



ORBE PLATINUM

Schedule of Benefits



WellAway®

ORBE PLATINUM Annual Limit: Unlimited

SCHEDULE OF BENEFITS

All benefits are subject to Usual, Reasonable and Customary Fees. Contact us and our ConciergeCare team will help you locate the most appropriate Select Provider for you and assist you in scheduling an appointment.

DEDUCTIBLE OPTIONS

This product features deductible options of \$0, \$500, \$1,000, \$2,000, \$5,000, giving you control over your premium.

SELECT/IN-NETWORK PROVIDER

100%

OUT-OF-NETWORK

50%

Zone 1 Worldwide (including the USA)

Zone 2 Worldwide (excluding: USA, Bahamas, Bermuda, Brazil, Canada, China, Hong Kong, Japan, Panama, Singapore, Switzerland, and United Kingdom.)

- We always recommend that you use a Select Provider for all medical services, treatments, and procedures. The use of a Select Provider will keep your excess Usual, Reasonable and Customary amounts to a minimum. If you do not choose a Select Provider, you will be responsible for any amounts in excess of Usual, Reasonable and Customary.
- When an In-Network/Select Provider is not available within a 50-mile radius of your local residence, claims will be reimbursed at the applicable In-Network/Select Provider Network amount as specified under your Summary of Benefits.
- Coverage of pre-existing conditions may be available upon medical underwriting and application approval by WellAway Limited.
- Benefits are shown per person, per policy year.
- To reduce your cost contact your ConciergeCare counselor to help you determine the right select provider.
- Any payment or benefits under the ORBE product paid by the CFE or French Social Security (or an equivalent government program, public or private body in France or abroad), will be deducted from the reimbursement paid by WellAway.

USA Benefits Available with Zone 1

- Maximum amounts apply to certain services.
- Pre-authorization is required for certain services. Please refer to the terms and conditions of the Policy.
- When going to out-of-network providers in the USA, the member will be responsible for 50% of the allowable charges.
- You have access to special claims and administrative services within the USA. We provide you with access to more than 650,000 facilities, doctors, osteopaths and outpatient services via our provider network.

Worldwide Benefits Available with Zone 1 & 2

- Maximum amounts apply to certain services.
- All benefits are subject to Usual, Reasonable and Customary Fees based on the geographic location where services are rendered.
- Pre-authorization is required for certain services. Please refer to the terms and conditions of the Policy.
- Guarantee of Payment available upon hospital discretion to accept payment from WellAway Limited.

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WELLNESS PREVENTIVE

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	Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1	
		Select/In-network provider	Out-of-network provider
<p>Adult female: Wellness physical examinations office visit, lab work, urinalysis & papanicolaou (PAP) screening</p> <p>Mammogram (eligible age: 40 years or above)</p> <p>Colonoscopy (eligible age: 50 years or above)</p>	100% up to \$1,500 per person per policy year	100%	50% up to \$1,500 per person per policy year
<p>Adult male: Wellness physical examinations office visit, lab work & urinalysis</p> <p>PSA screening test & colonoscopy (eligible age: 50 years or above)</p>			
<p>Children: Wellness physical examinations, office visit, health history, development assessment, physical examination, age related diagnostic tests, vaccination and immunization.</p> <p>Preventive services include routine hearing examinations.</p>			
Podiatry	100% up to \$300 per session 15 visits per policy year	100%	50% up to \$300 per session 15 visits per policy year
<p>Alternative medicine (acupuncture, chiropractic, homeopathy, herbalism, cryotherapy, dietetics)</p>	100% Limited to 10 visits	100%	50% Limited to 10 visits
<p>Adult Immunizations Diphtheria, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza (flu shot), Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox)</p>	100% up to \$600 per policy year	100%	50% up to \$600 per policy year

HOSPITALIZATION AND SURGERY

<p>Hospitalization (inpatient)* (room & board, miscellaneous room services)</p>	100%	100%	50%
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HOSPITALIZATION AND SURGERY	ORBE PLATINUM	
	Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1
		Select/In-network provider
In-hospital advanced diagnostic services (e.g., MRI, CT scans, nuclear imaging)	100%	100% 50% up to \$5,000 per day
Parent accommodation for an insured person under 18 years old	100%	100% 50%
Routine x-ray and lab tests	100%	100% 50%
Intensive care unit (limited to 180 days per policy year)	100%	100% 50%
Physician & osteopath services (inpatient) (limited to 1 per day, per specialty when medically necessary)	100%	100% 50%
Rehabilitation (inpatient)*	100% 30 day limit per policy year	100% 50% 30 day limit per policy year
Renal failure dialysis (inpatient)*	100%	100% 50%
Hospice or palliative care	100%	100% 50%
Pre-admission testing (must be performed 3-5 days in advance)	100%	100% 50%
Oncology treatment* (includes chemotherapy, radiation and breast reconstruction)	100%	100% 50%
Reconstructive surgery* (due to illness or injury)	100%	100% 50%
Surgical appliance and prosthesis (covered for devices which are an integral part of the surgical procedure when medically necessary)	100%	100% 50%

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HOSPITALIZATION AND SURGERY	ORBE PLATINUM		
	Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1	
		Select/In-network provider	Out-of-network provider
Surgeon fees*	100%	100%	50%
Miscellaneous equipment and supplies	100%	100%	50%
Organ transplant* Maximum benefit 2 per lifetime	100%	100%	50%
Inpatient psychiatric / psychotherapy*	100% 30 day limit per policy year	100% 30 day limit per policy year	50%
Ambulatory surgical facility*	100%	100%	50%

OUTPATIENT CARE

Outpatient psychiatric visit / psychotherapist visit	100% 25 visits per policy year	100% 25 visits per policy year	50%
Primary care visit includes physicians, osteopaths and dietitians Dietitian visits limited to 10 (only if medically necessary)	100%	100%	50%
Specialist visit includes physicians and osteopaths (only if medically necessary)	100%	100%	50%
Durable medical equipment* (including hearing aids)	100%	100%	50%

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OUTPATIENT CARE

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	Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1	
		Select/In-network provider	Out-of-network provider
Allergy testing & treatment* (includes injections for allergies)	100%	100%	50% up to \$600 per year
Basic diagnostic services (when performed in a free-standing non-hospital facility, laboratory tests, x-rays, ultrasounds, EKG)	100%	100%	50%
Advanced diagnostic and imaging services* (when performed in a free-standing non-hospital facility, e.g., MRI, CT scans, PET scans, MRA, nuclear imaging)	100%	100%	50%
Outpatient therapeutic services (physical, occupational, speech, pulmonary & cardiac therapy - treatment plan must be provided)	100% up to \$170 per session, max 35 sessions per policy year	100%	50% up to \$170 per session, max 35 sessions per policy year
Home health care* (care must begin immediately following your hospital stay of no less than 3 days)	100% Max 90 days per policy year following hospital discharge	100%	50% Max 90 days per policy year following hospital discharge
Outpatient renal failure dialysis*	100% \$100,000 limit per policy year	100%	50% \$100,000 limit per policy year

EMERGENCY AND URGENT CARE

Emergency ground ambulance (limited to one way trip)	100%	100%	100%
Emergency medical services / emergency room	100%	100%	100%
Urgent care clinic / facility	100%	100%	50%
Emergency dental treatment (due to accident or injury to sound natural teeth and treated within 24 hours of the event)	100% up to \$1,000 per policy year	100%	50% up to \$1,000 per policy year

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PRESCRIPTION DRUGS

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		Select/In-network provider	Out-of-network provider
Prescription drugs Generic dispensed when available: - Brand will only be dispensed if generic is not available and it is medically necessary. - In the USA, brand will be paid at the equivalent cost of generic.	100%	100%	50%

EVACUATION & REPATRIATION

Emergency medical evacuation* Transfer to the nearest facility if the treatment needed is not available locally	Paid in full up to \$100,000 combined limit per covered person, per policy year	Paid in full up to \$100,000 combined limit per covered person, per policy year
Repatriation* (members can return to their country of origin following an evacuation to be treated as long as they are physically and medically stable)		
Companion coverage / bedside visit* (15 day limit per policy year, including accompanying children)	Transportation (economy-class flight) + \$3,000 for additional expenses	Transportation (economy-class flight) + \$3,000 for additional expenses
Repatriation of mortal remains* - Transportation cost	100%	100%
- Cost for burial or cremation	\$25,000	\$25,000

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Optional Coverage

MATERNITY CARE AND BIRTH BENEFITS* (optional)

(subject to 10 month waiting period)

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	Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1	
		Select/In-network provider	Out-of-network provider
Maternity care (includes hospital, obstetrician and anesthesiologist)	100% up to \$15,000	100% up to \$15,000	50% up to \$15,000
Complications of pregnancy (mother only)	100% up to \$50,000	100% up to \$50,000	50% up to \$50,000
Non-healthy newborn infant care (baby must be added to the policy)	100% up to \$50,000	100% up to \$50,000	50% up to \$50,000
Congenital conditions (baby must be added to the policy)	100% up to \$150,000	100% up to \$150,000	50% up to \$150,000

DENTAL AND VISION COVERAGE (optional)

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

		FIRST YEAR	SECOND YEAR	THIRD YEAR
Maximum benefit	\$3,500 per policy year	65%	80%	90%
Deductible	\$100 lifetime	25%	50%	65%
	Basic (routine)	100%	100%	100%
	Major restorative	10%	25%	50%
	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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WellAway®

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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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