



**WellAway World Elite
International Student 250
Summary of Benefits**

wellaway.com

WellAway

Policy Year: 2026-2027
Plan ID: WWE250-26-07

WellAway World Elite International Student 250 Summary of Benefits

This 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.

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.
- **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, seek immediate care or contact emergency services at 911. If the Services required can be performed in an Urgent Care setting (flu, sprains, rashes, etc.) these settings are lower costs and usually less waiting time for you. You may reach a ConciergeCare Counselor at +1.855.773.7810 or e-mail: Conciergecare@payerfusion.com to notify us of the Emergency

Pre-Attendance University Requirements

Immunizations	Your plan pays 100% if not covered by your Student Health Fee (must be obtained at the Student Health Center or an In-Network pharmacy)
TB Testing	Your plan pays 100% if not covered by your Student Health Fee (Policyholder only and must be performed in an In-Network independent free-standing laboratory or the Student Health Center)

Limit & Cost Sharing

	In-Network	Out-of-Network	Worldwide*
Annual limit	Unlimited	Unlimited	Unlimited
Deductible	\$250	\$500	\$250
Coinsurance (Your cost share)	20%	40%	No Coinsurance
Out-of-pocket maximum	\$5,500	\$5,500	Unlimited
Student Health Center	Services at the Student Health Center are 100% covered		

*Worldwide is outside the USA and Home Country

Wellness Care

	In-Network	Out-of-Network	Worldwide*
<p>Adult Wellness Care</p> <p>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).</p> <p>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.</p>	No charge	Deductible then you pay 40% Coinsurance	No Charge
<p>Child Wellness Care</p> <p>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.</p>	No Charge	Deductible then you pay 40% Coinsurance	No Charge
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)	No Charge	Deductible then you pay 40% Coinsurance	No Charge
Eye exams and eye glasses for children under 19 (includes one eye exam and one pair of glasses every benefit period)	No Charge	Deductible then you pay 40% Coinsurance	No Charge

Services that Require Hospitalization

	In-Network	Out-of-Network	Worldwide
Hospitalization*	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Emergency room 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 an emergency room in the Hospital for a non-emergency service, the Services will not be covered.	Deductible and \$200 copayment per visit (waived if admitted)	Deductible and \$200 copayment per visit (waived if admitted)	Deductible only
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 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Physician services (consultations by a physician or specialist while inpatient only when medically necessary)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Behavioral health services* (mental health & substance use disorder services)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Surgical procedures and surgeon fees (inpatient)* <ul style="list-style-type: none"> 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. 	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Oncology treatment, drugs & reconstructive surgery* <ul style="list-style-type: none"> 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 	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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 20% Coinsurance		Deductible only

* Prior Coverage Authorization required

Outpatient Care

In-Network

Out-of-Network

Worldwide

All ambulatory services must be performed in a free-standing independent ambulatory facility. If ambulatory services are not performed in a free-standing independent facility a Site of Service Differential will apply. It is indicated that the services below be performed in an In-Network Physician's office or in an In-Network free standing independent facility to maximize your benefit, reduce your costs and avoid Site of Service Differential costs.

	In-Network	Out-of-Network	Worldwide
Urgent care center	\$65 copayment then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Outpatient ambulatory surgical facility & surgical care* Free-standing only	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Surgeon Fees <ul style="list-style-type: none"> 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. 	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Oncology treatment, drugs & reconstructive surgery* <ul style="list-style-type: none"> 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. 	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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.	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Advanced diagnostic and interventional radiology services* When not performed in a free-standing non-hospital facility a Site of Service Differential cost will apply.	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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)	Deductible then \$30 copayment	Deductible then you pay 40% Coinsurance	Deductible only

* Prior Coverage Authorization required

Outpatient Care

In-Network

Out-of-Network

Worldwide

All ambulatory services must be performed in a free-standing independent ambulatory facility. If ambulatory services are not performed in a free-standing independent facility a Site of Service Differential will apply. It is indicated that the services below be performed in an In-Network Physician's office or in an In-Network free standing independent facility to maximize your benefit, 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)	\$30 copayment (limited to combined 15 visits)	Deductible then you pay 40% Coinsurance (limited to combined 15 visits)	Deductible only (limited to combined 15 visits)
Alternative medicine (combined benefit limits) Acupuncture, homeopathy, Chinese Medicine	\$30 copayment (limited to combined 15 visits)	Not covered	Deductible only (limited to combined 15 visits)
Behavioral health services* (outpatient facility for mental health & substance use disorder services) Prior Coverage Authorization not required for services provided at the Student Health Center.	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Emergency dental services (due to damage to natural sound teeth which is treated within 90 days of the accidental dental injury)	Deductible then you pay 20% Coinsurance up to \$10,000	Deductible then you pay 40% Coinsurance up to \$10,000	Deductible only up to \$10,000
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 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only

Physician Services

Cost Share amounts are waived at Student Health Center.

Telemedicine consultations (in the United States for illnesses of cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	\$10 copayment 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)	\$30 copayment	Deductible then you pay 40% Coinsurance	Not available
Primary care (includes general consultation, primary care visit, check-ups, office visits, and gynecologist when designated as your primary care physician)	\$30 copayment	Deductible then you pay 40% Coinsurance	Deductible only
Specialist consultation	\$30 copayment	Deductible then you pay 40% Coinsurance	Deductible only
Behavioral health (includes office visit/e-visit with a physician, psychologist or mental health professional, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy)	\$30 copayment	Deductible then you pay 40% Coinsurance	Deductible only
Allergy testing & treatment (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	\$30 copayment	Deductible then you pay 40% Coinsurance	Deductible only

* Prior Coverage Authorization required

Maternity Care

	In-Network	Out-of-Network	Worldwide
Prenatal and postnatal physician consultations	No Charge	Deductible then you pay 40% Coinsurance	Deductible only
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 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Complications of Pregnancy (mother only) miscarriage, preeclampsia, ectopic pregnancy and c-section	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Birth center	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only

Other Services

Skilled nursing facility*	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved by a physician)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
Dialysis* (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only
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)	Deductible then you pay 20% Coinsurance	Deductible then you pay 40% Coinsurance	Deductible only

* Prior Coverage Authorization required

Prescription Drugs

	EHIM In-Network Pharmacy	Out-of-Network	Worldwide
Preventive	No Charge	Not covered	Deductible only
Generic	\$5 copayment	\$5 copayment then you pay 40% Coinsurance	Deductible only
Brand	\$50 copayment	\$50 copayment then you pay 40% Coinsurance	Deductible only
Non-preferred brands	\$75 copayment	\$75 copayment then you pay 40% Coinsurance	Deductible only
Specialty	\$90 copayment	\$90 copayment then you pay 40% Coinsurance	Deductible only

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

*Prior Coverage Authorization required

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Keeping You Well, While You're Away.[®]

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WellAway Limited

c/o Compass Administration
Services Ltd.
PO Box HM 2879
Hamilton HM LX
Bermuda

Phone: +1 441-296-0651

info@wellaway.com
wellaway.com



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