New Horizon Plans
In-Network Benefits Plan Comparison

wellaway.com

WellAway

2025

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Cost Share Features	3000	5000	7000
Policy Year Deductibles - Embedded			
Individual Deductible (The amount you pay)	$3,000	$5,000	$7,000
Family Deductible (The amount your family pays)	$6,000	$10,000	$14,000
Coinsurance (This Summary of Benefits states the percentage of the Allowed Amount **you pay** for Covered Services)	20%	30%	40%
Out-of-Pocket Maximums - Embedded			
Individual Out-of-Pocket Maximum	$5,500	$7,000	$9,000
Family Out-of-Pocket Maximum	$11,000	$14,000	$18,000
MEDICAL HEALTH BENEFITS			
Preventive Services			
Adult Wellness Services (at all locations)	No Charge		
Child Wellness Services (at all locations)	No Charge		
Mammograms	No Charge		
Routine Colonoscopies Ages 45+ (every 10 years)	No Charge		
Office Services			
Office Visits rendered by Primary Care Physicians	$100 Copayment	$100 Copayment	$100 Copayment
Specialist Physicians and other health care professionals licensed to perform such Services	$150 Copayment	$150 Copayment	$150 Copayment
Allergy Injections rendered by Primary Care Physicians	$100 Copayment	$100 Copayment	$100 Copayment
Specialist Physicians and other health care professionals licensed to perform such Services	$150 Copayment	$150 Copayment	$150 Copayment

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Office Services	3000	5000	7000
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment	$250 Copayment	$250 Copayment
Specialist Physicians and other health care professionals licensed to perform such Services	$250 Copayment	$250 Copayment	$250 Copayment
Outpatient Physical Therapy and Spinal Manipulation Primary Care Physicians	$100 Copayment	$100 Copayment	$100 Copayment
Specialist Physicians and other health care professionals licensed to perform such Services	$150 Copayment	$150 Copayment	$150 Copayment
Virtual Health			
Virtual Visits General Medicine	No Charge		
Medical Pharmacy			
Prescription Drugs administered in a Physician's office Generic Medications only	$30 Copayment per Drug, per visit		
Outpatient Diagnostic Services			
Independent Clinical Lab *(Preferred Lab Quest Diagnostics)*	$100 Copayment	$100 Copayment	$100 Copayment
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment	$250 Copayment	$250 Copayment
All other diagnostic Services (e.g., X-rays)	$200 Copayment	$200 Copayment	$200 Copayment
Outpatient Hospital Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$500 Copayment	$500 Copayment	$500 Copayment
All other diagnostic Services (e.g., X-rays)	$300 Copayment	$300 Copayment	$300 Copayment

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Emergency and Urgent Care Services	3000	5000	7000
Ambulance Services	You pay 20% Coinsurance	You pay 30% Coinsurance	You pay 40% Coinsurance
Urgent Care	$60 Copayment	$60 Copayment	$60 Copayment
Emergency Room Visits Facility If you use the Hospital Emergency room for a non-emergency service, the Services will not be covered.	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Physician Services	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Hospital and Surgical Services			
Ambulatory Surgical Center Facility	$400 Copayment	$400 Copayment	$400 Copayment
Physician Services	You pay 20% Coinsurance	You pay 30% Coinsurance	You pay 40% Coinsurance
Inpatient Hospital Facility	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Physician Services	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Outpatient Hospital Facility	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Physician Services	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Behavioral Health Services			
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Outpatient Hospital, Psychiatric or Substance Abuse Facility	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Outpatient Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	$100 Copayment	$100 Copayment	$100 Copayment
Specialist Office	$150 Copayment	$150 Copayment	$150 Copayment
Primary Care Physician at all other locations	$100 Copayment	$100 Copayment	$100 Copayment
Specialist at all other locations	$150 Copayment	$150 Copayment	$150 Copayment

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Maternity Care	3000	5000	7000
Prenatal and postnatal physician consultations	$150 Copayment (initial visit only)	$150 Copayment (initial visit only)	$150 Copayment (initial visit only)
Labor and delivery	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Complications of Pregnancy	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Birthing center	$400 Copayment	$400 Copayment	$400 Copayment
Newborn care	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Infertility treatment	Not covered	Not covered	Not covered
Sterilization	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Other Services			
Dialysis Center	$400 Copayment	$400 Copayment	$400 Copayment
Durable Medical Equipment (motorized wheelchair – medical necessity must be established and 50% Coinsurance will apply)	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Enteral Formula	$60 Copayment	$60 Copayment	$60 Copayment
Home Health Care	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Outpatient Habilitative / Rehabilitative	$100 Copayment	$100 Copayment	$100 Copayment
Prosthetic and Orthotic Devices	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Skilled Nursing Facility	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Hospice	Deductible then you pay 20% Coinsurance	Deductible then you pay 30% Coinsurance	Deductible then you pay 40% Coinsurance
Evacuation & Repatriation			
Medical Evacuation	Paid in full up to $75,000 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	3000	5000	7000
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	Your plan pays 100% of UCR	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	Deductible then you pay 30% Coinsurance of UCR	Deductible then you pay 40% 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	Deductible then you pay 30% Coinsurance of UCR	Deductible then you pay 40% Coinsurance of UCR

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Pediatric Vision Benefits	3000	5000	7000
Eye exam - one every 12 months • including dilation (when professionally indicated)	Your plan pays 100% of UCR		
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* * 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 UCR		
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 UCR		

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