New Horizon 7200 Brochure

wellaway.com

WellAway

November 2022

Plan ID: 720022-01

Why choose Wellaway?

WellAway is a truly international private medical insurance company with health plans for today's global citizen.

You are always our priority. Our cultural diversity allows members to be serviced with the utmost consideration for their expatriate lifestyle. With worldwide coverage and access to the UnitedHealthcare Global network of over 1.2M+ providers in the U.S., we aim to provide stability and security for individuals, families and groups on the forefront of health insurance globalization.

- Emergency Medical Assistance
- Multi-Lingual Customer Service
- Telemedicine Services
- Competitive Prices
- Customizable Group Plans

24/7 ConciergeCare

Professional customer support

WellAway provides white glove customer service and expertise in international medical insurance with innovative benefits and resources. Our 24/7 multi-lingual ConciergeCare services are designed with you in mind. Let us help with setting up appointments, go in-depth with explanation of benefits or find a provider that's right for you.

- Provider search assistance
- Disease management
- 24/7 emergency medical assistance & evacuation
- Appointment setting with best-in-class providers
- White glove customer service
- Multi-lingual

Our Health Partner: Teladoc

Access to your doctor 24/7 (USA only)

Teladoc Health transforms how people access healthcare globally. Providing a new kind of healthcare experience, one with better convenience, outcomes and value.

- Talk to a doctor anytime, when you are in the USA.
- Receive quality care via phone, video or mobile app.
- Prompt treatment. Talk to your doctor in minutes.
- A network of doctors that can treat every member of the family.
- Prescriptions sent to pharmacy of choice if medically necessary.
- Teladoc is less expensive than the ER or urgent care.

Get The Care You Need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink Eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

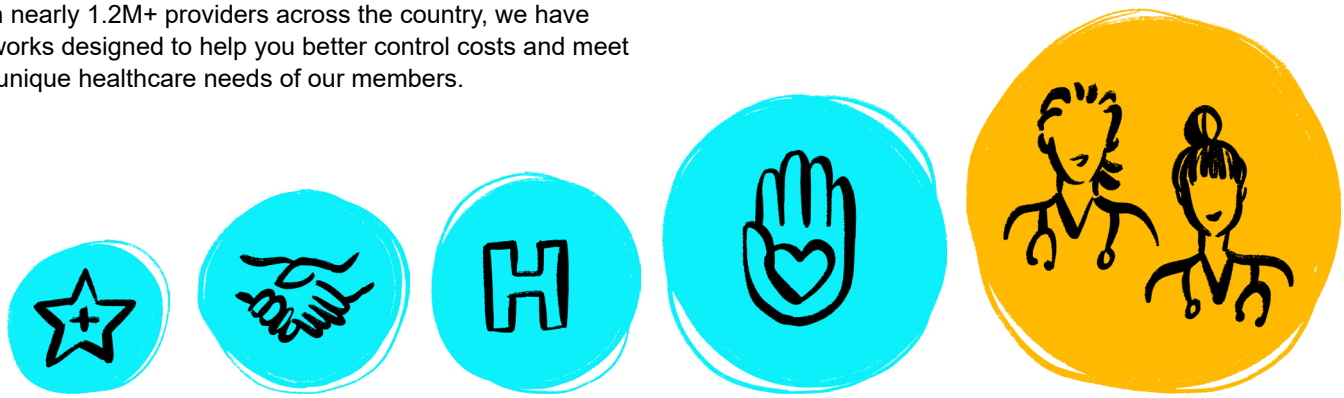
Talk to a doctor any time! Teladoc.com 1-800-TELADOC (835-2362)

Available on the iPhone App Store | ANDROID APP ON Google play

Our Health Partner: UnitedHealthcare Global

Networks that deliver greater accountability and value.

With nearly 1.2M+ providers across the country, we have networks designed to help you better control costs and meet the unique healthcare needs of our members.



643
Centers of Excellence

1,800+
Convenience Care Centers

6,500+
Hospitals

111K+
UnitedHealth Premium® Care Physicians
(Those meeting UnitedHealth Premium Quality and Cost Efficiency Criteria)

1.2M+
Doctors and Health Professionals

New Horizon 7200

ACA-compliant coverage specifically for US-bound expatriates with international coverage for up to 179 days.

The New Horizon is an all-encompassing health & lifestyle product designed to meet the needs of US-bound expatriates. Our comprehensive health product has USA-compliant coverage and support tools that allow members to rest assured that they are abiding by the United States' health insurance mandates. All plans meet the minimum essential coverage required by the Affordable Care Act, including unlimited annual maximums.

Our members are comforted knowing that home is always with them in all matters relating to their health and well-being. The New Horizon provides health benefits, wellness tools and access to medical services designed for the expatriate lifestyle. Feel empowered with WellAway's assistance in finding the right medical provider in your area from our expansive network of healthcare professionals or allowing you to request second medical opinions for complex diagnoses. We are committed to developing a complete support system for foreign nationals.

Coverage Highlights

Annual Limit:
UNLIMITED

For US-bound expatriates seeking health and wellness solutions to maintain their expat lifestyles.

- Fully accredited plan for coverage in the USA, meeting all Minimum Essential Coverage requirements as mandated by the Affordable Care Act.
- Deductible: $7,200 individual, $14,400 family
  Annual Out-of-Pocket Maximum: $8,700 individual, $17,400 family
- Provider Access within the U.S.: as an exclusive member, you are covered at 100% of Usual, Reasonable and Customary charges when receiving care by Premium Care Physicians and at In-Network Facilities with UnitedHealthcare Global.
- Worldwide coverage available for up to 179 days per benefit period. Provider Access outside of the U.S.: An open-access network allows our members the flexibility to see a variety of doctors. Contact us and we will help you find the best doctor at the fairest price.
- Our plans are flexible to meet your needs. Dental & vision coverage are available.
- Unmarried dependent children are covered up to age 26.
- 24/7 multi-lingual ConciergeCare service included at no extra cost.

New Horizon 7200 Summary of Benefits

All benefits are subject to Usual, Reasonable and Customary Charges. Our ConciergeCare team will help you locate the most appropriate Provider for you and assist you in scheduling an appointment.

Important Points You Should Know

- The UnitedHealth Premium® program has a wide network of providers which have been evaluated based on cost and quality of health care. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. It's easy to find a UnitedHealth Premium Care Physician when you visit **https://www.wellaway.com/provider-search/** and click on UnitedHealthcare. Click **Find a Doctor** and look for the blue hearts.
- When Premium Care Physicians and/or In-Network Facilities with UnitedHealthcare Global are not available within a 50-mile radius of your local residence, claims will be reimbursed at the applicable Premium Care Physician and/or In-Network Facility amount as specified under your Summary of Benefits.
- Benefits are shown per person, per benefit period.

USA Benefits

- Maximum amounts apply to certain services.
- All benefits are subject to Usual, Reasonable and Customary charges based on the geographic location where services are rendered.
- Pre-authorization is required for certain services. Please refer to the terms and conditions of the policy.
- You have access to special claims and administrative services within the USA.
- We provide you with access to more than 1.2M+ providers with UnitedHealthcare Global.

Worldwide Benefits (Available for up to 179 days per benefit period)

- Maximum amounts apply to certain services.
- All benefits are subject to Usual, Reasonable and Customary Fees based on the geographic location where services are rendered.
- Pre-authorization is required for certain services. Please refer to the terms and conditions of the policy.
- Guarantee of Payment available upon hospital discretion to accept payment from WellAway.

Summary of Benefits

This Summary of Benefits is part of your Policy, which specifies detailed information about your benefits. Review your Summary of Benefits carefully as it contains your share of the expenses (which include Deductible, Coinsurance and Copayment amounts) for the Covered Services you receive.

Cost Share Features	In-Network (INN)	Out-of-Network (OON)	Worldwide
Policy Year Deductibles - Embedded			
Individual Deductible (The amount you pay)	$7,200	$0	$0
Family Deductible (The amount your family pays)	$14,400	$0	$0
Coinsurance (This Summary of Benefits states the percentage of the Allowed Amount **your plan pays** for Covered Services)	60%	50%	100%
Out-of-Pocket Maximums - Embedded			
Individual Out-of-Pocket Maximum	$8,700	$0	$0
Family Out-of-Pocket Maximum	$17,400	$0	$0

The amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to the Out-of-Pocket Maximum?

- Deductible
- Coinsurance
- All Copayments (excluding Pharmacy)

What **does not apply** to Out-of-Pocket Maximum?

- Non-covered charges
- Charges in excess of the Allowed Amount
- Benefit penalties
- Premium payments

Medical Health Benefits

Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Services.

Your Cost Share for Covered Services will vary based on In-Network services or Out-of-Network services. You should always verify a Provider's participation status before you receive Health Care Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

Unless indicated otherwise, Copayments listed in the charts that follow, apply per visit.

Preventive Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Adult Wellness Services (at all locations)	No Charge	Not Covered	Your plan pays 100%
Child Wellness Services (at all locations)	No Charge	Not Covered	Your plan pays 100%
Mammograms	No Charge	Not Covered	Your plan pays 100%
Routine Colonoscopies (Ages 50+)	No Charge	Not Covered	Your plan pays 100%

Office Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Office Visits rendered by Primary Care Physicians	$50 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Specialist Physicians and other health care professionals licensed to perform such Services	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Allergy Injections rendered by Primary Care Physicians	$50 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Specialist Physicians and other health care professionals licensed to perform such Services	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Specialist Physicians and other health care professionals licensed to perform such Services	$250 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Outpatient Physical Therapy and Spinal Manipulation Primary Care Physicians	$50 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Specialist Physicians and other health care professionals licensed to perform such Services	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%

Virtual Health	In-Network (INN)	Out-of-Network (OON)	Worldwide
Virtual Visits General Medicine	Your plan pays 100%		

Please visit Teladoc for more information on Virtual Visits.

Medical Pharmacy	In-Network (INN)	Out-of-Network (OON)	Worldwide
Prescription Drugs administered in a Physician's office Generic Medications only	$30 Copayment per Drug, per visit	Not Covered	Not Covered

Important: The Cost Share for Medical Pharmacy Services applies to the Generic Prescription Drug only and is in addition to the office Services Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered through the EHIM PBM Mediation Program. Please refer to your Policy for a description of your EHIM PBM Medication Program.

Outpatient Diagnostic Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Independent Clinical Lab *(Preferred Lab Quest Diagnostics)*	$50 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
All other diagnostic Services (e.g., X-rays)	$200 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Outpatient Hospital Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$400 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
All other diagnostic Services (e.g., X-rays)	$300 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%

Emergency and Urgent Care Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Ambulance Services	Your plan pays 60% Coinsurance		Your plan pays 100%
Urgent Care	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Emergency Room Visits Facility	$400 Copayment then your plan pays 60% Coinsurance	$400 Copayment then your plan pays 60% Coinsurance	Your plan pays 100%
Physician Services	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 60% Coinsurance	Your plan pays 100%

Hospital and Surgical Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Ambulatory Surgical Center Facility	$400 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Physician Services	Your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Inpatient Hospital Facility	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Physician Services	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Outpatient Hospital Facility	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Physician Services	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%

Behavioral Health Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Outpatient Hospital, Psychiatric or Substance Abuse Facility	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Outpatient Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	$50 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Specialist Office	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Primary Care Physician at all other locations	$50 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Specialist at all other locations	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%

Other Services	In-Network (INN)	Out-of-Network (OON)	Worldwide
Birth Center	$400 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Dialysis Center	$400 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Durable Medical Equipment (motorized wheelchair – medical necessity must be established and 50% Coinsurance will apply)	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Enteral Formula	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Home Health Care	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Outpatient Habilitative / Rehabilitative	$60 Copayment then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Prosthetic and Orthotic Devices	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Skilled Nursing Facility	Deductible then your plan pays 60% Coinsurance	Not Covered	Your plan pays 100%
Hospice	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 50% Coinsurance	Your plan pays 100%

Benefit Maximums

All benefit maximums apply per person and are based on the Benefit Period.

Home Health Care Visits	0
Inpatient Habilitative Days	45
Inpatient Rehabilitative Days	45
Outpatient Habilitative Therapies Visits	20
Outpatient Rehabilitative Therapies Visits	20
Physical Therapy Visits	40
Spinal Manipulation Visits	15
Skilled Nursing Facility Days	0

Medication Program

EHIM PBM Medication Program
Prescription Drug coverage is subject to our selected pharmacy management (PBM) administered by **EHIM and based on the pharmacy formulary** as explained in your Policy. If you use an Out-of-Network Pharmacy for these Services you will be responsible for the full charge, except for Emergency Services.

For a list of In-Network Pharmacies, you may contact our ConciergeCare Team or access the EHIM provider directory online.

Cost Share Tier	Retail Pharmacy (for each One-Month Supply*)	Mail Order Pharmacy (up to a Three-Month Supply)
Tier 1: Preventive Care Generic Prescription Drugs and Supplies	$0 Copayment	Not Covered
Tier 2: Condition Care Generic Prescription Drugs and Supplies	$20 Copayment	Not Covered
Tier 3: All Other Generic Prescription Drugs and Supplies	$50 Copayment	Not Covered
Tier 4: Condition Care Brand Name Prescription Drugs and Supplies	$75 Copayment	Not Covered
Tier 5: Preferred Brand Name Prescription Drugs, and Supplies	$75 Copayment	Not Covered
Tier 6: Non-Preferred Brand Name Prescription Drugs and Supplies	50% Coinsurance	Not Covered
Tier 7: Specialty Generic and Brand Name Prescription Drugs, and Supplies **	50% Coinsurance	Not Covered

Other Important Information affecting the amount you will pay:

* You can get up to a One Month Supply of a Covered Prescription Drug or Covered Prescription Supply.
** Preauthorization required on Prescription Drugs over $400

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

Pediatric Dental Services

	In-Network/ Out-of-Network and Worldwide
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 URC
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 your plan pays 60% Coinsurance of URC
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 your plan pays 60% Coinsurance of URC

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.

Covered Service	In-Network/ Out-of-Network and Worldwide
Eye exam - one every 12 months • including dilation (when professionally indicated)	Your Plan pays 100% of URC
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 URC
Frames one every 12 months from the Pediatric Frame Selection* * 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.	Your Plan pays 100% of URC
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). ** 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.	Your Plan pays 100% of URC

Dental and Vision Coverage (Optional)

Dental & Vision benefits are offered as a package and may ***not*** be purchased separately

Maximum Benefits	$3,500 per Policy Year
Deductible	$100 Lifetime
Preventative	100% (deductible not applicable)

Dental Benefit	**First Year**	**Second Year**	**Third Year**
Basic Routine	65%	80%	90%
Major Restorative	25%	50%	65%
Orthodontic treatment (subject to 6 month waiting period, $1,200 Lifetime maximum per child and $600 Annual Limit)	10%	25%	50%

Vision Benefit (Available after member has been covered for 6 months)

Routine Vision Exam One Vision Exam per year. Includes any fees for contact lens fitting.	$75 $10 copay
Frames Limited to one per benefit period.	Paid in full up to $225
Lenses Single vision, bifocal, trifocal Limited to one every 24 months.	Paid in full up to $200
Contact Lenses In lieu of frames	Paid in full up to $225

WellAway

Keeping You Well, While You're Away.®

United Healthcare Global

TELADOC

payerfusion

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