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NEW AMERICAN

Summary of Benefits

WellAway®

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PREMIER FREEDOM 4500

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WellAway®

Coverage USA & Worldwide

NEW AMERICAN/ SUMMARY OF BENEFITS

The use of a Select Provider will keep your costs to a minimum. If you do not choose a Select Provider, you will be responsible for the excess amount above 100% of the Usual, Reasonable and Customary Charges. Contact our ConciergeCare team to help you locate a Select Provider and assist you in scheduling an appointment.

PREMIER FREEDOM 4500

COST SHARE	Select/In-Network (USA)	Out-of-Network (USA)	Worldwide
Annual Limits	Unlimited	Unlimited	$1,000,000
Deductible The amount you owe for certain health care services, as indicated below.	$4,500 Individual $9,000 Family	$9,000 Individual $18,000 Family	No Deductible
Coinsurance Your share of costs on a covered health care service.	30%	50%	30%
Annual out-of-pocket maximum This amount is the maximum you will pay each benefit period. Deductibles, coinsurance and co-payments are included in reaching this amount.	$7,150 Individual $14,300 Family	$14,300 Individual $28,600 Family	No Out-of-Pocket Maximum

HOSPITALIZATION

Hospitalization (inpatient care)	Deductible then 30%	Deductible then 50%	30%
Rehabilitative services (inpatient care)	Deductible then 30%	Deductible then 50%	30%
Physician services (inpatient care)	Deductible then 30%	Deductible then 50%	30%
Psychiatric hospitalization	Deductible then 30%	Deductible then 50%	30%
Emergency medical transportation	$110 copay	$110 copay	30%

WELLNESS CARE

Routine physical exams	Paid in full	Not covered	30%
Cancer screening (mammogram, pap test, prostate)	Paid in full	Not covered	30%
Cryotherapy	Paid in full	Not covered	Paid in full
Teladoc	$10 copay through a Teladoc provider		

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PRESCRIPTION DRUGS	Select/In-Network (USA)	Out-of-Network (USA)	Worldwide
Preventive (e.g. oral contraceptives)	Paid in full	Not covered	30%
Generic	$15 copay	Not covered	30%
Brand	$30 copay	Not covered	30%
Non-preferred brands	$60 copay	Not covered	30%
Specialty (purchase from specialty pharmacy)	$110 copay	Not covered	30%

MATERNITY CARE

Prenatal and postnatal consultations	Paid in full	Deductible then 50%	30%
Labor and delivery - hospital stay	Deductible then 30%	Deductible then 50%	30%
Birthing center	$310 copay	Deductible then 50%	30%
Newborn care	Deductible then 30%	Not covered	30%
Congenital anomaly (e.g. cleft lip/ palate)	Deductible then 30%	Deductible then 50%	30%
Infertility treatment	Not covered	Not covered	30%
Sterilization (e.g. tubal ligations and vasectomies)	Paid in full	Deductible then 50%	30%

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OUTPATIENT CARE	Select/In-Network (USA)	Out-of-Network (USA)	Worldwide
Urgent care center	$60 copay	$110 copay	30%
Emergency room (waived with hospital admission)	$260 copay	$260 copay	30%
Outpatient hospital facility & surgical care	Deductible then 30%	Deductible then 50%	30%
Skilled nursing facility (limited to 20 visits)	$260 copay/day *($780 limit)*	Deductible then 50%	30%
General consultation / primary care visit	$30 copay	Deductible then 50%	30%
Specialist consultation	$50 copay	Deductible then 50%	30%
Psychiatric consultation	$50 copay	Deductible then 50%	30%
Laboratory tests (independent clinical lab)	$60 copay	Deductible then 50%	30%
Basic radiology (x-ray, ultrasound)	$60 copay	Deductible then 50%	30%
Advanced radiology (MRI, CT, MRA)	$110 copay	Deductible then 50%	30%
Durable medical equipment	Deductible then 30%	Deductible then 50%	30%
Rehabilitation and habilitation services	$40 copay	Deductible then 50%	30%
Physical & speech therapy, spinal manipulation	Deductible then 30%	Deductible then 50%	30%
Cancer treatment, drugs & reconstructive surgery	Deductible then 30%	Deductible then 50%	30%
Dialysis	Deductible + $310 copay	Not covered	30%

EVACUATION & REPATRIATION

Medical evacuation Transfer to the nearest medical facility if the treatment the member needs is not available locally.	Paid in full up to $120,000 Limit per covered person, per benefit period
Medical repatriation Members can return to their country of origin to be treated as long as physically and medically stable.	Paid in full up to $50,000 Lifetime limit per covered person
Repatriation of mortal remains	Paid in full up to $25,000 Lifetime limit per covered person

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CHILD WELLNESS CARE

	Select/In-Network (USA)	Out-of-Network (USA)	Worldwide
Routine child exams & immunizations	Paid in full	Deductible then 50%	30%
Annual routine tests	Paid in full	Deductible then 50%	30%
Routine dental exams for children under 19	Paid in full	Deductible then 50%	30%
Eye exams for children under 19	Paid in full	Deductible then 50%	30%
Eye glasses for children under 19	Paid in full	Deductible then 50%	30%

NEW AMERICAN Optional Coverage

DENTAL AND VISION COVERAGE (OPTIONAL)

			FIRST YEAR	SECOND YEAR	THIRD YEAR
Maximum Benefit	$3,500 per policy year	**Basic** (routine)	65%	80%	90%
Deductible	$100 lifetime	**Major Restorative**	25%	50%	65%
		Preventive (exams & cleanings, 2 per year)	100%	100%	100%
		Orthodontic Treatment (covered for children under the age of 19 - $,200 lifetime maximum per child, $1600 annual limit)	10%	25%	50%

Vision Care

Routine Vision Exam $75, $10 copay (one vision exam per year - includes any fees for contact lense fittings)	**Lenses** (single vision, bifocal, trifocal)	Paid in full up to $225 (limited to one every 24 months)
	Frames (limited to one per benefit period)	Paid in full up to $200
	Contact Lenses (in lieu of frames)	Paid in full up to $100

IMPORTANT NOTE: If you decide to purchase a WellAway product, you will be provided with a member package that contains a complete description of benefits, conditions, limitations and exclusions of coverage. All benefits are subject to Usual Reasonable and Customary Fees (UCR). All benefits reflected in USD.

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If you decide to purchase a WellAway product, you will be provided with a member package that contains a complete description of benefits, conditions, limitations and exclusions of coverage. Products and services may not be available in all jurisdictions and are expressly excluded where prohibited by applicable law.

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THANK YOU!