

New American Plans
In-Network Benefits Plan Comparison

wellaway.com

WellAway

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	1500	3000	5000
COST SHARE FEATURES			
Annual limit	Unlimited	Unlimited	Unlimited
Policy Year Deductible- Embedded Individual Deductible (The amount you pay)	$1,500 individual	$3,000 individual	$5,000 individual
Family Deductible (The amount your family pays)	$3,000 family	$6,000 family	$10,000 family
Coinsurance (This Summary of Benefits states the percentage of the Allowed Amount **you pay** for Covered Services)	10%	20%	30%
Out-of-pocket maximum Individual Out-of-Pocket maximum	$4,000 individual	$5,500 individual	$7,000 individual
Family Out-of-Pocket maximum	$8,000 family	$11,000 family	$14,000 family
WELLNESS CARE			
These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility otherwise they will not be covered.			
Adult Wellness Services (at all locations) Periodic routine health exams include: • routine gynecological exams including pap smears • immunizations • prostate specific antigen (age specific supported by the U.S. Preventive Services Task Force) • routine mammograms (age specific supported by the Health Resources and Services Administration) • measure your height, weight, blood pressure and take other routine measurements • review your medical and family history assess your risk factors and treatment options • review your health risk assessment questionnaire • update your list of providers and prescriptions • look for signs of cognitive impairment • set up a screening schedule for appropriate preventive services	No Charge	No Charge	No Charge

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WELLNESS CARE			
These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility otherwise they will not be covered.			
Child Wellness Services (at all locations) Periodic age specific physical examinations and developmental assessment in accordance with pediatric guidelines • office visit • health history • hearing examinations • age related diagnostic tests • vaccination and immunization necessary for prevention	No Charge	No Charge	No Charge
SERVICES THAT REQUIRE HOSPITALIZATION			
Hospitalization* (Facility)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Emergency room (Facility) (Emergency means when your health is in jeopardy, your symptoms are severe potentially causing loss of life, limb or death (medically necessary)) If you use the Hospital Emergency for a non-emergency service, the Services will not be covered	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Physician Services (Primary Care Physicians and Specialist Physicians)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Rehabilitative services* (treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	Deductible then you pay 10% Coinsurance Limited to 45 days combined with Habilitative Services	Deductible then you pay 20% Coinsurance Limited to 45 days combined with Habilitative Services	Deductible then you pay 30% Coinsurance Limited to 45 days combined with Habilitative Services
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Deductible then you pay 10% Coinsurance Limited to 45 days combined with Rehabilitative Services	Deductible then you pay 20% Coinsurance Limited to 45 days combined with Rehabilitative Services	Deductible then you pay 30% Coinsurance Limited to 45 days combined with Rehabilitative Services
Behavioral health services* (mental health such as psychotherapy and counseling & substance use disorder services)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance

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SERVICES THAT REQUIRE HOSPITALIZATION			
Surgical procedures and surgeon fees* • refers to the fees charged by the main surgeon that performed the surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. • Services provided by an anesthesiologist during a covered surgical procedure.	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Oncology treatment* (includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Reconstructive surgery* (due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve the ability in restoring normal life functions)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Organ transplant* (includes heart, lung, heart and lung, kidney, pancreas, kidney and pancreas, liver, cornea, allogenic and autologous bone marrow and peripheral stem cell transplants)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Emergency ambulance services (from emergency location to nearest facility, from one hospital to another, or from hospital to your home or skilled nursing facility)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
OUTPATIENT CARE			
When Services are not performed in a Physician's office or in a free-standing non-hospital facility, a Site of Service Differential cost will apply.			
Urgent care center	$55 Copayment	$55 Copayment	$60 Copayment
Outpatient ambulatory surgical facility* (Free-standing non-hospital Facility only)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Outpatient Surgery Physician/Surgical Services • refers to the fees charged by the main surgeon that performed the surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. • Services provided by an anesthesiologist during a covered surgical procedure.	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Oncology treatment* (includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance

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OUTPATIENT CARE			
When Services are not performed in a Physician's office or in a free-standing non-hospital facility, a Site of Service Differential cost will apply.			
Reconstructive surgery* (due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve the ability in restoring normal life functions)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Routine X-rays and Laboratory Tests	$95 Copayment	$95 Copayment	$95 Copayment
Advanced diagnostic and imaging services* (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment	$250 Copayment	$250 Copayment
Rehabilitative services* (for treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	$45 Copayment (limited to 20 visits per benefit period)	$45 Copayment (limited to 20 visits per benefit period)	$45 Copayment (limited to 20 visits per benefit period)
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	$45 Copayment (limited to 20 visits per benefit period)	$45 Copayment (limited to 20 visits per benefit period)	$45 Copayment (limited to 20 visits per benefit period)
Outpatient physical therapy* (physical therapy for the purpose of aiding in the restoration of normal physical function lost due to a Condition or to attain age appropriate function for activities of daily living - treatment plan must be provided)	$45 Copayment (limited to 40 visits per benefit period)	$45 Copayment (limited to 40 visits per benefit period)	$45 Copayment (limited to 40 visits per benefit period)
Outpatient Chiropractic Services (chiropractic services and spinal manipulation *(to correct a slight dislocation of a bone or joint that is demonstrated by x-ray)* when restoring function loss due to a medical condition or to attain age-appropriate function for activities of daily living - treatment plan must be provided)	Deductible then you pay 10% Coinsurance (limited to combined 15 visits per benefit period)	Deductible then you pay 20% Coinsurance (limited to combined 15 visits per benefit period)	Deductible then you pay 30% Coinsurance (limited to combined 15 visits per benefit period)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	$45 Copayment	$45 Copayment	$45 Copayment
Emergency dental services (due to damage to natural sound teeth which is treated within 62 days of the accidental dental injury)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance

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PHYSICIAN SERVICES			
Virtual Visits (for illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	No Charge	No Charge	No Charge
Primary Care (includes general consultation, primary care visit, check- ups, office visits, and gynecologist when designated as your primary care physician)	$25 Copayment	$25 Copayment	$25 Copayment
Specialist consultation (consultation or office visit for a specific condition or specialty)	$40 Copayment	$40 Copayment	$40 Copayment
Behavioral Health (includes office visit, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a physician, psychologist or mental health professional for the treatment of a mental health illness or substance use disorder)	$45 Copayment	$45 Copayment	$45 Copayment
Allergy testing & treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	$40 Copayment Maximum Benefit $1,500	$40 Copayment Maximum Benefit $1,500	$40 Copayment Maximum Benefit $1,500
MATERNITY CARE			
Prenatal and postnatal physician consultations	No Charge	No Charge	No Charge
Labor and delivery Hospital stay minimum 48 hours for normal delivery and 96 hours for c-section (includes hospital, obstetrician, midwife, anesthesiologist, pediatrician (well baby) for a normal delivery)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Complications of Pregnancy (mother only - miscarriage, pre-eclampsia, ectopic pregnancy and c-section)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Birthing center (includes a team of highly qualified professionals from midwifery, nursing, obstetrics, family medicine and childbirth)	$305 Copayment	$305 Copayment	$305 Copayment

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MATERNITY CARE			
Newborn care (a newborn child who is properly enrolled will be covered from the moment of birth for injury or illness, including routine care, and the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and premature birth)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
PRESCRIPTION DRUGS			
Preventive	No Charge	No Charge	No Charge
Generic	$15 Copayment	$15 Copayment	$15 Copayment
Brand	$35 Copayment	$35 Copayment	$35 Copayment
Non-preferred brands	50% Coinsurance	50% Coinsurance	50% Coinsurance
Specialty	50% Coinsurance	50% Coinsurance	50% Coinsurance
OTHER SERVICES			
Skilled nursing facility* (following a hospital stay of no less than three (3) days and care must begin within 14 days following your hospital stay)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Home healthcare* (care must begin within 14 days following your hospital stay, prescribed by a physician and provided under the supervision of a registered nurse)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved and certified by a physician)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance

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OTHER SERVICES			
Dialysis* (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	$305 Copayment	$305 Copayment	$310 Copayment
Durable medical equipment (helps to complete your daily activity and includes walker, wheelchair, crutches, canes, oxygen equipment, hearing aids or other equipment that can withstand repeated use which must be medically necessary and prescribed by a physician)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
Prosthetic & Orthotics Devices (when prescribed by a Physician and designed and fitted by a Prosthetist or Orthotist as applicable)	Deductible then you pay 10% Coinsurance	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance
EVACUATION & REPATRIATION			
Medical evacuation*	Paid in full up to $100,000 limit per covered person, per benefit period		
Repatriation of mortal remains*	Paid in full up to $25,000 lifetime limit per covered person		

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PEDIATRIC DENTAL SERVICES

Pediatric Dental Services which exceed $500 are subject to Prior Coverage Authorization

Preventive Dental Services • Oral Exam - *Once every 6 months in a Benefit Period* • Cleaning and fluoride treatments - *Once every 6 months in a Benefit Period* • Sealants – *Once per unrestored permanent molar every 36 months* • Space maintainers to replace prematurely lost teeth. • X-ray (bitewing – two films) – *Once every six months in a Benefit Period*	Your Plan pays 100% of UCR
Basic Dental Services • Anesthesia – general anesthesia and intravenous sedation is covered only when rendered in connection with a covered surgical procedure. • Endodontics – minor (such as pulpal therapy) • Extractions (removal of teeth-except extractions for orthodontics) • Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse). • Periodontics – minor (such as deep cleaning) • Prosthodontics – minor (such as repair and relining of bridges, crowns and dentures) • Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold)	Deductible then you pay 20% Coinsurance of UCR
Major Dental Services • Endodontics – major (such as root canal treatment) • Periodontics – surgical (such as gingivectomy) • Prosthodontics – major (such as crowns and dentures - *limited to once every 60 months*). • Implants and orthodontia Services may be covered, when Medically Necessary, and with prior coverage authorization.	Deductible then you pay 20% Coinsurance of UCR

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PEDIATRIC VISION BENEFITS

Pediatric Vision Services are covered **only** when by rendered by an Optometrist. Pediatric Vision Services rendered by an Ophthalmologist are subject to applicable **Cost Share amounts** in your medical plan. Pediatric Vision Benefits are not covered when rendered by Out-of-Network Providers, except for Emergency Services. Pediatric Vision Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

Eye exam - one every 12 months	Your Plan pays 100% of UCR
• including dilation (when professionally indicated)	
Lenses one pair per member every 12 months (provided there were no benefits paid for contact lenses during the same benefit period).	Your Plan pays 100% of UCR
Frames one every 12 months from the Pediatric Frame Selection*	Your Plan pays 100% of UCR
* If you choose a frame that is not in the Pediatric Frame Selection you will be responsible for the difference in cost between the price of the frame selected and those available in the Pediatric Frame Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.	
Contact Lenses (instead of eye glasses) once every 12 months from the Pediatric Contact Lens Selection** including the evaluation, fitting and follow-up care (provided there were no benefits paid for contact lenses during the same benefit period).	Your Plan pays 100% of UCR
** If you do not select contact lenses from the Pediatric Contact Lens Selection you will be responsible for the difference in cost between the contact lenses selected and those available in the Pediatric Contact Lens Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.	

WellAway

Keeping You Well, While You're Away.®

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