Concordia University

International Student Health Insurance

Frequently Asked Questions

Q. How Can I access information about the plan?
A. For a comprehensive look at the benefits, a Plan Summary is available for download at:
https://www.1stagency.com/umbraco/Surface/College/BrochureText/91

In general, the Plan provides 100% coverage in network. Some benefits have a small co-pay (physical therapy and chiropractic have co-pay of $50 per visit, for example)

Q. What is my deductible?
A. In-Network: $100 Out-of-Network: $250 (if an out-of-network provider in the U.S is used)

A deductible is the amount of covered Allowable charges that will be payable by the Plan Participant during each period of insurance before the plan benefits are applied.

Q. What is my prescription drug benefit?

- Up to 31 day supply per prescription
- CVS/Caremark network pharmacy must be used
- More information is available at www.caremark.com

Q. What is my Emergency Room Benefit?

- $100 co-payment, waived if admitted
- 50% coinsurance for non-emergency use*

* suggest using an Urgent Care Center / Walk-In Clinic as opposed to an Emergency Room for non-emergencies

Q. Are immunizations covered under this plan?
A. Routine and Medically Necessary Immunizations are covered

Q. Are pre-existing conditions covered?
A. There is a 60 day waiting period (new students only)

Q. How can I reach the company with questions (Customer Service, Pre-Authorization, Help Locating a Provider)?
A. Worldwide Collect: +1.786.814.4125
Inside USA/Canada toll free +1.866.914.5333
Email: GBGAssist@gbg.com Website: www.gbg.com

We invite you to visit our Member Services portal at www.gbg.com and register as a New Member. The Member Services Portal allows you to conveniently access our Provider Directory, download forms, submit claims, and utilize other valuable tools and services.

Q. What is the Preferred Provider Network for this plan?
A. Aetna. The link to the Provider Network is as follows (indicate United States for the correct network):
https://portals.gbg.com/ProviderSearch/ProviderSearch.aspx?Network=AETNA

Q. Does this plan provide coverage for dental care?

A. Dental care is not covered under this plan, except for Emergency Dental and Palliative Dental. Emergency Dental is limited to accidental injury to sound, natural teeth that is sustained while covered under the Plan. Palliative Dental provides a maximum of $500 per period of insurance for the sudden onset of pain.

Q. Does this plan provide coverage for Vision care?

A. No, Vision coverage is not provided under the Plan

Q. Where Am I covered under this plan?

A. This plan covers you on a Worldwide basis, excluding your Home Country

Q. What are the Pre-Authorization requirements?

A. **Pre-Authorization is a process by which a Plan Participant obtains approval for certain medical procedures or treatments prior to the commencement of the proposed medical treatment. This requires the submission of a completed Pre-Authorization Request form to GBG Assist a minimum of five business days prior to the scheduled procedure or treatment date.**

The following services require Pre-Authorization:

- Any Hospitalization
- Outpatient or Ambulatory Surgery
- All Cancer Treatment (including Chemotherapy and Radiation)
- Air Ambulance – service will be coordinated by Insurer's air ambulance provider
- Prescription medications in excess of $3,000 per refill
- Any condition, which does not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per year

Medical Emergency Pre-Authorizations must be received within 48 hours of the admission or procedure. In instances of an emergency, you or the Plan Participant should go to the nearest hospital or provider for assistance even if that hospital or provider is not part of your Network.

Failure to obtain pre-authorization will result in a 30% reduction in payment of covered expenses. Any such penalty will apply to the entire episode of care and does not apply to the Out-of-Pocket maximum. If treatment would not have been approved by the Pre-Authorization process, all related claims will be denied.

Q. How Do I file a claim?

A. Claims must be filed within 180 days of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service provider does not bill the Insurer directly, and when you have out-of-pocket expenses to submit for reimbursement.

Claim forms are available at the following link:
https://www.1stagency.com/umbraco/Surface/College/ClaimForm/91

Q. When do I need to file a claim form?

A. Claim forms should only be submitted when the medical service provider does not bill the Insurer directly, and when you have out-of-pocket expenses to submit for reimbursement. See above question for filing directions.

Q. How do I check the status of a claim?

A. Plan participants wishing to request the status of a claim or have questions, please submit the status request form via www.gbg.com or email Customer Service at gbgassist@gbg.com . Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.