

KIMBER® STUDENT HEALTH INSURANCE

Affordable national health insurance
coverage for students.

KIMBER[®] STUDENT HEALTH INSURANCE

THE WORLD ELITE SERIES

Affordable national health insurance
coverage for students.

ABOUT KIMBER HEALTH

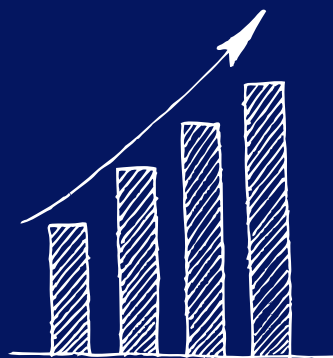
We strive to provide affordable or \$0 healthcare to international students nationwide.

With COVID-19 and high healthcare costs in the US, it is imperative for individuals and families coming to United States for their studies, travel, or immigration to receive adequate health coverage. At Kimber Health, we believe that having health coverage is a fundamental right. As such, we have dedicated ourselves to assisting all eligible individuals with attaining health coverage.

Kimber Health is the health insurance arm of New York Wealth Planning Group (NYWPG), a seasoned wealth planning firm based out of NYC.



Applicants from
100+ countries



No.1 largest agency for
United Healthcare's
Essential Plan **in 2023**

AFFORDABLE INSURANCE FOR NON NEW YORK RESIDENTS & NEW YORK RESIDENTS BELOW AGE 21

COVERAGE HIGHLIGHTS

- Meets minimum U.S. health insurance requirements for valid F-1 and M-1 visas in the USA / ages 17 to 45 / Non-US citizens
- Provider Access within the U.S.: as an exclusive member, you are covered when receiving care at In-Network Facilities with UnitedHealthcare Global
- Worldwide Coverage (excluding Home Country)
- Provider Access outside of the U.S.: An open-access network allows our members the flexibility to see a variety of doctors. Contact us and we will help you find the best doctor at the fairest price
- Insurance plans are offered by WellAway Limited and claims are administered by PayerFusion Holdings LLC
- Multi-lingual customer service • No medical exams, no paperwork
- Instant proof of coverage
- Coverage of immunizations and vaccines including COVID-19
- Coverage of pre-existing conditions for Students
- Medical evacuation and repatriation
- Prescription medication and contraceptives included
- Benefits are shown per person, per policy period
- Maximum amounts apply to certain benefits
- Pre-authorization is required for certain benefits. Refer to the terms and conditions of the policy.

CANCELLATION AND REFUND

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

- 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 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. WellAway will be entitled to retain an administrative fee in the amount of \$50 for any approved refund.



ACA COMPLIANT & UNLIMITED MAXIMUM WORLD ELITE INSURANCE

UNITED HEALTHCARE® PPO



WORLD ELITE 450

\$1500/YR

AGES 17-25

\$2088/YR \$3048/YR

AGES 26-27

AGES 28-29

Unlimited Maximum Limit
\$450 Deductible (In-Network)
\$5,000 Out-of-Pocket Maximum
80% Co-Insurance (In-Network)

WORLD ELITE 250

\$1740/YR

AGES 17-25

\$2232/YR \$3516/YR

AGES 26-27

AGES 28-29

Unlimited Maximum Limit
\$250 Deductible (In-Network)
\$5,500 Out-of-Pocket Maximum
80% Co-Insurance (In-Network)

WORLD ELITE PLUS

\$2136/YR

AGES 17-25

\$2460/YR \$4464/YR

AGES 26-27

AGES 28-29

Unlimited Maximum Limit
\$0 Deductible (In-Network)
\$5,000 Out-of-Pocket Maximum
100% Co-Insurance (In-Network)

For pricing on plans for individuals above the age of 30, please contact us.



WORLD ELITE 250

Unlimited MAXIMUM LIMIT

\$1740/YR(AGES 17-25)

\$2232/YR(AGES 26-27)

\$3516/YR(AGES 28-29)

WellAway World Elite International Student 250 Summary of Benefits

The Summary of Benefits will tell you about certain coverages and features of this 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 questions about your coverage, contact a ConciergeCare Counselor: +1-855-773-7810, International +1-786-453-4008 (collect) or e-mail: Conciergecare@payerfusion.com.

Important Information

- Student Health Center:** *All Cost Share amounts will be waived and Prior Coverage Authorization will not be required for any Services rendered at the Student Health Center.* If your educational institution provides a Student Health Center, visit the Student Health Center for all your medical services, treatments, and procedures, when available. If you do not utilize the Services which are 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 In-Network 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 Copayment when you use an emergency room (waived if admitted). *If you use an emergency room in the Hospital for a non-emergency service it 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.

Pre-Attendance University Requirements

Immunizations	Your plan pays 100% if not covered by your Student Health Fee (must be obtained at the Student Health Center or an In-Network pharmacy)
TB Testing	Your plan pays 100% if not covered by your Student Health Fee (Policyholder only and must be performed in an In-Network independent free-standing laboratory or the Student Health Center)

Limit & Cost Sharing

	In-Network	Out-of-Network	Worldwide
Annual limit	Unlimited	Unlimited	\$1,000,000
Deductible	\$250	\$500	\$250
Coinsurance (WellAway cost share)	80%	60%	100%
Out-of-pocket maximum	\$5,500	\$5,500	\$0
Student Health Center	Services at the Student Health Center are 100% covered		

Wellness Care

Adult Wellness Care Periodic routine health exams, routine gynecological exams, immunizations and related preventive services such as prostate specific antigen (PSA), routine mammograms, pap smears and colonoscopies for colorectal cancer screenings (please refer to benefit description for Preventive Services in this Policy). 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%	Deductible then your plan pays 60% Coinsurance	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%	Deductible then your plan pays 60% Coinsurance	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%	Deductible then your plan pays 60% Coinsurance	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%	Deductible then your plan pays 60% Coinsurance	Your plan pays 100%

Services that Require Hospitalization

	In-Network	Out-of-Network	Worldwide
Hospitalization*	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then 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). If you use an emergency room in the Hospital for a non-emergency service, the Services will not be covered.	Deductible and \$200 copayment per visit (waived if admitted)	Deductible and \$200 copayment per visit (waived if admitted)	Deductible then your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then your plan pays 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 when indicated by evidence-based medicine. Services provided by an anesthesiologist during a covered surgical procedure is a covered service. 	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 100%

* Prior Coverage Authorization required

Outpatient Care

In-Network

Out-of-Network

Worldwide

All ambulatory services must be performed in a free-standing independent ambulatory facility. If ambulatory services are not performed in a free-standing independent facility a Site of Service Differential will apply. It is indicated that the services below be performed in an In-Network Physician's office or in an In-Network free standing independent facility to maximize your benefit, reduce your costs and avoid Site of Service Differential costs.

Urgent care center	\$65 copayment then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Outpatient ambulatory surgical facility & surgical care* Free-standing only	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Surgeon Fees <ul style="list-style-type: none"> Some complex medical procedures may require an assistant surgeon or co-surgeon performing services when indicated by evidence-based medicine. Services provided by an anesthesiologist during a covered surgical procedure is a covered service. 	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 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 your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Routine X-rays and laboratory tests When not performed in a physician's office or in a free-standing non-hospital facility a Site of Service Differential cost will apply.	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Advanced diagnostic and interventional radiology services* When not performed in a free-standing non-hospital facility a Site of Service Differential cost will apply.	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
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 60% Coinsurance	Deductible then your plan pays 100%
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 60% Coinsurance	Deductible then your plan pays 100%
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	Deductible then your plan pays 60% Coinsurance (limited to 40 visits)	Deductible then your plan pays 100%

* Prior Coverage Authorization required

Outpatient Care

In-Network

Out-of-Network

Worldwide

All ambulatory services must be performed in a free-standing independent ambulatory facility. If ambulatory services are not performed in a free-standing independent facility a Site of Service Differential will apply. It is indicated that the services below be performed in an In-Network Physician's office or in an In-Network free standing independent facility to maximize your benefit, reduce your costs and avoid Site of Service Differential costs.

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)	Deductible then your plan pays 60% Coinsurance (limited to combined 15 visits)	Deductible then your plan pays 100% (limited to combined 15 visits)
Alternative medicine (combined benefit limits) Acupuncture, homeopathy, Chinese Medicine	\$30 copayment (limited to combined 15 visits)	Not covered	Deductible then your plan pays 100% (limited to combined 15 visits)
Behavioral health services* (outpatient facility for mental health & substance use disorder services) Prior Coverage Authorization not required for services provided at the Student Health Center.	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then your plan pays 100%

Physician Services

Cost Share amounts are waived at Student Health Center.

Telemedicine consultations (in the United States for illnesses of cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	\$10 copayment Limited to 12 visits	Not covered	Not available
Physician E-Visits (E-visits are available for established patients and should not exceed 1 visit in a 7 day period. E-Visits are limited to 1 per day per Physician and must be legally authorized in your state of residence)	\$30 copayment	Deductible then your plan pays 60% Coinsurance	Not available
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 your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Specialist consultation	\$30 copayment	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Behavioral health (includes office visit/e-visit with a physician, psychologist or mental health professional, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy)	\$30 copayment	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%
Allergy testing & treatment (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	\$30 copayment	Deductible then your plan pays 60% Coinsurance	Deductible then your plan pays 100%

* Prior Coverage Authorization required

Maternity Care

	In-Network	Out-of-Network	Worldwide
Prenatal and postnatal physician consultations	Paid in Full	Deductible then your plan pays 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then your plan pays 100%
Birth center	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then your plan pays 100%

Other Services

Skilled nursing facility*	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then 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 60% Coinsurance	Deductible then your plan pays 100%

* Prior Coverage Authorization required

Prescription Drugs

	EHIM In-Network Pharmacy	Out-of-Network	Worldwide
Preventive	100%	Not covered	Deductible then your plan pays 100%
Generic	\$5 copayment	\$5 copayment then your plan pays 60% coinsurance	Deductible then your plan pays 100%
Brand	\$50 copayment	\$50 copayment then your plan pays 60% coinsurance	Deductible then your plan pays 100%
Non-preferred brands	\$75 copayment	\$75 copayment then your plan pays 60% coinsurance	Deductible then your plan pays 100%
Specialty	\$90 copayment	\$90 copayment then your plan pays 60% coinsurance	Deductible then your plan pays 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

* Prior Coverage Authorization required



This material is for informational purposes only and is subject to change. If you decide to purchase a Kimber Health/WellAway product, you will be provided with a member package that contains a complete description of the benefits, conditions, limitations and exclusions of coverage. Products and services may not be available in all jurisdictions and are expressly excluded where prohibited by applicable law.