WellAway World Elite Student In-Network Benefits Plan Comparison

WellAway

wellaway.com

2023

WELLAWAY WORLD ELITE STUDENT
In-Network Benefits Plan Comparison

LIMIT & COST SHARING	250	450	Plus
Annual limit	Unlimited	Unlimited	Unlimited
Deductible	$250	$450	$0
Coinsurance (WellAway cost share)	80%	80%	100%
Out-of-pocket maximum	$5,500	$5,000	$5,000

WELLNESS CARE

It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to 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.	Your plan pays 100%	Your plan pays 100%	Your plan pays 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.	Your plan pays 100%	Your plan pays 100%	Your plan pays 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)	Your plan pays 100%	Your plan pays 100%	Your plan pays 100%
Eye exams and eye glasses for children under 19 (includes one eye exam and one pair of glasses every benefit period)	Your plan pays 100%	Your plan pays 100%	Your plan pays 100%

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SERVICES THAT REQUIRE HOSPITALIZATION	250	450	Plus
Hospitalization*	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Emergency room When your symptoms are severe and your health is in jeopardy, causing loss of life, limb or death (medically necessary)	Deductible and $200 copayment per visit (waived if admitted)	Deductible then $200 copayment per visit (waived if admitted)	$200 copayment per visit payable at Usual, Reasonable and Customary
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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Physician services (consultations by a physician or specialist while inpatient only when medically necessary)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Behavioral health services* (mental health & substance use disorder services)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Surgical procedures and surgeon fees (inpatient)* • 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%

* Pre-authorization required

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OUTPATIENT CARE	250	450	Plus
It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.			
Urgent care center	$65 copayment then your plans pays 80% Coinsurance	Deductible then $50 copayment	$50 copayment
Outpatient ambulatory surgical facility & surgical care* Free-standing only	Deductible then your plan pays 80% Coinsurance	$100 copayment then your plans pays 80% Coinsurance	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	$25 copayment
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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	$25 copayment
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)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	$25 copayment
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	$25 copayment

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OUTPATIENT CARE	250	450	Plus
It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.			
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)	Deductible then $30 copayment (limited to 40 visits per benefit period)	Deductible then $15 copayment (limited to 40 visits per benefit period)	$25 copayment (limited to 40 visits per benefit period)
Outpatient chiropractic & spinal manipulation* (chiropractic services and spinal manipulation *(to correct a slight dislocation of a bone or joint that is demonstrated by x-ray)* 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)	$30 copayment (limited to combined 15 visits per benefit period)	Deductible then $15 copayment (limited to combined 15 visits per benefit period)	$25 copayment (limited to combined 15 visits per benefit period)
Alternative medicine (combined benefit limits) Acupuncture, homeopathy, Chinese Medicine	$30 copayment (limited to combined 15 visits per benefit period)	Deductible then $15 copayment (limited to combined 15 visits per benefit period)	$25 copayment (limited to combined 15 visits per benefit period)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Emergency dental services (due to damage to natural sound teeth which is treated within 90 days of the accidental dental injury)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
PHYSICIAN SERVICES			
Teladoc® consultations (for illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	$10 copayment Limited to 12 visits per benefit period	$10 copayment Limited to 12 visits per benefit period	Limited to 12 visits per benefit period
Primary care (includes general consultation, primary care visit, check- ups, office visits, and gynecologist when designated as your primary care physician)	$30 copayment	Deductible then $20 copayment	$25 copayment
Specialist consultation	$30 copayment	Deductible then $20 copayment	$25 copayment
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)	$30 copayment	Deductible then $20 copayment	$25 copayment
Allergy testing & treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	$30 copayment	Deductible then $20 copayment	$25 copayment

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MATERNITY CARE	250	450	Plus
Prenatal and postnatal physician consultations	Paid in Full	Paid in Full	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Complications of Pregnancy (mother only) miscarriage, preeclampsia, ectopic pregnancy and c-section	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Birthing center	Deductible then your plan pays 80% Coinsurance	$200 copayment	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
OTHER SERVICES			
Skilled nursing facility*	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved by a physician)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Dialysis* (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%
Durable medical equipment (helps to complete your daily activity and includes walker, wheelchair, crutches, canes, oxygen equipment or other equipment that can withstand repeated use which must be medically necessary and prescribed by a physician)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 80% Coinsurance	Your plan pays 100%

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PRESCRIPTION DRUGS	250	450	Plus
Preventive	100%	100%	Your plan pays 100%
Generic	$5 copayment	$15 copayment	$5 copayment
Brand	$50 copayment	$40 copayment	$40 copayment
Non-preferred brands	$75 copayment	$75 copayment	$60 copayment
Specialty	$90 copayment	$100 copayment	$90 copayment

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

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WellAway

Keeping You Well, While You're Away.®

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