



**WellAway World
Elite Student 450
Plan Guide & Summary of Benefits**

wellaway.com

WellAway

2021

Why choose WellAway?

WellAway is a truly international private medical insurance company with health plans for today's international student.

You are always our priority. Our cultural diversity allows students to be serviced with the utmost consideration for their studies abroad. With coverage in over 180 Countries and a UnitedHealthcare Global network of over 1.2M+ providers in the U.S., we aim to provide stability and security for students on the forefront of health insurance globalization.



- ✓ **Emergency Medical Assistance**
- ✓ **Multi-Lingual Customer Service**
- ✓ **Telemedicine Services**
- ✓ **Competitive Prices**

24/7 ConciergeCare

Professional customer support

WellAway provides white glove customer service and expertise in international medical insurance with innovative benefits and resources. Our 24/7 multi-lingual ConciergeCare services are designed with you in mind. Let us help with setting up appointments, go in-depth with explanation of benefits or find a provider that's right for you.

- Provider search assistance
- Disease management
- 24/7 emergency medical assistance & evacuation
- Appointment setting with best-in-class providers
- White glove customer service
- Multi-lingual



💰 **ConciergeCare services are at no extra cost to you.**

Our Health Partner: Teladoc

Access to your doctor 24/7 USA ONLY



Teladoc Health transforms how people access healthcare globally. Providing a new kind of healthcare experience, one with better convenience, outcomes and value.

- Talk to a doctor anytime, when you are in the USA.
- Receive quality care via phone, video or mobile app.
- Prompt treatment. Talk to your doctor in minutes.
- A network of doctors that can treat every student and his/her family.
- Prescriptions sent to pharmacy of choice if medically necessary.
- Teladoc is less expensive than the ER or urgent care.

Get The Care You Need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink Eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!



Talk to a doctor any time! [Teladoc.com](https://www.teladoc.com) 1-800-TELADOC (835-2362)



Our Health Partner: UnitedHealthcare Global



Networks that deliver greater accountability and value.

With nearly 1,100,000 providers across the country, we have networks designed to help you better control costs and meet the unique health care needs of our students.



643
Centers of
Excellence



1,800+
Convenience
Care Centers



6,500+*
Hospitals



111K+
UnitedHealth Premium®
Care Physicians
(Those meeting UnitedHealth Premium
Quality and Cost Efficiency Criteria)



1.2M+*
Doctors and Health
Professionals

Our network strategy is built on:



Delivering Value

- Affordability
- Quality
- Connectivity



Transforming Health Care Delivery

- Affordability
- Quality
- Connectivity

*As of Q4 2017

WellAway World Elite Student 450

ACA-compliant coverage specifically for US-bound international students, US out-bound students and third country national students in need of worldwide coverage.

Our comprehensive health product has USA-compliant coverage and support tools that allow members to feel rest assured that they are abiding by the United States' health insurance mandates. All plans meet the minimum essential coverage required by the Affordable Care Act, including unlimited annual maximums.



For more information about the approval of our plan under the Affordable Care Act, please visit:
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/MEC-Approved-Plans.pdf>

Our members are comforted knowing that home is always with them in all matters relating to their health and well-being. WellAway World Elite Student provides health benefits, wellness tools and access to medical services designed for the student lifestyle. Feel empowered with WellAway's assistance in finding the right medical provider in your area from our expansive network of healthcare professionals or allowing you to request second medical opinions for complex diagnoses. We are committed to developing a complete support system for international students.

This Student Guide provides a description of the WellAway World Elite Student Health Plan. The coverage is provided Worldwide, excluding the Covered Person's Home Country and countries restricted by U.S. economic sanctions and embargo programs. If you are visiting your Home Country during a scheduled school break, your Home Country coverage prevails. A complete description of the benefits, conditions, limitations and exclusions of coverage governing this insurance are contained in the policy terms and conditions and the Certificate of Coverage issued to you. If you would like a copy of the policy terms and conditions, please email us at students@wellaway.com. If there is a difference between this Guide and the policy terms and conditions, the policy terms and conditions will control.

Important Information

- **Where do I go for medical care?**

- **Student Health Center:** We always recommend that you visit your Student Health Center for all your medical services, treatments, and procedures, when available. Your Deductible and Copayments will be waived when you use your Student Health Center. If you do not utilize the Services which are typically provided by the Student Health Center without charge to you, or Services covered or provided through the payment of your student health fee, these Services will be excluded from coverage under this Policy; and you will be responsible for any amounts charged to you.
- **Non-Emergency/Non-Urgent Care:** If the Student Health Center does not provide the required care and you have a non-emergency situation, please contact a ConciergeCare counselor at the telephone number on the back of your ID card to guide you to the appropriate Premium Care Physician (i.e., local doctor, walk-in clinic, or urgent care facility) in your area and assist you in scheduling an appointment. Utilizing a hospital emergency room for non-emergency care will result in additional expenses and out of pocket costs to you. You will be charged a \$200 Copayment when you use an emergency room (waived if admitted). ***If you use an emergency room in the Hospital for a non-emergency service, the Services will not be covered.***
- **Emergency Care:** In case of a serious medical emergency, contact emergency services at 911. After the proper authorities have been contacted, contact ConciergeCare so we can lead you in the right direction and help you through any hardship you may have.

If you are unsure whether you should visit an urgent care center/convenience care clinic or an emergency room, contact a ConciergeCare counselor who may guide you to the appropriate Provider. You may reach a ConciergeCare Counselor at +1.855.773.7810 or e-mail: Conciergecare@payerfusion.com. In the event of an emergency, however, you should always contact emergency services wherever you are located.

- **Certain procedures and medical services covered by your Policy require Pre-Authorization.** If Services have not been coordinated or approved by the Plan Administrator, if required under the Policy, it will result in a penalty (if a covered Service) or denial of the entire episode of care (all Services including, but not limited to, Hospitalization, Procedures, Treatments, and Physician fees) if the Service would not have been approved under this Policy. **Please refer to your Summary of Benefits for all Services and Procedures that require Pre-Authorization (which are indicated by an asterisk).**
- **Prescription Medication:** You must present your ID card to the pharmacy, along with your Copayment, when the prescription is filled. If you do not use an approved pharmacy, you will be responsible for paying the full cost for the Prescription Drug. If you do not present your ID card, you may need to pay for the Prescription Drug and contact ConciergeCare within 48 hours in order to reimburse you if the medication is included in the formulary. For inquiries regarding your Medication Program, Prescription Drug Benefits or to obtain information regarding participating pharmacies, please contact your ConciergeCare Counselor or visit the PBM website at www.ehimrx.com.
- **Out-of-Network benefits are subject to Usual, Reasonable and Customary Charges.** We do not cover any amounts that are not within Usual, Reasonable and Customary Charges. We recommend that you notify us of any planned inpatient procedure, outpatient procedure, diagnostic services or laboratory tests to ensure full reimbursement of the medical services provided. Your Provider should advise you of the costs of the recommended Treatment or Procedure. If the costs of the Treatment or Procedure are likely to exceed Usual, Reasonable and Customary Charges, you should request a written estimate and contact WellAway before any Treatment or Procedure takes place.

When Your Coverage Begins and Ends

Your coverage takes effect at 12:01 a.m. on the date stated on your ID card as the Effective Date and the Premium has been paid. The period of coverage is referred to as the Benefit Period and will end at 11:59 p.m. on the date indicated your ID card. If a Covered Person was repatriated back to his/her Home Country, coverage will terminate upon the departure from the United States.

Eligibility

- You must be between the ages of 17 and the attained age of 64 at the time of enrollment.
- You must be:
 - (i) a non-US citizen for U.S.-bound international student, a U.S. out-bound student or a third country national student in need of worldwide coverage;
 - (ii) who is a full-time student enrolled in either: (a) an accredited educational program or in an associate, bachelor, master, or Ph.D. program at a university or other recognized higher education institution; (b) a language-training program; or (c) a vocational program; or
 - (iii) who is a full-time visiting faculty, scholar or other person engaged in research activities (as defined by the educational institution). Students must actively attend classes. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend class.
- You must be residing outside your Home Country and depart not more than thirty (30) days from purchasing this plan. You must remain engaged in full-time educational or research activities outside your Home Country during the Benefit Period. You are **not** eligible for this Policy if your intent is to live in a fixed location outside your Home Country (living abroad versus traveling).
- You must notify us within 30 days of your return to your Home Country and coverage will terminate 30 days following your return to your Home Country during the Benefit Period.
- You must not have obtained residency status in the United States.
- You must hold a valid passport and a valid F-1 or M-1 visa. An F-1 visa holder on OPT is not eligible for this Policy. Policyholder must, at all times during the Benefit Period, meet all requirements of the applicable US visa that has been obtained to enter the United States. An Insured Person with an F-1 or M-1 Student Status, Form I-20 will be provided to you by your school which you and your school official must sign. We may request a copy of the I-20 or DS2019 and your current visa.
- You must be in good health and not confined to a Hospital or nursing home, not be pregnant, hospitalized or disabled as of the Policy Effective Date.

- Students under the age of 18: the parent or legal guardian must complete the documentation with the applicable sponsoring organization as follows:
 - Parental authorization form completed and signed by the parent or guardian.
 - Vaccination agreement.
 - Student-parent agreement form completed and signed by the student and the parent or guardian. The parent or legal guardian is required to sign the application and purchase the policy on behalf of the student.
 - Student application completed and signed by the student and the parent or guardian.
 - Student behavior agreement.
- If the Policyholder is also eligible as a Dependent under a different policy, he/she may only be covered once under a Policy.
- WellAway has the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If it is discovered the eligibility requirements are not met, the insurance coverage will be terminated.

Cancellation and Refunds

You will only be allowed to cancel your Policy and obtain a refund of your Premium if:

1. Your waiver is not approved by your educational institution within thirty (30) days of the Effective Date of coverage because your Policy benefits do not meet the educational institution's minimum insurance requirements. You must provide written proof that your educational institution has denied your waiver request stating the reason for the denial; or
2. You withdraw from classes within thirty (30) days from the Effective Date of coverage under a school-approved leave of absence. You must provide written proof of the approved leave of absence and return date to your Home Country.

You must provide written notification to the Insurer of your refund request within thirty (30) days of the Effective Date of coverage. You will not be eligible for a refund if there are any claims on file during the Benefit Period. A Force Majeure event will not operate to automatically entitle any Covered Person to a refund of Premium previously paid and will also not operate to extend the Benefit Period. **WellAway will be entitled to retain an administrative fee in the amount of \$50 for any approved refund.**

In-Network Provider

WellAway provides its members with access to the UnitedHealthcare Options PPO Network and we always recommend that you use a **Premium Care Physician and an In-Network Facility** in order to minimize your costs and allow you to obtain significant savings. Premium Care Physicians are those Physicians who meet the UnitedHealth Premium program quality and cost-efficient care criteria. In order to minimize your costs, (i) certain Services require Pre-Authorization; (ii) must be rendered by a Premium Care Physician and in an In-Network facility (**except when such Services are Medical Emergency Services**); and (iii) be performed in a physician's office or in a free standing diagnostic center. Our In-Network free standing facilities are conveniently located and provide Basic Diagnostic Services, Advanced Imaging/Diagnostic Testing and other Outpatient Services. For laboratory tests, visit Quest Diagnostics. You will be responsible for the difference between the Usual, Reasonable and Customary Charges and the fees charged by the provider rendering the Services. **Your ID Card is your key to accessing all of the Providers available to you as a member. Please present your ID Card to your Provider at the time of receiving Services. If you need assistance, contact our ConciergeCare team via the telephone number on your ID Card. We are experienced in guiding you to the most appropriate providers for you.**

Pre-Authorization

Certain Services require Pre-Authorization and we always recommend that you use a **Premium Care Physician and an In-Network Facility** in order to minimize your costs. Pre-Authorization is a process by which an Insured Person obtains approval for certain non-Emergency medical Services prior to the commencement of the proposed Service. Please contact our ConciergeCare team to request a Pre-Authorization at least five (5) business days prior to the scheduled Service, unless a greater time period is required as stated in this Policy. When you contact us for Pre-Authorization, we will recommend that you use a Premium Care Physician and an In-Network Facility within the Network if we anticipate that the contracted amount with the Provider will exceed the Usual, Reasonable and Customary Charges. Complete medical records must be submitted to our Plan Administrator for review of Medical Necessity in accordance with the terms of the Policy. A cost Estimate of the Services will also be required at the time of the request for Pre-Authorization for any Services. **Services and Procedures that require Pre-Authorization are indicated by an asterisk.**

If you do not obtain prior authorization or provide pre-service notification, we may:

1. Deny payment of the claim; or
2. Apply a benefit penalty when the claim is presented to us for payment consisting of one of the following:
 - a. \$500;
 - b. 20% of the total Allowed Amount of the claim; or
 - c. The lesser of \$500 or 20% of the total Allowed Amount of the claim.

The decision to apply a penalty or deny the claim will be made uniformly and the applicable denial/penalty will be identified in the notice describing the prior coverage authorization and pre-service notification programs. Notification of Medical Emergency Services must be received by the Insured Person, or someone acting on behalf of the Insured Person, within 48 hours of an Admission or Procedure. In the event of an Emergency, the Insured Person should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Network.

Pre-Authorization approval does not guarantee payment of the claim and the Insured Person is responsible for any Deductible amounts and any costs which are not within the Usual, Reasonable and Customary Charges (for Out-of-Network Services). The use of a Premium Care Physician and an In-Network facility will keep your excess Usual, Reasonable and Customary Charges to the lowest possible amount. If you do not choose an In-Network Premium Care Physician and facility, you will be responsible for any amounts in excess of the Allowable Charges.

Worldwide Coverage

If the Covered Person travels during a college/university scheduled winter, spring or summer break or if the Policyholder enrolls in a study abroad program outside the United States which is sponsored by the student's college or university, this Policy will provide worldwide coverage for the duration of the travel or the study abroad program, as applicable (*the student will be required to provide documentation of the study abroad enrollment and any other relevant documentation requested by Insurer*). Services provided outside the United States (*excluding the Home Country and Restricted Areas*), are covered per Covered Person for those Services stated in the section titled "What is Covered."

All covered Services must be Medically Necessary for the treatment of a Covered Person's Condition. All benefits are subject to Usual, Reasonable and Customary Charges. Please refer to your Summary of Benefits for applicable Cost Share amounts.

We will attempt at all times to settle the costs directly with the Hospital and/or Provider; however, it is in the Hospital's and/or Provider's discretion to accept direct payment from us. In the event a direct settlement is not accepted by the Provider or Hospital, WellAway will:

- (i) send the remittance to the Covered Person at the time Services are rendered or upon discharge via credit/debit card or other financial instrument; or
- (ii) request the Covered Person to settle the invoices in full directly with the Hospital and/or Provider. Thereafter, the Covered Person may submit the invoices for reimbursement; provided, however, reimbursement will be in the amount of the Usual, Reasonable and Customary Charges for such Services. All reimbursement requests must be done in accordance with the Post-Service Claims section of this Policy.

WellAway World Elite Student 450 Summary of Benefits

This Guide will tell you about certain coverages and features of your plan. However, it is important that you read and understand the Policy (which contains a complete description of the terms and conditions), to make sure you are aware of any conditions, limitations and exclusions to your coverage. Benefits may be subject to Deductible, Coinsurance, and Copayment amounts. For complete details of coverage, contact a ConciergeCare Counselor: +1-855-773-7810, International +1-786-453-4008 (collect) or e-mail: Conciergecare@payerfusion.com.

Limit & Cost Sharing	Premium Care Physician	In-Network	Out-of-Network	Worldwide
Annual limit	Unlimited	Unlimited	Unlimited	\$1,000,000
Deductible	\$450	\$450	\$500	\$450
Coinsurance (WellAway cost share)	90%	80%	50%	100%
Out-of-pocket maximum	\$5,000	\$5,000	\$5,500	\$0

Wellness Care

These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.

Adult Wellness Care Periodic routine health exams, routine gynecological exams, immunizations and related preventive services such as prostate specific antigen (PSA), routine mammograms and pap smears. Your physician will measure your height, weight, blood pressure and take other routine measurements; review your medical and family history; assess your risk factors and treatment options; review your health risk assessment questionnaire; update your list of providers and prescriptions; look for signs of cognitive impairment; and set up a screening schedule for appropriate preventive services.	100%	100%	Deductible then 100%	100%
Child Wellness Care Periodic age specific physical examinations and developmental assessments; office visit; health history; hearing examinations; age related diagnostic tests; vaccination and immunization necessary for prevention; and track growth and development in accordance with pediatric guidelines.	100%	100%	Deductible then 100%	100%
Preventive dental services for children under 19 (includes oral exams, cleaning and fluoride treatment every 6 months, sealants every 36 months, space maintainers, and x-rays every 6 months)	100%	100%	Deductible then 70% Coinsurance	100%
Eye exams and eye glasses for children under 19 (includes one eye exam and one pair of glasses every benefit period)	100%	100%	Deductible then 50% Coinsurance	100%

Services that Require Hospitalization

	Premium Care Physician	In-Network	Out-of-Network	Worldwide
Hospitalization*	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Emergency room When your symptoms are severe and your health is in jeopardy, causing loss of life, limb or death (medically necessary)	90% Coinsurance after \$200 co-payment (waived if admitted)	Deductible and \$200 co-payment (waived if admitted)	50% Coinsurance after \$200 co-payment (waived if admitted)	Deductible then 100%
Rehabilitative services* (treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Physician services (consultations by a physician or specialist while inpatient only when medically necessary)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Behavioral health services* (mental health & substance use disorder services)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Surgical procedures and surgeon fees (inpatient)* <ul style="list-style-type: none"> Refers to the fees charged by the main surgeon that performed the surgical procedure Some complex medical procedures may require an assistant surgeon or co-surgeon performing services (maximum coverage amount is 20% of the approved fees for the main surgeon). This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by evidence based medicine. Services provided by an anesthesiologist during a covered surgical procedure is a covered service by an in-network provider (maximum coverage amount is 30% of the approved fees for the main surgeon). 	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Oncology treatment, drugs & reconstructive surgery* <ul style="list-style-type: none"> Oncology treatment includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution Reconstructive surgery due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability 	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Organ transplant* (includes heart, lung, heart and lung, kidney, pancreas, kidney and pancreas, liver, cornea, allogenic and autologous bone marrow and peripheral stem cell transplants)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%

* Pre-authorization required

Services that Require Hospitalization

Premium Care Physician In-Network Out-of-Network Worldwide

Emergency ambulance services

(from emergency location to nearest facility, from one hospital to another, or from hospital to your home or skilled nursing facility)

Deductible then 90% Coinsurance

Deductible then 100%

Outpatient Care

These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.

Urgent care center

\$50 co-payment

Deductible then \$50 co-payment

Deductible then 50% Coinsurance

Deductible then 100%

Outpatient ambulatory surgical facility & surgical care*

Free-standing only

\$100 co-payment then 90% Coinsurance

\$100 co-payment then 80% Coinsurance

\$100 co-payment then 50% Coinsurance

Deductible then 100%

Surgeon Fees

- Some complex medical procedures may require an assistant surgeon or co-surgeon performing services (maximum coverage amount is 20% of the approved fees for the main surgeon). This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by evidence based medicine.
- Services provided by an anesthesiologist during a covered surgical procedure is a covered service by an in-network provider (maximum coverage amount is 30% of the approved fees for the main surgeon)

Deductible then 90% Coinsurance

Deductible then 80% Coinsurance

Deductible then 50% Coinsurance

Deductible then 100%

Oncology treatment, drugs & reconstructive surgery*

- Oncology treatment includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution
- Reconstructive surgery due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability

Deductible then 90% Coinsurance

Deductible then 80% Coinsurance

Deductible then 50% Coinsurance

Deductible then 100%

Basic diagnostic services and laboratory tests

When performed in a physician's office or in a free-standing non-hospital facility, e.g., x-rays, ultrasounds, EKG, colonoscopy, heart cardiac test, echocardiography, stress test (this list is not exclusive)

Deductible then 90% Coinsurance

Deductible then 80% Coinsurance

Deductible then 50% Coinsurance

Deductible then 100%

Advanced diagnostic and imaging services*

When performed in a free-standing non-hospital facility, e.g., MRI, CT scans, PET scans, MRA, angiography, nuclear imaging, biopsy, CTA, CT coronary angioplasty, diagnostic colonoscopy/endoscopy (this list is not exclusive)

Deductible then 90% Coinsurance

Deductible then 80% Coinsurance

Deductible then 50% Coinsurance

Deductible then 100%

* Pre-authorization required

Outpatient Care

Premium Care Physician

In-Network

Out-of-Network

Worldwide

These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.

Rehabilitative services* (for treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	\$15 co-payment and 90% Coinsurance (limited to 20 visits per benefit period)	Deductible and \$15 co-payment (limited to 20 visits per benefit period)	Deductible then 50% Coinsurance (limited to 20 visits per benefit period)	Deductible then 100% (limited to 20 visits per benefit period)
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	\$15 co-payment and 90% Coinsurance (limited to 20 visits per benefit period)	Deductible and \$15 co-payment (limited to 20 visits per benefit period)	Deductible then 50% Coinsurance (limited to 20 visits per benefit period)	Deductible then 100% (limited to 20 visits per benefit period)
Outpatient physical therapy* (physical therapy and spinal manipulation when restoring function loss due to a medical condition or to attain age appropriate function for activities of daily living - treatment plan must be provided)	\$15 co-payment and 90% Coinsurance (limited to 40 visits per benefit period)	Deductible and \$15 co-payment (limited to 40 visits per benefit period)	Deductible then 50% Coinsurance (limited to 40 visits per benefit period)	Deductible then 100% (limited to 40 visits per benefit period)
Outpatient chiropractic & spinal manipulation* (chiropractic services and spinal manipulation <i>(to correct a slight dislocation of a bone or joint that is demonstrated by x-ray)</i> when restoring function loss due to a medical condition or to attain age appropriate function for activities of daily living - treatment plan must be provided)	Deductible then \$15 co-payment (limited to combined 15 visits per benefit period)	Deductible then \$15 co-payment (limited to combined 15 visits per benefit period)	\$15 co-payment and 50% Coinsurance (limited to combined 15 visits per benefit period)	Deductible then 100% (limited to combined 15 visits per benefit period)
Alternative medicine (combined benefit limits) Acupuncture, homeopathy, Chinese Medicine	Not applicable	Deductible then \$15 co-payment (limited to combined 15 visits per benefit period)	Not covered	Deductible then 100% (limited to combined 15 visits per benefit period)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	90% Coinsurance	80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Emergency dental services (due to damage to natural sound teeth which is treated within 62 days of the accidental dental injury)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%

Physician Services

Teladoc® consultations (for illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	\$10 co-payment Limited to 12 visits per benefit period	\$10 co-payment Limited to 12 visits per benefit period	Not covered	Not available
Primary care (includes general consultation, primary care visit, check-ups, office visits, and gynecologist when designated as your primary care physician)	\$20 co-payment	Deductible then \$20 co-payment	Deductible then 50% Coinsurance	Deductible then 100%

* Pre-authorization required

Physician Services

	Premium Care Physician	In-Network	Out-of-Network	Worldwide
Specialist consultation	\$20 co-payment	Deductible then \$20 co-payment	Deductible then 50% Coinsurance	Deductible then 100%
Behavioral health* (includes office visit, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a physician, psychologist or mental health professional for the treatment of a mental health illness or substance use disorder)	\$10 co-payment	\$10 co-payment	Deductible then 50% Coinsurance	Deductible then 100%
Allergy testing & treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	\$20 co-payment	\$20 co-payment	Deductible then 50% Coinsurance	Deductible then 100%

Maternity Care

(member must notify WellAway within 30 days of pregnancy confirmation)

Prenatal and postnatal physician consultations	Paid in Full	Paid in Full	Deductible then 50% Coinsurance	Deductible then 100%
Labor and delivery Hospital stay minimum 48 hours for normal delivery and 96 hours for c-section (includes hospital, obstetrician, midwife, anesthesiologist, pediatrician (well baby) for a normal delivery)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Complications of Pregnancy (mother only) miscarriage, preeclampsia, ectopic pregnancy and c-section	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Birthing center	\$200 co-payment	\$200 co-payment	Deductible then 50% Coinsurance	Deductible then 100%
Newborn care (a newborn child who is properly enrolled will be covered from the moment of birth for injury or illness, including routine care, and the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and premature birth)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Infertility treatment	Not covered	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%

Other Services

	Premium Care Physician	In-Network	Out-of-Network	Worldwide
Skilled nursing facility* (care must begin within 14 days following your hospital stay)	Deductible and \$150 co-payment	Deductible and \$150 co-payment	\$150 co-payment and 50% Coinsurance	Deductible then 100%
Home healthcare* (care must begin within 14 days following your hospital stay, prescribed by a physician and provided under the supervision of a registered nurse)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved by a physician)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Dialysis (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%
Durable medical equipment (helps to complete your daily activity and includes walker, wheelchair, crutches, canes, oxygen equipment, hearing aids or other equipment that can withstand repeated use which must be medically necessary and prescribed by a physician)	Deductible then 90% Coinsurance	Deductible then 80% Coinsurance	Deductible then 50% Coinsurance	Deductible then 100%

Prescription Drugs

	EHIM In-Network Pharmacy	Out-of-Network	Worldwide
Preventive	100%	Not covered	Deductible then 100%
Generic	\$15 co-payment	\$15 co-payment then 70% Coinsurance	Deductible then 100%
Brand	\$40 co-payment	\$40 co-payment then 70% Coinsurance	Deductible then 100%
Non-preferred brands	\$75 co-payment	\$75 co-payment then 70% Coinsurance	Deductible then 100%
Specialty	\$100 co-payment	\$100 co-payment then 70% Coinsurance	Deductible then 100%

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

* Pre-authorization required

Exclusions

The following is a partial list of examples of expenses which are not covered under the insurance plan:

1. **General Exclusions:**

- (i) Services, Procedures or Prescription Drugs not specifically listed in this Policy as covered. Expenses for any complications directly caused by an Illness, Injury or Procedure for which we exclude or limit coverage.
- (ii) charges in excess of Usual, Reasonable and Customary Charges for any Covered Service or Procedure or the number of visit limitations.
- (iii) any medical Service, Supply or Prescription Drug which is: (a) not ordered, recommended, or approved by a Physician; (b) not rendered under the scope of a Physician's license; or (c) not Medically Necessary or in accordance with established Evidence Based Medicine even if prescribed, recommended or approved by the Student Health Center or by your attending physician or dentist.
- (iv) claims and costs for medical Services, Procedures or Prescription Medication/Drugs occurring before the Policy Effective Date or with dates of Service after the Policy expiration/termination date.
- (v) charges not submitted within 120 days from the date the Service was rendered, except in the event of legal incapacity.
- (vi) charges for which we are unable to determine liability because the Insured Person failed, within one hundred twenty (120) days, or as soon as reasonably possible to: a) authorize us to receive all the medical records and information we request; or b) provide us with information we requested regarding the circumstances of the claim or Other Insurance Plan.
- (vii) missed appointments, "after hours" expenses, or home visits.
- (viii) Professional Services received from a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption including, guardian, domestic partner or non-marital partner or at a Facility owned partially or completely by the aforementioned persons.
- (ix) Services for which you are not legally obligated to pay for or Services which no charge is made to you in the absence of insurance coverage.
- (x) Charges for taxes, assessments, charges, fees or surcharges imposed by any governmental agency or fees for required medical records where an Insured Person is required to substantiate his/her claim.

2. **Home Country Coverage:** expenses incurred within your Home Country or Country of Origin or medical Treatment that is available under any governmental or national health plan except when a charge is made which you are required to pay.

3. **Podiatric Care:** Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails, Treatment of hammer, claw and mallet toes, structural and functional Treatment of the feet, Treatment of weak/fallen arches, weak, strained or flat feet, bunions, any Symptomatic complaints of the feet, congenital foot disorders, or any foot Treatment resulting from an Illness or Injury. Orthopedic shoes, orthotic or other supportive devices or inserts of any kind, or any other preventative Services or Supplies are also excluded from coverage.

4. **Fertility and Infertility Treatments:** (i) any and all fertility/infertility Services, Procedures, tests or Supplies that promote conception including, but not limited to, fertility/infertility drugs, any Prescription Medications, or any complications directly or indirectly related thereto; or (ii) any Procedure, Treatment or medication to prevent pregnancy or which is aimed at making a person unable to reproduce, including, but not limited to, male contraception and any expenses for male or female reversal of sterilization.

5. **Coverage Under Other Plans or Sources:** Services, Supplies or Procedures, including Prescription Drugs and/or Medical Emergency Services, that are provided by or payment is available from: (i) workers' compensation law, occupational disease law or similar law concerning job related conditions; (ii) an Other Insurance Plan or governmental program; or (iii) under the direction of public authorities related to epidemics and pandemics.

6. **Services for Administrative Purposes:** Health check-ups, inoculations, immunizations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.), *other than as provided for under the Wellness and Preventive Services benefit*. If Services are provided by your Student Health Center and you do not utilize the Student Health Center for such Services which are covered for free or provided through the payment of your student health fee, these Services will be excluded from coverage under this Policy.

7. **Elective and Cosmetic Surgeries, Treatments and Procedures:** (i) any elective and/or cosmetic Service, Surgery, Procedures, Treatments, technologies, Prescription Drugs, devices, items, products, and Supplies that are not Medically

Necessary, whether or not due to a covered Injury or Illness or for psychological purposes, and that may only be provided for the purpose of improving, altering, enhancing, or genetically manipulated the quality of an existing condition including, but not limited to, hair, skin, eyes, nose (deviated septum, submucous resection, nasal and sinus surgery), vision, teeth, hearing, physical size, aging, athletic or sexual capabilities or other mental or physical attributes not falling into these categories; (ii) any complications arising directly or indirectly therefrom; or (iii) Services or Treatment for breast reductions or augmentation, regardless of a Physician's recommendation of Medical Necessity, or any Treatment or complication related to or arising from breast implants, even if due to an Accident (except in connection with breast Reconstructive Surgery after a mastectomy).

8. **Weight Related Services:** weight reduction and the cost of all Surgical Procedures, Treatments, Supplies, Services or Prescription Medication for weight reduction, appetite suppression, weight reduction programs, morbid or non-morbid obesity, medical fast diets, weight loss programs or complications arising directly or indirectly from the same (*unless provided under the Obesity and Weight Loss benefit*).
9. **Dental, Vision and Hearing Care (adult and children):** (i) any dental Treatment or orthodontic Treatment (*unless covered as stated in What is Covered*); (ii) dental cosmetic Procedures, including, but not limited to, veneer restorations, tooth whitening, dental implants, or cosmetic contouring; (iii) any Treatment in relation to gum or gum disease including, but not limited to, flap Surgery, pocket reduction Surgery, bone grafts, soft tissue grafts, guided tissue regeneration or bone Surgery, Treatment for gingivitis, periodontitis, or any other similar Treatment is specifically excluded; (iv) Treatment for temporomandibular malocclusion joint disorders; (v) dental reconstructive surgery, microsurgery, replantation and plastic surgery; (vi) routine eye examinations, Services and Supplies related to visual therapy, radial keratotomy and photo refractive keratectomy Procedures, Lasik, or eye Surgery to correct refractive errors or deficiencies, including myopia or presbyopia, nearsightedness, farsightedness or astigmatism, orthoptics, eyeglasses, contact lenses, sunglasses, and photorefractive keratectomy (*unless covered as stated in What is Covered*); or (vii) routine hearing examinations, hearing aids or devices (*unless covered as stated in What is Covered*). Surgical implantation of, or removal of bone anchored hearing devices and cochlear implants are excluded from coverage under this Policy.
10. **Illegal Activities:** Services, Treatments and Procedures related to Injuries and Illnesses resulting, arising from or occurring during the commission or perpetration of a violation of law by a Covered Person.
11. **Sports and Activities:** (i) Any Services, Treatments or Procedures for Injuries or Illnesses arising from participating in or providing instruction for semi or Professional Sports, intercollegiate or competitive sports; (ii) traveling to or from any of the above sports, contests or competition as a participant; or (iii) while participating in any practice or conditioning program for such sport, contest or competition; (iv) hazardous or extreme sports or activities or any deliberate exposure to exceptional danger; (v) the use of any type of firearms (any device that discharges a projectile of any type); (vi) any activity relating to flying either as a Pilot in Command, student pilot, sport flying or the business or trade of flying (except while traveling as a passenger in a fully-licensed passenger carrying aircraft); (vii) the use of a motor vehicle by the Insured Person unless the Insured Person is carrying a legally issued driver's license and insurance from the country in which he/she is an eligible Policyholder; (viii) racing or speed testing any motorized vehicle or conveyance; or any other powered devices whether the vehicle is in motion or not; (ix) any sport that requires a higher degree of knowledge or training and has an increased risk of injury or death; or (x) sports-related devices and services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation are not covered. Determination and coverage for a sport not listed in this exclusion is at the Insurer's discretion and its decision is final. Services for injuries from participation in all types of recreational activities or amateur sports are covered.
12. **Genetic Testing and Counseling:** genetic molecular testing is not covered except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed. As used herein, "genetic molecular testing" means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.
13. **Experimental and/or Investigational Services:** Services, Supplies or Prescription Medications, as determined by Insurer to be Experimental and/or Investigational (not including Clinical Trials as outlined in the policy terms and conditions). The Plan Administrator's decision, whether a Prescription Drug or its use is "investigational" or "experimental" shall be binding.
14. **Therapeutic Services:** (i) vocational or recreational therapy, vocational rehabilitation, or occupational therapy (*unless covered as stated in What is Covered*); (ii) stays in a cure center, a bath center, a spa, a health resort or a recovery center, even if they are medically prescribed. This also includes thermal baths, saunas and any kind of wellness massages; or (iii) Rolting; carbon dioxide therapy; aroma therapy; bio-electromagnetic therapy; magnetic therapy; vitamin therapy; nutritional consultations;

naturopathic medicine; ayurvedic medicine; biofield therapies; energy medicines; color puncture; light therapy; hypnotherapy; reflexology; spiritual healing; Ti-chi; traditional oriental medicine; or chelation therapy. We do not recognize nutriment, tonics, mineral water, cosmetics, hygiene and body-care products and bath additives as Medically Necessary and these items are not covered.

15. **Sexual Dysfunction and Sex Change Services:** (i) any Service, Procedure, Treatment, Supply or Prescription Drug for sexual dysfunction, impotency or inadequacies, including sexual enhancement drugs; or (ii) any Service, Surgery, Procedure, Treatment, Prescription Drugs including hormone therapy to change the biological sexual characteristics to those of the opposite sex, implantation or sexual transformation.
16. **Sleep Studies and Disorders:** Any Treatment, Procedures, Services or investigations for insomnia, sleeping disorders, sleep studies and other Treatments relating to sleep apnea, jet lag, fatigue, or stress or any related conditions.
17. **Self-Administered Treatment:** (i) where Treatment or Advice of a medical condition, whether related or not, was a result of self-treatment or auto therapy (self-administered); or (ii) any Services, Procedures or Treatment that arise from, are related to or associated with specific medical Advice which has been disregarded (including travel where an Insured Person has traveled against medical Advice), any changes in Prescription Drugs, therapies or diet that are a result of a previously known condition that can affect degrade or alter the Insured Person's health, or any Services, Procedures or Treatment that is abandoned against medical advice.
18. **War and Terrorism:** Illnesses and Injuries, and their consequences, as well as the consequences of Accidents and deaths caused by the following: (i) martial law or state of siege, or any event or causes which determine the proclamation or maintenance of martial law or state of siege; (ii) foreseeable acts of war or any act of war, declared or undeclared; (iii) civil unrest, or involvement in civil commotion or an illegal act, mutiny, riot, strike, military or popular uprising, insurrection, rebellion, military or usurped power; including resultant imprisonment; (iv) any act of any person acting on behalf of or in connection with any terrorist organization; (v) criminal acts unless the Insured Person suffers an Injury as a non-involved third party who has not put themselves in danger in a deliberate or negligent way and such Injury has not been paid or is not payable by a state crime victims compensation program or similar type of governmental program which reimburses victims for crime-related expenses. We will not provide coverage if the Insured Person moves to a territory where direct combat is taking place or provides services for any of the parties involved in that conflict; or (vi) Illnesses, Injuries and Accidents, directly or indirectly, as well as their consequences, which have been caused by nuclear energy (nuclear reactions, radiations, and contamination, asbestosis or any related condition), as well as Illnesses, Injuries and Accidents, as well as their consequences caused by chemical or biological weapons.
19. **Foreseeable Events/Restrictions on Travel:** (i) any Services, Procedures or Treatments that arise from, are related to or associated with, an actual or likely contagious disease, epidemic or pandemic, the threat of a contagious disease, epidemic or pandemic or any foreseen event. This exclusion is designed to exclude losses caused by reasonably foreseeable events. The moment an event becomes a foreseen event, it will not be covered; (ii) any Services, Procedures or Treatments that arise from, or are associated with, travel to countries or parts of a country for which: (a) an advice or warning has been released by any governmental or official body, the Federation of European Risk Management Association, the US Government Department of Foreign Affairs and Trade, or the US Centers for Disease Control and Prevention, and the advice or warning risk rating is "reconsider your need to travel" or "do not travel" (or words to that effect) or the advice or warnings advise against all non-essential travel to or in that location or advise against specific transport arrangements or participation in specific events or activities; or (b) the mass media has indicated the existence or potential existence of circumstances (including circumstances referred to in clause (a) above that may affect your travel, and you did not take appropriate action to avoid or minimize any potential claim under your Policy (including delay of travel to the country or part of the country referred to in the relevant advice(s), warning(s) and/or mass media statement(s)).
20. **International Sanction Laws:** Any Services, Procedures or Treatments, to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose Insurer to any sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or the United States including, but not limited to, any Services, Procedures or Treatments provided in the Restricted Areas.

This list of exclusions is not complete; refer to the policy terms and conditions for a complete list of exclusions. Plan benefits are subject to the terms and conditions of the insurance plan.

Claims Payment

In the United States, the Hospital or Provider should submit the claim directly to us and we will pay any Covered Expenses directly to the Provider or Hospital. You must present all health care Providers with a copy of your Identification Card. Your Provider will then contact us to verify Eligibility and the coverage provided under this Policy. You will only be responsible for: (i) expenses that are not covered by this Policy; (ii) any Deductible; (iii) any amounts in excess of Usual, Reasonable and Customary Charges; and (iv) any amounts in excess of the Maximum Benefit.

Note:

1. Your Providers must submit claims to us within **one hundred twenty (120) days** from the date of Service. No benefits will be paid for claims exceeding this time period.
2. Medical claims submitted by Providers within the United States must be in CMS 1500 formats, or UB04 CMS formats. If you have already paid the Provider, you must submit your reimbursement pursuant to the guidelines set forth above. We will reimburse you in accordance with the terms of the Provider contract, if one exists.
3. In the event that you utilize a Non-Network Provider that has chosen to “opt-out” of billing an insurance company and did not provide you with a medical claim in CMS 1500 formats, or UB04 CMS formats, your claim will be deemed a non-reimbursable claim.

Whenever possible, we will settle the expenses directly with the Providers for Services rendered. When not possible or for claims from outside the United States, we will reimburse the Policyholder in accordance with the terms and conditions of this Policy. In order to receive reimbursement under this Policy, you must submit to us a completed claim form and the supporting documents within **one hundred twenty (120) days** from the date of Service. The claim form is available at www.wellaway.com or you may request the claim form by contacting a ConciergeCare Counselor at +1.855.773.7810 or e-mail: Conciergecare@payerfusion.com.

Please send us the following information with your completed claim form:

1. Claimant's name;
2. Physician's specialty;
3. Detailed description of Service rendered (office visits, Surgery, etc.);
4. Original itemized invoices with fees on Physician/Hospital letterhead. Invoice must include patient's full name, date of birth, Diagnosis (type of Illness), date of the visit, Treatment type, Physician's charges and acceptable proof of payment (credit card receipt);
5. In the case of hospitalization, you must attach the Hospital medical notes or reports, and our Pre- Authorization provided to you. Please ensure that your invoice details the cost of private or semi-private room; and
6. Type of Currency

To receive reimbursement for a Prescription Drug, you will be required to provide the following:

1. Completed claim form;
2. Copy of Physician's prescription;
3. Prescription Drug invoice; and
4. Proof of payment.

Prescription medications must clearly provide the name of the patient, the price of the Drug, and prescription quantity.

The Insurer will pay the benefit as soon as the validity of the claim for benefits has been reasonably satisfied. Expenses incurred in relation to the substantiation of a claim will not be the responsibility of the Insurer. You may submit your claim via e-mail to conciergecare@payerfusion.com, courier, or by postal service. Mail your completed claim documents to:

PayerFusion Holdings, LLC
2100 Ponce de Leon Boulevard
Mezzanine Level – Suite 200
Coral Gables, FL 33134

Note: We encourage you to keep copies of the invoices for your records. Copies of claims are accepted as long as the integrity of the document is not altered. However, we reserve the right to request original documents at our discretion. We will notify you, in writing, if the claim is denied or if additional information is necessary for the review and/or payment of the claim within the terms of this Policy. The claim will be paid at the exchange rate based on date of service.

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided by WellAway. It is designed to avoid duplication of payment for Covered Services and/or Supplies. We shall coordinate payment of Covered Services to the maximum extent allowed by law.

To File a Complaint

We aim to keep our customers satisfied; however, we understand that there are instances whereby we may not be able to meet your expectations. For a formal complaint, please contact us by post, telephone or e-mail.

WellAway Limited
Victoria Place
31 Victoria Street
5th Floor
PO Box HM 1624
Hamilton HM GX
Bermuda
Phone: 1-441-296-0651
Email: Conciergecare@wellaway.com
Website: www.wellaway.com

About Us and Our Contact Numbers

This Student Guide provides a description of the WellAway World Elite Student Health Plan approved as Minimum Essential Coverage under the United States Patient Protection and Affordable Care Act. The plan is underwritten by Davies (SAC) Limited on behalf of the WellAway Segregated Account and Arch Re rated "A+" (Excellent) AM Best Company and administered by PayerFusion Holdings, LLC, a licensed third party administrator in the United States. A complete description of the benefits, conditions, limitations and exclusions of coverage governing this insurance are contained in the policy terms and conditions. If you would like a copy of the policy terms and conditions, please email us at students@wellaway.com. If there is a difference between this Guide and the policy terms and conditions, the policy terms and conditions will control.

For inquiries:
Email: students@wellaway.com
Phone: +1-441-296-0651

For a ConciergeCare Counselor, to request Pre-Authorization, or to check on the status of a claim, we can be reached at the following numbers:

PayerFusion Holdings, LLC
United States: +1-855-773-7810
International: +1-786-453-4008 (collect) or
E-mail: Conciergecare@payerfusion.com

WellAway[®]

Keeping You Well, While You're Away.[®]



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