



NEW AMERICAN ELITE FREEDOM 1000

Schedule of Benefits



ELITE FREEDOM 1000

SCHEDULE OF BENEFITS

WORLDWIDE SELECT NETWORK IN-NETWORK OUT OF NETWORK

LIMIT & COST SHARING

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Annual limit	Unlimited	Unlimited	Unlimited	Unlimited
Deductible	\$1,000 individual \$2,000 family	\$1,000 individual \$2,000 family	\$1,000 individual \$2,000 family	\$2,000 individual \$4,000 family
Out-of-pocket maximum	\$0	\$3,500 individual \$7,000 family	\$3,500 individual \$7,000 family	\$7,000 individual \$14,000 family

INPATIENT CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Hospitalization	Deductible	Deductible	Deductible	Out of network deductible
Rehabilitative services	Deductible	Deductible	Deductible	Out of network deductible
Physician services	Deductible	Deductible	Deductible	Out of network deductible
Psychiatric hospitalization	Deductible	Deductible	Deductible	Out of network deductible
Emergency medical transportation	\$100 copay	\$100 copay	\$200 copay	Out of network deductible

WELLNESS CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Routine medical exam	100%	100%	100%	Not covered
Cancer screening	100%	100%	100%	Not covered
Cryotherapy	100%	100%	100%	Not covered

PRESCRIPTION DRUGS

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Preventive	100%	100%	100%	Not covered
Generic	100%	\$5 copay	\$5 copay	Not covered
Brand	100%	\$20 copay	\$20 copay	Not covered
Non-preferred brands	100%	\$50 copay	\$50 copay	Not covered
Specialty	100%	\$100 copay	\$100 copay	Not covered

All benefits with 100% coverage are payable up to the policy limit.
All coverages are in US Dollar amounts.

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WORLDWIDE

SELECT NETWORK

IN-NETWORK

OUT OF NETWORK

MATERNITY CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Prenatal and postnatal consultations	100%	\$50 copay	Deductible	Out of network deductible
Labor and delivery - hospital stay	100%	\$250 copay	Deductible	Out of network deductible
Birthing center	100%	\$300 copay	Deductible	Out of network deductible
Newborn care	100%	\$100 copay	Deductible	Out of network deductible
Congenital anomaly	100%	\$250 copay	Deductible	Out of network deductible
Infertility treatment	Not covered	Not covered	Not covered	Not covered
Sterilization	100%	100%	Deductible	Out of network deductible

OUTPATIENT CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Urgent care center	100%	\$50 copay	\$70 copay	Out of network deductible
Emergency room	100%	\$250 copay	\$300 copay	Out of network deductible
Outpatient hospital facility & surgical care	100%	\$250 copay	Deductible	Out of network deductible
Skilled nursing facility	100%	\$100 copay (\$750 limit)	\$255 copay (\$750 limit)	Out of network deductible
General consultation / primary care visit	100%	\$20 copay	\$50 copay	Out of network deductible
Specialist consultation	100%	\$40 copay	\$70 copay	Out of network deductible
Psychiatric consultation	100%	\$40 copay	\$70 copay	Out of network deductible
Laboratory tests	100%	\$50 copay	\$100 copay	Out of network deductible
Basic radiology	100%	\$50 copay	\$100 copay	Out of network deductible
Advanced radiology	100%	\$100 copay	\$200 copay	Out of network deductible
Durable medical equipment	100%	\$100 copay	Deductible	Out of network deductible
Rehabilitation and habilitation services	100%	\$30 copay	\$60 copay	Out of network deductible
Physical & speech therapy, spinal manipulation	100%	\$30 copay	Deductible	Out of network deductible
Cancer treatment, drugs & reconstructive surgery	100%	Deductible	Deductible	Out of network deductible
Dialysis	100%	\$300 copay	\$400 copay	Out of network deductible

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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			

CHILD WELLNESS CARE

Routine child exams & immunizations	100%	100%	100%	Out of network deductible
Annual routine tests	100%	100%	100%	Out of network deductible
Routine dental exams for children under 19	100%	100%	100%	Out of network deductible
Eye exams for children under 19	100%	100%	100%	Out of network deductible
Eye glasses for children under 19	100%	100%	100%	Out of network deductible

DENTAL & VISION COVERAGE (OPTIONAL)

Dental & vision benefits are offered a package and may not be purchased separately.

			FIRST YEAR	SECOND YEAR	THIRD YEAR
Maximum benefit	\$3,500 per policy year	Basic (routine)	65%	80%	90%
Deductible	\$100 lifetime	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

(vision subject to 6 month waiting period)

Routine vision exam (one vision exam per year - includes any fees for contact lens fittings)	\$75 \$10 copay
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Lenses (single vision, bifocal, trifocal)	Paid in full up to \$200 (limited to one every 24 months)
Frames (limited to one per policy year)	Paid in full up to \$225
Contact lenses (in lieu of frames)	Paid in full up to \$225

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CONTACT US



Bermuda: +1 441 296 0651
UK: +44 2036 036 804
France: +33 1 78 90 38 68
Belgium: +32 9 352 00 22
Skype: +1 888 983 2370



info@wellaway.com
WellAway Limited
Canon's Court, 22 Victoria Street
Hamilton HM 12, Bermuda



www.wellaway.com

