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# La Vie À l'Étranger

## Schedule of Benefits

WellAway®

Sécurité Sociale
Caisse des Français
de l'Étranger

www.wellaway.com

# PREMIER 4500

## Schedule of Benefits

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# LA VIE À L'ÉTRANGER/ SCHEDULE OF BENEFITS

## COST SHARE

## PREMIER 4500

| | In-Network (USA) | Out-of-Network (USA) | Worldwide |
|---|---|---|---|
| **Annual Limits** | Unlimited | Unlimited | $1,000,000 |
| **Deductible**<br>The amount you owe for certain health care services, as indicated below. | $4,500 Individual<br>$9,000 Family | $9,000 Individual<br>$18,000 Family | No deductible |
| **Coinsurance**<br>Your share of costs on a covered health care service. | 30% | 50% | No coinsurance |
| **Annual out-of-pocket maximum**<br>This amount is the maximum you will pay each benefit period. Deductibles, coinsurance and co-payments are included in reaching this amount. | $7,150 Individual<br>$14,300 Family | $14,300 Individual<br>$28,600 Family | No Out-of-Pocket Maximum |

## HOSPITALIZATION

| | | | |
|---|---|---|---|
| **Hospitalization**<br>(inpatient care) | Deductible then 30% | Deductible then 50% | $300 copay then paid in full (UCR) |
| **Rehabilitative services**<br>(inpatient care) | Deductible then 30% | Deductible then 50% | $300 copay then paid in full (UCR) |
| **Physician services**<br>(inpatient care) | Deductible then 30% | Deductible then 50% | $300 copay then paid in full (UCR) |
| **Psychiatric hospitalization** | Deductible then 30% | Deductible then 50% | $300 copay then paid in full (UCR) |
| **Emergency medical transportation** | $110 copay | $110 copay | $40 copay |

## WELLNESS CARE

| | | | |
|---|---|---|---|
| **Routine physical exams/Preventative care** | Paid in full | Not covered | Paid in full up to $200 |
| **Cancer screening**<br>(mammogram, pap test, prostate) | Paid in full | Not covered | Paid in full up to $200 |

# LA VIE À L'ÉTRANGER/ SCHEDULE OF BENEFITS

## PRESCRIPTION DRUGS

### PREMIER 4500

| | In-Network (USA) | Out-of-Network (USA) | Worldwide |
|---|---|---|---|
| **Preventive** (e.g. oral contraceptives) | Paid in full | Not covered | Paid in full |
| **Generic** | $15 copay | Not covered | $15 copay |
| **Brand** | $30 copay | Not covered | $15 copay |
| **Non-preferred brands** | $60 copay | Not covered | $60 copay |
| **Specialty** (purchase from specialty pharmacy) | $110 copay | Not covered | $60 copay |

## MATERNITY CARE

| | | | |
|---|---|---|---|
| **Prenatal and postnatal consultations** | Paid in full | Deductible then 50% | Paid in full (UCR) up to the maximum amount |
| **Labor and delivery - hospital stay** | Deductible then 30% | Deductible then 50% | $300 copay less CFE reimbursement up to a maximum of $10,000 |
| **Birthing center** | $310 copay | Deductible then 50% | Not applicable |
| **Newborn care** | Deductible then 30% | Not covered | $300 copay less CFE reimbursement up to a maximum of $10,000 |
| **Congenital anomaly** (e.g. cleft lip/ palate) | Deductible then 30% | Deductible then 50% | $300 copay less CFE reimbursement up to a maximum of $10,000 |
| **Infertility treatment** | Not covered | Not covered | Not covered |
| **Sterilization** (e.g. tubal ligations and vasectomies) | Paid in full | Deductible then 50% | $300 copay less CFE reimbursement up to a maximum of $10,000 |

# LA VIE À L'ÉTRANGER/ SCHEDULE OF BENEFITS

## PREMIER 4500

## OUTPATIENT CARE

| | In-Network (USA) | Out-of-Network (USA) | Worldwide |
|---|---|---|---|
| **Urgent care center** | $60 copay | $110 copay | Not Applicable |
| **Emergency room** (waived with hospital admission) | $260 copay | $260 copay | $300 copay then paid in full (UCR) |
| **Outpatient hospital facility & surgical care** | Deductible then 30% | Deductible then 50% | $300 copay then paid in full (UCR) |
| **Skilled nursing facility** (limited to 20 visits) | $260 copay/day *($780 limit)* | Deductible then 50% | Not Applicable |
| **General consultation / primary care visit** | $30 copay | Deductible then 50% | Paid in full up to a maximum allowable of $55 including CFE reimbursement |
| **Specialist consultation** | $50 copay | Deductible then 50% | Paid in full up to a maximum allowable of $85 including CFE reimbursement |
| **Psychiatric consultation** | $50 copay | Deductible then 50% | 100% up to a maximum allowable of $85 including CFE reimbursement up to a maximum of 10 visits per year |
| **Laboratory tests** (independent clinical lab) | $60 copay then 30% | Deductible then 50% | Paid in full (UCR) |
| **Basic radiology** (x-ray, ultrasound) | $60 copay then 30% | Deductible then 50% | Paid in full (UCR) |
| **Advanced radiology** (MRI, CT, MRA) | $110 copay | Deductible then 50% | Paid in full (UCR) |
| **Durable medical equipment** | Deductible then 30% | Deductible then 50% | $50 copay less CFE reimbursement |
| **Rehabilitation and habilitation services** | $40 copay | Deductible then 50% | $100 copay less CFE reimbursement |
| **Physical & speech therapy, spinal manipulation** | Deductible then 30% | Deductible then 50% | $30 copay per visit (limited to 20 visits) |
| **Cancer treatment, drugs & reconstructive surgery** | Deductible then 30% | Deductible then 50% | $300 copay less CFE reimbursement |
| **Dialysis** | $310 copay, deductible then 30% | Not covered | $300 copay less CFE reimbursement |

## 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 |
| **Repatriation of mortal remains** | Paid in full up to $25,000 Lifetime limit per covered person |

# LA VIE À L'ÉTRANGER/ SCHEDULE OF BENEFITS

## PREMIER 4500

## CHILD WELLNESS CARE

| | In-Network (USA) | Out-of-Network (USA) | Worldwide |
|---|---|---|---|
| Routine child exams & immunizations | Paid in full | Deductible then 50% | Paid in full up to $200 |
| Annual routine tests | Paid in full | Deductible then 50% | Paid in full up to $200 |
| Routine dental exams for children under 19 | Paid in full | Deductible then 50% | Paid in full up to $200 |
| Eye exams for children under 19 | Paid in full | Deductible then 50% | Paid in full up to $200 |
| Eye glasses for children under 19 | Paid in full | Deductible then 50% | Paid in full up to $200 |

## LA VIE À l'ÉTRANGER 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 lense 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 |

**CFE benefits are primary to WellAway benefits.** Out-of-Pocket costs are reimbursed according to the CFE fee schedule. Copays at the hospital do not apply if the CFE reimburses directly. For information on CFE benefits, please refer to the CFE schedule.

**IMPORTANT NOTE:** 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.

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