



Prestige - Freedom 80 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 \$2,500 Individual USD \$5,000 Family	USD \$5,000 Individual USD \$10,000 Family
Coinsurance	80%	50%
Annual Out of Pocket Maximum*	USD \$3,500 Individual USD \$7,000 Family	USD \$7,000 Individual USD \$14,000 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.



WellAway

In Network

Out of Network

Obesity & Weight Loss	100% After Deductible and Coinsurance*	50% After Deductible and Coinsurance*
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Emergency & Urgent Care

Urgent Care Center	USD \$55 co-pay*	USD \$105 co-pay*
Emergency Room (Waived if admitted to the hospital)	USD \$255 co-pay*	USD \$255 co-pay*
Emergency Medical Transportation	USD \$105 co-pay*	USD \$105 co-pay*

Outpatient Office Visits

Physician Office Visits	USD \$25 co-pay (Limited to 30 visits)*	50% After Deductible*
Specialist Physicians	USD \$45 co-pay (Limited to 25 visits)*	50% After Deductible*

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WellAway

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 \$55 co-pay*	50% After Deductible*

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In Network

Out of Network

Advanced Imaging (e.g. CT, CAT Scan, MRI, MRA)	USD \$105 co-pay*	50% After Deductible*
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Outpatient Rehabilitation & Habilitation

Rehabilitation Services (Limited to 20 visits per year)	USD \$35 co-pay*	50% After Deductible*
Habilitation Services (Limited to 20 visits per year)	USD \$35 co-pay*	50% After Deductible*
Skilled Nursing (Limited to 20 visits per year)	USD \$255 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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Mental Health Substance Dependency

Specialist Office Visits	USD \$45 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 \$305 Co-pay*	50% After Deductible*
Newborn Care	100% After Deductible and Coinsurance*	Not Covered
Congenital Anomaly - Cleft Lip/ Palette	100% After Deductible and Coinsurance*	50% After Deductible*
Infertility Treatment	Not Covered	Not Covered

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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 \$305 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 \$10 co-pay*	Not Covered
Brand Drugs - Tier 2 (Retail Pharmacy/Mail Order)		
Condition care Rx (e.g. asthma, cholesterol, diabetes, high blood pressure)	USD \$15 co-pay*	Not Covered
All other Preferred Brands	USD \$25 co-pay*	Not Covered
Non-Preferred Brand Drugs - Tier 3 (Retail Pharmacy/Mail Order)		

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Non-Preferred Brand	USD \$55 co-pay*	Not Covered
Specialty Drugs - Tier 4 (Retail Pharmacy/Mail Order)		
Special (Purchase from Specialty Pharmacy)	USD \$105 co-pay*	Not Covered

** MAF

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

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