WellAway

Premier - Freedom 70 Plan

New American - Expat Coverage in the USA

Schedule of Benefits

Plan Details	In Network	Out of Network
Coverage Area	*USA*	*USA*
Annual Maximum Benefit Limit	Unlimited	Unlimited
Deductible	USD $4,600 Individual USD $9,200 Family	USD $9,200 Individual USD $18,400 Family
Coinsurance	70%	50%
Annual Out of Pocket Maximum*	USD $6,300 Individual USD $12,600 Family	USD $12,600 Individual USD $25,200 Family

Hospital & Surgical Care

In-Patient Hospital Facility	100% After Deductible and Coinsurance	50% After Deductible and Coinsurance
Inpatient Rehabilitative & Habilitative Services (Limited to 45 days)	100% After Deductible and Coinsurance	50% After Deductible and Coinsurance
Physicians Services (All Locations)	100% After Deductible and Coinsurance	50% After Deductible and Coinsurance
Ambulatory Surgical Center	100% After Deductible and Coinsurance	50% After Deductible and Coinsurance
Outpatient Hospital Facility	100% After Deductible and Coinsurance	50% After Deductible and Coinsurance

**** Member Out-of-Pocket costs are reimbursed according to the CFE fee schedule.***

	In Network	Out of Network
Obesity & Weight Loss	100% After Deductible and Coinsurance	50% After Deductible and Coinsurance

Emergency & Urgent Care

Urgent Care Center	USD $60 co-pay	USD $110 co-pay
Emergency Room (Waived if admitted to the hospital)	USD $260 co-pay	USD $260 co-pay
Emergency Medical Transportation	USD $110 co-pay	USD $110 co-pay

Outpatient Office Visits

Physician Office Visits	USD $30 co-pay (Limited to 30 visits)	50% After Deductible
Specialist Physicians	USD $50 co-pay (Limited to 25 visits)	50% After Deductible

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	In Network	Out of Network
Preventive Services		
Preventive and Wellness Care (physical, mammogram, immunizations)	100%	100% 100% (mammogram and colonoscopy) **
Vision & Dental Services for Children Under the Attained Age of 19		
Routine Eye Exam for Children (Optometrist or Ophthalmologist) (limited to 1 visit/benefit period)	100%	50% After Deductible*
Eyeglasses for Children (1 item per year)	100%	50% After Deductible*
Dental Check-up for Children (limited to 2 visits per year)	100% After Deductible and Coinsurance*	50% After Deductible*
Outpatient Diagnostic Services		
Independent Clinical Lab	100% After Deductible and Coinsurance*	50% After Deductible*
Basic Imaging (e.g. X-ray, Ultrasound)	USD $60 co-pay*	50% After Deductible*

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	In Network	Out of Network
Advanced Imaging (e.g. CT, CAT Scan, MRI, MRA)	USD $110 co-pay*	50% After Deductible*

Outpatient Rehabilitation & Habilitation

Rehabilitation Services (Limited to 20 visits per year)	USD $40 co-pay*	50% After Deductible*
Habilitation Services (Limited to 20 visits per year)	USD $40 co-pay*	50% After Deductible*
Skilled Nursing (Limited to 20 visits per year)	USD $260 co-pay per day (USD $750 limit/admit) *	50% After Deductible*
Durable Medical Equipment	100% After Deductible and Coinsurance*	50% After Deductible*
Therapies & Spinal Manipulation (Limited to 60 visits per year)	100% After Deductible and Coinsurance*	50% After Deductible*
Home Health	100% After Deductible and Coinsurance*	50% After Deductible*
Hospice Care	100% After Deductible and Coinsurance*	50% After Deductible*

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	In Network	Out of Network
Mental Health Substance Dependency		
Specialist Office Visits	USD $50 co-pay (Limited to 25 visits)*	50% After Deductible*
Inpatient Facility	100% After Deductible and Coinsurance (Limited to 15 days)*	50% After Deductible*
Maternity Care		
Prenatal and Postnatal – Office Visit	100%	50% After Deductible*
Labor and Delivery – Hospital Stay	100% After Deductible and Coinsurance*	50% After Deductible*
Birthing Center	USD $310 Co-pay*	50% After Deductible*
Newborn Care	100% After Deductible and Coinsurance*	Not Covered
Congenital Anomaly - Cleft Lip/ Palete	100% After Deductible and Coinsurance*	50% After Deductible*
Infertility Treatment	Not Covered	Not Covered

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	In Network	Out of Network
Other Benefits		
Cancer treatment, oncological drugs and treatment, including reconstructive surgery for breast cancer	100% After Deductible and Coinsurance*	50% After Deductible*
Dialysis Center	USD $310 co-pay then 100% After Deductible and Coinsurance*	Not Covered
Prescription Drugs		
Generic Drug Tier 1 (Retail Pharmacy/Mail Order)		
Preventive (e.g. oral contraceptives)	USD $0 / $0	Not Covered
All other generic	USD $15 co-pay*	Not Covered
Brand Drugs - Tier 2 (Retail Pharmacy/Mail Order)		
Condition care Rx (e.g. asthma, cholesterol, diabetes, high blood pressure)	USD $20 co-pay*	Not Covered
All other Preferred Brands	USD $30 co-pay*	Not Covered
Non-Preferred Brand Drugs - Tier 3 (Retail Pharmacy/Mail Order)		

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	In Network	Out of Network
Non-Preferred Brand	USD $60 co-pay*	Not Covered
Specialty Drugs - Tier 4 (Retail Pharmacy/Mail Order)		
Special (Purchase from Specialty Pharmacy)	USD $110 co-pay*	Not Covered

** MAF

Notes: 1. Maximum Eligibilty Age - 64 2. **Non-Tobacco** users are eligible for a 10% discount on their premium rates.

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