WellAway

La Vie a l'Etranger

Member Guide

For Health Coverage in the USA

Including the CFE,

Caisse des Français de l'Etranger

February 2015

Keeping you well, while you're away!

WellAway, Ltd.

Canon's Ct., 22 Victoria St.,

PO Box HM1179

Hamilton, HM EX, Bermuda

Contents

Welcome to La Vie a l'Etranger…

Introduction

On behalf of us all at WellAway, Ltd., welcome to La Vie a l'Etranger. As an exclusive member, you now have access to healthcare coverage and other wellness tools and services delivered from the best health care professionals across the USA.

How to use this Member Guide

This Member Guide is an important document. It sets out your rights and our obligations to you. Along with your Schedule of Benefits and Policy Terms & Conditions, this guide outlines how to use your La Vie a l'Etranger membership to seek medical, pharmacy, vision, dental and wellness services in the USA and in France.

Inside you will find details of:

- The benefits available to you
- Your rights and responsibilities
- How to make a claim or file for reimbursement
- How your Plan is administered
- How to contact customer support
- Other services available to you under your plan

Your Personal ConciergeCare Counselor

As a WellAway member, you are assigned a personal ConciergeCare Counselor who can help answer all your general questions and inquiries.

You can contact your ConciergeCare Counselor at any time by dialing **+1 (855) 773-7810** or by logging in to your **Member Portal** online at portal.wellaway.com.

Additionally, your ConciergeCare Counselor can assist you with accessing a number of different services at any location. Our ConciergeCare services include:

- 24/7 Emergency Medical Assistance
- 5-Star Customer Service from French-Speaking Individuals
- Travel Allowances for medically necessary Services in France
- Disease Management
- Online Personal Health Records with Medical Record Retrieval
- Provider Search Assistance with Appointment Setting, e-Consultations, and Second Medical Opinions

About WellAway

WellAway, Ltd. is an insurance manager headquartered in Bermuda with offices in Belgium, Florida, and France. WellAway provides a portfolio of flexible coverage options and customized solutions to meet the ever-changing needs of today's global citizen.

We specialize in health and travel insurance for expatriates including unique health programs for foreign nationals living throughout the world. Each of our products offer an extensive set of benefits coupled with the highest standard of customer service to provide unquestionable peace-of-mind for expatriates and their families, employers, students and global travelers.

Our Mission is to empower global travelers and expatriates with the support and coverage options to keep them healthy and safe wherever they may roam.

Our Values

- Exceptional member service is not just a goal; it's built into every service and every interaction. We place the satisfaction, health and well being of our members at the forefront of everything we do.
- Integrity and transparency are the foundations of our business and our stellar reputation. We honor our commitments and keep our promises.
- Accessibility is the key driver to our service and product design. We seek to offer the most efficient coverage available with benefits and resources tailored to suit your lifestyle.
- Home is always where the heart is. We try to help all our members believe that home is one call away with WellAway.

La Vie a l'Etranger & You

Program Overview

For French citizens seeking health & wellness solutions to match their Expat lifestyles...

La Vie À l'Étranger is a health & lifestyle program designed to meet the needs of French expatriates residing in the USA. As a member, you gain the comfort of knowing that home is always with you in all matters relating to your health and well being.

Coverage options for wherever life may take you...

With USA-compliant coverage, La Vie À l'Étranger allows you to use your CFE (Caisse des Français de l'Etranger) benefits to cover out-of-pocket medical costs. Our robust global medical provider network and wellness tools are uniquely designed for expatriates and their families.

Exceptional service is part of what makes us different.

Through our unmatched customer service, we ensure that our valued members are treated with the utmost care, attention and professionalism. WellAway is committed to developing a health, wellness and expat support system for French citizens that is unlike any other product on the market.

Our unique combination of health coverage and wellness tools provide French expatriates with benefits like never seen before...

As a member of La Vie À l'Étranger you get more than just health insurance - we provide you with a complete array of tools and coverage options to protect you and your family's health while living abroad.

Your CFE Complémentaire

As an official partner of the CFE (Caisse des Français de l'Etranger), La Vie a l'Etranger includes a CFE Complémentaire that provides you with extensive health benefits to keep you healthy and safe while abroad or while seeking medically necessary services in France.

Your CFE Complémentaire contains two parts – an ACA-Compliant Health Plan for In-Network and Out-of-Network services provided in the USA and your CFE Reimbursements for services provided in the USA and worldwide. By combining these two parts, we are able to reduce your share of your healthcare expenses to its minimum.

Depending on your coverage purchased, your CFE Complémentaire will include varied deductibles, coinsurances, and out-of-pocket maximums.

Coverage options include the Elite, Prestige and Premier Plan.

	Elite		Prestige		Premier	
Annual Maximum	Unlimited		Unlimited		Unlimited	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Coinsurance	10%	50%	20%	50%	30%	50%
Deductible Individual/Family	USD $1,000/$2,000	USD $2,000/$4,000	USD $2,500/$5,000	USD $5,000/$10,000	USD $4,600/$9,200	USD $9,200/$18,400
Out-of-Pocket Max Individual/Family	USD $1,500/$3,000	USD $3,000/$6,000	USD $3,500/$7,000	USD $7,000/$14,000	USD $6,300/$12,600	USD $12,600/$25,200

Please refer to your Schedule of Benefits or approved Application Form for clarification of your coverage.

Part 1 – WellAway Covered Services

Your WellAway health plan has been designed to meet **Minimum Essential Coverage** and has been approved by the Center for Medicare Services in the USA. In order to maintain compliancy, these benefits and services are provided with an **unlimited annual maximum** and include all **Essential Health Benefits** (EHBs) mandated under the ACA. These include:

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Pregnancy, Maternity, and Newborn Care
5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment
6. Prescription Drugs
7. Rehabilitative and Habilitative Services and Devices
8. Laboratory Services
9. Preventive and Wellness Services and Chronic Disease Management
10. Pediatric Services

Each of the individual benefits or covered services included in the mandated EHBs can be found within the WHAT IS COVERED section of your Policy Terms & Conditions or within your Schedule of Benefits.

Part 2 – CFE Covered Services

While WellAway provides coverage for the medical services received via In-Network or Out-of-Network providers in the USA, as a CFE contributor you are also entitled to receive further reimbursements based on the allowed amounts for the same or a similar service in France. These benefits are only provided to you as long as you continue to make your quarterly contribution to the CFE.

The CFE will provide varied reimbursements for non-hospitalized or hospitalized services including, but not limited to:

1. Medical
2. Surgery
3. Maternity & Delivery
4. Intensive Care
5. Dialysis
6. Chemotherapy

For a complete list of covered services under your CFE benefits, please refer to the "CFE in the USA" column of your Schedule of Benefits, or visit www.cfe.fr for more information.

Part 3 - Other Benefits

Medication Program

Coverage for prescription drugs and Supplies and select Over-the-Counter ("OTC") drugs purchased at a participating pharmacy is provided through the **WellAway - EHIM PBM Medication Program** administered by EHIM PBM described in this section.

Medication Program features include:

- Direct Billing Pharmacy Network
- Drug Abuse Prevention Programs
- 24/7 Customer Support
- Convenient Mail-In Pharmacy
- 4 Tiers of Coverage:
  - Tier 1: Preferred Generic Prescription Drugs and Covered OTC Drugs.
  - Tier 2: Preferred Brand Name Prescription Drugs and Supplies.
  - Tier 3: Non-Preferred Prescription Drugs.
  - Tier 4: Specialty Drugs

Some health care services are available in a pharmacy and in a medical office or facility, however we will only pay for them under one benefit (medical or pharmacy). For this reason, some items are excluded from this program but covered under the medical benefits.

In the **Medication Guide** provided you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs, Covered OTC Drugs, Specialty Drugs and all drugs that require pre-authorization. You may be able to reduce your out-of-pocket expenses by: 1) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; 2) choosing Generic Prescription Drugs rather than Brand Name Prescription Drugs; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

To verify if a pharmacy is a participating pharmacy, or to view the Medication Guide you may access the Medication Guide on your member portal at portal.wellaway.com or call your personal ConciergeCare Counselor using the phone number on your ID Card.

Vision

Please contact your **ConciergeCare Counselor** at **+1 (855) 773-7810** for assistance and listing of participating vision providers in your area.

Dental

Please contact your **ConciergeCare Counselor** at **+1 (855) 773-7810** for assistance and a complete listing of participating dental providers in your area.

ConciergeCare Services

WellAway prides itself on offering its services in the most approachable and relatable manner possible. For this reason, each policyholder and their dependents have been assigned a personal **ConciergeCare Counselor** to assist with all and any inquiries regarding their coverage or membership.

As an exclusive member of our *La Vie À l'Étranger* program you are entitled to all ConciergeCare Services at **no extra cost**.

Your personal **ConciergeCare Counselor** will provide the following services:

- *White Glove Customer Service in French*

  This includes assisting with all or any member requests, personal policy management as well as providing updates on claim statuses, advice on health or wellness decisions and more.

- *Provider Search Assistance*

  While our Open-Access provider network boasts over 1.1 million healthcare professionals, finding the right provider can often be difficult. By navigating the network carefully, you can help control the out-of-pocket costs you may be responsible for when seeking care. Members can contact their ConciergeCare Counselor to further discuss the provider options available in their local area, or they can access our Provider Search online here at www.wellaway.com/provider-search.

- *Appointment Setting with Best-In-Class Providers*

  In addition to helping you find a provider, your ConciergeCare Counselor can also help schedule an appointment ahead of time and coordinate any other medical visits necessary during your episode of care.

- *Disease & Case Management Programs*

  WellAway's medical team offers unmatched disease and case management services to help improve the experience of each of our members as they undergo their course of treatment. Your ConciergeCare Counselor is your liaison between you and our medical team. They will provide

updates on your episode of care as well as any information arising from our concurrent reviews or cost-containment efforts.

- *24/7 Emergency Medical Assistance*

  Our ConciergeCare team is available 24/7 to ensure you and your family that regardless of the time or your whereabouts, we can always assist you with any emergency medical situation and help you avoid the hassle of locating the necessary services yourself.

- *House Visits*

  For members whom are unsure if they need to visit an urgent care center or emergency room, your ConciergeCare Counselor can instead arrange a house visit from our network of doctors offering house-call services. Doctors can treat, diagnose, prescribe medication and recommend further treatment if necessary. This is an ideal option for those with minor injuries or illnesses and can save you having to pay more out-of-pocket costs or copays.

  Important: House Visits are limited to four (4) visits per Policy Year up to $100 USD and must be pre-authorized by your ConciergeCare Counselor.

Contacting your Personal ConciergeCare Counselor

Important: You can contact your ConciergeCare Counselor by calling +1 (855) 773-7810

This number is also located on your ID Card and within your Policy Terms & Conditions.

Additionally, you can contact your ConciergeCare Counselor online via your member portal at portal.wellaway.com.

Online Personal Health Record

As a member, you and your family are provided with their own **Online Personal Health Record (PHR)** to help manage their health and wellbeing. PHRs are also accessible via an **iOS or Android** mobile app.

PHR Platform Features:

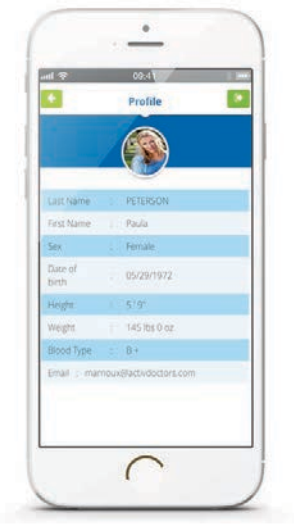
- Health History
- Health Tracker
- Medical Documents
- Medical Record Assistance
- Reminders

Benefits to Individuals & Families:

- Lower your medical expenses.

- Upload medical records for multiple doctors.
- Share your records with family members, friends, doctors and other caregivers.
- Improve your health by tracking key vitals.
- Avoid unnecessary procedures and diagnostic tests.
- Receive reminders about upcoming appointments and medications that need to be refilled.

Setting Up Your Online PHR



Your online PHR is powered by our partner, **ActivDoctors Online**. To log in to your online PHR, please follow the instructions in the email notifications you received upon your coverage's Effective Date. You, your spouse and your dependents will each receive three (3) emails including a welcome letter, your temporary username and password, and a digital authorization form to allow the collection and maintenance of your personal health information.

Important: You must complete this authorization as it ensures WellAway, Ltd and/or any of its representatives are not liable for any damages to or unlawful uses of your Personal Health Information. This liability is assigned to ActivDoctors Online under your authorization.

Additionally, you can log in to your PHR or find a link to download the ActivDoctors mobile app via your Member Portal.

Once you have accessed your PHR, it is recommended you take the following steps:

1. Confirm your permanent username and password.
2. Ensure your Personal ConciergeCare Counselor has been assigned to your PHR by visiting the contacts section of your dashboard.
3. Begin completing any personal health information available.
4. Once your spouse or dependents have done the same, add them to your contacts to ensure you have access to all your family members' health information.
5. Compile and submit a list of your previous doctors or physicians whom you may need to collect past medical records from.
6. Inform your doctor or physician that you now have access to an online Personal Health Record.

For assistance with setting up your online PHR for you and your family, feel free to contact your Personal ConciergeCare Counselor.

Second Medical Opinions & e-Consultations

As an additional service included in your Online PHR platform, our e-Consultations and Second Medical Opinions allow you to schedule a "virtual office" visit with physicians over the Internet via webcam and over the phone on a secure, encrypted platform or even review a diagnosis you may be unsure about. Physicians or doctors can discuss your symptoms, diagnose conditions, recommend treatment plans, and prescribe medication when needed. Key features included in these services are:

- 48 hour Second Medical Opinions for simple or complex diagnosis
- Access to a large network of credentialed and best-rated doctors and medical specialists with e-consultation capabilities
- Set appointments online and on the go from your mobile phone
- Integration with your online personal health records for quick retrieval of your medical history
- Receive a medical report with diagnosis and recommended treatment plan
- Reduced ER visits and unnecessary treatments

e-Consultations and Second Medical Opinions are charged on a per case basis and are NOT included in your premium. They are charged as follows:

e-Consultations: $25 per each session Second Medical Opinion: $300 per each request

IMPORTANT: All Second Medical Opinions & e-Consultations are additional charges per each service as determined by the agreement between ActivDoctors Online and WellAway, Ltd. These services are at your or your dependents expense and are not reimbursable or applicable to the out of pocket maximum.

How to Request a Second Medical Opinion

1. Click on Second Medical Opinions across the top of your dashboard in your online or mobile PHR.
2. Complete the required fields. Be sure to include details of your medical condition, past physician visits and concerns about current or past diagnosis.
3. Agree to authorize physician access and to provide accurate medical history.
4. Click Submit.
5. Your request will be sent to your ConciergeCare Counselor and they will confirm your request via email.

How To Schedule an e-Consultation

1. Click e-Consultations across the top of your dashboard in your online or mobile PHR.
2. Complete all required fields in Steps 1 and 2 of the dialogue window including your location, time-zone, desired date, consultation type (video, phone, etc), and condition. You can also have this information sent to your primary care physician or treating doctor.
3. You will be presented with a medical summary of your requested e-Consultation. Check the 3 boxes at the bottom of your window and agree to all terms and conditions.
4. Click submit and confirm your billing information in the next window.
5. Once confirmed, your e-Consultation request will be sent to your ConciergeCare Counselor and you will receive further confirmation of the assigned physician and exact date & time via email.
6. You can check the status of your e-Consultation requests in the same e-Consultation window via the button on your PHR dashboard.
7. Once the status has been determined as scheduled, be sure to return to this request on the date and time you have chosen to conduct your e-Consultation as it will be conducted via a secure platform accessed through this section.

"Return Home" Travel Allowances

Exclusive to La Vie a l'Etranger members, we will provide **travel allowances** for you or your covered family member requiring medically necessary services **back in France** or their country of origin.

This service is provided to you in order to grant you the comfort of having **family and friends back home** at your side during treatment or having a **familiar surgeon** perform their medically necessary operation.

Our "Return Home" option includes:

- Allowance for a standard round-trip economy airline ticket back home per year per covered individual.
- 24/7 customer support in your native language.
- Post-care or post-treatment Medical Record Retrieval.

How To Schedule a "Return Home" Travel Allowance

The *"Return Home"* option is available to you or your family members who are enrolled as a spouse or dependent in your policy. This option includes a reasonable allowance for one (1) economy airline ticket back to France or your country of origin per each policy member per year.

The *"Return Home"* option can only be utilized when the treatment sought in France or your country of origin is medically necessary as approved by a physician or doctor in writing and should be submitted to your

ConciergeCare Counselor for prior-authorization. Please note: You must have approval and clearance to travel from your treating physician or doctor in order to exercise this option.

Additionally, this option will only be approved for the following treatments or services available in France or your country of origin upon diagnosis:

- ✓ Invasive Cancer Treatment
- ✓ Multiple Sclerosis
- ✓ End Stage Renal Disease
- ✓ Spinal Chord Injuries
- ✓ Angioplasty In Relation to a Cardiac Condition
- ✓ An Episode of Rehabilitation due to a Severe Injury

To schedule your trip, ensure you complete the following steps:

1. Obtain a written approval from your doctor or physician in the USA clearly stating that the treatment or services you are seeking are medically necessary and that you are cleared to travel.
2. Submit your approval to your ConciergeCare Counselor for prior-authorization via your member portal or by email.
3. Identify a provider in France or your country of origin and ensure they will provide the required services.
4. Identify the dates and times for your travel itinerary. Once you've found available dates, pay for and book your ticket. Be sure to save a copy of the confirmation or receipt, as you will need it to claim your travel allowance.
5. Next, you must a submit a properly completed claim form, your travel Itinerary with proof of payment receipt to your ConciergeCare Counselor **within 30 days** from the date of purchase via your member portal or by email. We will review your request and notify you within 48 hours of our approval of the submitted documents.
6. Your pre-approved reimbursement will be processed and refunded to you **within 30 days** of our approval.

Pre-approved travel claim reimbursement requests must be sent to:

PayerFusion Holdings LLC
5200 Blue Lagoon Drive, Suite 100
Miami Fl 33126

Exclusions & Limitations

The "Return Home" option is limited to and excludes the following:

1. You and each of your enrolled family members are allowed one (1) "Return Home" option per member per policy year.
2. The value of one (1) economy airline ticket has been limited to $1,200 USD as determined by WellAway, Ltd. The Insured will be responsible for any additional costs beyond this amount.
3. All pre-approved travel reimbursements incurred by you or your covered dependent must be submitted within 30 days from the date of purchase. Reimbursement request past the 30 days of purchase will not be covered even if pre-approved.
4. If the full value of your ticket is below our allowance maximum, the remaining balance is waived and will NOT be available for another trip during that Policy Year.
5. This option is limited to only seeking the approved medical services for the diagnoses mentioned above. It excludes all and any other services or treatments not mentioned.
6. All services or treatments administered in France or your country of origin are limited only to the treatment or service itself and does not include diagnosis, second medical opinions, or peer reviews.
7. Lodging, meals, transportation or any other fees incurred while exercising the "Return Home" option are not included and will not be reimbursed by WellAway.
8. Any appointments, travel arrangements or medical services utilized without receiving prior authorization from your ConciergeCare Counselor will not be reimbursed.

Using our Open-Access Provider Network

Another key way you can contain the costs of the medical services you are receiving while living here in the USA is by taking advantage of our Open-Access Provider Network. These In-Network Providers have been contracted to provide medical services at a pre-negotiated rate to maximize the savings achieved on your medical bill. These amounts are clearly identified on your Schedule of Benefits and adhere to the In-Network Provider provisions outlined in your Policy Terms and Conditions.

Finding A Provider

We have provided our members with two options when needing to locate a provider. As outlined under the ConciergeCare Services above, you can call your ConciergeCare Counselor and request assistance in locating a provider depending on your location or specialty needed. Your ConciergeCare Counselor will then present you with a variety of options and help you choose the best provider based on their past performance with other members as well as a number of other factors including cost, efficiency and more.

If the provider you are seeking is an out-of-network provider, your ConciergeCare Counselor may suggest an in-network provider that offers the same services.

Alternatively, you can access our online provider search by clicking here www.wellaway.com/provider-search

Once you have reached our Provider Search page, complete the following steps:

1. Choose your search method from the available tabs.
2. Complete the required selections based on the type of provider you are seeking and the location you are searching.
3. **Important**: Always select the Primary PPO Network in the "Select a Plan" drop-down.
4. Click "Search".

After locating a provider, take advantage of our appointment setting service by contacting your ConciergeCare Counselor.

*Disclaimer: We are not responsible for the accuracy of the information provided on Aetna's Provider Search. Provider information contained in this directory is subject to change at any time. Therefore please check with the provider before scheduling your appointment or receiving services to confirm he or she is participating in Aetna's network as specified under your plan. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna nor WellAway. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

Please contact your **ConciergeCare Counselor** should you require any additional assistance.

At the Doctor's Office/Hospital/Clinic/etc.

Now that you've arrived at one of our in-network providers, be sure to present BOTH your WellAway ID Card and CFE ID Card. You must inform your provider that your coverage is provided by two insurances – WellAway and the CFE.

Your provider will contact WellAway for verification of your eligibility and confirm your estimated responsibility for your visit or treatment.

If you have already met your Out-of-Pocket Maximum for the Policy Year, many of our in-network providers will not have to collect any money from you for covered services. If they do require you make a payment at that time, be sure to hold on to any and all receipts. You will need these if you have to file a post-service claim.

About Your Policy

Premium Payments

Your coverage is not effective until we receive and accept the Policyholder's application and the first Premium payment, in full. All future Premium payments are due, in full, in advance or within the Grace Period. If we do not, for any reason, provide you with a notice of payment due, you, as the Policyholder, are still obligated under this Policy to pay Premiums on time, even if you do not receive a bill from us. You, as the Policyholder, are solely responsible for submitting the Premium by the end of the Grace Period.

Paying Your Premium

All premiums are payable monthly, quarterly, or on an annual basis.

You can pay your premium using:

1. Automatic Payments – If you select to arrange automatic payments at the time you enrolled in your WellAway coverage, your credit card or debit card will have the amount due directly debited on the due date indicated on your bill.

Note: Your contributions towards the CFE are not included in your WellAway Premium and must be paid separately as they become due directly to the CFE. If you fail to pay your CFE contribution, your WellAway Premium will be readjusted to reflect the non-CFE rates available.

For more information on your premium or paying your premium, please refer to the PAYMENT OF PREMIUMS section in your Policy Terms & Conditions.

CFE Contributions

Please refer to your CFE member materials for further information on making your contribution payment.

Adding Dependents

A person who meets the standards required by the Affordable Care Act and meets the eligibility criteria specified below is eligible to apply for coverage under this Policy as an Eligible Dependent only if the person: 1) was named on the initial application for, or properly enrolled under, this Policy; 2) pays the required Premium; and is:

1. The Policyholder's spouse under a legally valid existing marriage;
2. The Policyholder's or Covered Domestic Partner's natural, newborn, Adopted, or step child (or a child for whom the Policyholder or Covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Policy Year in which he or she reaches age 26, regardless of the dependent child's student or marital status, financial dependency on the covered

parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan;

3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: You are solely responsible, as the Policyholder, to establish that a child meets the eligibility rules. Eligibility will end when the child no longer meets the eligibility rules required to be an Eligible Dependent described above. For dependents that no longer meet eligibility due to passing the attained age of 26, we can offer the option to enroll in their own individual policy.

For more information regarding your dependent's eligibility, please refer to the ELIGIBILITY FOR ENROLLMENT section in your Policy Terms & Conditions or contact your ConciergeCare Counselor.

Conditions of Renewal & Termination

This Policy is guaranteed renewable while you are domiciled or living in the United States and you may fall under the guidance of the Affordable Care Act (ACA). This means that it automatically renews each year on the Anniversary Date unless terminated earlier in accordance with the terms of this Policy. We may terminate this Policy or refuse to renew it if:

1. Premiums are not paid in accordance with the terms of this Policy or we have not received timely Premium payments;

2. You perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact; or

3. You fail to comply with a material provision of the Policy.

If we decide to terminate the Policy or not renew it, based on one or more of the actions listed above, we will provide at least 45 days advance written notice.

Member Resources

Policy Documents

As a part of your Welcome Package, you should have received the following policy documents:

1. Your **Policy Terms & Conditions** – This document serves as a legally binding contract to your Policy and Us. Within it, you will find information on what is and is not covered, your pharmacy benefits, rules for enrollment, dependent eligibility, and more.
2. Your **Outline of Benefits** – This document highlights the different type of coverage available to you when using your in-network, out-of-network or CFE benefits. It includes information regarding your deductible, out-of-pocket maximum, coinsurances, copays and any limits to your coverage.
3. Your **Summary of Benefits & Coverage** – This document, as mandated by the ACA, provides you with real-life examples of how your coverage will work and what cost-share amounts are your responsibility in certain situations.
4. This **Member Guide** – As outlined in the prior sections, this document includes useful information surrounding how to use your Policy and Benefits.
5. A copy of your **Application** – This has been provided to you for you benefit. It is encouraged you keep a copy of your approved application for future reference.
6. Your **WellAway ID Cards** – As indicated below, this document includes important information for using your benefits when visiting or seeking treatment from a provider.

For copies of these documents in both digital and print form, please contact your ConciergeCare Counselor.

ID Cards

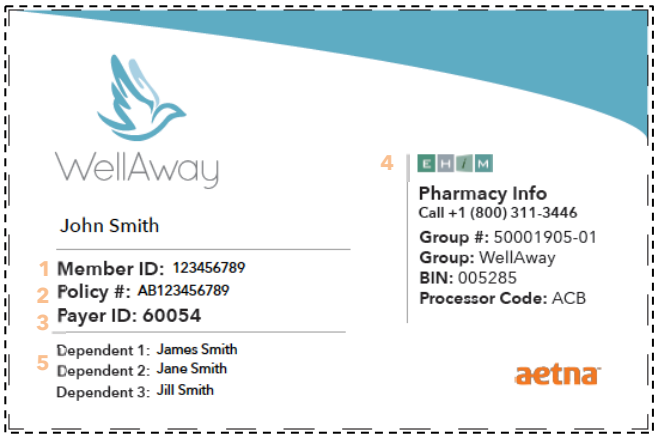
Your WellAway ID Cards are your key to accessing all of the services available to you as a member. These cards are issued to you and each of your dependents in addition to your CFE ID card. Each contains the necessary information needed by your provider in order to submit your claim to us for proper processing.

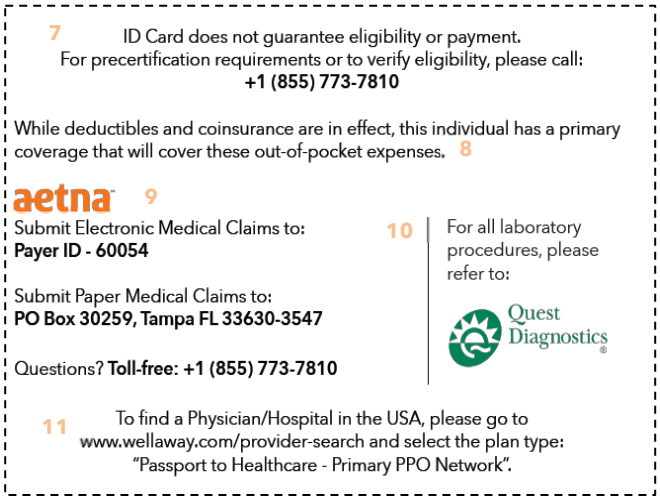
It is important you ensure the information on this ID Card is accurate. If not, please contact your ConciergeCare Counselor and request a new copy with the correct information.

It is recommended you print your ID Card and keep it safe. Additionally, you can digitally save your ID Card on your phone or download one online through your member portal.

Understanding your ID Card

Below you will find an example of the ID Card that you should have received in your Welcome Package. Each contains the individual's name, their Member ID, the Policy Number and more.





1. Member ID – This is unique to you as a Policyholder and each of your enrolled dependents.

2. Policy # – This is unique to your policy.

3. Payer ID – This is our unique identifier to indicate to your provider how and whom to direct bill.

4. Pharmacy Info – This section includes the necessary information to access your pharmacy benefits via our Pharmacy Benefit Manager - EHIM

5. Covered Dependents Under 18 – This section indicates your covered dependents whom are under the age of 18.

6. Your Provider Network – This logo indicates the provider network you are given access to as a member.

7. Precertification – Accessing your benefits using this card requires your provider to verify you are covered by contacting us.

8. Primary Coverage – This indicates to your provider that you do not have to pay any out-of-pocket costs at the place of service.

9. Instructions to Submit a Claim – These instructions are intended to direct your provider where and how they should submit their claim for your billed services.

10. Laboratory Procedures – This section indicates whom your provider should refer you to or arranges an appointment with for all your laboratory procedures.

11. Provider Search – Here you will find instructions on how to search for a provider in the USA.

Member Portal

Your member portal is designed to be the central location for everything surrounding your La Vie a l'Etranger membership. This portal will not only act as a place to store important documents pertaining to your policy or to a claim, it will also include links to useful resources such as your online PHR, digital health & wellness guides, and our Provider Search.

Additionally, you can contact your ConciergeCare Counselor by sending them a message through your member portal or even submit a post-payment claim.

Your member portal username and temporary password will be sent to you separately for security purposes.

You can log in to your member portal by clicking here portal.wellaway.com

Useful Information

Below you will find different links and contact information that may be useful when using your benefits or coverage under this policy:

Important Links

WellAway.com	https://www.wellaway.com
Member Portal	portal.wellaway.com
WellAway Provider Search	https://www.wellaway.com/provider-search
Online Personal Health Record	https://login.activdoctorsonline.com/
CFE & Moi Maternite (iOS & Android)	http://www.cfe-maternite.com/

Contact Phone Numbers

WellAway – General	+33 1 78 90 38 68
Your Personal ConciergeCare Counselor	+1 (855) 773-7810

Contact Emails

WellAway – General	info@wellaway.com
Your Personal ConciergeCare Counselor	conciergecare@wellaway.com

Mailing Address

WellAway – Bermuda	Canon's Ct., 22 Victoria St., PO Box HM1179 Hamilton, HM EX, Bermuda

Definitions

The following definitions will help you understand the terms that are used in this Policy, including the Schedule of Benefits and any Endorsements that are part of this Member Guide. As you read through this Member Guide you can refer to this section; we have identified defined terms in the Policy, the Schedule of Benefits and any Endorsements by capitalizing the first letter(s) of the term.

Adoption or Adopt(ed) means the act of creating a legal parent/child relationship where it did not exist, declaring that the child is legally the child of the adoptive parents and their heir-at-law and is entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as defined by state or federal law, or a similar applicable law of another state.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Policy in connection with:

1. a Pre-Service Claim or a Post-Service Claim;

2. a Concurrent Care Decision, as described in the CLAIMS PROCESSING section; or

3. Rescission of coverage, as described in the TERMINATION OF COVERAGE section

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider, this amount will be established in accordance with the applicable agreement between that Provider and WellAway.
2. In the case of an In-Network Provider located outside of your state of residence or domicile this amount will generally be established in accordance with the negotiated price that our Third Party Administrator passes on to us, including any secondary or tertiary networks as permitted by law.
3. In the case of Out-of-Network Providers located outside of your service area who participate in the Network Traditional Program, this amount will generally be established in accordance with the negotiated price that the Area Networks passes on to us, except when the Area Provider Network is unable to pass on its negotiated price due to the terms of its Provider contract.
4. In the case of an Out-of-Network Provider that has not entered into an agreement with WellAway or its Third Party Administrator to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by WellAway that may be based on several factors, including but not limited to: (i) payment for such Covered Services under the Medicare programs; (ii) payment often accepted for such Covered Services by that Out-of-Network Provider and/or by other Providers, in other comparable market(s), that we determine are comparable to the Out-of-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating Providers in other Provider networks of third-party payers which may include, for

example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by us, with our Provider network strategies (e.g., does not result in payment that encourages Providers participating in a WellAway network or its Third Party Administrator Network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services

In no event will the allowed amount be greater than the amount the Provider actually charges.

If a particular Covered Service is not available from any Provider that is In-Network, as determined by us, the Allowed Amount, means the usual and customary charge(s) of similar Providers or the Medicare fee schedule for the geographic area.

You may obtain an estimate of the allowed amount for particular Services by calling the customer service phone number on your ID Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Policy apply. You should refer to the WHAT IS COVERED? section of this Policy and your Schedule of Benefits to determine what is covered and how much we will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with WellAway or its Third Party Administrator to provide access to a discount from the billed amount of that Provider, the allowed amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between our allowed amount and the amount billed for Covered Services by any such Out-of-Network Provider.

Anniversary Date means the date your new Policy Year begins, 12 months following your initial Effective Date of coverage.

Application Forms means those forms, electronic or paper, used to maintain accurate enrollment files under the Policy and which are approved for use by us.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to you with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without the proposed Ssrvices being rendered.

Coinsurance means the sharing of health care expenses for Covered Services between you and us. After your Deductible is met, we will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Company means under this Policy, the Insurance Company insuring the risk, by the name of Anahita Insurance Corporation.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized coverage, benefits, or payment for that course of treatment or number of treatments in writing.

As defined herein, a concurrent care decision shall not include any decision to deny, reduce, or terminate coverage, benefits or payment under the Case Management subsection of the WELLAWAY" BE HEALTHY" PROGRAMS section.

Condition means a disease, illness, ailment, injury, or pregnancy.

Copayment or Copay means the dollar amount established solely by us, which must be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost share may include, but is not limited to Coinsurance, Copayment and Deductible amounts. Applicable cost share amounts are identified in your Schedule of Benefits.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements, described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under the Policy other than as a Policyholder.

Covered Person means a Policyholder or Covered Dependent.

Covered Services means those Health Care Services which meet the criteria listed in the WHAT IS COVERED? section.

Creditable Coverage means health care coverage, which is continuous to a date within 63 days of your Enrollment Date. Such health care coverage may include any of the following:

1. a group health plan;
2. individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. benefits to members and certain former members of the uniformed services and their dependents;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a State health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan;
10. a health benefit plan of the Peace Corps;
11. Children's Health Insurance Program (CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider who is recognized for payment under this Policy, before our payment for Covered Services begins. Not all plans include a deductible.

Dentist means a person who is properly licensed by State or Federal regulation a similar applicable law in another state, as a doctor of Dental Surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the Service is rendered and acting within the scope of his or her license.

Domestic Partner means a person of the same or opposite gender with whom the Policyholder has established a Domestic Partnership.

Domestic Partnership means a relationship between the Policyholder and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. the Policyholder has submitted to us acceptable proof of evidence of common residence and joint financial responsibility; and
5. the Policyholder has completed and submitted any required forms to us and we have determined the Domestic Partnership eligibility requirements have been met.

Effective Date means, with respect to eligible individuals properly enrolled, when coverage first becomes effective, 12:01 a.m. on the date printed on the first page of this Policy; and with respect to eligible individuals who are subsequently enrolled, means 12:01 a.m. on the date coverage will begin as specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may reasonably be expected to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

Emergency Services means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient.

Endorsement means a document issued by us that changes or modifies language in this Policy. Endorsements may also be referred to as amendments.

Enrollment Date means the date of enrollment of the individual under this Policy.

Essential Health Benefits (EHB) means health care services included in the Affordable Act's definition and includes Services in the following ten categories:

1. Ambulatory Patient services
2. Emergency services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental Health and Substance Use Disorder services, including Behavioral Health treatment
6. Prescription drugs
7. Rehabilitative and Habilitative services and devices
8. Laboratory services
9. Preventive and Wellness services and Chronic Disease Management
10. Pediatric Services including Oral and Vision care

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by us:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the appropriate State Health authority and approval for marketing has not, in fact, been given at the time such is furnished to you;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the condition in question, as evidenced in the most recently published Medical Literature using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by us):

1. records maintained by physicians or hospitals rendering care or treatment to you or other patients with the same or similar condition;
2. reports, articles, or written assessments in authoritative medical literature and scientific literature;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating physician or institution or the protocols of another physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating physician or institution or by another physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the condition in question.

Note: Services or supplies which are determined by us to be Experimental or Investigational are excluded as described in the WHAT IS NOT COVERED? section. In making benefit determinations, we may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

FDA means the United States Food and Drug Administration.

Grace Period means the period immediately following the Premium due date as indicated on the Policyholder's billing statement.

Grievance means a written expression of dissatisfaction that is not an adverse benefit determination.

Health Care Services or Services means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other Services rendered or supplied, by or at the direction of, a licensed Provider.

Identification (ID) Card means the cards we issue to Policyholders. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Policy.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on your Schedule of Benefits under the heading "In-Network".

Otherwise, In-Network means, when used in reference to a Provider, any health care Provider who, at the time Covered Services are rendered to you, the Provider is an In-Network Provider under the terms of this Policy.

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under Policy with us to participate In-Network:

1. as an In-Network Provider for Services subject to an In-Network Provider Provision; or
2. as a Preferred Provider included in the panel of Providers designated by us as "In-Network" for your specific plan. (Please refer to your Schedule of Benefits).

For payment purposes under this Policy only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the State of domicile or residence who or which, at the time Health Care Services are rendered to you, participates as In-Network Program Provider under WellAway, Ltd. or its Third Party Administrator.

In-Network Provider Provision means any provision that conditions payment of benefits for select health care services, in whole or in part, on the use of In-Network Providers or Exclusive Pharmacies.

Medically Necessary or Medical Necessity means that, with respect to a health care service, a Provider, exercising prudent clinical judgment, provided, or is proposing or recommending to provide, the health care service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was/is:

1. In accordance with Generally Accepted Standards of Medical Practice;
2. Clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, disease or symptoms;
3. Not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider; and
4. Not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

- When determining whether a Service is not more costly than the same or similar Service as referenced above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

a. The Allowed Amount for the Service at the location for the delivery of the Service versus an alternate setting;
b. The amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or,
c. An analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

Note: The distance you have to travel to receive a health care service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

- Reviews we perform of Medical Necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular service. In performing Medical Necessity reviews, we may take into consideration and use cost data , which may be proprietary.

It is important to remember that any review of Medical Necessity by us is solely for the purpose of determining coverage or benefits under this Policy and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Policy as determined by us. In applying the definition of Medical Necessity in this Policy, we may apply our coverage and payment guidelines then in effect. You are free to obtain a service even if we deny coverage because the service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

Medication Guide for purposes of this Policy means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan. Note: The Medication Guide is subject to change at any time. Please visit www.wellaway.com for the most current guide or you may call the customer service phone number on your Identification Card.

Network means, or refers to, the preferred provider network comprised of both Providers and In-Network Providers, established and so designated by us, which is available to members under this Policy.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on your Schedule of Benefits under the heading "Out-of-Network".

Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered to you, is not an In-Network Provider under the terms of this Policy.

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to participate In-Network.

Out-of-Pocket Costs means your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Pharmacy Benefit Manager (PBM) In the United States, a **Pharmacy Benefit Manager** (**PBM**) is most often a third party administrator (TPA) of prescription drug programs. They are primarily responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

Policy includes this document, your application for this Policy, any Application Forms signed by the Policyholder and any amendments and/or Endorsements.

Policyholder means an individual who meets and continues to meet all applicable eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under Policy other than as a Covered Dependent.

Policy Year means the period of coverage lasting 12-months from the beginning of your Policy's Effective Date.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

Preferred Provider means a Provider of health care or a group of Providers of health care that has entered into a written agreement with us to render Health Care Services under this Policy.

Premium means the total amount required to be paid by the Policyholder to us in order to be covered under this Policy. The Premium is determined on the basis of the applicable Rates, Risk Class and certain demographics of individuals covered under this Policy.

Prescription means an order for drugs, Services or supplies by a Physician or other health care professional authorized by law to prescribe such drugs, Services or supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Policy condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A pre-service claim may be a Claim Involving Urgent Care. As defined herein, a pre-service claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Policy do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Primary Care Physician (PCP) means a Physician who specializes in internal medicine, family practice, general practice, or pediatrics.

Provider means any facility, person or entity recognized for payment by us under this Policy.

Rate means the amount we charge for coverage. The rate will vary depending on the Risk Class of each covered individual.

Rescission or Rescind refers to WellAway's action to retroactively cancel or discontinue coverage under this Policy. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

Risk Class is a grouping of Covered Persons who have similar characteristics. For example, Covered Persons who: are the same age; use tobacco products; live in the same geographical area; and who have elected the same benefit plan may be grouped into a Risk Class. The Risk Class of each Covered Person is determined by WellAway.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Specialty Drug means an FDA-approved Prescription Drug that has been designated solely by us, as a specialty drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to provide specific Prescription Drug products, as determined by us. In-Network specialty pharmacies are listed in the Medication Guide. The fact that a pharmacy is a participating pharmacy does not mean that it is a specialty pharmacy.