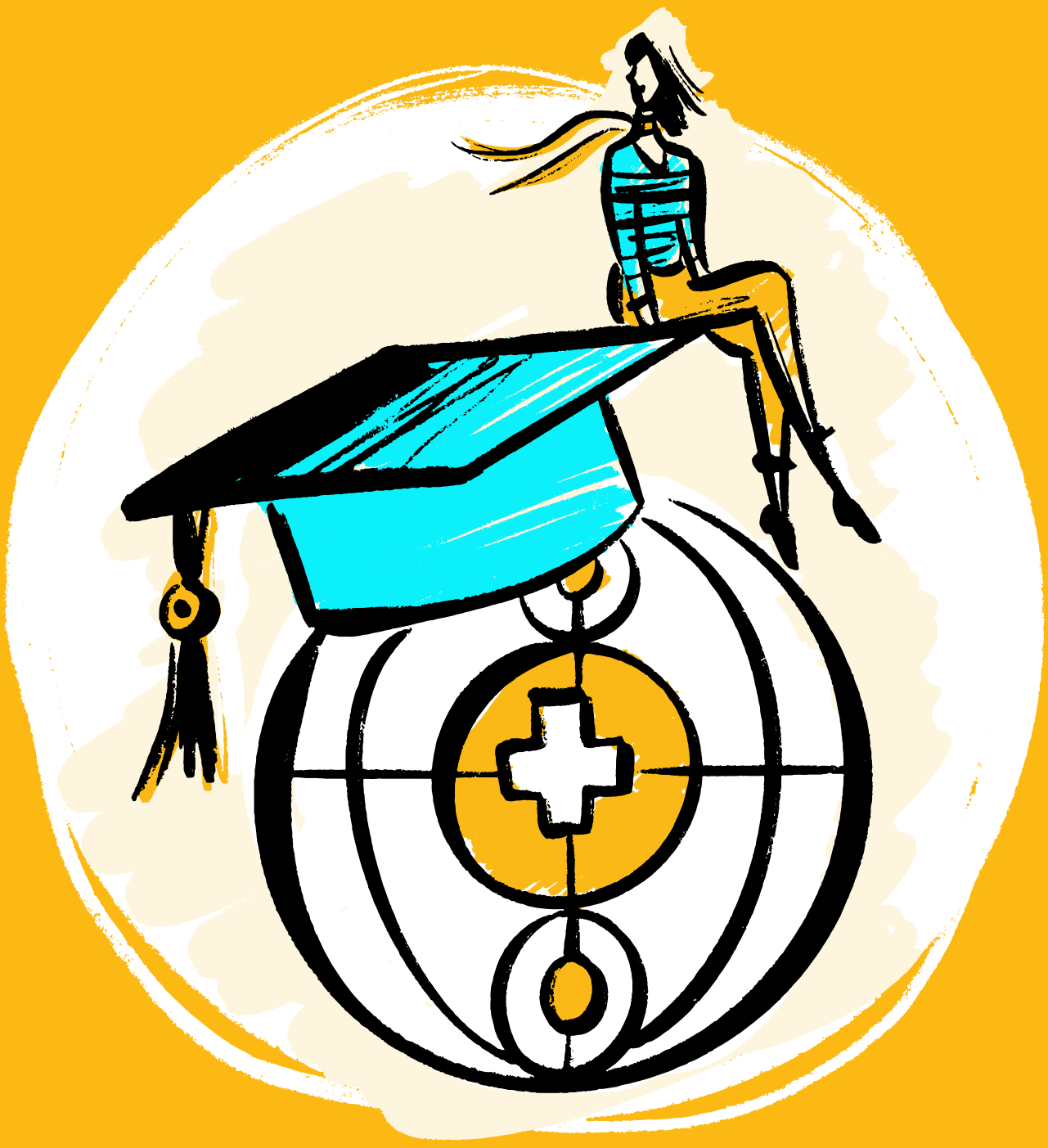

WellAway World
Elite Student Plus
Summary of Benefits

WellAway

wellaway.com

2022

WellAway World Elite Student Plus Summary of Benefits

The Summary of Benefits will tell you about certain coverages and features of this plan. However, it is important that you read and understand the Policy (which contains a complete description of the terms and conditions), to make sure you are aware of any conditions, limitations and exclusions to your coverage. Benefits may be subject to Deductible, Coinsurance, and Copayment amounts. For complete details of coverage, contact a ConciergeCare Counselor: +1-855-773-7810, International +1-786-453-4008 (collect) or e-mail: Conciergecare@payerfusion.com.

Limit & Cost Sharing

	Premium Care Physician and In-Network	Out-of-Network	Worldwide
Annual limit	Unlimited	Unlimited	$1,000,000
Deductible	$0	$200	$0
Coinsurance (WellAway cost share)	100%	100% if covered	100%
Out-of-pocket maximum	$5,000	$10,000	Unlimited

Wellness Care

These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.

Adult Wellness Care Periodic routine health exams, routine gynecological exams, immunizations and related preventive services such as prostate specific antigen (PSA), routine mammograms and pap smears. Your physician will 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; and set up a screening schedule for appropriate preventive services.	100%	Not covered	100%
Child Wellness Care Periodic age specific physical examinations and developmental assessments; office visit; health history; hearing examinations; age related diagnostic tests; vaccination and immunization necessary for prevention; and track growth and development in accordance with pediatric guidelines.	100%	Not covered	100%
Preventive dental services for children under 19 (includes oral exams, cleaning and fluoride treatment every 6 months, sealants every 36 months, space maintainers, and x-rays every 6 months)	100%	Not covered	100%
Eye exams and eye glasses for children under 19 (includes one eye exam and one pair of glasses every benefit period)	100%	Not covered	100%

Services that Require Hospitalization	Premium Care Physician and In-Network	Out-of-Network	Worldwide
Hospitalization*	100%	Not Covered	100%
Emergency room When your symptoms are severe and your health is in jeopardy, causing loss of life, limb or death (medically necessary)	Deductible then $200 copayment per visit (waived if admitted)	Deductible then $200 copayment per visit (waived if admitted)	100%
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)	100% limited to 45 days	Not Covered	100% limited to 45 days
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	100% limited to 45 days	Not Covered	100% limited to 45 days
Physician services (consultations by a physician or specialist while inpatient only when medically necessary)	100%	Not Covered	100%
Behavioral health services* (mental health & substance use disorder services)	100%	Not Covered	100%
Surgical procedures and surgeon fees (inpatient)* • 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 (maximum coverage amount is 20% of the approved fees for the main surgeon). This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by evidence based medicine. • Services provided by an anesthesiologist during a covered surgical procedure is a covered service by an in-network provider (maximum coverage amount is 30% of the approved fees for the main surgeon).	100%	Not Covered	100%
Oncology treatment, drugs & reconstructive surgery* • Oncology treatment includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution • 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 function and ability	100%	Not Covered	100%
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)	100%	Not Covered	100%

* Pre-authorization required

Services that Require Hospitalization	Premium Care Physician and In-Network	Out-of-Network	Worldwide
Emergency ambulance services (from emergency location to nearest facility, from one hospital to another, or from hospital to your home or skilled nursing facility)	100%		Deductible then 100%

Outpatient Care

These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.

Urgent care center	$50 copayment then 100%	Not Covered	100%
Outpatient ambulatory surgical facility & surgical care* Free-standing only	100%	Not Covered	100%
Surgeon Fees • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services (maximum coverage amount is 20% of the approved fees for the main surgeon). This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by evidence based medicine. • Services provided by an anesthesiologist during a covered surgical procedure is a covered service by an in-network provider (maximum coverage amount is 30% of the approved fees for the main surgeon)	100%	Not Covered	100%
Oncology treatment, drugs & reconstructive surgery* • Oncology treatment includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution • 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 function and ability	100%	Not Covered	100%
Basic diagnostic services and laboratory tests When performed in a physician's office or in a free- standing non-hospital facility, e.g., x-rays, ultrasounds, EKG, colonoscopy, heart cardiac test, echocardiography, stress test (this list is not exclusive)	$25 copayment then 100%	Not Covered	100%
Advanced diagnostic and imaging services* When performed in a free-standing non-hospital facility, e.g., MRI, CT scans, PET scans, MRA, angiography, nuclear imaging, biopsy, CTA, CT coronary angioplasty, diagnostic colonoscopy/endoscopy (this list is not exclusive)	$25 copayment then 100%	Not Covered	100%

* Pre-authorization required

Outpatient Care

	Premium Care Physician and In-Network	Out-of-Network	Worldwide
These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.			
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)	$25 copayment (limited to 20 visits per benefit period)	Not covered	100% (limited to 20 visits per benefit period)
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	$25 copayment (limited to 20 visits per benefit period)	Not covered	100% (limited to 20 visits per benefit period)
Outpatient physical therapy* (physical therapy and spinal manipulation 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)	$25 copayment (limited to 40 visits per benefit period)	Not covered	100% (limited to 40 visits per benefit period)
Outpatient chiropractic & spinal manipulation* (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)	$25 copayment (limited to combined 15 visits per benefit period)	Not covered	100% (limited to combined 15 visits per benefit period)
Alternative medicine (combined benefit limits) Acupuncture, homeopathy, Chinese Medicine	$25 copayment (limited to combined 15 visits per benefit period)	Not covered	100% (limited to combined 15 visits per benefit period)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	100%	Not covered	100%
Emergency dental services (due to damage to natural sound teeth which is treated within 62 days of the accidental dental injury)	100%	Not covered	100%
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	100%	Not covered	100%

Physician Services

Teladoc® consultations (for illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	Limited to 12 visits per benefit period	Not covered	Not available
Primary care (includes general consultation, primary care visit, check-ups, office visits, and gynecologist when designated as your primary care physician)	$25 copayment	Not covered	100%

* Pre-authorization required

Physician Services

	Premium Care Physician and In-Network	Out-of-Network	Worldwide
Specialist consultation	$25 copayment	Not covered	100%
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)	$25 copayment	Not covered	100%
Allergy testing & treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	$25 copayment	Not covered	100%

Maternity Care*

(Pre-authorization required)

Prenatal and postnatal physician consultations	100%	Not covered	100%
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)	100%	Not covered	100%
Complications of Pregnancy (mother only) miscarriage, preeclampsia, ectopic pregnancy and c-section	100%	Not covered	100%
Birthing center	100%	Not covered	100%
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)	100%	Not covered	100%
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	100%	Not covered	100%

* Pre-authorization required

Other Services

	Premium Care Physician and In-Network	Out-of-Network	Worldwide
Skilled nursing facility* (care must begin within 14 days following your hospital stay)	100%	Not covered	100%
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)	100%	Not covered	100%
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved by a physician)	100%	Not covered	100%
Dialysis (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	100%	Not covered	100%
Durable medical equipment (helps to complete your daily activity and includes walker, wheelchair, crutches, canes, oxygen equipment or other equipment that can withstand repeated use which must be medically necessary and prescribed by a physician)	100%	Not covered	100%

Prescription Drugs

	EHIM In-Network Pharmacy	Out-of-Network	Worldwide
Preventive	100%	Not covered	100%
Generic	$5 copayment	Not covered	100%
Brand	$40 copayment	Not covered	100%
Non-preferred brands	$60 copayment	Not covered	100%
Specialty	$90 copayment	Not covered	100%

Evacuation & Repatriation*

Medical evacuation	Paid in full up to $120,000 limit per covered person, per benefit period
Medical repatriation	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

* Pre-authorization required

WellAway

Keeping You Well, While You're Away.®

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