WellAway World Elite International Student Plus Summary of Benefits

WellAway

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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 questions about your coverage, contact a ConciergeCare Counselor: +1-855-773-7810, International +1-786-453-4008 (collect) or e-mail: Conciergecare@payerfusion.com.

Limit & Cost Sharing

	In-Network	Out-of-Network	Worldwide
Annual limit	Unlimited	Unlimited	$1,000,000
Deductible	$0	$0	$0
Coinsurance (WellAway cost share) ***Premium Provider: Student Health Center (100% covered)***	100%	Not applicable	100%
Out-of-pocket maximum	$5,000	Unlimited	Unlimited

Important Information

- **Student Health Center:** ***All Cost Share amounts will be waived and Prior Coverage Authorization will not be required for any Services rendered at the Student Health Center.*** If your educational institution provides a Student Health Center, visit the Student Health Center for all your medical services, treatments, and procedures, when available. If you do not utilize the Services which are provided by the Student Health Center without charge to you, or Services covered or provided through the payment of your student health fee, these Services will be excluded from coverage under this Policy; and you will be responsible for any amounts charged to you.

- **Non-Emergency/Non-Urgent Care**: If the Student Health Center does not provide the required care and you have a non-emergency situation, please contact a ConciergeCare counselor at the telephone number on the back of your ID card to guide you to the appropriate In-Network Physician (i.e., local doctor, walk-in clinic, or urgent care facility) in your area and assist you in scheduling an appointment. Utilizing a hospital emergency room for non-emergency care will result in additional expenses and out of pocket costs to you. You will be charged a Copayment when you use an emergency room (waived if admitted). ***If you use an emergency room in the Hospital for a non-emergency service it will not be covered.***

- **Emergency Care:** In case of a serious medical emergency, contact emergency services at 911. After the proper authorities have been contacted, contact ConciergeCare so we can lead you in the right direction and help you through any hardship you may have.

If you are unsure whether you should visit an urgent care center/convenience care clinic or an emergency room, contact a ConciergeCare counselor who may guide you to the appropriate Provider. You may reach a ConciergeCare Counselor at +1.855.773.7810 or e-mail: Conciergecare@payerfusion.com. In the event of an emergency, however, you should always contact emergency services wherever you are located.

Wellness Care

	In-Network	Out-of-Network	Worldwide
It is indicated that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs and avoid Site of Service Differential costs.			
Adult Wellness Care Periodic routine health exams, routine gynecological exams, immunizations and related preventive services such as prostate specific antigen (PSA), routine mammograms, pap smears and colonoscopies for colorectal cancer screenings (please refer to benefit description for Preventive Services in this Policy). 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.	Your plan pays 100%	Not covered	Your plan pays 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.	Your plan pays 100%	Not covered	Your plan pays 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)	Your plan pays 100%	Not covered	Your plan pays 100%
Eye exams and eye glasses for children under 19 (includes one eye exam and one pair of glasses every benefit period)	Your plan pays 100%	Not covered	Your plan pays 100%

Services that Require Hospitalization	In-Network	Out-of-Network	Worldwide
Hospitalization*	Your plan pays 100%	Not Covered	Your plan pays 100%
Emergency room When your symptoms are severe and your health is in jeopardy, causing loss of life, limb or death (medically necessary). If you use an emergency room in the Hospital for a non-emergency service, the Services will not be covered.	$200 copayment per visit payable at Usual, Reasonable and Customary	$200 copayment per visit payable at Usual, Reasonable and Customary	Your plan pays 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)	Your plan pays 100%	Not Covered	Your plan pays 100%
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Your plan pays 100%	Not Covered	Your plan pays 100%
Physician services (consultations by a physician or specialist while inpatient only when medically necessary)	Your plan pays 100%	Not Covered	Your plan pays 100%
Behavioral health services* (mental health & substance use disorder services)	Your plan pays 100%	Not Covered	Your plan pays 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 when indicated by evidence-based medicine. • Services provided by an anesthesiologist during a covered surgical procedure is a covered service.	Your plan pays 100%	Not Covered	Your plan pays 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	Your plan pays 100%	Not Covered	Your plan pays 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)	Your plan pays 100%	Not Covered	Your plan pays 100%
Emergency ambulance services (from emergency location to nearest facility, from one hospital to another, or from hospital to your home or skilled nursing facility)	Your plan pays 100%		Your plan pays 100%

* Pre-authorization required

Outpatient Care

It is indicated that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs and avoid Site of Service Differential costs.

	In-Network	Out-of-Network	Worldwide
Urgent care center	$50 copayment	Not Covered	Your plan pays 100%
Outpatient ambulatory surgical facility & surgical care* Free-standing only	Your plan pays 100%	Not Covered	Your plan pays 100%
Surgeon Fees • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services when indicated by evidence-based medicine. • Services provided by an anesthesiologist during a covered surgical procedure is a covered service.	Your plan pays 100%	Not Covered	Your plan pays 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.	Your plan pays 100%	Not Covered	Your plan pays 100%
Routine X-rays and laboratory tests* When not performed in a physician's office or in a free-standing non-hospital facility a Site of Service Differential cost will apply.	$25 copayment	Not Covered	Your plan pays 100%
Advanced diagnostic and interventional radiology services* When not performed in a free-standing non-hospital facility a Site of Service Differential cost will apply.	$25 copayment	Not Covered	Your plan pays 100%
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	Not covered	Your plan pays 100%
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	$25 copayment	Not covered	Your plan pays 100%
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	Not covered	Your plan pays 100%

* Pre-authorization required

Outpatient Care

	In-Network	Out-of-Network	Worldwide
It is indicated that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs and avoid Site of Service Differential costs.			
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)	Not covered	Your plan pays 100% (limited to combined 15 visits)
Alternative medicine (combined benefit limits) Acupuncture, homeopathy, Chinese Medicine	$25 copayment (limited to combined 15 visits)	Not covered	Your plan pays 100% (limited to combined 15 visits)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	Your plan pays 100%	Not covered	Your plan pays 100%
Emergency dental services (due to damage to natural sound teeth which is treated within 90 days of the accidental dental injury)	Your plan pays 100%	Not covered	Your plan pays 100%
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	Your plan pays 100%	Not covered	Your plan pays 100%

Physician Services

Telemedicine consultations (in the United States for illnesses of cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	Limited to 12 visits	Not covered	Not available
Physician E-Visits (E-visits are available for established patients and should not exceed 1 visit in a 7 day period. E-Visits are limited to 1 per day per Physician and must be legally authorized in your state of residence)	$25 copayment	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	Your plan pays 100%
Specialist consultation	$25 copayment	Not covered	Your plan pays 100%
Behavioral health (includes office visit/e-visit with a physician, psychologist or mental health professional, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy)	$25 copayment	Not covered	Your plan pays 100%
Allergy testing & treatment (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	$25 copayment	Not covered	Your plan pays 100%

* Pre-authorization required

Maternity Care

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

Other Services

Skilled nursing facility*	Your plan pays 100%	Not covered	Your plan pays 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)	Your plan pays 100%	Not covered	Your plan pays 100%
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved by a physician)	Your plan pays 100%	Not covered	Your plan pays 100%
Dialysis* (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	Your plan pays 100%	Not covered	Your plan pays 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)	Your plan pays 100%	Not covered	Your plan pays 100%

* Pre-authorization required

Prescription Drugs

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

* Pre-authorization required

WellAway

Keeping You Well, While You're Away.®

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