CFE Prestige Plan

Summary of Benefits & Coverage

What This Plan Covers & What it Costs

Coverage Period:
Coverage for Indiv. & Family

Note: *This is only a summary. For more detail about coverage and costs please refer to your summary of benefits or plan document.*

Important Questions	Answers	Why This Matters
What is the overall deductible?	**In-Network:** USD $2,500 Individual / USD $5,000 Family **Out-of-Network:** USD $5,000 Individual / USD $10,000 Family For In-Network Providers, deductible does not apply for preventive services, pre-natal & post-natal care, oral contraceptives and prescriptions drugs.	*You must pay all the costs up to the deductible amount before the plan begins to pay for covered services. This is a calendar year deductible that begins on January 1st of each year. See chart on page 2 showing how much you pay for covered services after you meet the deductible.*
Are there other deductibles for specific services?	No. There are no other specific deductibles.	*You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.*
Is there an out-of-pocket limit on my expenses?	**In-Network:** USD $3,500 Individual / USD $7,000 Family **Out-of-Network:** USD $7,000 Individual / USD $14,000 Family	*The out-of-pocket limit is the most you could pay during a calendar year. This limit helps you plan for health care expenses.*
What is not included in the out-of-pocket limit?	Premiums, prescription co-payments, balanced-billed charges, pre-certification penalties and non-covered expenses.	*Even though you pay these expenses, they do not count towards the out-of-pocket limit.*
Is there an overall annual limit on what the plan pays?	No. This plan has an Unlimited Annual Limit	*The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.*
Does the plan use a network of providers?	Yes. This plan accesses the Aetna Passport for Healthcare Primary PPO Network. For a list of in-network providers contact a ConciergeCare Counselor or visit www.wellaway.com/provider-search	*If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart on page 2 for how this plan pays different kinds of providers.*
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	*You can see the specialist you choose without permission from this plan.*
Are there services this plan doesn't cover?	Yes.	*Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about excluded services.*

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's **allowed amount** for an overnight stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network provider charges more than the **allowed amount,** you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles, copayments** and **coinsurance amounts.**

Common Medical Event	Services You May Need	Your Costs In-Network	Your Costs Out-of-Network	Limitations & Exceptions
If you visit a healthcare provider's office or clinic.	Primary Care Visit to Treat Injury or Illness	USD $25 Co-pay	50% Coinsurance*	*Subject to Deductible (Limited to 30 visits)
	Specialist Visit	USD $45 Co-pay	50% Coinsurance*	*Subject to Deductible (Limited to 25 visits)
	Preventive Care/Screening/Immunization	No Cost	No Cost	
If you have a test.	Diagnostic Test	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
	Imaging *Basic - X-ray, Ultrasound* *Advanced - CT, CAT Scan, MRI, MRA*	Basic: USD $55 Co-pay Advanced: USD $105 Co-pay	50% Coinsurance*	*Subject to Deductible

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Coverage Period:
Coverage for Indiv. & Family

Common Medical Event	Services You May Need	Your Costs In-Network	Your Costs Out-of-Network	Limitations & Exceptions
If you need drugs to treat your illness or condition.	Generic Drugs*	USD $10 Co-pay	Not Covered	Must Use In-Network Pharmacy *Generic Preventive Drugs are No Cost
	Preferred Brand Drugs *Condition Care Rx* *All Other*	USD $15 Co-pay USD $25 Co-pay	Not Covered	Must Use In-Network Pharmacy
	Non-Preferred Brand Drugs	USD $55 Co-pay	Not Covered	Must Use In-Network Pharmacy
	Speciality Drugs	USD $105 Co-pay	Not Covered	Must Use In-Network Pharmacy
If you have outpatient surgery.	Facility Fee	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
	Physician/Surgeon Fee	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
If you need medical attention.	Emergency Room Services (Waived if Admitted to Hospital)	USD $255 Co-pay	USD $255 Co-pay	None
	Emergency Medical Transportation	USD $105 Co-pay	USD $105 Co-pay	None
	Urgent Care	USD $55 Co-pay	USD $55 Co-pay	None
If you have a hospital stay.	Facility Fee (E.g. Hospital Room)	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
	Physician/Surgeon Fee	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible

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Coverage Period:
Coverage for Indiv. & Family

Common Medical Event	Services You May Need	Your Costs In-Network	Your Costs Out-of-Network	Limitations & Exceptions
If you have a mental health, behavioral health, or substance abuse needs.	Mental/Behavioral Health Outpatient Services	USD $45 Co-pay	50% Coinsurance*	*Subject to Deductible
	Mental/Behavioral Health Inpatient Services	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
	Substance Use Disorder Outpatient Services	USD $45 Co-pay	50% Coinsurance*	*Subject to Deductible
	Substance Use Disorder Inpatient Services	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
If you are pregnant.	Prenatal & Postnatal Care	No Cost	50% Coinsurance*	*Subject to Deductible
	Delivery and All Inpatient Services	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
If you need help recovering or have other special health needs.	Home Health Care	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
	Rehabilitation Services	USD $35 Co-pay	50% Coinsurance*	*Subject to Deductible *Limited to 20 visits per year.*
	Habilitation Services	USD $35 Co-pay	50% Coinsurance*	*Subject to Deductible *Limited to 20 visits per year.*
	Skilled Nursing Care	USD $255 Co-pay per day	50% Coinsurance*	*Subject to Deductible *Limited to 20 visits per year.* *Co-pay limited to USD $750/admit*
	Durable Medical Equipment	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible
	Hospice Service	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible

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Common Medical Event	Services You May Need	Your Costs In-Network	Your Costs Out-of-Network	Limitations & Exceptions
If your child needs dental or eye care.	Eye Exam - Optometrist or Opthamologist	No Cost	50% Coinsurance*	*Subject to Deductible *Limited to 1 visit per policy year.*
	Glasses	No Cost	50% Coinsurance*	*Subject to Deductible *Limited to 1 item per year.*
	Dental Check-up	20% Coinsurance*	50% Coinsurance*	*Subject to Deductible *Limited to 2 visits per year.*

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This is not a complete list. Check your plan document for other excluded services)

- Accupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the US.
- Private-duty Nursing
- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This is not a complete list. Check your plan document for other excluded services)

- Cancer Treatment - Including oncological drugs & treatment and reconstructive surgery for breast cancer
- Dialysis Center
- Return to country of origin for treatment.

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Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, you may contact WellAway to provide you with the appropriate level of health coverage most suitable for your needs. The coverage may be limited in duration and in benefits until you are able to acquire other coverage. Other limitation on coverage may apply. For more information please contact WellAway at +44 2036 036 804.

Your Grievance and Appeals Rights

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact WellAway at +44 2036 036 804.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services

Español: Para obtener asistencia en Español, llame a WellAway a +44 2036 036 804.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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Coverage Examples

About These Coverage Examples

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is NOT a Cost-Estimator!

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. See the next page for important information about these examples.

Example 1

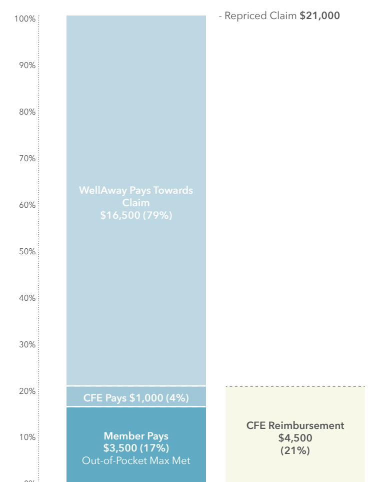
Plan: Prestige Plan ($2,500 Ind. Ded./$3,500 OOP Max/80:20 Coinsurance)
Occurence: Inpatient Surgical Hospitalization (In-Network)
Total Claim Cost: $47,000 USD

Billed Amount	$47,000 USD
Repriced Amount	$21,000 USD

Member Pays	
Ind. Deductible	$2,500 USD
Coinsurance	$1,000 USD
Out-of-Pocket/Occurence	**$3,500 USD** OOP Max Met

CFE Reimbursement to WA	$4,500 USD
WellAway To Member	$3,500 USD
WellAway To Provider	$1,000 USD

WellAway Reimbursement	**$16,500 USD**



Example 2

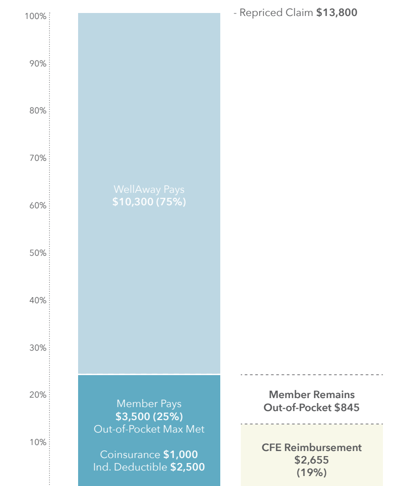
Plan: Prestige Plan ($2,500 Ind. Ded./$3,500 OOP Max/80:20 Coinsurance)
Occurence 1: Inpatient Maternity Care In-Network
Total Claim Cost: $31,000 USD

Billed Amount	$31,000 USD
Repriced Amount	$13,800 USD

Member Pays	
Ind. Deductible	$2,500 USD
Coinsurance	$1,000 USD
Out-of-Pocket/Occurrence	**$3,500 USD** OOP Max Met

CFE Reimbursements to WA	$2,655 USD
WellAway To Member	$2,655 USD

WellAway Reimbursement	**$10,300 USD**



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Questions and Answers About Coverage Examples

What are some of the assumptions behind the coverage examples?

- Costs don't include premiums.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance.

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