



AKIN

Schedule of Benefits



AKIN/ SCHEDULE OF BENEFITS



COST SHARE

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Annual Limits	\$2,500,000	\$2,500,000	\$1,000,000
Deductible The amount you owe for certain health care services, as indicated below.	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family	No Deductible
Coinsurance - Your share of costs on a covered service - WellAway's share of costs on a covered service, after deductible and copay	20% 80%	50% 50%	20% 80%
Annual out-of-pocket maximum This amount is the maximum you will pay each benefit period. Deductibles, coinsurance and co-payments are included in reaching this amount.	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family	No Out-of-Pocket Maximum



HOSPITALIZATION

Hospitalization (inpatient care)	80% after deductible	50% after deductible	80%
Rehabilitative services (inpatient care)	80% after deductible	50% after deductible	80%
Physician services (inpatient care)	80% after deductible	50% after deductible	80%
Psychiatric hospitalization	50% after deductible <i>in Preferred Facility</i>	Not covered	80%
Emergency medical transportation	\$105 copay**	\$105 copay**	80%



WELLNESS CARE

Percentage refers to WellAway's share of costs on a covered service after your deductible and copay

Routine physical exams	Paid in full \$1,000 limit per policy year	Not covered	80%
Cancer screening (mammogram, pap test, prostate)	Paid in full \$1,000 limit per policy year	Not covered	80%

** No deductible applies

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PRESCRIPTION DRUGS

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Percentage refers to WellAway's share of costs on a covered service after your deductible and copay			
Preventive (e.g. oral contraceptives)	Paid in full	Not covered	80%
Generic	\$10 copay**	Not covered	80%
Brand	\$25 copay**	Not covered	80%
Non-preferred brands	\$55 copay**	Not covered	80%
Specialty (purchase from specialty pharmacy)	\$105 copay**	Not covered	80%



MATERNITY CARE

(90 day waiting period)

Percentage refers to WellAway's share of costs on a covered service after your deductible and copay

Prenatal and postnatal consultations	80% after deductible	50% after deductible	80%
Labor and delivery - hospital stay	80% after deductible	50% after deductible	80%
Birth center	80% after deductible	50% after deductible	80%
Newborn care	80% after deductible	Not covered	80%
Congenital anomaly (e.g. cleft lip/ palate)	80% after deductible	50% after deductible	80%
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (e.g. tubal ligations and vasectomies)	80% after deductible	50% after deductible	80%

** No deductible applies

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OUTPATIENT CARE

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Urgent care center	\$55 copay**	\$105 copay**	80%
Emergency room (waived with hospital admission)	\$255 copay**	\$255 copay**	80%
Outpatient hospital facility & surgical care	80% after deductible	50% after deductible	80%
Skilled nursing facility (limited to 20 visits)	\$255 copay per day	50% after deductible	80%
General consultation / primary care visit	\$25 copay**	50% after deductible	80%
Specialist consultation	\$45 copay**	50% after deductible	80%
Psychiatric consultation (limited to 20 visits per year)	\$45 copay**	50% after deductible	80%
Laboratory tests (independent clinical lab)	\$55 copay then 80%	50% after deductible	80%
Basic radiology (x-ray, ultrasound)	\$55 copay then 80%	50% after deductible	80%
Advanced radiology (MRI, CT, MRA)	\$105 copay**	50% after deductible	80%
Durable medical equipment	80% after deductible	50% after deductible	80%
Rehabilitation and habilitation services	\$35 copay**	50% after deductible	80%
Physical & speech therapy, spinal manipulation	80% after deductible	50% after deductible	80%
Cancer treatment, drugs & reconstructive surgery	80% after deductible	50% after deductible	80%
Dialysis	80% after deductible	Not covered	80%



EVACUATION & REPATRIATION

Medical evacuation

Transfer to the nearest medical facility if the treatment the member needs is not available locally.

Paid in full up to \$120,000
Limit per covered person, per benefit period

Medical repatriation

members can return to their country of origin to be treated as long as physically and medically stable.

Paid in full up to \$50,000
Lifetime limit per covered person

** No deductible applies

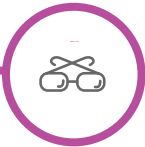
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CHILD WELLNESS CARE

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Routine child exams & immunizations	Paid in full	50% after deductible	80%
Annual routine tests	Paid in full	50% after deductible	80%
Routine dental exams for children under 19	Paid in full	50% after deductible	80%
Eye exams for children under 19	Paid in full	50% after deductible	80%
Eye glasses for children under 19	Paid in full	50% after deductible	80%

AKIN Optional Coverage



DENTAL AND VISION COVERAGE (OPTIONAL)

		FIRST YEAR	SECOND YEAR	THIRD YEAR
Maximum benefit	\$3,500 per policy year			
Deductible	\$100 lifetime			
	Basic (routine)	65%	80%	90%
	Major restorative	25%	50%	65%
	Preventive (exams & cleanings, 2 per year)	100%	100%	100%
	Orthodontic treatment (covered for children under the age of 19 - \$1,200 lifetime maximum per child, \$600 annual limit)	10%	25%	50%
Vision Care				
Routine vision exam	\$75, \$10 copay (one vision exam per year - includes any fees for contact lens fittings)	Lenses (single vision, bifocal, trifocal) Paid in full up to \$225 (limited to one every 24 months)		
		Frames (limited to one per benefit period) Paid in full up to \$200		
		Contact lenses (in lieu of frames) Paid in full up to \$100		

IMPORTANT NOTE: This product does not meet Minimum Essential Coverage. If you decide to purchase a WellAway product, you will be provided with a member package that contains a complete description of benefits, conditions, limitations, and exclusions of coverage. All benefits are subject to Usual Reasonable and Customary Fees (UCR). All benefits reflected in USD.

WellAway products are not limited to French nationals and may be purchased by other expat nationalities inbound to the USA. WellAway insurance benefits act as a "Top Up Plan" for those French members that have selected La Caisse des Français de L'Étranger (CFE) while living outside of France. CFE reimbursement are based on the French health System fee schedules and may assist in covering all or part of your co-payments while in the USA. If you are a CFE member and require information about its benefits and fee schedules, please contact the CFE directly.



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If you decide to purchase a WellAway product, you will be provided with a member package that contains a complete description of benefits, conditions, limitations and exclusions of coverage. Products and services may not be available in all jurisdictions and are expressly excluded where prohibited by applicable law.

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