outside the U.S. and Canada)
- Email: GBGAssist@gbg.com

Find a Provider, Download Forms (Claims, Pre-Authorization), or Log-In:

Website: www.gbg.com

We look forward to servicing you this year.

Bob Dubrish
CEO
GBG Insurance Limited

[1] This GBG Insurance Limited Policy is an international medical insurance Policy. GBG Insurance Limited is an insurance company incorporated in Guernsey with the registration number 42729 and licensed by the Guernsey Financial Services Commission to conduct insurance business under the Insurance Business (Bailiwick of Guernsey) Law, 2002 as amended. As such, this Policy is subject to the laws of the Bailiwick of Guernsey, and the Insured should be aware that laws governing the terms, conditions, benefits and limitations in medical insurance policies issued and delivered in other countries including the United States are not applicable to this Policy. If any dispute arises as to the interpretation of this document, the English version shall be deemed to be conclusive and taking precedence over any other language version of this document.

[2] The Employee Benefit Guide includes the Schedule of Benefits that is part of the Policy issued to the Policyholder. In the event of any conflict between the Group Master Policy and the Schedule of Benefits, the Schedule of Benefits will govern.

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SCHEDULE OF BENEFITS

POLICY DESIGN			
Area of Coverage	Worldwide: Provides coverage in any country in the world.		
U.S. Network	Aetna Passport		
Pre-Existing Conditions Coverage Pre-Existing conditions are covered according to the terms of the policy, without a waiting period.			
Your Coverage Effective Date For Insureds enrolling onto the group plan for the first time, coverage for accident and sickness becomes effective when the primary Insured becomes actively-at-work at their work location. Prior to this occurring, coverage for accident only is in effect.			
Annual Maximum Per Covered Person (Per policy year)	$1,000,000		
Lifetime Maximum Per Covered Person	Unlimited		
	Outside U.S.	**U.S. In-Network** (Preferred Allowance)	**U.S. Out-of-Network**
Annual Individual Deductible (Per policy year)[3] Family Deductible is 3 times Individual	$0	$2,000	$2,000
Plan Coinsurance	100%	100%	80% UCR
Insured Person Coinsurance (after the Deductible)	0%	0%	20%
Individual Out-of-Pocket Maximum[4] Family Out-of-Pocket is 3 times Individual	N/A	N/A	Unlimited
Dental Coverage	Included see Attached Schedule		
Vision Coverage	Included see Attached Schedule		
Benefit: Enhanced Preventive Care (Not subject to Deductible)	$400		
RIDERS: None			
ATTACHMENTS: Attachment #1 Notice of Privacy Practices			

[3] The Deductible for "Outside U.S." and "U.S. In-Network" is combined. The Deductible for "U.S. Out-of-Network" is separate.
[4] The Annual Out-of-Pocket Maximum for "Outside U.S." and "U.S. In-Network" is combined. The Annual Out-of-Pocket Maximum for "U.S. Out-of-Network" is separate.

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, Copayments, and Maximum Benefits.	PLAN REIMBURSEMENT Once the Annual Out-of-Pocket Maximum is met, the Plan reimbursement is 100%.		
	Outside U.S.	**U.S. In-Network** (Preferred Allowance)	**U.S. Out-of-Network**
HOSPITALIZATION AND INPATIENT BENEFITS			
Accommodations • Semi-private room • Intensive care (Medically Necessary) • Medical treatment, medicines, laboratory, and diagnostic tests • Inpatient consultation by a Physician or Specialist • Inpatient surgery/Surgeon • Inpatient ancillary services	100%	100%	80% UCR
Parent Accommodations • Insured child up to age 18 • Annual Maximum Benefit: 30 days	100%	100%	80% UCR
Reconstructive Surgery • The surgery or therapy restores or improves function • Reconstruction is required as a result of Medically Necessary, non-cosmetic surgery • If surgery is the result of an Accident then the Accident must have occurred while covered under this Policy	100%	100%	80% UCR
Extended Care/Inpatient Rehabilitation • Must be confined to a facility immediately following a Hospital stay	100%	100%	80% UCR
SURGICAL BENEFITS (OUTPATIENT)			
Outpatient Facility or Daycare Treatment • Physician's office or other free standing surgical facility	100%	100%	80% UCR
Surgery/Surgeon and Anesthesiology Services	100%	100%	80% UCR
EMERGENCIES			
Non-Emergency use of Emergency Room in the U.S.	N/A	50%	50% UCR
Emergency Room and Medical Services	100%	100%	100% UCR
Ground Ambulance Services • Ground only (to the nearest Hospital)	100%	100%	100 % UCR

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, Copayments, and Maximum Benefits.	PLAN REIMBURSEMENT Once the Annual Out-of-Pocket Maximum is met, the Plan reimbursement is 100%.		
	Outside U.S.	**U.S. In-Network** (Preferred Allowance)	**U.S. Out-of-Network**
EMERGENCIES (CONTINUED)			
Emergency Dental • Limited to Accidental Injury only • Annual Maximum Benefit: $5,000	100%	100%	80% UCR
OUTPATIENT BENEFITS			
Outpatient Physician Visit/Consultation by Specialist	100%	100%	80% UCR
Outpatient Diagnostic Testing • Echocardiography, Ultrasound, CAT Scan, PET Scan, MRI Endoscopy (e.g. gastroscopy, colonoscopy, cystoscopy), X-Rays, and Laboratory	100%	100%	80% UCR
Alternative Medicine • Homeopathy, Acupuncture, and Traditional Chinese Medicine for a covered Illness • Annual Maximum Benefit: $500 all therapies combined	100%	100%	80% UCR
Therapeutic Services • Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy • Annual Maximum Benefit, all therapies combined: $5,000	100%	100%	80% UCR
PREVENTIVE CARE			
Deductible is waived for the following benefits: **Child Wellness** (up to age 12 months) • Includes child immunizations and routine medical exams • Maximum 9 visits **Adult Female Screenings** • PAP Screening and baseline mammogram with office visit **Adult Male Screenings** • PSA Screening with office visit **Family Medical History Screenings** • Screening exam/testing due to family medical history • Annual Maximum Benefit: $250	100%	100%	80% UCR
Benefit: Enhanced Preventive Care • Includes annual physical examination, tests, and adult immunizations • Refer to Policy Design page to determine if this is included • Annual Maximum shown on Policy Design page	100%	100%	80% UCR

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, Copayments, and Maximum Benefits.	PLAN REIMBURSEMENT Once the Annual Out-of-Pocket Maximum is met, the Plan reimbursement is 100%.		
	Outside U.S.	**U.S. In-Network** (Preferred Allowance)	**U.S. Out-of-Network**
MATERNITY CARE			
Normal delivery or Medically Necessary caesarean section, prenatal and postnatal care • Covered up to $7,500, 50% Coinsurance thereafter • Dependent daughters are not covered • Fertility/infertility services, treatments, drugs and/or procedures are excluded from coverage	100%	100%	80% UCR
Complications of pregnancy, premature birth, congenital conditions, and birth anomalies • Not subject to overall maternity maximum	100%	100%	80% UCR
OTHER BENEFITS			
Mental Health • Lifetime Benefit Maximum: $25,000 • Inpatient Annual Maximum Benefit: 180 days • Outpatient Annual Maximum Benefit: 20 visits	100%	100%	80% UCR
Alcohol and Substance Abuse • Rehabilitative treatment only • Annual Maximum Benefit: $2,500	100%	100%	80% UCR
Diabetic Supplies • Insulin Pumps and associated supplies • Annual Maximum Benefit: $5,000	100%	100%	80% UCR
Durable Medical Equipment • Wheelchairs, Hospital beds, and other similar equipment • Reimbursement of rental up to purchase price	100%	100%	80% UCR
Prosthetic Devices • Limbs and other devices intended to replace the functionality of a body part • Hearing aids are excluded	100%	100%	80% UCR
Home Health Care Including Nursing Services • Annual Maximum Benefit: 100 days/year	100%	100%	80% UCR
Transplant Services (Human Organ, Bone Marrow, Stem Cell) • Expenses for donor are not covered • Institute of Excellence required in the U.S.	100%	100%	80% UCR

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Coinsurance, Copayments, and Maximum Benefits.	PLAN REIMBURSEMENT Once the Annual Out-of-Pocket Maximum is met, the Plan reimbursement is 100%.		
	Outside U.S.	**U.S. In-Network** (Preferred Allowance)	**U.S. Out-of-Network**
OTHER BENEFITS (CONTINUED)			
Hospice • Inpatient Lifetime Maximum Benefit: 45 Days • Outpatient Lifetime Maximum Benefit: $5,000	100%	100%	80% UCR
Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV +), AIDS Related Complex (ARC), sexually transmitted diseases and all related conditions • Benefit is not covered if condition was diagnosed a Pre-Existing Condition	100%	100%	80% UCR
Medical Evacuation/Repatriation • Emergency air transportation		100%	
Repatriation of Remains		$20,000 Maximum Benefit	
War and Terrorism (Passive only)		Included	

PRESCRIPTION DRUG BENEFITS (REIMBURSEMENT PLAN)

	Outside U.S.	U.S. In-Network Pharmacy	U.S. Out-of-Network Pharmacy
Prescription Drugs	20% Member Coinsurance 90 Day per Prescription Fill	20% Member Coinsurance 180 Day Supply per Prescription Fill	40% Member Coinsurance 180 Day Supply per Prescription Fill
Mail Order Drugs	Contact Customer Service (only available for delivery within the U.S.)		

Pre-Authorization through GBG Assist is required if you have a medication that will be in excess of $3,000 per refill, otherwise, it may not be covered under this plan.

Important Notes:

1. Generic drugs are required if available.
2. The medical plan Deductible does not apply to the pharmacy benefit.
3. The Coinsurance or Copayment amounts for the pharmacy benefit do not accrue to the medical plan Out-of-Pocket Maximum.
4. Oral contraceptives are included.

VSP ACCESS PLAN/ VSP SIGNATURE NETWORK

The VSP Access plan is a **discount only program;** all Out-of-Pocket expenses applied after the discounts are the responsibility of the Insured Person

Well Vision Exam	• 20% off a thorough eye exam.
Glasses	• 20% off unlimited complete pairs of prescription glasses, all lens options, and unlimited non-prescription sunglasses.
Contact Lenses	• 15% off contact lens services, excluding materials • Exclusive offers for VSP members include: mail-in rebate savings up to $110 on eligible Bausch & Lomb contacts and up to $125 on eligible ACUVUE Brand Contact Lenses.
Laser Vision Care Program	• VSP contracted laser centers provide discounts for laser surgery including PRK, LASIK, and Custom LASIK. • Discount average 15% off or 5% off is the laser center is offering a promotional price.

DENTAL BENEFITS	
Annual Maximum Per Covered Person[5] (Class 1, Class 2, and Class 3 services included)	$1,500
Annual Dental Deductible (Class 2 and Class 3) • Family Deductible is 3 times Individual	$100
Orthodontic Treatments (Class 4)	$500 Annual Maximum Benefit

COVERED SERVICES	BENEFIT LEVELS
Preventive Dental Services (Class 1) • Not subject to dental Deductible • Necessary diagnostic examinations and preventive treatment	100%
Basic Dental Services (Class 2) • Basic restoration, periodontal treatments, endodontic, and oral surgery	80%
Major Dental Services (Class 3) • Crowns, inlays, bridges, and extraction of wisdom teeth. Covered Expenses include the necessary supplies and services of a Physician for installation or replacement	50%
Orthodontic Dental Services (Class 4) (Available to insureds up to age 19) • Study models (including pan oral x-rays), impressions, removable string appliances (braces), fixed appliances (including adjustments), extractions, and re-cementing of brackets	50%

Dental Exclusions:

- Cosmetic surgery or supplies or procedures, or
- Replacement of lost, missing or stolen crown, bridge or dentures, or
- Services or supplies which do not meet general accepted dental standards, or
- Experimental treatment and treatment which is not Medically Necessary, or
- Implantology and all related services, or
- Treatment for temporomandibular joint disorders (TMJ) and complications thereof, except as otherwise covered under the Policy.
- Dentures or false teeth, and
- Night mouth guards or other services for teeth grinding.

[5] Dental Coinsurance does not apply to the medical Out-of-Pocket Maximum.

OPTIONAL VISION BENEFITS	
Examination (each policy year)	$75
Frame Allowance	$75
Lens Allowance	
• Single Lens	$90
• Bifocal	$125
• Trifocal	$150
• Contact Lenses	$150
Exclusions • Optional Lens Coating for anti-glare, anti-scratch, UV sun protection. • Sunglasses and/or related accessories are not included in coverage.	