WellAway®

OneWorld

Global Health Insurance

www.wellaway.com

02/2017





We're making it easier to stay healthy and safe.

WellAway offers the most complete health coverage for expatriates worldwide. Our comprehensive set of health benefits, services and tools, make it easy to stay healthy and safe wherever life takes you.

Let us guide you through our global network of over 650,000 highly rated health care professionals. File claims in any language and get reimbursed in a variety of currencies.

Our products include medical evacuation and repatriation coverage to ensure our members can explore the world and build their life abroad with confidence.

A Better Experience

Competitive Costs

Our plans are competitively priced and include one of the highest annual limits on the market.

High Quality Coverage

Access to quality care is available through our global network of top-rated healthcare providers.

First-Class Service

Comprehensive health coverage is paired with white-glove ConciergeCare service that offers reliable support, coordination of care and assistance with claim processing.

24/7
reliable member support.

650,000
top-rated healthcare professionals.

180
countries included in our network of coverage.

Worldwide Coverage

- Routine Healthcare
- Prescription Medication
- Hospitalization
- Evacuation and Repatriation
- Maternity *(Optional)*
- Vision and Dental *(Optional)*
- Life and Disability *(Optional)*
- Kidnap and Ransom *(Optional)*
- New Terrorism *(Optional)*

$5,000,000
Annual Limit

One of the highest annual limits on the market.

OneWorld

Zone 1 / Worldwide (Including USA)

Schedule of Benefits (Summary of Benefits)

Annual Limit
$5,000,000

	Silver	Gold	Platinum
	In-Network | Out-of-Network	In-Network | Out-of-Network	In-Network | Out-of-Network
Deductible The amount you owe for covered health care services before your health plan begins to pay.	None | $2,000 individual $4,000 family	None | $1,000 individual $2,000 family	None | $500 individual $1,000 family
Coinsurance Your share of costs on a covered service.	30% | 50%	20% | 50%	10% | 50%
	70% | 50%	80% | 50%	90% | 50%
Out-of-Pocket Maximum (OOP) The maximum you will pay each benefit period. Deductibles, coinsurance and copayments are included in reaching your OOP.	$6,300 individual | N/A $12,600 family	$3,500 individual | N/A $7,000 family	$1,500 individual | N/A $3,000 family

In-Network (applicable to USA only)
Refers to a group of physicians, hospitals and other health care facilities that have entered into an agreement with WellAway to provide medical care to its members. Health care providers that have not entered into an agreement with WellAway are called "Out-of-network provider". Out-of-network services carry financial penalties.

Important Note: 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.
All Benefits are subject to Usual Customary and Reasonable Fees (UCR)
All Benefits reflected in USD.

Zone 1 Worldwide (including USA)
Zone 2 Worldwide (excluding USA)
Zone 3 Worldwide excluding: Bahamas, Brazil, China, Hong Kong, Japan, Singapore, Switzerland, United Kingdom and USA.
Zone 4 Rest of the World excluding: Angola, Argentina, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Barbados, Belgium, Bolivia, Bosnia and Herzegovina, Brazil, Bulgaria, Canada, Chile, China, Cyprus, Colombia, Costa Rica, Croatia, Czech Republic, Denmark, Djibouti, Dominican Republic, Ecuador, Finland, France, Georgia, Germany, Greece, Guatemala, Hong Kong, Hungary, Iceland, Ireland, Israel, Italy, Japan, Kazakhstan, Kuwait, Lebanon, Lithuania, Liechtenstein, Luxembourg, Malaysia, Mexico, Monaco, Mozambique, Netherlands, New Zealand, Nigeria, Norway, Oman, Panama, Peru, Portugal, Qatar, Russia, Saint Barthelemy, Saint Martin, Saint Pierre and Miquelon, Saudi Arabia, Slovakia, Spain, Singapore, South Africa, Sweden, Switzerland, Taiwan, Thailand, Turkey, UAE, United Kingdom, Ukraine, Uruguay, USA, Venezuela, Vietnam and Wallis and Futuna Islands.

OneWorld

Schedule of Benefits Zone 1

Hospitalization and Surgery

Important Note

Some services require pre-authorization

Contact us immediately about any serious illness or accident where you have to go into a hospital or emergency room. If you are unable to contact us because the condition is life, limb, sight, or organ threatening, please do so within 48 hours of the incident.

Planned treatment requires a minimum of 5 days prior notice.

USA
+1 855 773 7810

Outside USA
+1 786 453 4800
(call collect)

Skype
+1 888 983 2370

	Silver In-Network | Out-of-Network	Gold In-Network | Out-of-Network	Platinum In-Network | Out-of-Network
Hospitalization (inpatient) Pre-authorization required Semi-private room & board, miscellaneous services (eg. x-ray, lab test, anesthesia, MRI, CT scans). Limited to 180 days per Benefit Period.	**$500 copay then 70%** | $1,000 copay then 50%	**$450 copay then 80%** | $950 copay then 50%	**$350 copay then 90%** | $900 copay then 50%
Intensive care unit (limited to 180 days per Benefit Period)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Physician services (inpatient) (limited to one (1) per day, per specialty when medically necessary)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Rehabilitation (inpatient) Pre-authorization required	**70%** | 50% (30 day limit per Benefit Period)	**80%** | 50% (45 day limit per Benefit Period)	**90%** | 50% (60 day limit per Benefit Period
Renal failure dialysis (inpatient) Pre-authorization required (limited to six (6) weeks per Benefit Period)	**$500 copay then 70%** | $900 copay then 50%	**$450 copay then 80%** | $800 copay then 50%	**$350 copay then 90%** | $700 copay then 50%
Hospice	**70%** | 50% (30 day limit Lifetime)	**80%** | 50% (60 day limit Lifetime)	**90%** | 50% (90 day limit Lifetime)
Pre-admission testing (must be performed 3-5 days in advance)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Ambulatory/outpatient surgical facility Pre-authorization required	**$450 copay then 70%** | $900 copay then 50%	**$400 copay then 80%** | $750 copay then 50%	**$300 copay then 90%** | $600 copay then 50%
Oncology treatment Pre-authorization required (includes chemotherapy, radiation, and breast reconstruction)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Reconstructive surgery (due to Illness or Injury first sustained while under the plan and performed within 12 months from date of accident)	**$450 copay then 70%** | $900 copay then 50%	**$400 copay then 80%** | $750 copay then 50%	**$300 copay then 90%** | $600 copay then 50%
Surgical appliance and prosthesis (covered for devices which are integral part of the surgical procedure when medically necessary)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Anesthesiologist (inpatient/outpatient)	**30% of approved fees****	**30% of approved fees****	**30% of approved fees****
Surgeon fees (inpatient/outpatient) (multiple surgery guidelines apply)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Assistant surgeon fees (inpatient/outpatient when medically necessary and pre-authorized)	**20% of approved fees****	**20% of approved fees****	**20% of approved fees****
Diabetic equipment and supplies	**70%** | 50%	**80%** | 50%	**90%** | 50%
Home health care Pre-authorization required	**70%** | 50% (15 day limit per Benefit Period)	**80%** | 50% (30 day limit per Benefit Period)	**90%** | 50% (45 day limit per Benefit Period)
Organ transplant Pre-authorization required (subject to six (6) month waiting period)	**70%** | Not covered Up to $150,000 Lifetime	**80%** | Not covered Up to $200,000 Lifetime	**90%** | Not covered Up to $250,000 Lifetime
Outpatient renal failure dialysis	**70%** | 50% $10,000 limit per Benefit Period	**80%** | 50% $15,000 limit per Benefit Period	**90%** | 50% $25,000 limit per Benefit Period

** Approved fees means the amount approved to be paid by insurance company to the principal surgeon, after deductible and coinsurance

OneWorld
Schedule of Benefits
Zone 1

Wellness and Outpatient Care

	Silver	Gold	Platinum
	In-Network | Out-of-Network	In-Network | Out-of-Network	In-Network | Out-of-Network
Inpatient psychiatric Pre-authorization required (subject to 10 month waiting period)	**$300 copay** then **70%** | $600 copay then 50% 10 day limit per Benefit Period	**$200 copay** then **80%** | $500 copay then 50% 15 day limit per Benefit Period	**$100 copay** then **90%** | $250 copay then 50% 25 day limit per Benefit Period
Outpatient psychiatric consultation (subject to 10 month waiting period)	**$70 copay** then **70%** | $90 copay then 50% 10 visit limit per Benefit Period	**$80 copay** then **80%** | $120 copay then 50% 15 visit limit per Benefit Period	**$60 copay** then **90%** | $80 copay then 50% 25 visit limit per Benefit Period
Primary care consultation	**$60 copay** then **70%** | $125 copay then 50% 30 visit limit per Benefit Period	**$50 copay** then **80%** | $120 copay then 50% 45 visit limit per Benefit Period	**$40 copay** then **90%** | $80 copay then 50% 50 visit limit per Benefit Period
Specialist consultation	**$70 copay** then **70%** | $150 copay then 50% 30 visit limit per Benefit Period	**$60 copay** then **80%** | $145 copay then 50% 45 visit limit per Benefit Period	**$50 copay** then **90%** | $100 copay then 50% 50 visit limit per Benefit Period
Chiropractic services	**$40 copay** then **70%** | $65 copay then 50% 5 session limit per Benefit Period up to $80 per session	**$35 copay** then **80%** | $60 copay then 50% 5 session limit per Benefit Period up to $90 per session	**$30 copay** then **90%** | $60 copay then 50% 15 session limit per Benefit Period up to $90 per session
Podiatry	**$70 copay** then **70%** | $90 copay then 50% Limited to $500 per Benefit Period	**$60 copay** then **80%** | $120 copay then 50% Limited to $600 per Benefit Period	**$50 copay** then **90%** | $100 copay then 50% Limited to $1,000 per Benefit Period
Durable medical equipment	**70%** | 50% Limited to $900 per Benefit Period	**80%** | 50% Limited to $1,000 per Benefit Period	**90%** | 50% Limited to $1,500 per Benefit Period
Outpatient therapeutic services - rehabilitation: physical, occupational, speech, pulmonary & cardiac therapy (treatment plan must be provided)	**$60 copay** then **70%** | $90 copay then 50% Limited to 15 sessions per therapy type per Benefit Period	**$40 copay** then **80%** | $60 copay then 50% Limited to 20 sessions per therapy type per Benefit Period	**$20 copay** then **90%** | $40 copay then 50% Limited to 25 sessions per therapy type per Benefit Period
Injections/allergy treatment	**$30 copay** then **70%** | $60 copay then 50%	**$20 copay** then **80%** | $40 copay then 50%	**$10 copay** then **90%** | $20 copay then 50%
Basic diagnostic services (laboratory tests, x-rays, ultrasounds, EKG)	**70%** | 50%	**80%** | 50%	**90%** | 50%
Advanced diagnostic services/imaging Pre-authorization required~ (including but not limited to: MRI, CT scans, Pet scans, MRA, nuclear imaging)	**$400 copay** then **70%** | $800 copay then 50%	**$350 copay** then **80%** | $700 copay then 50%	**$250 copay** then **90%** | $500 copay then 50%
Routine physical examinations (subject to 10 month waiting period)			
Adult female: office visit, routine physical exam, routine lab work, urinalysis, routine mammogram, papanicolaou (PAP) screening, colonoscopy based on family medical history. **Adult male**: office visit, routine physical exam, routine lab work, urinalysis, PSA screening test, colonoscopy based on family medical history. **Children:** routine physical exam, health history, development assesment, physical examination, age related diagnostic tests and immunizations in accordance with CDC recommendation for age.	**Paid in full** up to $250 per Benefit Period | 50% up to $250 per Benefit Period	**Paid in full** up to $300 per Benefit Period | 50% up to $300 per Benefit Period	**Paid in full** up to $500 per Benefit Period | 50% up to $500 per Benefit Period

Note
Maternity benefits are not automatically included in this Policy and are only available to the Insured Person upon the payment of an additional Premium for the purchase of the maternity rider.

WellAway®

Zone 2 / 3 / 4

Annual Limit

$5,000,000

One of the highest limits on the market.

	Silver	Gold	Platinum
Deductible The amount you owe for covered health care services before your health plan begins to pay.	None	None	None
Coinsurance Your share of costs on a covered service.	30%	20%	10%
Out-of-Pocket Maximum (OOP) The maximum you will pay each benefit period. Deductibles, coinsurance and copayments are included in reaching your OOP.	$6,300 individual $12,600 family	$3,500 individual $7,000 family	$1,500 individual $3,000 family

Important Note: 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.
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All Benefits reflected in USD.

Zone 1 Worldwide (including USA)
Zone 2 Worldwide (excluding USA)
Zone 3 Worldwide excluding: Bahamas, Brazil, China, Hong Kong, Japan, Singapore, Switzerland, United Kingdom and USA.
Zone 4 Rest of the World excluding: Angola, Argentina, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Barbados, Belgium, Bolivia, Bosnia and Herzegovina, Brazil, Bulgaria, Canada, Chile, China, Cyprus, Colombia, Costa Rica, Croatia, Czech Republic, Denmark, Djibouti, Dominican Republic, Ecuador, Finland, France, Georgia, Germany, Greece, Guatemala, Hong Kong, Hungary, Iceland, Ireland, Israel, Italy, Japan, Kazakhstan, Kuwait, Lebanon, Lithuania, Liechtenstein, Luxembourg, Malaysia, Mexico, Monaco, Mozambique, Netherlands, New Zealand, Nigeria, Norway, Oman, Panama, Peru, Portugal, Qatar, Russia, Saint Barthelemy, Saint Martin, Saint Pierre and Miquelon, Saudi Arabia, Slovakia, Spain, Singapore, South Africa, Sweden, Switzerland, Taiwan, Thailand, Turkey, UAE, United Kingdom, Ukraine, Uruguay, USA, Venezuela, Vietnam and Wallis and Futuna Islands.

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HOSPITALIZATION AND SURGERY

Important Note

Some services require pre-authorization

Contact us immediately about any serious illness or accident where you have to go into a hospital or emergency room. If you are unable to contact us because the condition is life, limb, sight, or organ threatening, please do so within 48 hours of the incident.

Planned treatment requires a minimum of 5 days prior notice.

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(call collect)

Skype
+1 888 983 2370

	Silver	Gold	Platinum
Hospitalization (inpatient) **Pre-authorization required** Semi-private room & board, miscellaneous services (eg. x-ray, lab test, anesthesia, MRI, CT scans). Limited to 180 days per Benefit Period.	70% of UCR	80% of UCR	90% of UCR
Intensive care unit (limited to 180 days per Benefit Period)	Paid in full	Paid in full	Paid in full
Physician services (inpatient) (limited to one (1) per day, per specialty when medically necessary)	Paid in full	Paid in full	Paid in full
Rehabilitation (inpatient) **Pre-authorization required**	Paid in full 30 day limit per Benefit Period	Paid in full 45 day limit per Benefit Period	Paid in full 60 day limit per Benefit Period
Renal failure dialysis (inpatient) **Pre-authorization required** (limited to six (6) weeks per Benefit Period)	70% of UCR	80% of UCR	90% of UCR
Hospice	Paid in full (30 day limit Lifetime)	Paid in full (60 day limit Lifetime)	Paid in full (90 day limit Lifetime)
Pre-admission testing (must be performed 3-5 days in advance)	Paid in full	Paid in full	Paid in full
Ambulatory/outpatient surgical facility **Pre-authorization required**	70% of UCR	80% of UCR	90% of UCR
Oncology treatment **Pre-authorization required** (includes chemotherapy, radiation, and breast reconstruction)	Paid in full	Paid in full	Paid in full
Reconstructive surgery (due to Illness or Injury first sustained while under the plan and performed within 12 months from date of accident)	70% of UCR	80% of UCR	90% of UCR
Surgical appliance and prosthesis (covered for devices which are integral part of the surgical procedure when medically necessary)	Paid in full	Paid in full	Paid in full
Anesthesiologist (inpatient/outpatient)	30% of approved fees**	30% of approved fees**	30% of approved fees**
Surgeon fees (inpatient/outpatient) (multiple surgery guidelines apply)	Paid in full	Paid in full	Paid in full
Assistant surgeon fees (inpatient/outpatient when medically necessary and pre-authorized)	20% of approved fees**	20% of approved fees**	20% of approved fees**
Diabetic equipment and supplies	Paid in full	Paid in full	Paid in full
Home health care **Pre-authorization required**	Paid in full 15 day limit per Benefit Period	Paid in full 30 day limit per Benefit Period	Paid in full 45 day limit per Benefit Period
Organ transplant **Pre-authorization required** (subject to six (6) month waiting period)	Paid in full Up to $150,000 Lifetime	Paid in full Up to $200,000 Lifetime	Paid in full Up to $250,000 Lifetime
Outpatient renal failure dialysis	Paid in full $10,000 limit per Benefit Period	Paid in full $15,000 limit per Benefit Period	Paid in full $25,000 limit per Benefit Period

** Approved fees means the amount approved to be paid by insurance company to the principal surgeon, after deductible and coinsurance

OneWorld
Schedule of Benefits *(Outside USA)*

WELLNESS AND OUTPATIENT CARE

	Silver	Gold	Platinum
Inpatient psychiatric **Pre-authorization required** (subject to 10 month waiting period)	70% of UCR Limited to 10 days per Benefit Period	80% of UCR Limited to 15 days per Benefit Period	90% of UCR Limited to 25 days per Benefit Period
Outpatient psychiatric consultation (subject to 10 month waiting period)	70% of UCR Limited to 10 visits per Benefit Period	80% of UCR Limited to 15 visits per Benefit Period	90% of UCR Limited to 25 visits per Benefit Period
Primary care consulation	70% of UCR Limited to 30 visits per Benefit Period	80% of UCR Limited to 45 visits per Benefit Period	90% of UCR Limited to 50 visits per Benefit Period
Specialist consulation	70% of UCR Limited to 30 visits per Benefit Period	80% of UCR Limited to 45 visits per Benefit Period	90% of UCR Limited to 50 visits per Benefit Period
Chiropractic services	70% of UCR Limited to 5 sessions per Benefit Period up to $80 per session	80% of UCR Limited to 5 sessions per Benefit Period up to $90 per session	90% of UCR Limited to 10 sessions per Benefit Period up to $90 per session
Podiatry	70% of UCR Limited to $500 per Benefit Period	80% of UCR Limited to $600 per Benefit Period	90% of UCR Limited to $1,000 per Benefit Period
Durable medical equipment	70% of UCR Limited to $900 per Benefit Period	80% of UCR Limited to $1,000 per Benefit Period	90% of UCR Limited to $1,500 per Benefit Period
Outpatient therapeutic services - rehabilitation: physical, occupational, speech, pulmonary & cardiac therapy (treatment plan must be provided)	70% of UCR Limited to 15 sessions per therapy type per Benefit Period	80% of UCR Limited to 20 sessions per therapy type per Benefit Period	90% of UCR Limited to 25 sessions per therapy type per Benefit Period
Injections/allergy treatment	70% of UCR	80% of UCR	Paid in full
Basic diagnostic services (laboratory tests, x-rays, ultrasounds, EKG)	Paid in full	Paid in full	Paid in full
Advanced diagnostic services/imaging **Pre-authorization required** (including but not limited to: MRI, CT scans, Pet scans, MRA, nuclear imaging)	70% of UCR	80% of UCR	90% of UCR
Routine physical examinations (subject to 10 month waiting period)			
Adult female (office visit, routine physical examination, routine lab work, urinalysis, routine mammogram, papanicolaou (PAP) screening, colonoscopy based on family medical history)	Paid in full Limited to $250 per Benefit Period	Paid in full Limited to $300 per Benefit Period	Paid in full Limited to $500 per Benefit Period
Adult male (office visit, routine physical examination, routine lab work, urinalysis, PSA screening test, colonoscopy based on family medical history)	Paid in full Limited to $250 per Benefit Period	Paid in full Limited to $300 per Benefit Period	Paid in full Limited to $500 per Benefit Period
Children (routine physical examination, health history, development assesment, physical examination, age related diagnostic tests and immunizations in accordance with CDC recommendation for age)	Paid in full Limited to $250 per Benefit Period	Paid in full Limited to $300 per Benefit Period	Paid in full Limited to $500 per Benefit Period

NOTE
Maternity benefits are not automatically included in this Policy and are only available to the Insured Person upon the payment of an additional Premium for the purchase of the maternity rider.

OneWorld
Schedule of Benefits *(Outside USA)*

	Silver	Gold	Platinum
PRESCRIPTION DRUGS			
Tier 1 Preferred Generic	Paid in full	Paid in full	Paid in full
Tier 2 Preferred Generic Brand Name	70%*	80%*	90%*
Tier 3 Non Preferred Brand	70%*	80%*	90%*
Tier 4 Specialty Medication	70%*	80%*	90%*
	*Up to $7,000 limit per Benefit Period		
EMERGENCY AND URGENT CARE			
Emergency ground ambulance *(limited to one way trip)*	70% of UCR	80% of UCR	90% of UCR
Emergency medical services/emergency room *(if admitted to hospital, inpatient copayment would apply in lieu of emergency room copayment)*	70% of UCR	80% of UCR	90% of UCR
Urgent care facility	70% of UCR	80% of UCR	90% of UCR
Emergency dental treatment *(due to accident or injury to sound natural teeth and treated within 24 hours of the the event)*	Paid in full Limited to $600 per Benefit Period	Paid in full Limited to $700 per Benefit Period	Paid in full Limited to $1,000 per Benefit Period
EVACUATION & REPATRIATION			
Emergency medical evacuation **Pre-authorization required** Transfer to the nearest medical facility if the treatment needed is not available locally.	Paid in full up to $15,000 (Limit per covered person, per Benefit Period)	Paid in full up to $20,000 (Limit per covered person, per Benefit Period)	Paid in full up to $25,000 (Limit per covered person, per Benefit Period)
Medical repatriation **Pre-authorization required** Members can return to their country of origin to be treated as long as they are physically and medically stable.	Cost of transportation (economy-class flight) $15,000 Lifetime maximum		
Companion coverage/bedside visit (15 day limit per Benefit Period)	Transportation (economy-class flight), Hotel stay ($75 per day limit), Economy car rental ($30 per day limit), Daily meal allowance ($25)		
Repatriation of mortal remains **Pre-authorization required**	Paid in full $5,000 Maximum Lifetime	Paid in full $10,000 Maximum Lifetime	Paid in full $15,000 Maximum Lifetime

Optional Benefits: Maternity, Dental and Vision (Page 13)

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OneWorld
Schedule of Benefits

Maternity
(Optional)

Subject to 10 month waiting period.

	Worldwide	USA					
	Silver, Gold, Platinum	*Silver*		*Gold*		*Platinum*	
		In-Network	Out-of-Network	**In-Network**	Out-of-Network	**In-Network**	Out-of-Network
Maternity global period coverage	Paid in full up to $9,500	*70% up to $9,500*	*50% up to $9,500*	*80% up to $9,500*	*50% up to $9,500*	*90% up to $9,500*	*50% up to $9,500*
Complications of pregnancy	Paid in full up to $75,000	*70% up to $75,000*	*50% up to $75,000*	*80% up to $75,000*	*50% up to $75,000*	*90% up to $75,000*	*50% up to $75,000*
Newborn infant care	Paid in full up to $100,000	*70% up to $100,000*	*50% up to $100,000*	*80% up to $100,000*	*50% up to $100,000*	*90% up to $100,000*	*50% up to $100,000*
Congenital / Hereditary	Paid in full up to $250,000	*70% up to $250,000*	*50% up to $250,000*	*80% up to $250,000*	*50% up to $250,000*	*90% up to $250,000*	*50% up to $250,000*

VISION AND DENTAL COVERAGE
(Optional)

Dental Treatment *(Optional Coverage)*

Maximum Benefit	$3,500 per Policy Year		
Deductible	$100 Lifetime		
Preventive *Exams and cleanings (2 per year)*	Paid in full *no deductible applies*		
	First Year	*Second Year*	*Third Year*
Basic (Routine)	65%	80%	90%
Major Restorative	25%	50%	65%
Orthodontic Treatment *Covered for children under the age of 19. $1,200 lifetime maximum per child, $600 Annual Limit.*	10%	25%	50%

Vision Care *(Optional Coverage)*

(Available after member has been covered for 6 months)

Routine Vision Exam *One vision exam per year. Includes any fees for contact lense fi tings.*	$75 $10 copay
Frames *Limited to one per benefit period*	Paid in full up to $200
Lenses *(Single vision, bifocal, trifocal)* *Limited to one every 24 months.*	Paid in full up to $225
Contact Lenses *In lieu of frames.*	Paid in full up to $100

Our vision is to promote health and wellbeing across the world by delivering outstanding products and exceptional service.

Our cultural diversity and strong insights on the health care industry make us well suited to work with expats from around the world.

WellAway Limited is a Bermuda-based business founded in 2015 by health care innovator Griselle Chernys.

Contact Us

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Bermuda

Keeping you well, while you're away.®

WellAway®