www.wellaway.com

La Vie À l'Étranger

Schedule of Benefits

WellAway®

Sécurité Sociale
Caisse des Français
de l'Étranger

www.wellaway.com

PRESTIGE 2500

Schedule of Benefits

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Sécurité Sociale
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Coverage USA & Worldwide

LA VIE À L'ÉTRANGER/ SCHEDULE OF BENEFITS

COST SHARE

PRESTIGE 2500

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Annual Limits	Unlimited	Unlimited	$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 health care service.	20%	50%	No coinsurance
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)	Deductible then 20%	Deductible then 50%	$275 copay then paid in full (UCR)
Rehabilitative services (inpatient care)	Deductible then 20%	Deductible then 50%	$275 copay then paid in full (UCR)
Physician services (inpatient care)	Deductible then 20%	Deductible then 50%	$275 copay then paid in full (UCR)
Psychiatric hospitalization	Deductible then 20%	Deductible then 50%	$275 copay then paid in full (UCR)
Emergency medical transportation	$105 copay	$105 copay	$35 copay

WELLNESS CARE

Routine physical exams/ Preventative care	Paid in full	Not covered	Paid in full up to $250
Cancer screening (mammogram, pap test, prostate)	Paid in full	Not covered	Paid in full up to $250

LA VIE À L'ÉTRANGER/ SCHEDULE OF BENEFITS

PRESCRIPTION DRUGS

PRESTIGE 2500

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Preventive (e.g. oral contraceptives)	Paid in full	Not covered	Paid in full
Generic	$10 copay	Not covered	$10 copay
Brand	$25 copay	Not covered	$10 copay
Non-preferred brands	$55 copay	Not covered	$55 copay
Specialty (purchase from specialty pharmacy)	$105 copay	Not covered	$55 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 20%	Deductible then 50%	$275 copay less CFE reimbursement up to a maximum of $10,000
Birthing center	$305 copay	Deductible then 50%	Not applicable
Newborn care	Deductible then 20%	Not covered	$275 copay less CFE reimbursement up to a maximum of $10,000
Congenital anomaly (e.g. cleft lip/ palate)	Deductible then 20%	Deductible then 50%	$275 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%	$275 copay less CFE reimbursement up to a maximum of $10,000

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PRESTIGE 2500

OUTPATIENT CARE

	In-Network (USA)	Out-of-Network (USA)	Worldwide
Urgent care center	$55 copay	$105 copay	Not Applicable
Emergency room (waived with hospital admission)	$255 copay	$255 copay	$275 copay then paid in full (UCR)
Outpatient hospital facility & surgical care	Deductible then 20%	Deductible then 50%	$275 copay then paid in full (UCR)
Skilled nursing facility (limited to 20 visits)	$255 copay/day *($765 limit)*	Deductible then 50%	Not Applicable
General consultation / primary care visit	$25 copay	Deductible then 50%	Paid in full up to a maximum allowable of $65 including CFE reimbursement
Specialist consultation	$45 copay	Deductible then 50%	Paid in full up to a maximum allowable of $95 including CFE reimbursement
Psychiatric consultation	$45 copay	Deductible then 50%	100% up to a maximum allowable of $95 including CFE reimbursement up to a maximum of 10 visits per year
Laboratory tests (independent clinical lab)	$55 copay then 20%	Deductible then 50%	Paid in full (UCR)
Basic radiology (x-ray, ultrasound)	$55 copay then 20%	Deductible then 50%	Paid in full (UCR)
Advanced radiology (MRI, CT, MRA)	$105 copay	Deductible then 50%	Paid in full (UCR)
Durable medical equipment	Deductible then 20%	Deductible then 50%	$45 copay less CFE reimbursement
Rehabilitation and habilitation services	$35 copay	Deductible then 50%	$90 copay less CFE reimbursement
Physical & speech therapy, spinal manipulation	Deductible then 20%	Deductible then 50%	$25 copay per visit (limited to 20 visits)
Cancer treatment, drugs & reconstructive surgery	Deductible then 20%	Deductible then 50%	$275 copay less CFE reimbursement
Dialysis	$305 copay, deductible then 20%	Not covered	$275 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

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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 $250
Annual routine tests	Paid in full	Deductible then 50%	Paid in full up to $250
Routine dental exams for children under 19	Paid in full	Deductible then 50%	Paid in full up to $250
Eye exams for children under 19	Paid in full	Deductible then 50%	Paid in full up to $250
Eye glasses for children under 19	Paid in full	Deductible then 50%	Paid in full up to $250

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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