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NEW AMERICAN
PRESTIGE FREEDOM 1500

Schedule of Benefits

WellAway®

PRESTIGE FREEDOM 1500
SCHEDULE OF BENEFITS

The use of a Select Provider will keep your costs to a minimum. If you do not choose a Select Provider, you will be responsible for the excess amount above 100% of the Usual, Reasonable and Customary Charges. Contact our ConciergeCare team to help you locate a Select Provider and assist you in scheduling an appointment.

	WORLDWIDE	SELECT / IN-NETWORK PROVIDER	OUT OF NETWORK PROVIDER
LIMIT & COST SHARING			
Annual limit	Unlimited	Unlimited	Unlimited
Deductible	$1,500 individual $3,000 family	$1,500 individual $3,000 family	$3,000 individual $6,000 family
Out-of-pocket maximum	$0	$5,000 individual $10,000 family	$10,000 individual $20,000 family
INPATIENT CARE			
Hospitalization	Deductible	Deductible	Out of network deductible
Rehabilitative services	Deductible	Deductible	Out of network deductible
Physician services	Deductible	Deductible	Out of network deductible
Psychiatric hospitalization	Deductible	Deductible	Out of network deductible
Emergency medical transportation	$105 copay	$105 copay	Out of network deductible
WELLNESS CARE			
Routine medical exam	100%	100%	Not covered
Cancer screening	100%	100%	Not covered
Cryotherapy	up to $100 per session limited to $500 per policy year		
PRESCRIPTION DRUGS			
Preventive	100%	100%	Not covered
Generic	100%	$10 copay	Not covered
Brand	100%	$25 copay	Not covered
Non-preferred brands	100%	$55 copay	Not covered
Specialty	100%	$105 copay	Not covered

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MATERNITY CARE

	WORLDWIDE	SELECT / IN-NETWORK PROVIDER	OUT OF NETWORK PROVIDER
Prenatal and postnatal consultations	100%	Paid in Full	Out of network deductible
Labor and delivery - hospital stay	100%	Deductible	Out of network deductible
Birthing center	100%	$405 copay	Out of network deductible
Newborn care	100%	Deductible	Out of network deductible
Congenital anomaly	100%	Deductible	Out of network deductible
Infertility treatment	Not covered	Not covered	Not covered
Sterilization	100%	Deductible	Out of network deductible

OUTPATIENT CARE

	WORLDWIDE	SELECT / IN-NETWORK PROVIDER	OUT OF NETWORK PROVIDER
Urgent care center	100%	$55 copay	Out of network deductible
Emergency room	100%	$255 copay	Out of network deductible
Outpatient hospital facility & surgical care	100%	$255 copay	Out of network deductible
Skilled nursing facility	100%	$150 copay ($765 limit)	Out of network deductible
General consultation / primary care visit	100%	$25 copay	Out of network deductible
Specialist consultation	100%	$45 copay	Out of network deductible
Psychiatric consultation	100%	$45 copay	Out of network deductible
Laboratory tests	100%	$55 copay	Out of network deductible
Basic radiology	100%	$55 copay	Out of network deductible
Advanced radiology	100%	$105 copay	Out of network deductible
Durable medical equipment	100%	$105 copay	Out of network deductible
Rehabilitation and habilitation services	100%	$35 copay	Out of network deductible
Physical & speech therapy, spinal manipulation	100%	$35 copay	Out of network deductible
Cancer treatment, drugs & reconstructive surgery	100%	Deductible	Out of network deductible
Dialysis	100%	$305 copay	Out of network deductible
Home healthcare	100%	$150 copay ($765 limit)	Out of network deductible
Hospice	100%	Deductible	Not covered

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EVACUATION & REPATRIATION

	WORLDWIDE	SELECT / IN-NETWORK PROVIDER	OUT OF NETWORK PROVIDER
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%	Out of network deductible
Annual routine tests	100%	100%	Out of network deductible
Routine dental exams for children under 19	100%	100%	Out of network deductible
Eye exams for children under 19	100%	100%	Out of network deductible
Eye glasses for children under 19	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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