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NEW AMERICAN

PREMIER FREEDOM 4500

Schedule of Benefits

WellAway®

PREMIER FREEDOM 4500
SCHEDULE OF BENEFITS

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
LIMIT & COST SHARING				
Annual limit	Unlimited	Unlimited	Unlimited	Unlimited
Deductible	$4,500 individual $9,000 family	$4,500 individual $9,000 family	$4,500 individual $9,000 family	$9,000 individual $18,000 family
Out-of-pocket maximum	$0	$7,150 individual $14,300 family	$7,150 individual $14,300 family	$14,300 individual $28,600 family
INPATIENT CARE				
Hospitalization	100%	Deductible	Deductible	Out of network deductible
Rehabilitative services	100%	Deductible	Deductible	Out of network deductible
Physician services	100%	Deductible	Deductible	Out of network deductible
Psychiatric hospitalization	100%	Deductible	Deductible	Out of network deductible
Emergency medical transportation	$110 copay	$110 copay	$210 copay	Out of network deductible
WELLNESS CARE				
Routine medical exam	100%	100%	100%	Not covered
Cancer screening	100%	100%	100%	Not covered
Cryotherapy	100%	100%	100%	Not covered
PRESCRIPTION DRUGS				
Preventive	100%	100%	100%	Not covered
Generic	100%	$15 copay	$15 copay	Not covered
Brand	100%	$30 copay	$30 copay	Not covered
Non-preferred brands	100%	$60 copay	$60 copay	Not covered
Specialty	100%	$110 copay	$110 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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MATERNITY CARE				
Prenatal and postnatal consultations	100%	$65 copay	Deductible	Out of network deductible
Labor and delivery - hospital stay	100%	$310 copay	Deductible	Out of network deductible
Birthing center	100%	$310 copay	$310 copay	Out of network deductible
Newborn care	100%	$120 copay	Deductible	Out of network deductible
Congenital anomaly	100%	$260 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				
Urgent care center	100%	$60 copay	$80 copay	Out of network deductible
Emergency room	100%	$260 copay	$360 copay	Out of network deductible
Outpatient hospital facility & surgical care	100%	$260 copay	Deductible	Out of network deductible
Skilled nursing facility	100%	$175 copay ($765 limit)	$260 copay ($780 limit)	Out of network deductible
General consultation / primary care visit	100%	$30 copay	$60 copay	Out of network deductible
Specialist consultation	100%	$50 copay	$80 copay	Out of network deductible
Psychiatric consultation	100%	$50 copay	$80 copay	Out of network deductible
Laboratory tests	100%	$60 copay	$110 copay	Out of network deductible
Basic radiology	100%	$60 copay	$110 copay	Out of network deductible
Advanced radiology	100%	$110 copay	$210 copay	Out of network deductible
Durable medical equipment	100%	$110 copay	Deductible	Out of network deductible
Rehabilitation and habilitation services	100%	$35 copay	$40 copay	Out of network deductible
Physical & speech therapy, spinal manipulation	100%	$35 copay	Deductible	Out of network deductible
Cancer treatment, drugs & reconstructive surgery	100%	Deductible	Deductible	Out of network deductible
Dialysis	100%	$305 copay	$410 copay	Out of network deductible

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EVACUATION & REPATRIATION

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
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.

Maximum benefit	$3,500 per policy year
Deductible	$100 lifetime

	FIRST YEAR	SECOND YEAR	THIRD YEAR
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

(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

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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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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